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RESEARCH ARTICLE

Moving Organizational Culture from Volume to Value: A Qualitative Analysis of Private Sector Accountable Care Organization Development

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Objective. The concept of shifting from volume (i.e., billing for as many patients and services as possible) to value (i.e., reducing costs while improving quality) has been a key underpinning of the development of accountable care organizations (ACOs), yet the cultural change necessary to make this shift has been previously unexplored.

Data Sources/Study Setting. Primary data collected through site visits to four private sector ACOs.

Study Design. Cross-sectional, semi-structured interview study with analysis done at the ACO level to learn about ACO development.

Data Collection. One hundred and forty-eight interviews recorded and transcribed verbatim followed by rigorous qualitative analysis using a grounded theory approach.

Principal Findings. The importance of shifting organizational culture from volume to value was emphasized across sites and interviewees, particularly when defining an ACO; describing the shift in organizational focus to value; and discussing how to create value by emphasizing quality over volume. Value was viewed as more than cost–benefit, but rather encapsulated a paradigmatic cultural change in the way care is provided.

Conclusions. We found that moving from volume to value is central to the culture change required of an ACO. Our findings can inform future efforts that aim to create a more effective value-based health care system.

Key Words. Accountable care organizations, population health management, managed care organizations, health reform, qualitative, value-based care

Across the health care landscape in the United States, momentum is shifting away from volume-based care and building toward value-based care—most often interpreted as a function of reducing cost while simultaneously improving quality (Shortell and Casalino 2008; Devers and Berenson 2009; Porter

2009). This shift toward value is driven by several national policy initiatives, such as Value-Based Purchasing, bundled payments, patient-centered medical homes (PCMHs), Comprehensive Primary Care Plus (CPC+), the Merit-based Incentive Payment System (MIPS), and the Medicare Access and CHIP (Children's Health Insurance Program) Reauthorization Act of 2015 (MACRA) (Centers for Medicare & Medicaid Services 2016a). These policies have spurred a significant health care delivery reform, yet substantial progress in achieving the triple aim of better quality, lower cost, and improved population health remains elusive (Keehan et al. 2017).

Accountable care organizations (ACOs) serve as a prime example of the difficulty in creating significant change. ACOs have proliferated, and over 900 Medicare, Medicaid, and private sector ACOs now cover over 32 million lives, making them one of the largest efforts to reshape delivery systems (Muhlestein, Saunders, and McClellan 2017). However, evidence remains mixed about the success of this strategy in delivering higher value care (McWilliams et al. 2015a, 2015b, 2016). For example, while Medicare's Pioneer ACOs have shown limited success in improving quality and lowering costs, Medicare Shared Saving Program (MSSP) ACOs have only been successful at improving quality (Centers for Medicare & Medicaid Services 2016b). The evidence on private sector ACOs is less clear, but a recent comparison to the Medicare ACOs shows that they are more successful with cost and quality improvements (Lewis et al. 2014; Peiris et al. 2016).

For private sector ACOs, recent literature highlights some of the challenges ACOs have experienced in improving quality and lowering costs, including implementation issues such as staff with sufficient training in team-based care (McAlearney, Hilligoss, and Song 2017; Walker et al. 2017), patient engagement issues (Shortell et al. 2015; Hilligoss, McAlearney, and Song 2017), coordination (Kreindler et al. 2012; Larson et al. 2012; Rundall et al. 2016), and governance challenges (Hilligoss, Song, and McAlearney 2016).

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Health information technology (HIT) issues are also noted as affecting both public and private sector ACOs (Walker, Mora, and McAlearney 2016; Wu et al. 2016). Overcoming these barriers is critical for an ACO to be successful; yet examining each issue in isolation may miss the broad cultural change being pursued as organizations implement the ACO model. Consideration in the academic literature of the overarching transformation necessary for the ACO model generally focuses on operational change management, with culture change as a side note (Burns and Pauly 2012; Larson et al. 2012). One recent exception is a study by Phipps-Taylor and Shortell (2016) that highlights nonfinancial elements of physician culture as central to strategic change toward ACO development.

