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## Guest Commentary



# No Longer a Unicorn: Improving Health Through Accountable Care Organizations

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As recently as 2012, accountable care organizations (ACOs) were often described as “mythical unicorn creatures.” We’ve come a long way in a few short years, thanks to the incentives included in the 2010 Affordable Care Act that encourage medical centers, clinics, and practitioners to band together and create these coordinated, integrated healthcare entities that may finally end the problematic fee-for-service payment model.

There were only 64 ACOs at the end of 2011, but by January 2015, their numbers had increased to 744, serving 23 million people—6.1% of the US population.<sup>1</sup> This upward trajectory is almost certain to accelerate as government-sponsored ACO models introduced in the last couple of years, such as the Medicare Share Savings programs, start to come online in greater numbers.

The Robert Wood Johnson Foundation has been supporting, watching, and learning from ACOs for several years now, deciphering what they mean for healthcare quality and value, for the patient experience, and for population health. We believe they have a key role to play in our vision of building a Culture of Health, one in which every person in America has access to quality, affordable care and the opportunity to live the healthiest life possible.

ACOs are designed to reduce waste, increase care coordination, and align incentives within healthcare systems—in other words, improve both quality of care and affordability. When ACOs succeed, they can improve the overall health of large groups of patients. But I see an even larger role for ACOs—they can be accountable not just for improving the health of their patients, but for improving the health of their entire community, by collaborating with local nonprofits and government entities to address such social determinants of health as housing, poverty, and unsafe neighborhoods.

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Some ACOs are already doing this, or are connecting to larger accountable health community initiatives, although it is still the early days for these projects. Several structural issues must be ironed out, chief among them the payment models. An ACO is a network of healthcare providers, which can include primary care physicians, specialists, hospitals, and clinics, that agrees to be responsible for the quality and cost of care for a group of patients; provider payments are based on how well the ACO meets cost and quality goals. Studies by Leavitt Partners<sup>1</sup> indicate that while most ACOs have realized quality improvements, cutting costs is more difficult.

Startup costs can be large as an ACO redesigns its practices, and recouping them a difficult challenge. And, as ACOs shift from the traditional fee-for-service payments, they must develop incentives that are strong enough to encourage providers to change behavior, but not so demanding that providers won't participate, all while ensuring that the ACO itself can provide quality care without losing money. “I always talk about co-evolution, in pay-

ment reform and in delivery system reform,” says Stephen M. Shortell, PhD, MPH, MBA, director of the Center for Healthcare Organizational and Innovation Research.

I would add a third reform—addressing the Triple Aim, a framework developed by the Institute of Healthcare Improvement (IHI) in 2008 that calls on health systems to simultaneously pursue 3 goals: improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of healthcare.

To achieve these 3 aims, the IHI posits that certain preconditions must exist, including the the existence of an organization that accepts responsibility for all 3 aims for an identified population by acting as a partner with individuals and families, managing population health, and integrating all aspects of the health system—in other words, the very definition of an ACO.

The safety net ACOs that have formed in at least 18 state Medicaid programs are particularly important in reaching the Triple Aims. At a “safety net hospital,” 30% or more of patients are enrolled in Medicaid. Not only are Medicaid patients reimbursed at a lower rate than privately insured patients, but they are often sicker than the general population, and have complex unmet social and economic needs that directly impact health. Consequently, safety net ACOs are leading the way in addressing the issues that can impact health once a patient exits from the hospital or clinic, back into the community.

Although safety net ACOs have been slower to form than those serving Medicare and commercial patients, their numbers are rapidly expanding. There are currently Medicaid ACOs in Arkansas, Colorado, Illinois, Iowa, Maine, New Jersey, Oregon, Utah, and Vermont, while 6 other states have announced emerging ACO-like or pilot programs—and they are beginning to make a difference.

Take Minneapolis-based Hennepin Health, which started enrolling patients in an accountable care model in 2012. It is now a leading example of a safety net ACO that recognizes how socioeconomic factors can impact health. By integrating screening and coordination strategies, Hennepin uses risk assessment data to identify patients’ social and economic needs, such as housing (fifty percent of Hennepin’s high-need patients are homeless). As a result, the hospital has been able to secure housing units and other county-provided resources for its patients most in need.

The strategy is working. Between 2012 and 2013, Hennepin’s emergency department visits decreased by 9.1%

and outpatient visits increased by 3.3%. An increased number of chronically ill patients also receive coordinated diabetes, heart disease, and asthma care. The resulting savings have been invested in bringing on additional nursing staff at a homeless shelter, an interim shelter for people who cannot be discharged from the hospital due to insecure housing, and the launch of a pilot psychiatric consultation service.

There isn’t just 1 model for success, however. Regional medical centers are instead figuring out what works best for them and their patient populations. On the west coast, the Oregon Alliance, established in 2012, is using a home health model as a cornerstone of 16 ACO-like efforts that it calls coordinated care organizations (CCOs).

Each CCO is given a lump sum to provide care in its region, and considerable latitude in determining how to allocate its resources. If a CCO determines that a patient is suffering from heat exhaustion, it might pay for an air conditioner. Health Share, Oregon’s largest CCO, is currently exploring how to provide housing services for eligible patients. And as part of its state ACO program, Oregon trains community health workers.

It’s not all that easy to make such drastic changes in care provision. Safety net ACOs and CCOs deal with many patients who have very complex psychological, medical, and social issues that are costly and complicated to address. In Oregon, they have yet to see a significant shift in costs.

Still, these ACOs are innovating, trying new ways to improve the health of the people and communities they serve. This is a big change, and it isn’t going to happen in a year or two. But Dr Martin Luther King taught us that “Change does not roll in on the wheels of inevitability.” If we want to reform health in America, we must commit to the long haul.

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