ADVANCING NATIONAL HEALTH REFORM

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POLICY BRIEF
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Advancing the Capabilities of Safety Net Accountable Care Organizations (ACOs)

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Advancing the Capabilities of Safety Net Accountable Care Organizations

INTRODUCTION

This policy brief is the third in a series on "Advancing National Health Reform." The first policy brief in this series (August 2011) highlighted some of the legal and regulatory issues contained in the original Accountable Care Organization (ACO) rules and regulations that proved problematic for safety net organizations. A number of these concerns were addressed in the publication of the final rules and regulations in October 2011. Of greatest significance, these included more flexible criteria allowing Federally Qualified Health Centers (FQHCs) and Rural Health Centers to be eligible to form and participate in ACOs, a reduction in the number of quality measures to be provided from 65 to 33, and the development of an Advance Payment Model in which applicants could receive anticipated savings in advance to pay for the implementation of electronic health records and related infrastructure needed to provide more cost-effective care.

The second policy brief (December 2011) focused on California's specific statutory and regulatory issues. It sought to illuminate issues unique to California, such as the corporate practice of medicine doctrine and the state's unique regulatory structure. In addition, the brief discussed issues that all states will face to some degree, such as potential shifts in medical liability and the need to examine scope of practice rules.

While the first two policy briefs focused primarily on the external rules and regulations governing safety net ACO formation at the national and state levels, this third policy brief highlights the internal capabilities that safety net organizations will need in order to provide more accountable care.

BACKGROUND

The landmark Affordable Care Act (ACA) passed by Congress in 2010 will ultimately extend health insurance coverage to approximately 32 million Americans. While there are many challenges to implementing the legislation, perhaps the most daunting is whether the current U.S. healthcare delivery system can meet the expanded demand for care in a way that controls cost growth at the same time as maintaining or improving quality. While the primary focus of the ACA is on health insurance expansion, it contains some provisions designed to reform the delivery system. Foremost among these is legislation charging the Centers for Medicare and Medicaid Services (CMS) to develop new payment models that encourage the formation of Accountable Care Organizations (ACOs). ACOs are defined as entities that agree to be held accountable for the cost and quality of care for a defined

population of patients in return for sharing in potential savings that may result from delivering care for less than an agreed-upon expenditure target.

The recently published final rules and regulations provide for three types of ACOs. The first is the general *Medicare Shared Savings Program*, in which qualified organizations agree to participate in potential shared savings on a 50/50 basis with CMS without necessarily accepting any downside risk. Those who agree to accept some downside risk would be eligible for sixty percent of the savings. The second program, designed to encourage additional applicants to apply who might not have all the capabilities to initially achieve expenditure targets or quality standards, is the *Advance Payment Model*. In this program, participants are paid in advance from a pool of funds based on projected savings. These payments can be used to develop electronic health record infrastructure, care management capabilities, and related support. The final rules and regulations also allow payments to practices in which nurse practitioners and physician assistants act as patients' primary care providers, as is often the case with safety net and rural providers. It is expected that this program may help attract safety net providers, networks of small physician practices, and rural providers. The third CMS program is the *Pioneer Program*, which is designed for more advanced organizations willing and able to eventually accept capitated payment for a population of patients from both CMS and potentially other payers. These organizations will be rewarded with a greater percentage of savings achieved upon providing quality care within their capitated budget. Key provisions of the final rules and regulations involving ACOs are summarized in Appendix A.

MAJOR ISSUE

A major issue for all providers is whether they can develop the capabilities to provide cost-effective care across the entire continuum to take advantage of the incentives provided by the new ACO payment models. This issue is particularly acute for safety net providers such as federally qualified health centers, community clinics, and public and private disproportionate share hospitals, which generally lack capital resources needed to create more integrated, cost-effective systems of care. This challenge is exacerbated by the extreme pressure to reduce costs, or at least the rate of increase in cost, given California's fiscal crisis. Payment rates for Medi-Cal patients are among the lowest in the nation and further cuts are expected. Thus, it will be incumbent upon safety net organizations to innovate and develop new ways of providing care that maximize the impact of whatever resources may be available.

To address this issue we developed a survey instrument designed to assess the capabilities of safety net organizations to provide more accountable care (see Appendix C for the final instrument). Based on advice of an external advisory committee (see Appendix B), we pilot tested the instrument in two counties: Alameda County in Northern California and Orange

County in Southern California. In discussion with our advisory committee, we sought to identify counties that were very distinct from each other. For example, though we hoped to identify counties that had conducted initial brainstorming sessions around the implication of the Affordable Care Act, it was acceptable (and even beneficial) for the two counties to have different approaches about how to proceed in light of the historic legislation.

The Alameda Alliance for Health (the Alliance) and the Alameda Health Care Services Agency oversee the provision of care to 211,000 Medicaid and uninsured individuals, including over 1.4 million patient encounters per year. The Alliance is a health plan comprised of 15 hospitals, 29 community clinics, and over 1,700 physicians and is governed by a 12-member board. Alliance members include the Alameda County Board of Supervisors, the Alameda County Medical Center, Asian Health Services, La Clinica de la Raza, labor representation, and many more.

Orange County oversees the provision of care to approximately 212,000 Medicaid and uninsured individuals involving approximately 600,000 patient encounters per year. Major organizations working to serve this population include the Health Funders Partnership of Orange County, the Coalition of Orange County Community Health Centers, the Orange County Health Care Agency, Cal-Optima and its private safety net hospital partners, and Children's Hospital of Orange County Health Alliance.

The sections that follow describe the survey, the results, and our policy conclusions and recommendations.

THE SURVEY

The survey instrument was developed through a comprehensive review of existing ACO assessment instruments including those of the National Coalition for Quality Assurance (NCQA), the American Medical Group Practice Association (AMGA), the Medical Group Management Association (MGMA), the Health Research and Educational Trust (HRET) of the American Hospital Association, the Premier Hospital Alliance, Group Health Cooperative of Puget Sound, the Brookings Dartmouth ACO Learning Collaborative, the Dartmouth Institute, and the California Association of Physician Groups (CAPG). The study advisory committee reviewed various drafts of the tool. The final pilot instrument contained 90 questions organized into 9 categories. These categories were: 1) organizational mission and population served; 2) governance and leadership; 3) partnerships; 4) finance and contracts; 5) information technology infrastructure; 6) managing clinical care; 7) performance reporting; 8) legal and regulatory issues and barriers; and 9) overall assessment. Each of these categories is briefly described below (see Appendix C for the final instrument).

Organizational Mission and Population Served

Of special relevance to safety net organizations is their mission of providing care to Medicaid and uninsured populations. Thus, it is important to assess the extent to which meeting requirements for more accountable care might require adjustments to the organization's mission and/or changes in the population served. This section also asked about the adequacy of physicians, hospitals, and other health professionals and provider organizations to serve the target population.

Governance and Leadership

This section asked about the adequacy of the organization's governance structure and leadership with a focus on the central involvement of physicians and overall clinical and managerial leadership.

Partnerships

This section recognized the need for many safety net organizations to develop relationships with new provider organizations beyond those that currently exist. Questions were asked about the readiness of potential partner organizations to provide accountable care and their willingness to add or delete services to meet target population needs.

Finance and Contracts

The ability to bear financial risk and enter into risk-bearing contracts is central to the success of ACOs. This section asked a series of questions related to the ability to bear risk, manage contractual relationships, and distribute shared savings. It also asked whether or not the group was able to afford the potential upfront costs of becoming an ACO.

Information Technology Infrastructure

The development of electronic health record (EHR) functionality is a key capability to manage patient risk and to assess and report on performance metrics. This section asked a series of questions involving many of the "meaningful use" EHR criteria.

Managing Clinical Care

This section included questions on the cultural competence, which is key to providing care to the safety net population. Questions related to various care management processes, the integration of behavioral health services, and the overall ability to provide more cost-effective care were also included.

Performance Reporting

This section asked for responses on the ability of the organization to report on the 65 metrics listed in the preliminary ACO regulations. These included measures of patient experience, care coordination, patient safety, prevention measures, and measures of care for at risk populations. In the final ACO rules and regulations, the number of metrics was reduced to 33. Thus, organizations completing a revised instrument might have a higher score for this section.