During the process of a comprehensive study of private sector ACO development and impact (McAlearney, Hilligoss, and Song 2017), the issue of how ACOs conceptualize and operationalize the shift to value-based care emerged across sites and interviews. Given that the interview guides did not ask questions about this issue, we conducted additional analyses of study data to investigate this unprompted discussion of cultural change and examine in detail how private sector ACOs interpret and manifest value-based care. This paper thus aims to move beyond the current research that explains how ACOs can succeed with operational changes and explores important considerations about the concomitant cultural changes necessary to be successful. The evidence we present will be useful for ACOs attempting to advance the new delivery model within their organizations.

Study Design and Methods

Site Selection

We purposively selected four ACOs for intensive study to learn about how ACOs are developing in the private sector. Instead of signing on to a single, defined Centers for Medicare and Medicaid Services (CMS)-backed product, such as the Medicare Pioneer or Shared Savings Programs, a private sector ACO has flexibility in developing the terms of accountable care contracts with commercial payers, Medicaid managed care plans, or Medicare Advantage plans, among others (Muhlestein 2015). Because the definition of an ACO or ACO contract in the private sector is not as well defined as a Medicare ACO, we identified key eligibility criteria that organizations in our study had to meet in order to be considered an ACO and participate in the study. The first was that the organization had to self-identify as a private sector ACO. Second, the

organization had to assume responsibility for both cost and quality of a defined population. Third, the contracts had to assume some level of downside financial risk, that is, penalties in addition to shared savings.

Study Sites

Our study ACOs differed along several dimensions: geography, organizational age, and populations served (pediatric vs. adult). Information about our study sites is included below. Additionally, a sister publication from the parent study includes a table with more details about each site (McAlearney, Hilligoss, and Song 2017).

New West Physicians, Golden, Colorado. New West Physicians, established in 1994, is a physician-owned primary care group practice and medical management company located outside Denver, with 16 locations in the metropolitan area. New West serves 15,000 Medicare Advantage patients through a full-risk capitated contract with a Medicare managed care plan, and additional populations are cared for under other pay-for-performance and fee-for-service arrangements.

AdvocateCare, Chicago, Illinois. AdvocateCare is the ACO launched in 2011 by Advocate Physician Partners as part of a contract with Blue Cross Blue Shield of Illinois, the state's largest health insurer. The ACO is associated with Advocate Health Care system—a large regional health system—and has global capitation arrangements with multiple commercial payers and serves a patient panel of 435,000 through commercial plans and 105,000 through Medicare Advantage.

Partners for Kids, Columbus, Ohio. Established in 1994, Partners for Kids (PFK) is the largest and oldest pediatric ACO. PFK is a not-for-profit Physician Hospital Organization, jointly owned by Nationwide Children's Hospital (NCH) and by the primary care physicians and specialists involved in the ACO. The ACO assumes full risk for 300,000 Medicaid-covered children through capitated arrangements with five Medicaid managed care plans.

Children's Mercy Pediatric Care Network, Kansas City, Missouri. The Children's Mercy Pediatric Care Network (PCN), launched in 2012, is an integrated delivery network comprised of Children's Mercy Hospitals and Clinics, employed physicians, community pediatricians, and other health care

providers in the greater Kansas City area. Currently the ACO is focused entirely on a Medicaid-eligible population, coordinating the medical care of 110,000 Medicaid-covered pediatric patients.

Data Collection

Data were collected from each ACO through a combination of key informant interviews, document collection, and review. Semi-structured key informant interviews were conducted by one to three investigators during two rounds of 2-day site visits to each of the study ACOs during the spring/summer of 2013 and then the following spring/summer of 2014.

Prior to site visits, our research team developed an a priori list of organizational roles/functions for which we wanted to interview key informants. We then worked with a contact person at each ACO to identify the most appropriate individuals to interview. In some cases, we interviewed additional informants based on our contact person's recommendations and/or information obtained through the site visit process in order to ensure we obtained a comprehensive understanding of the ACO. Across the sites and visits we interviewed a total of 89 individual informants, 51 administrative (i.e., executives —CEO, COO, CFO, CMO—and managers in the areas of strategic planning, operations, quality/performance improvement, business development, and contracting), and 38 clinical (i.e., practicing physicians and nurses) (see Table 1). No informant approached for this study refused to participate. This study was approved by the Institutional Review Board of The Ohio State University.

