

**Accountable Care Organizations
Baltimore Accelerated Development Learning Session
Synthesis of Resources and Literature
Sorted by Learning Module**

General

Accountable Care Organizations (ACOs) create incentives for health care providers to work together to treat an individual patient across care settings—including doctors' offices, hospitals, and long-term-care facilities.

These resources provide background on ACOs and explain several aspects essential for their successful development. Because the resources deal with many topics of concern, they can be useful in addressing the majority of the core competencies. They represent some of the current and comprehensive reports and toolkits available on the topics covered in the ACO Accelerated Development Learning Session (ADLS). Overall, these resources could be helpful to any organization interested in developing into an ACO.

- Brookings–Dartmouth Toolkit: Accountable Care Learning Network
 - <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>
- AHA Research Synthesis Report: Accountable Care Organizations
 - <http://www.hret.org/accountable/resources/ACO-Synthesis-Report.pdf>
- Dartmouth Institute for Health Policy and Clinical Practice: “Better to Best: Value-Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations”
 - http://www.pcpcc.net/files/better_best_guide_full_2011.pdf
- The American Medical Association: “ACOs, CO-Ops and Other Options: A ‘How-To’ Manual for Physicians Navigating a Post-Health Reform World”
 - <http://www.ama-assn.org/resources/doc/psa/physician-how-to-manual.pdf>
- National Institute for Healthcare Reform: Lessons from the Field: Making Accountable Care Organizations Real
 - <http://www.nihcr.org/Accountable-Care-Organizations.pdf>
- CHQPR: “How to Create Accountable Care Organizations”
 - <http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf>
- CHQPR: “Transitioning to Accountable Care”
 - <http://www.chqpr.org/downloads/TransitioningtoAccountableCare.pdf>
- Commonwealth Fund Newsletter
 - http://www.commonwealthfund.org/~media/Files/Newsletters/Quality%20Matters/2010_06_24_QM_sba.pdf

- Commonwealth Fund: “High Performance Accountable Care: Building on Success and Learning from Experience”
 - http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Apr/1494_Guterman_high_performance_accountable_care_v3.pdf
- Health Affairs: Fostering Accountable Health Care: Moving Forward in Medicare
 - <http://content.healthaffairs.org/content/28/2/w219.full.pdf>
- Care Continuum Alliance: “Achieving Accountable Care: Essential Population Health Management Tools for ACOs”
 - http://www.carecontinuum.org/pdf/CCA_ACO_Toolkit.pdf
- Advocate Physician Partners 2011 Value Report
 - <http://www.advocatehealth.com/body.cfm?id=439>
- Kaiser Health News: FAQ on ACOs: Accountable Care Organizations, Explained
 - <http://www.kaiserhealthnews.org/Stories/2011/January/13/ACO-accountable-care-organization-FAQ.aspx>
- Health Affairs: “A Model for Integrating Independent Physicians into Accountable Care Organizations”
 - <http://content.healthaffairs.org/content/30/1/161.full.pdf>
- Health Affairs: “The Accountable Care Organization: Whatever Its Growing Pains, The Concept Is Too Vitally Important to Fail”
 - <http://www.amga.org/AboutAMGA/ACO/Articles/haCrosson.pdf>

Learning Modules

The following resources are organized into the different learning modules. Resources specific to each module have been included, although many resources from the General section may provide useful information as well. Certain resources may also be used across several modules.

Module 1: Care Delivery – Primary Care & Care Redesign

- Minnesota medical home criteria and practice self assessment worksheet
 - <http://www.health.state.mn.us/divs/fh/mcshn/medhm/docs/mhiprovider.pdf>
- Commonwealth Fund: “Making Care Coordination A Critical Component of the Pediatric Health System: A Multidisciplinary Framework.”
 - http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2009/May/Making%20Care%20Coordination%20a%20Critical%20Component/1277_Antonelli_making_care_coordination_critical_FINAL.pdf
- Berenson RA. “Is there room for specialists in the Patient Centered Medical Home?” Chest 2010; 137; 10-11
 - <http://chestjournal.chestpubs.org/content/137/1/10.full.pdf>