Legal and Regulatory Issues and Barriers

This section asked whether the organization was aware of the legal or regulatory issues and barriers that they might face if they choose to form an ACO. Relevant issues included the corporate practice of medicine doctrine, the involvement of tax-exempt healthcare providers, issues of compliance, and related regulatory and legal challenges.

Overall Assessment

Three questions were included regarding respondents' overall assessment of how ready the organization was to assume the responsibilities of providing more accountable care.

METHODS

Twenty-six respondents from Alameda County and twenty-five respondents from Orange County completed the survey instrument for a total of fifty-one respondents. It was administered online through Qualtrics (www.Qualtrics.com). The results reported below are for the overall assessments of both counties' readiness to provide accountable care. A subset of respondents were asked to complete the survey twice in order to separate out their assessment of readiness for the county overall versus the individual organization for which they were responsible. The results below are reported for assessments of the readiness of the county overall.[i]

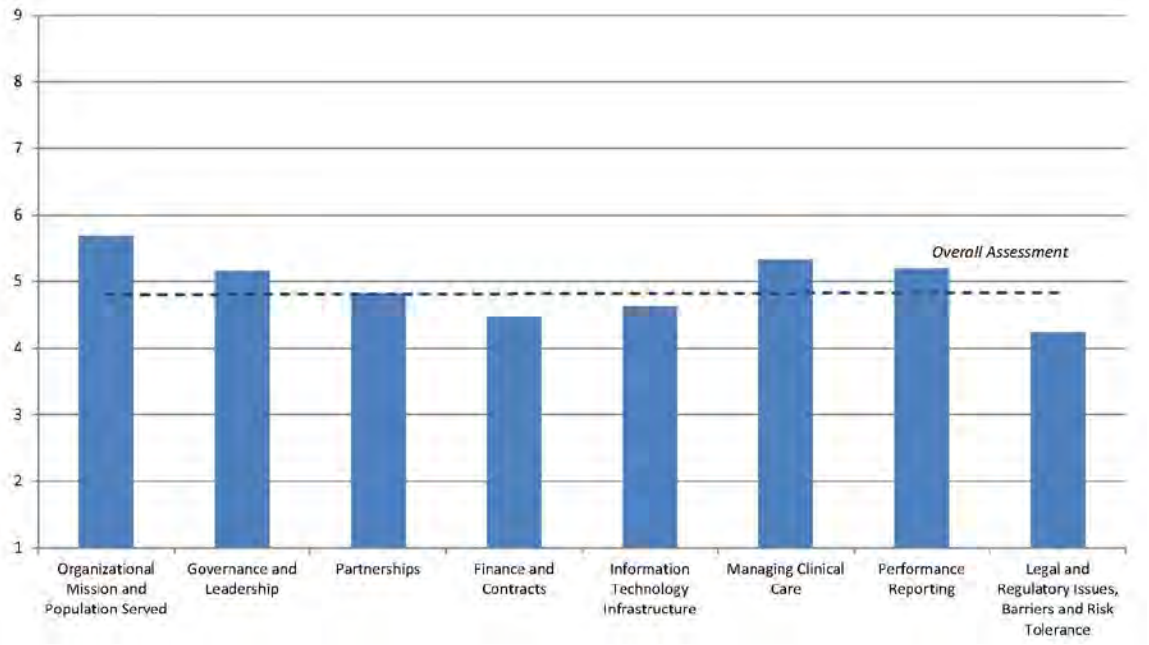
In order to assess the internal consistency reliability of the survey, we calculated a statistic called Cronbach Alpha for each of the nine question categories. These coefficients ranged from 0.63 to 0.91, with most of the coefficients being above 0.70 – a commonly accepted cut-off point for demonstrating reliability.

[i] Fourteen surveys on the readiness of the respondents' own organization were used where no survey on the overall county was completed.

RESULTS

The pilot survey results across the nine categories are shown in Exhibits 1 and 2 below. The average scores across all categories are in the range of approximately 4-5 (on a scale of 1 as low to 9 as high), indicating that respondents in the two counties felt that they have some of the capabilities to form successful ACOs. At the same time, however, the assessments indicate that more preparation and work is needed in almost all categories. The highest score is for the Organizational Mission and Populations Served category. Even here, however, respondents indicated that there is need for additional information on new populations that may be served including their socio-demographic characteristics, healthcare utilization, and health status. In addition, and of particular significance, is the fact that respondents indicated that there might be a shortage of providers and resources necessary to treat the population served.

Exhibit 1. Summary of Responses[ii]



[ii] Overall Assessment represents the last of the nine categories mentioned above and is not an average of the other eight categories shown.

Exhibit 2. Section-Level Summary

	Mean	Median	Standard Deviation	Range
Organizational Mission and Population Served	5.69	5.75	1.03	[2.86, 7.75]
Governance and Leadership	5.16	5.00	1.91	[1.20, 9.00]
Partnerships	4.82	4.93	1.60	[1.00, 8.33]
Finance and Contracts	4.47	4.25	1.90	[1.00, 8.67]
Information Technology Infrastructure	4.63	4.64	1.77	[1.00, 9.00]
Managing Clinical Care	5.33	5.36	0.82	[3.55, 7.25]
Performance Reporting	5.20	5.00	1.93	[1.33, 8.67]
Legal and Regulatory Issues, Barriers, and Risk Tolerance	4.23	4.33	1.78	[1.13, 8.67]
Overall Assessment	4.80	5.00	1.81	[1.00, 9.00]

The lowest rated categories were Legal and Regulatory Issues, Barriers, and Risk Tolerance, Finance and Contracting, and Information Technology Infrastructure. With regard to legal and regulatory issues, respondents indicated the following as key barriers: the need for ensuring that they are able to protect the tax-exempt status of participating organizations and the need for a strategy to deal with the corporate practice of medicine doctrine as it might influence relationships with new partners.

In the finance and contracts category, respondents indicated that more needs to be done to develop the information systems to track utilization and costs under risk-bearing contracts. There is also the need to examine the upfront investments needed to become an ACO and the resources necessary to cover them. More focus on the actual distribution of shared savings was another area that respondents indicated needed attention.

As expected, respondents reported the need for greater capabilities with regards to electronic health record functionality including using disease registries, embedding practice guidelines, incorporating information from non-participating providers, and constructing electronic patient communication and engagement tools.

The major areas of improvement with regards to managing clinical care included the need to integrate behavioral health programs into primary care, develop systems to close gaps in continuity of care such as care transition programs, improve quality measures such as for hospital readmissions, and expand provider training in continuous quality improvement.

Respondents also indicated the need for ongoing work in establishing hospital and specialist physician partners, involving physicians earlier in planning conversations, and considering the use of new categories of health care workers in providing care.

With regard to the overall assessment of their readiness to assume responsibilities for providing more accountable care, respondents indicated that they felt more ready to meet

the quality metrics but were much more concerned about the ability to meet expenditure and cost targets. This evaluation is particularly significant given the cost pressures noted earlier.

Further analysis of the data indicated that higher scores on the *ability to form partnerships* and *address legal and regulatory issues* were most strongly associated with the overall readiness assessment scores. In addition, higher scores on *performance reporting capabilities* were most strongly associated with confidence in meeting quality of care measures.