We used two standard guides (available upon request) to conduct interviews to ensure consistency in data collection. One version was tailored for administrative interviewees and another for clinical interviewees. As our original study was designed to improve understanding of private sector ACO development, the interview guide domains covered history, implementation,

Table 1: Key Informants Interviewed, by Type and Study Site

	New West Physicians (Golden, CO)	*Advocate Care (Chicago, IL)*	*Partners for Kids (Columbus, OH)*	*Children's Mercy Pediatric Care Network (Kansas City, MO)*
Administrators	11	14	14	12
Clinicians	10	13	7	8
Totals	21	27	21	20

consumer involvement, population impact, quality and cost measures, and challenges and facilitators of ACO development. There were no specific questions about the shift from volume to value. Interviews lasted 30–60 minutes, depending on the key informant interviewed. The vast majority of our interviews were conducted in person during site visits. All interviews were recorded and transcribed verbatim to permit rigorous data analyses.

Data Analysis

Throughout the analysis process, we used an iterative approach that involved reading interview transcripts, reviewing the literature, and discussing findings among investigators as the study progressed. With the original study data, a coding team, established by the lead investigator, first created a preliminary coding dictionary defining broad categories of findings from the transcripts. We further classified data in these broad codes into themes, following Constas' constant comparison methods (Constas 1992), conducting a second round of coding of all transcripts (Miles and Huberman 1994). Coders met periodically throughout the coding process to ensure consistency and review any new codes or themes that emerged, consistent with a grounded theory approach (Glaser and Strauss 1967). We used the Atlas.ti software program to support the coding process.

Although it was neither a question domain, nor a focus of the study, the concept of shifting the organization's culture from volume to value was mentioned across sites and interviewees. The persistence of this emergent theme led to subsequent analyses of the specific codes of "culture," "accountability," and "defining success," as well as analysis of the concept of "volume to value" as described by interviewees.

STUDY FINDINGS

Shifting from Volume to Value

For the ACOs we studied, the importance of shifting from volume to value was emphasized across sites and interviewees, and this was evident in three areas in particular: (1) *using the concept of value to define an ACO*; (2) *describing the need to shift organizational focus from volume to value;* and (3) *noting that creating value requires an emphasis on quality and not volume.* Below we describe each of these areas of emphasis further, and we provide additional evidence showing the importance of this volume to value shift in Table 2.

First, a variety of interviewees defined an ACO in the context of delivering value. As one informant explained, "Well, it's basically an organization that really is focused on improving the quality of care of a population while providing increased value at the lowest possible cost, and having the highest level of satisfaction amongst its members. It's kind of like the Triple Aim all over again." Another interviewee described the ACO as "a real solution here on how we can improve value and reduce the cost curve and improve better outcomes."

Second, a commonly mentioned goal for each of these ACOs involved an attempt to shift organizational focus from volume to value. As an interviewee at one of the pediatric ACOs explained, "So, it's changing that behavior to make everybody accountable. And . . . that takes moving the ship, which is already what we've been doing with the PCN [primary care network]. You know, getting the whole hospital system to this value, value-based way of thinking." Another interviewee at an adult ACO explained, "We're on a journey of volume to value, so that this year, we're 95 percent volume, 5 percent value, and the value measures are, in part, health outcomes . . . . So it's enough that people are really paying attention . . . and then we'll be moving to 15 percent next year . . . ."

Third, interviewees noted that creating value requires an emphasis on quality and efficiency, with volume only relevant to the extent that it affects cost. As one interviewee summarized, "It really isn't getting more patients within our [ACO] walls for financial purposes, but it's really for quality purposes. We truly believe, and are advocates of this, that less-fragmented care, more coordinated care, with better transitions, better hand-offs, is better care. And when we can do it at a lower cost. So it's really all about that paradigm: higher quality at a lower cost, and that's what I think an ACO is really striving to achieve." Similarly, another interviewee noted that the goal was "to provide the most evidence-based care in kind of the most efficient fashion in a way that provides kind of seamless care to patients and doing all at better outcomes and lower cost."