- Kirschner N, Barr MS. “Specialists / subspecialists and the Patient Centered Medical Home” Chest 2010: 137; 200-204
 - <http://chestjournal.chestpubs.org/content/137/1/200.full.pdf>
- NEJR: “Primary Care and Accountable Care – Two Essential Elements of Delivery-System Reform”
 - <http://www.nejm.org/doi/full/10.1056/NEJMp0909327>
- AJMC: “Value of the Medical Home: Effects of Transformed Primary Care”
 - http://www.ajmc.com/media/pdf/AJMC_10augGilfillan607to614.pdf
- Dartmouth Institute for Health Policy and Clinical Practice: “Better to Best: Value-Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations”
 - http://www.pcpcc.net/files/better_best_guide_full_2011.pdf
- PCMH/AHRQ: “The Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Patient Care”
 - http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483
- NCQA: “Patient-Centered Medical Home”
 - <http://www.ncqa.org/tabid/631/default.aspx>
- The Journal of Family Practice: “The Impact of Patient-Centered Care and Outcomes”
 - http://www.jfponline.com/Pages.asp?AID=2601&issue=September_2000&UID
- Journal of the American Board of Family Medicine: “The Medical Home: Growing Evidence to Support a New Approach to Primary Care”
 - <http://www.jabfp.com/cgi/reprint/21/5/427>
- Patient-Centered Primary Care Collaborative
 - <http://www.pcpcc.net/content/care-coordination>
- Physician: “Patient Activation Measures: How Do We Know If Patients Are Ready”
 - <http://www.staywellhealthmanagement.com/LinkClick.aspx?fileticket=MLlxzFLDX0Q%3D&tabid=175>
- Health Services Research: “Patient Engagement in Health Care”
 - <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2011.01254.x/pdf>
- New York Times: “The Missing Ingredient in Accountable Care”
 - http://www.nytimes.com/2011/01/27/health/views/27chen.html?_r=1
- Health Services Research: “Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers”
 - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361049/pdf/hesr_269.pdf

- “How Engaged are Consumers in Their Health and Health Care, and Why Does it Matter”
 - <http://ualr.edu/seniorjustice/uploads/2008/12/How%20Engaged%20Are%20Consumers%20in%20Their%20Health%20and%20Health%20Care.pdf>
- Center for Advancing Health: “A New Definition of Patient Engagement: What Is Engagement and Why Is It Important?”
 - http://www.cfah.org/pdfs/CFAH_Engagement_Behavior_Framework_2010.pdf
- Institute for Patient- and Family-Centered Care
 - <http://www.ipfcc.org/>
- The American Journal of Managed Care: “High-Risk Population Health Management—Achieving Improved Patient Outcomes and Near-Term Financial Results”
 - http://www.ajmc.com/media/pdf/AJMC2000julLynch781_791.pdf
- Milliman: “How Using Care Management Guidelines can Help Accountable Care Organizations Achieve Success”
 - <http://publications.milliman.com/publications/healthreform/pdfs/how-using-care-management.pdf>
- NEJM: “Coordinating Care — A Perilous Journey through the Health Care System”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMhpr0706165>
- National Transitions of Care Coalition: Health Care Professionals Tools
 - http://www.ntocc.org/Portals/0/TOC_Checklist.pdf (ASSESSMENT TOOL)
 - http://www.ntocc.com/Home/HealthCareProfessionals/WWS_HCP_Tools.aspx
- The Care Transitions Program
 - <http://www.caretransitions.org/index.asp>
- Care Coordination Measures Atlas (Assessment tool)
 - <http://www.ahrq.gov/qual/careatlas/careatlas.pdf>
- Improving Chronic Illness Care
 - http://www.improvingchroniccare.org/index.php?p=Care_Coordination&s=326
- National Academy for State Health Policy: “Care Coordination for People with Chronic Conditions”
 - http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf
- APS Healthcare: “A Challenge for Medicaid Agencies”
 - <http://www.apshealthcare.com/site/files/cm/file/whitepapers/CareCoordination.pdf>
- The Colorado Foundation for Medical Care (CFMC): “Care Transitions Quality Improvement Organization Support Center”
 - <http://www.cfmc.org/caretransitions/>

