Hartford HealthCare’s ACO: How is it Working? What Does it Mean to Me?

In January 2013, Hartford HealthCare (HHC), working with ConnectiCare, took a big step in implementing health care reform.

We were accepted as an accountable care organization (ACO) in the Centers for Medicaid & Medicare Services (CMS) Medicare Shared-Savings Program (MSSP), an Obamacare initiative designed to lower health care costs by rewarding ACOs for effectively managing the care and health of Medicare patients who fall under the Medicare fee-for-service plan. We are among 400 such ACOs in the nation.

Our ACO has a targeted population of about 9,500 Medicare fee-for-service patients, who use HHC primary care services. Our goal is for us and for them to manage their health more effectively so they stay out of emergency departments and avoid hospital readmissions. This includes medication and disease management with a focus on wellness.

The HHC ACO includes all HHC members, including Hartford HealthCare Medical Group, Hartford Hospital, MidState Medical Center, The Hospital of Central Connecticut, Windham Hospital, Natchaug Hospital, Rushford, Central Connecticut Senior Health Services, VNA HealthCare, Clinical Laboratory Partners and the HHC Rehabilitation Network. As an ACO, our job is to ensure that once any of our targeted 9,500 patients moves from primary, to specialty, to home and other levels of care, he or she does it seamlessly and successfully.

Our experience so far has been positive. We’re creating a care-management team with six care-manager RNs, two care-coordinator assistants and one social worker to follow and support our top 10 percent high-risk patients who have histories of frequent admissions and emergency department visits. In addition, as required by the CMS MSSP, we are reporting and improving on 33 quality metrics – many of which are focused on chronic diseases such as diabetes, COPD and heart disease that result in high health care costs when not managed appropriately. We believe we have improved the coordination of care in our health care venues, which has led to improvement in the quality of care. Although we haven’t seen a cost reduction yet, we expect that to come in the near future.

Managing any population’s health requires data to determine where the greatest needs and opportunities exist. ConnectiCare brings us the tools, resources and expertise in managing data so we can determine how to best care for and engage our patients and promote good health. Our ACO is showing us the path to the future: The move from silos of care to systems of care and to delivery systems paid on value (high-quality patient outcomes), not volume (fee for service).

Our experience also illustrates that we must identify high-risk patients through data and the primary care provider. We have embedded care coordinators in certain practices so they can assess patient needs and develop and monitor care plans. We see the necessity of primary care offices working closely with care coordinators on care plans and referrals and the need for care coordinators or assistants to facilitate follow-up appointments and other communications. We also need resources to address a patient’s behavioral, social, functional and pharmaceutical needs for maintenance of overall health.

Integrated Care Partners, a community of physicians working together, is moving us more quickly into this new health care environment and future, which is approaching us at warp speed. We’ve seen through our ACO what can be accomplished and the great benefits to patients – and providers.

Patrick Carroll, Director, HHC ACO
Chief Medical Officer, Integrated Care Partners
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Dr. Patrick Carroll is the chief medical officer of Integrated Care Partners, Hartford HealthCare's clinical integration organization. He also is the medical director for HHC’s Medicare Shared-Savings Program, an accountable care organization (ACO) with more than 10,000 patients. The ACO is a Medicare/Centers for Medicare & Medicaid Services (CMS) shared-risk pilot program that began Jan. 1, 2013. Dr. Carroll plays a key role in leading HHC’s efforts in the transition from fee-for-service care to value-based care in a time of a rapidly changing health care landscape.

Dr. Carroll formerly was chief medical officer with the Granite Medical Group in Quincy, Mass., a 40-provider multispecialty and primary care group that is part of Atrius Health, a 1,000-medical provider group. He was deeply involved in Atrius’ Pioneer ACO and the associated quality improvement efforts implemented at Granite.

Dr. Carroll received his bachelor’s degree from the College of the Holy Cross and his medical degree from Dartmouth Medical School. He completed his residency in family practice at Middlesex Hospital, where he served as chief resident. He has had a varied career. He worked in the Indian Health Service, where he was part of the leadership team for the development and implementation of the Medical Home Model for 50,000 primary care patients at Northern Navajo Medical Center in New Mexico. He started and ran a private practice in New Hampshire for a decade in the mid-1990s and used both electronic medical records and APRNs, which were significant innovations at the time. He also served as medical director for a large insurer and for a private boarding school. Dr. Carroll was recognized by Columbia University for work in mental health screening for Navajo Adolescents at the TeenScreen National Center and received the Area Directors’ Award for Outstanding Clinical Leadership for Navajo Area Indian Health Service Development of School-Based Health Clinic Network Navajo Research. Dr. Carroll is board certified in family practice and in adolescent medicine.

Dr. Carroll is joined in his return to the Connecticut area by his wife Kathy, an RN working in obstetrics and gynecology. They have three adult children.

**Integrated Care Partners**

**Our Mission**

To improve the health of the patients in the communities we serve through a strong physician-led partnership of dedicated health care providers. We will deliver integrated, efficient and effective care based on best practices, seamless care coordination, and measured outcomes to ensure the highest value.


“To keep the body in good health is a duty... otherwise we shall not be able to keep our mind strong and clear.”

– Buddha