

A Physician-led Accountable Care Organization: From Award to Implementation

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LAUREN M. STECKLER, MHA; SUE S. FELDMAN, PHD, MED, RN;
AND CAROLYN A. WATTS, PHD

ABSTRACT

OBJECTIVES: Physician-led accountable care organizations (ACOs) are experiencing greater growth than health-system ACOs, yet little has been published on their implementation. We identified ACO readiness gaps in order to determine the readiness of a group of independent physician practices to implement an ACO. We then established management and governance structures in a complex organization to address those gaps.

STUDY DESIGN: Data were collected from a questionnaire and interviews with physician leaders and practice administrators.

METHODS: The Hastings Gap Analysis Model was used as a conceptual framework to construct an ACO readiness questionnaire and develop an interview protocol. Data collection consisted of a qualitative ACO readiness paper-based questionnaire and ten 60-minute interviews with physician leaders and practice administrators. Using standardized data extraction methods, data were extracted from the questionnaires and interview notes for analysis.

RESULTS: The most common gaps in ACO readiness were a lack of human and fiscal resources, few care management tools, and underutilization of health information technology. Challenges involved communication and knowledge of quality performance measures.

CONCLUSIONS: Early and thorough assessment of ACO readiness appears critical to expose gaps and understand resource allocation during ACO implementation.

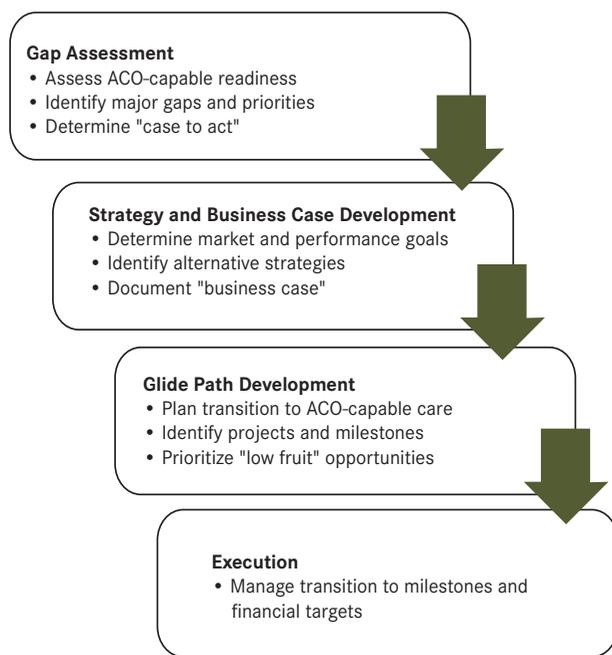
Since the passage of the Health Maintenance Organization (HMO) Act of 1973, there have been several attempts to restructure healthcare providers into organizations that deliver more value to consumers. Most recently, the Affordable Care Act (ACA), enacted March 23, 2010, provides incentives for the creation of accountable care organizations (ACOs) with a similar purpose. While there have been many types of ACOs, to date there have been few generalizable conclusions about the factors leading to their success.

In this paper, we describe federal policy initiatives encouraging the formation of organizations that can deliver higher value to consumers and the factors that affect the success of physician-led ACOs. We then present the Hastings Gap Analysis Model to examine the development of a physician-led ACO, and apply it to the formation and implementation of MD Valuecare (MDVC).

HMOs, encouraged by the HMO Act of 1973, were an early effort to address escalating healthcare costs and to increase value in care.¹ They were an early type of managed care organization, which have historically been valued for their “bottom line” organizational efficiencies. Recently, CMS and other payers embraced the Institute of Healthcare Improvement’s Triple Aim by extending value to include more holistic values: better care, for fewer dollars, with increased patient satisfaction.²

One early attempt to embrace the Triple Aim was the patient-centered medical home (PCMH) model. The National Committee for Quality Assurance developed quality measures for PCMH recognition: emphasis on primary care, comprehensive and coordinated care, chronic disease management, and use of electronic medical record (EMR) systems.³

Figure 1. Hastings Gap Analysis Model



ACO indicates accountable care organization.

