



ACCOUNTABLE CARE GUIDE FOR INTERNAL MEDICINE

Preparing Internists for the
Approaching Accountable Care Era



The Accountable Care Guide For Internal Medicine

ACKNOWLEDGMENT

This strategic guide involved input through participation by many thought leaders of the following sponsoring organizations who have come together to form the Toward Accountable Care Consortium and Initiative (“TAC”). This paper would not have been possible without the generous support of all TAC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. Special thanks to the North Carolina Academy of Family Physicians and North Carolina Society of Anesthesiologists, whose seminal ACO white papers are the underpinning of this Toolkit. We are grateful to Julian D. (Bo) Bobbitt, Jr. of the Smith Anderson law firm, for compiling the information in this non-technical “blueprint” format, and to the following physicians for their expertise and input: Yuri Cabeza, MD, Cornerstone Health Care; Martha Chesnutt, MD, Boice-Willis Clinic; Nancy Henley, MD, NC Department of Health and Human Services; Richard Orr, MD, Cornerstone Health Care; and Grace Terrell, MD, Cornerstone Health Care. This guide would not have been possible without the efforts of these individuals.

County / Regional Medical Societies

Cleveland County Medical Society
Craven-Pamlico-Jones County Medical Society
Durham-Orange County Medical Society
Mecklenburg County Medical Society
Forsyth-Stokes-Davie County Medical Society
New Hanover-Pender County Medical Society
Pitt County Medical Society
Rutherford County Medical Society
Western Carolina Medical Society
Wake County Medical Society

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Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of American College of Cardiology
North Carolina Chapter of the American College of Physicians
North Carolina College of Emergency Physicians
North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Radiologic Society
North Carolina Society of Anesthesiologists
North Carolina Society of Asthma, Allergy & Clinical Immunology
North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Gastroenterology
North Carolina Society of Otolaryngology – Head and Neck Surgery
North Carolina Oncology Association
North Carolina Society of Pathologists
North Carolina Society of Plastic Surgeons
North Carolina Spine Society
North Carolina Urological Association

State Societies / Organizations

Community Care of North Carolina
Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Association of Local Health Directors
North Carolina Community Health Center Association
North Carolina Foundation for Advanced Health Programs
North Carolina Healthcare Quality Alliance
North Carolina Medical Group Managers
North Carolina Medical Society

The Accountable Care Guide For Internal Medicine

INTRODUCTION

This strategic guide involved input through participation by many thought leaders who have come together to form the Toward Accountable Care Consortium and Initiative (“TAC”). This paper would not have been possible without the generous support of all TACC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. We are grateful to Julian D. (“Bo”) Bobbitt, Jr. of the Smith Anderson law firm, who has many years of experience providing strategic counsel regarding integrated care, for compiling the information in this non-technical “blueprint” format.

Part One contains the necessary elements for a successful Accountable Care Organization (“ACO”) and implementation guidance that transcend specialty or facility and apply equally to all ACO stakeholders.

The purpose of this paper is to arm you with knowledge and confidence as you consider joining or forming an ACO.

Part Two applies the principles and processes of the Guide to provide specific strategies and practical step-by-step guidance using concrete examples used by different physician specialties, including how to apply successfully for the Medicare Shared Savings Program.



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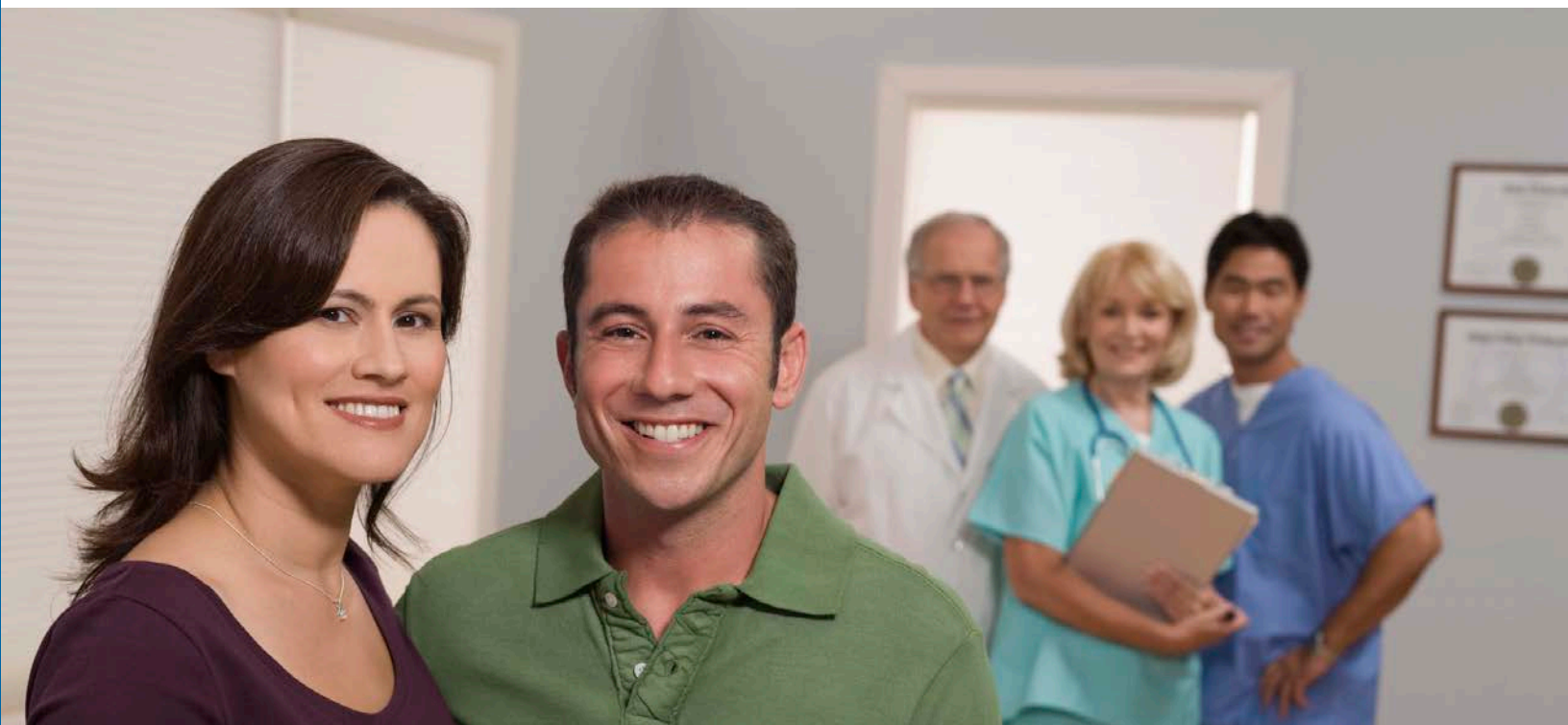
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The Physician's Accountable Care Toolkit

How to Identify and Implement the Essential Elements for Accountable Care Organization Success



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I. Purpose Of The Accountable Care Guide

Accountable Care Organizations (“ACOs”) are emerging as a leading model to address health care costs and fragmented care delivery. For example, in 2012, Accountable Care is being considered for implementation by virtually every private and public payor in North Carolina. It transcends federal health regulatory legislation and Medicare. The purpose of this ACO Guide is to bring together in one source a non-technical explanation of the essential elements required for any successful ACO and practical step-by-step guidance on how to achieve each element. Because a successful ACO must be “win/win”, with every collaborative participant incented and empowered to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payor relationship, or facility type. This Guide works for you whether you are a primary care physician, a hospital CEO, or a specialist physician. Although ACOs are still evolving and definitive predictions are impossible at this time, the goal of the Guide is to give any reader a firm sense of the strengths and weaknesses of any ACO model they may encounter and confidence about whether to join one or to create one. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development to be followed.¹

II. What Is An ACO?

A. Definitions

Former Administrator of the Centers for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. described an ACO as follows: “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”² Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs....[T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers...ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.”³ (Emphasis added.)

Strategic Note: The part of the definition relating to patient populations represents a major shift in practice orientation, and is very alien to a typical physician’s training and day-to-day focus.

¹ It is not the purpose of this Guide to provide legal advice. Any person or organization considering participation in an ACO should seek the advice of legal counsel.

² Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

³ National Committee for Quality Assurance, *Accountable Care Organization (ACO) Draft 2011 Criteria*, p. 3. (hereinafter “NCQA”).

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Without grasping this shift, an understanding of ACOs will remain elusive. It also is important to note what is not in the definition. No definitions specify any particular type of legal entity (i.e., IPA, PHO, employed). There is no mandatory organizational form for an ACO.

The final Medicare Shared Savings Program rule (Final Rule)⁴ released by CMS in 2011 contains an interesting definition emphasizing structure in contrast to the ones above focusing on function: “Accountable Care Organization (ACO) means a legal entity that is recognized and authorized under applicable State law, as identified by a Taxpayer Identification Number (TIN), and comprised of an eligible group (as defined at § 425.5(b)) of ACO participants that work together to manage and coordinate care for Medicare fee-for-service beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO’s decision-making process.”⁵

B. PPACA Requirements

ACOs eligible for the Medicaid Shared Savings Program under the Patient Protection and Affordable Care Act of 2010⁶ must meet the following criteria:

- That groups of providers have established structures for reporting quality and cost of health care, leadership and management that includes clinical and administrative systems; receiving and distributing shared savings; and shared governance.
- Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- Minimum three-year contract.
- Sufficient primary care providers to have at least 5,000 patients assigned.
- Processes to promote evidence-based medicine, patient engagement, and coordination of care.
- Ability to demonstrate patient-centeredness criteria, such as individualized care plans.

The Medicare Final Rule and three other related documents involving five federal agencies amplify these PPACA criteria. A special section devoted to the Medicare Shared Savings ACO Program is found in Part Two of the Toolkit.

⁴ 76 Fed. Reg. 67802 (Nov. 2, 2011)

⁵ 76 Fed. Reg. 67974

⁶ Section 3022 of the Patient Protection and Affordable Care Act of 2010 (amends Title XVIII of the Social Security Act (42 USC 1395 *et seq.*)).

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C. How Is It Different From a Medical Home?

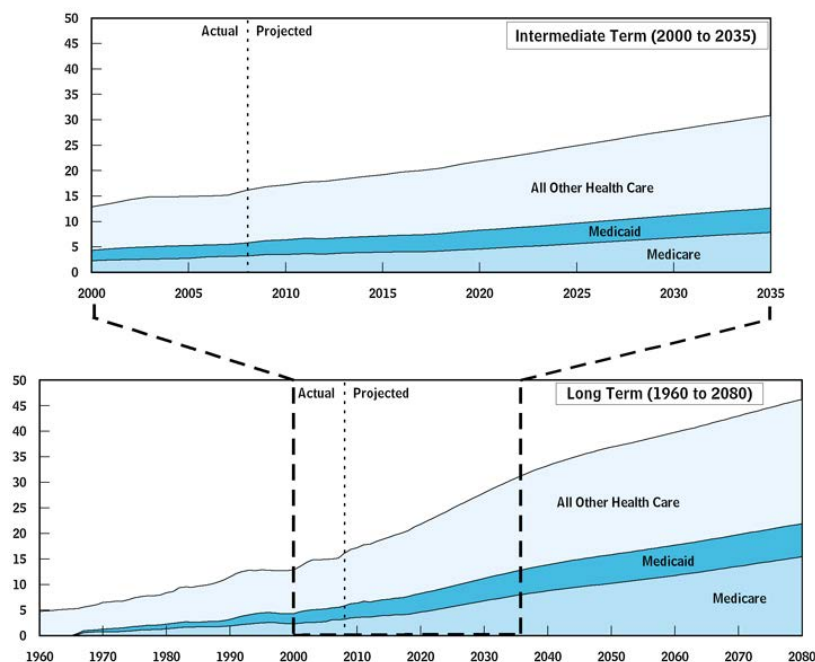
The Patient-Centered Medical Home (“Medical Home”) emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives - The Medical Home lacks the shared accountability feature in that it does not have financial incentives, such as shared savings, motivating providers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction. (2) Specialists/ Hospital Linkage - Even though there are Medical Home-only ACOs, a typical ACO is also different from a Medical Home in that it tends to have relationships with select specialists and hospitals across the full continuum of care for the targeted initiative.

III. Why Should I Care?

Health spending is unsustainable, even before coverage expansion of the 2010 federal health reforms. With 19% of Gross Domestic Product (“GDP”) being the rough estimate of the amount the United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are predicted to consume 13% of GDP and health care costs will consume 31% of GDP. In other words, health care alone will cost well over all we collect. By 2080, absent drastic change, Medicaid and Medicare will consume all of our tax and other revenues, and total health spending will claim 46% of GDP. The rest, defense, education, roads, etc. we can only pay for by borrowing. President Obama is the first President facing bankruptcy of the Medicare System during a term in office.

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Total Spending for Health Care Under the Congressional Budget Office's Extended Baseline Scenario



There is consensus that much of this is avoidable. The now-famous New Yorker article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. It said: “The real puzzle of American Healthcare... is not why McAllen is different from El Paso. It’s why El Paso isn’t like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone.”⁷



Article By Influential Writer Sparks Strong Debate

The Congressional Budget Office Report on the ACO's predecessor, the Bonus-Eligible Organization, includes this rationale: “[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.”

⁷ Atul Gawande, *The Cost Conundrum*, *The New Yorker* (June 1, 2009)

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These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country's health care system costing 50% more as a percentage of GDP than any other in the world but ranking only 37th in overall health and 50th in life expectancy.⁸

Because of the crisis, drastic efforts at health care cost reform seem inevitable. President Obama stated it bluntly: "So let me be clear: If we do not control these costs, we will not be able to control the deficit."⁹ Private insurers see it, too. The President of Blue Cross and Blue Shield of North Carolina recently stated: "Even if federal health overhaul is rejected by the Supreme Court or revamped by Congress, the market must continue to change. The system that brought us to this place is unsustainable. Employers who foot the bill for workers' health coverage are demanding that Blue Cross identify the providers with the highest quality outcomes and lowest costs."¹⁰

Flattening the cost curve is possible through the ACO's marketplace incentives without rationing care, imposing new taxes, or cutting provider reimbursement. Doing nothing is not an option, and all these alternatives appear unacceptable. In short, there is no "Plan B."

IV. Are ACOs Really Coming?

A. If They Repeal Health Reform, Won't This Go Away?

No. Federal health reform has three prongs: Expand Coverage (individual and employer mandates, no pre-existing condition exclusions, etc.), Fraud Control, and Waste Controls (ACOs, bundled payments, value-based purchasing, CMS Innovation Center, etc.). Many experts think that expanding coverage into our broken system has made health care even more unsustainable. However, as noted, the cost curves, even without health reform, will bankrupt our resources, and the value-based reimbursement movement was well underway before the federal legislation was passed. Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features of accountability at the medical community level, transparency to the public, flexibility to match local strengths to value-enhancement opportunities, and shifting to paying for value, not volume.

B. Isn't This Capitation Revisited?

You may fairly ask, "Isn't this the 'next big thing' to save health care, like capitation? Won't it fizzle away like that did?"

ACOs with shared savings are unlike capitation in several crucial ways. First, the payments are commonly only bonus payments in addition to fee for service payments.

⁸ World Health Organization, *World Health Statistics* 2009.

⁹ President Barack Obama, interview excerpt, July 23, 2009.

¹⁰ Brad Wilson, President of BlueCross BlueShield of North Carolina, *The News & Observer* (January 29, 2011).

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In the shared savings only models, there is no downside risk. Second, vital administrative capabilities, data measurement capability, identified common metrics, severity adjustment, and electronic health information exchange sophistication were not present in the capitation era.

Strategic Note: Though many experts propose that newly-formed ACOs assume financial risk through financial penalties, or partial or whole capitation, the 15 years clinical integration experience of this author strongly suggests that ACOs TRY NOT TO ACCEPT DOWNSIDE RISK UNTIL THEY HAVE THREE CONSECUTIVE YEARS OF MEETING BUDGET ESTIMATES.¹¹ There are just too many new partners, roles, moving parts, untested data metrics, and variables beyond the control of the ACO. Even taking a smaller share of the savings pool to recognize the absence of downside risk is preferred to accepting the responsibility of unanticipated medical expenses without the tools to control them. Having some “skin in the game” is clearly a logical way to incentivize accountability for providing value, but thrusting that on an unready health care system could do more harm than good.

C. Can't I Wait Until Things Get Clearer?

With hospitals and physicians having lots of other things on their plates and this bearing a resemblance to other reforms that never quite panned out, a wait-and-see attitude might at first seem reasonable. However, as the next chapter describes, successful ACO creation will require deep transformational change. The changes will have less to do with infrastructure and technology than culture. This is equally true in integrated systems with a fully-employed medical staff, as it is with other models. “Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake...Organizations that have not yet started down this path in earnest will need to move much more aggressively to prepare for the post fee-for-service world.”¹² You cannot wait to plan. Being unprepared is not an option. But there is a difference between having a plan and implementing a plan. If you are a hospital CEO or in a particular specialty you may want to wait until value-based reimbursement has reached the tipping point relative to fee for service before you “pull the trigger” in implementing your plan.

V. What Are The Essential Elements Of A Successful ACO?

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. Because element one is not as objectively verifiable, it is very counterintuitive that the most vital element is by far the most difficult element to obtain will be creation of an interdependent culture of mutual accountability committed to higher quality and patient satisfaction at the lowest cost. “[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change.”¹³

¹¹ The Final Rule was substantially revised from the proposed regulations in that a new ACO had the option in the first term of the MSSP not to accept risk, whereas under the proposed regulations CMS would mandate acceptance of risk for the third year of the initial three-year contract. 76 Fed. Reg. 19643.

¹² Gary Edmiston and David Wofford, *Physician Alignment: The Right Strategy; the Right Mindset*, Healthcare Financial Management Association (December 1, 2010).

