# Atlantic ACO Resource Guide

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PRIDE in Accountable Care

David J. Shulkin, MD

Health care administrators and clinical leaders need replicable and actionable systems of care in order to improve and streamline patient care. This editorial will focus on systems of care that support economic incentives for providers to reduce costs and on population-based health strategies to improve care delivery. While not intended to be a comprehensive review of approaches to improve cost and quality, a model of care will be described that is practical and replicable in the era of accountable care.

Personalized Regionally Integrated Disease Entities (PRIDE) are organized medical systems, the goal of which is to introduce accountable care into communities to reduce costs while improving outcomes. PRIDE systems are models of care that are of utility for health care systems looking to meet the health needs of their community.

Although some skeptics suggest that they may be only the next fleeting health care gimmick, coordinated care and value-based reimbursement likely will remain powerful tools for reforming the system. The accountable care movement's direction will depend as much on the ability to learn lessons from work already under way as from the ability to avoid the mistakes of the past. This analysis supports coordinated and accountable approaches to care.

Avoiding Past Mistakes

Skeptics of accountable care claim that similar models have failed in the past; in particular, they point to strategies employed by managed care organizations in the 1990s that proved successful in bending the cost curve but were overwhelmingly unpopular with the public. The well-documented backlash against health maintenance organizations focused on the dislike of gatekeeping systems and the resulting barriers imposed to access knowledgeable specialists. Using financial incentives to withhold care contributed significantly to the mistrust that developed between managed care and the health care consumer. Additionally, many reimbursement strategies have encouraged clinicians to limit time with patients; the resulting erosion of the doctor-patient relationship has been confirmed by studies. Benefit designs have not rewarded providers adequately for prevention and wellness, or for compliance with coordinated disease management approaches to care. Open network insurance plans and concierge-style medicine have grown increasingly fashionable as a result.

What Works

Given that a minority of patients consumes the majority of health care resources, disease and case management strategies hold promise to reduce health care costs. Just over half of the interventions that have been studied in this regard yielded significant cost savings. What works can be further refined and enhanced. With proper risk identification, intensive ambulatory models of care that offer coordinated approaches to chronic illness management appear to be most promising. Risk appraisals and biometric screening programs yield promising results in reducing overall employee health care costs to employers. Ambulatory intensive care units for patients with complex and severe conditions have proved effective in reducing these costs and improving health outcomes. In Washington State, where high-risk employees at Boeing received intensive ambulatory services, per capita health spending was reduced by 20%, physical functioning improved by 14.8%, and missed work days were cut by over 56%.

Primary care medical homes have demonstrated significant improvements in health outcomes. Such impact appears to be the result of a responsible practice site that can track and coordinate preventive and disease-oriented services. In somewhat contrary findings, “Principal Care,” a specialist-centered model, also has demonstrated superior results when specialists take similar responsibility for disease states. Accountability appears to be the key ingredient in achieving improvements. Additional work has demonstrated that the most successful recipe for positive health outcomes is that of health care professionals working in teams to deliver more comprehensive and effective care. Team-based approaches can work when primary care physicians and specialists work in coordinated plans of care, supported by other health care professionals.

Patients expect their care teams to speak to each other and to be knowledgeable about differing clinical perspectives. They want care delivered in a manner that recognizes their individual needs. Standardization of care with greater reliance on evidence-based approaches may be more effective, but also can be perceived as cold and impersonal. Patients want attention, bidirectional communication, and care that is coordinated to meet their personal needs.

Finally, health services researchers repeatedly show that financial incentives are one of the strongest predictors of...
change in clinical practice patterns. Gainsharing, which aligns the economic interests of hospitals and physicians, has been shown to dramatically reduce utilization of resources in hospitals. Quality improves as well when incentives target clinical outcomes.

The PRIDE Model

The PRIDE model incorporates what works and limits what does not (Table 1). Each component of PRIDE is described below:

**Personalized care**

In accountable care models, patients are assigned through attribution models to primary care practices, facilitating establishment of a longitudinal relationship between doctor and patient. Upon assignment to a PRIDE, patients are contacted to begin an individualized evaluation of their risk profile. Through these active outreach efforts, risk assessments develop personalized care plans. Risk stratification is best accomplished using a standardized risk assessment tool in combination with biometric screening tools.

Patients at low risk need support to adhere to preventive service guidelines and wellness programs. Patients identified as higher risk, including smokers, the obese, and patients with hypercholesterolemia or hypertension, are prescribed risk-modifying programs. Patients with chronic disease are directed into appropriate medical programs that include disease management structured pathways, registries, care managers, or health coaches. They enter into personalized contracts with their primary care practices to develop a mutually agreeable plan based upon their specific objectives, beliefs, values, behaviors, and genetics.

**Regional care**

The hallmark of PRIDE in accountable care organizations is the delivery of services in a decentralized model of care. Regional accountable care entities have governance structures comprised of primary care providers, specialists, and hospital or other institutional membership. Regional governance determines provider network membership criteria, utilization and medical management strategies, and shared savings distributions. PRIDE governance is intended to be predominantly, but not exclusively, physician controlled.

