

Minnesota and the Emerging ACO

When you think about subjects for Internet videos that go viral, Accountable Care Organizations probably won't top your list. But one such video produced by Centura Health of Colorado did just that in 2010—at least within health care circles.

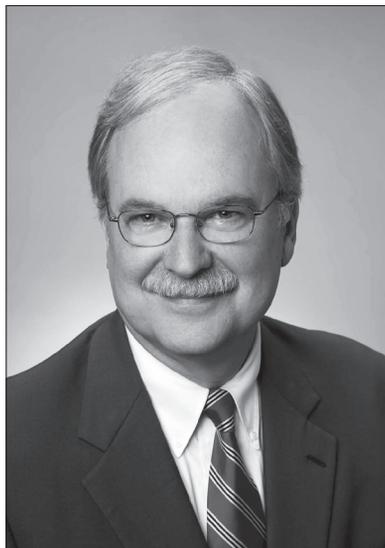
In the video¹, an animated health care executive stands before a consultant. He's heard that starting an Accountable Care Organization would be a great way for his system to succeed under health care reform. He and his board of directors are anxious to get started.

"O.K.," says the consultant. "What do you know about Accountable Care Organizations?"

The executive stammers. It's clear he has no idea. And after the consultant asks a few difficult questions, the executive admits, "This sounds way harder than I expected."

The video is meant to be funny, and it is, but there's some truth underlying the humor. Many administrators and clinicians have felt some discomfort and confusion around what ACOs are, about what they ought to be, and even about how we should have a discussion about them on national and local levels.

As we enter 2011, though, the ACO picture is at last beginning to clarify. While we might chuckle a bit at the confused cartoon executive of today, we're also seeing the ACO move from concept to applied reality. It no longer takes a leap of faith to imagine ACOs transforming health care delivery in a serious way. And as has so often been the case with health care innovation, one can trace much of this progress back to work being done here in Minnesota.



Minnesota as a Home for Model ACOs

We've seen many different approaches to health care reform in recent years, but at some level they all seek to address some common, inter-related challenges. We know, for example, that the health of American populations could be better—and in many cases, much better. We know that quality of care is improving, but it's not improving as quickly as it could or should. We know that consumers want a better and more satisfying experience of care. And above all, we know we can't sustain our giant increases in health care costs.

At the same time, health care leaders are focusing on finding ways to achieve "Triple Aim" outcomes—the simultaneous improvement of the health of a defined population, the experience of each individual within it, and the affordability of care.

Enter the ACO.

Formulated in large part by Dr. Elliott

Fisher, professor at Dartmouth Medical School, and informed by a seminal 2001 Institute of Medicine report called *Crossing the Quality Chasm*, the concept of the ACO is designed to address a key problem: The fragmented, disconnected nature of fee-for-service health care delivery in most parts of the U.S.—and the ways in which it rewards volume instead of results. As ACO models have matured, they've been increasingly connected with the Triple Aim, recognizing that associating goals, measurements and transparency with each of those aims is important to transforming the system overall.

Approaches vary, but in practice, an ACO should allow hospitals, clinics, administrators and clinicians to work together—usually across systems—to address challenges in planned, measurable ways. It should be able to manage a continuum of care as an integrated system—either an actual integrated system or a virtual one. It should be large enough to support meaningful and comprehensive performance measures. And lastly, it should be able to distribute payments of shared savings (as well as allow the sharing of risk) internally among participants.

Furtherance of the ACO concept was greatly strengthened in 2010 through legislation. The Affordable Care Act, for example, set aside \$10 billion for the creation of a Medicare Center for Innovation to evaluate new approaches to health care, such as ACO reforms and payment models, through 2019. It also called for Medicare to be able to pay for care provided in ACOs and to collaborate with private and state-based systems in doing so. The federal government is expected to issue guidelines early this year about ACO regulation, and the National Committee for Quality

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Assurance (NCQA) is developing ACO accreditation standards expected to be finalized this spring.

As these factors align in support of ACO development, the Minnesota medical community is especially well-suited to create them. HealthPartners, as an integrated organization with a health plan, medical group and hospitals, for example, already operates in many ways as a self-contained ACO, as do several other systems around the country. These organizations have a comprehensive view of populations, data from multiple sources and perspectives, and experience with evaluating and managing risk and provider networks—many of the capabilities needed to begin an ACO.

Many other Minnesota health systems share aspects of these same capabilities, including Allina Hospitals & Clinics, Fairview Health Services, Park Nicollet Health Services, the Mayo Clinic and St. Mary's/Duluth Clinic Health System.

A Minnesota ACO Example: The Northwest Metro Alliance

Within the HealthPartners organization, we've

been focused on achieving Triple Aim results for the past decade, and made formal commitments to structure our system around pursuit of them in recent years. By developing reliable care processes that deliver consistent care, customizing care that is adapted to the values and needs of our patients, improving access to care, information and knowledge for patients, and coordinating care across sites, specialties, conditions and time, we've seen our cost of care decline to 90 percent of the market average while seeing improvements in quality of care and the experience of care we provide our patients (see Fig. 1).

This work was a valuable precursor to our recent, seven-year collaboration with Allina Hospitals and Clinics called the Northwest Metro Alliance. We view the Alliance as an ACO "learning lab" that's consistent with other pilot approaches being explored locally and nationally. It seeks to improve the health of the more than 300,000 people receiving care from our organizations in the northwestern Twin Cities suburbs by targeting cost and care improvements, optimizing available network and specialty services, and by preventing duplication of capital or other outlays for patient care services.