¹³ *Id.*

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The Eight Essential Elements of a Successful ACO



A. Essential Element No. 1: Culture of Teamwork – Integration



The most important element, yet the one most difficult to attain, is a team-oriented culture with a deeply-held shared commitment to reorganize care to achieve higher quality at lower cost. A fully-functional ACO will catalyze the transformation of health delivery. “While strong hospital-physician alignment has always been a cornerstone of success, the necessary degree of future collaboration, partnership, and risk-sharing will dwarf what has come before it. Hospitals and physicians will have to recognize, embrace, and leverage their growing interdependence to create organizational structures and incentive models that are strategically aligned and mutually rewarding.”¹⁴

1. Challenges for Physicians. Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Reimbursement rewards an individualistic “eat what you kill” mentality. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than just banding together for contracting purposes. Physicians will have to be willing to change utilization, referral, and care-management patterns. In many settings, specialists will need to release primary control of patient care decision-making to the Medical Home primary care physician.

¹⁴ *Toward Accountable Care*, The Advisory Board Company (2010).

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Physicians are justifiably cynical about prior “next best things,” such as HMOs, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning. But, “[I]f providers do not change their decision-making and behavior, ACOs will go the way of most PHOs and IPAs...to the bone yard. More importantly, the healthcare crisis will persist, and more drastic solutions will be mandated.”¹⁵

2. Challenges for Hospitals. Will hospitals be willing to embrace a true ACO structure, which will likely drive down hospitalization? Will they be willing to distribute shared savings as intended, to incentivize and reward those who created it through high-performance care delivery and improved coordination, or will they try to take any savings dollars “off the top” to make up for the lost revenue from the reduction in avoidable hospitalizations and readmissions? Will the increased market share from joining an ACO make up for the lost revenue? Exacerbating these business risks for sharing governance with physicians and committing without reservation to an orientation of higher quality and lower costs, is a deeper cultural barrier: control. Hospitals are complex organizations, and a degree of control over operations and direction has been historically important for their viability.

“The most significant challenge of becoming accountable is not forming an organization, it is forging one.”¹⁶

Strategic Note: Tips on How to Create a Collaborative Culture:

- **Champions.** Vision comes first, but to sell that vision, you need physician leaders able to articulate a clear and compelling vision of change. They need to be champions of the transformational changes needed. As few as one, and rarely more than five, are needed. If a hospital is involved, the CEO needs to show commitment to the shared vision.
- **Governance Structure.** The structure must have meaningful input from the various parties to have status and credibility. It must exhibit shared control. Management teams can be pairings of physicians with hospital administrators. As noted, shared governance is such a point of emphasis that the Final Rule includes that phrase in the definition of “Accountable Care Organization.”¹⁷
- **Incentives Drive Alignment.** “[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage.... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform.”¹⁸ Compensation plans for hospital-employed physicians must not be limited to individual productivity, but also have incentives for accountability for success of the ACO team.

¹⁵ Phillip L. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity, Appendix (November 2010), p. 40.

¹⁶ *Id.*

¹⁷ 76 Fed. Reg. 67974.

¹⁸ Ann Robinow, *Accountable Care News*, The Top 3 Obstacles to ACO Implementation, (December 2010).

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- **“Spiral of Success.”** The following strategy could help meld team culture: An early pilot project for your ACO should be consistent with the new vision, led by champions and cut across specialty and department lines. A multi-disciplinary team decides how to collect and share data in new ways to facilitate this care initiative. The data, in paper or electronic format, is available at the point of care. Quality goes up and there is a savings pool. New team habits begin to emerge. Small scale is OK, but it must succeed, so the “spiral of success” can start. Trust goes up and buy-in for the next collaboration will occur more quickly.
- **Employment Not a Panacea.** Isn't the most obvious path to integration through hospital employment? This is a feasible approach if the parties have worked together in the past and there is a pre-existing level of trust and respect. This will not work if there are not shared goals and the control and financial incentive issues are not resolved. “Current trends in physician employment represent neither a necessary nor sufficient condition for true integration; value-added integration does not necessarily require large-scale physician employment and simply signing contracts does not ensure progress toward more effective care coordination.”¹⁹

B. Essential Element No. 2: Primary Care Physicians



1. **What Is the Role of Primary Care In ACOs?** As discussed in detail in Section V.G. below, the highest-impact targets identified for ACOs lie in the following areas: (a) prevention and wellness; (b) chronic disease management; (c) reduced hospitalizations; (d) improved care transitions across the current fragmented system; and (e) multi-specialty co-management of complex patients. Primary care can be drivers in all of these categories.

Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, “it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.”²⁰ He envisions different levels of ACOs, with the core Level One consisting primarily of primary care practices. Level Two would include select specialists and potentially hospitals. As the diverse patient populations are included, Level Three expands to more specialists and facilities, and Level Four includes public health and community social services. As noted, primary care is the only provider or health care facility mandated for inclusion to qualify for PPACA's ACO Shared Savings Program.

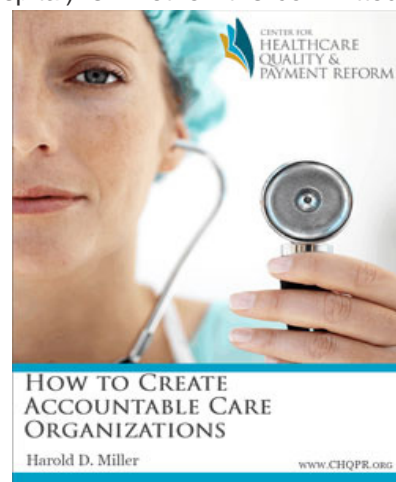
¹⁹ *Toward Accountable Care*, The Advisory Board Company (2010).

²⁰ Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, p. 8, (September 2009).

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2. **What Are the Roles of Specialists In ACOs?** It is becoming clear that specialists are going to serve important roles in ACOs. Given the opportunities for ACOs listed in Section V.B.1. above, specialists should see roles in Medical Home coordination on diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and in multi-specialty complex patient management. Inpatient specialists can tackle hospital through-put, minimizing avoidable adverse events and readmissions, and quality improvements. Specialists intent on preserving volume at the expense of best practices have no role in an ACO.

3. **What Are the Roles of Hospitals In ACOs?** Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and HIT infrastructure, ACOs are consistent with their missions, and hospitals are often a medical community's natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, "the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in opposition to one another."²¹ A litmus test for hospital membership (or whether to join an ACO that includes a hospital) is whether it is committed to overall increased savings, improved quality, and improved patient satisfaction for patient populations, even if hospitalization rates are reduced. It is also unacceptable if a hospital permanently seeks to capture most of the shared savings "off the top" to make up for lost revenue. A hospital at over-capacity should not have this conflict. Moreover, many hospitals see full institutional commitment to accountable care as the best way to prepare for the future, maximize their fair share of the shared savings dollar, and grow market share. Once the tipping point of the shift from payment for volume to payment for value has been reached, these conflicts should dissolve.



In summary, because primary care will drive so many of an ACO's most high-yielding initiatives, it is an essential element of a lasting and successful ACO. "Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs. It must be about proactive and preventive care and not reactive care. It must be about outcomes and not volume or processes. It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home."²²

²¹ *Id.*, p. 15.

²² Terry McGeeney, M.D., *The Patient-Centered Medical Home and the Accountable Care Organization*, <http://transformed.com/CEOREports/PCMH-and-ACO.cfm>, (2010).

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C. Essential Element No. 3: Adequate Administrative Capabilities



What Kind of Organization Can Be an ACO? The very label “accountable care organization” tends to convey an impression that an ACO must be a particular type of organization. In retrospect, it probably should have been called “Accountable Care System.” **It is about function, not form.** The NCQA’s ACO criteria look to core competencies and infrastructure to implement them, but are “agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association).”²³ Similarly, a wide array of organizations may become eligible for CMS Shared Savings Program under PPACA and the Final Rule:²⁴ group practice arrangements, networks of practices, joint ventures between providers and hospitals, hospitals employing providers, and other approved structures. There are three essential infrastructure functional capabilities: (1) performance measurement, (2) financial administration, and (3) clinical direction. A legal entity of some sort is necessary, and a number of choices are available. The form ultimately chosen should be driven by what most readily facilitates achievement of the functional needs of the ACO initiatives in your community. The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. The key to achieving this goal is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols and transparent measurement and reporting. **“While ACO formation and ongoing structural, operational, and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development.”**²⁵

What Are Key Legal Issues Affecting ACOs? ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors. All of these characteristics, and more, in furtherance of health policy, also happen to raise a number of challenging legal-compliance issues for a body of state and federal health care law largely premised upon the fee-for-service model. Adaptations of the most problematic laws and regulations are underway. On October 20, 2011, the Departments of Health and Human Services, Treasury, and Justice, and the Federal Trade Commission jointly released federal policies concerning implementing the MSSP in order to provide guidance. A properly configured ACO should be successful in navigating this legal minefield. The principal bodies of law affecting ACOs are:

- Antitrust
- Anti-kickback
- Stark
- Civil Monetary Penalties Law

²³ NCQA, pp. 7-8.

²⁴ 76 Fed. Reg. 67975.

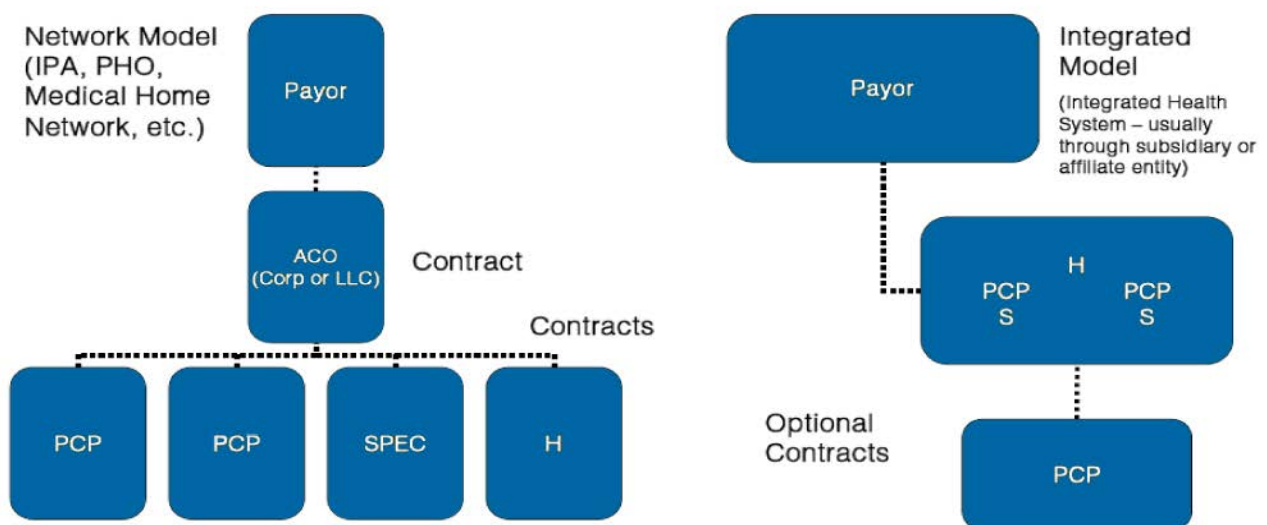
²⁵ Doug Hastings, Accountable Care News (December 2010), p. 6.

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- Tax
- HIPAA
- Malpractice
- Corporate Practice of Medicine
- Insurance
- Intellectual Property
- State Self-Referral Laws
- Business Law

For a detailed legal analysis, please review the “Accountable Care Legal Guide.”

Possible Organizational Forms



1. Network Model

a. **Independent Practice Associations (“IPAs”)** – An IPA is basically an umbrella legal entity, usually an LLC, for-profit corporation or nonprofit organization, with physician participation contracts with hospital-employed and independent physician practices. Payors contract with the IPA. These structures became familiar in the fee-for-service and capitation eras, and the form is still suitable for the accountable care era. However, the IPA now needs to have ACO-level infrastructure as described in this Guide. It is particularly dependent on robust health information exchange, as the continuum of care is more “virtual” because the providers are independent. The

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participation agreements are different, too. The provider agrees to undertake the responsibilities agreed upon by the ACO and accept some type of performance-based incentive, like shared savings, in addition to fee-for-service. It can have any combination of specialists, primary care, hospital, and tertiary care participating contracts. An IPA is owned by physicians. Legal issues of note in IPAs involve antitrust, self-referral, insurance regulation, HIPAA, malpractice, and the Stark law.

b. **Physician/Hospital Organization (“PHO”)** – The PHO is very similar to an IPA, but the main difference is that it is co-owned and governed by physicians and a hospital or health system and includes a hospital participation contract. The same requirements and caveats apply.

c. **Medical Home-Centric Model** – Under this variation, an umbrella entity is owned by Medical Home practice members or networks. It contracts with payors, initially for the medical-home-related primary care services, but includes accountable care financial arrangements and performance measurement capabilities. It broadens the scope of initiatives and patient populations by adding select specialists and hospitals through contractual arrangements. These may be sub-ACO arrangements whereby the contract is with a PHO or hospital ACO. The same requirements and caveats of the other Network Model forms apply. Community Care of North Carolina is an example of a statewide confederation of 14 Medical Home-Centric Networks.

2. **Integrated ACO Structure** – With this variation, the hospital, health system, foundation, or multi-specialty clinic employs, rather than contracts with, the physician. It may own, capitalize, and control the ACO, with physicians on advisory committees. The HIT and other infrastructure is within the controlling entity. It may have contracts with independent providers and facilities if necessary to round out the breadth, depth, and reach of services needed to accomplish its initiatives.

D. **Essential Element No. 4: Adequate Financial Incentives**



1. **Isn’t This the Same As Insurance?** No. An insurance company assumes the financial risk of whether a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for higher performance treatment of patients once they become ill. This gets fuzzy when one remembers that the ACO will be responsible for an entire patient population, especially as it assumes more risk, as in full capitation. However, this distinction is why the ACO performance expectations need to be severity-adjusted.

2. **What Are the Types of Financial Incentive Models for ACOs?** There are three tiers: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.

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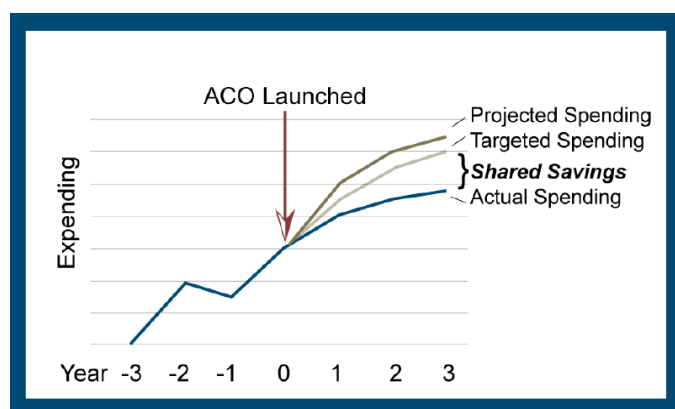
a. **Shared Savings** – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the MSSP Final Rule) of those savings is shared with the ACO. This is stacked on top of the provider's fee-for-service payments. To maximize incentivization, the savings pool should be divided in proportion to the level of contribution of each ACO participant. This aligns incentives of all ACO participants to keep patients as well as possible, and if ill, to receive optimum care in a team environment across the care continuum. If primary care has especially high medical home management responsibility, this may be accompanied by the addition of a flat per member/per month payment.

Some of the savings pool distributions should be used to maintain the ACO infrastructure, but as much as possible should go to reward providers and facilities for the extra time and attention devoted to patient management and technology investments. As mentioned, it should not go to pay affected physicians or hospitals for reduced revenues under fee-for-service for reductions in volume.

A strength of this model is that it is easy to understand and transition to, since it builds upon the familiar fee-for-service system. That is also its weakness, since fee-for-service still rewards volume, not value. This shared savings model has been criticized as being "asymmetric" or "one-sided," with no consequence if there are higher costs or no care improvement. Another problem is that there is by necessity a lag time to measure the "delta," or the difference between the actual costs and the expected costs, so the ACO is uncertain whether there will be revenues. The delay saps the incentivization to adhere to the ACO's best practices and coordination.

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The Shared Savings Model



*Courtesy of the Brookings Institution

Strategic Note 1: How to Calculate Shared Savings. Although the concept is simple – the ACO gets 50% of the difference between what the costs for the population turned out to be versus what the costs would have been if the ACO were not in place – DO NOT try to do this by comparing your population costs year-to-year. It might work the first year, but will be inappropriate after that. Having to beat your performance from the prior year, every year, is like calling an Olympic medalist a failure if she does not break her world record the next time out. In some CMS demonstration projects, relatively unmanaged counties in other parts of the country were picked as the control populations. Another way that works is to use an actuary that can predict the medical costs for your region or comparable community and use that actuarially valid projected amount as your unmanaged “comparable.” A variation of this latter approach has been chosen by CMS for calculation of the MSSP savings.²⁶

Strategic Note 2: Be Patient Before Taking on Risk. Do not repeat the disaster of the '90s, when providers took on risk without proper technology, infrastructure, best practices, or experience. We recommend that you come within 5% ± of your predicted costs for three consecutive years before leaving the shared-savings upside-only model. You may have unexpected costs over which you have no control. You will likely want to improve your Health Information Exchange, include relevant data elements, and see which of your ACO providers “get it.” In our experience, fears are overblown that lack of downside risk will deter performance improvement. To the contrary, a meaningful bonus payment is very motivating, as much as a recognition of and respect for the clinical leadership of the physicians as it is for the benefit of dollars involved. Individual distributions that differ based on performance determined by peers is also a “grade” that high-achieving individuals work hard to earn.

²⁶ 76 Fed. Reg. 67985-67988.

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b. **Savings Bonus Plus Penalty** – As with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks, but also will be liable for expenses that exceed spending targets. This model is called “symmetric” or “two-sided” and the bonus potential is increased to balance the accountability for exceeding pre-set goals. Fee-for-service is retained. This resembles the “two-sided” model mentioned in the Final Rule.²⁷

c. **Capitation** – A range of partial capitation and full capitation models are possible. Fee-for-service payments are replaced by flat payments plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should attempt this level of risk. Yes, the upside is higher, but the disasters of the '90s should not be forgotten.

3. **Is This the Same as Bundled Payment or Episode of Care Payment?** ACO incentives can be aligned with these and other payment experiments under consideration. An “episode of care” is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment covers providers who would have been paid separately under fee-for-service, that is a “bundled payment.” Such a payment mechanism that excludes payment for treatment of avoidable readmission or hospital-acquired infections motivates better care. These approaches do not incentivize prevention and medical-home coordination to avoid the episode in the first place.