The ACA advocated newer value-based payment models, including ACOs^{4,5}—defined by CMS as groups of doctors, hospitals, and other healthcare providers who voluntarily collaborate to deliver coordinated, high-quality care to Medicare patients.⁶ ACOs are designed to use outcomes and utilization data to drive quality through evidence-based medicine, preventive care, and transparent quality performance reporting. Compared with earlier attempts to defragment care and contain costs, key ingredients enabling ACO sustainability include actionable outcomes and utilization data, clearer evidence-based guidelines and quality metrics, increased knowledge about preventive medicine's role in reducing healthcare costs, and shared goals between collaborating organizations (including greater physician control in decision making).^{7,8}

Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP), initiated October 20, 2011, rewards ACOs for demonstrating lowered healthcare costs, meeting or exceeding care quality performance measures, and succeeding in enhancing the patient experience.⁹ ACOs producing results congruent with the Triple Aim—evidenced in quality performance reporting, claims data analysis, and patient surveys—share the savings with CMS.

Physician-led MSSP ACOs

Since 2012, physician-led ACOs have grown 138%—nearly 1.4

times more than hospital-sponsored ACOs.¹⁰ Approximately 51% of ACOs are physician-led, while 33% are hospital-sponsored.¹¹ Shortly after introduction of the ACO model, physician-led ACOs were commonly viewed as disadvantaged because of their typically small size, lack of capital, and inattention to systematic quality improvement. However, research by Farzad Mostashari, MD, former National Coordinator for Health IT, showed that 29% of physician-led ACOs earned savings in their first MSSP year compared with fewer than 20% of hospital-sponsored ACOs.¹²

Dr Mostashari explains why physician-led ACOs are well-suited for meeting MSSP requirements: “Hospital-sponsored ACOs must contend with ‘demand destruction’ on their fee-for-service lines of business if they reduce procedures, admissions, and emergency department visits. However, physician-led ACOs are not similarly encumbered, and this model provides them with a ‘safe’ transitional path toward taking risk.”¹³

Critical Success Factors of Physician-led ACOs

Little is known about the scope of ACO implementation,^{4,14} but the limited literature does identify 4 critical success factors: 1) using health information technology, 2) using practice leaders to drive change management, 3) including frontline workers, and 4) learning from peer organizations.^{15,16}

Health Information Technology

Physician groups that have invested in EMRs may be better equipped to handle MSSP quality reporting requirements. Generally, the use of health information technologies (ITs), such as transition of care alerts and health information exchanges (HIEs), has been considered a major contributor to successful progress toward the Triple Aim, and critical in achieving systemwide collaboration.^{17,18}

Use of Practice Leaders to Drive Change Management

Change management literature demonstrates that organizational change occurs best when internal champions are identified. Physician practices that participate in ACOs must undergo extensive transformations, often entailing significant changes to daily practice work flows and technologies. For physician-led ACOs with many separate practices, it is critical that a physician champion at each practice leads the charge in communicating shared goals and responsibilities, implementing necessary changes, and mollifying those who object to needed changes within and among practices. Additionally, physicians can influence the use of resources (eg, radiology, prescriptions)—a critical component in cost containment or avoidance.^{19,20} Cornerstone Health Care, a North Carolina MSSP ACO, credits support from the chief medical officer and physician buy-in as critical in vetting systemwide redesign at participating practices.¹⁶

Inclusion of Frontline Workers

Physicians cannot successfully accomplish ACO implementation alone. Their success depends on physicians' ability to integrate front-

Factors That Contribute to a Patient's Adherence During Care Transitions
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line workers into the practice work flow. Frontline workers perform many routine and essential tasks needed for MSSP ACO success (eg, medication reconciliation) that do not require physician oversight.

Learning From Peer Organizations

While organizations may work through various programs to achieve the Triple Aim, they must learn from the mistakes and successes of others, including peer organizations. Physician-led ACOs can learn from other physician-led ACOs, as well as from organizations such as group purchasing organizations (GPOs). GPOs are traditionally regarded for supply chain efficiencies, but their experience has generated extensive resources, knowledge, and expertise in successful value-based healthcare transformations.

