Title

A Framework for Understanding Physician Organizations' Orientation to Accountable Care Organizations (ACO)

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Publication Date

2014

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

A Framework for Understanding Physician Organizations' Orientation to Accountable Care Organizations (ACO)

A dissertation submitted in partial satisfaction of the

requirements for the degree of Doctor of Public Health

by

Thanh-Nghia Nguyen Tran

2014

ABSTRACT OF THE DISSERTATION

A Framework for Understanding Physician Organizations' Orientation

to Accountable Care Organizations (ACO)

by

Thanh-Nghia Nguyen Tran

Doctor of Public Health

University of California, Los Angeles, 2014

Professor Paul R. Torrens, Committee Chair

Introduction

ACOs are seen as an important development in the quest to provide quality care and control health care costs. The pace of ACO adoption has waned after a blistering start. The calculus for ACO adoption has changed and there is little understanding of the reasons for the change. The objectives of this dissertation are to understand physician organizations' motivation to form ACOs, explore physician organizations' ACO readiness, and identification of barriers and facilitators to ACO adoption. The dissertation also proposes an ACO Orientation Conceptual Model and tests the model from case studies of six physician organizations in Orange County, CA. By understanding the reasons physician organizations accept or reject ACO contracts,

leaders and administrators can adjust parameters that will influence future accountable care movement.

Background

ACO is an entity comprised of hospitals and physician organizations who join together to assume responsibility for providing integrated high quality care at a sustainable cost level for a patient population. The idea originated in the medical establishment and entered the policy arena through MedPAC, an agency that advises Congress on Medicare matters. The Dartmouth Institute for Health Policy and Clinical Practice, the Engelberg Center for Health Care Reform at Brookings, and MedPAC pushed ACO onto the national agenda. ACO became a formal part of the health reform movement when the ACA was signed into law. As of October 2013, there were 23 Pioneer ACOs, 35 Advanced Payment ACOs, 220 SSP ACOs, and 235 private sector ACOs.

Aims and Objectives

The dissertation seeks to understand physician organizations' motivation to form or not form ACOs, proposes and tests an ACO Orientation Conceptual Model, and identifies barriers and facilitators to ACO adoption.

Methodology

The dissertation uses a qualitative, non-experimental, cross-case study method supplemented by a survey. Six case study participants were selected from a combined list of physician organizations from Cattaneo and Stroud and California Association of

Physician Groups (CAPG). Using a semi-structured interview guide, an in-depth interview with an executive in the physician organization and an administration of a Physician Organization ACO Readiness Survey for each organization completed the data collection process. Information from key informant interviews was integrated with publicly available reports, state government agency reported data, information on a physician organization's website, and other Internet resources related to the physician organizations forming the basis for the case studies. Analysis was also performed across the physician organizations to identify common themes and unearth insights. The ACO Orientation Conceptual Model was tested based on the responses to the semi-structured interview questions and the ACO readiness survey.

Findings

Of the external causal attributes described by the ACO Motivation Conceptual Model, only business rationale, competitor activity, and a policy window were found by case study participants to be applicable. None of the participants cited necessity or timing as an external causal attribute. Of the internal causal attributes described by the ACO Motivaton Conceptual Model, only culture, leadership, and quality care were found by case study participants to be valid. The only internal causal attribute that garnered concensus among all six case study participants was a focus on quality care improvements.

Testing of the ACO Orientation Conceptual Model found that along the strategic typology dimension, of the six case study participants in the study, four case study

participants were classified as *Analyzers* and two were classified as *Prospectors*. None of the case study participants had a *Defender* classification. Along the ACO readiness dimension, five of the six case study participants had high ACO readiness scores and one case study participant recorded a low ACO readiness score. Using assessments from the case study participants, the model successfully predicted that *Analyzers* with high ACO readiness scores and *Prospectors* with low ACO readiness scores would consider becoming ACOs. The model also predicted correctly that *Prospectors* with high ACO readiness scores would become ACOs.

Enviromental barriers identified by case study participants included an ACO's broad scope, intensive resource investment requirements, rules and regulations interpretation and enforcement, and a risk/reward imbalance. Organizational barriers identified by case study participants included physician organization and hospital misalignment of incentives, a lack of infrastructure, a lack of data, difficulties in getting providers to buy-in, and beneficiary inertia.

Facilitators identified by case study participants include communication, trust, technology, information exchange, a strong primary care network and network management, scalability, and experience with risk, continuity of care, and managed care programs.

Conclusion

Understanding physician organization ACO adoption and diffusion may benefit from additional qualitative and quantitative studies. The specific recommendations are to conduct case studies in other geographic areas outside of Orange County, CA, empirically study to see if physician organizations changed strategies due to ACOs, and finally, measure the performance and outcomes of selected ACO strategies. There are three implications for health policy makers. First, for physician groups participating in the Shared Savings Program (SSP), there is a desire to attract Medicare fee-for-service (FFS) beneficiaries into the Medicare Advantage plans. This motivation is different from those of physician organizations serving commercial ACOs. Second, reduce the environmental and organizational barriers to ACO adoption. Finally, healthcare leaders and practitioners should be prepared to address system-wide implications resulting from the massive shifts in the physician organization strategy as a response to ACOs.

The dissertation of Thanh-Nghia Nguyen Tran is approved.

Gerald F. Kominski

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2014

Dedication

To my father, Thanh-Dat Nguyen, MD, who gave me intellectual curiosity and an unwavering will and spirit.

To my mother, Kim-Sang Tran and grandmother, Ba Duong, who both taught me how to think and live; thank you for your blessings from above.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
ACO	Accountable Care Organization
CAPG	California Association of Physician Groups
CFO	Chief Financial Officer
CMS	Centers for Medicare and Medicaid Services
FFS	Fee for service
HCFA	Health Care Financing Administration
HMO	Health maintenance organization
IPA	Independent Practice Association
MA	Medicare Advantage
MedPAC	Medicare Payment Advisory Commission
PCMH	Patient-Centered Medical Home
PMPM	Per Member Per Month
PPO	Preferred Provider Organization
PPS	Prospective Payment Systems
SGR	Sustainable Growth Rate
SSP	Shared Savings Program

Acknowledgments

No journey is ever made alone and this one is no different. Many people have helped me in my journey. First, I would like to thank my family—mom, dad, grand-mom, all my siblings, especially my sisters Thanh-Hai Nguyen, Thanh-Tuyen Nguyen, and Thanh-Thien Nguyen who gave me nourishment, my brother, Thanh-Nhan Nguyen, who shouldered my chores, my brother-in-law, Jean-Luc Gauvreau, who provided encouragement, and the love of my life, Quynh-Nhu Nguyen Ly, who believed in me and walked side by side with me. You all gave me the time and freedom to focus on my studies. I also would like to thank my nieces, Bao-Hieu Gauvreau, Bao-Hanh Gauvreau, Bao-Hoa Gauvreau, and nephew, Bao-Huan Gauvreau for your patience and compassion. Yes, we can go play now.

I'd like to thank my managers at Pfizer, Mike Steinmetz, Jennifer Craighead, Gene Gosselin, Ryan Micallef, and Matthew Hurlburt, who believed in my capabilities and gave me the flexibility and time to carry on with work and attend school. I am indebted to my committee chair, Dr. Paul Torrens, who provided guidance and direction, even in retirement, and the other committee members Drs. Dylan Roby, Gerald Kominski, Carl Stevens, and Stuart Schweitzer, for your collegial support and advice. I'm also grateful for the support from the Students Affairs Office, especially Josie Wei, Sukhwinder Sagoo, Jill Richardson, and Jessica Shim. You can finally close my files. A special thanks to Fifi Klein, for her technical support. And finally, a word of thanks to my doctoral student cohort. Our journey continues…

Vita

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1996 – 1998	Business Analyst Protocare Sciences
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CHAPTER 1: INTRODUCTION

Overview

The Centers for Medicare and Medicaid Services' (CMS) Shared Savings Program (SSP): Accountable Care Organization (ACO) has drawn intense interest from physician organizations since the rules were finalized in November 2011. Focused on the Medicare fee-for-service (FFS) population, SSP:ACOs are groups of doctors, hospitals, and other healthcare providers who partner together to provide coordinated care for their patients (CMS, Accountable Care Organizations, 2013). ACOs are seen as models for achieving the dual goals of delivering high quality care and controlling costs (Salmon RB, 2012), (Fisher ES, 2011). Unlike an FFS system where payment is made regardless of quality considerations, provider groups in an ACO have to meet quality standards and achieve medical cost targets for the patient population they manage. Only when these two criteria are met are the provider groups rewarded with a portion of the savings.

Given the interest in ACOs and their growth, a research base is being built around ACOs in the areas of administration, economics, and policy. From an administrative perspective, research was focused on who should create ACOs (Fuchs & Schaeffer, 2012), ACO formation and barriers and facilitators to ACO adoption (Fisher ES, 2011), and ACO evaluation (Shortell, Casalino, & Fisher, 2010), (Fisher, Shortell, Kreindler, Van Citters, & Larson, 2012). From an economic perspective, literature documented the financial impact on providers (Reynolds & Roble, 2011), variability on spending

growth (McWilliams & Song, 2012), and payment reform (Goroll & Schoenbaum, 2012). From a policy perspective, research explored ACOs for academic centers (Tallia & Howard, 2012), the vulnerable population (Lewis, Larson, McClurg, Boswell, & Fisher, 2012), and considerations of social values in ACO creation (Keren & Littlejohns, 2012).

These types of studies portray ACOs as beneficial to the healthcare system and fuel their development and growth. As of October 2013, there were 220 ACOs in the Shared Savings Program (CMS, Accountable Care Organizations, 2013). Spurred on by CMS, ACO-like contracting has also emerged in the private sector. A consulting firm reported 235 private sector ACOs as of August 2013 (Petersen, Muhlestein, & Gardner, 2013). However, a recent report found that the pace of ACO formation has slowed dramatically (Mulhstein, 2013). The calculus for ACO adoption has changed and there is little understanding of the reasons for the change. What drives a physician organization to invest human and financial resources to form an ACO? Why does another physician organization, in the same market, decide not to become an ACO? The limited research available focuses on commercial ACOs. There are individual case studies that report the experiences of Healthcare Partners (Los Angeles, CA), Monarch Healthcare (Orange County, CA), Norton Healthcare (Louisville, KY), and Tucson Medical Center (Tucson, AZ) as part of the Brookings-Dartmouth ACO Pilot Program (Van Citters, et al., 2012). These examples add to the literature base on ACOs, but do not provide a unified concept of ACO diffusion. Additionally, Fisher et al. argued that the ACO field is young, therefore both quantitative and qualitative research on ACOs

are needed (Fisher, Shortell, Kreindler, Van Citters, & Larson, 2012). Specifically, the authors wrote:

> "Another key insight has to do with the rapid pace of change. Memories fade rapidly, so it is critical to track over time not only the characteristics of ACOs and their environments, but also the perceptions of their leaders about what goals were considered important, what the leaders did to achieve these goals, what implementation activities leaders engaged in, and their motivation for doing so."

This dissertation fills some of the gaps in the literature through a study of physician organizations' motivation to form ACOs, an exploration of a physician organization's ACO readiness, and identification of barriers and facilitators to ACO adoption. The dissertation also proposes an ACO Orientation Conceptual Model and tests the model using data from case studies of six physician organizations in Orange County, CA.

Study Aim and Objectives

This study aims to identify and understand physician organizations' motivation and rationale for pursuing ACOs or avoiding ACOs. The main question this dissertation tries to answer is, "Why do physician organizations form an ACO or not form an ACO?" To answer this question, the characteristics of a physician organization, its mission, motivations and goals, and the economic, organizational, and social factors around the physician organization were assessed.

Key to any decision is information. A basic piece of information that a physician organization contemplating becoming an ACO may want is: how prepared is the group

to become an ACO? This dissertation positions this question as a second line of inquiry; whether a physician organization's state of ACO readiness influences its decision to become an ACO. To answer this question, an ACO readiness survey was administered. The hypothesis is that physician organizations with higher "ACO readiness" scores are more likely to choose to become ACOs.

Finally, using organizational change theory and organizational strategy theory as a foundation and layering organization readiness for change theory on top of this base, an ACO Orientation Conceptual Model was proposed to help understand the characteristics of ACO diffusion. This model was tested through a series of case studies on six physician organizations in Orange County, California. Causal attributes were reported individually, by physician organization, and common themes and insights were gleaned across the physician organizations. Strategic typology and ACO readiness were used to predict ACO orientation. The findings may be useful to policy makers, payers, and provider organizations in understanding the ACO due diligence and formation process.

Chapter Summary

ACOs are seen as an important development in the quest to provide quality care and control health care costs. The pace of ACO adoption has waned after a blistering start. The calculus for ACO adoption has changed and there is little understanding of the reasons for the change. The objectives of this dissertation are to understand physician organizations' motivation to form ACOs, explore physician organizations' ACO

readiness, and identify barriers and facilitators to ACO adoption. The dissertation also proposes an ACO Orientation Conceptual Model and tests the model using case studies of six physician organizations in Orange County, CA. By understanding the reasons physician organizations accept or reject ACO contracts, leaders and administrators can change parameters that will influence future accountable care movement.

CHAPTER 2: BACKGROUND

Given the nascent field of ACO research, it is important to understand and document the ACO's origin. In this section, a conception of the idea of an ACO and its emergence into the medical establishment are explored. Second, a major catalyst for the consideration of ACO as a credible concept was the inclusion of ACO in the Affordable Care Act (ACA). By writing ACO into law, Congress committed financial and human resources to jumpstarting ACO adoption and diffusion. Almost overnight, ACO became legitimate and was backed by the U.S. government. How an idea from the private sector rose to the national agenda and became law is described using "agenda setting" theory. See Figure 1. ACO Development Timeline for a summary. To conclude an exploration of ACO background, the current state of ACO implementation is reported through a thorough review of public and private ACOs.

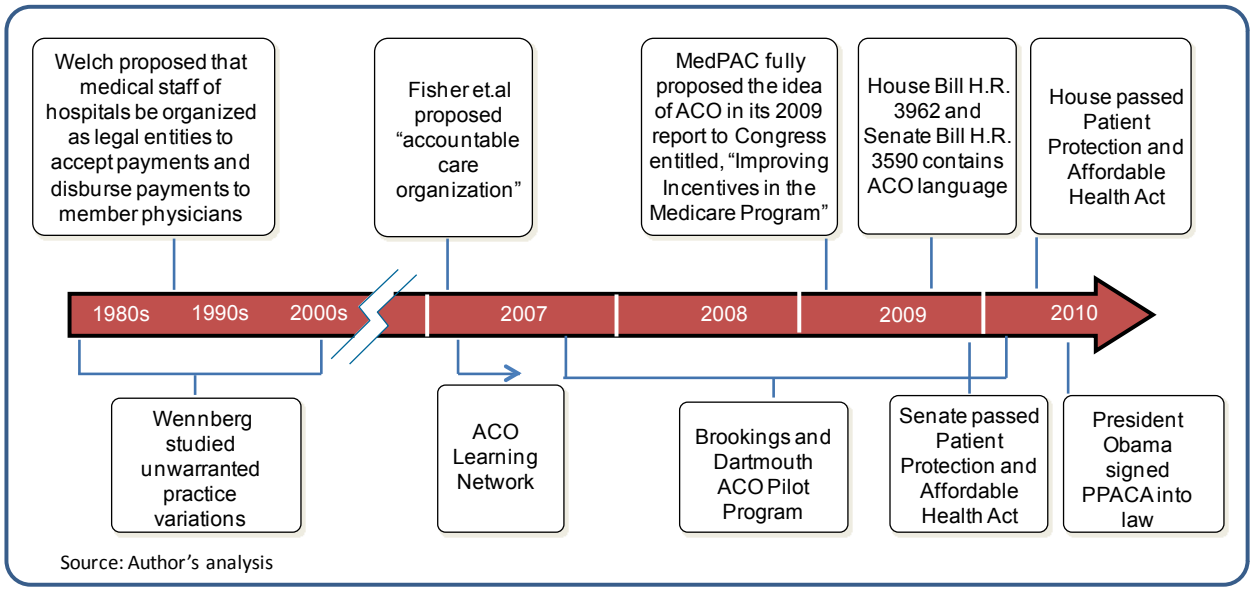


Figure 1. ACO Development Timeline

ACO Policy: From Conception to Birth

The term “accountable care organization” was first proposed in the medical literature by Fisher, et al. (Fisher, Staiger, Bynum, & Gottlieb, 2007). Dr. Eliot Fisher and Mr. Glenn Hackbarth, Chairman, Medicare Payment Advisory Commission (MedPAC) conceived of the term “accountable care organization” as a reference to an extended hospital medical staff or a large multi-specialty practice at an MedPAC meeting in 2006. Fisher et al., described an ACO as a “virtual” organization “comprising local hospitals and the physicians who work within and around them” and whose objective is to “improve the quality and lower the cost of care by fostering greater accountability on the part of providers for their performance.” This description faithfully describes what we know as ACOs today. Becoming law in 2010, the Medicare Shared Savings Program section in the ACA stated that an ACO is a legal entity comprising of participants (e.g., physicians or physician organizations, hospitals) that is accountable for the quality, cost, and overall care of beneficiaries assigned to that ACO (Federal Register, 2011).