Primary care pods (PCPs) are the building blocks of the PRIDE system. PCPs are groupings of primary care physicians that offer a comprehensive set of health services to their patients. PCPs have the ability to coordinate primary care, specialty care, prevention, and wellness, and to address the social and psychological needs of patients. PCPs offer extensive services to ensure that patients receive coordinated care. Foundational to a regional approach is the coordination of PCPs and local employers, senior centers, and religious organizations where many patients seek assistance with health problems. With a strong primary care foundation and these linkages to the larger community, patients benefit from good working relationships between government, community, and private health system resources. Regional accountable care structures allow for the coordination of physician and hospital services, including home care, transportation services, and subacute and rehabilitation care. PRIDE units link together into a broad, accountable care structure (Fig. 1). Services that can be shared among PRIDE units can be centralized in the accountable care structure. Information system infrastructure, health information exchanges, call centers, and risk-bearing financial instruments are examples of shared services among PRIDE units.

**Integrated care**

PRIDE facilitates close collaboration between primary care and specialist physicians through the alignment of clinical and financial resources. A primary care physician and a specialist dyad jointly develop and coordinate care plans for patients with chronic illness. Patients with both acute and chronic illness benefit from broader multidisciplinary approaches to care. Advanced practice nurses, pharmacists, psychologists, and occupational therapists are important contributors to this integrated approach to illness and wellness. These health care professionals may be embedded in PCPs that are large enough themselves or alternately shared among several PCPs within a PRIDE (Table 2).

Specialist-centered care may be the most effective and efficient plan of care for chronic conditions. In this circumstance PCPs engage in coordinating service; however, the specialist is still the primary driver of the coordination. Some decisions regarding primary care-based planning versus

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<th>Table 1. PRIDE</th>
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<td><strong>Disease</strong></td>
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**FIG. 1.** Accountable care with PRIDE.
Table 2. Team-based Approaches with PRIDE

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<th>Pride Practice Units</th>
<th>Functions</th>
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<tr>
<td>Primary care pods</td>
<td>Risk stratification, prevention and wellness programs</td>
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<td>Primary care/specialist pairings</td>
<td>Diagnostic evaluations, acute and straightforward chronic care management using agreed-upon pathways</td>
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<tr>
<td>Multidisciplinary teams (physicians and other health care professionals)</td>
<td>Complex chronic care management</td>
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<td>Advanced practice nurses</td>
<td>Routine and protocol-driven care delivery</td>
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<td>Health coaches, care managers</td>
<td>Group classes, patient compliance, care coordination</td>
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<td>Information technology professionals, clinical leadership, and community resources</td>
<td>Registries, outcomes tracking, and continuum of care service offerings</td>
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<td>Employers and payers</td>
<td>Assessment of value (cost/quality)</td>
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Principal care are made at the PRIDE level. In either case, primary care providers and specialists agree upon care plans and the tracking of health outcomes.

**Disease-oriented care**

The most common ambulatory and inpatient medical conditions require that care plans be developed. These care plans define goals related to the functional and health status of the patient. Evidence-based practices facilitate a process in which there is clarification about the role of the provider and patient and the relevant outcome measures. A coordinated approach is necessary to ensure compliance with the care plan. Information systems are useful for tracking compliance and providing decision-support tools designed to integrate these approaches to illness and to alert for unintentional deviations in ongoing care plans. Disease registries and trackable outcomes measures can be built into the information systems utilized by providers and patients. This leads to flexible, adaptable condition management.

**Entity management**

Among all segments of the health care system accountable care organizations provide a mechanism to incentivize waste reduction and improved health outcomes. PRIDE models offer economic units that allow the community to share benefits generated by their coordinated efforts. An essential function of PRIDE is to report regularly on the impact of their efforts with regard to community health and resource use. Shared savings models also help integrate the efforts of various provider-based groups with payers and employers.

**The Value of Implementing PRIDE**

Participation in PRIDE requires regular communication with payers and employers to demonstrate effectiveness and to look for further opportunities to collaborate and align with each other. Accountable care organizations set up regional systems consisting of local practitioners and community-based health care organizations. The governance for accountable care should be local. Multiple PRIDE can integrate into larger accountable care structures in order to share infrastructure and spread risk. A PRIDE consists of PCPs and primary care-specialist pairings that manage care through collaboration or operate within specialist-directed models. Multidisciplinary teams of advanced practice nurses and other health professionals deliver routine or pathway-based care plans. Health coaches are employed to engage patients and their families. Patients receive personalized risk stratification and individualized care planning. A PRIDE has information systems that track quality measures and outcomes and report financial results. PRIDE’s data-reporting capabilities provide regular feedback on clinical and economic performance to internal and external groups in the community. Such data serve as the basis for shared savings models and performance-based compensation plans.

Moving forward, the challenge will be not only to find effective models that reduce costs and improve quality but also to build a system of care that inspires and engages patients, providers, and payers. Building a system that is attractive to both health professionals and to patients who want to receive care must be the goal. PRIDE is a way to make us all proud of what our health care system can deliver.