Hastings Gap Analysis Model

An organization preparing for ACO transformation typically undergoes several rounds of careful deliberation. Douglas A. Hastings provides a conceptual framework for weighing the pros and cons of ACO implementation. The Hastings Gap Analysis Model (see **Figure 1**) comprises 4 phases:

1. **Gap Assessment:** quickly assessing ACO-capable readiness, addressing key questions, pinpointing major gaps and priorities, and determining the “case to act”;
2. **Strategy and Business Case Development:** determining market and performance goals, identifying alternative strategies, developing the preferred strategy, and documenting the “business case”;
3. **Glide Path Development:** considering how to manage the transition to ACO-capable care, detailing individual projects and milestones, and prioritizing “low hanging fruit” opportunities; and
4. **Execution:** managing the transition to milestones and financial targets.²¹

Hastings notes that Glide Path Development typically requires 2 to 3 months, whereas Execution can be 2 to 3 years.²¹

Background

Physician-led ACOs are rarely implemented in a vacuum. This is primarily because they do not have the administrative, technology, analytic, or reporting infrastructure. As such, they seek to employ or consult with experts who advise on and execute the elements necessary for implementation of an ACO.

MD Valuecare, LLC (MDVC)

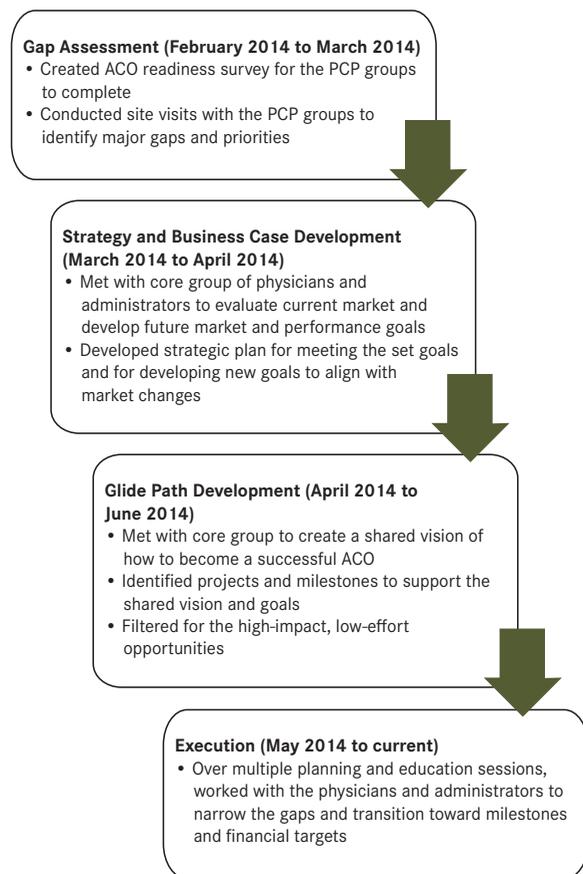
MDVC was formed in April 2012 by a group of independent physician practices in Richmond, Virginia. The original 12 practices of MDVC shared a vision to provide better care for fewer dollars with increased patient satisfaction, while maintaining autonomy and sharing responsibility. MDVC now has 20 practices (5 primary care

physician [PCP] practices and 15 specialty practices) with over 450 physicians. The MDVC ACO sees more than 13,000 assigned Medicare lives (60% female; aged 20 to 104 years).

nHEALTH

Founded in 1996 in Richmond, Virginia, inHEALTH, LLC provides ACO services for MDVC, including governance, administrative support, HIE, data analytics, quality performance reporting, and care management. inHEALTH is a joint physician-hospital venture dedicated to improving efficiency and effectiveness of healthcare delivery through advanced health IT and enhanced care management support, and it has performed well in Triple Aim initiatives targeting Medicare, Medicaid, and commercial populations. MedVirginia, its HIE subsidiary, provides inHEALTH clients with information and analytics services supporting population health and accountable care.

Figure 2. Hastings Gap Analysis Model Applied to Methods



ACO indicates accountable care organization; PCP, primary care physician.

