Building an Accountable Care Organization for All the Wrong Reasons

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I sometimes wonder if we started an accountable care organization (ACO) for all the wrong reasons. We did not form our ACO to save money for the system, although it would be great if we did save some. We also did not begin this effort because we had identified specific quality problems, although undoubtedly we will find some. No, we started our ACO because we needed to create a health care delivery system that allows physicians, hospitals, and other health care organizations to better address the health needs of our community. To make progress on cost and quality, we knew that we first needed to shape the building blocks: collaboration and coordination among health care professionals.

That is why we formed the Atlantic Health System ACO, a New Jersey–based limited liability corporation owned by the Atlantic Health System that includes 6 hospitals and 1400 health care professionals. What is unusual about our starting an ACO is that New Jersey is not well known for integrated health care. Physicians and hospitals tend to be economically and clinically isolated, with trends in physician employment and toward integrated models of care lagging well behind the nation. As a result, citizens who live in New Jersey have a 25% greater chance of staying in an intensive care unit, a 50% greater rate of physician visits, and a 75% greater use of specialists; more than 46% of patients have 10 or more doctors in the last 6 months of life (Table). In fact, New Jersey is number 1 in the nation in health care costs in the last 2 *years* of life.[1,2]

New Jersey needed a catalyst for change. Specifically, we lacked a market force that would promote systems of care; collaboration among health care professionals; coordination of community-based resources; public engagement; innovative models of health care delivery; system-wide metrics on cost, quality, and service; and aligned incentives. The Medicare Shared Savings Program (MSSP) presented us with just that opportunity.

TABLE. New Jersey Utilization Rates in the Last 6 Months of Life

Indicator in last 6 mo of life	New Jersey	US average
Intensive care unit days	5.50	3.40
Physician visits	48.50	30.50
Ratio: specialist to primary care visits	1:76	1:04
Patients seeing more than 10 physicians (%)	46.80	30.40

From Wennberg et al,[2] with permission.

Many health care leaders found fault with the first set of ACO regulations released by the Centers for Medicare and Medicaid Services (CMS).[3-5] However, where most health care executives saw a system filled with barriers and problems, we saw potential and opportunity. True, the economic and operational realities of the initial ACO regulations were burdensome, but they still represented a possibility for fundamental change in our marketplace. We were confident that the CMS would listen to candid feedback from the industry, so we did not slow the planning of our ACO. On the contrary, we proceeded "full steam ahead" in 2010 and 2011. When the revised regulations were released in October 2011 and indeed addressed many of our concerns, we were far along with our ACO's planning and infrastructure development.[6]

A similar dynamic recurred as the US Supreme Court considered the constitutionality of the Patient Protection and Affordable Care Act. Some health care organizations, anticipating a decision that would have overturned the law, stopped planning for reform and innovation. Others took a wait-and-see attitude. For our part, we did not believe that we should stop or even slow our plans for reform, as our system is unsustainable in its current condition. Regulations and laws can change quickly, but the pace of system reform can be glacial.

When physicians in our region first learned about the ACO, many were skeptical about participating in an organized system of care, particularly one involving government. Most understood that structural modifications were likely coming to our health care system, and they were unsure whether they wanted to be contributors to this change. Some feared lower income from decreased utilization of services; others were concerned about risk. The Atlantic ACO chose the 1-sided model in the MSSP to avoid taking downside risk. In fact, the most important change in the final regulations from our perspective was that the CMS allowed health care professionals to enter the program with limited risk. Sure enough, as physicians learned more about the

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ACO and its operating principles and governance structure, more joined.

On April 10, 2012, the Atlantic ACO was awarded an MSSP contract. We learned that of the 27 approved ACOs that began operating on April 1, 2012, ours was the second largest in the country, with approximately 50,000 attributed Medicare patients. The Atlantic ACO is structured as 4 pods, based in 4 distinct geographic regions of New Jersey. Each pod consists of a hospital, physicians, and other community-based organizations in the region.[7] The pod's governing board has a physician majority but also includes hospital and system executives and a Medicare beneficiary. Together, these board members ensure appropriate community health care planning and coordination. Care itself is coordinated by a network of clinical navigators who collaborate with primary care physician offices to identify patients with short-term and long-term care needs and guide them through planned pathways of care. Case managers work with high–medical acuity patients who require intensive assistance with care planning. Clinical information is coordinated through a health information exchange, and medical records systems are integrated when possible.

Our ACO has now embarked on a systematic redesign of care. For example, our Cardiac Success program has achieved 4% to 6% 30-day all-cause readmission rates by incorporating protocol-based approaches that rely on nurse practitioners and home care nurses coordinating with heart failure specialists and referring physicians. However, we have 16 other centers of high performance that incorporate multidisciplinary approaches to care management. Our participation in the Medicare Gain Sharing Program has helped identify ways to eliminate waste in our system, while our home care company's use of telemonitoring has provided lessons in utilizing technology to create greater efficiencies. Overall, quality data with comparative benchmarking has been a long-standing part of our approach to advancing performance. We understand that solutions will require reductions throughout our cost structure as well as improvements in outcomes, service delivery, and access to care.

The outcomes of our efforts will take a while to determine. For one thing, claims data from the CMS will lag behind. For another, Medicare is having difficulty attributing patient data to specific health care professionals, making accountability for outcomes and costs a challenge. Shared savings distributions, if realized, are a good 18 months away. That is a long time to hold the attention and loyalty of a large group of independent health care providers.

Yet no matter the results of the cost data and quality metrics, we are confident that the ACO will be successful. How do we know? We can already hear a change in the conversations among our doctors, our hospital leaders, and our patients. Our ACO meetings are filled with discussions about finding better ways to deliver care, using resources more efficiently, tackling tough issues like futile care, and holding each other accountable for performance. With each problem addressed, each solution crafted, we are creating a culture of working together and of problem solving. Little by little, New Jersey's fragmented health care system is being replaced with coordination and integration. This represents real progress.

I learned some time ago, when I studied under Dr John Eisenberg as a Robert Wood Johnson Foundation Clinical Scholar at the University of Pennsylvania, that the strongest motivator of physician behavior change is providing actionable data in a setting of strong financial incentives. The ACO holds the promise to do just this. Payers, health care professionals and organizations, employers, community coalitions, and all levels of government now have the opportunity to join their efforts and accelerate these results. Thus, the ACO represents a real opportunity for us to work toward meaningful change in health care. It will surely be interesting to see where all our work ends up, but the journey is going to be the best part.

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