- The Just Culture Community
 - <http://www.justculture.org/default.aspx>
- Team STEPPS
 - <http://teamstepps.ahrq.gov/>
- Intermountain Healthcare
 - http://intermountainhealthcare.org/qualityandresearch/institute/Documents/miniATP_Goals_and_Lecture_layout%2010-27-08.pdf: “Quality Improvement Training Program”
 - <http://intermountainhealthcare.org/qualityandresearch/institute/Documents/Chapter7.pdf>: “Sustaining and Extending Clinical Improvements: A Health System’s Use of Clinical Programs to Build Quality Infrastructure”
 - <http://intermountainhealthcare.org/qualityandresearch/institute/Documents/GuidebookMaster.pdf>: “Clinical Work Process-Based Organizational Structure”
- Institute for Healthcare Improvement
 - <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>
 - <http://www.ihl.org/IHI/Programs/ImprovementMap/>
- Profile of the Marshfield Clinic’s approach to HIT:
 - AHRQ Health Care Innovations Exchange: “Electronic Medical Record-Facilitated Care Process Redesign Enhances Access to Care, Reduces Hospitalizations and Costs for Patients with Chronic Illnesses”: <http://www.innovations.ahrq.gov/content.aspx?id=1725>
- HFMA (requires log-in): “The Physician Value Index: A Tool for Effective Physician Integration”
 - <http://www.hfma.org/Templates/InteriorMaster.aspx?id=24919>
- Health Affairs: “Prospects for Improved Decision Making About Medical Necessity”
 - <http://content.healthaffairs.org/content/20/1/200.full.pdf+html>
- Qualis Health: Publications & Tools
 - <http://www.qhmedicalhome.org/safety-net/publications.cfm>
- AAFP: The Value of Primary Care and Family Physicians
 - <http://www.aafp.org/online/en/home/media/browse/advocacy/the-value-of-primary-care-and-family-physicians.html>

Module 2: Care Delivery – Coordinating Care and Managing High Risk, High Cost Beneficiaries

- The American Journal of Managed Care: “High-Risk Population Health Management—Achieving Improved Patient Outcomes and Near-Term Financial Results”
 - http://www.ajmc.com/media/pdf/AJMC2000julLynch781_791.pdf

- Milliman: “How Using Care Management Guidelines can Help Accountable Care Organizations Achieve Success”
 - <http://publications.milliman.com/publications/healthreform/pdfs/how-using-care-management.pdf>
- NEJM: “Coordinating Care—A Perilous Journey Through the Health Care System”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMhpr0706165>
- National Transitions of Care Coalition: Health Care Professionals Tools
 - http://www.ntocc.org/Portals/0/TOC_Checklist.pdf (ASSESSMENT TOOL)
 - http://www.ntocc.com/Home/HealthCareProfessionals/WWS_HCP_Tools.aspx
- The Care Transitions Program
 - <http://www.caretransitions.org/index.asp>
- Care Coordination Measures Atlas (Assessment tool)
 - <http://www.ahrq.gov/qual/careatlas/careatlas.pdf>
- National Academy for State Health Policy: “Care Coordination for People with Chronic Conditions”
 - http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf
- APS Healthcare: “A Challenge for Medicaid Agencies”
 - <http://www.apshealthcare.com/site/files/cm/file/whitepapers/CareCoordination.pdf>
- The Colorado Foundation for Medical Care (CFMC): “Care Transitions Quality Improvement Organization Support Center”
 - <http://www.cfmc.org/caretransitions/>
- The Colorado Foundation for Medical Care (CFMC): “Care Transitions Quality Improvement Organization Support Center”
 - <http://www.cfmc.org/caretransitions/>
- National Academy for State Health Policy: “Care Coordination for People with Chronic Conditions”
 - http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf
- Care Coordination Measures Atlas (Assessment tool)
 - <http://www.ahrq.gov/qual/careatlas/careatlas.pdf>
- NEJM: “Coordinating Care — A Perilous Journey through the Health Care System”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMhpr0706165>

Module 3: Connecting Providers and Health Information Technology

- Dartmouth Institute for Health Policy and Clinical Practice: “Better to Best: Value-Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations”
 - Better Health IT, p. 28: http://www.pcpcc.net/files/better_best_guide_full_2011.pdf
- Care Continuum Alliance: “Achieving Accountable Care: Essential Population Health Management Tools for ACOs”
 - Section IIC, Infrastructure and HIT: http://www.carecontinuum.org/pdf/CCA_ACO_Toolkit.pdf
- Profile of the Marshfield Clinic’s approach to HIT:
 - AHRQ Health Care Innovations Exchange: “Electronic Medical Record-Facilitated Care Process Redesign Enhances Access to Care, Reduces Hospitalizations and Costs for Patients with Chronic Illnesses”: <http://www.innovations.ahrq.gov/content.aspx?id=1725>
- One vendor analysis of HIT needs for ACOs:
 - CSC: “Health Information Requirements for Accountable Care”: http://assets1.csc.com/health_services/downloads/CSC_HIT_Requirements_for_Accountable_Care.pdf
- PWC: “Designing the Health IT Backbone for ACOs”
 - <http://pwchealth.com/cgi-local/hregister.cgi?link=reg/designing-a-health-it-backbone-for-acos.pdf>
- Health Data Management: “Getting Ready for Accountable Care Organizations”
 - http://www.healthdatamanagement.com/issues/19_4/getting-ready-for-accountable-care-organizations-42230-1.html?pg=1
- Health Affairs: “Health Information Technology: Layering the Infrastructure for National Health Reform”
 - <http://content.healthaffairs.org/content/29/6/1214.full.pdf>
- NEJM: “The Meaningful Use Regulation for Electronic Health Records”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMp1006114>
- The American Journal of Managed Care: “High-Risk Population Health Management—Achieving Improved Patient Outcomes and Near-Term Financial Results”
 - http://www.ajmc.com/media/pdf/AJMC2000julLynch781_791.pdf
- Milliman: “How Using Care Management Guidelines can Help Accountable Care Organizations Achieve Success”
 - <http://publications.milliman.com/publications/healthreform/pdfs/how-using-care-management.pdf>
- NEJM: “Coordinating Care—A Perilous Journey Through the Health Care System”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMp0706165>