**Author Disclosure Statement**

Dr Shulkin disclosed no conflicts.

**References**


Address correspondence to:
Dr. David J. Shulkin
100 Madison Ave.
Morristown, NJ 07962

E-mail: David.Shulkin@AtlanticHealth.org
Dear ACO Provider:

Welcome to the ACO!

This binder is intended to serve as the Atlantic ACO Resource Guide. As we begin to transform healthcare in Northern New Jersey and America, this guide will be updated with the most current ACO information to include: ACO contacts, background information, frequently asked questions, care coordination guidelines and quality metrics information as well as information for beneficiaries.

Contacts at a Glance:

**ACO Administration**
973-971-7499

**ACO Care Coordination Center**
855-ACO-7171

**Morris Region ACO Liaison**
Steven Alderson, 973-971-4359

**Sussex Region ACO Liaison**
Jim Furgeson, 973-579-8390

**Union, Essex, and Somerset Region**
John Rossellini, 908-522-4978

**Valley Region ACO Liaison**
Dr. Phyllis Marino, 201-291-6135

**Centers of Excellence**

**Atlantic Health System Heart Success**
973-971-4179

**Valley Hospital Heart Failure**
201-447-8284 or 201-448-2621

**Centers of Excellence**

**Atlantic Health System Pulmonary**
866-961-8006

**The Valley Hospital Pulmonary**
201-447-8673

You can also find us online at atlanticaco.org

Atlantic ACO
465 South Street, Suite 102
Morristown, New Jersey 07960
atlanticaco@atlantichealth.org
Atlantic ACO
Description

The Atlantic ACO is comprised of more than 1,300 physician members and includes Morristown Medical Center, Newton Medical Center, Overlook Medical Center and The Valley Hospital in four regions of northern New Jersey, primarily in Bergen, Essex, Morris, Sussex, Union and Somerset counties. Our mission is to improve the quality of care through cooperation and coordination among providers and reduce the cost of care to defined populations. We will achieve the following goals:

› Undertake joint activities to improve health care delivery by developing and implementing effective clinical and administrative systems
› Promote and create strategic physician and hospital alignment
› Engage the patient/member population toward improved health in coordination with their physician
› Achieve better care for individuals and better health for populations served by the ACO.
› Operate the ACO efficiently and effectively
› Achieve reductions in health care cost for populations served by the ACO
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<tr>
<th>Committee</th>
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<tr>
<td>Nominating</td>
<td>Responsible for nominating candidates for vacancies on the Governing Board. Identify qualified individuals to become members of the Governing Board. Recommend qualified member nominees to the Governing Board. Conducting annual evaluation of the nominating Committee.</td>
</tr>
<tr>
<td>Credentialing</td>
<td>Responsible for credentialing and re-credentialing each applicant for membership or participation in AHS/ACO, LLC. Reviewing the credentials of new applicants for membership participation in the company. Re-reviewing the credentials of existing members or participants in the company on a regular basis.</td>
</tr>
<tr>
<td>Performance</td>
<td>Physician-directed quality assurance and process improvement committee to oversee, establish internal performance standards for quality of care and services, cost effectiveness, and process and outcome improvements and hold ACO participants accountable. Promote evidence-based medicine. Oversee the Care Coord. Sub-Committee. Lead the effort to promote beneficiary engagement. Lead the effort to report on quality &amp; cost metrics. Lead the effort to coordinate care across and among primary care physicians, specialist and acute post-acute providers and suppliers. Monitor participants and provider supplier performance. Collaborate with IT, Oversee the selection of the CMS certified vendor. Oversee the work of the Research Grants sub-Committee.</td>
</tr>
<tr>
<td>Finance</td>
<td>Responsible for all financial management consideration for AHS. Advising the Governing board. Reviewing policies and procedures for financial management. System for claims processing Bookkeeping &amp; physician reimbursement. Financial aspects of any proposed contractual arrangement. Reviewing annual operating and capital budgets and prepared.</td>
</tr>
<tr>
<td>Information</td>
<td>Oversees the infrastructure of the AHS, ACO, LLC to enable the Company to collect &amp; evaluate data and provide feedback to the Company participant including providing info to influence point of care.</td>
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atlanticaco.org
Accountable Care Organizations: What Providers Need to Know

FACT SHEET
http://www.cms.gov/SharedSavingsProgram

Overview

On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), finalized new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings— including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

In developing this final rule, CMS worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Shared Savings Program.

CMS encourages all interested providers and suppliers to review this final rule and consider participating in the Shared Savings Program.

This fact sheet provides an overview of ACOs.

What Is an ACO?

Under the final rule, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the Medicare Fee-For-Service patients they serve. The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a Fee-For-Service payment system in which different providers
receive different, disconnected payments. The ACO will be a patient-centered organization where the patient and providers are true partners in care decisions.