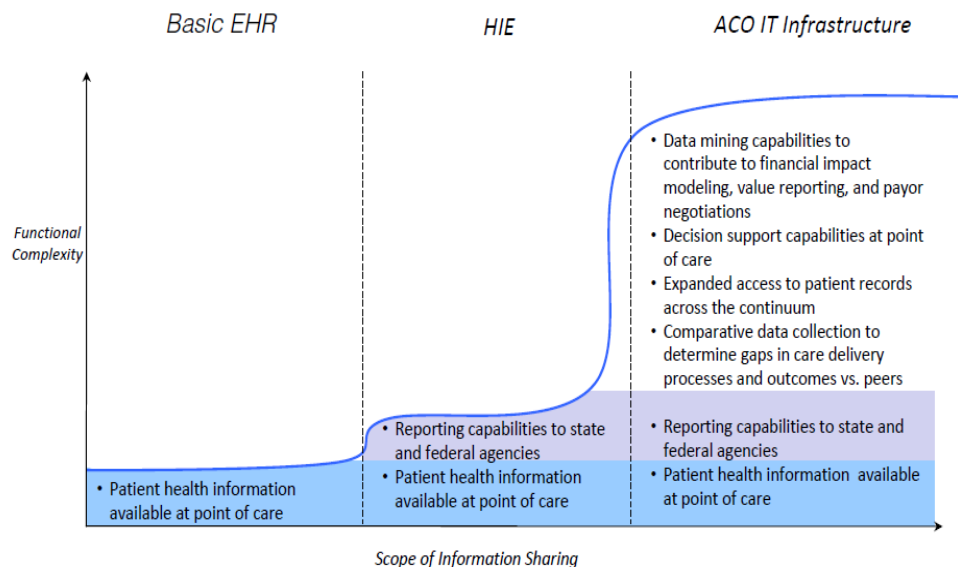
4. **“Meaningful Use” Regulations Incentives.** We include the “Meaningful Use” payments as an ACO financial incentive because the basic Health Information Exchange within your ACO will likely qualify the ACO’s providers for the Phase Two and Phase Three “Meaningful Use” incentives.²⁸ If your ACO can go ahead and establish its data flow needs relatively soon as outlined in this ACO Guide, you stand a good chance that the federal government will help finance the ACO’s HIT needs. See Section V.E. below for more detail.

²⁷ 76 Fed. Reg. 67986-67987.

²⁸ 75 Fed. Reg. 44314 (July 28, 2010).

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E. Essential Element No. 5: Health Information Technology and Data



1. **What Data?** ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It will usually have outcomes and process measures. Nationally-accepted benchmarks are emerging. There are three categories of data needs for an ACO:

a. **Baseline Data** – This is often overlooked. To compare anything, there needs to be a beginning reference point. Can you collect costs and quality data? Who owns it now? Who collects it? Do you trust them to be accurate and objective? Use it to preform a “gap analysis”: Where are your local quality and cost numbers outliers to the ideal? This tells you where your “low-hanging” fruit may be. Match those outlier opportunity areas with the particular strengths of the provider array of your ACO and you have your prioritized initiatives or targets.

b. **Performance Data** – In the value-based reimbursement era, it will not be enough to provide exceptional cost-effective care; you must prove it. A practical way to determine your ACO’s needed performance data is to start by selecting the ACO’s targeted initiative as mentioned above. Then select from emerging nationally recognized quality and efficiency metrics, if they apply. Even if they do apply, convene a multi-specialty committee of clinicians to vet their clinical validity. This committee will recommend performance benchmarks from scratch if national standards are not yet available for all of the care pathways of your initiative. They should address quality, patient satisfaction, and efficiency. They need to be severity-adjusted. Obviously, if and when a third-party payor, including CMS, sets the performance benchmarks, they should be part of the performance array. Many payors want to allow local flexibility and clinical leadership in metric-setting.

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Who collects the data? Are there variables outside of your control affecting your performance scores (i.e., patient non-compliance)? What financial incentives/penalties are tied to each?

c. **Data As a Clinical Tool** – Once the ACO targeted care initiatives are selected, the best practices across the care continuum will be determined. The appropriate ACO committee will then usually “blow up” each pathway into each component and assign clinical leadership, decision support, data prompts, and embed relevant clinical data into each step at the point-of-care. ACOs are discussing virtual workstations and data dashboards. Coordination with downstream providers will be optimized with the real-time sharing of upstream care results and scheduling.

Strategic Notes: (1) The ACO should periodically internally grade itself against the performance benchmarks to create a constant quality/efficiency/satisfaction improvement loop. This not only will hone the contributions of the ACO initiatives, but also will prepare it to increase its financial rewards once the performance results drive a savings pool or bundled payments. Gaps in care should be flagged and addressed before your compensation depends on it. Clearly, clinically valid, accurately collected, severity-adjusted, and properly benchmarked data are essential for any compensation model based on performance. (2) Data that reflects a track record of high performance serves as a bargaining tool when reimbursement is being negotiated, even in fee-for-service. (3) Use data first to target the “low-hanging fruit,” high-impact, value-add initiatives in your area best suited to your specialty or facility. Next, use data to collect evidence of your performance. There will be specific baseline, performance, and clinical data elements needed for each participant to meet objectives, maximize their measured contribution, and thus reap a meaningful reward from the savings pool.

d. **The MSSP Final Rule Provides Details** – Down from 65 in the Proposed Rule, the Final Rule requires reporting on 33 measures across your domains: patient/caregiver experience; care coordination; patient safety; preventative health; and at-risk population/frail elderly health. The goals of measure setting include seeking a mix of standards, processes, outcomes, and patient experience measures, severity adjusted and, to the extent practicable, nationally endorsed by a stakeholder organization.

e. **HIE Capability** – Your ACO will need Health Information Exchange (“HIE”) capabilities sufficient to move this data across the continuum in a meaningful way. This HIE is aligned with the Meaningful Use regulations. It will need to be able to aggregate data from multiple sources into user-friendly formats with decision support and relevant data that follows the patient to maximize chances of success in the ACO’s targeted initiatives. It needs to minimize the data collection burden on workflows.

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F. Essential Element No. 6: Best Practices Across the Continuum of Care



Another essential element of a successful ACO is the ability to translate evidence-based medical principles into actionable best practices across the continuum of care for the selected targeted initiative or initiatives. An ACO may start out with a single patient population (i.e., morbidly obese patients) or disease-state (i.e., diabetes).

The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75% of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multi-specialty care coordination of complex patients.

“The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today’s delivery system, unnecessary spending relating to substandard clinical coordination, aggravated with the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice.”²⁹

As discussed earlier in Section V.B., the richest “target fields” from this array will vary by specialty and type of facility. Looking at these suggested initiatives, it is no wonder why primary care is emphasized as key for ACOs, since they could play a significant role in every area. The ACO should match its strengths against the gaps in care in the ACO’s market to find the proverbial “low-hanging fruit.”

G. Essential Element No. 7: Patient Engagement



Patient engagement is another essential element. Without it, an ACO will not fully meet its potential. Unfortunately, many of today’s health care consumers erroneously believe that more is better, especially when they are not “paying” for it, insurance is. Patient noncompliance is a problem, especially regarding chronic diseases and lifestyle management. It is difficult to accept a compensation model based on input on improved patient population health when that is dramatically affected by a variable outside of your control, patient adherence. Currently, asking a patient to be a steward of his or her own care puts a fee-for-service payor at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by PPACA for an ACO to qualify for CMS’ Shared Savings Program.³⁰

²⁹ *Toward Accountable Care*, The Advisory Board Company (2010)

³⁰ Section 3022 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. §§ 1395, et seq.). See also 76 Fed. Reg. 67976.

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What Can an ACO Do to Engage Patients?

Better information at a societal level and also at the medical home point of care.

- **The Patient Compact** – Some ACOs, such as the Geisinger Clinic, engage the patient through a compact, or agreement. It may involve a written commitment by the patient to be responsible for his or her own wellness or chronic care management, coupled with rewards for so doing, education, tools, self-care modules, and shared decision-making empowerment. The providers will need to embrace the importance of patient involvement and hold up their end of the engagement bargain.
- **Benefit Differentials for Lifestyle Choices** – The financial impact of many volitional patient lifestyle choices is actuarially measurable. A logical consequence of the patient choice could be a benefit or financial differential reflecting at least partially these avoidable health care costs.

H. **Essential Element No. 8: Scale-Sufficient Patient Population**



It is OK, even desirable, to start small; to “walk before you run,” so to speak. However, it is often overlooked that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. PPACA's Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to it.

Strategic Note: Some ACOs commence activities through a single pilot, or demonstration project, without a sustainable patient population scale. It can de-bug the initiative and test-run the ACO early enough to fix problems before ramping up. This must succeed, however. If it does, it will be much easier for the ACO champions to gain buy-in from others.



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The elements do come together and mesh. Culture dominates. Each one can be built. These are not mysterious. They are doable. It will be hard. Once the ACO organizers embrace the opportunity in this change, achieving all of the elements for sustainable success is quite feasible. In addition, if you are evaluating a previously organized ACO, there are clear indicators regarding these essential elements that will predict reliably its likelihood of success.

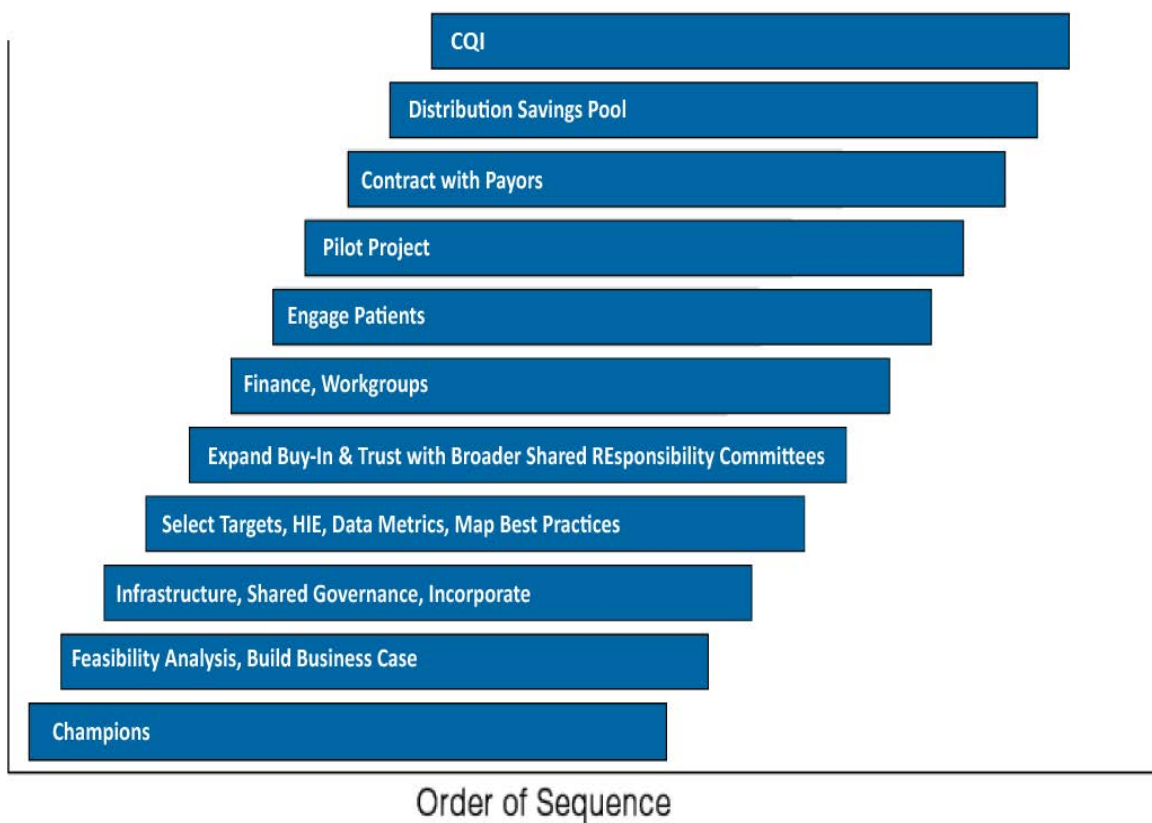
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VI. Successful Implementation – A Step-By-Step Guide

A. Where Do I Start?

OK, you now may be saying: “I know what an ACO is, why it is important, and how to identify ones that will succeed. However, how do I build one? Where do I start? I know where I need to go now, but how do I get there?” The creation of an ACO follows basic business planning and start-up principles. Expert advice on ACO development is uniform. The following is a step-by-step guide to building an ACO.

B. Step-By-Step Guide



1. Informed Champions – Perhaps even ahead of this first step may be that there needs to be some ACO information available to plant the seed of awareness with a few local champions. These champions, whether hospital CEO, family physician, or neurosurgeon, will need to invest their “sweat equity” to get up to speed (the main purpose of this ACO Guide). The champions need to reach beyond silos and see whether cultural compatibility is possible.

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2. Strategy Formulation/Gap Analysis – Next, a small core group should honestly assess where they are and where they need to go. What is the target market (i.e., chronic disease, Medicaid, the elderly)? Does an ACO make sense? What do we target? How do we make sure this is fair and successful so that we get buy-in? Some experts recommend a phased approach starting with primary care, then adding select specialists and hospitals around targeted high-impact initiatives, then a comprehensive panel, and then, finally, including public health and social services. Other experts recommend matching the natural strengths of the ACO with the greatest gaps in care for the local area. Then they would have the ACO model a strategic business case, to create a roadmap to development. How will it achieve all of the 8 Essential Elements? Keep the team very small at this stage.

3. Clear Vision – The organizing group needs to have credibility and will need to unite around a clear and compelling shared vision.

4. Clinical Integration – Through shared decision-making and champion leadership, build capabilities of a clinically integrated organization. Review the plan for presence of the 8 Essential Elements listed in Chapter V. The TACC is creating specialty-specific strategic toolkits to assist each specialty in building in capabilities and programs to optimize that specialty's contribution to, and thus reward from, an ACO. Please see Part Two, Section II, for the completed toolkits. If yours is not present, please contact Melanie Phelps at mphelps@ncmedsoc.org to see how you and your specialty society can partner with the TACC to develop a state-of-the-art toolkit.

- a. Start with your initial targeted initiatives.
- b. From them, establish best practices for the continuum of care for all providers involved with that type of patient.
- c. “Blow up” the best practices into component parts and assign clinical leadership responsibility for each.
- d. Identify which clinical data sets and decision support tools are needed at each step.
- e. Assign performance metrics and financial accountability for same.
- f. Determine HIT technical requirements.
- g. Determine best financial tools to incentivize desired behavior by all involved (i.e., share savings with predetermined performance benchmarks and distribution methodology). The TACC has engaged the law firm of Smith Anderson Blount Dorsett Mitchell & Jernigan, LLP and the health care valuation firm of HORNE, LLP to develop a multi-based shared savings distribution model for use by ACOs with multiple specialties. It will be made available by the TACC.

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5. **Structural Foundation** – Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not controlled by success for any particular stakeholder. Establish membership criteria and a shared decision-making structure. Design and undertake training. Develop payor strategy and contract terms. Do “ROI” predictive modeling to estimate savings and quality benefits. Create credible value talking points for all stakeholders. If you choose to participate in the Medicare Shared Savings Program, make sure you meet all the structural requirements, which are not onerous.
6. **Expand Buy-In** – Broaden structured involvement. Create a multi-disciplinary integration committee with HIT, best practices, patient engagement, and finance subcommittees.
7. **Accountability Function** – Develop data metrics, measurement capability, and sophisticated financial administration capabilities to manage financial shared savings distribution. Set performance targets. Normalize data. Make sure your performance-based incentives target your ACO objectives.
8. **Start Small** – Start with a demonstration or pilot project.
9. **Contract with Payors** – Once ready, contract to provide integrated accountable care services on a shared savings basis, at least initially, for your target patient population. The patient population scale must be adequate to achieve economies of scale. Consider a Medicare ACO starting in January of 2014 as part of a broader strategy. (See Part Two for a blueprint on applying to the Medicare ACO and Medicare ACO Advance Payment Model programs.
10. **Assess and Improve** – Assess results of the process. Make adaptations to create a constant quality improvement (“CQI”) loop. Collect and distribute the savings pool roughly in proportion to contributions to it.

VII. Conclusion

The Accountable Care Organization holds great promise to address many of the ills of America’s health care system. However, it will require new skill-sets, collaboration partners, technology, and systems. It will require a radically different approach to shared accountability. It is the goal of this ACO Guide to demystify ACOs for all stakeholders and to provide some tools and confidence to allow health care leaders to take prudent risks for greater success than they otherwise would have.

For more information on any aspect of this ACO Guide, please contact Julian (“Bo”) Bobbitt at either 919-821-6612 or bbobbitt@smithlaw.com. (www.smithlaw.com)

Part Two: The Accountable Care Guide for Internal Medicine

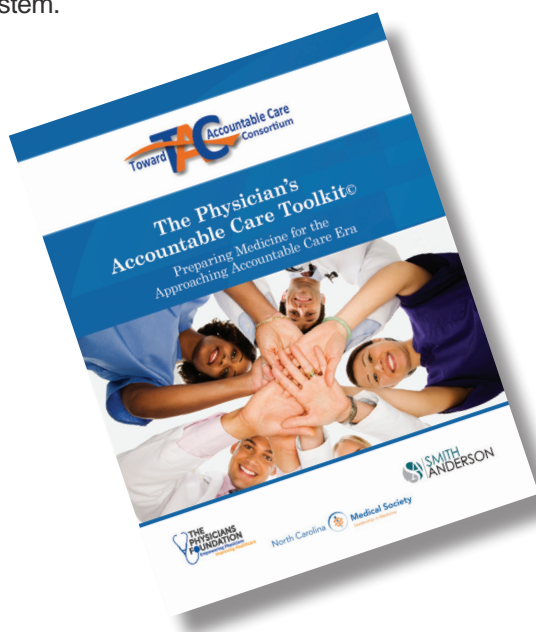


The Accountable Care Guide For Internal Medicine

I. Introduction

A. Purpose of this Guide

The companion *The Physician's Accountable Care Toolkit*® describes what it takes to create a successful Accountable Care Organization (ACO) and the steps to get there. Because it is fundamental that an ACO be a win/win for all involved, it applies whether one is a primary care physician, specialist physician or surgeon. This *Accountable Care Guide for General Internal Medicine*, on the other hand, spells out specific strategies for internists, whether in a small rural setting, a large independent practice or employed in a health system.