Table 1. Key Roles

ROLE	TITLE
ACO executive ^a	Chief executive officer
Care management project lead ^a	Senior vice president of clinical services
Medical direction and oversight ^a	Chief medical officer
Finance and accounting ^a	Chief financial officer
Research, evaluation, and analytics ^a	Health informaticist
Governance ^a	ACO program coordinator
Physician leader	One physician from each PCP practice

ACO indicates accountable care organization; PCP, primary care physician.

^aAn inHEALTH resource.

METHODS

To find and understand the gaps in ACO readiness, the 5 PCP groups completed a questionnaire. Interviews with physician leaders and administrators from each practice provided deeper information on how and why certain work flows succeed.²² Lessons learned from the interviews helped inform the strategic and business case, leading to the creation of future market and performance goals. Planning transitions and identifying opportunities entailed understanding how each physician and practice would change the ways it conducts business and provides patient care. The Hastings Gap Analysis Model provided a conceptual framework for identifying and addressing gaps in ACO readiness. **Figure 2** summarizes how this model applies to the methods used and illustrates the associated timeline.

Hastings Gap Analysis Model Phases

Gap Assessment

The questionnaire covered 6 broad domains: 1) human and fiscal resources, 2) office work flows and communication, 3) care management, 4) technology and data use, 5) quality, and 6) prevention screening outreach. Questionnaire results helped focus interviews and subsequent assistance in areas of greatest need or least readiness.

Strategy and Business Case Development

Frequent meetings of a core group of PCPs, specialist physicians, and practice administrators led to shared understandings of the current market and to developing MDVC performance goals. The group developed a plan for meeting the set goals and developing new goals aligned with market changes.

Glide Path Development

This phase involved the core group described above. Through several sessions, the group created a shared vision of what was required to become a successful ACO, identified projects and milestones supporting their vision and goals, and identified high-impact, low-effort opportunities.

Execution

Although a core group was responsible for Gap Assessment, Strategy and Business Case Development, and Glide Path Development, a larger group was needed to narrow the gaps and manage milestones and financial targets (**Table 1** lists the final group and associated roles.) The Execution phase included multiple planning and education sessions at different levels.

RESULTS

Gap Assessment

This phase, from February through March 2014, revealed several resources or processes that were lacking at the practices: automated appointment reminders; referral follow-ups; dedicated care manager for patients with chronic conditions; admission, discharge, and transfer (ADT) clinical alerts; knowledge of ACO MSSP quality measures; and human and fiscal resources.

Table 2 summarizes results of the ACO-readiness questionnaire for the 5 PCP groups. Questions from the office work flow and communications domain concentrated on office work flow for same-day appointments and communications about appointment reminders, as well as work flow and communications about referral follow-ups. Three of the 5 practices reported effective work flow for same-day appointments; lack of such a process may increase patients' emergency department use. Three practices used some type of automated appointment reminder, 1 used a manual process, and 1 used various processes between offices. Appointment reminders help ensure that wellness checks occur and chronic conditions are monitored to avoid unnecessary hospitalizations and escalating healthcare costs.

Few practices have a systematic and consistent process for referral follow-ups. Two practices reported generating a "summary of care" from the EMR for a referral, and 1 practice has a referral specialist but did not report a formalized process. A formalized referral process can be important for increasing care coordination and keeping referrals within the ACO network where physicians share a vision.

Care management provides another opportunity to offer lower-cost care and reduce hospitalizations and readmissions. Only 1 practice reported using nurse practitioners for care management; formalized care management was a gap for all practices.

Health technology and data usage is considered a major enabler of the Triple Aim, so it was important to understand which functions practices used and what opportunities existed. A nearly real-time notification of ADT increases the likelihood that physicians know about transitions in care. Currently, only one practice receives ADTs from a local hospital. All practices have an EMR, but the 5 practices use 3 different EMRs and only 1 practice has an EMR administrator. An EMR offers advantages for MSSP ACOs (scoring metrics), as reporting becomes difficult if each physician documents in different places or uses nondiscrete methods. All 5 practices have some connection to a lab information system, so patients' lab results are automatically populated into their charts.