The Affordable Care Act specifies that an ACO may include the following types of groups of providers and suppliers of Medicare-covered services:

- ACO professionals (i.e., practitioners meeting the statutory definition) in group practice arrangements,
- Networks of individual practices of ACO professionals,
- Partnerships or joint ventures arrangements between hospitals and ACO professionals,
- Hospitals employing ACO professionals, or
- Other Medicare providers and suppliers as determined by the Secretary.

In the final rule, the Secretary has determined that certain critical access hospitals, federally qualified health centers, and rural health clinics are eligible to participate independently in the Shared Savings Program. Additionally, any other Medicare enrolled provider or supplier in good standing is encouraged to participate in an ACO since all providers are important for the ACO to achieve its goal of better coordinating care.

**How Can Providers Participate?**

To participate in the Shared Savings Program, providers must come together to become a Medicare ACO and the ACO must apply to CMS. An existing ACO will **not** be automatically accepted into the Shared Savings Program. To be accepted, ACOs must meet all eligibility and program requirements, must serve at least 5,000 Medicare Fee-For-Service patients and agree to participate in the program for at least 3 years. Medicare providers who participate in an ACO in the Shared Savings Program will continue to receive payment under Medicare Fee-For-Service rules.

The statute also requires each ACO to establish a governing body representing ACO providers of services, suppliers, and Medicare beneficiaries. The ACO will be responsible for developing processes to promote evidence-based medicine, promote patient engagement, internally report on quality and cost, and coordinate care. The ACO will be responsible for maintaining a patient-centered focus.

**How Will Shared Savings Work?**

Under the final rule, Medicare will continue to pay individual providers and suppliers for specific items and services as it currently does under the Medicare Fee-For-Service payment systems. CMS will also develop a benchmark for each ACO against which ACO performance is measured to assess whether it qualifies to receive shared savings, or for ACO’s that have elected to accept responsibility for losses, potentially be held accountable for losses. The benchmark is an estimate of what the total Medicare Fee-For-Service Parts A and B expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO, even if all of those services
were not provided by providers in the ACO. The benchmark will take into account beneficiary characteristics and other factors that may affect the need for health care services. This benchmark will be updated for each performance year within the agreement period.

CMS is implementing both a one-sided model (sharing savings, but not losses, for the entire term of the first agreement) and a two-sided model (sharing both savings and losses for the entire term of the agreement), allowing the ACO to opt for one or the other model for their first agreement period. CMS believes this approach will have the advantage of providing an entry point for organizations with less experience with risk models, such as some physician-driven organizations or smaller ACOs, to gain experience with population management before transitioning to a shared losses model, while also providing an opportunity for more experienced ACOs that are ready to share in losses to enter a sharing arrangement that provides a greater share of savings, but with the responsibility of repaying Medicare a portion of any losses.

CMS will also establish a Minimum Savings Rate (MSR) and a Minimum Loss Rate (MLR) to account for normal variations in health care spending. The MSR is a percentage of the benchmark that ACO expenditure savings must meet or exceed in order for an ACO to qualify for shared savings in any given year. Similarly, an ACO with expenditures at or above the MLR will be accountable for repaying shared losses. Under the final rule, ACOs in the one-sided model that have smaller populations (and having more variation in expenditures) will have a larger MSR and ACOs with larger populations (and having less variation in expenditures) have a smaller MSR. Under the two-sided model, CMS will apply a flat 2 percent MSR to all ACOs.

Under both models, if an ACO meets quality standards and achieves savings and also meets or exceeds the MSR, the ACO will share in savings, based on the quality score of the ACO. ACOs will share in all savings, not just the amount of savings that exceeds the MSR, up to a performance payment limit. Similarly, ACOs with expenditures meeting or exceeding the MLR will share in all losses, up to a loss sharing limit.

**ACOs that Participate in the Two-Sided Risk Model Can Obtain Greater Shared Savings**

To provide a greater incentive for ACOs to adopt the two-sided approach, the maximum sharing percentage based on quality performance is higher for the two-sided model. ACOs adopting this model will be eligible for a sharing rate of up to 60 percent, while ACOs in the one-sided model will be eligible for a sharing rate of up to 30 percent. Under both models, CMS will base the actual savings percentage for the individual ACO (up to the maximum for that model) on its performance score for the quality measures.

The final rule also provides a methodology for determining shared losses for ACOs in the two-sided model if the assigned beneficiary per capita cost is at least 2 percent higher than the benchmark. As with shared savings, the amount of shared losses will be based in part on the ACO’s quality
performance score. Additionally, CMS will limit losses by capping the ACO’s loss sharing rate at 60 percent and by limiting the dollar amount at 5 percent of the updated benchmark in the first year of the Shared Savings Program, 7.5 percent in the second year, and 10 percent in the third year.

**ACOs May Obtain the Maximum Sharing Rate in Their First Performance Year if They Successfully Report Quality Measures**

CMS is encouraging providers to participate in the Shared Savings Program by setting the quality performance standard to reporting only for the first performance year of the ACO’s agreement period and providing a longer phase in to performance over the second and third performance years. This means that ACOs will be eligible for the maximum sharing rate (60 percent for the two-sided model and 50 percent for the one-sided model) if the ACO generates sufficient savings and successfully reports the required quality measures. After the first year, the ACO must not only report but also perform well on selected quality measures. This flexibility will allow newly formed ACOs a grace period as they start up their operations and learn to work together to better coordinate patient care and improve quality.