The Alliance has three key components:

Coordinated care management: The Alliance strengthens connections between primary care clinics, hospitals, and associated payer services to deliver coordinated care for patients with chronic conditions and to reduce admissions and readmissions. This includes identifying the high-risk and high-cost patients in the community, working to engage them in case management and other care services, and ultimately improving their self-management ability to avoid future readmissions.

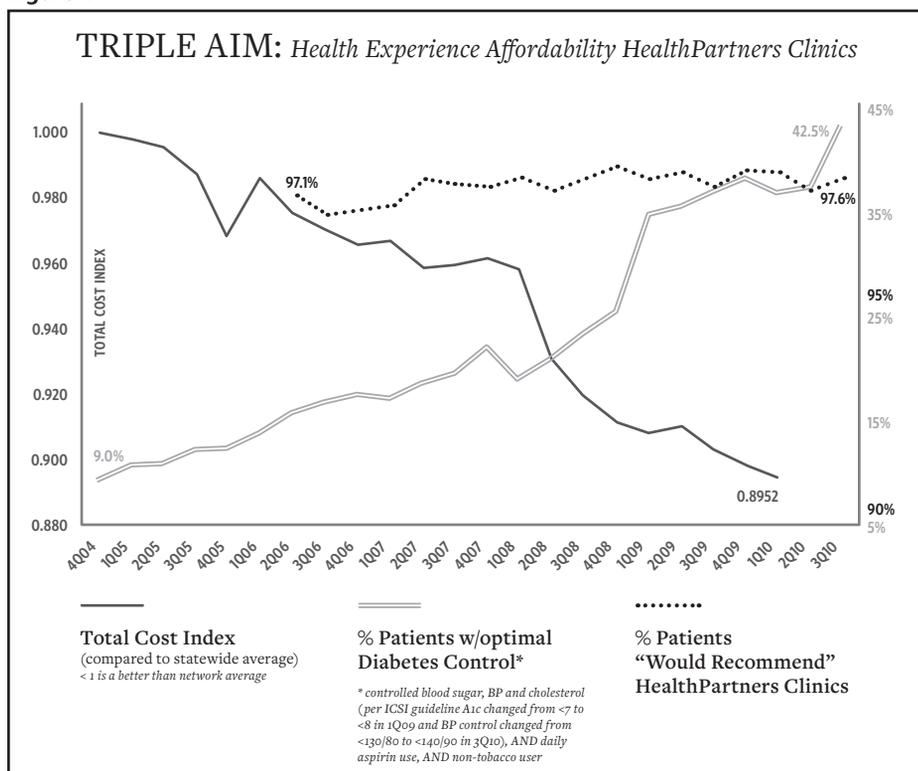
Payer-based data models: The Alliance uses HealthPartners' multiple population-health data models to understand the patient population, to identify variation in treatment patterns and clinical practice, and reveal the total cost of care and health care treatment patterns in the community and market.

Electronic health information sharing: The Alliance involves use of electronic health information to coordinate care, improve efficiency and safety and improve the patient experience, allowing shared access to each organization's electronic health record.

The Alliance also involves creation of shared tool kits and clinical best practice protocols and contracting models, development of standard performance metrics to manage, identify and track opportunities for improvement, and open and transparent communication of progress and results. It's governed by an agreement outlining the overall terms of the partnership and providing a structure and process for planning and joint venture developments. Chief medical officers and medical leadership meet monthly to review data and evaluate progress against goals.

Success is measured by performance against the three goals of the Triple Aim, and a model of withholds and incentives has been established to return shared savings to all participants based on results. The results to date have been encouraging. At the end of the first year, preliminary data suggested movement in the right direction on total cost of care trends. We saw good sharing and collaboration among all the key players within our organizations, and we're seeing signs of cultural change supporting this new model of care delivery.

Figure 1



But while early results are positive, it remains an experiment. The complexity and learning curve associated with an initiative like the Alliance reinforces the reality that there isn't a "silver bullet" for accomplishing Triple Aim results. Joint planning requires effort, and those involved face hurdles. It takes time and a willingness to build new operating structures in stages—not in one fell swoop. Above all, it takes engaged, committed leadership and a clear intent of all organizations involved to create change for the better.

Future Implications for the Minnesota Medical Community

Here in Minnesota as well as nationally, administrators and clinicians have viewed the emergence of ACOs with a mixture of excitement and apprehension. There are concerns that ACOs could reduce autonomy, create downward pricing pressure, or stipulate new transparency about performance and results—none of which might be immediately welcomed. At the same, many see ACOs as opportunities to demonstrate their ability to provide superior care in line with Triple Aim goals.

In any case, and regardless of the exact form ACOs take in coming years, Minnesota will likely continue to be an early ACO proving ground and provide a pathway for others nationally to model. In that light, the development of ACOs will begin to gradually change the practice of medicine in Minnesota, and clinicians will likely see changes in several areas.

For example, clinics and doctors who aren't part of larger systems will see expectations, and even requirements, for working in conjunction with others outside of their own system, with reimbursement increasingly tied to cooperative efforts. Joint management of care will increase clinician reliance on EHR systems and other technologies for performing their work. And a focus on results measurement, tracking and reporting will continue to gain more prominence at every level of care.

Above all, it makes sense for all of us within the Minnesota medical community to keep a creative and open mind about the possibilities of ACOs to help transform the care delivery system in our state. Instead of a system that's increasingly consolidated and resistant to Triple Aim outcomes, we can work together to lay the foundation for a system

that's increasingly collaborative and that supports better health, better experiences and affordability. It's my hope that—based on good work done to date—we can continue to reach across traditional boundaries and constraints to do just that. ♦

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Footnote:

- 1) "In Search of an Accountable Care Organization," Centura Health. <http://www.youtube.com/watch?v=IF8bK7AJyL0>. Accessed Jan. 11, 2010.

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