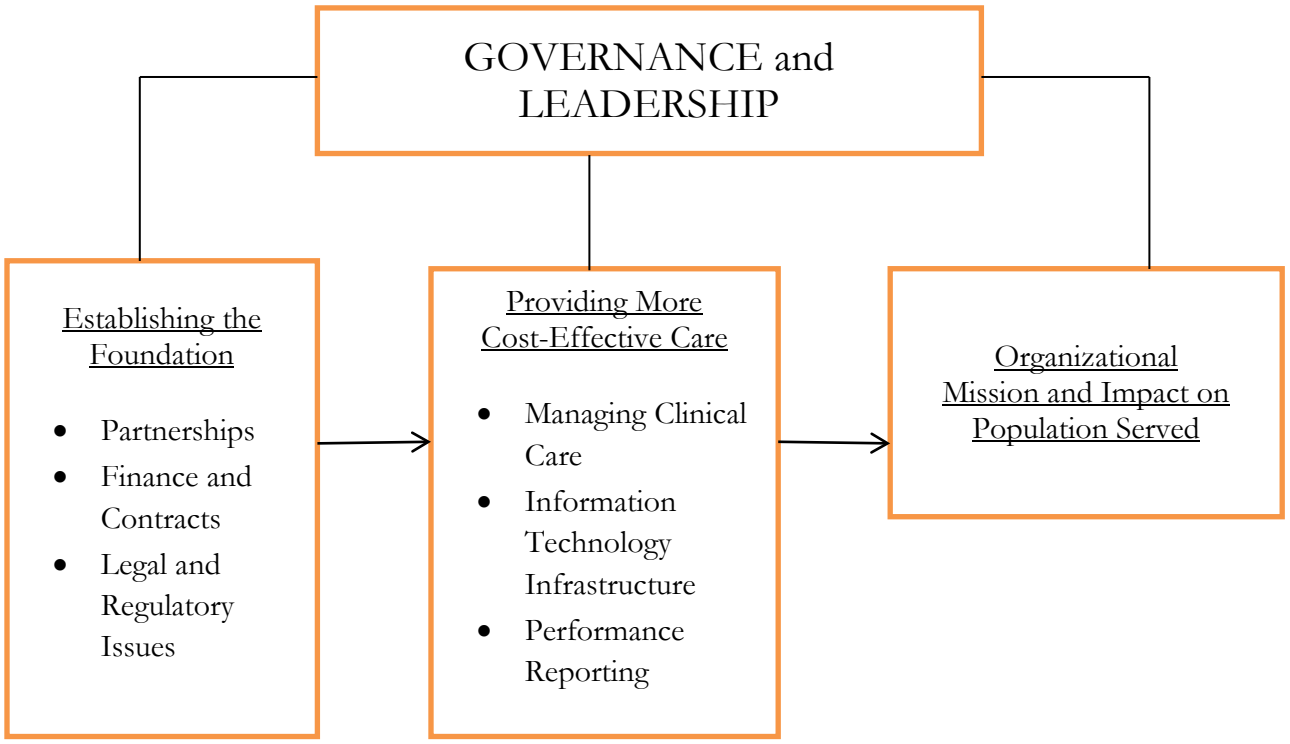
LIMITATIONS

The policy recommendations that follow must be considered within the context of several limitations. First, the findings are based on the two California counties selected. While we believe that the issues raised are germane for the state as a whole and, indeed nationally, they cannot be strictly generalized to other settings. Second, we learned that the questions dealing with finance and contracts as well as those related to legal and regulatory issues are best addressed by respondents with specific knowledge and experience with those areas as opposed to respondents possessing more general knowledge of their safety net organization's capabilities (which is who completed the survey in this pilot phase). Third, while we believe that we included the major categories of issues facing safety net organizations, there may be some additional issues that emerge and that will need to be included in future assessments.

POLICY IMPLICATIONS AND RECOMMENDATIONS

Addressing the issues identified in the survey instrument will require concerted attention by policy makers and safety net provider organizations alike. It is important to recognize that the issues involved are interdependent in that a change in one area can have a pervasive impact on other areas that will influence the provision of more accountable care to targeted populations. The framework shown in Exhibit 3 provides a conceptual picture recognizing these interdependencies. As shown, there are a set of issues involved in "establishing the foundation" for more accountable care. These include the categories of forming a necessary partnership, arranging for the specific risk bearing contracts, and being cognizant of the legal and regulatory issues involved. In turn, this platform will influence the actual provision of more cost-effective care involving the capabilities to actively manage clinical care, to provide the information technology infrastructure for such care, and the ability to report on the performance metrics. The platform and the actual provision of care will then influence the intermediate and ultimate impact on the targeted populations served and the mission of the organization. As shown, all of this will require strong governance and leadership.

Exhibit 3. Framework for Assessing Safety Net ACO Capabilities



Some of the issues noted above can only be addressed by the safety net providers themselves. However, there are a number of areas where public policy can play a facilitating role and where organizations hoping to become safety net accountable care organizations may wish to focus their efforts. We suggest nine areas below in the form of specific recommendations for consideration.

Recommendation 1
Broaden Scope of Practice to Expand Workforce Capacity

Based on respondents' assessments, there will be great need for *greater workforce capacity* to meet the needs of the safety net population given resource constraints. Thus, to promote workforce capacity and flexibility, we recommend that the state consider reexamining current scope of practice laws and regulations to encourage the broadest possible use of nurse practitioners, physician assistants, pharmacists, and other health professionals consistent with evidence of their ability to perform required competencies. For example, a physician currently must supervise certified medical assistants. Consideration should be given as to whether nurse practitioners can take on this role. At the same time, we encourage legislation that would provide for the training of new categories of health workers

such as promotoras, medical assistants, and community health workers. Specific attention also needs to be paid to the need for language translation, health education, and transportation services for safety net populations. Implementing this recommendation will help support further development of the patient-centered health home model.

Recommendation 2
Expand Governance and Increase Physician Leadership

Any ACO providing care to safety net populations should *include public and private safety net provider organizations in its governance structure and ensure adequate physician involvement* in key planning conversations. This type of wider involvement is needed to develop the buy-in crucial for new care management approaches to promoting more coordinated, cost-effective care for safety net populations.

Recommendation 3
Provide Incentives for Cost-Effective Specialty Care

Based on respondent assessments of specialist relationships, we recommend that the state Medi-Cal program and other payers consider bonus payments to safety net providers, including both public and private disproportionate share hospitals, who *concentrate their referrals to high-quality / low-cost specialists*. This will create incentives for specialists to work with safety net providers and to push greater volume to those specialists who are more cost-effective. This is an important issue to address because the lack of access to specialty care is a recognized barrier for many safety net populations.

Recommendation 4
Provide Incentives for Rural Safety Net Providers to Establish Partnerships

Medi-Cal and other payers should use *financial incentives similar to the CMS Advance Payment Model* for rural safety net providers and others who establish a relationship with needed private sector partners, including private safety net hospitals. Forging these relationships is likely to be difficult for some areas of the state and financial inducements will be needed to implement them.

Recommendation 5
Provide Technical Assistance for the Implementation of EHRs

Given respondent assessments of the challenge of implementing electronic health records (EHRs), the California Department of Health Services should provide assistance to safety net provider organizations to allow them to *take full advantage of the financial incentives (federal and otherwise) to adopt and implement electronic health records* and to participate in Health Information Exchanges through Cal E-Connect and other initiatives. Given that safety net populations frequently have multiple chronic conditions and access care across multiple providers and facilities, the ability to link information across providers and settings is particularly important.

Recommendation 6
Provide Incentives to Integrate Behavioral Health Care into Primary Care

Respondents were particularly concerned about the integration of behavioral health care into primary care. Given that depression is the number one co-morbid condition for almost all other health conditions, it is imperative that behavioral health care be better integrated into overall primary care for the targeted populations. We recommend that consideration be given to having the state Medi-Cal program and other payers provide a *coordination bonus* to safety net providers who integrate behavioral healthcare into overall primary care. The integration may take many forms, including direct employment of clinical psychologists, social workers, psychiatrists, and other mental health professionals into the practice. The coordination bonus could be paid from eventual projected savings resulting from fewer hospitalizations and emergency department visits.

Recommendation 7
Develop a Statewide Safety Net Quality Improvement Collaborative

Respondents indicated that they need to do a significant amount of work to enhance their quality improvement capabilities. Thus, we recommend that the state and private sector organizations develop *a statewide safety net quality improvement collaborative* with a particular focus on providing more cost-effective care to high-cost, high-risk patients. This should build on existing efforts and should specifically include clinics, health centers, public and private disproportionate share hospitals, and health plans serving safety net populations. The

collaborative should also seek to promote public-private partnerships between and among safety net providers.

Recommendation 8
Incorporate Socio-Demographic Characteristics into Reporting

The metrics used for performance reporting for ACOs serving safety net populations need to *take into account the socio-demographic characteristics of the populations served* with regard to race/ethnicity, education, income, place of residence, and related factors.