**The Quality Measurement in the Final Rule Is Aligned with Other CMS Quality Initiatives**

CMS will measure quality of care using nationally recognized measures in four key domains: patient experience, care coordination/patient safety, preventive health, and at-risk population.

These measures are aligned with the measures in other CMS programs such as the Electronic Health Records (EHR) and Physician Quality Reporting System (PQRS). Eligible professionals in an ACO that successfully report the quality measures required under the Shared Savings Program in any year of the program will be deemed eligible for the PQRS bonus, regardless of whether the ACO qualifies to share in savings.

Providers and suppliers who are already participating in another shared savings program or demonstration under Fee-For-Service Medicare, such as the Independence at Home Medical Practice pilot program, will not be eligible to participate in a Shared Savings Program ACO.

**Existing Clinically Integrated Entities Need Not Form New Entities to Participate in the Shared Savings Program**

If a group of providers and suppliers are already a self-contained financially and clinically integrated entity that has a board of directors or other governing body, the organization need not form a separate governing body or create a new legal entity to participate in the Shared Savings Program. The existing organization, however, must be recognized under applicable State or tribal law, be capable of receiving and distributing shared savings and repaying shared losses, and meet the other ACO functions identified in the statute.
How ACOs Help Doctors Coordinate Care

Health care providers have reported that a barrier to improving care coordination is lack of information. While they may know about the services they provide to the beneficiary, they don't know about all other services provided to the beneficiary. To better treat patients and to coordinate their care, ACOs will be able to request Medicare claims information about their patient from CMS. Before doing so, ACOs must notify a beneficiary in writing that it will request the beneficiary's claims information from CMS. ACOs must allow beneficiaries to decline having their claims information shared with the ACO. Declining to have this information shared, however, does not affect the provider's participation in the ACO or CMS' use of the patient's data for the purpose of assessing ACO's performance on quality or cost measures. This notification may happen by mail but must also happen the first time an ACO practitioner provides a primary care service to the beneficiary.

Resources

The Shared Savings Program final rule can be downloaded at http://www.ofr.gov/inspection.aspx on the Internet.

It will appear in the November 2, 2011, issue of the "Federal Register." The Shared Savings Program will be established January 1, 2012.

For information about applying to participate in the Shared Savings Program, visit http://www.cms.gov/sharesavingsprogram on the CMS website.
This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.
Frequently Asked Questions for Office Managers

**Question #1: What is a Medicare ACO?**

**Answer:** ACO is the acronym for “Accountable Care Organization.” An ACO is an organization of providers that can include Primary Care Providers, specialists, suppliers, and hospitals. In an ACO, providers are responsible for reducing the cost of care and improving the quality of care for their patients.

The Centers for Medicare and Medicaid Services (CMS) has launched the “Medicare Shared Savings Program Accountable Care Organization (ACO);” this program focuses solely on Medicare fee-for-service beneficiaries.

**Question #2: What does an ACO do?**

**Answer:** ACOs in the “Medicare Shared Savings Program” have a three-part aim: (1) to improve patient care, (2) to improve population health, and (3) to reduce the cost of providing medical care. An ACO in the “Medicare Shared Savings Program” can achieve these goals in a variety of ways, including:

1. Coordinating care amongst providers through data sharing, Electronic Medical Records, or Health Information Exchanges
2. Engaging patients through websites or regular communications
3. Ensuring that patients receive appropriate wellness and preventative services
4. Coordinating care of patients with chronic illnesses like diabetes.

**Question #3: Our office is participating in the Medicare Shared Savings Program … now what?**

**Answer:** Early in the process, your provider will be asked to fill out a one-page survey with information such as their Tax Identification Number, NPI, and use of Electronic Medical Records and e-prescribe (if any). Your provider may also be asked to participate in the Atlantic ACO’s committees or workgroups.

CMS will ultimately give the Atlantic ACO a list of Medicare fee-for-service beneficiaries that the ACO will be responsible for.

You will continue to bill CMS as usual for your Medicare fee-for-service beneficiaries and you will continue to receive payments from CMS for those beneficiaries. Any payments associated with the “Medicare Shared Saving Program” will be paid-out at the end of each performance year in addition to your regular fee-for-service payments.

Your office will be required to post a notice to inform Medicare fee-for-service beneficiaries that you are participating in a “Medicare Shared Savings Program.”

The Atlantic ACO and /or you will also be required to notify your Medicare beneficiaries of the option to decline sharing their identifiable claims data with the ACO. These notifications will be provided to you by Atlantic ACO; you will not be asked to draft any materials.