From a CMS ACO perspective, there are three characteristics that make ACOs unique. First, ACOs have to be organized as a separate legal entity. Second, ACOs have to meet quality standards. Third, ACOs have to control costs. These three factors differentiate ACOs from other CMS quality and payment reform efforts. Historically, quality initiatives have focused solely on quality or quality reporting. Controlling cost was not included as part of these programs. For example, under the Hospital Value Based Purchasing Program, CMS provided incentive payments to acute-care hospitals based on the hospital’s achievement on selected quality measures or on the hospital’s

incremental improvement on selected quality measures compared to baseline. The Physician Quality Reporting System (PQRS) is an example of a program that incentivized physician's (technically called "eligible professionals") reporting of quality information.

Cost control was addressed through payment reform. CMS reformed hospital payment by instituting a prospective payment system (PPS) for hospital inpatient care in 1983. CMS defined PPS as, "a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services)" (CMS, 2013). Physician payment reform has been slow, with the current system being a fee schedule with a Sustainable Growth Rate (SGR) provision. Instituted in 1996, SGR ties annual fee schedule updates to cumulative expenditures. In years when expenditures exceed targets, the fee schedule was to be reduced. With intense lobbying from providers, Congress has yet to allow any downward adjustment to take effect. Observing its ineffectiveness, MedPAC has called for SGR's outright repeal (MedPAC, 2011). For the most part, these payment systems do not take quality of care into account.

These quality programs and payment schemes allow participating entities to participate as they are legally organized. They do not require participating entities to set up new organizations and legal structures. ACO is the first initiative to require a separate legal structure for participation, achieving quality targets, and cost control. (Note:

Commercial ACOs do not have to be separate legal entities from the participants. For example, a medical group and a hospital are not required to set up a separate legal entity to enter into an "ACO" contract with a commercial payer. However, the goals of achieving a designated level of quality and cost control remain.)

The requirement for ACO to be a separate entity can be linked to early Medicare reform efforts. After the implementation of PPS for hospitals in 1983, a natural extension was to implement a PPS for physician services (related to a hospital admission). To do so would require agreement about who to pay and assurance that the entity will be able to control costs. In 1989, Welch suggested that payment go to a group of physicians (vs. individual physicians) because there would be an enhanced ability to control utilization (Welch, 1989). Welch specifically proposed that medical staff of hospitals be organized as legal entities to accept payments and disburse payments to member physicians. Independent Practice Associations existed at the time, but was nascent in its development and adoption. The predominant medical practice consisted of small physician groups serving fee-for-service (FFS) or discounted FFS patients. Fisher et al. build upon Welch's idea of a medical staff as a point of coordination and included it in their ACO concept. Similar language was found in the ACA legislation requiring ACOs to be separate legal entities.

ACO Public Policy: A View through Agendas

It took three years (2007-2010) for ACOs to evolve from a concept to become reality in a major piece of legislation—the ACA. An exploration of how this was possible follows

using John Kingdon's Multiple Streams theory of policy setting (Kingdon, 1995). According to this theory, three streams—problem, politics, and policy alternatives—converge to create a window of opportunity for an issue to be included in a policy-setting agenda. In the problem stream, problems are defined through tracking and reporting of indicators (e.g., expenditures, disease rates), focusing events (e.g., crisis, disaster), or by feedback from current programs and efforts. The political stream works through the national mood, organized political forces, or changes in administration/personnel. In the policy stream, solutions and recommendations arise from communities of specialists. Described as a "policy primeval soup," ideas appear, hover around, fade, merge, or survive based upon criteria such as technical feasibility, value acceptability, and anticipation of future constraints. Policy entrepreneurs, working alone or through policy communities, work to advance an issue on an agenda and take advantage of a window of opportunity to match their proposal to an identified problem. Using Kingdon's framework, an exploration of how ACOs came onto the national agenda follows.

Problem Identification

Since the inception of Medicare in 1965, Medicare enrollment and expenditures have skyrocketed (see Table 1). Using Medicare data reported in *Health United States, 2011* (National Center for Health Statistics, 2012), a percent change was calculated for four decades (1970-1980, 1980-1990, 1990-2000, and 2000-2010) for enrollees, expenditures, and expenditures per enrollees. The results show that the percent growth for enrollees have consistently been in the low double-digits in the last four decades.

The percent growth for expenditures have consistently been in the triple-digits in the last four decades. The percent growth in expenditures per enrollees were in the triple-digits in the decades 1970-1980 and 1980-1990, and double-digits in the decades 1990-2000 and 2000-2010.

Table 1. Medicare Percent Growth by Decade

Percent Growth	1970-1980	1980-1990	1990-2000	2000-2010
Enrollees	39%	21%	16%	20%
Expenditures	391%	202%	100%	136%
Expenditures per Enrollee	252%	150%	73%	97%
Source: Author's analysis based Health United States, 2011.				

Academicians (Thorpe, Ogden, & Galactionova, 2010), advocacy organizations (Moffit & Senger, 2013), and a government commission (MedPAC, 2013) argue that unbridled Medicare spending is a national problem. However, the problem is not cost alone; it is cost and quality. First, working at Dartmouth Medical School, and later, on the Dartmouth Atlas of Health Care project, John Wennberg tracked and documented unwarranted practice variations in the United States. The variations are unwarranted because they cannot be explained by severity of illness or by patient preference. Using Medicare FFS data, the Atlas project reported on the rates of resource use and medical care across the hospital service area and described three types of variations: variations in effective care and patient safety, variations in preference-sensitive care, and variations in supply-sensitive care (Wennberg, 2002).

Variations in effective care and patient safety involve evidence-based proven services. Patients meeting treatment requirements should be provided treatment. Non-treatment could be described as under-utilization. An example is the use of β blockers at the time of discharge from a hospital after a heart attack. Variations in preference-sensitive care involve conditions for which there are multiple medically acceptable options and it is up to the patient to choose an option. An example is the treatment of early stage prostate cancer. The options available include surgery, radiation, or watchful waiting. Variations in supply-sensitive care is the phenomenon where the capacity of a healthcare system dictates the frequency of its use. For example, regions with more hospital beds tend to record more inpatient stays, on a per-capita basis.

Unwarranted practice variations have an impact on cost. For example, while studying Medicare admissions to hospitals for back problems in Maine, Wennberg found that the rate in the Portland hospital area was less than 60% of the average while it was 30% higher than average in the Augusta area. It was estimated that if the Augusta area rates were standard, the medical cost outlays would have been 2.36 times more than if the Portland area rates were standard (Wennberg, 1984). Studying Medicare payments in different metropolitan service areas, Welch et al. found that 1989 overall payments per beneficiaries were $1,338 in Los Angeles compared to $872 in San Francisco (Welch, Miller, Welch, Fisher, & Wennberg, 1993). These types of variations existed throughout hospital service areas and MSA covering the U.S. Savings from reducing areas of variations has been estimated to save up to 30% of Medicare spending (Fisher, Wennberg, Stukel, Gottlieb, Lucas, & EL, 2003).

Unwarranted practice variations also have an impact on quality. Although variations vary across the country, more spending is not associated with higher quality. Using a cohort study that isolated variations due to physician practices, Fisher et al. found that regions with higher spending did not provide higher quality care (e.g., myocardial infarction patients receiving aspirin in the hospital and β blockers upon discharge) (Fisher, Wennberg, Stukel, Gottlieb, Lucas, & EL, 2003) or better health outcomes (e.g., mortality, change in functional status) (Fisher, Wennberg, Stukel, Gottlieb, Lucas, & Pinder, 2003).

Policy Stream

A number of proposals have been put forth as a remedy for unwarranted variations ranging from enhancing the role of patients in decision making for preference sensitive care (O'Connor, Llewellyn-Thomas, & Flood, 2004) to using population-based provider specific measures of performance to manage resource use and utilization for supply-sensitive care (Wennberg, Fisher, Stukel, & Sharp, 2004). Yet, variations continue to exist due to an unbalanced focus on the medical errors instead of improving the quality of patient decision making and a lack of economic incentives that reward efficient provider practice (Wennberg, 2004). Fisher et al. critiqued efforts such as public reporting, pay for performance, and quality reporting from accreditation organizations as provider centric and a missed opportunity to incentivize the coordination of care and enhance performance across provider settings (Fisher, Staiger, Bynum, & Gottlieb, 2007). The authors proceeded to propose ACOs as a means to control costs and achieve quality of care.

Aside from ACOs, other policies in the policy "primeval soup" included patient-centered medical home (PCMH) and bundled payment. PCMH is an approach for organizing and delivering primary care that is patient-centered, comprehensive, coordinated, assessable, and focused on quality and safety (Agency for Healthcare Research and Quality, 2013). PCMH adoption has been brisk, and preliminary results have found positive effects for patient and staff experiences but were inconclusive for quality and cost indicators. Additionally, although the "comprehensive" principle does include accountability of the patient's care, it does not include accountability for cost; a major shortcoming.

Bundled payment is a payment model that pays a fixed dollar amount to cover a set of services (described as an episode-of-care) over a defined period of time (RWJF, 2013). For this to work, it requires defining an episode-of-care for a common procedure or a disease condition and agreeing on a price for that episode. All professional and institutional charges are encompassed in the payment. This model can control cost and incent against inappropriate utilization due to its fixed pricing scheme. Withhold and payment of withhold can be made contingent on meeting quality standards. The drawbacks of bundled payment have pertained to the definitions of an episode, the clinical tension over the guidelines used to define an episode, and implementation challenges from the health plan level down to the hospital and provider levels (Lischko, 2008).

ACOs have their supporters but also detractors. Burns and Pauly described a few "Achilles' Heels" of ACOs including a focus on primary care physicians where there is a shortage of these professionals, a need for physician practice organization (large organized physician groups) where this type of practice is limited to selected states or regions, and out-of-network utilization where such costs are counted against the ACO yet this is an area where ACOs have limited influence (Burns & Pauly, 2012). Weil was more direct in stating that, "ACOs are in the long haul doomed for failure." Weil's rationale was that hospitals and medical groups have historically been poor partners and now requiring these entities to partner, coordinate care, and share in savings seemed challenging. More importantly, Weil argues that the reward (e.g., savings) is not commensurate with the risks (e.g., start-up costs, ability to manage patients effectively) (Weil, 2012).

These negative sentiments did little to dampen the Medicare Payment Advisory Commission's (MedPAC) enthusiasm for ACOs. MedPAC is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program and was created by merging two separate Medicare advisory agencies: ProPAC and the Physician Payment Review Commission (PPRC). MedPAC was aware of alternative policies to stem Medicare costs and improve quality. However, MedPAC was drawn to Fisher et al.'s work on ACOs and briefly introduced the concept of ACO in its 2008 report to Congress entitled, "Reforming the Delivery System" (MedPAC, 2008) and fully proposed

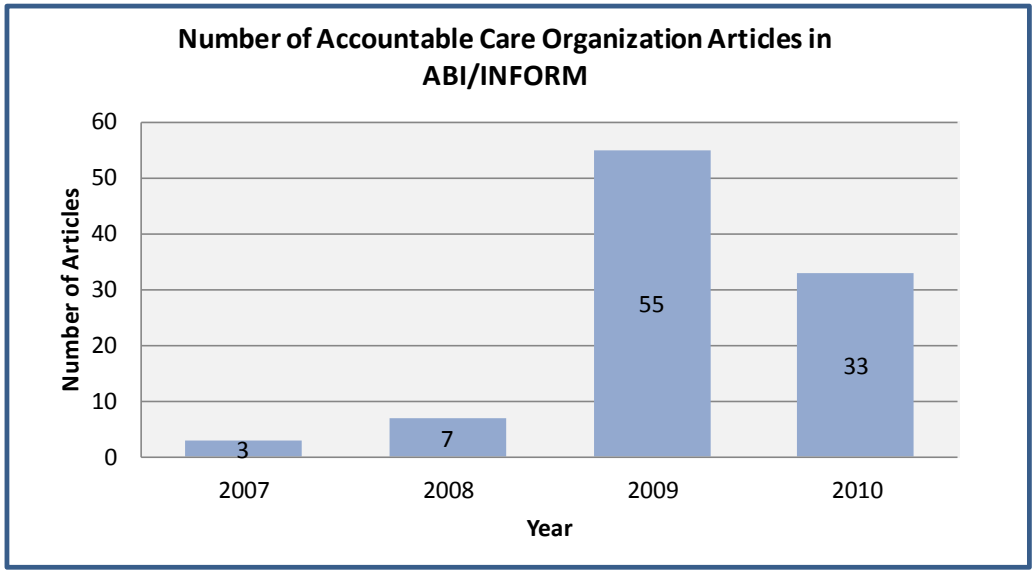
the idea of ACO in its 2009 report to Congress entitled, “Improving Incentives in the Medicare Program” (MedPAC, 2009).

Politics Stream

The third stream of the policy setting agenda theory is the political stream. This stream works through the national mood, organized political forces, or changes in administration/personnel. The national mood will be assessed by reviewing trade and scholarly journals and newspaper articles leading up to the passage of the legislation. Political forces will be discussed by identifying the policy entrepreneurs and their activities. There were no changes in administration/personnel so this will not be covered.

An ABI/Inform Complete search of trade journals, scholarly journals, and newspaper articles from January 1, 2000 to March 23, 2010 (the date of passage of the ACA) that included the words “accountable care organizations” resulted in 106 articles. Eight duplicates were identified and removed reducing the results to 98 articles. Figure 2 shows the distribution by year of the 98 articles. No articles prior to 2007 were found. A distribution resembling a “hockey stick” can be seen from 2007 through 2009. For 2010, the cut-off date was March 23, 2010, the date the ACA became law. Although not quite three months, the number of articles was more than half the number of articles published in 2009. From this trend, it can be interpreted that there was some interest in ACOs immediately after their introduction (2007-2008). Interest intensified greatly in

2009, when ACO moved from concept closer to reality through its inclusion in draft ACA legislation. National interest was maintained in 2010 at the time of ACA passage.

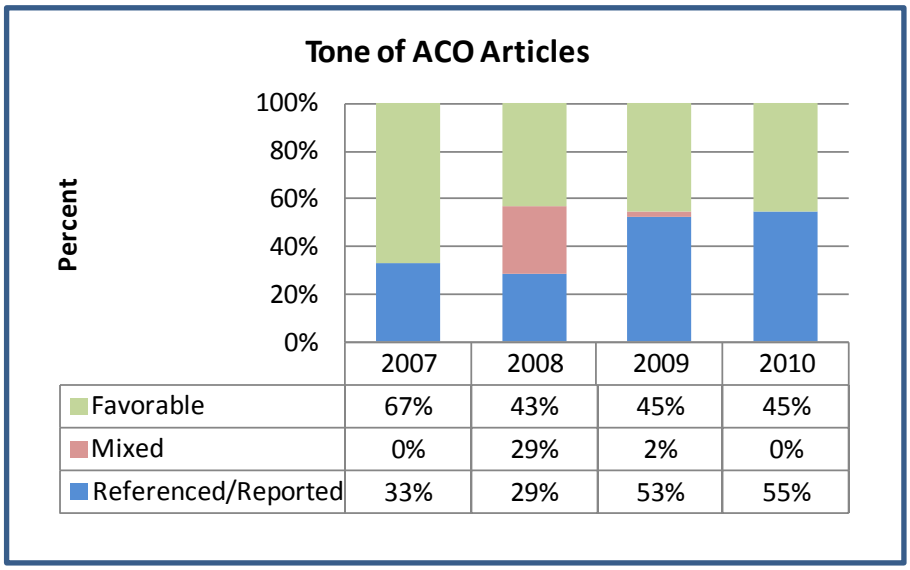


Source: Author's analysis

Figure 2. Distribution of ACO Articles from January 1, 2007 through March 23, 2010

To ascertain the national mood on ACOs, the tone of the articles was assessed. The articles were coded from a review of the abstract or actual articles based on the perception of accountable care organizations as "favorable," "unfavorable," "mixed," or "referenced/reported." Favorable articles were those in which the authors supported ACOs. Unfavorable articles were those in which the authors rejected ACOs. Mixed articles were those in which the authors noted the promises of ACOs but also offered other alternatives. Referenced/reported articles were those in which the authors, working on a tangential topic, cited an ACO paper or were reporting facts on ACOs' legislative developments. Figure 3 shows the tone of the ACO articles. Most of the ACO coverage was either "Favorable" or "Referenced/Reported." A few "Mixed"

coverage occurrences were noted in 2008 and 2009 as ACOs were considered along with other alternatives. There were no "negative" toned articles. From these results, it can be interpreted that the national mood was positive to ACOs. Outright "favorable" was 67% in 2007 and never fell below 43% between 2008 and 2010. Even the high percentage of ACO articles characterized as "Reference/Reported," especially in 2009 and 2010, can be seen as supportive of ACO in that there was sufficient interest to reference or cover its developments.



Source: Author's analysis

Figure 3. Tone of ACO Articles

Political Forces

Three policy entrepreneurs were critical to pushing ACO onto the national health policy agenda; the Dartmouth Institute for Health Policy and Clinical Practice (Dartmouth) led by Dr. Elliot Fisher, the Engelberg Center for Health Care Reform at Brookings (Brookings) led by Dr. Mark McClellan (a Former Food and Drug Administration

Commissioner and CMS Administrator), and MedPAC, led by Mr. Glenn Hackbarth. Drs. Fisher and McClellan pushed the ACO agenda in the private sector. Mr. Hackbarth simultaneously pushed the ACO agenda in the public sector. Together, they attached ACOs onto the legislative "surf board" and rode the healthcare reform wave to ultimately write ACOs into law.