Recommendation 9
Consider Modifying California's Corporate Practice of Medicine Doctrine

Considerable cost is now involved in the work-around of establishing a relationship between hospitals and physicians through the foundation model. While we recognize that there are opposing viewpoints on this issue, we suggest that it is time to give serious consideration to *modifying California's corporate practice of medicine doctrine* to permit new arrangements between hospitals and physicians designed to promote clinical integration and more cost-effective care.

CONCLUSION

Based on the pilot study findings, it is clear that Alameda and Orange counties are at least moderately well prepared to respond to the new payment models and incentives associated with providing more accountable care. At the same time, significantly more work is required to achieve the ambitious goals established by those promoting ACO development. Much of the responsibility for developing the needed capabilities must reside with the safety net organizations themselves. But they will be greatly assisted by the development and implementation of a portfolio of legislative policies and payment incentives outlined in this brief. The revised version of this Safety Net Accountable Care Organization Readiness Assessment Survey Instrument[iii] can be used by safety net organizations to establish baseline metrics on their capabilities to provide coordinated, cost-effective care and to chart their progress over time.

[iii] Available at the Warren Institute website (as of Mar 2012): http://www.law.berkeley.edu/12895.htm.

Appendix A

Summary of Relevant Final ACO Rules and Regulations

Provision	Explanation
Risk-Bearing Requirements	• ACOs do not have to bear downside risk in their first 3-year contract with CMS (Track 1), though if they do not bear downside risk they will receive a smaller potential portion of the upside savings
Member Assignment	• Members will preliminarily be assigned to primary care providers using prospective assignment methods, with a retrospective reconciliation occurring at the end of each year • Primary care providers can be non-physician providers, including nurse practitioners and physician assistants
Quality Measures	• Required to report on 33 quality measures in four categories • In year one only reporting is required, with performance requirements being phased-in in years two and three • The use of electronic medical records remains highly encouraged but is not required
Shared Savings	• ACOs will share on first dollar savings once an initial threshold has been achieved (2% above benchmark) • ACOs bearing downside risk will receive 60% of savings, while those not bearing downside risk will receive 50%
Eligible Parties	• CMS specified that Federally Qualified Health Centers and Rural Health Centers will both be eligible to form and participate in ACOs
Advanced Payment Model	• ACOs can receive prepayment of expected shared savings to build their capacity to provide high quality, coordinated care and generate cost savings • The following ACOs are eligible: a) ACOs that do not include any inpatient facilities and have less than $50 million in total annual revenue, and b) ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and have less than $80 million in total annual revenue • ACOs that are co-owned with a health plan will be ineligible
FTC Review	• ACOs may choose to seek voluntary review from the ACO if they are concerned about antitrust issues; the requirement of mandatory preliminary review from the proposed rule has been eliminated

Appendix B

Expert Advisory Committee

Name	Affiliation
Elaine Batchlor	LA Care Health Plan
Andrew Bindman	UCSF School of Medicine
Thomas S. Bodenheimer	UCSF School of Medicine
Carmela Castellano-Garcia	California Primary Care Association
Thomas L. Greaney	St. Louis University School of Law
Timothy Jost	Washington & Lee School of Law
Gerald F. Kominski	UCLA School of Public Health
Marty Lynch	Lifelong Medical Care
Carmen R. Nevarez	Public Health Institute
James C. Robinson	UC Berkeley School of Public Health
Patricia R. Terrell	Health Management Associates
Tom Williams	Integrated Healthcare Association

Appendix C: User's Guide and Readiness Assessment Tool[iv]

USER'S GUIDE

Purpose

The Safety Net Accountable Care Organization (ACO) Readiness Assessment Tool is designed for the leaders in your organization (and whomever else that you wish) to assess how ready your organization is to take on the responsibilities of becoming an accountable care organization serving your population of safety net patients.

An ACO is defined as an organization of healthcare providers that agrees to become or is committed to becoming accountable for the quality, cost, and overall care of a group of patients. This requires that the ACO: 1) directly provide or manage the entire continuum of care for patients as a real or virtually integrated delivery system, 2) be of sufficient size to support comprehensive performance measurement, and 3) be capable of designing a provider/payer contract that supports prospective budget planning and internal distribution of shared savings.

This tool may be useful to you even if you do not intend to sign a formal ACO contract with a third party payer such as Medicare, Medicaid, or a commercial insurer. This is because the primary focus of the tool is on your organization's capabilities to provide more coordinated, cost-effective, and high-quality care to your patients, whether or not you decide to become a formal ACO.

[iv] Note that the readiness assessment tool shown here is the final version created based on feedback received during the pilot phase of the project (© 2012 UC Berkeley School of Public Health). Sections were reordered and questions were rewritten as a result of the pilot phase, but no significant substantive changes were made to the tool. Any results shown from the pilot phase are based on the pilot readiness assessment tool, not shown here.

Instrument Development

The instrument was developed by the School of Public Health and the Warren Institute's Health, Economic & Family Security Program at the University of California, Berkeley (UC Berkeley), under a grant from Blue Shield of California Foundation. It was piloted in two California counties – Alameda and Orange – serving a high percentage of uninsured and Medi-Cal patients. In early 2012, the workgroup held a conference entitled "Safety Net ACOs: Barriers and Benefits." Pilot study respondents (n=51) and conference participants felt that the instrument covered the most important issues facing safety net organizations and offered suggestions for improvement, which have been incorporated into the current version of the instrument.

Content Covered

Based on an extensive review of existing instruments and the advice of a nationally prominent advisory committee, questions were developed in nine categories. These categories include: 1) organizational mission and population served, 2) governance and leadership, 3) partnerships, 4) information technology and related infrastructure, 5) managing clinical care, 6) performance reporting, 7) finance and contracts, 8) legal and regulatory issues, barriers, and risk tolerance, and 9) overall assessment. Based on the experience of survey responders during the pilot test phase, categories one through six and category nine can be completed by all of your organization's top leadership team, while categories seven (finance and contracts) and eight (legal and regulatory issues, barriers, and risk tolerance) are best completed by only those individuals with specific knowledge and expertise in those areas.

Suggestions for Use

1. This instrument is primarily intended to be completed by the top leadership team of your organization. The top leadership team is typically considered to be the CEO, or equivalent position in the organization, and all of the people who directly report to this individual. However, you may choose to administer the instrument to additional individuals whose assessment you desire to have.
2. This instrument is intended for organizations providing the full continuum of primary and specialty care to a range of safety net patients, as opposed to organizations providing care to specialized populations, such as pediatric ACOs, or providing only specialized services, such as behavioral health or renal dialysis. Though we believe that many of these other organizations would also benefit from completion of the instrument, they will need to add supplemental questions to address their specific populations and/or services.
3. While the instrument is most useful when completed in its entirety, some organizations may wish to administer only certain sections that may be of greatest interest. In brief, the instrument can be used flexibly in modular form.
4. As noted in the instrument itself and as previously noted above, the sections on finance and contracts and legal and regulatory issues should be completed by people with specific knowledge and expertise in these subject matter areas. The remainder of the instrument can be completed by all members of the organization's top leadership team and other designated individuals.
5. To ensure a high response rate, it is very important that the leader of the organization emphasize the importance of completion to those selected to respond and explain how the data would be used to guide decision-making. High response rates are important to

ensure that everyone's perspectives are considered. The instrument can be completed either online or in a self-administered paper and pencil format. Online administration tools that will be useful include Qualtrics (www.qualtrics.com) and Survey Monkey (www.surveymonkey.com).

To ensure candid, honest assessments, respondents should not be asked to identify themselves and responses should be kept confidential. In order to keep track of who has responded and who has not, you should identify someone in the organization who can assign identification numbers to each questionnaire linking it to a given respondent. This will also allow you to send follow up reminders to those who have not responded. Once the response is received, however, the identification number should be destroyed. All analysis should be conducted on aggregate responses only, not on individual responses.

In order to ensure a high response rate, a set date should be established for completion. Based on experience, we recommend that the instrument be completed within five working days from receipt. Based on pilot study experience, most individuals are able to complete the instrument in thirty minutes.