While the day-to-day impact of participating in the “Medicare Shared Savings Program” will be minimal, success in the program will require high-achievement on quality metrics. Precise medical claims coding and record documentation will optimize your provider’s ability to successfully report quality metrics and appropriate care coordination. Your office will receive information from Atlantic ACO to help you in this effort. Your office will not be required to report any information to CMS directly; Atlantic ACO will collect all necessary information from your office and will report to CMS on your behalf.
Frequently Asked Questions for Providers

Question #1: What is an ACO?
Answer: ACO is the acronym for "Accountable Care Organization." An ACO is an organization of providers that can include Primary Care Providers, specialists, suppliers, and hospitals. In an ACO, participating providers are responsible for reducing the cost of care and for improving the quality of care for their patients.

The Centers for Medicare and Medicaid Services (CMS) has launched the "Medicare Shared Savings Program Accountable Care Organization (ACO);" this program focuses solely on Medicare fee-for-service beneficiaries. Many commercial payers are also interested in creating ACOs to encourage reduced cost and improved quality for their patients. The Atlantic ACO will be a vehicle for participating providers to contract with payers for value-based contracts with shared savings, gain sharing, and risk bearing models.

Question #2: How will I know which Medicare beneficiaries are in the ACO?
Answer: The "Medicare Shared Savings Program" will include all your Medicare fee-for-service beneficiaries. As a participating provider, you will continue to bill Medicare fee-for-service as usual. Any shared savings payments will be distributed after each performance year (beginning 1st quarter 2014) and will not impact your normal fee-for-service billing or payments received from the Centers for Medicare and Medicaid Services (CMS).

Question #3: How will the CMS determine which Medicare beneficiaries belong to my practice?
Answer: CMS will compile historical claims data for all Medicare fee-for-service beneficiaries in the Atlantic ACO service area. Then, CMS will review all primary care services furnished by providers. Beneficiaries will be attributed to Atlantic ACO if the plurality of allowable charges for primary care codes are provided by the ACO.

Question #4: Can beneficiaries decline to participate in the Atlantic ACO?
Answer: Once attributed to an ACO provider, the beneficiary can see any provider as part of their Medicare benefit. Beneficiaries may decline to share their medical claims data with the ACO. If the patient chooses to decline data sharing, the ACO will still be responsible for cost and quality metrics of the beneficiary but will not receive any identified claims information on them.

Question #5: What if one of my beneficiaries did not see me during the benefit year or goes to see another Primary Care Provider?
Answer: Medicare fee-for-service beneficiaries will not be restricted to ACO-only providers and may seek care wherever they wish. As such, some beneficiaries may switch providers during and throughout the performance year. To account for this activity, CMS will update Atlantic ACO’s beneficiary attribution quarterly. Providers will not be held accountable for quality and cost performance on beneficiaries that are removed from their attribution by CMS.

Question #6: How are the quality measures collected?
Answer: Quality metrics are collected in one of three ways: (1) medical claims data, (2) self-reporting, and (3) patient surveys.
Question #7: What Quality Measures will be reported to CMS? How will this be accomplished?

CMS has issued 33 quality measures for the "Medicare Shared Savings Program." The measures will be collected in one of three ways: (1) CAHPS Survey (no action required by provider to report), (2) claims data, or (3) self-reporting via GPRO. Below is a list of the quality measures; Atlantic ACO will also distribute a more detailed document regarding the quality measures and data collection:

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>DATA COLLECTION METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting timely care, appointments, and information</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>How well your doctors communicate</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Patients’ rating of doctor</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Access to specialists</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Health promotion and education</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Health status/functional status</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Risk-Standardization, All Condition Readmission</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Congestive Heart Failure (CHF) Admission Rate</td>
<td>NO ACTION REQUIRED BY PROVIDER TO REPORT</td>
</tr>
<tr>
<td>Medication Reconciliation after discharge from an Inpatient Facility</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Screening for Fall Risk</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Influenza Immunization</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Pneumococcal Vaccination</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Adult Weight Screening and Follow-up</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Tobacco Use Assessment and Tobacco Cessation Intervention</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Mammography Screening</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
<tr>
<td>Screening for High Blood Pressure</td>
<td>Medical Claims, Paper Medical Records, Electronic Medical Records, or Registry</td>
</tr>
</tbody>
</table>
Question #8: How much shared savings can I expect to receive?
Answer: A number of factors will influence shared savings distribution. First, the savings must be statistically significant, meaning that Atlantic ACO must save at least 2.0% to 3.9% of our benchmark (depending on the final number of attributed beneficiaries) to qualify for payment. Next, Atlantic ACO must have exceptional achievement on the quality metrics; poor performance on quality measures will reduce the payment that Atlantic ACO is eligible to receive. Atlantic ACO’s Regional Boards, in concert with the Atlantic Governing Board, will decide how to distribute shared savings to participating providers.

Question #9: I am part of a group practice. Can some providers in my practice join the ACO and others not?
Answer: No. CMS will track participation at the TIN level. This means that any provider billing with the group TIN will be included in the ACO.

Question #10: I’ve heard specialists can join more than one ACO. How does this work?
Answer: Yes, although there are instances where a specialist will only be able to join one ACO. If a beneficiary is not attributed to a Primary Care Provider, they may be attributed to a specialist. For a specialist to qualify as a Primary Care Provider, a beneficiary must not have received any primary care service from a Primary Care Provider but, rather, received a primary care service from a specialist. In this case, the beneficiary will be attributed to the specialist that received the plurality of charges for providing their primary care. If a specialist is attributed beneficiaries under this scenario, they must be exclusive to one ACO.