Dr. Fisher and Mr. Hackbarth coined the phrase "accountable care organization" in November 2006 at a MedPAC meeting. Dr. Fisher published a paper calling for the creation of ACO in early 2007. Also in 2007, Dr. Fisher and Dr. McClellan began working together to foster the adoption of ACOs. The first fruit of this effort was the creation of an ACO Learning Network which provided members with:

- ACO implementation tools and resources
- Webinar series
- Member driven workshops
- Online ACO resources and research (ACO Learning Network, 2013)

In 2009, Brookings and Dartmouth launched an ACO Pilot Program to support selected providers in creating ACOs with private payers in different markets across the country. These providers included Healthcare Partners (Los Angeles, CA), Monarch Healthcare (Orange County, CA), Norton Healthcare (Louisville, KY), and Tucson Medical Center (Tucson, AZ). Case studies were published to illustrate the experience and success of these pilot programs (Larson, et al., 2012). The ACO Learning Network and the ACO Pilot Program served to bring legitimacy to the ACO concept and fostered its adoption in the industry.

In the government realm, MedPAC introduced ACO as concept to reform the healthcare delivery system in its 2008 Report to Congress. In its 2009 Report to Congress, MedPAC discussed ACO in detail and provided rationale as to why ACOs made sense for Medicare. With time, these developments would build support and bring action from Congress. However an article published in the New Yorker magazine entitled, "The Cost Conundrum," proved to be a catalyst for rapid change. The author, Atul Gawande, explored why McAllen, TX, a border town with Mexico, is one of the most expensive healthcare markets in the country and yet has quality standards below the national average (Gawande, 2009). This article sparked a "strong reaction" across the nation, was called one of the most influential healthcare stories by the New York Times, and was a "must read" for the Congress and President Obama's Administration (Kaiser Health News, 2009).

Politics

The public and private efforts from MedPAC and Dartmouth and Brookings helped to advance ACOs in the legislative process. On November 7, 2009, the U.S. House of Representatives passed a bill called the Affordable Healthcare for America Act (H.R. 3962). In it, the bill established incentive payment pilots encouraging ACOs in both Medicare and Medicaid. The Senate health reform bill, the Patient Protection and Affordable Health Care Act (H.R. 3590), approved on December 24, 2009, allowed ACOs to share in any cost savings generated for Medicare (Kaiser Family Foundation, 2009). The ACO structure in these bills was very similar to the Brookings and Dartmouth model.

The Senate passed a reconciled conference bill, the Patient Protection and Affordable Healthcare Act, on December 24, 2009. The House of Representatives passed this bill on March 11, 2010. President Obama signed the landmark healthcare legislation into law on March 23, 2010. ACOs can be found in the ACA under Section 3022: Medicare Shared Saving Program (SSP). Authorized by Congress, CMS proceeded to propose rules for the SSP. The proposed rules were published in the Federal Register on April 7, 2011 and the final rules were published in the Federal Register on November 2, 2011.

Real World Adoption: Public Sector Programs

CMS administers three ACO programs: SSP, Pioneer, and the Advanced Payment ACO program. SSP, a national program, is the largest of the three and since its initiation in January 2012 has had three cohorts, totaling 220 organizations, in the program. SSP gives an ACO a choice to select between two savings models: (1) a one-sided model that allows for shared savings, but not losses, and (2) a two-sided model that allows for shared savings and shared losses. ACOs choosing a two-sided model are allowed to share in up to 60% of savings whereas a one-sided model ACO may only share in up to 50% of the savings. Regardless of which model is chosen, ACOs have to meet quality standards to participate in the savings. Table 2 lists the number of organizations recognized as an SSP ACO by performance period (CMS, 2013). See Appendix A for a list of SSP ACOs.

Table 2. Number of Organizations Recognized as SSP ACOs

Performance Period	Date	Number of Organizations
First	April 1, 2012	27
Second	July 1, 2012	87
Third	January 1, 2013	106
	Total	**220**

Source: Author's analysis

The Pioneer ACO program is a demonstration pilot designed for organizations that have had experience in providing coordinated care and managing population health. There are three main differences between a Pioneer and an SSP ACO. First, the Pioneer ACO program offers higher levels of rewards and risks as compared to the SSP ACOs. Second, Pioneer ACOs that successfully earn savings in the first two years will be moved to a population-based payment model, with full risk, in subsequent years. Third, Pioneer ACOs have to develop outcomes-based payment arrangements with other payers by the end of the second year. Started on September 2012 with 32 organizations, on October 2013, 23 organizations remain as Pioneer ACOs (CMS, 2013). See Appendix B for a list of Pioneer ACOs.

The Advanced Payment ACO program is a demonstration pilot designed to assist healthcare organizations without inpatient facilities and less than $50 million in total revenue or rural healthcare organizations in the formation of ACOs. Chosen from a subset of the SSPs, participating ACOs would receive an advanced payment from CMS to cover fixed and variable costs needed to established an ACO. Medicare would recoup the investments through savings generated by the ACO. As of October 14,

2013, there were 35 participants in the Advanced Payment ACO program (CMS, 2013). See Appendix C for a list of Advanced Payment ACOs.

Real World Adoption: Private Sector Programs

Unlike public sector ACOs, there is no requirement to formally organize an ACO as a separate entity in the private sector. Hospitals and medical groups have been collaborating with each other to accept ACO-like contracts from commercial payers. There is no consensus on a definition of a commercial ACO. The population, payment models, cost and quality targets have been defined and negotiated by each payer and medical group/hospital partners. Standard to commercial ACO contracts are quality metrics and cost goals. A report estimated that there were 235 private sector ACOs as of August, 2013 (Petersen, Muhlestein, & Gardner, 2013).

Chapter Summary

ACO is an entity comprised of hospitals and physician organizations who join together to assume responsibility for providing integrated high quality care at a sustainable cost level for a patient population. The idea originated in the medical establishment and entered the policy arena through MedPAC, an agency that advises Congress on Medicare matters. The Dartmouth Institute for Health Policy and Clinical Practice, the Engelberg Center for Health Care Reform at Brookings, and MedPAC pushed ACO onto the national agenda. ACO became a formal part of the health reform movement when the ACA was signed into law. As of October 2013, there were 23 Pioneer ACOs, 35 Advanced Payment ACOs, 220 SSP ACOs, and 235 private sector ACOs.

CHAPTER 3: LITERATURE REVIEW AND ACO FRAMEWORK DEVELOPMENT

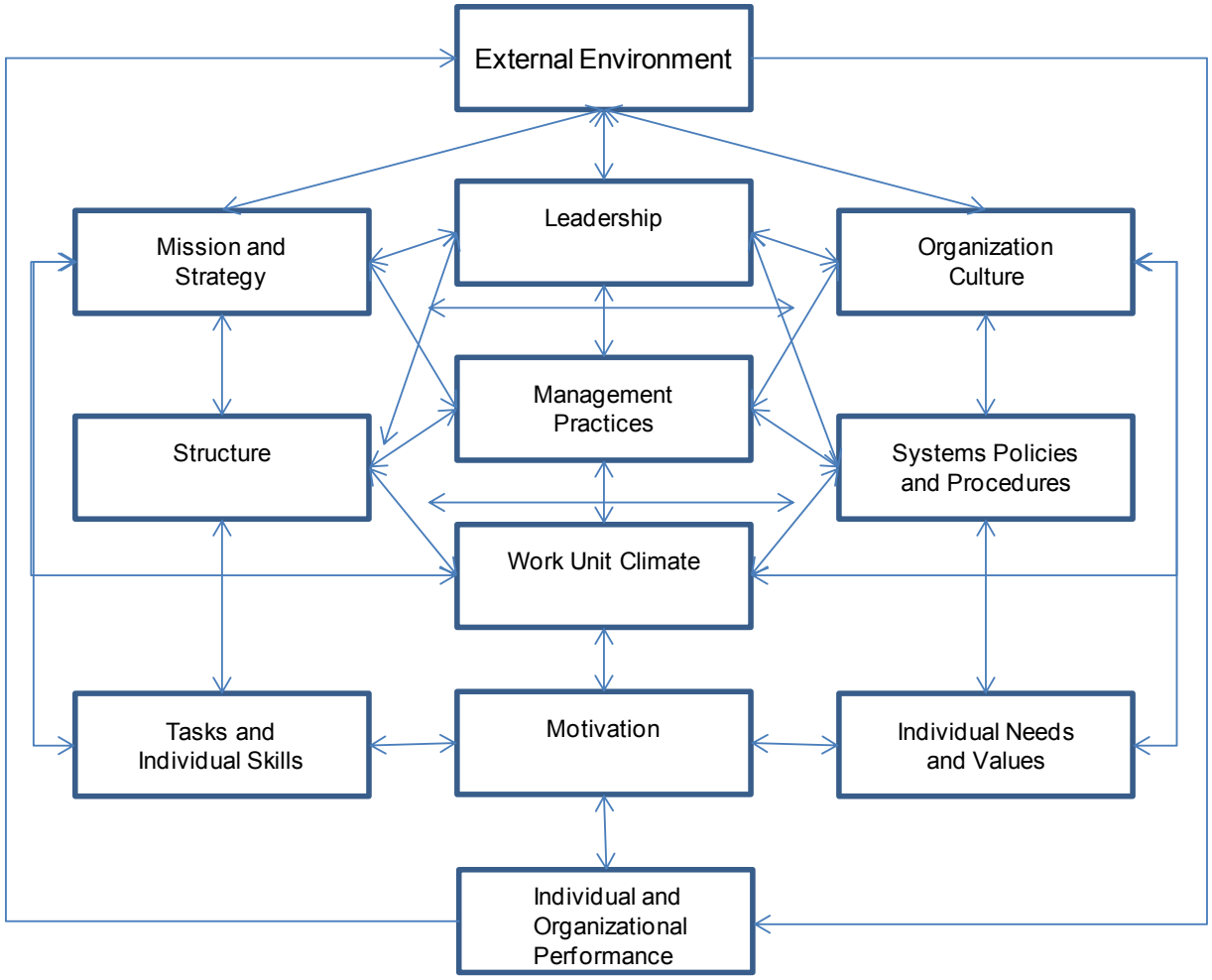
The literature review is divided into four parts. The first part presents and discusses two conceptual models that formed the basis for understanding organization change and organization readiness to change. The second part discusses ACO as an organization strategy. The third part explores healthcare organizations' readiness for change. The fourth part synthesizes information from the first three sections and proposes an ACO Orientation Conceptual Model.

Part 1. Organizing Conceptual Models

This section presents Burke et al.'s Causal Model for Organization Performance and Change (Burke & Litwin, 1992) and Weiner's theory of Organizational Readiness to Change (Weiner, 2009) as two organizing conceptual models that guided the development of the ACO Orientation Conceptual Model.

Causal Model for Organization Performance and Change

Burke et al. introduced a performance and change model in 1992 for organizational effectiveness diagnosis (see Figure 4). The model predicts organization behavior and performance indicators with a cause and effect perspective, with cause being the organization complex and the effects being the results.



Burke, WW; Litwin, GH. A causal model of organization performance and change. Journal of Management, 1992; 18(3): 523-545

Figure 4. A Model of Organization Performance and Change

The model presents the organizational dimensions that are key to successful change and the causal linkages between those dimensions that create change results. External Environment, Mission and Strategy, Leadership, Organization Culture, and Individual Organizational Performance are the *transformational* factors or "areas in which alteration is likely caused by interaction with environmental forces (both within and without) and will require entirely new behavior sets from organizational members" (Burke & Litwin, 1992). The lower portion of the model forms the *transactional* factors

where “the primary way of alteration is via relatively short-term reciprocity among people and groups” (Burke & Litwin, 1992).

A key strength of the model includes its ability to integrate change theory from the world of organization development with change process theory (Burke & Litwin, 1992). Another benefit of the model is the explanation of the relationship and interaction between the *transformational* and *transactional* factors (Spangenberg & Theron, 2013). The explanation of the transformational-transactional paradigm provided for an understanding of the difference between leadership and management (Kinnear & Roodt, 1998).

There are two main limitations of Burke et al.'s model. The first limitation is its incongruence with more recent transformational and transactional leadership theory. Although the four I’s of transformational leadership (idealized influence, inspirational motivation, intellectual stimulation, individualized consideration) (Avolio, Waldman, & Yamarino, 1991) are more aligned to Burke et al.'s model, a transactional leadership model where leaders form exchanges or set up agreements with their followers is misaligned (Bass & Avolio, 1993). A second limitation is its inability to incorporate business process reengineering, a major change management tool used to drive organizational strategy and performance (Davenport & Short, 1990).

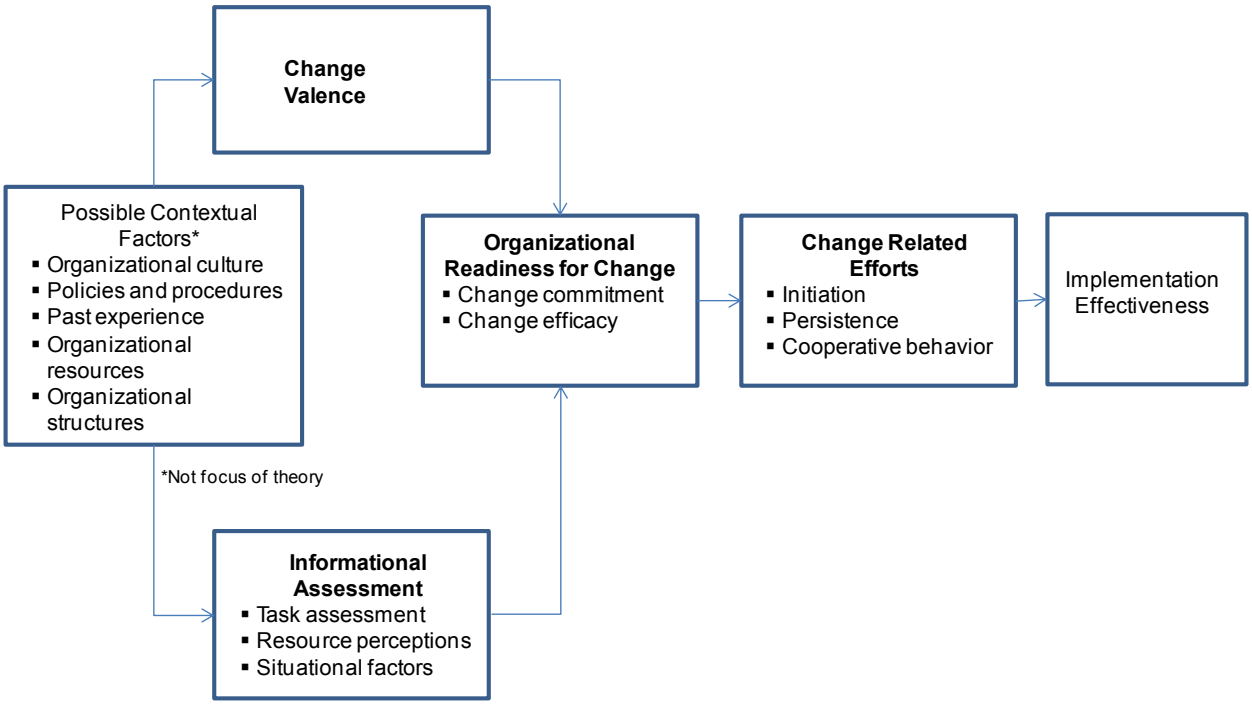
Burke et al.’s Causal Model for Organization Performance and Change underscores the important role that external environment, leaders, and mission and strategy plays within the acceptance and mobilization of change within an organization (Burke & Litwin,

1992). The “sudden” introduction of ACOs has required physician organizations to contemplate change in strategy and operations (Nguyen & Choi, 2011). There is significant variation in the number and types of ACO initiatives in the U.S. (Petersen, Muhlestein, & Gardner, 2013). Burke et al.’s model allows for a study of the cause and process of change within physician organizations in response to ACOs.

Theory of Organizational Readiness to Change

Weiner used individual readiness for change concepts as a basis to define organizational readiness for change and developed a theory of organizational readiness determinants and outcomes (Weiner, 2009). In the model (see Figure 5), Weiner explores factors that influence each other in a sequential manner. Five contextual factors of organizational culture, policies and procedures, past experience, organizational resources, and organizational structure drive elements called “change valence” and “informational assessment.” “Change valence” is the notion where the value of change (i.e., business need, importance) is understood by members of the organizations leading to higher levels of engagement execution and follow-through. ”Informational assessment” is a concept describing an organizational member’s appraisal of implementation capabilities related to task demand, resource availability, and situational factors. “Change valence” is a precursor to organization change commitment (organizational member’s resolve to implement a change) and “informational assessment” is a precursor to organization change efficacy (shared belief in a collective ability to change). Organizational readiness then is defined as an organization member’s change commitment and change efficacy to implement

organization change. Organizational readiness emanates through change-related efforts such as initiation, persistence, and cooperative behavior which results in some form of implementation effectiveness. It is important to note that organizational readiness does not guarantee a successful implementation outcome. Misjudgment of factors along the chain may facilitate change throughout the organization but the outcome may be less successful than expected.



Weiner, BJ. A theory of organizational readiness for change. Implementation Science, 2009; 4:67.