Before the initial administration of the tool, an organizational leader may wish to meet with those selected to complete the instrument in a group face-to-face setting to highlight the importance of completion. The initial distribution of the tool should be followed by at least two reminder emails five working days apart, if necessary. These reminders are useful, but it will be critical to emphasize from the beginning the importance of everyone completing the instrument. In order to maximize the completion rate, you may wish to consider offering an incentive reward such as gift cards, lunch, entertainment event or related reward. These incentives can be provided

to individual responders or to groups that achieve a certain completion rate (e.g., 100%).

Instrument Scoring

Survey respondents are asked to rate each question on a 9-point, behaviorally anchored scale. Possible responses for each question are broken down into three categories of answers based on the organization's readiness: 1-3 (low), 4-6 (medium), and 7-9 (high). A visual 9-point scale is provided to ensure the accuracy of responses.

Numerous computations can be conducted to analyze survey responses.

1. **Question Analysis**: For each question, calculate the average response by adding up all survey respondent scores to that question and dividing that figure by the number of respondents who answered the question. Note that the denominator should not be the number of respondents to the entire survey in case some respondents chose to skip individual questions. To further augment the analysis, calculate the median score per question, the minimum and maximum values selected by respondents, and the standard deviation.
2. **Section Analysis**: For each of the nine question categories (a.k.a. sections), begin by calculating individual-level average section scores for each individual who answered the section. To do this, add up all of each individual's scores to the 9-point, behaviorally anchored questions within that section and divide by the number of questions that the individual answered within that section.[v] Next, add up all individual-level section averages and divide by the number of respondents to that section. Note that the

[v] Yes / No questions should not be included in this analysis.

denominator should not be the number of respondents to the entire survey in case some respondents chose to skip individual sections. To further augment the analysis, calculate the median score per section, the minimum and maximum values selected by respondents, and the standard deviation. Information gathered during this analysis can be displayed graphically or in table form. Exhibits 1 and 2 provide sample displays of data using results from the pilot survey.

Exhibit 1. Sample Graphical Display of Section Analysis using Pilot Data (n = 51)[vi]

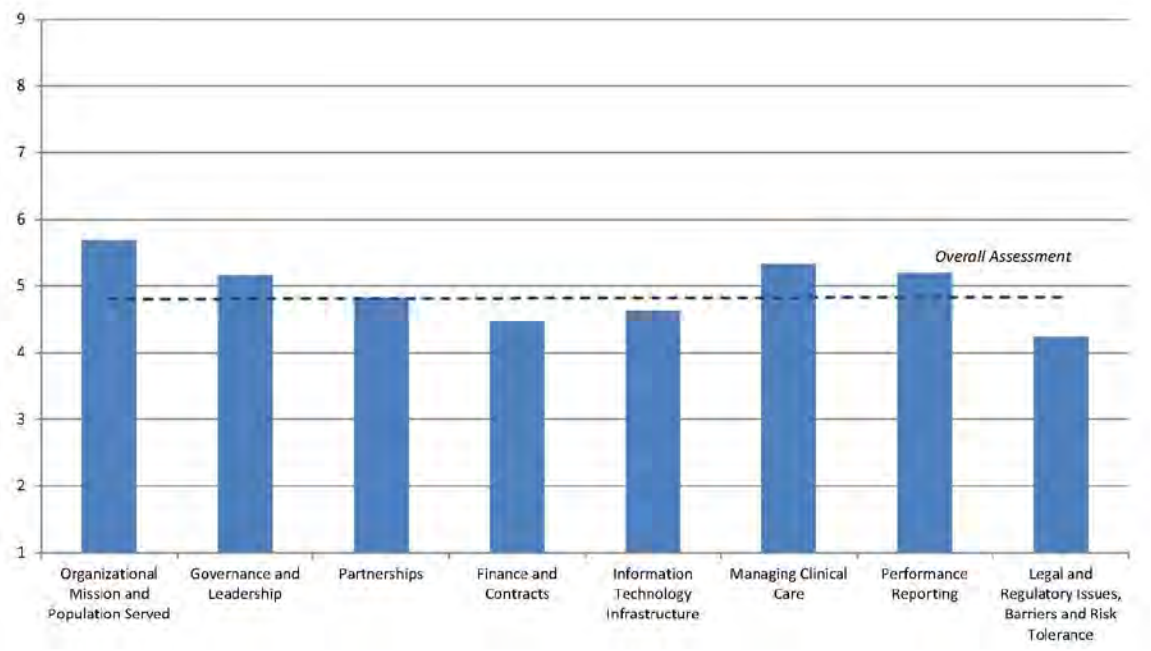


Exhibit 2. Sample Table Display of Section Analysis using Pilot Data (n = 51)

	Mean	Median	Standard Deviation	Range
Organizational Mission and Population Served	5.69	5.75	1.03	[2.86, 7.75]
Governance and Leadership	5.16	5.00	1.91	[1.20, 9.00]
Partnerships	4.82	4.93	1.60	[1.00, 8.33]
Finance and Contracts	4.47	4.25	1.90	[1.00, 8.67]
Information Technology Infrastructure	4.63	4.64	1.77	[1.00, 9.00]
Managing Clinical Care	5.33	5.36	0.82	[3.55, 7.25]
Performance Reporting	5.20	5.00	1.93	[1.33, 8.67]
Legal and Regulatory Issues, Barriers, and Risk Tolerance	4.23	4.33	1.78	[1.13, 8.67]
Overall Assessment	4.80	5.00	1.81	[1.00, 9.00]

[vi] Overall Assessment represents the last of the nine categories mentioned above and is not an average of the other eight categories shown.

3. **Overall Analysis**: Begin by calculating individual-level average survey scores by adding up all of each individual's scores to the 9-point, behaviorally anchored questions and dividing the sum you attain by the number of questions that the individual answered.[vii] Then, add up all individual-level average survey scores and divide by the total number of survey respondents.

Using the Results

The assessment tool will identify the relative strengths and weaknesses of your organization in its capabilities to provide accountable care. This information can be used in your organization's strategic planning, setting of priorities, and decisions on where it can best invest resources and training. The instrument can also be re-administered from time to time to assess the impact of various actions taken to strengthen your organization's ability to provide accountable care, and internal benchmarks can be established to monitor progress against an agreed-upon goal. Correlating your organization's overall scores with quality of care, patient experience, and cost data will enable further monitoring of progress.

[vii] Yes / No questions should not be included in this analysis.

SURVEY INSTRUMENT

Introduction

Thank you for agreeing to respond to this survey instrument to help your organization determine its level of readiness to provide accountable care to its population of patients.

Please indicate your number responses on the 1 to 9 scales provided for each question below. This is an assessment, not a test. Accordingly, there are no right or wrong answers. The survey asks for your honest assessments. **Only skip a question if you have absolutely no idea how to assess the issue**. **Otherwise, please provide your best estimate.**

For the purposes of this survey, an **ACO is defined** as an organization of health care providers that agrees to become, or is committed to becoming, accountable for the quality, cost and overall care of a group of patients such that the ACO: 1) can provide or manage the continuum of care for patients as a real or virtually integrated delivery system, 2) is of sufficient size to support comprehensive performance measurement, and 3) is capable of designing a provider-payer contract that supports prospective budget planning and internal distribution of shared savings.

A. Organizational Mission / Population Served

A1. To what extent would becoming an ACO require your organization to make changes in its mission to serve the underserved in your community?

Will require significant change in our mission and might cause us to lose focus on the underserved.			Will require some change in our mission but is largely consistent with our historical mission to provide care to the underserved.			Consistent with our mission; will require no change. May actually enhance our ability to provide care to the underserved.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A2. How well do you feel you "know" the population your organization is currently serving with regard to **socio-demographic characteristics, health care utilization, and costs of care**?

We have very little knowledge on the above characteristics for the population we serve.			We have some data on the above characteristics but need to collect further data.			We have very good, complete data on the above characteristics for the population we serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A3. How well do you feel you "know" the population your organization is currently serving with regard to the **quality, clinical outcomes, and health status of the population**?

We have very little knowledge on the above characteristics for the population we serve.			We have some data on the above characteristics but need to collect further data.			We have very good, complete data on the above characteristics of the population we serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A4. To what extent would becoming an ACO involve serving a *different population* in addition to the population you are currently serving?