Question #11: Can I join an ACO after the application period?
Answer: Yes. However, providers that join an ACO after the application is submitted may not be attributed beneficiaries until the next performance year. As such, those providers may not be eligible for shared savings in the first performance year.

Question #12: How will joining an ACO impact my day-to-day office operations?
Answer: While the day-to-day impact of participating in the “Medicare Shared Savings Program” will be minimal, success in the program will require high-achievement on quality metrics. Precise medical claims coding and record documentation will optimize your provider’s ability to successfully report quality metrics. Your office will receive information from the Atlantic ACO to help you in this effort. Your office will not be required to report any information to CMS directly; the Atlantic ACO will collect all necessary information from your office and will report to CMS on your behalf.
Care Coordination Model

Primary Care Doctor

Beneficiary/Family/Caregivers

Community Resources
- Transportation
- Acute Rehab
- Sub-Acute Rehab
- Long Term Acute Care Hospital (LTACH)
- Long Term Care Facilities
- Hospice, Palliative, Comfort Care

Hospital
- Urgent Care
- Emergency Department

Outpatient Services
- Specialists & Centers of Excellence
- Home Care
- DME
- Private Duty Nursing

Pharmacy Services

Mental Health Care

Home

Care Coordination Center

atlanticaco.org

April, 2012
ACO
Care Coordination Center
855-ACO-7171

Care Coordinators
Nurse Navigators

Post Acute Facilities
Centers of Excellence
In-Patient Care ACO Care Manager
Physician Specialists
Complex Case Management

HOURS OF OPERATION
Monday – Friday 8am – 5pm and Saturday 9am – 3pm
Tel.: 855-ACO-7171; Fax: 973-379-8413
On-call services will be available
An on-call number will be provided on the voicemail that is reached after hours
Care Coordination Center
Description

The Care Coordination Center (CCC) will provide support and education to physicians, their office staff, and their patients regarding the Atlantic ACO Services and how to obtain easy access to those services.

The Care Coordination Center will also assist physicians with the management of their patients in order to ensure coordination and continuity of care.

The components of the Care Coordination Center will be the following:

› Post Acute Services
› Centers of Excellence
   - Heart Failure
   - Pulmonary
› In Patient Care Management
   - Dedicated Inpatient Care/Case Managers
› Information regarding Specialists
› Complex Care Management
   - Nurse Navigators
› Resource for Community Resources/System Resources

**Hours of Operation:**
Monday through Friday 8:00am to 5:00pm and Saturday 9:00am to 3:00pm. On-call services will be available. An on-call number will be provided on the voice mail that is reached after hours.

**The Care Coordination number is 855-ACO-7171.**
Care Coordination Center
Training Module

How To Activate Different Functions

Target Audience: Office Managers of participating ACO Physicians

Referrals TO the Care Coordination Center (CCC)
Why should you call?

Assistance with coordination of care, including
› Referrals to Centers of Excellence
› Heart failure
› COPD

Referrals for disease management
› Diabetes
› CAD
› Total Joint Replacement
› Complex wounds
› Homecare
› Outpatient Rehab
› Pain Management
› Lymphedema
› Geriatric Assessment
› Breast Cancer
› Stroke Center

Community Resources
Transportation issues
Noncompliance
› Assistance with medication management
› Education needed on disease management
› Poor adherence to self-management tasks

Overwhelmed caregiver
Unsafe in current living arrangement
High risk for avoidable hospitalization.

ANY general questions regarding ACO call: 855-ACO-7171

Referrals FROM the Care Coordination Center (CCC)
Why you may receive a call from the CCC…