Figure 5. Theory of Organizational Readiness for Change

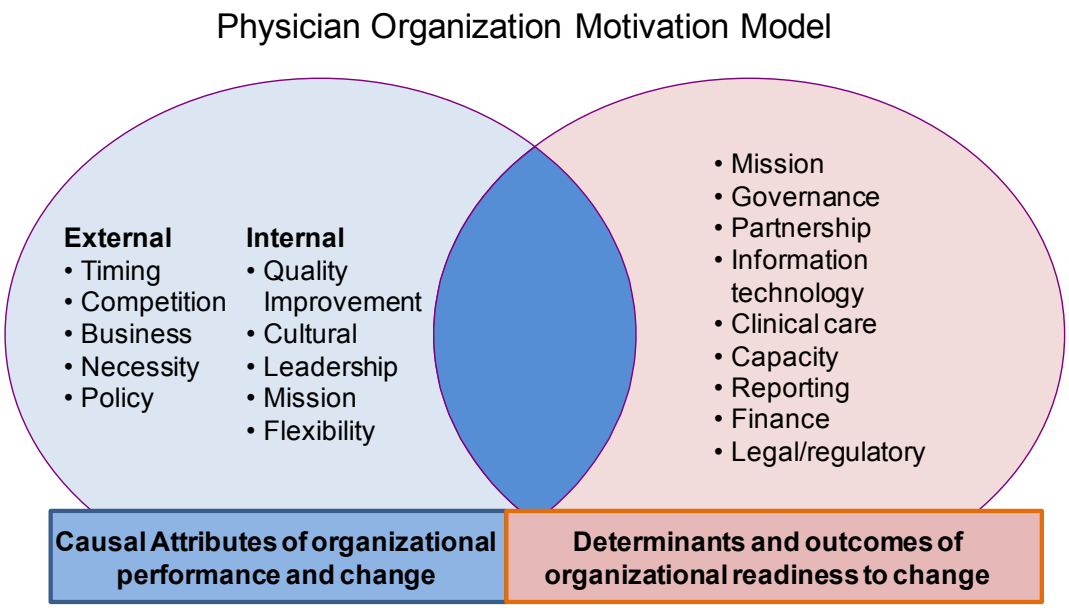
A major strength of Weiner's model is its consistency with established motivation theory and social cognitive theory developed when studying individual readiness to change. Weiner leveraged Bandura's concept of goal commitment (Bandura, 1997) to describe

organization change commitment and Gist and Mitchell's concept of efficacy, which is a "comprehensive summary or judgment of perceived capability to perform a task" (Gist & Mitchell, 1992). The model also establishes a distinction between the individual and organization as both the agent and target of change and treats readiness for change not as a general state of affairs but as a focused effort upon an impending organizational change (Mueller, Jenny, & Bauer, 2012).

A limitation of Weiner's model is the lack of explanation of the "contextual factors." Elements of culture, norms, measurement, accountability, previous success, support, information systems, and structure are thought to play a crucial role as "contextual factors" in a healthcare organization's ability to spread and sustain change (Duckers, Wagner, Vos, & Groenewegen, 2011). Nonetheless, the model is useful in guiding the dissertation implementation plan; specifically the development and administration of the ACO readiness survey.

Synthesis of Conceptual Organizing Models

Burke et al.'s model provides a framework to understand why organizations change. Weiner's model describes factors that are important in preparing organizations for change. These organizing models are useful to study physician organizations' reactions to change. Below is a summary of how the Model of Organizational Performance and Change and the Determinants and Outcomes of Organizational Readiness for Change Model have been combined to form a conceptual model for understanding ACO motivation and diffusion (see Figure 6).



Source: Author's analysis

Figure 6. Physician Organization Motivation Model

The Physician Organization Motivation Conceptual Model is comprised of two concentric circles. One circle contains the factors explaining the conditions for physician organization change. A second circle describes the characteristics to understand a physician organization's capacity to affect change. This sets up the argument that physician organizations will be motivated to change when (1) they want or feel a need to change and (2) they have the capacity to change. This line of reasoning is consistent with consumer theory, where a potential buyer of products or services will take action when they perceive there is value in the product or services and they have the resources to acquire the goods or services (Nixon, 2006), and in psychology and the study of individual motivation where patients psychologically and behaviorally take action when they are willing and able to do so (Prochaska & DiClemente, 1983). In the later, application of individual motivation has been

successfully implemented into motivational interviewing and heath behavior change constructs; these models have been successful in improving patient engagement (Rollnick, Mason, & Butler, 1999), (Martin, Haskard-Zolnierek, & DiMatteo, 2010).

The model shows that causes of physician organizational change may emanate from internal or external sources. Internal sources may include a desire to provide quality care continuously (Weeks, et al., 2009), a culture of innovation (Nembhard, Singer, & Shortel, 2012), leaders that recognize the importance of change (Holt, Self, Thal, & Lo, 2003), pursuit of an organization mission (Studer, 2003), and organizational "flexibility" (Dunford, Palmer, Beaumont, & Steele, 2013). External sources include market timing or opportunity (Staudenmayer, Tyre, & Perlow, 2002), competition and survival of the fittest (Whelan-Berry, Gordon, & Hinings, 2003), a business environment conducive to change (Whelan-Berry, Gordon, & Hinings, 2003), a requirement to change or perish (Zell, 2003), and a window of opportunity to take advantage of a new policy or regulation (Guterman, Davis, Schoenbaum, & Shih, 2009). A physician organization's readiness for change is defined according to a number of attributes including mission, governance, partnership, information technology, clinical care, capacity, reporting, finance, and legal and regulatory (Shortell & Weinberger, 2012).

The proposed model is a multi-level model. Physician organization motivation may occur and be assessed at the individual, group, unit or department level. The intermingling of information and ideas among individuals or group of individuals within the physician organization form the basis for data gathering and assessment. However,

this model is theoretical and does not allow for data collection or analysis. To make this more pragmatic, a step is taken from this intermediary position to construct a framework to study physician orientation to ACO.

Part 2. ACO as an Organizational Strategy

Given the promises of ACOs, one might expect markets to converge on similar models of ACO adoption. The reality is that physician organizations' decisions to pursue ACOs vary across and within markets. Several factors plausibly account for these variations. Individual physician organization characteristics and health market characteristics may affect the ACO evaluation process. Policy makers may also influence ACO developments through their roles as Medicare ACO administrators. However, this is unlikely given the strict adherence to administrative rules based on the ACA.

To understand why physician organizations consider ACO contracts in the first place, a foray into the business realm is needed. In the business literature, "a company's business model relates to how and why a company's product and offerings can generate attractive revenues and still create value for the customers. Business models convert new innovation to economic value for the firm and the customer. Crafting strategy sets the course, direction, objectives and performance capabilities for implementing and actualizing a chosen strategic outcome. An organization formulates a strategy to establish a difference in the market and to out-perform rivals" (Madu, 2013). ACO is a strategy that physician organizations can employ to beat their competitors.

Miles et al.'s (Miles, Snow, Meyer, & Coleman, 1978) strategic typology of *Defenders*, *Analyzers*, and *Prospectors* helps to explain how organizations select and deploy their strategies (Griffith, Kiessling, & Dabic, 2012). This typology was selected because it describes firms as dynamic entities (Cho, 2013) and has been shown to be a stable descriptor of an organization's characteristics (Zahara & Covin, 1993). *Defenders* seek to create a stable environment that allows them to seal off market share and maintain their current businesses. They aggressively use pricing schemes and operational prowess to prevent competitors from succeeding in the market. Given their laser focus on the existing market, *Defenders* tend to ignore and dismiss trends and opportunities outside their area of specialization. Successful *Defenders* become niche players over time and thrive in stable markets.

Prospectors have characteristics opposite that of *Defenders*. They continually find, develop, and pursue new product and market opportunities. *Prospectors* value being known as innovators and may place this aspect higher in importance than profitability. The constant market scan undertaken by *Prospectors* help them outperfrom in rapidly changing and competitive markets. If *Defenders* and *Prospectors* form ends of a spectrum, *Analyzers* would be situated in the center of the spectrum. *Analyzers* strive to minimize risk while maximizing opportunity. They cautiously exploit new product and market opportunities while maintaining core products and serving existing customers. *Analyzers* can be thought of as "second movers," imitating "first movers" only after success has been demonstrated (Griffith, Kiessling, & Dabic, 2012).

With firm (physician organization) characteristics in place, an exploration of health market conditions follows. Kaufman argued that heath systems are looking to ACOs and PCMHs in an attempt to solve the cost equation (Kaufman, 2011). With health reform in full swing, bundled payments and population-based reimbursements are within sight. As such, health systems cannot depend on the traditional strategy of cost shifting (i.e., making up the difference in lower Medicare/Medicaid reimbursement by demanding premium rates from private/commercial payers) and instead are forced to look for ways to take substantial costs out of the system. This cost equation will not be easy to balance because there is a need to invest in systems and operations that support team-based integration and population health. The healthcare system can also be viewed through the lens of supply and demand (Burns & Robinson, 1997). Supply side is composed of the number of physician practices (solo or small group), the growth of large integrated group practices, and the under/over-supply of primary care and specialty physicians. Demand side consists of medical expenditures, the entrenchment of managed care, the power of large purchasers, and consolidation. The dynamic healthcare market conditions have lead physician organizations to find ways to maintain access to markets (Zismer, 2013), grow patient volume, and find savings and efficiencies (Stenson & Thompson, 2013).

Part 3. Organization Readiness for Change

Organizational readiness for change is a multi-level and multi-faceted construct (Weiner, 2009). From a multi-level perspective, readiness may be identified at an individual, team, department, or firm level. It is multi-faceted in that there has to be a

knowledge of the change, a change commitment, and finally, an ability to implement the change successfully. Early exploration of organizational readiness in healthcare focused on quality and continuous improvement. Penland described a model to create organizational readiness consisting of (1) strategic leadership, (2) vision perspective, and (3) positive culture (Penland, 1997). Recent research studied organizations' readiness for evidence-based practice (Newhouse, 2010), clinical information systems (Pare, Sicotte, Poba-Nzaou, & Balouzakis, 2011), and chronic care (Gagnon, et al., 2011). In a thorough review on the subject, Weiner et al. analyzed 106 peer-reviewed articles (along with 43 instruments) and found little consistency in defining "organizational readiness," varied levels of analysis from individual to organization to both, and limited evidence of reliability and validity of most currently available instruments (Weiner, Amick, & Lee, 2008).

The field of ACO readiness research is in its infancy but has covered health plans, hospitals, and provider groups. Higgins et al. reported on the characteristics of accountable care models implemented by a number of health plans (Higgins, Stewart, Dawson, & Bocchino, 2011). The characteristics covered program scope, provider selection, patient roles and attributions, performance measurements and targets, and payment methods. The authors identified critical success factors such as sharing data and reports, providing flexibility in arrangements, defining a role for the patient, and building a capability for longitudinal measurement. Audet et al. surveyed hospitals' readiness to participate in ACOs along the dimensions of payer partners and payment models, managing financial risk, population care management, care coordination and

care transitions, and tracking performance data (Audet, Kenward, Patel, & Joshi, 2012). The authors found that a majority of hospitals operated ACOs as a joint venture between physicians and hospitals with commercial payers. The dominant payment method was shared savings. Shared savings and shared risk, global capitation, and partial capitation was a distant second, third, and fourth, respectively. Almost 85% of respondents participating in ACOs or preparing to participate have information systems to track performance. Less than a third of the respondent hospitals have population care management programs for their patients. Finally, from a provider's perspective, Nguyen and Choi described ten steps to consider when forming an ACO (Nguyen & Choi, 2011). The steps included:

1. Assess readiness for accountable care
2. Assemble the right project team
3. Create the legal and organizational framework for the ACO
4. Form the right leadership team
5. Strategically align human capital
6. Ensure minimal operational requirements are met
7. Assess all dimensions of financial readiness
8. Integrate IT to the point of "meaningful use"
9. Strengthen partner relationship and business network
10. Engage the community as an ally

Shortell and Weinberger (Shortell & Weinberger, 2012) specifically created an ACO readiness survey for physician organizations covering organizational mission and population served, governance and leadership, partnerships, information technology and related infrastructure, managing clinical care, performance reporting, finance and contracts, and legal and regulatory issues, barriers, and risk tolerance. This instrument was used in this dissertation to assess case study participants' state of ACO readiness.

Part 3. ACO Orientation Conceptual Model

All of the elements now are available for available for reconstruction. Recall the organizing models of Causal Model of Organizational Performance and Change (Burke and Litwin) and Determinants of Organizational Readiness for change (Weiner). These two models were combined to describe physician organizations' response to change. In this dissertation, ACO is positioned as the change. The question becomes how will physician organizations respond to ACOs? Although this question is difficult to answer, organizational change theory and organization readiness for change theory suggest a way to frame a potential response (see Figure 7).

Miles et al.'s typology framework consists of one dimension of the ACO Orientation Model. A physician organization may be characterized as a *Defender*, *Analyzer*, or *Prospector*. A second dimension of the ACO Orientation model is ACO readiness. The dissertation uses Shortell's ACO readiness survey for this assessment (the survey is discussed extensively in the Methodology Section). The following figure present a conceptual model and hypotheses for understanding a physician organization's ACO orientation.

		Strategic Typology		
		Defender	**Analyzer**	**Prospector**
ACO Readiness	**High**	No	Maybe	Yes
	Low	No	No	Maybe

Source: Author's analysis

Figure 7. ACO Orientation Conceptual Model

According to the conceptual model, physician organizations displaying *Defender* typology would not pursue ACOs regardless of the state of their readiness. Physician organizations characterized as *Analyzers* would consider ACOs if they had high ACO readiness but would not pursue ACO status if had low readiness. Physician organizations depicted as *Prospectors* would pursue ACOs if their ACO readiness was high and would consider pursuing ACOs even if ACO readiness was low. In this dissertation, a series of case studies was undertaken to test the conceptual model.

Chapter Summary

The Causal Model for Organization Performance and Change and the Theory of Organizational Readiness for Change are organizing conceptual models that formed the basis for understanding why organizations change and when they are ready to change. The synthesis of these organizing conceptual models resulted in a proposed Physician Organization Motivation Model. This model follows consumer and psychology theories and argues that physician organizations' motivation to change is driven by a need to change and their capacity to change. In this dissertation, ACO is positioned as the change. To complete the model building, Miles et al.'s strategic typology was used on one dimension to explain how physician organizations select and deploy their ACO strategy and Shortell's ACO readiness survey formed the basis for the second dimension. Together they form a proposed ACO Orientation Conceptual Model; a framework to understand a physician organization's ACO strategy.

CHAPTER 4: METHODOLOGY

This dissertation uses a qualitative, non-experimental, cross-case study method supplemented by a survey. Case study is an appropriate method of inquiry when the type of the research question formed is “how” or “why,” when the investigator has no control over the actual behavioral event, and when the degree of focus is on a contemporary event as opposed to a historical event (Yin, 2009). This dissertation meets these criteria. First, this dissertation seeks to understand the reasons why six Orange County, California physician organizations became ACOs or decided not to become ACOs. Additionally, this dissertation explores whether the physician organizations’ state of ACO readiness influenced its decision to form an ACO. Second, the investigator has no control over the organizations or events. Finally, the research is focused on a contemporary event: adoption of ACOs. The case study approach allows for an in-depth exploration of the external factors and internal organizational features that influence the decision-making process. It also aids in understanding the aims and objectives, level of organizational commitment, and lessons learned from the ACO due diligence process.

A list of 34 physician organizations with an Orange County service area was compiled from a Cattaneo and Stroud medical group database. A second list of 123 physician organizations was provided by the California Association of Physician Groups (CAPG), a trade association representing physician organizations in California. There were 15 physician organizations common to these two lists. Letters were mailed to nine physician organizations requesting their participation in the case study. Mailed

solicitations were followed up with telephone calls. Six physician organizations responded favorably to the request. An in-depth interview with an executive in the physician organization and an administration of a Physician Organization ACO Readiness Survey for each organization completed the data collection process.

Interview Guide

An interview guide was prepared based upon a Fisher et al. framework for understanding ACOs. This included understanding ACO characteristics, ACO structure, capabilities and activities, and the context within which the ACO is forming or operating (Fisher, Shortell, Kreindler, Van Citters, & Larson, 2012). Additionally, considerations were given to CMS' ACO program requirements. The interview guide consisted of four sections: 1) a "General" section seeking to understand descriptive attributes of a physician organization; 2) a "Characteristics" section querying the ACO exploration process; 3) an "If ACO" section covering the ACO application and implementation process and lessons learned; and 4) an "If not ACO" section exploring strategies and tactics to remain independent of ACOs.

The semi-structured interview questionnaire was piloted with two physician group leaders. Based on the pilot interviews, some of the interview questions were re-arranged and re-worded. No statistical review was needed because the study is based on qualitative methods. Information from key informant interviews was integrated with publicly available reports, state government agency reported data, information on a physician organization's website, and other Internet resources related to the physician

organizations forming the basis for the case studies. Analysis was also performed across the physician organizations to identify common themes and unearth insights. The ACO Orientation Conceptual Model was tested based on the responses to the semi-structured interview questions and the ACO readiness survey. The interview guide may be found in Appendix D.