Becoming an ACO would involve very little or no change in the population we currently serve.			Becoming an ACO would involve some change in the population we currently serve.			Becoming an ACO would require quite extensive change in the population we currently serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

If you responded to the question above (A4) indicating a response of between 4-9, please answer the following two questions (A5 and A6). Otherwise, please skip to question A7.

A5. How much knowledge do you have of the additional population you may be serving if you become an ACO in regard to their **socio-demographic characteristics, health care utilization, and potential costs of providing care to them**?

We have very little or no knowledge on the above characteristics.			We have some data on the above characteristics but need to collect further data.			We have very good, complete knowledge on the above characteristics.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A6. How much knowledge do you have of the additional population you may be serving with regard to the **quality, clinical outcomes, and health status of that population**?

We have very little knowledge on the above characteristics.			We have some data on the above characteristics but need to collect further data.			We have very good, complete knowledge on the above characteristics.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A7. Have you considered the primary geographic service area you would like the potential ACO to serve?

We have not considered this at all.			We have a general sense of where the ACO's patients might reside.			We have specific data on where our current patients reside and projected data on where ACO patients might reside.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A8. Have you considered whether any of the proposed participants in your potential ACO would be considered dominant providers, as defined by service volume, in your proposed ACO service area?

We have not considered this.			We are aware of this concern but have not calculated the market share of any provider.			We are aware of this concern and are taking steps to calculate the market share of each proposed ACO provider.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A9. To what extent do you believe you have an adequate number of physicians, nurse practitioners, physician assistants and other primary care providers to meet the specific needs of the population you intend to serve?

We have a serious shortage of these providers to treat the population we intend to serve.			We have some shortage of these providers to treat the population we intend to serve.			We have an adequate number of these providers to treat the population we intend to serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A10. To what extent do you believe you have an adequate number of hospitals, home health, and behavioral health resources to meet the specific needs of the population you serve?

We have a serious shortage of these resources to treat the population we intend to serve.			We have some shortage of these resources to treat the population we intend to serve.			We have a fully adequate number of these resources to treat the population we intend to serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

A11. To what extent do the providers have the linguistic and overall cultural competence skills to meet the needs of the population you intend to serve?

The providers have very little or no needed linguistics or cultural competence skills to treat the population we intend to serve.			The providers have some linguistic and cultural competence skills but require additional training to meet the needs of the population we intend to serve.			The providers have most or all of the needed linguistic and cultural competence skills to meet the needs of the population we intend to serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

B. Governance and Leadership

B1. To what extent is your current governing body structure adequate to meet the requirements and needs of becoming an ACO?

Current governance structure is not adequate and will definitely need to be changed.			Current governance structure meets some but not all of the needs and requirements to become an ACO.			Current governance structure meets most or all the needs and requirements to become an ACO.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

B2. To what extent is your current governance structure able to incorporate potential new members as needed?

Current governance structure is not in a position to accept new members.			Current governance structure has some ability to incorporate new members.			Current governance structure is largely or completely able to incorporate new members.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

B3. To what extent are you ready to address issues that might prevent you from forming a multi-provider ACO governance structure such as involving FQHC or County Boards?

Little or no readiness to address issues.			Some readiness to address issues, but we need to do more.			A very high or complete degree of readiness to address issues.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

B4. To what extent is there a broad base of clinical and managerial leadership throughout the organization united in its mission with a demonstrated shared vision?

There is an insufficient base of clinical and managerial leadership.			Some of the clinical and managerial leadership is in place but more is needed.			There exists a broad base of clinical and managerial leadership throughout the organization.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

B5. To what extent are physicians actively involved in exerting influence in the potential development of an ACO?

There is relatively little or no physician involvement in ACO discussions or potential decision-making.			There is some physician involvement in ACO discussions and decision-making but more is needed.			There is extensive and active involvement of physicians in ACO discussions and decision-making.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

C. Partnerships

C1. Forming an ACO may require developing relationships with organizations you are currently competing with. Assuming this is the case, to what extent is your organization able to effectively engage competing organizations in ACO discussions?

We currently have no or little ability to engage competing organizations.			We have some ability to engage competing organizations, but we need to further develop our capabilities.			We have very good to outstanding ability to successfully engage competing organizations in ACO discussions.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

C2. To what extent do partnerships exist with local hospitals to enable your organization to provide cost effective care to an ACO population?

No or very few hospital partnerships exist that would permit for providing more cost-effective care.			Some hospital partnerships exist to create more cost - effective care but more are needed.			Very good to excellent hospital relationships exist to create more cost-effective care.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

C3. As you think about your current and potential hospital partners, how ready are they to participate in an ACO?

Potential hospital partners have a low level of readiness at present.			Potential hospital partners have some readiness to participate but need additional skills and resources.			Potential hospital partners are very to completely ready to participate. They have the necessary skills and resources.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

C4. To what extent do partnerships exist with local specialist physicians to enable your organization to provide cost-effective care to an ACO population?

No or very few local specialist partnerships exist that would allow for providing more cost-effective care.			Some local specialist partnerships exist to create more cost-effective care but more are needed.			Very good to excellent local specialist relationships exist to create more cost-effective care.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

C5. As you think about your current and potential specialist physicians, how ready are they to participate in an ACO?

Potential specialist physicians have a low level of readiness at present.			Potential specialist physicians have some readiness to participate but need additional knowledge and resources.			Potential specialist physicians are very to completely ready to participate. They have the necessary knowledge and resources.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

C6. To what extent are your current or potential future provider partners willing to add services or delete redundant services to better serve an ACO population?

Little or no willingness to add services or delete redundant services.			Some willingness to add services or delete redundant services but more consideration is needed.			Very or completely willing to add services or delete redundant services.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D. Information Technology and Related Infrastructure

D1. To what extent are you able to integrate outpatient and inpatient data from ***participating*** providers (including medication data, lab results, and health status appraisals)?

We have no or very little ability to integrate these data.			We integrate some of these data but need to do more.			We integrate all or nearly all of these data.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D2. To what extent are you able to integrate outpatient and inpatient data from ***non-participating*** providers (including medication data, lab results, and health status appraisals)?

We have no or very little ability to integrate these data.			We integrate some of these data but need to do more.			We integrate all or nearly all of these data.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D3. To what extent are your electronic systems able to generate prescriptions and transmit them to pharmacies?

We have little or no ability to generate or transmit prescriptions electronically.			We have some ability to generate and transmit prescriptions electronically but need to do more.			We have complete or near complete ability to generate and transmit prescriptions electronically.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D4. To what extent do all care providers have access to and use a common EHR system (or interoperable EHR systems)?

No or very few providers have access to a common EHR system.			Some of our providers have access to a common EHR system.			All or nearly all of our providers have access to a common EHR system.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D5. To what extent are practice guidelines embedded in the EHR with the appropriate alerts for clinical decision support?

We do not have this capability, but plan to develop it.			We are starting to implement embedded practice guidelines with alerts.			We have fully or near fully embedded practice guidelines into our EHR with appropriate alerts.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D6. To what extent are there systems in place for risk assessment and risk stratification of patient populations?

We do not have these systems but plan to develop them.			We have limited systems in place but need to do more.			We have systems fully or near fully in place for risk assessment and stratification.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D7. To what extent are registries used for patients with chronic conditions and adult and pediatric preventative measures? Can registries be linked to the EHR?

We do not use registries but plan to develop them.			We use these registries but have not linked them with our EHR.			We have registries and they are fully or near fully linked to our EHR.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D8. To what extent is a formulary in place to encourage use of generic drugs when appropriate?

We do not have a formulary, but plan to develop one.			We have a formulary that includes some generic drugs but more needs to be done.			We have a complete or near complete formulary in place covering a wide range of generic drugs.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D9. To what extent are you able to provide relevant referral information electronically from primary care providers to specialists and obtain relevant and timely feedback electronically from specialists?

No or very little ability to provide relevant referral information electronically and receive timely feedback.			Some ability to provide relevant referral information electronically and receive timely feedback but more is needed.			A lot or complete ability to provide relevant referral information electronically and receive timely feedback.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D10. To what extent are electronic patient communication and patient engagement tools, such as interactive personal health records and provider-email, in place and widely used?