B. Recap of The Physician's Accountable Care Toolkit®

1. **What Is an ACO?** – Former Administrator of the Centers for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. described an ACO as follows: “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”¹ Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of

¹ Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

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simultaneously improving health, improving patient experiences, and reducing per capita costs, ... [T] here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers.... ACOs also will need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.”²

2. **This is Big, Different and Inevitable** – If we stay on the current spending glide path, by 2035, health care costs in this country will be more than the total of all tax and other revenues collected in our country, and by 2080, taxpayer funded health care will equal all of our governmental revenues, meaning everything else—defense, roads, education—must be funded by borrowing. The other options are simply unthinkable: tax increases, rationing care or drastic reimbursement cuts. As a country, our health care costs are more than 50 percent more than in any other country, but we now are ranked 32nd in what we get for our investment. The Congressional Budget Office laid the groundwork for accountable care’s “pay-for-value” underpinning when it reported much of the blame for our runaway health care costs should be placed on our fee-for-service payment system where “providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.”

Besides fragmentation, duplication and “more is better” excess, there are significant unjustified variations in quality and costs of care for similar patient populations. Yet, when motivated providers collaborate to drive the highest quality outcomes and the lowest costs, they do. Wonderful things happen—the patient is happier, employers finally see a slackening of spiraling health care costs, physicians regain control of the physician-patient relationship, and there is “found money” in savings from squeezing out waste to reward them for their efforts.

Yes, reversing the way health care is paid for is big, and it will require significant change. But, physician-led accountable care is the best way to fix health care and provide physicians financial and professional reward.

² National Committee for Quality Assurance, Accountable Care Organization (ACO) Draft 2011 Criteria, p. 3.

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C. What Are the Essential Elements of a Successful ACO?



There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. **As early ACO success and failure reports confirm, besides the obvious “deal killer” of no or inadequate financial incentives, by far the most important element for ACO success is the creation of an interdependent culture of mutual accountability committed to higher quality at the lowest cost.**

1. **Culture** – Full collaboration and true partnering among hospitals, physicians, and other providers will drive success. This must be coupled with a buy-in to change habits to work in teams to drive value with a “win/win” population management philosophy. This is way, way out of physicians’ and hospital administrators’ comfort zones. Physicians love independence, autonomy and often just want to see patients. Administrators have so far succeeded through strong leadership direction and infrastructure control. **“The most significant challenge of becoming accountable is not forming an organization, it is in forging one.”**³ Culture keys are: champions, governance and merit-incentives.

2. **Primary Care Physicians** – When reviewing Element 6 below, the core role of primary care becomes clear. Prevention, wellness, care transition and patient coordination management are the “low-hanging fruit” for ACO improvements and savings and are all in primary care’s sweet spot. Primary care is the only sub-specialty required in Medicare’s ACO program. Sophisticated ACOs will thrive with hospitals, specialists and community health partners, but primary care, at least one-third of the total membership, will always be at the core. For a patient population with a large patient census of children,

³ Phillip L. Rowing, *Becoming Accountable*, HFMP Compendium Contemplating the ACO Opportunity, Appendix, p. 40 (Nov. 2010).

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the primary care focus shifts more toward internists, pediatricians and child psychiatrists, as well as family physicians.

3. **Adequate Administrative Capabilities** – ACO structural, operational and legal considerations are essential, but are relatively straightforward. Developing the interdependent culture and commitment to clinical transformation across the full continuum of care are more elusive and should receive most of the ACO leadership's attention. Ironically, because they are objective, readily measurable, and more familiar, structural, operational, legal and HIT issues often consume the bulk of planning time, leaving the subjective and "invisible" culture and care transformation issues behind.

4. **Adequate Financial Incentives** – "[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage.... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform."⁴ One rule of thumb may be found in antitrust law, where the behavior changing tipping point in health care is considered to be roughly 20 percent of total compensation. Fifty percent savings for ACOs not taking downside financial risk is a fairly common measure and viewed by most as adequate.

5. **Health Information Technology and Data** – Every successful ACO will run on a sound technology platform with meaningful, actionable data at the point of care, transferable across the continuum, and available in aggregate form to prioritize ACO initiatives, measure performance, and report to payers and health care regulators. In contrast to fee-for-service with its demands of physician time and lack of incentives to log and study data, ACO physicians clamor for such information. These HIT and data capabilities need not be prohibitively expensive nor mandate linking EMRs. Sometimes a "Chevy" will get you where you need to go just about as well as a "Cadillac."

6. **Best Practices Across the Continuum of Care** – The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75 percent of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multispecialty care coordination of complex patients.

⁴ Ann Robinow, *Accountable Care News*, *The Top 30 Obstacles to ACO Implementation*, (Dec. 2010).

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7. **Patient Engagement** – How can your compensation be based on outcomes when the patient is not “in the game?” Patient engagement and patient-centeredness are essentials to ACO success for this reason. The patient who has not self-referred to your office but should be more important to population health management than the one who has. Two simple strategies often seen in successful ACOs are longer face-to-face initial visits with patients/families employing true communication skills and nurse coordinators who follow up with patients after they leave the facility or office. Technology is extending the virtual reach of these physicians and coordinators. In lieu of a face-to-face visit, sufficient patient contact, feedback or collection of health status information might be more efficiently obtained through such things as telephone calls, emails or telehealth technologies.

8. **Scale-Sufficient Patient Population** – There are certain front-end investments and ongoing fixed costs requiring a minimum scale of patient population to succeed. Medicare’s ACO minimum threshold of 5,000 beneficiaries is a useful benchmark.

D. These Apply to Everyone

Because a successful ACO must be “win/win,” with all stakeholders motivated to achieve their optimum value-added contributions to the enterprise, these principles transcend medical specialty, employment status, payer relationship or facility type. They apply to you whether you are a primary care physician, hospital CEO, community nonprofit or specialist physician. They are not mysterious; they are doable; culture dominates. It is the goal of *The Physician’s Accountable Care Toolkit*® to serve as a roadmap for all readers to be able to unlock ACO success for their patients, themselves, and their ACOs.

II. Could Accountable Care Be A Good Thing For Internists?

In *The Physician’s Accountable Care Toolkit*®, we learned what an ACO is, that it will not be going away, and how to know if one stands to be successful. But what, specifically, will this mean for the general internal medicine field?

We recognize that there are various models for internal medicine practices. As a result, the following recommendations may not be applicable to all organizations. The recommendations are merely a starting point and reflect strategies that may be modified and adapted based on variables such as geographic location, provider team make-up and breadth of service offerings.

A. Cons

- Internists are working very hard and have run out of spare intellectual bandwidth to take on these changes.

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- Many an internist says “I just want to see my patients.”
- This too shall pass.
- You have seen this “next big thing” before and it didn’t work out as advertised.
- Many internists are now employed by health systems and may have no say in their ACO involvement.
- It will be difficult for physicians to give up independence and be interdependent with other physicians and hospitals.
- It costs money to create an ACO; internists don’t have “war chests;” the only payment, shared savings, takes 18 months; and many ACOs don’t get any.

B. Pros

- Internists are extremely well-positioned to drive significant outcome improvements and reduce population costs in accountable care.
 - Any ACO strategy for any physician subspecialty begins with determining if there are high-impact, value-add contributions for patients they manage. Because primary care can impact all five of the high-impact target areas in population management: (1) prevention, (2) chronic care management, (3) reduced hospitalizations, (4) care transitions, and (5) multispecialty coordination of complex patients, it is no wonder internal medicine and the other primary care subspecialties are the only ones required by law to be included in all Medicare Shared Savings Plan (MSSP) ACOs.
- Many internists will find the greatest positives of a well-organized ACO, such as improved communication and coordination of care among physicians on behalf of and with patients, already are components of internal medicine Patient-Centered Medical Home (PCMH) care models.
- As with all physicians who have been heroically battling a deeply fragmented system to provide cost-effective care, internists will find rewarding a model designed to truly gauge and value their contributions to health care, show respect for what they have been attempting to do and validate why they chose health care as a profession.
- Studies of attributes of successful ACOs find all emphasize empowerment and support of preventive care.⁵

⁵ McCarthy, D., The Commonwealth Fund, *The Road to Accountable Care: Building Systems for Population Health Management*, Commonwealth Fund No. 21, pub. 1768, (Oct. 2014).

III. The Recommended Approach For Developing Specialty Accountable Care Strategies

In the value-based reimbursement era, each specialty is rethinking its role. Some of the questions confronting specialists are: What is our maximum value-adding contribution across an entire patient population? How can we generate quality and savings improvements for the ACO and thus maximize performance rewards for our specialty? This rethinking is perhaps most dramatic regarding savings. The gain will not be from seeing a patient cheaper or quicker, but how to reduce costs for a patient population over a given period of time, often one to three years. Quality metrics exist to measure the quality of care rendered by one physician to one patient. But it is as fundamental as it is radically different, that accountable care strategic developments for any specialty focus on excising avoidable waste across the continuum of care for the entire patient population. New coordination transition, education and engagement metrics will need to be developed and properly weighted by peer clinicians.

A hint of what a specialty should prioritize is given by this review of the top five high-yield targets for ACOs:

- Wellness/prevention
- Chronic care management
- Reduced hospitalizations
- Care coordination and transitions
- Multi-specialty coordination of complex patients

From these potential initiatives, prioritize the ones which are likely to have the quickest and biggest results, proven metrics and community health care leaders willing to champion the effort. What is working elsewhere? This should reveal for the specialty its potential prioritized list of value-add ACO initiatives.

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Interventions work...but it may take time.

	Activity	Expected Impact	Time to Impact
Effects Within Months	Transitions of care management	Reduce readmissions	3 months
	Case management for high-risk patients with targeted conditions: diabetes, heart failure, COPD	Reduce primary admissions and ED	3-6 months
	Case management for other high-risk patients	Reduce primary admissions and ED	6-12 months
	Pharmacy management		6-12 months
Effects Within 1-2 Years	Nursing home management	Increase generic use Reduce readmissions/primary admissions	12-18 months
	More efficient specialists and ancillary providers	Decrease cost per episode of care	12-18 months
	High-end imaging	Reduce unnecessary testing	12-18 months
Effects Within 3-5+ Years	Interventions for low-risk chronic disease patients: disease registries, chronic disease care optimization	Improved control; avoid complications	2-5 years
	Preventive care; screening; lifestyle change; wellness	Earlier identification and treatment; decrease incidence of chronic diseases	2-5+ years

Source: Geisinger

Once this list is in hand, the last step is to marry them in a particular locale through a gap analysis to the areas of avoidable waste in that region. The specialist can then make a compelling case that an area of the patient population's greatest need is matched with that specialty's greatest strengths.

The specialists also can benefit from ACO negotiation and marketing tips, knowledge of how to ensure fair savings pool distribution, and what clinically valid metrics should be used to accurately measure their performance.

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Ideally, this process should be led by a well-respected and diverse peer “Accountable Care Workgroup” of a national or state professional society, of that category of providers.

IV. The Process Followed For Creation Of This Accountable Care Guide For General Internal Medicine

Strategic Note: Many, if not most, of the non-preventive care best practices from the fee-for-service environment may not be particularly useful without adaptation, as they tend to focus on specialist care and treatment interventions in a fee-for-service setting of an individual patient. In contrast, internal medicine focuses on patient engagement and goals of medical decision making, pushing knowledge “upstream,” or transitioning across a “siloe,” fragmented system. Likewise, metrics abound evaluating individual care, but are not yet common in areas such as transition, care coordination, care team education or increased access through telemedicine.

A group of internal medicine leaders saw the need to prepare a practical *ACO Guide* specifically designed for use by the practicing general internist. They associated with the TAC Consortium and Initiative and convened a live introductory meeting to overview goals and development steps, and to review the preliminary value-add strategies raised for consideration based on research by the TAC support team. Potential initiatives underwent further review by the General Internal Medicine Accountable Care Workgroup, with the TAC Consortium and Initiative support team directed to perform more in-depth analysis of select possible target areas. These findings were further reviewed and revised by the General Internal Medicine Accountable Care Workgroup and presented to the TAC Consortium and Initiative Physician Advisory Committee. The *Guide* was then reviewed and approved by the North Carolina Chapter of the American College of Physicians. Macro predictive cost savings estimates were made, but a refined financial predictive modeling analysis, though needed, is beyond the scope of this project. Likewise, while guidance on the nature and type of performance metric selection is provided, the actual full mapping of those metrics is beyond the scope of this project. The researchers and physician peer reviewers are comfortable this represents a useful start in this important and rapidly evolving field. This *Guide* is a beginning, not an end, to the process.

V. Recommended Accountable Care Initiatives For General Internal Medicine Profession

A. Overview

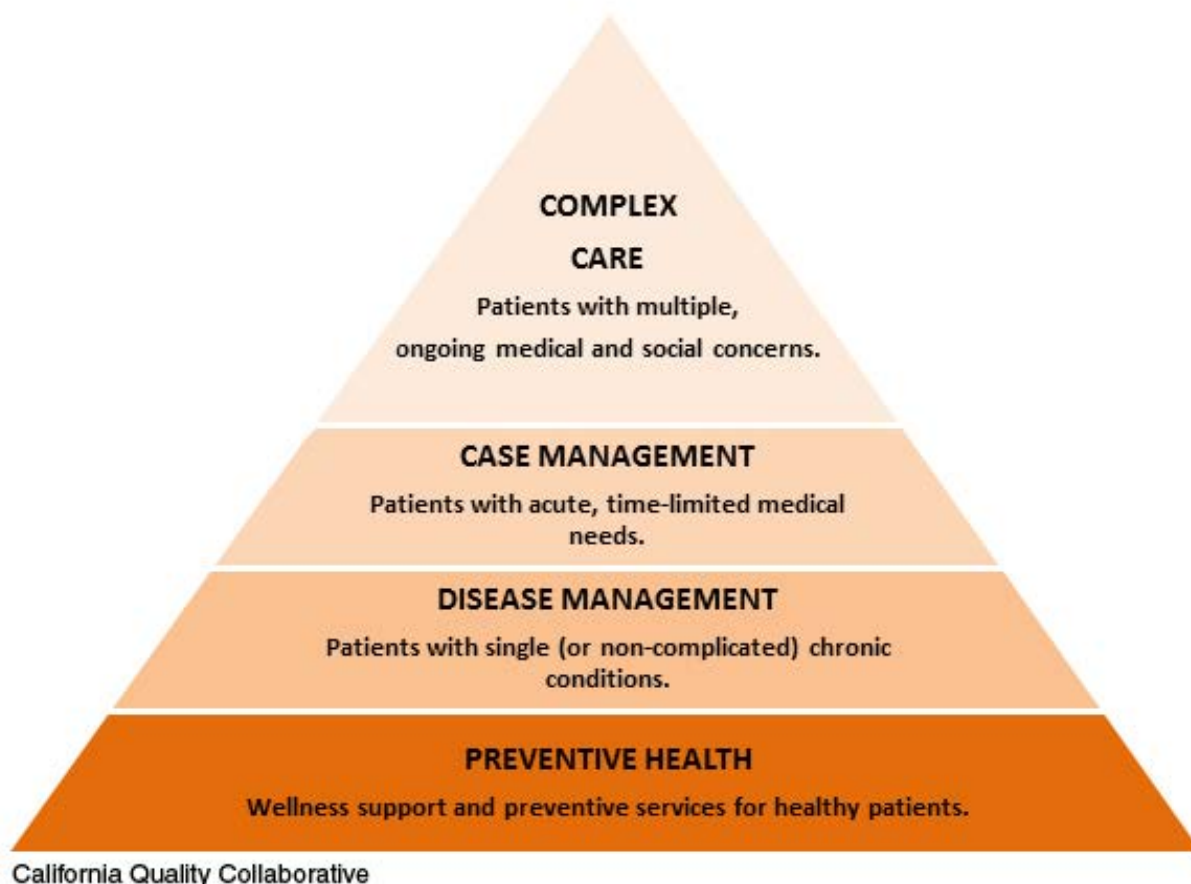
As noted, internal medicine is in the “sweet spot” on all five of the identified high value-add areas of opportunity in ACOs: (1) prevention, (2) chronic care management, (3) reduced hospitalizations,

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(4) care transitions, and (5) multispecialty coordination of complex patients. For you, the question is not what to do; it is what not to do? What to prioritize? An October 2014 study of high-performing ACOs found the following key attribute present: “All three organizations are building on past efforts to redesign and strengthen primary care.”⁶

B. Internist as Patient-Centered Medical Home Quarterback

Optimize your role as head of the PCMH to unleash its potential in the ACO setting. Unlike fee-for-service, where your patient was the one who made an appointment, your concerns now are all the patients attributed to you in your ACO's defined patient population(s). That population should be evaluated and stratified according to diagnosis and severity. As the graphic below illustrates, separate ACO strategies unfold for each category of patient.



⁶ *Id.*

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Once the ACO provides you your population stratification, you and the PCMH team can create proactive care management opportunities. Additional “face time” with patients during the initial visit pays dividends in compliance and rapport. Medication reconciliation and patient education and self-management tips can be introduced. One Accountable Care Workgroup internist explained this was a much more enjoyable way to practice. “Figure out what buttons to push for which patient and which resources to bring to them.”

The high-risk complex patient receives special attention as detailed below in Section V.C. Some others may be grouped for prevention/wellness/lifestyle management; some for management of their chronic diseases, and perhaps others for access to behavioral health, community health resources, transition management or post-acute care management.

Strategic Note: Utilize “wellness visits” strategically. CMS reimburses for this smart value-building activity.⁷ One General Internal Medicine Accountable Care Workgroup member in a large multispecialty, single tax identification number ACO commented they have protocolized this population assessment methodology and found it was also “a big source of revenue for us.” Further, the CMS MSSP attribution calculations of assigning patients to the physician rendering the plurality of primary care services are notoriously fickle. The wellness visit is a good way to add a primary care “touch.”