ACO Readiness Survey

A Physician Organization ACO Readiness Survey was created based upon Shortell and Weinberger's *Safety Net Accountable Care Organization Readiness Assessment Tool* (Shortell & Weinberger, 2012). Shortell and Weinberger's instrument was created for physician organizations primarily serving safety net patients. Shortell and Weinberger reported that, "In developing this instrument we drew on preexisting instruments developed by 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 instrument was piloted in two California Counties and also benefitted from feedback from participants at a 2012 conference entitled, "Safety Net ACOs: Barriers and Benefits." However, the instrument has not been formally validated. Categories of content covered in the instruments included:

- Organizational mission and population served
- Governance and leadership
- Partnerships
- Information technology and related infrastructure
- Managing clinical care
- Performance reporting
- Finance and contracts
- Legal and regulatory issues, barriers, and risk tolerance
- Overall assessment

Permission to modify the survey instrument for standard physician organization use was emailed to Dr. Shortell's office on February 3, 2013 and approval was granted on February 4, 2013. The main modifications were deletions of safety net provider-specific questions and the removal of references to safety net lines of inquiry and generalization of the questions to make it applicable to a standard physician organization.

Survey responses were entered into a spreadsheet and data was analyzed using Microsoft Excel 2007. The mean, median, minimum, maximum, and standard deviation were calculated and reported for each responding physician organization by survey category and all categories. Data across all respondents were aggregated to calculate a set of overall score for the study. The ACO Readiness Survey may be found in Appendix E.

Study Participants

The study participants include six physician organizations with service areas in Orange County, California. The practice structures range from independent practice associations (IPAs) to medical groups. The number of physicians (primary care and

specialty care) range from a few hundred to over 1000 physicians. All study participants had commercial businesses while a few and Medicare and/or Medicaid businesses.

Orange County Market Characteristics

Orange County, CA has a population of around 3 million. Major cities in Orange County include Anaheim, Costa Mesa, Fullerton, Garden Grove, Huntington Beach, Irvine, Orange, and Santa Ana. Three health systems/hospitals comprise 45% of the market share for hospital services. These include St. Joseph Health System with a total of 1,448 beds and a 20% market share, Hoag with a total of 585 beds and a 13% market share, and MemorialCare with a total of 543 beds and a 12% market share. The major employers in Orange County are government-related. State government tops the list with 28,239 employees followed by Orange County government with 18,050 employees. The Boeing Company is the top private employer with 8,684 employees. Orange County has a 21% uninsured rate. Of the insured, 52% is commercial enrollment, 15% is Medicaid (or Medi-Cal in California), 10% is Medicare, and 2% duals eligible. For health plan enrollment, Wellpoint has the highest enrollment with 589,409 enrollees. This translate to a 24% market share. CalOPTIMA is second with 429,251 enrollees and a 18% market share. Kaiser Foundation Health Plans is third with 399,716 enrolles and a 17% market share (HealthLeaders-Interstudy, 2012). The market is very active with pressures of tighter integration leading to consolidation. For example, in 2012, OptumHealth, a subsidiary of UnitedHealth Group acquired Monarch Healthcare, a major IPA in Orange County. Healthcare reform, in general, and payment reform, in

particular will drive and shape the Orange County health market in the forseeable future.

Chapter Summary

This dissertation uses a qualitative, non-experimental, cross-case study method supplemented by a survey. Six case study participants were selected from a combined list of physician organizations from Cattaneo and Stroud and CAPG. Using a semi-structured interview guide, an in-depth interview with an executive in the physician organization and an administration of a Physician Organization ACO Readiness Survey for each organization completed the data collection process. Information from key informant interviews was integrated with publicly available reports, state government agency reported data, information on a physician organization's website, and other Internet resources related to the physician organizations forming the basis for the case studies. Analysis was also performed across the physician organizations to identify common themes and unearth insights. The ACO Orientation Conceptual Model was tested based on the responses to the semi-structured interview questions and the ACO readiness survey.

CHAPTER 5: FINDINGS

This chapter is divided into four parts. The first part covers results from an assessment of external and internal causal attributes. The second part reports the test results for the ACO Orientation Conceptual Model using strategic typology and ACO readiness results from the case study participants. The third part describes barriers and faciliators to ACO formation.

Part 1. Causal Attributes

One objective of the dissertation is to identify and understand physician organizations' motivation and rationale for pursuing ACOs or avoiding ACOs. An ACO Motivation Conceptual Model was proposed as a framework to understand this area (see Figure 6 on page 30). The model combines causal attributes, or factors explaining the conditions for physician organization change and readiness for change factors that describe a physician organization's capacity to affect change.

Of the external causal attributes described by the ACO Motivation Conceptual Model, only business rationale, competitor activity, and a policy window were found by case study participants to be applicable. Business rational was listed by three physician organizations. As an example, President and CEO of a study participant said that becoming an ACO was a "no brainer" and that coordinated care is the solution to the healthcare crisis. Two physician organizations listed competition as a reason. For example, one of the case study participant citing competition as a reason, was positioning itself to compete effectively against other large integrated delivery systems.

This case study participant had to compete using a medical group and affiliated provider model.

Finally, two physician organizations also agreed with a policy window as an external causal attribute. One of the case study participants had been following ACO developments while the ACA was in bill form. The interest grew intense after the ACA was passed into law. This case study partipant believed that ACOs, in concept, moved healthcare in the right direction. Here was an idea that linked quality care delivery with controlled costs. ACOs had flavors of managed care and this case study participant had managed care experience. This case study participant is a firm believer in the health maintenance organization (HMO) model where risk is given to an organized provider group and the group managed the risk. For this case study participant, ACO was an opportunity that needed to be explored. In January 2011, this case study participant began a process to become a Pioneer ACO. A limited liability corporation was formed. A board of directors was established. An application was submitted to CMS. CMS interviewed and selected this case study participant as one of 60 finalists. This case study participant even entered into contract negotiations with CMS. But in December 2011, this case study participant decided not to participate in the Medicare-sponsored ACO program because it did not make financial sense.

Counter to suggestions eminating from the literature and model, none of the participants cited necessity or timing as an external causal attribute. This may be due to the limited sample in this dissertation or the way the semi-structured interview was operationalized.

Of the internal causal attributes described by the ACO Motivaton Conceptual Model, only culture, leadership, and quality care improvements were found by case study participants to be valid. Only one physician organization indicated leadership as a factor.

Four physician organizations listed culture as a contributing component. All six case study participants agreed with quality care improvement as an internal causal attribute for ACO considerations. As an example, one case study participant's mission is to make quality care available locally in the communities it serves and it sees the promises of ACO as a way to meet this mission. In particular, this case study participant planned to leverage its strong care coordinating functions used in the HMO business towards the ACO pilot with CMS. Similarly, another case study participant teamed up with a partner hospital to show that a medical group and a hospital can serve as a model for clinical integration and achieving improved patient experience, improved health outcomes, and reduced per capita cost of care.

A few attributes that were mentioned by the case study participants that were not accounted for in the framework included using ACO as a way to attract physicians into the provider network, market uncertainty in the path of health reform, Medicare FFS to Medicare Advantage conversion, and ACO as an innovation. Given the market dynamic in Orange County, CA, there is pressure to integrate and consolidate so the need to add providers to a network is palpable. However, using ACO as an element of attraction appears to be unique to the responding physician organization. This rationale was not

supported by other case study participants. This also appears to be the case for the reason stated as market uncertainty in the path of health reform. The physician organization that cited this reason felt uncertain about the future operating environment for providers and chose to participate as an ACO to better control its destiny.

A third attribute not accounted for by the framework is ACO as an innovation. The case study participant citing this reason is known to be an innovator in the market. So, the novel concept of ACO fell in line with this group's other innovative efforts. These entities are labeled "trailblazers" or "organizations that are willing to take a step into the unknown and experiment with unproven models of managing a population's health" (Mulhstein, 2013). The "innovation" attribute may be linked to the attribute that says ACO may attract physicians into the provider network. Part of the appeal for physicians may be associating themselves with a leading, innovative physician organization.

The final attribute unaccounted for in the framework is Medicare FFS to Medicare Advantage conversion. Three physician organizations indicated this as a reason for pursuing ACO. Given their strong experience with managed care, these case study participants would have preferred serving Medicare Advantage patients in the ACOs. However, The current SSP program is implemented on a Medicare FFS patient population. Medicare is pursuing integrated patient care with the introduction of ACO but finds itself in a predicament of having to do so on the FFS patients. Medicare FFS is popular with patients largely due to the system's accomodating provider choice. With Medicare FFS, patients can see any physicians they like as long as the physician

accepts Medicare. One case study participant, in particular, cited the incongruence of their deligated medical group model with a FFS payment scheme as a reason for forgoing the SSP program. Instead, this participant pursued an ACO with a commercial payer. The two other physician organizations, however, felt that this was an opportunity to introduce managed care programs to the Medicare FFS patient population. Over the course of the ACO experiment, it is hoped that Medicare FFS patients will become more comfortable with the wrap-around services typically found in managed care plans (e.g., care coordination, disease management). When the ACO program ends, the hope is that these patients will consider enrolling in Medicare Advantage plans to enjoy the higher level of care management and coordination. This would play to the group's strength; managed care.

Why did physician organizations not form ACOs?

The research found that the reason for not pursuing ACOs, in general, was due to market/environment immaturity and the reasons for not pursuing Medicare ACOs, in particular, were due to rigid rules, a sense that there were too much risk and little reward, and a focus on FFS patient population that were inconsistent with the delegated medical group models in California. During the research period, one of the case study participants was not involved as an ACO; either Medicare Pioneer/SSP ACO or commercial ACO. However, this physician organization was building its care management and information technology capabilities to support "accountable-like care" for the Medicaid population. It was preparing for possible future ACO partnerships with the State of California and commercial payers. The evolution of ACOs has yet to reach

the Medicaid population fully. As such, this case study participant did not become an ACO because the market and the environment were not ready.

Three of the six case study participants did not form SSP ACOs because the Medicare SSP rules and regulations were rigid and not open to negotiation. Additionally, these organizations felt that the risk and reward benefit equations were not balanced. There was too much risk and insufficient reward for taking the risk. The risks included upfront investment costs to set up an organization with separate legal structures, implementation of a system-wide information technology platform, and hiring and training of medical, finance, technology staff. The reward was the promise of a distribution of savings, which was not guaranteed nor benefitted the ACO in full (the physician organization shares in any savings with CMS). Lastly, these same three case study participants stated that the SSP ACO's focus on the FFS Medicare patients were not in line with the core belief of the organizations. They did not want to support or further a system that propagated FFS medicine. All three physician organizations spurned Medicare ACOs. Two of the three, however, sought out health plans and had active ACO pilots with commercial payers. The third physician organization was in the process of negotiating with commercial payers for its own ACO.

Part 2. Testing the ACO Orientation Conceptual Model

This section reports the results for the ACO Orientation Conceptual Model using strategic typology and ACO readiness results from the case study participants. Figure 8 presents the ACO orientation quadrant for each case study participant according to

strategic typology and ACO readiness. Along the strategic typology dimension, of the six case study participants in the study, four case study participants were classified as *Analyzers* and two were classified as *Prospectors*. None of the case study participants had a Defender classification. Along the ACO readiness dimension, five of the six case study participants had high ACO readiness score and one case study participant recorded a low ACO readiness score.

		Strategic Typology						
		Defender	**Analyzer**			**Prospector**		
				Predicted	**Actual**		**Predicted**	**Actual**
ACO Readiness	**High**	None	Phys. Org. 1 Phys. Org. 2 Phys. Org. 3 Phys. Org. 4	Maybe	No Yes No Yes	Phys. Org. 5	Yes	Yes
	Low	None	None	No	None	Phys. Org. 6	Maybe	Yes

Source: Author's analysis

Figure 8. ACO Orientation Model Test Results

The ACO Orientation model predicted that *Analyzers* with high ACO readiness scores would be open to becoming ACO, but not at all times. The results are aligned with the prediction. Of the four case study participants in this quadrant, two formed ACOs while the remaining two did not. For *Prospectors*, the ACO Orientation model predicted that *Prospectors* with high ACO readiness scores would become ACOs. One case study participant occupied this quadrant and became an ACO. Finally, the ACO Orientation model predicted that *Prospectors* with low ACO readiness scores may consider

becoming ACO. One case study participant occupied this quadrant and chose to become an ACO.

Part 4. Barriers and Facilitators

A number of barriers to ACO formation were identified by case study participants. These barriers are identified as either environmental barriers or organizational barriers. Enviromental barriers included an ACO's broad scope, intensive resource investment requirements, rules and regulations interpretation and enforcement, and a risk-reward imbalance. A case study participant who identified scope of ACO as a barrier reflected that ACOs cover so many different areas (e.g., clinical, financial, legal, operations) that it takes a lot of time and resources to manage it successfully. Another case study participant seconded this notion agreeing that a high level of investments (i.e., financial, human, systems) is required to operationalize an ACO. This participant further cautioned that the ACO application process, although intense, is just the first step if accepted into the program. A third environmental barrier is the uncertainty in the interpretation and enforcement of the administrative rules. Some of the program rules have yet to be drafted. And even when it is written and published, there may not be a common understanding and interpretation of the rules. A participant's counsel on this matter is to stay flexible to effectively deal with these uncertainties. The final external barrier is a risk-reward imbalance. Three participants felt that the risk and reward benefit equations were not balanced. There was too much risk and insufficient reward for taking the risk. The risks included upfront investment costs to set up an organization with separate legal structures, implementation of a system-wide information technology

platform, and hiring and training of medical, finance, technology staff. The reward was the promise of a distribution of savings, which was not guaranteed and would not benefit the ACO in full (the physician organization shares in any savings with CMS).

Organizational barriers identified by case study participants included physician organization and hospital misalignment of incentives, a lack of infrastructure, a lack of data, difficulties in getting providers to buy-in, and beneficiary inertia. One case study participant spoke frankly about the misalignment of incentives between physician organizations and hospitals in an ACO saying that there is an, “inherent conflict between medical group Chief Financial Officers (CFO) and hospital CFOs.” In an ACO, medical group care coordination efforts aim to minimize inpatient stays. Hospitals naturally try to negate these efforts because it can impact their revenue and profits. This misalignment of incentives has to be addressed for an ACO to be successful.

The lack of infrastructure was identified as a second barrier. Without predictive modeling capabilities to identify and stratify patients, a system-wide electronic medical record, to capture, track, and report information, and knowledgeable clinicians and allied-health professionals to support patients outside the medical visit settings, patient care and the goals of the ACO may not be maximized. Electronic medical information systems need data to run effectively. From predictive modeling that identifies patients at risk, to risk stratification to recommending disease management or care management program to patients, to care manager follow-ups, claims, demographic, laboratory, and pharmacy, data are needed to drive all of these processes. Each of these data sets

have different data sources. Claims originate from payer/health plans. Demographics come from medical records. Laboratory tests and results come from a reference lab. Pharmacy data come from payer/health plan or pharmaceutical benefit management companies. Data errors and omission, a third barrier, can undermine the accuracy of the analysis and the intelligence derived from the analysis.

The fourth barrier is getting provider buy-in. According to a case study participant's ACO program rules, a patient automatically becomes a participant in ACO once their provider joins the ACO. As such, it is critical that providers are aware of the ACO, weighs its advantages and disadvantages, and makes a decision to join the ACO. Program administrators carried the burden to inform all network providers and convince a sufficient number of providers to become part of the ACO to make it a viable program. Even with physcian engagement, it is not sufficient. Patients also have to be engaged. Coined "beneficiary inertia" by a case study participant, this is the final organizational barrier identified. For SSP:ACOs, Medicare FFS patients prize their freedom to select providers and are wary of health programs and benefits that limit provider choice (e.g., managed care). Even though the ACO program maintains all the attributes of the Medicare FFS program, earning the trust of the beneficiary and overcoming their hesitation can be challenging. For SSP as well as commercial ACO, without buy-in from the patient, it may be difficult to provide care management services or coordinate care for the beneficiary.

Facilitators identified by a study participant include communication, trust, technology, information exchange, a strong primary care network and network management. Another participant offered scalability as a facilitator, which is the ability to transfer experiences from managing an ACO patient population to a non-ACO patient population. Another participant listed experience with risk, continuity of care, and managed care as a facilitator. Yet another participant indicated that CMS can play an important role in facilitating the education of providers and patients on the ACO program to increase acceptance and buy-in. A final participant listed the frequent reporting, review, and feedback process as a facilitator.

Chapter Summary

Of the external causal attributes described by the ACO Motivation Conceptual Model, only business rationale, competitor activity, and a policy window were found by case study participants to be applicable. None of the participants cited necessity or timing as an external causal attribute. Of the internal causal attributes described by the ACO Motivaton Conceptual Model, only culture, leadership, and quality care were found by case study participants to be valid. The only internal causal attribute that garnered concensus among all six case study participants was providing quality care.

Testing of the ACO Orientation Model found that along the strategic typology dimension, of the six case study participants in the study, four case study participants were classified as *Analyzers* and two were classified as *Prospectors*. None of the case study participants had a *Defender* classification. Along the ACO readiness dimension, five of

the six case study participants had high ACO readiness score and one case study participant recorded a low ACO readiness score. Using assessments from the case study participants, the model successfully predicted that *Analyzers* with high ACO readiness scores and *Prospectors* with low ACO readiness scores would consider becoming ACOs. The model also predicted correctly that *Prospectors* with high ACO readiness scores would become ACOs.