We do not have this capability but are considering it.			We have some electronic patient communication and engagement tools but more needs to be done.			We have electronic patient communication and engagement tools and they are widely used.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

D11. To what extent do you have HIPAA compliance practices in place at your practice (such as new employee training in HIPAA compliance, policies in place for portable and mobile devices, and processes for establishing compliance for new vendors)?

We do not have HIPAA compliance practices and protocols in place but are considering them.			We have some HIPAA compliance practices in place but need more.			We have complete or near-complete HIPAA compliance practices and policies in place.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E. Managing Clinical Care

Patient Access/Cultural Sensitivity

E1. To what extent does the organization provide around-the-clock 24/7 access for patients?

We have little or no means for such access either by phone, email, or in-person.			We provide some 24/7 coverage but need to provide more.			We provide near full or full 24/7, continuous access via phone, email, or in-person visits.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E2. To what extent does the organization train its providers in cultural competence skills to meet the needs of patients?

We have provided very little training to staff in cultural competence.			We have some programs to train staff but need to expand and provide broader coverage.			We have trained all or nearly all staff in cultural sensitivity skills to meet the needs of patients.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E3. To what extent are the organizations' providers routinely prompted to assess communication barriers in the delivery of care?

No or very little such prompting currently occurs.			There is some prompting for communication barriers on the part of providers in delivery of care but more is needed.			The organizations' providers are routinely prompted to assess communication barriers in the delivery of care.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E4. To what extent does the organization make use of spoken language and interpretation services and sign language assistance as needed?

We make little or no use of language and interpretation services.			We offer some language and interpretation services but need to expand them to cover more people.			We routinely offer language and interpretation services that covers all or nearly all patient needs.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

Visit Management

E5. To what extent does the organization engage in planned and continuous management of patient visits?

Little or no pre-visit planning, on-going medication management and review, or reminders for preventive care for specific tests are conducted.			Some pre-visit planning, on-going medication management and reminders are provided for preventive care and specific tests are conducted, but we need to do more.			Comprehensive pre-visit planning, medication management and review, and reminders for preventive care and specific tests are conducted.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

Care Coordination/Care Transitions

E6. To what extent does your organization have chronic care management processes and programs in place to manage patients with high volume, high cost chronic illnesses – including mental illness?

Have few or no chronic care management programs or processes, specifically to manage high volume, high cost chronic illnesses.			Have some chronic care management programs or processes in place to manage high volume, high cost chronic illness.			Have a comprehensive chronic care management program in place to manage high volume, high cost chronic diseases.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E7. To what extent are systems in place to assure smooth transitions of care across all practice settings including hospitals, long-term care, home care, adult day care, and community-based health and social services as needed?

Very few or no such systems are in place to promote smooth transitions across practice settings.			Some systems are in place to assure continuity of care across practice settings but more work is needed.			We have all or nearly all systems in place to assure smooth transitions of care across practice settings.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E8. To what extent does your organization integrate behavioral health programs into primary care?

There is little or no integration of behavioral health programs into primary care.			There is some integration of behavioral health programs into primary care but more work is needed.			We have nearly complete or fully complete integration of behavioral health programs into primary care.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

Self-Management and Patient Engagement

E9. To what extent does the organization encourage patients to be actively involved in decisions involving their care and self-management of their care?

Few or no processes in place to encourage expanded patient role in decision-making and self-management.			Some processes in place to encourage patient involvement in decision-making and self-management but more needs to be done.			Comprehensive program in place to encourage an expanded patient role in health care decision-making and self-management.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E10. To what extent does the organization help patients obtain and understand their health insurance coverage?

We infrequently or rarely help patients understand their health insurance coverage.			We provide some help to patients to understand their health insurance coverage but need to do more.			We routinely provide help to all or nearly all our patients in obtaining or understanding their health insurance coverage.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E11. If the organization were to become an ACO, to what extent could it explain clearly to patients what this would mean for their care?

It would be very difficult for us to explain to patients what becoming an ACO would mean for their care.			We would have some difficulty explaining to patients what becoming an ACO would mean for their care.			We would have little difficulty explaining to patients what becoming an ACO would mean for their care.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

Managing Population Health/Prevention

E12. To what extent does the organization work with local school systems to offer health or wellness programs for the community at large?

We have few or no activities with local school systems to offer health or wellness programs to the community at large.			We have some activities with local school systems to offer health or wellness programs but these could be expanded.			We have close relationships with local school systems and offer a variety of health and wellness programs for the community at large.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E13. To what extent does the organization work with other providers, public agencies, and community-based organizations to conduct a health status assessment survey of the community?

We do not currently work with or have relatively little involvement with other entities in conducting a health status assessment of the community.			We have some working relationships with other providers and entities in conducting a health status assessment of the community but could do more.			We work very closely with other providers and agencies in conducting a health status assessment of the community.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E14. To what extent is the organization involved in working with local schools, housing authorities, transportation bodies and other related agencies in improving community conditions that promote health for all?

We have little or no such involvement with the above entities in promoting conditions for community health.			We work with some of the above entities in promoting conditions to improve overall community health but could do more.			We have extensive involvement with the above entities in working actively to promote the conditions to improve community health.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

<u>Continuous Improvement</u>

E15. To what extent is the organization engaged in reducing preventable hospital readmissions?

We have very few or no activities that are currently directed towards reducing preventable hospital readmissions.			We have started to assess preventable hospital readmissions and remedial action but more action is needed.			We have a fully developed program to reduce preventable hospital readmissions.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E16. To what extent is the organization involved in reducing hospital admissions for ambulatory care sensitive conditions, such as asthma and diabetes?

The organization currently does nothing or very little to reduce hospital admissions for ambulatory care sensitive conditions.			The organization is studying and beginning to address the issue of reducing hospital admissions for ambulatory care sensitive conditions but needs to do more.			The organization is fully and actively engaged in programs to reduce hospital admissions for ambulatory care sensitive conditions.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E17. To what extent is the organization actively engaged in improving ambulatory care as evidenced by using preventive care screening data, such as HbA1c testing and eye exams for diabetes, and cholesterol levels?

Little or nothing is currently being done using the above measures to improve quality of care.			We are using some of the above measures to improve quality of care but need to do more.			We are using all or nearly all of these measures to improve quality of care for patients.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E18. To what extent is the organization actively engaged in assessing patient care satisfaction, whether data is provided by your organization or others such as CMS or private payers?

We currently do little or nothing to systematically measure patient care satisfaction.			We have started to systematically measure patient care satisfaction but need to add additional measures and survey more of the patients we serve.			We are systematically measuring patient care satisfaction covering the majority of patients we serve.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E19. To what extent is the organization assessing the inappropriate use of the emergency department (ED)?

We currently are not assessing inappropriate use of the ED.			We have started to assess inappropriate use of the ED but need to do more.			We routinely assess the inappropriate use of the ED and use this data to take action to reduce such use.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E20. To what extent is the organization training its providers in continuous quality improvement methods such as the Plan, Do, Study, Act (PSDA) improvement cycle, lean production, six sigma, and related tools?

We have few or no activities currently in place to train providers in continuous quality improvement methods.			We have some programs available to train providers in continuous quality improvement methods but need to do more.			We have a variety of quality improvement training programs for providers and currently the majority of our providers are trained in these methods and tools.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

E21. To what extent are quality improvement measures routinely shared with all members of the teams involved in providing care to your population?

We currently have little or no sharing of measures with our care teams.			We currently share some improvement measures with our care teams but need to do more.			We currently share all or nearly all of our quality improvement data with the majority of our care teams.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

F. Performance Reporting

F1. Under the Medicare Shared Savings Program, thirty-three quality measures must be reported. How well prepared are you to report on these measures?

We have little or no ability to report on these measures currently; we can report on fewer than 50% of them.			We have some ability to report on these measures; we can report on 50% to 74% of them.			We can report on nearly all of these measures; we can report on at least 75% of them.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

F2. How well prepared are you to report measures of **patient experience** to external bodies such as payers, regulators, and the public at large?

We have no or very little ability to collect, analyze, and report on patient experience.			We have some ability to collect, analyze, and report on patient experience measures.			We have a high ability to collect, analyze, and report on patient experience measures.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

F3. How well prepared are you to report measures of **care coordination and patient safety** to external bodies such as payers, regulators, and the public at large?