Table 2. ACO-Readiness Questionnaire Summary

	HUMAN AND FISCAL RESOURCES	OFFICE WORK FLOW AND COMMUNICATION	CARE MANAGEMENT	TECHNOLOGY AND DATA USE	QUALITY	PREVENTION SCREENING OUTREACH
Practice C	<ul style="list-style-type: none"> 6 offices 28 MDs 1 nurse and 1 MA per MD Physician leader 	<ul style="list-style-type: none"> Trying to standardize offices All offices do things differently Difficult to get same-day appointments Trying to standardize offices Difficulty with referrals 	<ul style="list-style-type: none"> Starting a formal program in 1 office only; not standardized across multiple offices 	<ul style="list-style-type: none"> eCW (2013) EMR administrator LIS No ADT alerts 	<ul style="list-style-type: none"> HEDIS MU 	<ul style="list-style-type: none"> Smoking Flu vaccine Pneumonia vaccine
Practice L	<ul style="list-style-type: none"> 1 office 6 MDs (2 are concierge) 1-2 nurses per MD 1 MA per MD Physician leader 	<ul style="list-style-type: none"> Plenty of open slots for same-day appointments Automated appointment reminders Provides CCD for referrals 	<ul style="list-style-type: none"> Nothing formal 	<ul style="list-style-type: none"> Allscripts (2013) LIS CCD for referrals Automated appointment reminders No ADT alerts, but do not need them 	<ul style="list-style-type: none"> HEDIS MU 	<ul style="list-style-type: none"> Nothing formal
Practice P	<ul style="list-style-type: none"> 1 office 5 MDs 1 nurse per MD 1 MA (shared) Physician leader 	<ul style="list-style-type: none"> Manual appointment reminder Difficult to get same-day appointment Provides CCD for referrals 	<ul style="list-style-type: none"> Nothing formal 	<ul style="list-style-type: none"> e-MDs (2004) LIS No ADT alerts 	<ul style="list-style-type: none"> PQRS HEDIS MU Commercial payer 	<ul style="list-style-type: none"> Nothing formal
Practice E	<ul style="list-style-type: none"> 2 offices 8 MDs (3 part-time) 2 NPs 2 nurses 8 MAs Physician leader 	<ul style="list-style-type: none"> Both offices operate the same way eCW appointment reminder Difficult to get same-day appointment 	<ul style="list-style-type: none"> Primarily handled by NPs 	<ul style="list-style-type: none"> eCW LIS ADT alerts from 1 hospital 	<ul style="list-style-type: none"> HEDIS PQRS MU 	<ul style="list-style-type: none"> No outreach; uses eCW's health-maintenance capability within the EMR
Practice D	<ul style="list-style-type: none"> 2 offices 3 MDs 1 MA per MD 	<ul style="list-style-type: none"> Phytel Remind No formal communications for referrals or follow-up, but have a referral specialist Designated times for same-day appointments 	<ul style="list-style-type: none"> Nothing formal 	<ul style="list-style-type: none"> Allscripts LIS No ADT alerts 	<ul style="list-style-type: none"> PCMH-certified HEDIS 	<ul style="list-style-type: none"> Phytel Outreach

ACO indicates accountable care organization; ADT, admission, discharge, and transfer; CCD, Continuity of Care Document; eCW, eClinical Works; EMR, electronic medical record; HEDIS, Healthcare Effectiveness Data and Information Set; LIS, Lab Information System; MA, medical assistant; MD, medical doctor; MU, Meaningful Use; NP, nurse practitioner; PCMH, patient-centered medical home; PQRS, Physician Quality Reporting System.

The 5 practices currently engage in quality performance reporting programs. However, CMS's MSSP quality measures and measures for CMS's other value-based initiatives (eg, the Physician Quality Reporting System) are only partially aligned. Several CMS measures pertain to preventive screening, but only 1 practice uses a formal and automated outreach program; 4 lack a formal mechanism for ensuring that patients obtain preventive screenings. Such screenings are important for MSSP quality measures and for ensuring that cancer screenings and vaccinations are current.

