The choice of words matter; they set the base and direction upon which thoughts and ideas flow forth, ultimately leading to structures and systems. One of the entrants into the healthcare lexicon is the accountable care organization (ACO). While there is much to like about ACOs and their proposed ability to improve health outcomes and efficiency while reducing unnecessary utilization and costs, there are some inherent flaws in the concept that will keep ACOs from achieving the results needed to create a sustainable healthcare system in the United States.

These flaws arise from the name and extend through the operational focus of ACOs. To better meet the goals of quality, costs and improved health outcomes requires a new organization with a broader constituency and a name that does not limit its structure to focusing on “care.” An expanded organization, an “accountable health organization (AHO),” would include the consumer as a central focus and extend well beyond the walls of the health system and the provision of care.

The Fundamentals of ACOs

With the passage of the Patient Protection and Affordable Care Act (PPACA), physicians, hospitals, health plans and even large employers are rapidly embracing ACOs as one of the newest approach to saving the healthcare system. They are meant to improve the coordination of care from within the system in order to improve health outcomes and reduce costs.

Kelly Devers and Robert Berenson in their seminal paper proposed that an ACO should have the following three essential characteristics:

- The ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post-acute care.
- The capability of prospectively planning budgets and resource needs.
- Sufficient size to support comprehensive, valid and reliable performance measurement.

While the ACO may be a fairly new name on the healthcare landscape, the concept is not that different from other structural approaches, such as physician/hospital organizations that were all the rage a few years ago. Many of these organizations accepted full risk or capitated contracts and were therefore accountable for the costs of the population they were managing.

The thinking behind the concept was that these models would ensure the efficient and appropriate utilization of services, resulting in lower costs and therefore a viable organization. Many of these organizations failed as they discovered that they were unable to manage the health cost risk.

As seen throughout the history of health reform, the vast majority of efforts have focused on the provider side and look at care and costs. Given the enormity of healthcare and the vast dollars, one would think that focusing on the supply side would make sense. There is much that can be done to fix the faults of fee-for-service medicine—inauthentic service delivery, fraud, tort reform and other areas. But this continual focus leaves out a basic but undeniably critical piece—the patient.

The Hippocratic oath includes these two lines: “I will prevent disease whenever I can, for prevention is preferable to cure. "I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.”

As healthcare has evolved in the United States it has focused on illness; one enters the system for the most part when ill and that illness requires some sort of treatment. Then the person leaves the system to return to his or her community.

The problem with this approach is that patients and their interactions outside of the healthcare system have much to do with creating or degrading health. In fact, the major healthcare cost driver of the past two decades resulting from this behavior has been the increasing prevalence of chronic diseases, such as cardiovascular disease and diabetes, among others.

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The Accountable Health Organization...continued...

The Centers for Disease and Control estimates that 80% of cardiovascular disease, 80% of diabetes and 40% of cancers are preventable. The majority of these illnesses are the result of lifestyle, little impacted by the care system.

How will the three essential characteristics of an ACO have much of an impact on an individual’s health in places like the Mississippi Delta, where lifestyle and the community play such a huge role? Will ACOs prevent the growing incidence of diabetes, heart disease or obesity, or will they merely “care” for these conditions more effectively after they have occurred?

A Logical Expansion

True success in the United States will not come from an ACO, which places an overwhelming majority of its efforts on the provider system and the care they provide, but rather from an AHO that includes the patient and the broader community as an active and necessary partner in the structure, management and indeed financial rewards and penalties required to make this work.

An AHO will require the integration of two additional components: the patient and their communities. This new model will:

- Seek to improve the health of all members, whether they have a current condition or not.
- Use population based tools, such as health risk appraisals to adequately understand the health risks, as well as the health conditions or medical acuity of the population.
- Place the patient at the center of the focus.
  - Assign appropriate accountability to the patient.
  - Provide incentives and shared savings if achieved.
- Provide services of primary, secondary and tertiary prevention that go beyond those services provided by or within the healthcare system
- Include the broader community in the planning and operations of the AHO to look at:
  - gaps in community services that lead to better health and
  - nutritional issues, such as access to healthy foods, school programs and the prevalence of unhealthy, fast foods, opportunities for exercise and physical activity.
- Work with local and state governments to develop appropriate policies for the creation of health within a community.
- Develop broader teams that include those from within the healthcare system, as well as those in the community.

ACOs may be a step in the right direction, but from their name, they are not focused correctly to truly impact a population and foster health at a population level. AHOs, which more deeply integrate the patient and their communities, combined with a “health” focus of comprehensive primary, secondary and tertiary prevention programs are the way to improve the health of all and thereby reduce the growing incidence of preventable chronic diseases and health expenditures.


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