Enviromental barriers identified by case study participants included an ACO's broad scope, intensive resource investment requirements, rules and regulations interpretation and enforcement, and a risk-reward imbalance. Organizational barriers identified by case study participants included physician organization and hospital misalignment of incentives, a lack of infrastructure, a lack of data, difficulties in getting providers to buy-in, and beneficiary inertia.

Facilitators identified by case study participants include communication, trust, technology, information exchange, a strong primary care network and network management, scalability, and experience with risk, continuity of care, and managed care programs.

Table 3 provides a summary view of the results.

Table 3. Case Study Summary Results

	Phys. Org. 1	Phys. Org. 2	Phys. Org. 3	Phys. Org. 4	Phys. Org. 5	Phys. Org. 6
Causal Attributes						
External						
Business	X			X		X
Competition		X				X
Necessity						
Policy Window			X		X	
Timing						
Internal						
Culture	X			X	X	X
Flexibility						
Leadership				X		
Mission					X	X
Quality Care	X	X	X	X	X	X
Other (case study derived)		• Medicare FFS to Medicare Advan-tage conver-sion • Attracting MDs into network • Market uncertainty	• Medicare FFS to Medicare Advantage conversion	• Medicare FFS to Medicare Advantage conversion • Innovation		
Strategic Typology						
Analyzer	X		X		X	X
Defender						
Prospector		X		X		
Other Assessments						
ACO Readiness	High	Low	High	High	High	High
ACO Orientation Predicted	Maybe	Maybe	Yes	Yes	Maybe	Maybe
ACO Orientation Actual	Yes	Yes	Yes	Yes	No	Yes
Barriers	• Physician organization vs. Hospital misalignment • Risk –Reward imbalance	• Resource investments • Rules and regulations interpretation and enforcement	• Lack of infrastruc-ture	• Provider buy-in • Lack of data • Beneficiary inertia	• Resource invest-ments • ACO broad scope	• Physician organiza-tion vs. Hospital misalign-ment
Facilitators	• Communica-tion • Trust • Technology • Information Exchange • Strong primary care network • Network mgt.	• Provider selection	• Scalability • Experience with risk, continuity of care, managed care	• CMS (trust-worthy source) • Education of providers and patients	• Potential legislative solutions to rising costs	• Frequent reporting, review, and feedback

CHAPTER 7: DISCUSSION

This chapter is organized into four parts. The first part discusses causal attributes in the context of the literature. The second part explores strategic typology in the context of prior research. The third part reviews the usefulness of the ACO Orientation Conceptual Model. Finally, the fourth part covers study limitations.

Causal Attribute Results in the Context of the Literature

As mentioned in the introduction, the Brookings-Dartmouth ACO Pilot Program produced case studies that report upon the ACO experiences of Healthcare Partners (Los Angeles, CA), Monarch Healthcare (Orange County, CA), Norton Healthcare (Louisville, KY), and Tucson Medical Center (Tucson, AZ) (Larson, et al., 2012). The following section compares and contrasts the experiences of the dissertation study participants with those in the Brookings-Dartmouth ACO Pilot Program.

Larson et al. found mainly organizatinal factors that contributed to the development of the ACOs for the four pilot sites. Organizational factors that are common to experiences of the six case study participants in this dissertation include leadership, providing quality care (via care coordination and care management) and culture. All of the Brookings-Dartmouth pilot sites indicated leadership as a driving factor, where as in the dissertation study, only one participant did so. This does not mean that leadership is not important for the case study participants. In fact, a review of the ACO readiness survey from the case study participants showed that, across the samples, the section on Governance and Leadership had an average score of 6.9 (out of 9). But the idea of

leadership did not emerge from the semi-structured interviews. One explanation could be a gap of coverage in the interview guide. Another explanation could be a difference in the environmental situation. The Brookings-Dartmouth pilot sites were one of the first organizations to form ACOs. They were early innovators and confidently ventured into the unknown. Strong leadership helps to navigate a course of action in the face of uncertainty and massive change (Duckers, Wagner, Vos, & Groenewegen, 2011). Case study participants referenced in this dissertation had, relatively, more time to assess the ACO landscape and perhaps did not require as strong, a leadership to drive the change.

Among the determinants of quality care and culture there were similarities between the pilot sites and the case study participants. All pilot sites and case study participants indicated providing quality care as a factor for pursuing ACOs. Most entities accomplished this through varying capabilities of integrated care coordination and care management programs. Finally, culture was indicated by three Brookings-Darthmouth pilot sites and four of the case study participants as factors in ACO formation.

Other organizational factors described by the Brookings-Dartmouth Pilot Program included payer/provider relationship, the presence of a community hospital partner, and management services organization (MSO) capabilities. These factors may have surfaced due to specific requirements and capabilities of the pilot sites. The Brookings-Dartmouth Pilot Program did not explore external or environmental factors that may

have driven physician organizations to form ACOs. These factors have been described earlier in the dissertation.

This study reported a number of challenges that were consistent with Larson et al. Two participants from this study and Tucson Medical Center in the Brookings-Dartmouth ACO Pilot Program all mentioned a need to compel hospital partners to think and operate in a new paradigm. Hospital partners may be wary of efforts to reduce inpatient stays because it affects their bottom line. Aligning system-wide goals and objectives will be central to overcoming this challenge. Physician engagement was identified as a challenge by two participants in this study as well as Healthcare Partners, Norton Healthcare, and Monarch Healthcare in the Larson et al.'s report. There is a need to unify support for the ACO across physician types including primary care physicians, specialists, and hospitalists. Without this support, care will not be fully coordinated and gaps in patient care will emerge, putting the ACO's quality and cost goals at risk.

Finally, Norton Healthcare from the Larson et al.'s report indicated that a challenge was having a comprehensive care management strategy. This aligns with sentiments by a participant in this study that the lack of infrastructure was a challenge. Without predictive modeling capabilities to identify and stratify patients, a system-wide electronic medical record, to capture, track, and report information, and knowledgeable clinicians and allied-health professionals to support patients outside the medical visit settings, patient care and the goals of the ACO may not be maximized. Reporting on a national survey of hospitals involved in ACOs, Audet et al. found similar challenges. This

included care management capabilities not being fully developed, the need to build trust with physicians, payers and other partners, and lining up legal and contractual arrangements (Audet, Kenward, Patel, & Joshi, 2012).

Strategic Typology in the Context of the Literature

Miles et al. asserts that the *Defender*, *Analyzer*, and *Prospector*s could be found in any industry operating in any environment: but with different distributions. Properly implemented, these strategies would yield satisfactory results. It has been proposed that the distribution of strategy types vary according to the environment. Specifically, specialist organizations tend to thrive in a stable environment by running on leaner and more efficient operations. Generalists, in contrast, maintain higher levels of excess capacity to accommodate uncertainties in the market (Hannan & Freeman, 1977). *Defenders* may be described as specialists because they offer a niche product or service offering. *Analyzers* and *Prospectors* may be described as generalists since they, often, will have broader product or service lines. Thus, it may be reasoned that as markets and environments become unstable, the number of *Defenders* will decrease and the number of *Analyzers* and *Prospectors* will increase. Hrebiniak and Joyce studied government regulations on the influence of the business environment in the context of strategic choices (Hrebiniak & Joyce, 1985). They predicted that the *Analyzer* typology, a hybrid strategy, would be the most prevalent strategy type in a turbulent environment where government regulations likely restrict organizational decision making. The ACO regulations in the ACA creates a turbulent environment for physician organizations (Goroll & Schoenbaum, 2012), (Fisher, McClellan, & Safran,

2011). In part, this has lead to vertical and horizontal integration as physician groups and other stakeholders jostle for prime position in the market to attract patients and the dollars that follow them.

The distribution of Mile et al.'s typology showed that *Analyzers* were the dominant typology type among the case study participants. This is consistent with Hrebiniak & Joyce's prediction of prevalent strategy type in a turbulent environment. The findings seem to contradict Miles et al.'s assertion that all typology can operate in any environment in that none of the case study participant were classified as *Defenders*. But, this is not the case. The limited sample of physician organizations in the case study likely excluded *Defenders* from assessment. As a point of reference, a 2008 study on nursing homes, a health-related but more "stable" industry, found that about 43 percent of surveyed nursing home administrators self-typed as *Defenders*, followed by *Analyzers* (33 percent), and *Prospectors* (19 percent) (Zinn, Spector, Weimer, & Mukamel, 2008).

ACO Orientation Conceptual Model: A Useful Tool

The ACO Orientation Conceptual Model is a simple framework to understand physician organizations' orientation to ACOs. Using a two–by-three grid with strategic typologies of *Defenders*, *Analyzers*, and *Prospectors* on one dimension and high or low ACO readiness on another dimension, physician organizations' characteristics may be mapped to the framework to identify placement in the appropriate section. Physician organizations classified as *Defenders* will likely not form ACOs, regardless of their state

of ACO readiness. Physician organizations classified as *Analyzers* will likely not form ACOs if their state of ACO readiness is low. However, these physician organizations will consider ACO formation if their ACO readiness is high. Physician organizations classified as *Prospectors* will likely form ACOs if their ACO readiness is high and will consider ACO formation if their ACO readiness score is low.

Results from the case studies were congruent with the framework's prediction. An assessment of the structural organization of the conceptual model indicate that the two ends of the extreme are instructive. On one end, *Defenders* will likely not form ACOs regardless of ACO readiness, as in the case with Analyzers with low ACO readiness. On the other end, *Prospectors* with high ACO readiness will likely form ACOs. The predictions are more definitive. In between these extremes, is a gray area in which the model's predictions are more ambiguous. Analyzers with high ACO readiness and Prospectors with low ACO readiness have a prediction of "maybe" for ACO formation. Depending upon the circumstances and individual physician organization characteristics, they may or may not pursue ACO formation. This range of flexibility built into the model allowed it to accommodate multiple levels of variations in physician organization's ACO orientation within range. But this flexibility is also its weakness. The model is unable to provide clarity in an area that can benefit from further refinement.

Limitations

First, the results represent findings from a selected number of physician organizations within a county area. Physician organization characteristics vary widely from county to county and from state to state. Caution is advised against generalization based upon a selected sample.

Second, ACO adoption and evolution are proceeding at a rapid pace. Concurrently, the market is consolidating both vertically (e.g., MemorialCare Medical Group acquisition of Bristol Park Medical group and horizontally (e.g., Davita acquisition of Healthcare Partners). This study reports physician organizations' strategies over a defined period of time. The physician organizations' characteristics, motivations, and decisions will likely change as ACOs mature and adapt to legislation, regulations, and market forces.

A third limitation concerns data. The data is coming from the key informant's perspectives and may be subject to response bias. It is possible that a respondent may present the physician organization and its capabilities in a more positive light.

Fourth, in the analysis of the ACO Readiness survey, missing data provides another limitation. The missing data can be caused by many things. In this case, the most likely reasons are that the respondents do not understand the question or feel that the question does not apply to their organization. The exact reasons are unknown. However, since the main calculation is the mean of the survey responses, the missing data may skew the results in affected survey sections of a particular respondent.

Finally, the selection of the case study participants may introduce bias. From a combined list of physician organizations from Cattaneo and Stroud and CAPG, nine physician organizations in Orange County were solicited to participate in the study. Six physician organizations agreed to participate giving rise to self-selection concerns. However, the six physician organizations in the study oversee a majority of the healthcare delivery in Orange County. The three physician organizations that did not respond to the solicitation were smaller niche players.

Chapter Summary

ACO organizational causal factors that are common to experiences of the six case study participants in this dissertation and those in other studies include leadership, providing quality care (via care coordination and care management) and culture. The study reported external factors such as business, competition, and policy that may have driven physician organizations to form ACOs. These factors were not confirmed by prior studies. Furthermore, the distribution of Mile et al.'s typology showed that *Analyzers* were the dominant typology type among the case study participants. This is consistent with others' predictions of prevalent strategy type in a turbulent environment. Finally, limitations to the study include county and case study participant selection, a static view of a dynamic process, C-suite limited viewpoints, and data gaps and omissions.

CHAPTER 8: RECOMMENDATIONS

Several research and health policy recommendations were identified based upon the study findings. First, the recommendations for future research will be covered followed by implications for health policy.

Recommendations For Future Research

The findings suggest a few areas for further study. First, perform additional case studies of physician orientation to ACOs in other geographic areas. Case studies from the Brookings-Dartmouth ACO Pilot Program were important contributions to the understanding of early ACOs. Likewise, case studies from this dissertation have added to the ACO literature. However, the generalization of case study results may be limited. The California health care market, in general, and the Orange County, healthcare market, in particular, have been progressive pushing for integration and accepting full-risk business. The composition of other markets and states may differ likely leading to different behavior. Each healthcare market has its unique mix of hospitals and health systems, physician organizations, health plans, Medicare, Medicaid, and employers. The way healthcare stakeholders interact, service, collaborate or compete with each other may influence the market dynamics. Each physician organization has its own operations to deliver care and capacity to change. Physician organization's response to ACO may be driven differently by differing market dynamics and internal capabilities.

Second, empirically study physician organizations responses to ACOs. Lewis et al. have taken a step in this direction studying market and demographic factors associated

with ACO formation (Lewis, Colla, Carluzzo, Kler, & Fisher, 2013). Performing multivariate analysis to assess what characteristics were associated with local ACO presence, Lewis et al. examined demographic characteristics (via a survey) and health care system characteristics (via Medicare fee-for-service claims data) and found that,

> "ACO formation is uneven. ACOs are more likely to have formed in high-cost areas and areas that are high performing on selected claims-based quality measures. ACOs are also more likely to have formed in regions with fewer physician groups, even when holding the overall number of physicians constant. Finally, ACOs are less likely to have formed in high-poverty regions and rural areas" (Lewis, Colla, Carluzzo, Kler, & Fisher, 2013)

This study provides the first empirical evidence on external factors influencing ACO formation. This area can benefit from additional research. For example, a study could examine the response of physician organization to ACO legislation. Two types of strategy classification (i.e., external assessment, self-typed) may be used in order to corroborate each method of assessment. Logistic regression may be used to analyze the categorical independent variables (i.e., size, type of ownership). ACO strategy change would be the dummy coded dependent variable. A study such as this could add to the empirical evidence base.

Finally, measure the performance and outcomes of selected ACO strategies. Epstein et al. analyzed early SSP:ACOs and defined their patient, structural, cost, and quality of care characteristics (Epstein, et al., 2013). For example, they found that ACOs were more concentrated in the South than other areas in the U.S. ACO patients were less likely to be younger than age sixty-five and more likely to be older than age eighty.

Hospitals participating in ACOs were more likely to be large, teaching, and have not-for-profit status. Finally, costs between ACO vs. non-ACO patients were found to be similar. This provides an important baseline to compare future cost trends. The next step is to assess the impact of ACOs. The question, "Do ACOs consistently provide quality care at controlled costs?" deserves an answer.

Implications for Health Policy

The study findings raise important health policy considerations. First, although physician organizations were focused on providing quality patient care, further analysis suggests causal differences exist between physician organizations participating in SSP:ACOs and commercial ACOs. Physician organizations participating in commercial ACOs are managing patients to improve individual and population health. A few physician organizations decided against joining the SSP:ACO program due to its stringent rules and regulations and an imbalance in the risk/reward equation. Physician organizations that participated in SSP:ACOs indicated that they too look to improve patient and population health. However, there is also a desire to attract Medicare FFS beneficiaries into the Medicare Advantage plans down the line. CMS is in a difficult situation. On one hand, CMS believes in the promises integrated healthcare in its pursuit of ACOs. On the other hand, CMS maintains its FFS payment system for Medicare beneficiaries which seems to encourage individual service delivery and discourage coordinated care. During this transition period, CMS is proving to be flexible by applying a new delivery system (i.e., ACO) on an old payment construct (i.e., FFS Medicare).

Since CMS wields tremendous influence in the healthcare market, what CMS does, the healthcare market tends to follow. Physician organizations are responding to CMS' leadership on ACOs, but perhaps, are not as aligned to CMS' intentions. Medicare FFS business does not appear to be appealing to delegated medical groups in Orange County who have extensive experience with full capitation. The Medicare Advantage patient populations are preferred. Commercial ACOs may have more agility and ability to innovate and work with physician organizations in this area. CMS administrators should be cognizant of a perceived competitive disadvantage for SSP:ACOs in more advanced healthcare markets.

Second, reduce the barriers to ACO adoption. Organizational barriers were identified in the study to be physician organization vs. hospital misalignment, a lack of data and infrastructure, provider buy-in, and beneficiary inertia. The physician-hospital misalignment is a particularly difficult barrier to address. A hospital executive speaking on overcoming barriers to community benefit provides a perspective that can be useful in dealing with this situation.

> "We got the backing from finance and operations executives by building the business case for community benefit. We provided them with facility-specific data on ambulatory care-sensitive conditions being treated in emergency rooms and inpatient units, and how much uncompensated care and Medicaid payment shortfalls could be reduced if those patients were treated in a timely manner in primary care settings. That data opened their eyes, and got us all working together for the good of both the community and our organization in ways that had never happened before" (Barsi, Jones, Kotsonis, Lowell, Paret, & McPherson, 2010)

Similarly, efforts may be made to share data with physician organization and hospital executives on the net impact of increased hospitalization on the health system. The short-term, bottom line focus may be acceptable to the hospital administrator but the net benefit to the health system may not be as positive unless there is alignment between physician organization efforts and a hospital partner's efforts in servicing ACO patients. Overall, these barriers fit into technical, structural, psychosocial, managerial, and goals and values categories and may be tempered through education, training, research and development efforts (Ziegenfuss, 1991) as well as changing attitudes of key stakeholders and a reorganization of services in support of the new objectives (Hulscher, Van Drenth, Mokkink, Van der Wouden, & Grol, 1997).