Strategic Note: Unleash the value of care coordinators. In the first several years of ACO operation, the high value of nurse care coordinators almost always catches the ACO by surprise. Once the patient population care management plans have been determined, care coordinators usually play key roles. For example, one Accountable Care Workgroup internist stated simply, “Figure out exactly what the patient’s needs are and then pass that on to the care navigator. It could be as simple as helping the patient to stop eating Little Debbie’s at night.” Regardless of the care plan, the one-on-one staff reinforcement increases compliance and self-management substantially. Nurse navigators who follow up with a home visit or telephone call post-discharge have proven especially valuable in avoiding readmissions. Patients with chronic diseases are assigned care coordinators. The transition/coordination role for complex high-risk patient care (addressed below in Section V.C.) is even higher. One primary care ACO member estimated that the “ROI,” or return on investment, for a nurse care coordinator is at least three-to-one. Another commented the coordinators handled a lot of routine care, allowing the physician to practice at the top of his or her license and to actually increase fee-for-service compensation by being able to code for more severe and complex services. The Workgroup internists could not overemphasize the benefit of care coordinators.

- Disease Management. Many patients will be appropriate for disease management, such as for diabetes, congestive heart failure, asthma and COPD.

⁷ The Wellness CPT codes are: G0402 IPPE Initial Preventative Physical Exam, G0438 Initial Annual Wellness, and G0439 Subsequent Annual Wellness.

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- OK, but how do I know if our disease management protocol works? The more common protocols are publically available. They should be collected and vetted by the Clinical Committee of the ACO, of which a primary care physician, preferably an internist, should be a member. For example, the nonprofit Community Care of North Carolina (“CCNC”) has honed disease management initiatives for a number of years and has posted them publically, including:

- Asthma Management
- COPD
- Diabetes Quality Initiative
- Heart Failure Program
- Pharmacy Initiative
- Pregnancy Medical Home ⁸

The full list of CCNC’s guidelines for adult care may be found at Attachment A at the end of this *Guide*.

Strategic Note: Use the MSSP quality metrics to show your central role in ACO success. The original 33 quality metrics found in the MSSP regulations track many of the prevention and disease management activities outlined above. Internists can use the correlation to illustrate the central role they play in ACO success. In fact, under the MSSP and similar programs, there will not be a savings distribution to the ACO even if there are savings, if the minimum metric thresholds are not met.

- **Transition Management** – Since the fee-for-service system is reactive, based on the patient self-selecting to see a physician or go to the emergency department, it is inevitable it will be lacking when it comes to proactive coordination/transition/communication approach for patient transition among providers and facilities. The PCMH and the ACO’s specialists can ameliorate this concern. One example is pre-operation evaluation and transition for a patient anticipating an inpatient procedure. Pre-anesthesia testing (“PAT”) coordination among internists, anesthesiologists and surgeons has been shown to dramatically reduce the number of costly cancellations and the number of tests ordered.⁹ It has been said that coordinating care across our fragmented system is the number one savings opportunity for ACOs. **“The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today’s delivery system, unnecessary spending allotted to substandard clinical coordination, aggravated by the complexity of navigating episodes of care, and unwanted variation in clinical outcomes driven by lack of adherence to best clinical practice.”** ¹⁰

⁸ Community Care of North Carolina, <http://www.communitycarenc.com/population-management>.

⁹ Perrin Jones, M.D.; pjones@plecticsms.com; email to Melanie Phelps, et al., (March 4, 2015).

¹⁰ The Advisory Board Company, *Toward Accountable Care*, (2010).

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Strategic Note: Take advantage of transition support codes. As with wellness visits, CMS will pay for certain care transition activities. CMS has figured out the payback in improved care is well worth the investment. One ACO physician mentioned coding for this ACO strategic value-add initiative resulted in over \$20,000 in increased Medicare payments in one year. One internist in the Workgroup noted her practice protocolized this process utilizing trained staffers. This greatly benefitted their ACO population management, but also generated over \$200,000 in additional fee-for-service revenues. “We’ve used that money to expand our wellness and coordination programs,” she said, “including hiring a nutritionist and more care navigators, and to expanding group education meetings.” The point is not the reimbursement, but rather this is an intelligent incentivization to induce the right kind of population management behavior. Medicare has begun paying physicians and their staffs for 30 days of transition care management—the time spent following up with patients after their discharge from an inpatient hospital setting or nursing facility. It covers coordination as the patient transitions back into the home or assisted living environment. This service is covered by two new Current Procedure Terminology (“CPT”) Codes—99495 and 99496. They both require face-to-face visits after discharge, which do not have to be at the practice.

- **Group Visits are Great** – The Workgroup team of internist experts strongly recommend group patient visits. One staffer can manage, and the benefits of patient engagement, self-management capability, medication reconciliations and lifestyle improvement are “high impact,” they report.
- **Integrate with Behavioral Health** – ACOs “may be well-positioned to increase the focus on managing behavioral health conditions ... through integration of behavioral health treatment and primary care.”¹¹ There is no clinical debate over the health delivery benefits of integrating mental and physical health care. As the National Alliance on Mental Illness puts it plainly in its family guide, *Integration of Mental Health and Primary Care*, “As individuals, we are not fragmented, we are whole people.”¹² The separation has largely been driven by the checkered fee-for-service payment system and to a lesser degree, a lack of shared traditions. The ACO model finally removes the financial disincentives to work together. “The ACO payment mechanism gives health care providers a new opportunity and incentives to rebuild the health care system in a way that reverses the separation between primary care and behavioral health care. ... If ACOs can effectively integrate behavioral health services into their care and connect patients to these services, they can be better positioned to reach both cost and quality benchmarks.”¹³

¹¹ Lewis, V., et al., *Health Affairs, Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse With Primary Care*, Hlth. Aff., No. 10, p. 1808, (Oct. 2014).

¹² Grattadago, D., et al., *NAMI, Integrating Mental Health and Primary Care*, (Nov. 2011).

¹³ Lewis, V., et al., *Health Affairs, Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse With Primary Care*, Hlth. Aff., No. 10, p. 1808, (Oct. 2014).

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The integration scheme will vary according to circumstances, but will develop along one of these general paths:

- **Awareness** – There is wide variance today in knowledge and awareness of potential synergies among the disciplines. Psychiatrists and internists can close the gap in an ACO by having joint planning and periodic “lunch and learn” sessions. Written protocols and guidelines can be developed,
- **Four Models** – ACOs incorporating primary care and behavioral health employed one of four models: (1) consulting; (2) co-location; (3) embedded or (4) for Medicaid contracts with large disadvantaged populations, reverse integration (primary care physicians are integrated into existing behavioral health programs.¹⁴ One psychiatrist practicing in an ACO environment commented that, “I participate in such a program and can attest to its effectiveness in three ways [medication management, earlier diagnosis, and identification and referral of severe mental disorders]. Almost all of my work is non-billable, but the ACO that employs me sees me as an important part of overall quality improvement and cost control.”¹⁵ For more detail on integrating behavioral health, see TAC’s ACO Guide for Child Psychiatry, <http://www.tac-consortium.org/resources/accountable-care-guide-for-child-psychiatrists>.
- **Integrate with Community Resources** – Dennis Weaver, M.D. commented that, “At its most basic, population health means actively working to keep your community healthy. When you think about it that way, it makes you wonder, ‘Who or what is influencing the health of individuals in my community the most?’ To date, population health care strategy has focused mainly on the role health care providers themselves play as the main influencers of health outcomes. But the reality is that we are not the only ones influencing the health status of the people we serve ... [Health] systems will need to engage with organizations that impact the health determinations in your community and influence individual’s behavior when they’re between provider visits.”¹⁶ Many patients do not receive certain clinical preventative services, cannot access the medical system and need help in self-management. Coordinating with external non-clinical organizations such as local health departments and community- and faith-based organizations can mitigate these problems. The MSSP requires ACOs to engage with community health resources. The benefits of such collaboration will be even more pronounced in inner-city and rural medically underserved areas. The Internal Medicine Accountable Care Workgroup recommends accessing the Agency on Aging for an inventory of available resources.

Remember, it is no longer just about the patient who shows up at your office. Your responsibility and opportunity now extends to your entire patient population. You can reach them so much better by

¹⁴ *Id.*

¹⁵ Interview with Arthur Kelley, M.D.

¹⁶ Weaver, D., The Advisory Board Company, *Who Really Influences a Population’s Health? (Hint: It’s Not Just Providers)*, Adv. Bd., Care Transformation Center Blog, <http://www.advisory.com/research/caretransformationcenter/care.transformation.center.blog/2014/07/sw-what-really-influences-population-health>, (July 30, 2014).

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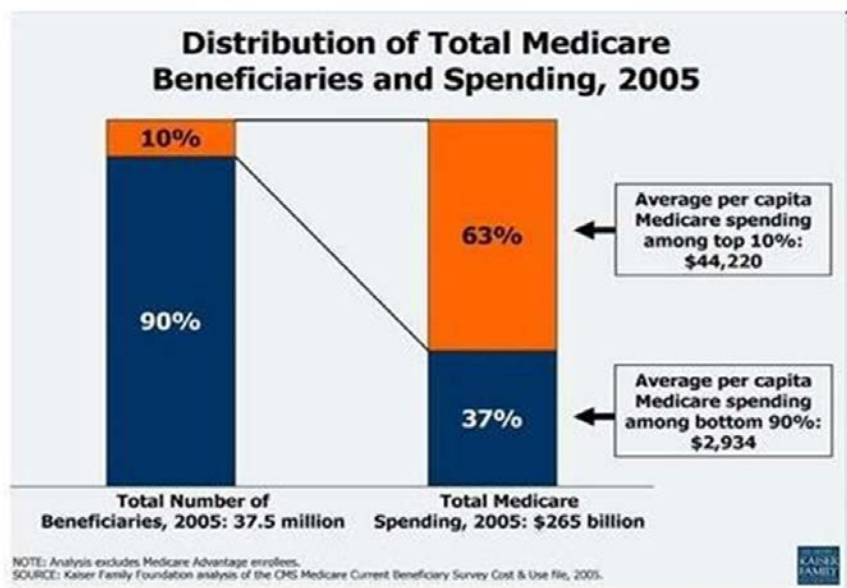
integrating with community health resources. ACO president, Grace Terrell, M.D., makes it clear: “Community partnerships MATTER MORE THAN PRACTICALLY ANYTHING in the world of value-based care.”¹⁷ For more information, refer to the *Accountable Care Guide for Community Health Resources*, found at www.tac-consortium.org/resources.

- **Utilize Emergency Department Avoidance Techniques** – The gap analysis of a population’s health as compared to the ideal invariably reveals overutilization of the emergency department (ED) for non-emergency services. Under fee-for-service, there were few adverse financial consequences for this, and it was a lot easier for providers to let this happen. Now, the ACO receives a minimum of 50 percent of the savings through mitigation of inappropriate ED utilization. Simple measures have proven successful, such as extended hours, weekend hours and walk-in urgent care clinics. A nurse triage “hotline” and embedded health professionals in the ED also have proven to be successful.

C. Internist as Complex Patient Care Management Coach

As noted in the introductory materials, the level of coordination and transition management of complex high-risk patients is both one of the greatest failings of the fee-for-service system and one of the greatest opportunities under accountable care. These patients commonly comprise around 10 to 20 percent of the patient population, yet consume 50 to 70 percent of the total costs.

10% of Medicare patients account for nearly 70% of spending



¹⁷ Email from Grace Terrell, M.D. to the TAC Physician Advisory Committee.

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Because this management yields significant overall contributions to the Triple Aim, they are considered “low-hanging fruit” by ACOs. Internists are ideally suited to serve leadership roles in such efforts. They can be logical extensions of the PCMH concept with more intensity of multispecialty site-of-service coordination and care navigators/community outreach involvement.

The process begins with the aforementioned population stratification. Patients with certain diagnoses, severity of illnesses and levels of resource utilization are assigned for structure intervention.

The October 2014 Commonwealth Fund study of common attributes of high-performing ACOs found the following:

“Care management of patients with costly, complex needs. All study sites have invested resources in deploying care managers, outreach workers, or virtual care teams to engage with and help improve outcomes for patients with complex needs or at risk of incurring high costs. All stress an individualized approach to identify and address unmet needs through in-person or telephone visits. For example, care teams that may include social workers as well as pharmacists and case managers have been deployed by urban safety-net clinics affiliated with Health Share and by Hill Physicians Medical Group to help address the psychosocial and clinical factors that play a role in improving patients’ health and treatment adherence. Marshfield Clinic embedded nurse care coordinators in all its primary care clinics to help patients avoid unnecessary hospital use, with the expectation that shared savings would help fund this infrastructure. It subsequently discontinued the program because it was partially duplicating a service offered by its health plan and because the program’s cost was not sustainable without support from other payers. The clinic retains a care management program serving heart failure patients, and is reconfiguring primary care teams to take over the care coordination responsibilities.”¹⁸

Other complex patient “best practices” of the high-performing ACOs revealed by the study included: (1) virtual care teams of pharmacists, social workers and case managers help primary care physicians manage the clinical and psychosocial needs of this population; (2) physicians are embedded in skilled nursing facilities to prevent avoidable hospital and emergency department admissions; (3) care coordination nurses navigate care and provide individualized care management; and (4) nurses receive electronic alerts when patients visit an emergency department or are discharged.

One of our Internal Medicine Accountable Care Workgroup members added that, “This is a much more enjoyable way to practice.” Having navigators, nutritionists, mental health and access to specialist input brings the right resources to the patient (and treating internist) at the right time and at the right place. Early and accurate intervention is enhanced and offsite physical referral needs are diminished. Discharge planning and post-acute care coordination for these complex patients pay

¹⁸ Lewis, V., et al., Health Affairs, *Few ACOs Pursue Innovative Models That Integrate Care for Mental Illness and Substance Abuse With Primary Care*, Hlth. Aff., No. 10, p. 1808, (Oct. 2014).

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dividends. The skillsets of internists make them particularly suited to serve as team leaders. We are moving from fragmented care to team-oriented integrated care. Because of their concentration in adult medicine training, including particularly for elderly complex patients, internists are the most appropriate subspecialty to serve as the team leader who brings the disparate parts together.

Strategic Note: The better home health, rehab and skilled nursing providers can be identified and made aware of the transition and coordination protocols. According to the Internal Medicine Accountable Care Workgroup, they had no problem getting them onboard because, as one member noted, “They love the referrals.” This is an example in which the internists, PCHM and ACO can exercise value-based “narrow network” steering which the payers increasingly are doing. Use care navigators to provide feedback on who are the best post-acute care providers.

Strategic Note: Take advantage of the new chronic care management codes payment to start in January 2015. Eligible patients are those with multiple chronic conditions, often your identified high-risk patient. The assessment of medical, mental and social needs care coordination and transition management should all be part of your high-risk patient management playbook. Payments are expected to be about \$42 per member/per month (PM/PM). The services may be provided by your allied provider(s) who you have trained to focus on this patient population. Electronic health record use is required.

D. Reduced Unjustified Variability Against Best Practices

Internists in top practices are inevitably surprised with the variability in treatment approaches, outcomes and costs for even common services, such as diabetes management. Population health shifts the culture from “I know I deliver high-quality care because I was well trained,” and the available scheduled time and memory of the physician; to standardized care following peer-vetted, clinically-valid evidence-based best practices.

An example of evidence-based best practices recommended by the American College of Physicians (ACP) may be found in the Choosing Wisely® Initiative¹⁹ :

- **Don't obtain screening exercise electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease.** In asymptomatic individuals at low risk for coronary heart disease (10-year risk <10 percent) screening for coronary heart disease with exercise electrocardiography does not improve patient outcomes.

¹⁹ <http://www.choosingwisely.org/>.

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- **Don't obtain imaging studies in patients with nonspecific low back pain.** In patients with back pain that cannot be attributed to a specific disease or spinal abnormality following a history and physical examination (e.g., nonspecific low back pain), imaging with plain radiography, computed tomography (CT) scan or magnetic resonance imaging (MRI) does not improve patient outcomes.
- **In the evaluation of simple syncope and a normal neurological examination, don't obtain brain imaging studies (CT or MRI).** In patients with witnessed syncope but with no suggestion of seizure and no report of other neurologic symptoms or signs, the likelihood of a central nervous system (CNS) cause of the event is extremely low and patient outcomes are not improved with brain imaging studies.
- **In patients with low pretest probability of venous thromboembolism (VTE), obtain a high-sensitive D-dimer measurement as the initial diagnostic test; don't obtain imaging studies as the initial diagnostic test.** In patients with low pretest probability of VTE as defined by the Wells prediction rules, a negative high-sensitivity D-dimer measurement effectively excludes VTE and the need for further imaging studies.
- **Don't obtain preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology imaging studies.**
- **Don't obtain preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology.** In the absence of cardiopulmonary symptoms, preoperative chest radiography rarely provides any meaningful changes in management or improved patient outcomes.

Another example may be found in the following list published on the ACP website²⁰ :

- **Nonsurgical Management of Urinary Incontinence in Women.** Urinary incontinence contributes to high medical spending in the United States. Approximately \$19.5-billion was spent on UI care in 2004, and UI accounts for 6 percent of nursing home admissions for elderly women, costing around \$3 billion. Physicians should utilize non-drug treatments as much as possible for UI. Kegel exercises for stress UI, bladder training for urgency UI and Kegel exercises with bladder training for mixed UI are effective, have few side effects and are less expensive than medications. Although various drugs can improve UI and provide complete continence, adverse effects often lead many patients to stop taking their medication.
- **Diagnosis of Obstructive Sleep Apnea in Adults.** Prior to diagnosis, patients with obstructive sleep apnea (OSA) have higher rates of health care use, more frequent and longer hospital stays, and greater health care costs than after diagnosis. Assessing patients for OSA in the absence of daytime sleepiness or treating individuals with low apnea-hypopnea index (AHI) scores is low value care because the evidence indicated it does not improve clinical outcomes.

²⁰ <http://www.acponline.org/>.