- National Transitions of Care Coalition: Health Care Professionals Tools
 - http://www.ntocc.org/Portals/0/TOC_Checklist.pdf (ASSESSMENT TOOL)
 - http://www.ntocc.com/Home/HealthCareProfessionals/WWS_HCP_Tools.aspx
- The Care Transitions Program
 - <http://www.caretransitions.org/index.asp>
- Care Coordination Measures Atlas (Assessment tool)
 - <http://www.ahrq.gov/qual/careatlas/careatlas.pdf>
- National Academy for State Health Policy: “Care Coordination for People with Chronic Conditions”
 - http://www.partnershipforsolutions.org/DMS/files/Care_coordination.pdf
- APS Healthcare: “A Challenge for Medicaid Agencies”
 - <http://www.apshealthcare.com/site/files/cm/file/whitepapers/CareCoordination.pdf>
- The Colorado Foundation for Medical Care (CFMC): “Care Transitions Quality Improvement Organization Support Center”
 - <http://www.cfm.org/caretransitions/>

Module 4: Risk Sharing, Incentives, and Startup/Capital Needs

- Health Affairs: “Are Higher Value Care Models Replicable?”
 - <http://healthaffairs.org/blog/2009/10/20/are-higher-value-care-models-replicable/>
- Becker’s Hospital Review: “Accountable Care & the Transfer of Financial Risk: 3 Tips for Providers”
 - <http://www.beckershospitalreview.com/hospital-physician-relationships/accountable-care-a-the-transfer-of-financial-risk-3-tips-for-providers.html>
- Milliman: “Nuts and Bolts of ACO Financial and Operational Success: Calculating and Managing to Actuarial Utilization Targets”
 - http://publications.milliman.com/publications/healthreform/pdfs/828_HDP.pdf
- Milliman: “A First Look at ACOs’ Risky Business: Quality is Not Enough”
 - <http://publications.milliman.com/publications/healthreform/pdfs/at-first-look-acos.pdf>
- Milliman: “ACOs: Beyond Medicare”
 - http://insight.milliman.com/article.php?cntid=7611&utm_source=healthreform&utm_medium=web&utm_content=7611&utm_campaign=Milliman%20On%20Healthcare
- CHQPR: “Transitioning to Accountable Care,” p.19–26, “Setting Prices, Managing Risk, and Ensuring Quality”
 - <http://www.chqpr.org/downloads/TransitioningtoAccountableCare.pdf>
- Care Continuum Alliance: “Achieving Accountable Care: Essential Population Health Management Tools for ACOs”
 - http://www.carecontinuum.org/pdf/CCA_ACO_Toolkit.pdf