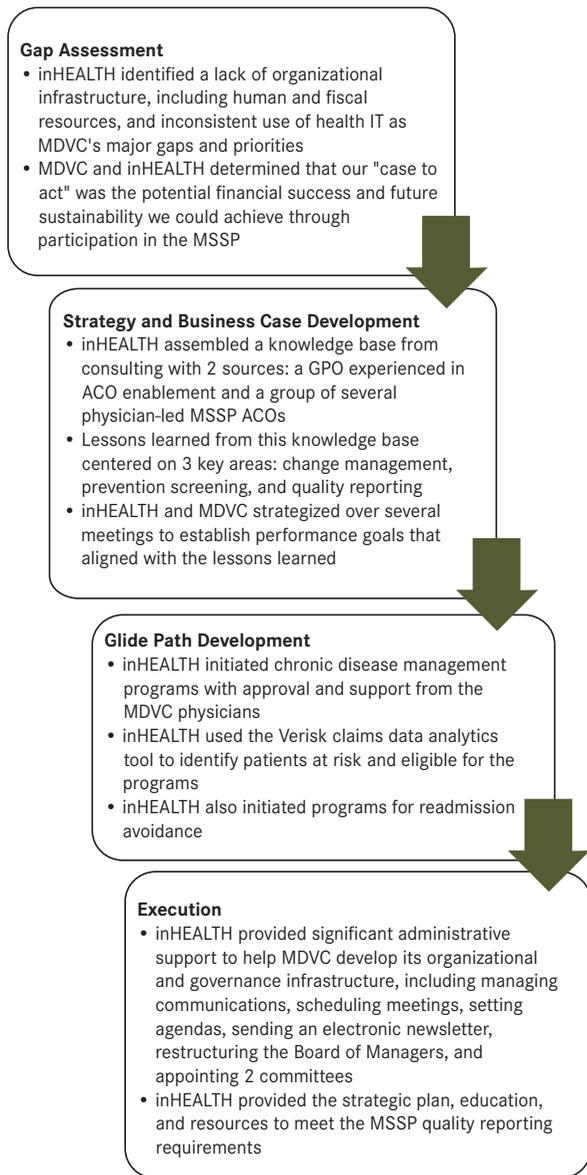
Many physician-led ACOs are self-funded, but few have adequate upfront capital to succeed in all areas, including human and fiscal resources. Physician-led ACOs are estimated to cost upwards of \$2 million for organizational infrastructure.²³ Fortunately, our gap as-

essment showed that all MDVC PCPs have EMRs, so that cost was not considered; however, other infrastructure and capabilities were needed. For example, existing administrative support was minimal and the governance structure required retooling to conform to CMS regulations. Although all practices had physician leaders, some were spread across several offices.

Strategy and Business Case Development

Peer organizations can provide valuable information about ACO implementation. The primary information sources in this regard were a GPO with extensive knowledge and background in ACO enablement and a group of physician-led MSSP ACOs. These 2 sources contributed a knowledge base that helped interpret the Gap Analy-

Figure 3. Hastings Gap Analysis Model Applied to Findings



ACO indicates accountable care organization; GPO, group purchasing organization; IT, information technology; MDVC, MD Valuecare; MSSP, Medicare Shared Savings Program.

sis and informed Glide Path Development and Execution. Lessons were learned in 3 areas—change management, prevention screening, and quality reporting—and shared with the core group of MDVC physicians and administrators, who developed processes reflecting procedures and methods used by successful peer organizations. The lessons also helped establish performance goals that would maintain

market competitiveness and could be achieved by MDVC. This development phase occurred in March through April 2014.

Glide Path Development

Glide Path Development occurred April through June 2014. The shared vision was deeply rooted in better patient care. To that end, inHEALTH initiated formal care management programs focusing on chronic diseases. A claims data analytics tool by Verisk Health identified at-risk patients to be recommended for care management programs. Data were provided to physicians, and programs were initiated for avoiding hospital readmissions. As this paper covers the period through implementation, those programs are not discussed.