Mechanisms Enabling the Shift to Value

Across the ACOs studied, explaining how the goal of value is being achieved was an important topic of many interviews. We identified three themes central to these discussions and propose these are important mechanisms ACOs use to shift the culture from volume to value: (1) *being accountable/taking responsibility for all attributed patients*; (2) *physicians focusing*

Table 2: Evidence of the Importance of the Shift from Volume to Value

	Representative Comments
Using the concept of value to define an ACO	• "An ACO is an effort to have physicians and hospitals come together to improve care for the community in a way that is value-driven." • "I would define an ACO as basically an organization that looks at quality of care and quality of care measures and takes that into account. And takes the risk for physicians who are members and signs contracts and payments based on those measures as far as the quality of care measures as opposed to volume of care." • "An organization that is taking accountability for, according to the Triple Aim, the total cost of care of a population, the quality, and the experience."
Describing the need to shift organizational focus from volume to value	• "We need to move, move to value-based payments, and not sort of the existing fee-for-service models." • "From a care delivery perspective it's about changing care delivery. It's about taking the system and really changing its focus truly to not just building capacity for increased volume and a specialty center, but doing population health community-based care, better collaboration with primary care." • "We needed to find folks that we just feel like frankly get it—understand transition from volume to value and sort of inherently want to do that because it's a better way to deliver care."
Noting that creating value requires an emphasis on quality and not volume	• "I think with accountable care it's quality. It's the quality that we—you don't historically, hadn't had. There's information that's being made available to providers, to the patients. I think it's more everyone's engaged in it and we're getting away from this whole fee-for-service, the more you do the more you get paid." • "The screening and the preventive care are a big part of our quality and making sure we provide that level of quality for all of our patients." • "It's promoting quality, improving the patient experience, and reducing cost and waste."

on population health management for their patient panel; and (3) *engaging physicians in the ACO*. We next describe these themes, with additional supporting comments provided in Table 3.

First, the shift to value was often described as the organization and individual physicians taking risk and responsibility for patients and their

attributed patient population, frequently referred to as "accountability." As one ACO executive explained, "we're accountable for these patients, and that is why we're here. So we're kind of having to turn that switch on, and the medical system and the provider is too, you know. That's our job! We're accountable for them. That's what this is all about." At another ACO an interviewee explained with a specific example:

> In the old world, the patient shows up in the emergency room because they can't make it to the dialysis center because they don't have cab money. Right? And they get admitted. In the new world, we pay for the cab fare, arrange for ongoing transportation. So right care, dialysis center, right? 'Cause they are familiar with that patient's ongoing needs. Right time schedule, you know, right place: . . . outpatient versus inpatient. You know, it's all, but only, the necessary care to drive the best health outcomes.

The next mechanism enabling a shift to value involved focusing on population health management (PHM) for a patient panel. One interviewee explained, "it's population management, in which case we're accountable both for the quality of the care and at least controlling expense." A practicing physician at a different ACO similarly noted, "Now that we have accountability for the population, there's much more incentive in terms of this true lifelong relationship. We are managing the overall health and wellness of individuals." In the context of these comments, physicians framed accountability as being accountable for the overall health of the "patient panel" attributed specifically to that physician and/or his/her clinic location. PHM efforts directed toward the patient panel included wellness registries, gaps in care analyses, and care coordination outreach (see (Hefner et al. 2016) for a detailed description of these PHM efforts).

Finally, each of the ACOs studied noted specific efforts to engage physicians as a critical part of their mission to shift to a focus on value. As one interviewee noted of their ACO, "physician engagement's going to be the key to being successful, because they control all the costs." An interviewee at another ACO explained that they were heavily involved in "evangelizing" to the physician community to get them thinking about population health and broader processes, sharing fundamental principles of how professionals need to think differently, and making the transition from volume to value. As one interviewee summarized, "They [the physicians] want to do the right thing by the patient, and if we can share with them how we're helping them to do that, that just aligns them stronger to the ACO."