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- [Screening Pelvic Examination in Adult Women](#). Screening pelvic examination exposes adult, asymptomatic, average risk non-pregnant women to unnecessary and avoidable harms, including anxiety, embarrassment and discomfort, and may even prevent some women from getting needed medical care. False positive findings can lead to unnecessary tests or procedures, adding additional unnecessary costs to the health care system.
- [Treatment of Anemia in Patients with Heart Disease](#). Current evidence does not support the benefit of liberal blood transfusions in patients with asymptomatic anemia and heart disease. Therefore, ACP does not support the liberal use of blood transfusions in the management of mild to moderate anemia in patients with cardiovascular disease. The probability that transfusion may be beneficial is higher in patients with lower hemoglobin levels (<7 g/dL) and lower in less anemic patients (hemoglobin >10 g/dL)(67). ACP does not support the use of ESAs for treating patients with mild to moderate anemia and heart disease because the harms outweigh the benefits for these patients.
- [Screening, Monitoring and Treatment of Stage 1-3 Chronic Kidney Disease](#). ACP found no evidence screening for chronic kidney disease in patients without risk factors improves clinical outcomes. In the absence of any known benefits, ordering screening laboratory studies is not going to have any impact on the clinical outcomes of the patient and will add unnecessary costs to the health care system due to increased medical visits and unnecessary tests.
- [Obstructive Sleep Apnea](#). Physicians should stress the importance of compliance with treatments, especially Continuous Positive Airway Pressure (CPAP). Doctors should weigh patient preferences and the likelihood of therapy adherence against costs before initiating CPAP.
- [Inpatient Glycemic Control](#). High blood glucose is associated with poor outcomes in hospitalized patients, and use of intensive insulin therapy (IIT) to control hyperglycemia is a common practice in hospitals. But the recent evidence does not show a consistent benefit and even shows harms associated with the use of IIT.
- [Screening for Prostate Cancer](#). Men between the ages of 50 and 69 should discuss the limited benefits and substantial harms of the prostate-specific antigen test with their doctor before undergoing screening for prostate cancer.
- [Diagnostic Imaging for Low Back Pain](#). [See Choosing Wisely® list above.]
- [Oral Pharmacologic Treatment of Type 2 Diabetes Mellitus](#). On the basis of the evidence reviewed in this paper, ACP has found strong evidence in most patients with Type 2 diabetes in whom lifestyle modifications have failed to adequately improve hyperglycemia, oral pharmacologic therapy

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with metformin (unless contraindicated) is an effective management strategy. It is cheaper than most other pharmacologic agents, has better effectiveness and is associated with fewer adverse effects; of note, it does not result in weight gain.

- **Screening for Colorectal Cancer.** Currently, no evidence shows screening more frequently than recommended improves patient outcomes or reduces cancer-related deaths. On the other hand, screening more frequently than recommended can contribute substantially to avoidable health care costs.
- **Upper Endoscopy for Gastroesophageal Reflux Disease.** Upper endoscopy is commonly used in the diagnosis and management of gastroesophageal reflux disease (GERD). Evidence demonstrates it is indicated only in certain situations and inappropriate use generates unnecessary costs and exposes patients to harm without improving outcomes.

E. Awareness/Leadership/Urgency: Internists' Role in Guiding Change

Internists need to know what an ACO is, how to recognize one with a likelihood of success, and the professional opportunities and risks involved (the purposes of this *Accountable Care Guide for General Internal Medicine*). A number of leaders need to get up to speed and be catalysts for this transformative change. These champions need to act with confidence, but also with a sense of urgency. This is mentioned as a strategy in and of itself because the biggest risk of failure of the accountable care movement and either collapse of Medicare and Medicaid or default to Draconian alternatives is lack of informed provider leadership. If you do not become involved, there is a good chance the roles of internists will not be optimized. Every successful ACO starts with a few champions. Why not have one be an internist? As Bert Coffey, M.D., said: "If you don't have a seat at the table, you are on the menu."

VI. We've Got Some Great ACO Contributions - Now What?

As noted, there are some clear strategies for improving care and reducing overall costs for commonly occurring disorders, which are ideal for accountable care's emphasis on collaboration and value-based reimbursement. But how does an internist find the right ACO partner, mesh these initiatives into programming and be rewarded fairly?

A. Pick the Right ACO(s)

Culture will usually be the tell-tale indicator on whether any ACO has a chance for success.

- **Physician-Led** – Longstanding habits of individualism and competition among individual

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physician groups will have to transform to a culture of cooperation and collaboration. Physicians have not led complex change, are resistant to capital risk and worry fewer tests and procedures will lower incomes.

- **Hospital-Led** – Hospitals need to shift focus from the current business model of providing acute inpatient care and address head-on the operational impact of decreased admissions. Hospitals need to adopt a partnering culture with physicians and depart from a command and control approach encouraged by the bureaucratic fee-for-service system.

Remember, even if an internist performs perfectly, he/she will still fail if the rest of the ACO is flawed.

As detailed in the companion white paper, *The Physician's Accountable Care Toolkit*®, there are eight elements essential for every successful ACO. They are agnostic as to who or what owns or hosts the ACO, but they must all be present.

The eight elements will determine the attractiveness of the ACO regardless of whether it is part of a hospital system, under the roof of a large multi-specialty clinic or a network of small practices. However, each model has its nuances and presents different strengths and weaknesses. Available ACO options will, of course, be different in metropolitan and rural settings. The presence or absence of internists affects ACO partnering options.

B. You Have Picked a Winning ACO, Now Have the ACO Want to Pick You

1. **Build Relationships** – Internists should be engaged with all the medical specialties and the local health care delivery system. This is a first step to team-building and readiness to partner.
2. **Have a Compelling Story** – As noted, the skill sets of internists are ideally suited for ACOs. Utilizing them in an ACO is a “no-brainer.” We have heard of the “elevator pitch” for startups, whereby the entrepreneur can tell a convincing reason to invest in her company in the length of the time it takes to ride an elevator. Internists have a great story and should reduce it to one or two pages. These initiatives are simple “plug and play” add-ons to the ACO's existing activities, are synergistic and will help the ACO meet quality and savings goals. Good calling cards to open an ACO discussion are: your ability to drive so many of the MSSP's metrics and the fact MSSP ACO patients are attributed only to designated primary care subspecialties, of which internal medicine is one.

Strategic Note: Start simple. Start with your one best initiatives, and then expand later.

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3. **Primary Care Is the Client** – In the new era, success will depend on the patient-centered medical home and neighborhood. Though primary care in some cases has lost its decision-making authority to health systems, payers and large clinics, at the end of the day, primary care is the core of all successful ACOs. Since you are primary care, do not default on this new position.

VII. What Are The Relevant Metrics?

A. The Basic Categories and Sources

You will need baseline data, of course, to create the comparison point on quality, efficiency and patient satisfaction “before” the ACO took over so you can compare it to what happened “after.” Hopefully, some of this data also will be useful to determine local gaps in care to help you pinpoint initiatives to pursue. Broadly, the measures chosen will need to cover quality, efficiency and patient satisfaction. An ACO may choose to match clinical initiatives and metrics (e.g., prevention of readmissions for heart failure and the readmission rate for heart failure), but early metrics could be more general. The Joint Commission National Quality Core Measures, the National Institutes of Health, the Centers for Disease Control and Prevention (CDC), and the National Quality Forum are recommended sources for nationally validated metrics. The AMA-convened Physician Consortium for Performance Improvement® and your own specialty society are other important sources of validated evidence based measures. Thinking of ACO common interests will be helpful in decisions about metrics for your specialty. For example, in addition to metrics specific to internists, think about those also important to the ACO (e.g., the MSSP quality measures, utilization or cost saving indicators) your hospital partner (Joint Commission measures) and payers. The Brookings Institution's *Adopting Accountable Care: An Implementation Guide for Physician Practices (the “Brookings Guide”)* contains useful metrics on care management, tracking referrals to specialists and identifying high-value specialists.²¹

VIII. I SEE THE ROLE OF GOOD DATA IS HUGE, BUT HOW DO I GET IT?

You must have meaningful, actionable data. Let's be careful about the scope of data needed. Health status is primarily influenced by nonmedical factors such as stress at home, education, jobs (or lack thereof) and other social determinants. The Brookings Guide provides the following overview of data sources to consider:

²¹ The Engelberg Center for Health Care Reform at Brookings, *Adopting Accountable Care: An Implementation Guide for Physician Practices*, p. 16, www.acolearningnetwork.org, (Nov. 2014).

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SOURCE	ADVANTAGES	DISADVANTAGES
Claims Data	<ul style="list-style-type: none"> • Important starting point since ACO is measured on costs/patient at end of year. • Information includes diagnoses, admissions, visits to the ED and outpatient providers, diagnostic tests and procedures. 	<ul style="list-style-type: none"> • 30-60-day lag time between a clinical encounter and receipt of the claims report. • Only as accurate as the claims that are submitted by providers; depends on appropriate coding.
Clinical Data	<ul style="list-style-type: none"> • Medical records contain valuable data such as provider notes, lab results, vital signs and medication lists that can help to risk-stratify patients. 	<ul style="list-style-type: none"> • Data must be tagged into discrete fields to allow for sorting and analysis. • Analysis can be difficult for ACOs that do not have a single, comprehensive EHR.
Providers	<ul style="list-style-type: none"> • Clinicians with longstanding relationships with patients can provide intangible information that can help identify those at high risk. 	<ul style="list-style-type: none"> • Lack of literature on physicians' ability to identify patients at high risk of future health care utilization.
Patient-Reported Data	<ul style="list-style-type: none"> • Research shows patient reported outcomes and patient engagement metrics correlate with utilization and cost. • Many metrics freely available, including those for specific diseases. 	<ul style="list-style-type: none"> • Can be time-consuming to collect and measure these metrics from patients. • Patients may lack confidence/trust to accurately respond to survey questions.

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Where are your patients generating costs? How does this compare by provider and Zip Code? Clinical intuition is a powerful tool. For example, one of the best ways to find out which patients will be high-risk is asking the internist or other primary care physician which patients are at highest risk of being admitted to the ED or hospital in the next six months.

The most recent MSSP proposed regulations emphasize the use of health information technology to collect, sort, analyze and stratify relevant data. No one method will perfectly identify the disease status of patients, but many different approaches work reasonably well.

IX. How Do I Ensure That The Savings Pool Distribution Is Fair?

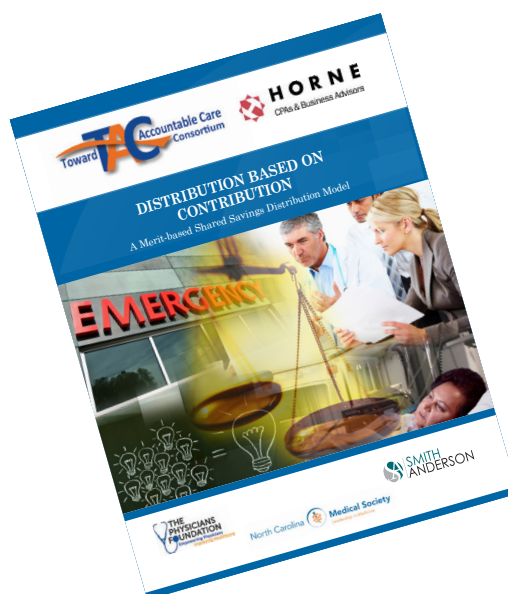
As mentioned in the *Toolkit*, some of the savings pool distributions should be used to maintain the ACO infrastructure, to “prime the pump” as it were. As much as possible should go to incentivize providers and facilities for the extra management time, practice pattern changes and effort to create those savings. To create maximum motivation and trust, presumably the proportion of distributions should be in proportion to the relative contributions to the pool. The more incentive, the greater the odds of increasing the size of the savings pool going forward.

²² *Id.*

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Strategic Note: Some ACOs may choose to use a portion of their shared savings to partially compensate hospitals and specialists who are seeing revenue reductions due to changes in practice patterns (which is not offset by increase in market share and overhead reductions). Some ACOs will distribute savings to capital investors. We caution such tactics will slow the transformational changes needed, sap motivation and ultimately challenge the competitive viability of the ACO altogether.

The TAC Consortium and Initiative has overseen the development of a merit-based shared savings pool distribution methodology for use with multi-specialty ACO initiatives. The *Guide* can be found here: http://www.tac-consortium.org/wp-content/uploads/2013/09/Shared-Savings-Guide_091013_revised_reduced-file.pdf.



X. Protect your interests: Negotiation Tips

A. Negotiating with ACOs

Physicians may be asked to sign participation agreements with an ACO. Although every provider who follows this *Guide* will bring much to the table and is in position to negotiate a reasonable contract, these are specialized arrangements and it is recommended you retain legal counsel knowledgeable in negotiating these types of agreements. Physicians should be particularly mindful of the following areas:

- **Investment** – Any ACO upfront cost obligations?

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- **Ongoing Risk** – What happens if the ACO takes on medical cost risk and does not meet targets? Are you proportionately responsible?
- **Distribution of Savings** – It should be distributed in proportion to contribution to savings, after expenses, but will savings go to investors, owners, to cover lost hospital or providers' revenues relative to fee-for-service?
- **Data** – Who collects it? Is the severity adjusted? Are the metrics clinically valid for your specialty?
- **Corrective Action** – Your continued participation is tied to performance. ACO contracts will have “teeth.” Review the fairness and peer review aspects of the contract.
- **Exclusivity** – Are you contractually bound to just one ACO? (Distinguish from extra-contractual restrictions of a payer, including CMS.)
- **Support** – ACOs are team-based systems that should provide you every reasonable tool and human support to help you optimize your performance and patient care. These should be spelled out. *The Physician's Accountable Care Toolkit*® is specific about what types of support you should seek from your ACO.

B. Negotiating with Private Payers

The bulk of this *Guide* promotes your reimbursement optimization by: (1) designing high value initiatives; (2) earning participation in a well-designed ACO by making the value case; and (3) protecting your interests by negotiating a merit-based shared savings distribution. However, both the ACO in its negotiations with commercial payers, and you, as its member depending on the results, need to know the agreement's hotspots.

- **Prepare Before You Negotiate** – A well-negotiated shared savings agreement merely creates the framework for providers to succeed. There must be a team committed to the shared savings principles who share a common culture of trust and willingness to be flexible and welcome changes. It also is important to know who are your accountable care partners. Your facility or practice group could be doing a great job, but the endeavor will fail if others do not provide the necessary quality and efficiency. You must match the strengths of your ACO with any gaps in care for your target patient population and determine whether the predicted return on infrastructure investment will be positive.²³

²³ Portions reprinted with permission from The Advisory Board Company©.

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- **Know Your Patient Population** – The arrangement could start with one population and eventually expand. Since the premise of determining savings depends on comparing actual costs with the anticipated unmanaged costs of a defined population, it is crucial to know exactly who is in the patient pool to determine baseline historical spending.
- **Understand How Patients Are Assigned to Physicians** – The predominant shared savings model, the MSSP, “attributes” patients to an ACO’s primary care physicians based on where they receive a plurality of primary care services. Medicare patients have freedom of choice, so in some areas, there is problematic patient leakage making care management and financial forecasting difficult. While this may become the default assignment standard, it is preferable in agreements with private payers to have the patient assigned to the network and reflect this on a patient’s enrollment card. It is important to determine how long patients must be enrolled before their performance measurements should occur.
- **Identify Any Service Carve-Outs** – Most arrangements cover the full range of services, which makes savings calculations much easier. However, sometimes pharmacy, mental health, organ transplants, dental, pediatric, out-of-area, emergency, catastrophic or untrackable services are carved out. It is possible a specialty or type of service not provided within a network may be excluded.
- **Strive to Achieve More Than Cost Savings** – The goals and performance metrics are to uphold CMS’ “Triple Aim” Vision—improved population health, enhanced patient satisfaction and decreased cost. Only if the hurdles of the first two are met are you eligible for shared savings.
- **Think Beyond Performance Metrics** – Performing well on payers’ list of metrics is the way to maximize reimbursement; however, it is not sufficient just to “teach to the test”. In order to succeed, an ACO needs to have the right infrastructure investments in place to deliver better quality and lower cost care for populations of patients. This includes investments in care management for engaging patients inside and outside of the health system, and information technology for tracking gaps in care and clinical outcomes over time. Metric selection should align with hospital initiatives to successfully redesign the delivery of care for patients and families. It also is prudent to standardize metrics across payers to the extent possible.
- **Pin Down How Savings Are Determined** – Although the concept is simple—the ACO gets a share of savings if it is able to do a good job at managing costs of the attributed population -- carefully reviewing how savings will be determined is essential. For example, shared savings contracts may include downside risk to the provider if cost targets are not met, and it’s important to consider your organization’s appetite for financial risk before entering into such an agreement. It also is recommended not to focus solely on year-over-year performance. Accountable care is a marathon, not a sprint, and requires a dedicated commitment from leadership to transform into an effective population manager.

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- **Obtain Payer Support** – Increasingly, payers are providing resources and support to fledgling ACOs to help achieve the goal of higher value care. Consider negotiating for such things as the following:
 - **Data** – Seek supplementary claims and other health and financial data. Payers sometimes offer database access, reporting tools and utilization, cost and other reports. ACOs cannot effectively assess where the waste is or how they are doing without access to this type of information.
 - **Help with PCMH** – Payers often assist providers in establishing accredited PCMHs and provide enhanced fee-for-service or performance payments to support practice transformation.
 - **Payer-supplied care coordination training.**
 - **Participation rights to roundtables and forums.**
- **Other Contract Considerations** – A shared-savings negotiation checklist should also include consideration of the following:
 - **Flexibility for the ACO to localize the most appropriate value-adding programs;**
 - **Description of duties of payer and providers;**
 - **Description of the association of shared savings with fee-for-service payments;**
 - **Benefit design and co-pays to facilitate achieving your care management goals; and**
 - **Marketing and steerage—will your organization be in a “narrow network?”**

X. Conclusion

America's health care system will soon become unaffordable absent major change. The accountable care movement holds promise to address runaway costs and thus must be taken quite seriously. There are opportunities for professional and financial reward for informed internists. Put another way, the risks of passivity just are too great. All the alternatives are unacceptable to a provider-led system of providing the highest quality at the lowest cost. Internists have skills and experience positioning them to lead in the success of ACOs, but this is not yet widely recognized within the medical community. To make sure a fair and sustainable ACO model becomes reality, it is important for internists to step up

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with like-minded providers to lead in this potentially career-changing transformation.