Environmental barriers were identified to be ACO broad scope, intensive investment requirements, a risk-reward imbalance, and variable rules and regulations interpretation and enforcement. For Medicare ACOs, prior to implementation of SSP, CMS tried to address a number of these barriers through its rule making process. CMS received 1,320 public comments on the SSP:ACO proposed rules and in its final rule incorporated significant modifications to reduce the burden and cost for participating ACOs (Federal Register, 2011). For commercial ACOs, efforts to support physician organization partners adoption of ACOs have not been consistent. Support from health plans have ranged from little or none to extensive. On the supportive end, for example, Blue Shield of California committed to investments in ACOs to offset income that exceeds 2% of revenue as part of its pledge to keep healthcare affordable (Blue Shield of California, 2013). Despite these efforts, barriers remain. Administrators from CMS to

health plans should be cognizant of these barriers and continue to work to modify program rules and procedures and/or provide financial and in-kind assistance to physician organizations on an as-needed basis.

Finally, the ACO movement, although in its infancy, is already creating shifts in the health care landscape. These have implications for the inputs and outputs of the healthcare system. Inputs may include staffing, information technology, team-based care processes and systems. For example, is there a sufficient number of care coordinators and/or care managers to manage a massive influx of ACO patients? Is there robust health information technology to collect, process, analyze, and report information? Is the provider ready to collaborate with other professionals to provide team-based care? As for the outputs, providing high quality patient care at a controlled cost is the goal. It remains to be seen whether ACOs can deliver on its promises.

Conclusion

Understanding physician organization ACO adoption and diffusion may benefit from additional qualitative and quantitative studies. The specific recommendations are to conduct case studies in other geographic areas outside of Orange County, CA, empirically study to see if physician organizations changed strategies due to ACOs, and finally, measure the performance and outcomes of selected ACO strategies. There are three implications for health policy makers. First, for physician groups participating in SSP, there is a desire to attract Medicare FFS beneficiaries into the Medicare Advantage plans. This motivation is different from those of physician organizations

serving commercial ACOs. Second, reduce the environmental and organizational barriers to ACO adoption. Finally, healthcare leaders and practitioners should be prepared to address system-wide implications resulting from the massive shifts in the physician organization strategy as a response to ACOs.

Postscript

Much has been learned by looking into the ACO's past and studying the ACO's present. This postscript takes a peek into the future. In the annals of health organization innovation, ACOs will likely be included in a "Top Ten" list because it is, arguably, the first concept that combines quality and cost under one construct. Despite its importance, the future for ACOs is unlikely to be completely rosy. The Medicare ACO programs are at risk and may disappear altogether unless major restructuring takes place. Commercial ACO programs have a brighter outlook.

First, the Medicare ACO programs. With much fanfare, the Pioneer ACO and the Shared Savings ACO programs had a spectacular debut for CMS. As noted in the dissertation, the excitement has already worn off and the future for the program looks bleak, especially when the operational reality sets in. Facing a dire need to control Medicare expenditures, CMS created the Pioneer and SSP ACO programs for the Medicare FFS patient population. The intent is sound but the implementation is fraught with troubles. In a June 2013 report to Congress, MedPAC stated that, "Medicare spending among FFS beneficiaries has increased significantly since 2002 across all sectors" totaling $297.5 billion in 2012 (MedPAC, 2013). Clearly, this is a runaway train that needs to be slowed down. Instead of applying the brakes, CMS places obstacles in front of it. Positioning ACOs as a cost control mechanism for Medicare FFS expenditures is akin to putting the proverbial sacrificial lamb on the track only to have a locomotive's cow catcher throw it back into the field, losing little momentum in the process. The Medicare ACO program is ill-designed for the job. First, there is a litany

of rules and regulations policing a range of activities from beneficiary outreach, to data collection, to quality and financial reporting. These requirements can be burdensome and add costs and frustrations to the management of the program. Second, patients in the ACO have the freedom to see providers outside of the ACO. Yet the ACO remains responsible for the costs incurred by the beneficiary. Finally, Medicare continues to pay individual providers and suppliers for products and services as it currently does under the Fee-For-Service payment systems. The only positive inducement in the program (the carrot) is the promise of shared savings if the ACO meets its quality standards and the expenditures of the assigned beneficiaries is below that of a designated benchmark. It is clear that Medicare wanted to maintain the integrity of the FFS Medicare program while testing the ACO concept. Presumably, this serves to not upset a potentially very vocal group of Medicare FFS beneficiaries. However, this has the effect of putting Medicare ACOs at a disadvantage even before they get out of the starting gate.

Another reason why Medicare ACOs will not fare well given its current configuration can be traced to local market responses. CMS implemented a common Pioneer and SSP ACO program across the United States with little regard for the local market characteristics. In the Orange County, CA market, 67% of the insured are in some form of managed care. Health plans contract with medical groups and IPAs on a capitated basis and delegate risk and responsibilities to these physician organizations. Large organized physician organizations in Orange County have decades of successful experience caring for managed care patients and have become less fond of FFS

medicine. Forced by the rules to manage Medicare FFS patients in order to participate in Medicare ACOs, a number of Orange County physician organizations have simply walked away from the opportunity. A few that agreed to join the program noted that they did so begrudgingly and were hopeful that FFS Medicare beneficiaries now exposed to managed care-like programs and principles as part of the Medicare ACO program will enroll in Medicare Advantage in the future.

A better solution for slowing down Medicare expenditures is offered by the National Commission on Physician Payment Reform who recently stated that, "The fee-for-service mechanism of paying physicians is the major driver of higher health care costs in the United States. It contains incentives for increasing the volume and cost of services (whether appropriate or not), encourages duplication, discourages care coordination, and promotes inefficiency in the delivery of medical services." Their recommendation? "Over time, payers should largely eliminate stand-alone fee-for-service payment to medical practices because of its inherent inefficiencies and problematic financial incentives" (Schroeder & Frist, 2013). Any lawmaker or CMS administrator who proposes this solution would be committing political suicide. The voices of and the votes from the 37 million FFS beneficiaries are just too strong. Unlike other decades during which key stakeholders don't know or pretend not to see the "800 pound gorilla," it is clearly recognized today. Someday, forces will align to bring about its downfall. Until the day come to pass, the current Medicare ACO offering will be just that; a sacrificial offering to the FFS gods.

The outlook for commercial ACOs is much brighter. The shortcomings of the Medicare sponsored ACOs have spurred on the development of commercial ACOs. For example, in Orange County, CA, a few physician organizations that could not substantiate participation in Medicare ACO have turned to developing and contracting with health plan partners for commercial ACO contracts. The appeal for these physician organizations include flexibility, managing a preferred patient population, and having full control of the provider network. First, in contrast to the Medicare ACO program where rules and regulations carry the weight of law and are difficult to change, terms of the ACO contract and ACO program requirements are negotiable between physician organizations and health plans sponsors. For example, a burdensome requirement Medicare ACO imposes on participants is the formation of a separate legal entity to enter into an ACO contract. Commercial ACOs have no such requirement. A physician organization can enter into an ACO contract with a health plan partner in its current legal form. Second, the patient population managed by commercial ACOs are managed care patients; often patients in PPO products. These patients are preferred over FFS patients because there is infrastructure already in place to provide patient care management. Additionally, FFS reimbursement is perceived to conflict with the mission of the physician organizations to provide high quality care, efficient, patient-centered care. Finally, because patients are in a managed care environment, they are used to accessing a preferred provider network. Patients have higher out-of-pocket costs if they choose to see physicians outside of this network. Having an ability to coordinate patient care using network providers allows physician organizations to better

coordinate care, manage the quality of care and control the cost of care as part of an ACO contract.

By and large, mature managed care markets like Orange County, CA were already moving towards better integration across payers and providers organization to enhance patient care, delivery better quality of care, and control costs. ACO merely serves as a catalyst to hasten the evolution of the delivery and payment models. Commercial ACOs appear to be better aligned to physician organization strategies. It is too early to call Medicare ACO an anachronism, but Medicare ACO clearly has one foot in the future and one foot in the past. Aside from focusing on the performance of Medicare ACOs, CMS administrators should closely monitor the operating environment and, more importantly, adjust the program requirements so that of all things, Medicare ACOs won't be characterized as "old-fashioned" and "out of place" when a "Top Ten" list is compiled.

Reflection

The timing and process for undertaking this research necessitate some comments. The research was performed during the nascent period of ACO development. In the future, it may be characterized as the "Wild West" period. Although the ACA was signed, the ink on the regulations were yet to dry. Stakeholders, government, commercial payers, and provider organizations alike were figuring out what to do; and more importantly, how to do it. No one had complete data or information. Entities made the best decision they could with the information they have. Research was carried out in the midst of organizational and environmental change. This could have easily become roadblocks.

But the applied nature of the Dr.PH line of inquiry allowed the research to take a “snap shot” in order to understand the situation and conditions and integrate new information or changes as it occurs and becomes available. This has elevated and enriched the learning experience.

A little advice for others contemplating similar work is to stay focus, take small steps, and never stop until the work is complete. There are many things that can be researched, but staying laser focused on a specific research question in mind will decrease some of elements that only to distract and help shed light on a path to take forward. And do move forward with small steps; step by step. Stay steadfast and true to the process. The iterative process aids in the learning, exploration, and retention—not of the findings or output, but the way to learn, self-discover, and grow. Lastly, do not stop or momentum will cease and the inertia of restarting again may gain strength. The task may seem overwhelming. But, by breaking the enormity down into a manageable components, one can digest even the biggest of specimens. From time to time, the meal may even seen to be—enjoyable.

APPENDIX

A. Shared Savings Program ACOs

Performance Period	Name	Location
1	Accountable Care Coalition of Caldwell County, LLC	North Carolina
1	Accountable Care Coalition of Coastal Georgia, LLC	Georgia
1	Accountable Care Coalition of Coastal Georgia, LLC	South Carolina
1	Accountable Care Coalition of Eastern North Carolina, LLC	North Carolina
1	Accountable Care Coalition of Greater Athens Georgia, LLC	Georgia
1	Accountable Care Coalition of Mount Kisco, LLC	New York
1	Accountable Care Coalition of Mount Kisco, LLC	Connecticut
1	Accountable Care Coalition of Southeast Wisconsin, LLC	Wisconsin
1	Accountable Care Coalition of Texas, Inc.	Texas
1	Accountable Care Coalition of the Mississippi Gulf Coast, LLC	Mississippi
1	Accountable Care Coalition of the North Country, LLC	New York
1	AHS ACO, LLC (Atlantic ACO)	New Jersey
1	AHS ACO, LLC (Atlantic ACO)	Pennsylvania
1	AppleCare Medical ACO, LLC	California
1	Arizona Connected Care, LLC	Arizona
1	Chinese Community Accountable Care Organization	New York
1	Catholic Medical Partners	New York
1	Coastal Carolina Quality Care, Inc.	North Carolina
1	Crystal Run Healthcare ACO, LLC	New York
1	Crystal Run Healthcare ACO, LLC	Pennsylvania
1	Florida Physicians Trust, LLC	Florida
1	Hackensack Physician-Hospital Alliance ACO, LLC	New Jersey
1	Hackensack Physician-Hospital Alliance ACO, LLC	New York
1	Jackson Purchase Medical Associates, PSC	Kentucky
1	Jackson Purchase Medical Associates, PSC	Illinois
1	North Country ACO	New Hampshire
1	North Country ACO	Vermont
1	Optimus Healthcare Partners, LLC	New Jersey
1	Physicians of Cape Cod ACO, Inc.	Massachusetts
1	Premier ACO Physician Network	California
1	Primary Partners, LLC	Florida
1	RGV ACO Health Providers, LLC	Texas

Performance Period	Name	Location
1	West Florida ACO, LLC	Florida
2	Accountable Care Coalition of Green Mountains, LLC	Vermont
2	Accountable Care Coalition of Maryland, LLC.	Maryland
2	Accountable Care Coalition of Northwest Florida, LLC	Florida
2	Accountable Care Coalition of Syracuse, LLC	New York
2	Accountable Care Coalition of The Tri-Counties, LLC	South Carolina
2	Accountable Care Partners, LLC	Florida
2	Accountable Healthcare Alliance, PC	Michigan
2	Advocate Physician Partners Accountable Care, Inc.	Illinois
2	Allcare Options, LLC	Florida
2	AnewCare Collaborative	Tennessee
2	AnewCare Collaborative	Kentucky
2	AnewCare Collaborative	North Carolina
2	AnewCare Collaborative	Virginia
2	ApolloMed Accountable Care Organization Inc.	California
2	Asian American Accountable Care Organization	New York
2	Aurora Accountable Care Organization LLC	Wisconsin
2	AzPCP-ACO, A Medical Corporation, PC	Arizona
2	Barnabas Health ACO-North, LLC	New Jersey
2	Beacon Health Partners, LLP	New York
2	BHS Accountable Care LLC	Texas
2	BJC HealthCare ACO, LLC	Illinois
2	BJC HealthCare ACO, LLC	Missouri
2	Central Utah Clinic, P.C.	Utah
2	Chautauqua Region Associated Medical Partners, LLC	New York
2	Chicago Health System ACO, LLC	Illinois
2	Circle Health Alliance, LLC	Massachussetts
2	Circle Health Alliance, LLC	New Hampshire
2	Concord Elliot ACO LLC	New Hampshire
2	Cornerstone Health Care, PA	North Carolina
2	Cumberland Center for Healthcare Innovation, LLC	Tennessee
2	Deaconess Care Integration, LLC	Indiana
2	Deaconess Care Integration, LLC	Kentucky
2	Deaconess Care Integration, LLC	Illinois
2	Dean Clinic and St. Mary's Hospital Accountable Care Organization, LLC	Wisconsin
2	Essentia Health	Minnesota
2	Essentia Health	North Dakota
2	Essentia Health	Wisconsin

Performance Period	Name	Location
2	Essential Care Partners, LLC	Texas
2	Florida Medical Clinic ACO, LLC	Florida
2	FPG Healthcare, LLC	Florida
2	Franciscan AHN ACO, LLC	Indiana
2	Genesis Accountable Care Organization, LLC	Illinois
2	Genesis Accountable Care Organization, LLC	Iowa
2	Golden Life Healthcare LLC	California
2	Greater Baltimore Health Alliance Physicians, LLC	Maryland
2	Harbor Medical Associates, PC	Massachussetts
2	Healthcare Provider ACO, Inc.	New York
2	HealthNet LLC	Florida
2	Heartland Regional Medical Center	Missouri
2	Independent Physicians ACO	New York
2	Indiana University Health ACO, Inc.	Indiana
2	Integrated Care Alliance, LLC	Florida
2	Iowa Health Accountable Care, L.C.	Iowa
2	John C. Lincoln Accountable Care Organization, LLC	Arizona
2	John Muir Physician Network	California
2	Maine Community Accountable Care Organization, LLC	Maine
2	MaineHealth Accountable Care Organization	Maine
2	Maryland Accountable Care Organization Of Eastern Shore LLC	Maryland
2	Maryland Accountable Care Organization Of Western MD LLC	Maryland
2	Medical Mall Services of Mississippi	Mississippi
2	Medical Mall Services of Mississippi	Alabama
2	Medical Practitioners for Affordable Care, LLC	Florida
2	Memorial Hermann Accountable Care Organization	Texas
2	Mercy ACO	Iowa
2	Mercy Health Select, LLC	Ohio
2	Meridian Holdings, Inc.	Hawaii
2	Meridian Holdings, Inc.	California
2	Meridian Holdings, Inc.	Texas
2	Meridian Holdings, Inc.	Florida
2	Meridian Holdings, Inc.	South Carolina
2	Meridian Holdings, Inc.	North Carolina
2	Meridian Holdings, Inc.	Maryland
2	Methodist Patient Centered ACO	Texas
2	MissionPoint Health Partners	Tennessee

Performance Period	Name	Location
2	Mount Sinai Care, LLC	New York
2	MPS ACO Physicians, LLC	Connecticut
2	Nevada Primary Care Network ACO, LLC	Nevada
2	North Bend Medical Center, Inc.	Oregon
2	North Coast Medical ACO, Inc.	California
2	Oakwood Accountable Care Organization, LLC	Michigan
2	Palm Beach Accountable Care Organization, LLC	Florida
2	Physicians ACO, LLC	Texas
2	Polyclinic Management Services Company	Washington
2	PriMed, LLC	Connecticut
2	ProHEALTH Accountable Care Medical Group, PLLC	New York
2	ProHealth Solutions, LLC	Wisconsin
2	ProMedica Physician Group, Inc.	Michigan
2	ProMedica Physician Group, Inc.	Ohio
2	Quality Independent Physicians	Kentucky
2	Quality Independent Physicians	Indiana
2	Southeast Michigan Accountable Care, Inc.	Michigan
2	Southern Kentucky Health Care Alliance	Kentucky
2	St. Thomas Medical Group PLLC	Tennessee
2	Summa Accountable Care Organization	Ohio
2	Summit Health Solutions	Tennessee
2	Texoma ACO, LLC	Texas
2	Texoma ACO, LLC	Oklahoma
2	Torrance Memorial Integrated Physicians, LLC	California
2	TP-ACO L.L.C.	Louisiana
2	TP-ACO L.L.C.	Tennessee
2	TP-ACO L.L.C.	Florida
2	Triad Healthcare Network, LLC	North Carolina
2	University Hospitals Coordinated Care	Ohio
2	University of Iowa Affiliated Health Providers, LC	Iowa
2	WellStar Health Network, LLC	Georgia
2	WESTMED Medical Group, P.C.	New York
2	WESTMED Medical Group, P.C.	Connecticut
3	A.M. Beajow, MD Internal Medicine Associates ACO, P.C.	Nevada
3	AAMC Collaborative Care Network	Maryland
3	Accountable Care Clinical Services, PC	California
3	Accountable Care Clinical Services, PC	Connecticut
3	Accountable Care Clinical Services, PC	Iowa
3	Accountable Care Clinical Services, PC	Massachusetts