Table 3: Mechanisms Enabling the Cultural Shift from Volume to Value

	Representative Comment
Being accountable for attributed patients	• "So, the accountability, our assuming the risk and having the confidence that based on our past experience we know we're going to do the right things to get the patients the care they need, and that will produce our results." • "You're responsible for that patient, not just to make sure they're getting the care they need. I think there needs to be a much different level of understanding and responsibility there." • "They now know who their patients are, and they can actually track them and know where they went, and know what happened to them. I think that's the key to the whole thing, our success, is it's all about patient ownership."
Focusing on population health management for a patient panel	• "It's about taking the system and really changing its focus truly to not just building capacity for increased volume and a specialty center, but doing population health, community-based care, better collaboration with primary care." • ". . . children in our region. We can keep them healthier, we can align that incentive, the financial incentive, with the mission of the hospital. Keep them healthy, we earn more money, or we spend less thereby keeping more." • ". . . responsible for the total care of a population. Total health care of a population. And the tactics might vary, but for us, it's promoting quality, improving the patient experience, and reducing cost and waste."
Engaging physicians in the ACO	• "If we share appropriately with the physicians and they're engaged, they will change the process themselves depending on how they want to improve their practice." • ". . . engages the provider to manage patient health versus an individual patient is coming to the door and managing their condition at the time . . . see their population as a whole and understand various checks, both of those checks need to be done if they have a certain disease state. . . . Whatever shots need to be done, or tests need to be done, things like that." • "Our value proposition to the community primary care doctor is essentially we realize you're under-resourced, there are a lot of things you would do if you could—you're either not paid to do or not resourced to do. We want to serve as an aggregator of resources to do that and deploy those so patient outreach and patient-served medical home and registries and all those things, data exchange, web-hosting, web content development—all of those things we are doing and intend to do."

Challenges and Solutions in Shifting from Volume to Value

In discussing the shift from volume to value, our interviewees also raised issues that were creating challenges for the ACO model: (1) *working without a closed attribution model*; (2) *reliance on retrospective review;* and (3) *patients' lack of understanding about the ACO.* Below we explain each of these issues in greater detail, and we provide additional evidence about these challenges and potential solutions ACOs are pursuing in Table 4.

With respect to attribution, interviewees complained that accountability was a challenge because patients had complete "freedom of choice" about where to receive their care. As one executive explained,

> People buying insurance need to have a choice. That they're joining a closed panel like an ACO. We believe they need to have a choice, not just be attributed by government, and now being attributed by their commercial carrier. Because they come into the exam room, the physician can be their advocate to guide them through the scary system and give them to our preferred specialist panel and everything. But they don't have to come to us, because they're not selecting a primary care in their products.

A manager at a different ACO similarly summarized this difference from managed care organizations (MCOs) of the 1990s explaining, "the expectation is different. You know, it's not just a gatekeeper to find out where you're sending someone. It's a gatekeeper on making sure they're getting all of the care, the kids are getting the care that they need to be healthy in their communities." Interestingly, interdisciplinary collaboration and coordination across the care continuum appears to be emerging as a solution to the attribution problem for many ACOs. As one administrator (Director of Medical Operations and a physician) explained, "Your [physicians] really can't be silo-ed in that kind of environment. . .. You're sort of forced to really collaborate and make sure. You're looking at the patient from physician practice, hospital, SNF [skilled nursing facility], transition of care, home health. We are working much more closely with any of those avenues than we ever have before, and I think that those avenues are looking at each other and saying 'Okay, what is it that is affecting the health of the patient, and how can we keep the patient as healthy as possible?'"