This *Guide* is intended to illustrate the significant opportunities for internists in accountable care, to assist them in avoiding the pitfalls and to help them develop accountable care strategies for internists in different settings. For further information, contact the Toward Accountable Care (TAC) Consortium and Initiative lead liaison, Melanie Phelps, at either mphelps@ncmedsoc.org or 919-833-3836.

Part Three: Executing the Accountable Care Strategic Plan



North Carolina  **Medical Society**
Leadership in Medicine

 **THE PHYSICIANS FOUNDATION**
Empowering Physicians
Improving Healthcare

 **SMITH ANDERSON**

 **Toward Accountable Care Consortium**

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I. General Strategies For All Specialties

A. Strategy Number 1: How to Successfully Navigate the Medicare MSSP and Advance Payment Model Application Process

America's largest payor, Medicare, has committed to the ACO model, with a minimum of 50% sharing of savings to ACO providers on top of fee-for-service payments. It may be totally or partially physician-driven, and only primary care physicians are required. To promote physician-only ACOs in non-metropolitan areas, CMS will prefund them through the Advance Payment Model. This level of sustainable funding through ongoing shared savings distributions can "pay for" your ACO operations that can in turn be used for Medicaid, private payor, or other patient population engagements. **The applications are consistent with the principles and strategies of this Physicians' ACO Toolkit, and it is a useful reference to assist in responding to substantive portions of the applications.**

To review, CMS established the Medicare Shared Savings Program (the "MSSP") to facilitate coordination and cooperation among health care providers through ACOs to improve the quality of care for Medicare beneficiaries, while reducing unnecessary costs. In addition, the PPACA established a new Center for Medicare and Medicaid Innovations (the "Innovation Center") to test innovative care and service delivery models, including the "Advance Payment Model." This Chapter will assist ACOs in navigating the MSSP and Advance Payment Model application process.

1. MSSP Application

Applying to the MSSP requires ACOs to submit a significant amount of information. As a result, organization, information gathering, and timing will all be critical for ACOs wishing to participate. The application process can be broken down into the following seven tasks: (a) identify timelines and deadlines; (b) creation and formation of the ACO; (c) file Notice of Intent to Apply; (d) obtain CMS User ID; (e) prepare and execute participation agreements; (f) prepare application; and (g) file application with CMS.

a. **Timelines and Deadlines** – Due to the sheer volume of information that must be submitted with the MSSP application, ACOs should begin the application process at least three months in advance. At the outset, ACOs interested in applying should review CMS's MSSP website, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html, and identify all relevant deadlines. The ACO should then create a task checklist to ensure that all documents, forms, and applications are timely filed. The list of tasks set forth below may serve as a useful template in creating such a checklist.

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b. **Creation and Formation of the ACO** – ACOs applying to the MSSP must ensure that they are properly organized or incorporated under applicable state laws. Newly formed ACOs will need to file Articles of Organization or Articles of Incorporation with the applicable Secretary of State. Newly formed ACOs will also need an Employer Identification Number from the IRS, which may be obtained online at <https://sa.www4.irs.gov/modiein/individual/index.jsp>.

The ACO must also have an identifiable governing body, such as a board of directors, with responsibility for oversight and strategic direction of the ACO. The ACO must ensure that its participants have at least 75% control of the governing body, and at least one member of the governing body must be a Medicare beneficiary. In addition, the governing body must have a conflict of interest policy that: (a) requires each member of the governing body to disclose relevant financial interests; (b) provides a procedure to determine whether a conflict of interest exists, and sets forth a process to address any conflicts that arise; and (c) addresses remedial action for members of the governing body that fail to comply with the policy.

Finally, the ACO must appoint officers with leadership and oversight responsibility for the ACO. At a minimum, such officers must include an executive officer, a medical director, and a compliance officer. The executive officer (such as a president, CEO, or executive director) must have leadership responsibility for the ACO, including the ability to influence or direct the ACO's clinical practices to improve efficiency, processes, and outcomes. The medical director must oversee the clinical management of the ACO. The compliance officer must be responsible for addressing compliance issues related to the ACO's operations and performance. The ACO will need to appoint all such officers prior to applying for the MSSP.

c. **Notice of Intent to Apply** – Before applying to the MSSP and Advance Payment Model, ACOs must file a Notice of Intent to Apply ("NOI") with CMS. ACOs should be aware that the filing deadline for the NOI will be approximately three months prior to the filing deadline for the MSSP application. While all ACOs that wish to apply to the MSSP must file the NOI, filing the NOI does not obligate the ACO to complete the application process. Thus, **ACOs that are even remotely interested in the MSSP should submit a Notice of Intent to Apply to preserve the opportunity to later submit the MSSP application.**

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d. **CMS User ID** – CMS currently requires all interested ACOs to file the MSSP application online using CMS's secure web portal, the Health Plan Management System ("HPMS"); CMS will not accept paper applications. In order to use HPMS, the ACO must obtain a user ID and password using the CMS Form 20037 Application for Access to CMS Computer Systems, available at: www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Downloads/EUAaccessform.pdf. After the ACO files the NOI, the ACO will receive an email from CMS with instructions for completing the Form 20037, along with the deadline for filing the Form 20037. The individual who will be preparing the MSSP application for the ACO should file the Form 20037.

e. **Participation Agreement** – ACOs applying to the MSSP must have participation agreements with their participating providers. At a minimum, the participation agreement must include: (a) an explicit requirement that the ACO participant will comply with the requirements and conditions of the MSSP; (b) a description of the ACO participants' rights and obligations in and representation by the ACO; (c) a description of how the opportunity for shared savings or other financial arrangements will encourage ACO participants to adhere to the ACO's quality assurance and improvement program and evidence-based clinical guidelines; and (d) remedial measures that will apply to ACO participants in the event of non-compliance with the requirements of their agreements with the ACO. The ACO will need to submit its signed participation agreements with each of its participants when it applies to the MSSP. As a result, ACOs will need to prepare their participation agreements well in advance of the application filing deadline and ensure adequate time to collect signed copies from participants.

f. **Preparing the Application** – As noted above, CMS now requires ACOs to file the MSSP application online using HPMS. Before completing the application online, however, ACOs should prepare all application materials in advance to ensure a smooth online application process. The ACO should first download and review the MSSP application template from the MSSP website. The ACO should use this document to assist in collecting and organizing contact information and other background information from ACO participants.

The ACO will also need to prepare a list of its participants, including the taxpayer identification number for each ACO participant. In order to avoid delays in the application process, the ACO will need to confirm that each participant's name and taxpayer identification number listed in the MSSP application match exactly what is listed in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) for such participants. In addition, the ACO will need to prepare an organizational chart that includes the names of the ACO participants, governing board members, committees and committee members, and officers.

A significant portion of the MSSP application consists of certain narrative responses that must be completed by the ACO. These narratives include descriptions of: (a) the ACO's history, mission, and

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organization; (b) how the ACO plans to use shared savings payments; (c) how the ACO will use and protect Medicare data; (d) how the ACO will require its participants to comply with and implement its quality assurance and improvement program; (e) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine; (f) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement; (g) how the ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics; and (h) how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. The ACO will need to carefully review the required elements of each narrative listed in the MSSP application and ensure that each element is discussed in detail; failure to address each required element may result in delay (or rejection) of the ACO's application. As mentioned, this Physicians' ACO Toolkit may be a useful aid in preparing this part of the application.

Assuming that the ACO has gathered all required information in advance, the process of filing the MSSP application through HPMS should be fairly straightforward. The ACO will first need to submit contact information for the ACO and complete certain attestations to ensure that the ACO meets all applicable requirements of the MSSP. The ACO will then submit supporting documentation (including the organizational chart, executed agreements, narratives, and other documentation described above). Prior to uploading this documentation, the ACO will need to review the MSSP application reference table for instructions regarding file names and other HPMS uploading requirements, which is available at: www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram/Downloads/MSSP-Reference-Table.pdf.

Finally, the ACO will need to complete the CMS Form 588 Electronic Funds Transfer Authorization Agreement. This agreement, along with a voided check, must be sent to CMS using tracked mail, such as certified mail, Federal Express, or United Parcel Service. The CMS Form 588 is available at: www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms588.pdf.

2. Conclusion

With this Medicare ACO roadmap, you should not feel concerned about successfully applying for both these programs. The substance sought by the actual questions is remarkably close to the principles and strategies of this Physician's ACO Toolkit. Together, if you have done the spadework to bring together the 8 Essential Elements, success should be straightforward.

B. Strategy Number 2: [UNDER CONSTRUCTION.]

C. Strategy Number 3: [UNDER CONSTRUCTION.]

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II. Specific Strategies for Specific Specialties

Accountable Care Guides for the following specialties can be accessed on the website for the Toward Accountable Care (TAC) Consortium and Initiative at <http://www.tac-consortium.org/resources/>.

A. Anesthesiologists. Previously, a separate copyrighted white paper and specialty-specific ACO strategic plan for anesthesiologists was developed by Smith Anderson and the North Carolina Society of Anesthesiologists (“NCSA”) ACO Task Force. It was underwritten by the NCSA, which holds distribution rights. If you are interested in obtaining a copy of these materials with permission, please contact the NCSA’s Executive Director, Karen Weishaar, at kweishaar@smithlaw.com.

http://www.tac-consortium.org/wp-content/uploads/2013/04/Anesthesiologist_ACO_Toolkit.pdf

B. Cardiologists. Accountable Care Guide for Cardiologists was developed by the Accountable Care Workgroup of the North Carolina chapter of American College of Cardiology and TAC personnel.

C. Child Psychiatrists. Accountable Care Guide for Child Psychiatrists was developed by the Accountable Care Workgroup of the North Carolina Council on Child and Adolescent Psychiatry and TAC personnel.

D. Community Health Partners. Accountable Care Guide for Community Health Partners was developed by the Accountable Care Workgroup of the North Carolina Foundation for Advanced Health Programs and TAC personnel.

E. Emergency Medicine Physicians. Accountable Care Guide for Emergency Medicine Physicians was developed by the Accountable Care Workgroup of the North Carolina College of Emergency Physicians and TAC personnel.

F. Family Physicians. Previously, a separate copyrighted white paper and specialty-specific ACO strategic plan was developed for family physicians. It was underwritten by the North Carolina Academy of Family Physicians, the American Academy of Family Physicians, and several state chapters. A copy of the paper and strategic plan may be accessed at www.ncafp.com or by contacting Brent Hazelett, Deputy Executive Vice President, at bhazelett@ncafp.com.

http://www.ncafp.com/files/ACOGuide-CME_1.pdf

G. Gynecologists. Accountable Care Guide for Gynecologists was developed by the Accountable Care Workgroup of the North Carolina Obstetrical and Gynecological Society and TAC personnel.

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H. Hospice and Palliative Care. Accountable Care Guide for Hospice and Palliative Care was developed by the Accountable Care Workgroup of the Carolinas Center for Hospice and End of Life Care and TAC personnel.

I. Hospitalists. Accountable Care Guide for Hospitalists was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

J. Internal Medicine. Accountable Care Guide for Internists was developed by the Accountable Care Workgroup of the North Carolina Chapter of the American College of Physicians and TAC personnel.

K. Nephrologists. Accountable Care Guide for Nephrologists was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

L. Neurologists. Accountable Care Guide for Neurologists was developed by the Accountable Care Workgroup of North Carolina Neurological Society and TAC personnel.

M. Obstetricians. Accountable Care Guide for Obstetricians was developed by the Accountable Care Workgroup of the North Carolina Obstetrical and Gynecological Society and TAC personnel.

N. Oncologists. Accountable Care Guide for Oncologists was developed by the Accountable Care Workgroup of the North Carolina Oncology Association and TAC personnel.

O. Orthopedics. Accountable Care Guide for Orthopedics was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

P. Pediatricians. Accountable Care Guide for Pediatricians was developed by the Accountable Care Workgroup of the North Carolina Pediatric Society and TAC personnel.

Q. Psychiatrists. Accountable Care Guide for Psychiatrists was developed by the Accountable Care Workgroup of the North Carolina Psychiatric Association and TAC personnel.

R. Radiologists. Accountable Care Guide for Radiologists was developed by the Accountable Care Workgroup of the North Carolina Radiologic Society and TAC personnel.

S. Urologists. Accountable Care Guide for Urologists was developed by the Accountable Care Workgroup of the North Carolina Urological Association and TAC personnel.

ATTACHMENT A - CCNC Guidelines

Adult Tool	Link	Description
Advanced Care Planning		
Advanced Directives and Medical Care Decisions (NC DHHS) (English)	http://www.ncmedsoc.org/non_members/public_resources/eol/MedicalCareDecisions-AdvanceDirectives.pdf	
DNR and MOST Forms: Order Forms Here (NC Division of Health Service Regulation)	http://www.ncdhhs.gov/dhsr/EMS/dnrmost.html https://neiforum.nhpco.org/eWeb/DynamicPage.aspx?Site=NHPCO&WebKey=a9338cdd-546a-42f5-9061-6b91dbdb31da	Web address for ordering MOST (Medical Orders for Scope of Treatment) and DNR (Do Not Resuscitate) forms. These are both to be filled out by the MD with the patient present. The MOST is more specific than the DNR
Hospice Locator by County: Search Page		Put in your county, find out what hospice providers operate in your county.
Palliative Care Resource: getPalliativecare.org	http://getpalliativecare.org/resources/	No PDFs available from this site, but good resource
Antipsychotics		
Antipsychotics: Questions to Ask Prescriber	http://www.ncfahp.org/Data/Sites/1/care-resources/foster-care/questions-to-ask-prescriber-final.pdf	
Adult Safety with Antipsychotic Prescribing	http://www.documentforsafety.org/pub/	Details here about NC Medicaid's prior authorization process for antipsychotics unless the drug is FDA approved for the condition.
Anxiety		
Generalized Anxiety Disorder Screener	http://www.uvm.edu/medicine/ahec/documents/Generalized_Anxiety_Disorder_Screener_GAD7.pdf	
Asthma/Allergy		
Anaphylaxis Action Plan (American Acad of Allergy, Asthma & Immunology) - English	https://www.aaaai.org/Aaaa/media/Medialibrary/PDF%20Documents/Libraries/Anaphylaxis-Emergency-Action-Plan.pdf	To go with patient to school, camp, or institution
Anaphylaxis Action Plan (American Acad of Allergy, Asthma & Immunology) - Spanish	http://www.aaaai.org/Aaaa/media/Medialibrary/PDF%20Documents/Spanish/Anaphylaxis-Emergency-Action-Plan-Spanish.pdf	To go with patient to school, camp, or institution
Asthma 1a - Initial Visit Instructions and Key Steps (CCNC)	https://www.communitycarenc.org/media/tool-resource-files/asthma1a-initial-visit-instructions-key-steps.pdf	
Asthma 1b: Follow Up Visit Instructions and Key Steps (CCNC)	https://www.communitycarenc.org/media/tool-resource-files/asthma1b-follow-visit-instructions-key-steps-.pdf	

Asthma 2 - Facts About Asthma (CCNC) English & Spanish	https://www.communitycarenc.org/media/tool-resource-files/asthma-2-facts-about-asthma-ccnc-english-spanish.pdf
Asthma 3 - Asthma Triggers (CCNC) English & Spanish	https://www.communitycarenc.org/media/tool-resource-files/asthma-3-asthma-triggers-ccnc-english-spanish.pdf
Asthma 4 - Medication Photos Posters (CCNC) English & Spanish	https://www.communitycarenc.org/media/tool-resource-files/asthma-4-medication-photos-posters-ccnc-english-sp.pdf
Asthma Action Plan (CCNC/NCAP/AANC) Print and Write On - English	https://www.communitycarenc.org/media/tool-resource-files/nc-asthma-action-plan-nc-dhhsdpi-english.pdf
Asthma Action Plan (CCNC/NCAP/AANC) Print and Write On - Spanish	https://www.communitycarenc.org/media/tool-resource-files/nc-asthma-action-plan-nc-dhhsdpi-spanish.pdf
Asthma Action Plan: How to Complete Written Plan (CCNC)	https://www.communitycarenc.org/media/tool-resource-files/asthma-action-plan-how-complete-written-plan.pdf
Asthma Action Plan: Instructions for Filling In (CCNC)	https://www.communitycarenc.org/media/tool-resource-files/asthma-action-plan.pdf
Asthma Action Plan: Type into PDF, Save and Print (CCNC) - English	https://www.communitycarenc.org/media/tool-resource-files/asthma-action-plan-one-page-version.pdf
Asthma Control Test age 12-Adult (QualityMetrics) - English	http://www.asthma.com/assets/pdf/asthma_act_adult.pdf
Cardiovascular	
Cardiovascular Risk Calculator (American College of Cardiology)	Tool to help you and your patient decide about statins based on Nov 2013 guidelines.
Statins/Aspirin Choice - Decision Aid (Mayo Clinic)	http://statindecisionaid.mavoclinic.org/
COPD	
My COPD Checklist & Action Plan (B-I Pharmaceuticals/Strategies for Chronic Care) - English	http://www.goldcopd.org/guidelines-pocket-guide-to-copd-diagnosis.html
Tobacco Cessation: 800-QUITNOW One Page Flier (NC DHHS) - Spanish	http://www.quitlinenc.com/docs/patient-resources/quitlinenc-fact-sheet---spanish.pdf?srsl=6
	Tool to use at COPD visits with patients.
	One page 1800QUITNOW flier in Spanish