We have no or very little ability to collect, analyze, and report on care coordination and patient safety measures.			We have some ability to collect, analyze, and report on care coordination and patient safety measures.			We have a high ability to collect, analyze, and report on care coordination and patient safety measures.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

F4. How well prepared are you to report measures of **preventive health** to external bodies such as payers, regulators, and the public at large?

We have no or very little ability to collect, analyze, and report on preventative health measures.			We have some ability to collect, analyze, and report on preventative health measures.			We have a high ability to collect, analyze, and report on preventative health measures.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

F5. How well prepared are you to report measures of **at-risk populations** to external bodies such as payers, regulators, and the public at large?

We have no or very little ability to collect, analyze, and report on at-risk populations.			We have some ability to collect, analyze, and report on at-risk populations.			We have a high ability to collect, analyze, and report on at-risk populations.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

F6. How well prepared are you to report measures of **total per-capita cost** for patients that you serve to external bodies such as payers, regulators, and the public at large?

We have no or very little ability to collect, analyze, and report on total per-capita costs.			We have some ability to collect, analyze, and report on total per-capita costs.			We have a high ability to collect, analyze, and report on total per-capita costs.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G. Finance and Contracts

This section should only be completed by individuals with specific knowledge and expertise in issues related to the finance and contracting capabilities of the organization.

G1. To what extent are you ready to set aside cost-based, volume-based reimbursement to accept risk-based payment for care delivery?

Not at all well prepared. We have done little or no analysis of what this would mean for the organization.			We have conducted some analysis of the financial implications of such changes in payment but more needs to be done.			We are well prepared to very well prepared for assuming risk-based payment. Considerable analysis of the implications has been conducted.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G2. How well prepared are you to bear financial risk for spending that exceeds established targets?

Not at all well prepared. Information systems to track utilization and risk are not in place, nor is the ability to compare the total cost of these services to projected revenues.			Somewhat prepared. We are developing systems to track utilization, risk, cost, and revenues received.			Well to very well prepared. We have systems in place to track utilization, risk, costs, and revenues received.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G3. To what extent have you conducted financial modeling of services provided to your population under different scenarios of risk-based payment?

We have conducted little or no such financial modeling.			We have conducted some financial modeling but more needs to occur.			We have conducted extensive financial modeling under different scenarios.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G4. To what extent are you able to afford the potential up-front costs of becoming an ACO if that amount were determined to be $2 million?

We are largely unable to afford these up-front costs.			We are fairly well prepared to afford these up-front costs.			We are fully able to afford up-front costs of up to $2 million.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G5. To what extent are you able to afford the potential up-front costs of becoming an ACO if that amount were determined to be $10 million?

We are largely unable to afford these up-front costs.			We are fairly well prepared to afford these up-front costs.			We are fully able to afford up-front costs of up to $10 million.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G6. How would you assess your ability to manage contractual relationships with payers?

We have little to no ability to manage these relationships. We lack staff, resources, and the needed information systems.			We have some ability to manage relationships with payers but require additional staff, resources, and more compatible information systems.			We have a very good to outstanding ability to manage contractual relationships with payers. We have sufficient staff/resources to manage contractual relationships with payers and compatible information systems.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

G7. To what extent are the legal structures in place to receive and distribute shared savings payments to participating care providers in compliance with existing state and federal laws?

No legal structures are in place and/or we have no ability to receive and distribute payments.			Some of the legal structures are in place and we have some ability to receive and distribute payments.			The necessary legal structures are in place and we are able to receive and distribute payments.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H. Legal and Regulatory Issues, Barriers, and Risk Tolerance

This section should only be completed by individuals with specific knowledge and expertise in issues related to the legal and regulatory issues, barriers and risk tolerance of the organization.

H1. Have you considered how you might structure your potential ACO's operations to protect the 501(c)(3) status of any participant?

We have not considered this.			We are in the process of considering this.			We have clarified the tax-exempt status of each participating entity, including providers of ancillary services, and are restructuring our ACO to preserve 501(c)(3) status for the relevant entities.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H2. Have you considered the involvement of a hospital or ambulatory surgical center in your potential ACO?

We have not considered this.			We have considered this and decided to involve a hospital or ambulatory surgical center, though we have not determined the exact relationship to the ACO.			We have identified a hospital, an ambulatory surgical center, or both as proposed participants in our ACO and have worked out the contractual relationship(s).		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

If you responded to the above question (H2) with an answer of between 4-9, please answer question H3 below. Otherwise, please skip to question H4.

H3. Have you considered whether you want that hospital or ambulatory surgical center to have an exclusive contract with your potential ACO?

We have not considered this.			We are considering this, including the difference the hospital or ambulatory surgical center's participation may make to defining the lines of health care services we propose to offer in our ACO.			We are including either or both of these entities as participants in our ACO and have analyzed any potential fair competition concerns that might be raised by the use of exclusive contracts on their part.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H4. Have you considered who might serve as the federal compliance officer for your potential ACO?

We have not considered this and were not previously aware of the requirement.			We know of this requirement but have not begun identifying a suitable individual.			We know of this requirement and are working to identify or have identified a suitable individual.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H5. Have you identified someone as compliance officer who would **not** be a member of the potential ACO board?

We have not considered this and were not previously aware of the requirement.			We understand this requirement but have not begun identifying a suitable individual.			We know of this requirement and are working to identify or have identified a suitable individual.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H6. Have you identified someone as compliance officer who would **not** also serve as legal counsel to the potential ACO?

We have not considered this and were not previously aware of the requirement.			We are aware of this requirement but have not acted to identify a suitable individual.			We are aware of this requirement and are working to identify or have identified a suitable individual.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H7. Have you considered how you might structure the distribution of a Medicare shared savings payments to avoid inducing physicians to reduce or limit medically necessary items or services?

We have not addressed the structure of shared savings payments with regard to the above concerns.			We are aware of this prohibition but have not moved to structuring the shared savings payments to address it.			We are educating ourselves on how other shared saving programs have met this test.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

H8. Are you located in a state that prohibits the corporate practice of medicine (e.g., California)?

Yes	No
1	2

If you responded to the above question (H8) with a 2 (No), please answer question H9 below and then skip to the next section (I. Overall Assessment). If you responded to the above question (H8) with a 1 (Yes), please skip to question H10.

H9. Are you currently employing physicians or are you considering employing physicians as part of the organization that could become an ACO?

Yes	No
1	2

H10. Have you considered whether you are within one of the exceptions or exemptions to the corporate practice of medicine bar (e.g. non-profit community clinic, teaching hospital)?

We have not considered this.			We are considering whether this is relevant to us but have not yet come to a final determination.			We have determined whether or not we are exempt from the corporate practice of medicine bar.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

If you responded to the above question (H10) with a 7, 8, or 9 and the determination is NOT EXEMPT, please answer question H11 below. Otherwise, please skip to the next section (I. Overall Assessment).

H11. Have you considered working around the corporate practice of medicine bar by forming a medical foundation?

We have not considered this.			We are considering this but we have not fully explored the steps involved.			We have fully considered this, including the cost implications.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

I. Overall Assessment

I1. Considering all of the above questions and categories, how well prepared do you believe your organization is to become an ACO?

We are not very well prepared to become an ACO. We need to do a lot of planning and acquire the skills and resources needed.			We are somewhat prepared. We have done some of the planning and have some of the skills and resources needed but need to do more.			We are very well prepared. We are far along in our planning and have most if not all of the skills and resources needed.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

I2. If your organization were to enter into a contract with a payer in which you would be *at risk* for the cost and quality of care provided to a defined population of patients, *how confident* are you that your organization could provide care that *would* ***be less than the expenditure targets*** *resulting in shared savings to your organization*?

Not at all confident.			Somewhat confident.			Very or completely confident.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

I3. If your organization were to enter into a contract with a payer in which you would be *at risk* for the cost and quality of care provided to a defined population of patients, *how confident* are you that your organization could provide care that *would* ***meet the quality of care performance measures***?

Not at all confident.			Somewhat confident.			Very or completely confident.		
[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]

Thank you for your participation.

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