The issue of retrospective review was a second common challenge noted. As one interviewee explained, "the claims data sometimes are 2 or 3 months delayed. So that makes it a little tough. If you make a change, you're

Table 4: Challenges and Possible Solutions in Shifting Culture from Volume to Value

Challenge	*Representative Comment*	*Possible Solution*	*Representative Comment*
Working with an attribution model	• "There's an attribution problem from the MCOs to us, and there's an attribution problem from us to the primary care physicians. If we're paying them cap [capitation], we've got to know who's in the pot. [. . .] It's a huge issue for us, but it's not unique to us." • "The challenges then become defining who your patients are versus who your competitors' patients are. And that's where the rules of patient attribution become very important, but then they're also very difficult to administer. Because what the insurance companies like are the unattributed patients, because that's where their profits are." • "An example would be—we've had patients that are attributed to us that have literally gone to two different primary care providers on the same day. All right? Who's attributable—whose patient is that now? I mean, there's a conundrum. They obviously didn't like what the first doctor told them, so they went to a second one. And you don't know if you were the first or the second one."	More interdisciplinary collaboration across the care continuum	• ". . . working with the specialty doctors and the inpatient setting, so they're becoming a little bit more cognizant of needing to really just collaborate, and not just focus specifically on their one little area, but trying to address as many of the concerns for the patient as is reasonable and possible." • "And when you start talking with doctors about clinical things and the right thing to do with their patients, that's what makes sense to them. That's what really hooks them in and grabs them in because they went into medicine for that reason, right?" • "Well it's based upon . . . a partnership amongst care providers in a geographic area—physicians, hospitals, a network, if you will, who come together to achieve the triple aim." • ". . . recognizing that we can't be silo-ed. If we're going to do this, we cannot all be in our own little world and worried about our own little world. We really have to extend ourselves out to the other areas to make sure that we have that safety net for the patient."

continued

Table 4. *Continued*

Challenge	*Representative Comment*	*Possible Solution*	*Representative Comment*
Reliance on retrospective review	• "We have to caveat with everybody. It's claims data. It's not perfect. It's not 100%." • "It can be frustrating when they see things, 'Oh, this person went to the ER 4 months ago.' They might have gone to another ER seven more times, you know?" • "So if you don't have that data though, how are you going to figure out how to take the risk, and what the risk should be?" • "If they're going to refer themselves, there's not much we can do, because we never know until after the fact."	Availability of near real-time quality and performance data	• "Once the user gets access, to whether it's physician, an office manager, or whatever, they can see all of their patients, they can see how they're doing on their quality measures, which of course can have implications for their set ups. They can see their patients that have gaps in care. They can risk-identify the population, they can run registries of patients with certain conditions, or condition with gaps in care, and send letters to those folks that have gaps in care." • "We had one physician tell us that, as a result of our program, his patients in his practice are getting better care. You know, because of the way that we measure diabetes. People were getting underneath the, you know, underneath his radar screen of not coming in and getting their diabetes checked. Not getting their eye exams, not getting their foot exams. And because [the ACO] measures those patients in his practice now, even the ones that are not measured are getting better care." • "We have to continually reinforce with the medical assistants that, you know, you missed it on this patient, you missed it on that patient, and just keep giving it back to them with the hopes that ultimately, it will improve."

continued

Table 4. *Continued*

Challenge	*Representative Comment*	*Possible Solution*	*Representative Comment*
Patients lack understanding about the ACO	• "We haven't been using the name 'ACO.'" • "They [the patients] won't know what the [ACO] is . . . that's not going to mean anything." • "It's not the [ACO] reaching out to these folks; it's their primary doctor reaching out."	Engaging and educating patients	• "I think we are very engaged as an organization in trying to really work with the patients, to bring them in, to be part of their care, and to really, to guide them through this." • ". . . providing the resources, education, and support."

not sure whether it made a difference or not." This delay also created problems when ACOs tried to proactively manage care, as one medical director explained, "Now the problem is that it's claims data, so it's at least thirty days old, sometimes sixty. And it's really hard to do any kind of effective ED [emergency department] outreach with sixty day-old claims data." The potential solution to the challenge of retrospective review that we saw emerging was increasing the ACOs' focus on guidelines and quality metrics. For instance, by creating reports with metrics that could be obtained in near real time, ACOs were reportedly improving their ability to manage the health of their populations. One interviewee explained their approach, "Within our EMR [electronic medical record], we've built some work in a work list that really is key in not only identifying the patient who is at high risk, moderate risk, and low risk for readmission, and then interventions that happen with that to make sure that we have a solid discharge plan for the patient, and what we implement, and also our transitional handoffs to the next level."