Tobacco Cessation: Resources for your Practice (NC DHHS Quitline)	http://www.quitlineinc.com/health-professionals/practice-resources/resources-for-your-practice	Posters, fliers, chart of NRT, etc
Tobacco Cessation: Quitline Fax Referral Form (NC DHHS) - English	https://www.communitycarenc.org/media/tool-resource-files/tobacco-cessation-quitline-fax-referral-form-nc-dh.pdf	Fax referral form asking Quitline to call the patient.
Tobacco Cessation: 800-QUITNOW One Page Flier (NC DHHS) - English	http://www.quitlineinc.com/docs/patient-resources/quitlineinc-fact-sheet.pdf?sfvrsn=6	One page flier with 1800-QUITNOW info.
WHO/GOLD/NHLBI - English, Arabic, Romanian, Italian; no Spanish	http://www.goldcopd.org/patient-guide.html http://www.ihpm.org/COPD/Mv%20COPD%20Plan%20of%20Action%20&%20Checklist.pdf	Guide for patients from WHO in multiple languages Jan 2014 Management recommendations- Stable COPD- p.19, Exacerbations- p.20.
WHO Pocket Guide for COPD Management		
Depression		
Adult Depression Flow Chart	https://www.communitycarenc.org/media/tool-resource-files/adult-depression-flow-chart.pdf	From CCNC Depression Toolkit used with NC Evidence Based Practice Center
Depression Differential Diagnosis Screening	https://www.communitycarenc.org/media/tool-resource-files/differential-diagnosis-screening.pdf	Grief Reaction Screening, Mania Screening, Alcohol Use/Abuse Screening
Depression Self-Care Action Plan	https://www.communitycarenc.org/media/tool-resource-files/self-care-action-plan.pdf	Used by CCNC and NC Evidence Based Practices Center
Depression Treatment Care Process Overview	https://www.communitycarenc.org/media/tool-resource-files/treatment-care-overview.pdf	From CCNC Depression Toolkit used with NC Evidence Based Practice Center
Guide to Antidepressants	https://www.communitycarenc.org/media/tool-resource-files/guide-antidepressants.pdf	2 page summary table from CCNC Depression Toolkit
PHQ-9 Screening and Diagnosis - English	https://www.communitycarenc.org/media/tool-resource-files/phq-9-screening-and-diagnosis.pdf	
PHQ-9 Screening and Diagnosis - Spanish	https://www.communitycarenc.org/media/tool-resource-files/phq-9-screening-and-diagnosis-spanish.pdf	
Postpartum Depression: Edinburgh Screening Questionnaire - English	https://www.communitycarenc.org/media/tool-resource-files/post-partum-depression-edinburg-screening-english.pdf	
Postpartum Depression: Edinburgh Screening Questionnaire - Spanish	https://www.communitycarenc.org/media/tool-resource-files/post-partum-depression-edinburg-spanish.pdf	
Diabetes		
Cardiovascular Risk Calculator (American College of Cardiology)	http://tools.cardiosource.org/ASCVD-Risk-Estimator/	Tool to help you and your patient decide about statins based on Nov 2013 guidelines.
Diabetes: A1c Stoplight Graphic (CCNC) - English	https://www.communitycarenc.org/media/tool-resource-files/diabetes-a1c-stoplight-graphic-ccnc-english.pdf	Discussion tool about A1c

Diabetes: A1c Stoplight Graphic (CCNC) - Spanish	https://www.communitycarenc.org/media/tool-resource-files/diabetes-a1c-stoplight-graphic-ccnc-spanish.pdf	Discussion tool about A1c
Diabetes: Adjusting Insulin Doses (Endocrine Society)	http://www.accurateinsulin.org/for-doctors/ http://www.ccwic.com/Forms/Diabetes/Patient%20Education/Diabetes%20Self%20Care%20Goals.pdf	
Diabetes: Self-Management Goal Sheet		
Infectious Disease		
HIV: Fact Sheets, Resources, FAQs (aidsinfonet.org) (English, Spanish and Nepali)	http://aidsinfonet.org/printing-downloading	Lots of info from New Mexico AIDS Education and Training Center funded by FDA and National Library of Medicine.
STDs Current Treatment Guidelines (CDC)	http://www.cdc.gov/std/treatment/default.htm	Regularly updated website with current guidelines for treatment of STDs.
Obesity		
Adult BMI Charts	http://www.eatSMARTmoveMorenc.com/BMI/BMI.html	Download PDFs here to use on screen or wall
Weight Loss: Adult Handouts (EatSMARTmoveMore NC)	http://www.eatSMARTmoveMorenc.com/PatientEducation/Packets/PatientEducationPackets.html	Links to BMI charts, several low literacy appropriate handouts (Move more for a healthy weight, Eating out, etc), but all English only.
Weight Loss: Find a Local Program (NC Alliance for Healthy Communities)	http://www.ncahc.org/weight-management-registry-north-carolina.html	Helps you to find weight management programs for your patients by zip code or county.
Weight Loss: Prescription 5-3-2-1 (EatSMARTmoveMore NC) - English	http://www.eatSMARTmoveMorenc.com/PediatricObesityTools/Texts/PrescripPadBW.pdf	Prescription for 5 servings fruit/veg, 3 meals/day, 2 hours or less screen-time, 1 hour or more of activity.
Weight Loss: Prescription 5-3-2-1 (EatSMARTmoveMore NC) - Spanish	http://www.eatSMARTmoveMorenc.com/PediatricObesityTools/Texts/PrescripPadSpBW.pdf	Prescription for 5 servings fruit/veg, 3 meals/day, 2 hours or less screen-time, 1 hour or more of activity.
Pain Management		
Chronic Pain Management Progress Note	https://www.communitycarenc.org/media/tool-resource-files/chronic-pain-management-progress-note.pdf	Personalized Progress Note
Diagnosis Intractability Reliability Efficacy (DIRE) - When Considering Opioids Long Term	https://www.communitycarenc.org/media/tool-resource-files/calculating-dire-score.pdf	
How to Make an Overdose Plan	https://www.communitycarenc.org/media/tool-resource-files/how-make-overdose-plan.pdf	Overdose Plan Directions
Interpreting Urine Toxicology Screens	https://www.communitycarenc.org/media/tool-resource-files/interpreting-urine-toxicology-screens.pdf	UNC Hospitals Guide to Urine Toxicology Screens
Management Algorithm - Neuropathic Pain	https://www.communitycarenc.org/media/tool-resource-files/management-algorithm-neuropathic-pain.pdf	Follow the clues to Neuropathic pain

Opioid Risk Tool (ORT) When Considering Use of Narcotics for Chronic Pain	https://www.communitycarenc.org/media/tool-resource-files/opioid-risk-tool.pdf	
Pain Assessment and Management Algorithms	https://www.communitycarenc.org/media/tool-resource-files/pain-assessment-and-management-algorithms.pdf	Modified from ICSI Management Algorithm
Pain Management Agreement	https://www.communitycarenc.org/media/tool-resource-files/pain-management-agreement.pdf	Patient Pain Management Agreement
Pain: NC Controlled Substances Reporting System - CSRS Login	https://hccsrsp.hidinc.com/	CSRS is a statewide reporting system designed to track the use of prescription drugs classified as Schedule II-V controlled substances. (log-in credentials required.)
Pain: NC Legal history (drug charges, DUIs, forgery, etc)	http://webapps6.doc.state.nc.us/opi/offendersearch.do?method=view	If your practice checks NC legal history prior to Narcotics Contracts with patients, you can do so here-- NC Offender Search is free and public, courtesy of the NC Department of Public Safety.
SBIRT Annual Screening Questionnaires	https://www.communitycarenc.org/media/tool-resource-files/sbirt-annual-screening-questionnaires.pdf	Questionnaires in English & Spanish
SBIRT Audit Forms	https://www.communitycarenc.org/media/tool-resource-files/sbirt-audit-forms.pdf	Forms in English and Spanish; scoring template
SBIRT DAST-10 Forms	https://www.communitycarenc.org/media/tool-resource-files/sbirt-dast-10-forms.pdf	Forms in English and Spanish; scoring template
Universal Precautions for Pain Medicine Prescribing	https://www.communitycarenc.org/media/tool-resource-files/universal-precautions-pain-medicine-prescribing.pdf	
Sickle Cell Disease		
Sickle Cell Care Guidelines Oriented by Problem (CDC/Grady Health System)	http://scinfo.org/problem-oriented-clinical-guidelines/	Guidelines for treating over 40 syndromes common in SC patients, developed with US DHHS funds and in use at Grady SC Center
Sickle Cell Care: Few BASIC Primary Care Guidelines (CDC/NHLBI)	http://www.cdc.gov/NCBDDD/sicklecell/recommendations.html	Few basic evidence based pearls that should be known by all providers treating patients with Sickle Cell
Substance/Alcohol Use		
Alcoholism: Find AA Meeting/Chapter by Zip Code (Alcoholics Anonymous) (English & Spanish Meetings)	http://www.aa.org/pages/en_US/find-aa-resources	Find local chapter by zip code. Call local chapter for schedule of local meetings and other information. Meetings in Spanish are available in most parts of NC.

Alcoholism: SBIRT- Click "next" Screening, Brief Interventions & Referral to Treatment (NIAAA)	http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide5.htm	National Institute of Alcohol Abuse and Alcoholism has put together pocket guide and more extensive clinician's guide-- this is a concise presentation of these materials. Click "next" to go through all SBIRT steps.
Calculating DIRE Score	https://www.communitycarenc.org/media/tool-resource-files/calculating-dire-score.pdf	
How to Make an Overdose Plan	https://www.communitycarenc.org/media/tool-resource-files/how-make-overdose-plan.pdf	Overdose Plan Directions
Interpreting Urine Toxicology Screens	https://www.communitycarenc.org/media/tool-resource-files/interpreting-urine-toxicology-screens.pdf	UNC Hospitals Guide to Urine Toxicology Screens
Pain: NC Controlled Substances Reporting System - CSRS Login	https://nccsrsp.hidinc.com/	CSRS is a statewide reporting system designed to track the use of prescription drugs classified as Schedule II-V controlled substances. (log-in credentials required.)
SBIRT Annual Screening Questionnaires	https://www.communitycarenc.org/media/tool-resource-files/sbirt-annual-screening-questionnaires.pdf	Questionnaires in English & Spanish
SBIRT Audit Forms	https://www.communitycarenc.org/media/tool-resource-files/sbirt-audit-forms.pdf	Forms in English and Spanish; scoring template
SBIRT DAST-10 Forms	https://www.communitycarenc.org/media/tool-resource-files/sbirt-dast-10-forms.pdf	Forms in English and Spanish; scoring template
Tobacco Cessation		
Tobacco Cessation: 800-QUITNOW One Page Flier (NC DHHS) - Spanish	http://www.quitlinenc.com/docs/patient-resources/quitlinenc-fact-sheet---spanish.pdf?sfvrsn=6	One page 1800QUITNOW flier in Spanish
Tobacco Cessation: Resources for your Practice (NC DHHS Quitline)	http://www.quitlinenc.com/health-professionals/practice-resources/resources-for-your-practice	Posters, fliers, chart of NRT, etc
Tobacco Cessation: Quitline Fax Referral Form (NC DHHS) - English	https://www.communitycarenc.org/media/tool-resource-files/tobacco-cessation-quitline-fax-referral-form-nc-dh.pdf	Fax referral form asking Quitline to call the patient.
Tobacco Cessation: Quitline Fax Referral Form (NC DHHS) - Spanish	http://www.quitlinenc.com/docs/provider-resources/spanishfaxreferralform.pdf?sfvrsn=2	Fax referral form asking Quitline to call the patient.
Tobacco Cessation: 800-QUITNOW One Page Flier (NC DHHS) - English	http://www.quitlinenc.com/docs/patient-resources/quitlinenc-fact-sheet.pdf?sfvrsn=6	One page flier with 1800-QUITNOW info.
Veterans		
Veteran's Crisis Line (US Department of Veteran's Affairs)	http://veteranscrisisline.net/ForVeterans.aspx	Online chat, text or phone support for vets or active military in crisis.

Well Care	
11-21 Years	
ABCD (Assuring Better Child health and Development) - Screening Overview	https://www.communitycarenc.org/media/tool-resource-ABCD-Assuring Better Child health and Development - Screening overview
Blood Pressure Table (Boys)	http://www.eatsmartmovemorenc.com/PediatricObesityTools/Texts/BPTTableBoys.pdf
Blood Pressure Table -- (Girls)	http://www.eatsmartmovemorenc.com/PediatricObesityTools/Texts/BPTTableGirls.pdf
Depression - PHQ-9 Depression Screen - English	http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf
Depression - PHQ-9 Depression Screen - Spanish	http://www.phqscreeners.com/pdfs/02_PHQ-9/PHQ9_Spanish%20for%20the%20USA.pdf
Depression - PHQ-9 Depression Screen, Scoring Instructions	http://brightfutures.aap.org/pdfs/Other%203/PHQ-9%20Instructions%20for%20Use.pdf
Obesity - Color-Coded BMI Chart (Boys)	http://www.eatsmartmovemorenc.com/PediatricObesityTools/Texts/BMIChartBoys.pdf
Obesity - Color-Coded BMI Chart (Girls)	http://www.eatsmartmovemorenc.com/PediatricObesityTools/Texts/BMIChartGirls.pdf
Screening - Guidelines for Adolescent Preventive Services (GAPS), ages 11-14 - English	http://www.capefearpediatrics.com/pdf/522781-younger%20adolescent%20english.pdf
Screening - Guidelines for Adolescent Preventive Services (GAPS), ages 11-14 - Spanish	http://www.capefearpediatrics.com/pdf/522777-younger%20adolescent%20spanish.pdf
Screening - Guidelines for Adolescent Preventive Services (GAPS), ages 15-21 - English	http://www.capefearpediatrics.com/pdf/522778-older%20adolescent%20english.pdf
Screening - Guidelines for Adolescent Preventive Services (GAPS), ages 15-21 - Spanish	http://www.capefearpediatrics.com/pdf/522779-older%20adolescent%20spanish.pdf
Screening - Guidelines for Adolescent Preventive Services (GAPS), Parent/Guardian - English	http://www.uvpediatrics.com/Docs/GAPSParenteng.pdf
Screening - Guidelines for Adolescent Preventive Services (GAPS), Parent/ Guardian - Spanish	http://www.capefearpediatrics.com/pdf/GAPS%20-%20Parent%20Sp.pdf
Screening – Pediatric Symptom Checklist (Youth Self-Report, age 11-18+) - English	http://www.massgeneral.org/psychiatry/assets/PSCY-35_English.PDF
Screening – Pediatric Symptom Checklist (Youth Self-Report, age 11-18+) - Spanish	http://www.massgeneral.org/psychiatry/assets/PSC_Y_Youth_Self_Report_Spanish.pdf
Sports Pre-Participation Physical Exam Form (AAP/AAFP/ACSM)	http://www.aafp.org/dam/AAFP/documents/patient_care/fitness/ppephysicalexamform2010.pdf
Well Child/Health Check Billing Guide (NC Medicaid)	http://www.ncdhhs.gov/DMA/healthcheck/HCBilling_Guide_2013.pdf
22-49 Years	

ACP Men's Preventive Plan	https://www.communitycarenc.org/media/files/acp-mens-preventive-plan.doc	
ACP Women's Preventive Plan	https://www.communitycarenc.org/media/files/acp-womens-preventive-plan.doc	
Men: Staying Healthy at Any Age- Preventive Services Recommendations (AHRQ) - English	http://www.ahrq.gov/patients-consumers/patient-involvement/healthy-men/healthy-men.pdf	
Men: Staying Healthy at Any Age- Preventive Services Recommendations (AHRQ- 2014) - Spanish	http://www.ahrq.gov/patients-consumers/patient-involvement/healthy-men/hombre.pdf	
Women: Staying Healthy at Any Age- Preventive Services Recommendations (AHRQ) - English	http://www.ahrq.gov/patients-consumers/prevention/lifestyle/healthy-women.pdf	
Women: Staying Healthy at Any Age- Preventive Services Recommendations (AHRQ) - Spanish	http://www.ahrq.gov/patients-consumers/prevention/lifestyle/mujer.pdf	
50-64 Years		
ACP Men's Preventive Plan	https://www.communitycarenc.org/media/files/acp-mens-preventive-plan.doc	
ACP Women's Preventive Plan	https://www.communitycarenc.org/media/files/acp-womens-preventive-plan.doc	
Women 50-plus: Preventive Care checklist (AHRQ) - English	http://www.ahrq.gov/patients-consumers/prevention/lifestyle/women-over-50.pdf	Great 2 page handout on preventive care- practices can get these for free by ordering them from AHRQ- see here: http://www.ahrq.gov/ppip/pporder.htm
Women 50-plus: Preventive Care checklist (AHRQ) - Spanish	http://www.ahrq.gov/patients-consumers/prevention/lifestyle/women50sp.pdf	Great 2 page handout on preventive care- practices can get these for free by ordering them from AHRQ- see here: http://www.ahrq.gov/ppip/pporder.htm or Call AHRQ at 1-800-358-9295- link checked
Men 50-plus: Preventive Care checklist (AHRQ) - English	http://www.ahrq.gov/patients-consumers/patient-involvement/healthy-men/men-over-50.pdf	Great 2 page handout on preventive care- practices can get these for free by ordering them from AHRQ- see here: http://www.ahrq.gov/ppip/pporder.htm
Men 50-plus: Preventive Care checklist (AHRQ) - Spanish	http://www.ahrq.gov/patients-consumers/patient-involvement/healthy-men/men50sp.pdf	Great 2 page handout on preventive care- practices can get these for free by ordering them from AHRQ- see here: http://www.ahrq.gov/ppip/pporder.htm or Call AHRQ at 1-800-358-9295- link checked 4/7/2011-pw
65+ Years		
ACP Men's Preventive Plan	https://www.communitycarenc.org/media/files/acp-mens-preventive-plan.doc	
ACP Women's Preventive Plan	https://www.communitycarenc.org/media/files/acp-womens-preventive-plan.doc	

Initial Preventive Phys Exam: "Welcome to Medicare" Encounter Form (AAFP)	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf	<p>This is a tool from CMS for MDs to use to ensure we do & document the 'Welcome to Medicare' exam appropriately. Note that there are new additions in this January 2009 version.</p>
Initial Preventive Physical Exam Requirements (CMS)	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf	
Medical Care Decisions and Advanced Directives (NC DHHS)	http://www.ncmedsoc.org/non_members/public_resources/eol/MedicalCareDecisions-AdvanceDirectives.pdf	
Medicare Annual Wellness Visit - Health Risk Assessment (ACP) - Paper	http://www.acponline.org/running_practice/payment_coding/medicare/hra.pdf	Paper version
Medicare Annual Wellness Visit - Health Risk Assessment (Dartmouth) - Computer	http://www.medicarehealthassess.org/ https://www.communitycarenc.org/media/tool-resources-files/medicare-annual-wellness-visit-practice-checklist.pdf	Fill out online and print results
Medicare Annual Wellness Visit - Practice Checklist (ACP)	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN90570_6.pdf	
Medicare Annual Wellness Visit Requirements (CMS)		

The Accountable Care Guide For Internal Medicine

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