Execution

While Hastings' Model suggests that the 4 phases happen sequentially, Execution overlapped with Glide Path Development. In examining the need for a gap assessment, a strategic plan, and alignment to market changes, MDVC realized that it lacked many resources—human or fiscal—to successfully execute ACO implementation. Such deficiencies are common among independent physician practices seeking to become ACOs; MDVC sought the comprehensive services of inHEALTH to provide administrative support and assistance with developing the organizational infrastructure and governance structure. This support relieved practice physicians and administrators of the burden of ensuring consistency, follow-through, and coordination throughout all processes.

Developing the organizational infrastructure and governance structure involved appointing 2 committees and restructuring the MDVC Board of Managers to include representation from ACO participants and Medicare beneficiaries. The Administration Committee comprises the practice administrator from each of the 20 MDVC practices; the Quality and Compliance Committee comprises 8 physicians from different MDVC PCP and specialty practices.

While narrowing the gaps and managing milestones and financial targets, communication was critical. A crucial turning point in execution was an "all provider" meeting in which all practices were presented with the gaps, a strategic plan, and an execution plan. This meeting helped defragment the execution and created a sense of shared responsibility and accountability for MDVC's success.

Quality performance reporting, necessary so every MSSP ACO can ensure compliance with 33 metrics across 4 program domains, is the gatekeeper to receiving shared savings. inHEALTH provided the strategic plan and resources to meet the MSSP's quality reporting requirements. Data on quality, cost, and patient satisfaction were obtained from a patient's chart (or charts, if seen by multiple providers), claims, and a patient satisfaction survey, respectively.

Quality performance measures required considerable education for the practices, mostly because MSSP measures only partially align with other quality measures familiar to physicians. Multiple training sessions for the practices entailed a comprehensive view of each

measure. A weekly electronic newsletter also included quality performance measure information.

DISCUSSION

Among the 4 critical success factors in the literature, the only gaps revealed were in the health IT factor: none of the practices used health IT to the extent possible. For example, their use of built-in EMR mechanisms for preventive and clinical measures was inconsistent. Similarly, few practices used consistent outreach methods for prevention screenings or documented a majority of information in discrete data fields that would facilitate quality performance reporting. Lastly, practices took little advantage of the robustness HIE offers, especially regarding care transition notification (ADT alerts) across disparate care environments. These areas created opportunities for high-impact, low-effort initiatives in Glide Path Development.

Applying the Hastings Gap Analysis Model to ACO implementation revealed several gaps in ACO readiness through the aforementioned domains: human and fiscal resources, office work flow and communication, care management, technology and data use, quality, and prevention screening outreach. **Figure 3** summarizes how the Hastings Gap Analysis Model applies to these findings and where in the model these gaps can be addressed.

Understandings gained between the initial gap analysis and ACO implementation supplement a rather thin body of literature on implementing physician-led ACOs and should assist others seeking to implement this type of ACO, MSSP or otherwise. One limitation of this work is that the practices already used an EMR system, thus providing upfront infrastructure savings. Additionally, each practice had a well-respected physician champion streamlining the change management process.

CONCLUSIONS

Early and extensive assessment of ACO readiness is critical for exposing gaps and understanding the allocation of human and fiscal resources during ACO implementation. Although the process at MDVC is still being implemented, one can envision how closing these gaps would contribute to achieving the Triple Aim. Future studies should examine physician-led MSSP ACOs that have succeeded in shared savings. For additional insights into implementing sustainable ACOs, researchers could explore the use of care management programs designed for specific chronic diseases and investigate motives and barriers to collaboration between PCPs and specialists associated with those diseases.

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Author Affiliation: Central Virginia Health Network (LMS, SSF), Richmond, VA; Arnold School of Public Health, University of

South Carolina (SSF), Columbia, SC; Department of Health Administration, Virginia Commonwealth University (CAW), Richmond, VA.

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Address correspondence to: Lauren M. Steckler, MHA, Central Virginia Health Network, 4900 Cox Rd, Ste 200, Glen Allen, VA 23060. E-mail: Laurensteckler23@gmail.com.

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