A third notable challenge was patients' lack of understanding about the ACO model itself. Given the aforementioned issues with attribution, interviewees noted that patients did not typically understand that they were part of an ACO. As one manager explained, "it's very difficult when you don't know who that population is, and they don't know who you are." As a result, interviewees at each ACO explained how they had to initiate outreach efforts and focus on patient education in order to appropriately manage their patient populations. One physician described, "You need to be educating all of your patients now that if they're sick, go to the [ACO hospital] where I'm on staff, because then I get the reports from the emergency room and I know you've been in the ER. If you go to some other hospital, where I'm not on staff, I don't know that. So the time to educate is now, before they need to go to the emergency room." Specific examples of attempts to educate patients were provided by a manager of another ACO: "We directly contact the patient through our outreach programs; again, there's educational materials and so forth that we send out, and then also through the care management program, I think is probably the other big arm. Calling patients." While most interviewees discussed patient education efforts consisting of a one-way transfer of information about the ACO, interviewees also noted a desire to move to the next step in this process, engaging patients in their care and the health improvement work of the ACO. Making patients aware of the existence and role of the ACO may be the solution to the challenge of a lack of patient understanding, and a critical step on the pathway toward patient engagement.

DISCUSSION

The concept of a culture shift from volume to value has supported several health policy initiatives, including the development of ACOs, yet research to date has overlooked how ACOs interpret and translate this concept to support culture change. Rather, investigators have focused more on contractual, implementation, and performance issues. Similarly, in our larger parent study, we questioned ACOs about topics such as implementation, quality and cost metrics, and challenges and facilitators of ACO development. In response to these questions, interviewees in a variety of positions within the studied ACOs repeatedly discussed the process of shifting to value-based care. Thus, it became clear that this emergent issue required further analysis. The findings we have presented highlight how ACOs are construing the concept of value-based care and articulate how they are operationalizing this concept in order to support the culture change necessary to implement that ACO model.

In a recent article summarizing evidence on the success of ACOs, the authors conclude by stating that "perhaps the most salient problem is indeed persistent uncertainty about the ultimate objectives of delivery system reform and the best ways of achieving them" (Song and Fisher 2016). Based on our research, we purpose that this ultimate objective for ACOs is to shift organizational culture from volume to value. If the ultimate objective is in fact to shift from volume to value, culture change throughout the ACO is necessary to support the sustainability of the ACO model and other future delivery models rewarding value rather than volume. Moreover, conceptualizing the ultimate objective of the ACO as pushing the organizational culture toward value and away from volume rebalances the health care business model to be more patient-centered. Viewing the ACO narrowly as a new payment plan ignores the concurrent shift that benefits consumers and helps to ensure a sustainable competitive advantage for ACOs (Macfarlane 2014). This ultimate objective also ties together the individual goals that comprise value-based care, such as improving quality, lowering costs, and delivering better care to the attributed population.

This study adds to the current understanding of previously identified operational factors (i.e., accountability, population health management, and engaging physicians) (Hefner et al. 2016; Hilligoss, McAlearney, and Song 2017; Hilligoss, Song, and McAlearney 2017; Hilligoss, Song, and McAlearney 2016; Walker et al. 2017) relevant to ACO implementation by framing these factors as the mechanisms enabling the cultural shift to

value. Interestingly, though not asked specifically about this shift, it was repeatedly discussed by interviewees who held a variety of jobs and also across diverse ACO sites. Another recent publication analyzing physician behavior change within ACOs presents four motivational domains for change beyond financial incentives—mastery, social purpose, autonomy, and relatedness (Phipps-Taylor and Shortell 2016). Our findings suggest that the work of engaging physicians in the ACO and panel management are mechanisms that can facilitate physician behavior change by increasing motivation through identification with the ACO culture of value over volume.