- Department of Health and Human Services: “What Providers Need to Know: Accountable Care Organizations”
 - http://www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf
- Commonwealth Fund: “High Performance Accountable Care: Building on Success and Learning from Experience,” p.28 and p.32
 - http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Apr/1494_Guterman_high_performance_accountable_care_v3.pdf
- NEJM: “Engaging Specialists in Performance-Incentive Programs”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMp1000650?ssource=hrcrc>
- NEJM: “Reforming Medicare by Reforming Incentives”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMp1104427>
- CHQPR: “How to Create Accountable Care Organizations”
 - <http://www.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf>
- Brookings/Dartmouth: “Reforming Provider Payment: Moving Toward Accountability for Quality and Value”
 - http://www.brookings.edu/events/2009/~media/Files/events/2009/0311_aco/issuebriefacofinal.pdf
- CHQPR: “Using Partial Capitation as an Alternative to Shared Savings to Support Accountable Care Organizations in Medicare”
 - <http://www.chqpr.org/downloads/PartialCapitationPaymentforACO.pdf>
- Kongstvedt, Peter (Ed.) (2007). *Essentials of Managed Health Care* (5th ed.). Sudbury, MA: Jones and Bartlett Publishers.
- AHA/McManis Consulting: “The Work Ahead: Activities and Costs to Develop an Accountable Care Organization”
 - <http://www.aha.org/aha/content/2011/pdf/aco-white-paper-cost-dev-aco.pdf>
- Brookings-Dartmouth Toolkit: Accountable Care Learning Network, Part 4 and Appendix 4A
 - <https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf>
- Vigen G, Coughlin S, Duncan I. “Measurement of Healthcare Quality and Efficiency: Resources for Healthcare Professionals.” 2010
 - <http://www.soa.org/research/research-projects/health/research-quality-report.aspx>
- Bruce S. Pyenson (Ed.) “Calculated Risk: A Provider’s Guide to Assessing and Controlling the Financial Risk of Managed Care.” Milliman & Robertson Inc. American Hospital Publishing Inc.
- “Managing Risk: A Leaders Guide to Creating a Successful Managed Care Provider Organization” Bruce S. Pyenson, Editor Milliman & Robertson Inc. Published in Cooperation with AHA Center for Health Care Leadership.
- Premier: Accountable Care Implementation Collaborative/ACO Financial Tool (requires membership)
 - <http://www.premierinc.com/about/news/11-mar/accountablecare030711.jsp>

Pre ADLS Webinar: Describing and Understanding Your Population's Clinical and Risk Profiles

- Milliman: "Whose Patient Is It? Patient Attribution in ACOs"
 - <http://publications.milliman.com/publications/healthreform/pdfs/whose-patient-is-it.pdf>
- Care Continuum Alliance: "Achieving Accountable Care: Essential Population Health Management Tools for ACOs"
 - http://www.carecontinuum.org/pdf/CCA_ACO_Toolkit.pdf
- CDC: "Measuring Population Health Outcomes"
 - http://www.cdc.gov/pcd/issues/2010/jul/pdf/10_0005.pdf
- "Accountable Care & the Transfer of Financial Risk: 3 Tips for Providers"
 - <http://www.beckershospitalreview.com/hospital-physician-relationships/accountable-care-a-the-transfer-of-financial-risk-3-tips-for-providers.html>
- Milliman: "Nuts and Bolts of ACO Financial and Operational Success: Calculating and Managing to Actuarial Utilization Targets"
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- CHQPR: "Transitioning to Accountable Care," p.19-26, "Setting Prices, Managing Risk, and Ensuring Quality"
 - <http://www.chqpr.org/downloads/TransitioningtoAccountableCare.pdf>
- Milliman: "A First Look at ACOs' Risky Business: Quality is Not Enough"
 - <http://publications.milliman.com/publications/healthreform/pdfs/at-first-look-acos.pdf>
- Dartmouth Institute for Health Policy and Clinical Practice: Better to Best: Value Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations
 - Better Health IT, p. 28: http://www.pcpcc.net/files/better_best_guide_full_2011.pdf
- Care Continuum Alliance: "Achieving Accountable Care: Essential Population Health Management Tools for ACOs"
 - Section IIC, Infrastructure and HIT: http://www.carecontinuum.org/pdf/CCA_ACO_Toolkit.pdf
- Profile of the Marshfield Clinic's approach to HIT:
 - AHRQ Health Care Innovations Exchange: "Electronic Medical Record-Facilitated Care Process Redesign Enhances Access to Care, Reduces Hospitalizations and Costs for Patients with Chronic Illnesses": <http://www.innovations.ahrq.gov/content.aspx?id=1725>
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 - CSC: "Health Information Requirements for Accountable Care": http://assets1.csc.com/health_services/downloads/CSC_HIT_Requirements_for_Accountable_Care.pdf

- PWC: “Designing the Health IT Backbone for ACOs”
 - <http://pwchealth.com/cgi-local/hregister.cgi?link=reg/designing-a-health-it-backbone-for-acos.pdf>
- Health Data Management: “Getting Ready for Accountable Care Organizations”
 - http://www.healthdatamanagement.com/issues/19_4/getting-ready-for-accountable-care-organizations-42230-1.html?pg=1
- Health Affairs: “Health Information Technology: Layering the Infrastructure for National Health Reform”
 - <http://content.healthaffairs.org/content/29/6/1214.full.pdf>
- NEJM: “The Meaningful Use Regulation for Electronic Health Records”
 - <http://www.nejm.org/doi/pdf/10.1056/NEJMp1006114>