Performance Period	Name	Location
3	Accountable Care Clinical Services, PC	Pennsylvania
3	Accountable Care Coalition of Central Georgia, LLC	Georgia
3	Accountable Care Coalition of DeKalb, LLC	Georgia
3	Accountable Care Coalition of Georgia, LLC	Georgia
3	Accountable Care Coalition of Greater Athens Georgia II, LLC	Georgia
3	Accountable Care Coalition of Greater Augusta & Statesboro, LLC	Georgia
3	Accountable Care Coalition of Greater Augusta & Statesboro, LLC	South Carolina
3	Accountable Care Coalition of New Mexico, LLC	New Mexico
3	Accountable Care Coalition of North Central Florida, LLC	Florida
3	Accountable Care Coalition of North Texas, LLC	Texas
3	Accountable Care Coalition of Southern Georgia, LLC	Georgia
3	Accountable Care Coalition of Western Georgia, LLC	Georgia
3	Accountable Care Coalition of Western Georgia, LLC	Alabama
3	Accountable Care Organization of New England	Connecticut
3	Accountable Care Organization of New England	Massachusetts
3	ACO of Puerto Rico, Inc.	Puerto Rico
3	Advocare Walgreens Well Network	New Jersey
3	Affiliated Physicians IPA	California
3	Akira Health, Inc.	California
3	Alegent Health Partners, LLC	Iowa
3	Alegent Health Partners, LLC	Nebraska
3	Alexian Brothers Accountable Care Organization, LLC	Illinois
3	Amarillo Legacy Medical ACO	Texas
3	American Health Alliance, LLC	Florida
3	American Health Network of Ohio PC	Ohio
3	APCN-ACO	California
3	Arizona Care Network, LLC	Arizona
3	Atlanticare Health Solutions	New Jersey
3	AVETA Accountable Care, Inc.	Puerto Rico
3	BAROMA Health Partners	Florida
3	Billings Clinic	Montana
3	Billings Clinic	Wyoming
3	Bon Secours Good Helpcare, LLC	Kentucky
3	Bon Secours Good Helpcare, LLC	New York
3	Bon Secours Good Helpcare, LLC	Ohio
3	Bon Secours Good Helpcare, LLC	South Carolina
3	Bon Secours Good Helpcare, LLC	Virginia

Performance Period	Name	Location
3	Cambridge Health Alliance	Massachusetts
3	Cape Cod Health Network ACO, LLC	Massachusetts
3	Cedars-Sinai Accountable Care	California
3	Central Florida Physicians Trust	Florida
3	Central Jersey ACO, LLC	New Jersey
3	Christie Clinic Physician Services	Illinois
3	Collaborative Care of Florida, LLC	Florida
3	Collaborative Health ACO	Massachusetts
3	Colorado Accountable Care, LLC	Colorado
3	Community Health Network	Minnesota
3	Diagnostic Clinic Walgreens Well Network	Florida
3	Doctors Connected	Virginia
3	Essential Care Partners II, LLC	Texas
3	Fort Smith Physicians Alliance ACO	Arkansas
3	Fort Smith Physicians Alliance ACO	Oklahoma
3	Franciscan Northwest Physicians Health Network, LLC	Washington
3	Franciscan Union ACO	Illinois
3	Franciscan Union ACO	Indiana
3	GPIPA ACO	Arizona
3	GPIPA ACO	New Mexico
3	Hartford HealthCare Affordable Care Organization, Inc.	Connecticut
3	HHC ACO, Inc.	New York
3	HNMC Hospital/Physician ACO	New Jersey
3	Independent Physicians' ACO of Chicago	Illinois
3	Indiana Care Organization, LLC	Indiana
3	Indiana Lakes ACO	Indiana
3	Integral Healthcare, LLC	Florida
3	Integrated ACO, LLC	Texas
3	KCMPA	Kansas
3	KCMPA	Missouri
3	KentuckyOne Health Partners, LLC	Indiana
3	KentuckyOne Health Partners, LLC	Kentucky
3	Keystone ACO	New York
3	Keystone ACO	Pennsylvania
3	Lahey Clinical Performance Accountable Care Organization, LLC	Massachusetts
3	Lahey Clinical Performance Accountable Care Organization, LLC	New Hampshire
3	Lower Shore ACO, LLC	Delaware

Performance Period	Name	Location
3	Lower Shore ACO, LLC	Maryland
3	Lower Shore ACO, LLC	Virginia
3	Marshfield Clinic	Wisconsin
3	Maryland Collaborative Care, LLC	District of Columbia
3	Maryland Collaborative Care, LLC	Maryland
3	MCM Accountable Care Organization, LLC	Florida
3	Medicare Value Partners	Illinois
3	Medicare Value Partners	Missouri
3	Mercy ACO, LLC	Arkansas
3	Meridian Accountable Care Organization, LLC	New Jersey
3	Meritage ACO, LLC	California
3	Morehouse Choice ACO-ES	Georgia
3	National ACO	California
3	Nature Coast ACO, LLC	Florida
3	NOMS ACO, LLC	Ohio
3	Northeast Florida Accountable Care	Florida
3	Northern Maryland Collaborative Care, LLC	Maryland
3	Northwest Ohio ACO	Michigan
3	Northwest Ohio ACO	Ohio
3	Ochsner Accountable Care Network	Louisiana
3	Ochsner Accountable Care Network	Mississippi
3	OneCare Vermont Accountable Care Organization, LLC	New Hampshire
3	OneCare Vermont Accountable Care Organization, LLC	Vermont
3	Owensboro ACO, LLC	Indiana
3	Owensboro ACO, LLC	Kentucky
3	Paradigm ACO, LLC	Florida
3	Partners in Care	Michigan
3	Physician Organization of Michigan ACO	Michigan
3	Physicians Collaborative Trust ACO, LLC	Florida
3	Physicians HealthCare Collaborative	North Carolina
3	Pioneer Valley Accountable Care, LLC	Connecticut
3	Pioneer Valley Accountable Care, LLC	Massachusetts
3	Primary Care Alliance, LLC	Florida
3	Primary Partners	Florida
3	ProCare Med, LLC	Florida
3	ProHealth Physicians ACO, LLC	Connecticut
3	Qualuable Medical Professionals	Tennessee
3	Qualuable Medical Professionals	Virginia
3	Rio Grande Valley Health Alliance	Texas

Performance Period	Name	Location
3	Saint Francis HealthCare Partners ACO, Inc.	Connecticut
3	San Diego Independent ACO	California
3	Scott & White Healthcare Walgreens Well Network, LLC	Texas
3	SERPA-ACO	Nebraska
3	South Florida ACO, LLC	Florida
3	Southcoast Accountable Care Organization, LLC	Massachusetts
3	Southcoast Accountable Care Organization, LLC	Rhode Island
3	Southern Maryland Collaborative Care, LLC	District of Columbia
3	Southern Maryland Collaborative Care, LLC	Maryland
3	St. Luke's Clinic Coordinated Care, Ltd.	Idaho
3	St. Luke's Clinic Coordinated Care, Ltd.	Oregon
3	Summit Health-Virtua, Inc.	New Jersey
3	The Premier Health Care Network, LLC	Georgia
3	The Premier Health Care Network, LLC	New Hampshire
3	UCLA Faculty Practice Group	California
3	UW Health ACO, Inc.	Wisconsin
3	Virginia Collaborative Care, LLC	Virginia
3	Wellmont Integrated Network	Tennessee
3	Wellmont Integrated Network	Virginia
3	Winchester Community ACO	Massachusetts
3	Winchester Community ACO	New Hampshire
3	Yavapai Accountable Care	Arizona
3	Yuma Connected Community	Arizona

Note: Performance period 1 began April 1, 2012. Performance Period 2 began July 1, 2012. Performance Period 3 began January 10, 2013.

Source: CMS. http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html. Access October 14, 2013.

B. Pioneer ACOs

No.	September 2012	October 2013
1	Allina Health	Allina Health
2	Atrius Health	Atrius Health
3	Banner Health Network	Banner Health Network
4	Beacon Health	Beacon Health
5	Bellin-Thedacare Healthcare Partners	Bellin-Thedacare Healthcare Partners
6	Beth Israel Deaconess Physician Organization	Beth Israel Deaconess Physician Organization
7	Brown & Toland Physicians	Brown & Toland Physicians
8	Dartmouth-Hitchcock ACO	Dartmouth-Hitchcock ACO
9	Fairview Health Systems	Fairview Health Systems
10	Franciscan Alliance	Franciscan Alliance
11	Genesys PHO	Genesys PHO
12	Healthcare Partners Medical Group	Heritage California ACO
13	Healthcare Partners of Nevada	Michigan Pioneer ACO
14	Heritage California ACO	Monarch Healthcare
15	JSA Medical Group, a division of HealthCare Partners	Montefiore ACO
16	Michigan Pioneer ACO	Mount Auburn Cambridge Independent Practice Association (MACIPA)
17	Monarch Healthcare	OSF Healthcare System
18	Montefiore ACO	Park Nicollet Health Services
19	Mount Auburn Cambridge Independent Practice Association (MACIPA)	Partners Healthcare
20	OSF Healthcare System	Renaissance Health Network
21	Park Nicollet Health Services	Sharp Healthcare System
22	Partners Healthcare	Steward Health Care System
23	Physician Health Partners	Trinity Pioneer ACO, LC
24	Plus	
25	Presbyterian Healthcare Services	
26	Primecare Medical Network	
27	Renaissance Health Network	
28	Seton Health Alliance	
29	Sharp Healthcare System	
30	Steward Health Care System	
31	Trinity Pioneer ACO, LC	
32	University of Michigan	
Source:	CMS: http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf. Accessed 10/14/2013.	CMS: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/#collapse-pioneerlist. Accessed 10/14.2013.

C. Advanced Payment ACOs

Performance Period	Name	Location
1	Coastal Carolina Quality Care, Inc	New Bern, NC
1	Jackson Purchase Medical Associates, PSC	Paducah, KY
1	North Country ACO	Littleton, NH
1	Primary Partners, LLC	Clermont, FL
1	RGV ACO Health Providers, LLC	Donna, TX
2	Accountable Care Partners ACO, LLC	Jacksonville, FL
2	Coastal Medical, Inc.	Providence, RI
2	Cumberland Center for Healthcare Innovation, LLC	Nashville, TN
2	Golden Life Healthcare LLC	Sacramento, CA
2	Harbor Medical Associates PC	South Weymouth, MA
2	Maryland Accountable Care Organization of Eastern Shore, LLC	National Harbor, MD
2	Maryland Accountable Care Organization of Western Maryland	National Harbor, MD
2	Medical Mall Services of Mississippi	Jackson, MS
2	MPS ACO Physicians, LLC	Middletown, CT
2	Physicians ACO, LLC	Houston, TX
2	PriMed, LLC	Shelton, CT
2	Quality Independent Physicians, LLC	Louisville, KY
2	Reliance Healthcare Management Solutions	Tampa, FL
2	St. Thomas Medical Group, PLLC	Nashville, TN
2	Texoma ACO, LLC	Wichita Falls, TX
3	American Health Alliance	Ocala, FL
3	American Health Network of Ohio PC	Indianapolis, IN
3	Central Florida Physicians Trust	Winter Park, FL
3	Fort Smith Physicians Alliance ACO	Fort Smith, AR
3	KCMPA	Kansas City, MO
3	Lower Shore ACO LLC	National Harbor, MD
3	National ACO	Beverly Hills, CA
3	Nature Coast ACO, LLC	Beverly Hills, FL
3	Northeast Florida Accountable Care	Jacksonville, FL
3	NOMS ACO, LLC	Sandusky, OH
3	Owensboro ACO	Owensboro, KY
3	Physicians Collaborative Trust	Maitland, FL
3	Primary Partners	Clermont, FL
3	Rio Grande Valley Health Alliance	McAllen, TX
3	SERPA-ACO	Crete, NE

Note: Performance period 1 began April 1, 2012. Performance Period 2 began July 1, 2012. Performance Period 3 began January 10, 2013.
Source: CMS: Accessed 10/14/2013.

D. Interview Guide

General	
Name of Physician Organization	
Address of Physician Organization (street, city, zipcode)	
Which of the following best describe your physician organization?*	1. Medical group 2. Medical group that owns or manages an independent practice association (IPA) 3. IPA 4. IPA that owns or manages a medical group 5. Academic general internal medicine clinic 6. Academic family practice clinic 7. Academic general pediatrics clinic 8. Community clinic 9. Other (Specify _____)
At the present point in time, approximately what is the total number of primary care physicians (ie. internal medicine, family medicine, general practice, and general pediatrics (Source: GAO)) practicing in your medical group across all its locations? (Please count both full and part-time)*	
At the present point in time, approximately what is the total number of specialists (ie. specialties OTHER THAN internal medicine, family medicine, general practice, and general pediatrics) practicing in your medical group across all its locations? (Please count both full and part-time)*	
Which ONE of the following three statements <u>best describes</u> your group?*	1. It is <u>mainly</u> primary care physicians. [please consider primary care physicians to include family practitioners, general internists, general practitioners, and general pediatricians] 2. It is a multispecialty group that includes both specialists and primary care physicians. 3. It is <u>mainly</u> non-primary care specialists. [If response is 3, please list the main specialty for your group]
Is your group's patient population mainly adult, mainly pediatric, or both?*	1. Mainly adult 2. Mainly pediatric 3. Both
At the present time, the medical group's **commercial** enrollment is:	
At the present time, the medical group's **Medicare** enrollment is:	
At the present time, the medical group's dual **Medicare/Medicaid** enrollment is:	
At the present time, the medical group's **Medicaid/Healthy Families** enrollment is:	
The medical group uses an **electronic medical record** (EMR; digital medical and treatment information of patients in the group (Source: Office of the National Coordinator for Health Information Technology (ONC))	Yes/No

General	
The medical group uses an **electronic health record** (EHR; digital information from all the clinicians involved in the patient's care – inside and outside the medical group (Source: ONC))	Yes/No
Is the physician organization an ACO or part of an ACO?	Yes / No
If no (to above question), the physician organization is preparing to become an ACO in:	1. 0-6 months 2. 7-12 months 3. 1-2 years 4. 3-5 years 5. >5 years
*D.R. Rittenhouse, L.P. Casalino, R.R. Gillies, S.M. Shortell, and B Lau, "Measuring the Medical Home Infrastructure in Large Medical Groups," *Health Affairs*, 27 (5), Sept/Oct 2008, pp. 1246-1258.	

Characteristics	
Type	
History	
Legal Structure	
Staffing/Service Area	
Patient served annually/type of plans	
Physicians (employed or contracted)	
Physicians (affiliated)	
Hospital (owned ore affiliated)	
Electronic Health Record System	
Governance	
Accountable Care Exploration - Existing infrastructure - Culture - HIT - Care coordination systems - Finance - Strategy	
If ACO…	
ACO Application - Preparing to submit application - Application submission process - Go live	
ACO Implementation - Structure/Governance/Leadership - Payment model/Contract terms - Patient attribution - Patient/physician engagement - Performance measurement/reporting	
Lessons Learned - Barriers - Facilitators	
If Not ACO…	
Strategy and tactics to remain independent of ACOs - Contracting strategy, with whom? - Physician engagement - Consolidation and integration activities - Assuming risk/economic viability	

E. ACO Readiness Survey

Medical Group ACO Readiness Assessment Tool

Modified by Thanh-Nghia Nguyen from Safety Net Accountable Care Organization Readiness Assessment Tool (Shortell SM, 2012) with permission

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 circle 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.

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.

Only skip a question if you have absolutely no idea how to assess the issue. Otherwise, please provide your best estimate.

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 patients in your community?

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

A4. 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

A5. 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

A6. 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

A7. 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 are you ready to address issues that might prevent you from forming a multi-provider ACO governance structure?

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

B3. 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 ***nonparticipating*** 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 HER 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

Care Coordination/Care Transitions

E1. 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

E2. 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

E3. 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

E4. 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

E5. 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 provide some help to patients to understand their health insurance coverage but need to do more.		
1	2	3	4	5	6	7	8	9

Continuous Improvement

E6. 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

E7. 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

E8. 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

E9. 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

E10. 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

E11. To what extent is the organization training its providers in continuous quality improvement methods such as the Plan, Do, Study, Act (PDSA) 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

E12. 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 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

H2. 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

H3. 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

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

END OF SURVEY.

THANK YOU.

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