The shift from volume to value is a cultural change that health care organizations are challenged to make to succeed in the current reimbursement climate. However, as evidence has shown across industries, culture change is extremely difficult (Schein 2010; Teal et al. 2012). Our research provides suggestions about how ACOs can address the challenges encountered related to culture change using approaches such as increasing collaboration, leveraging available data, and fostering patient engagement. While these solutions are among those highlighting key differences between ACOs and managed care organizations of the 1990s (Emanuel 2012), how to accommodate these differences in the new organizational model may be key to successful culture change.

Implications for Management and Policy

Amidst uncertainty and turmoil in health policies governing the structure of the health care delivery system, our findings suggest that the ACO model can support a cultural shift from volume to value. This shift reinforces the triple aim policy goals (Berwick, Nolan, and Whittington 2008). Importantly, the evidence that the ACO structure can in fact push organizations toward a culture of value-based care suggests that promoting the ACO payment model may be an effective policy approach to improve the health care delivery system.

Despite this promise, a particular challenge exists related to the culture shift in working with an attribution model where the patient is attributed to a specific provider and/or ACO that bears the "risk" for that patient, when the patient frequents a long list of providers that includes primary care physicians, specialty providers, ambulatory centers, and hospitals. A possible solution to this issue previously presented is a "soft lock-in" where ACO beneficiaries are educated about the ACO and make an informed choice to seek care within the

ACO (Devers and Berenson 2009). This choice could be a simple social contract, or a more complex system where the ACO offers financial incentives for beneficiaries. However, evidence regarding the success of this approach remains scant. Alternatively, interviewees across our diverse sites discussed the need for more interdisciplinary collaboration across the continuum of care as a viable solution that does not go as far as requiring patients to seek care within the ACO. We propose that this is a key to necessary culture change; a focus on value emerges from this collaboration and is not possible in a silo-ed care model.

Study Limitations

Our study should be interpreted in light of three important limitations. First, this study involved a small number of organizations. Our study was designed to obtain a deep understanding of ACO development in an understudied group of private sector ACOs, and our analysis permitted us to explore emergent themes in these organizations. Future work in the area of organizational culture change toward value can extend this study and validate our findings in larger samples. Specifically, we can compare how culture is changing in private and public sector ACOs, and potentially link this evolution to changes in care delivery and outcomes.

The second limitation pertains to the scope of our study. Specifically, while the issue of how ACOs shift from volume to value emerged as an intriguing area of inquiry, this topic was not the purpose of our original study. As a result, we were only able to investigate this issue among the private sector ACOs we studied rather than designing a comprehensive study to compare notions of volume to value in private versus public contracts. Nonetheless, given potential similarities in the "ultimate objective" between these two different groups and the pervasiveness of efforts to promote value-based care, we believe our findings are pertinent to public sector ACOs as well.

Third, our findings should be viewed in light of the changing landscape surrounding ACOs specifically, and value-based payments in general, since our data collection in 2013–2014. Given the time elapsed, mixed evidence regarding the success of value-based payment programs may have muted enthusiasm regarding the shift to a value-centric care delivery culture. However, both private and public sector ACOs continue to gain market share, and CMS has indicated that they will continue to support ACO development (Muhlestein, Saunders, and McClellan 2017). This growth may continue to

reassure ACOs regarding commitment to the operational and cultural changes required to augment their care delivery approach. As ACOs seek to manage the tensions between fee-for-service plans and value-based payment plans, focusing on culture change may help to encourage physician support (Ganguli and Ferris 2018). Future research should examine the iterative dynamic between culture change and the evolving policy environments surrounding both public and private sector ACOs.

Conclusion

As health policy uses a myriad of approaches to deliver value-based care, it remains of paramount importance to understand whether different approaches can fundamentally alter the paradigm through which care is delivered in the United States. These four private sector ACOs appear to have effectively incorporated the concept of value into their organizational culture, and the mechanisms described in this paper can be used to operationalize this approach in other organizations. Given uncertainty around health policy and the continued need to improve our health care system, engendering support for the transition from volume to value will likely be critical for future policy agendas that continue to pursue value-based care.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Appendix SA1: Author Matrix.