Transition, care coordination
Patient identified in ED, in-patient or subacute rehab as “complex” and high risk for readmission.
Nurse navigator collaborates with PCP to identify problem areas and develop action plan
Nurse navigator assists with case management, if requested
Medication reconciliation. Simplifying medication regimen.
<table>
<thead>
<tr>
<th>Type</th>
<th>Where it is located</th>
<th>Who it services</th>
<th>What type of service</th>
<th>Cost to the patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subacute Rehabilitation (SAR)</td>
<td>Licensed skilled nursing facility (SNF)</td>
<td>-Patients who are unable to return home but no longer require acute care. Patients must have a skilled need.*&lt;br&gt;-Patients who have had certified acute nights in-patient hospital stay or discharged from the hospital within the last 30 days.</td>
<td>Skilled services include intensive physical, occupational or speech therapy; wound care; intravenous therapy or tube feeding.&lt;br&gt;-Patients must be able to tolerate 1 to 3 hours of therapy, a minimum of 5 days a week.</td>
<td>Medicare Part A pays for up to 100 days per benefit period as long as they meet skilled criteria. Days 1-20 are covered at 100%. Days 21-100 are partially covered.</td>
</tr>
<tr>
<td>Acute Rehabilitation</td>
<td>A hospital or licensed facility</td>
<td>-Patients who require intensive multidisciplinary therapy to regain function or skills lost to injury or disability&lt;br&gt;-Qualifying patients must have specific conditions. These diagnoses include: Stroke or other neurologic disorders; major multiple trauma; traumatic brain injury; orthopedic injury; joint replacement; amputation; spinal cord injury; arthritis; burns.</td>
<td>-Intensive multidisciplinary therapy&lt;br&gt;-Patient must be able to tolerate 3 hours of therapy (including physical, occupational and/or speech), 5 days a week.</td>
<td>Medicare Part A covers up to 150 days of inpatient hospital care within a benefit period as long as the covered days are medically necessary.</td>
</tr>
<tr>
<td>Long-term care</td>
<td>Skilled nursing facility (SNF)</td>
<td>-Patients who require daily care and are unable to live alone.</td>
<td>-Provides room, meals, recreation, social engagement and nursing care including medication management, wound care, and tube feeding. Some facilities care for patients that are ventilator dependent. Nurses’ aides are available 24/7 to assist with activities of daily living.&lt;br&gt;-Some facilities have units specialized in the care of patients with dementia.</td>
<td>-Is not covered under Medicare. Facilities may accept Medicaid.&lt;br&gt;-2010: Daily average nursing home rate (in NJ) for a private room is $307. ($112,055.00 per year)&lt;br&gt;-Daily average nursing home rate (in NJ) for a semi-private is $277. ($101,105.00 per year)</td>
</tr>
<tr>
<td><strong>Home care</strong></td>
<td><strong>Patient home or assisted living facility (ALF)</strong></td>
<td>Patients who are homebound (leave home infrequently and only able to leave the home with another person to obtain medical care) and require skilled nursing care.</td>
<td>-Provides visiting nurse service; rehabilitation therapy; disease management/telehealth; wound care; pain management; and referrals to community resources. -Provides Home health aide (under the supervision of a nurse) for a limited number of hours to assist with activities of daily living including bathing. The aide is not available for housekeeping or supervision. The aide can only be provided while the patient needs continued therapy or skilled nursing care.</td>
<td>-Covered under Medicare A as long as patient needs continued therapy or skilled nursing care and is homebound. -Patients will have a coinsurance for any Durable Medical Equipment (DME).</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td><strong>Patient home, assisted living facility (ALF) or skilled nursing facility (SNF)</strong></td>
<td>Patients who have a terminal illness with a life expectancy of less than 6 months.</td>
<td>-Provides nursing care, counseling (including bereavement), medical social services, chaplains, certified home health aides, medications to manage the patient's pain and symptoms, volunteers, and respite care for 5 days or less to provide relief to the caregiver.</td>
<td>-Covered under Medicare A.</td>
</tr>
<tr>
<td><strong>In-patient hospice</strong></td>
<td><strong>Hospital or long-term care facility</strong></td>
<td>Patient who meet qualifications for hospice.</td>
<td>-Provides pain control or symptom management (may include dyspnea, uncontrolled nausea/vomiting, severe agitation/delirium; acute anxiety or depression, recurrent seizures) that cannot be accomplished in a patient home, ALF or SNF.</td>
<td>-Covered under the hospice benefit.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Setting</td>
<td>Qualifications</td>
<td>Description</td>
<td>Cost Information</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------------</td>
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</tr>
<tr>
<td>Adult Day Care Center</td>
<td>Community based center</td>
<td>Qualifications depend on the individual center. For seniors living in the community</td>
<td>Provides an outlet for recreational activities, custodial care of seniors, and respite for caregivers. Most centers provide transportation and offer meals.</td>
<td>Not covered under Medicare. Cost varies widely depending on the level of services provided and charitable contributions. (NJ average cost is $81/day)</td>
</tr>
<tr>
<td>Adult Day Health Care Center</td>
<td>Community based center</td>
<td>Qualifications depend on the individual center. For seniors living in the community</td>
<td>Provides a program similar to the adult day care center but also provide elements of health care. Depending on the program this may include medication management, some physical therapy and skilled nursing care. Some programs cater specifically to individuals with dementia.</td>
<td>Not covered under Medicare. Cost varies widely depending on the level of services provided and charitable contributions. (NJ average cost is $81/day)</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>Provided in a residence</td>
<td>Patients who may require more assistance than can be provided in the home or are socially isolated.</td>
<td>Provides room, meals, assistance with activities of daily living, recreation, and medication management. Some facilities have an Alzheimer’s unit with trained staff and appropriate safety measures. ALFs are required to meet the needs of all patients 24 hours/day. NJ ALFs may not admit or keep a resident that requires a ventilator; is bedridden for more than two weeks; is a danger to self or others; needs two or more people to assist in moving or needs complete help with four or more ADLs.</td>
<td>Not covered under Medicare. Range in cost in the NJ is $2600 to $5600 per month ($31,200 to $67,200 per year)</td>
</tr>
<tr>
<td>Private services</td>
<td>Patient preference (can be at home, SNF, ALF, acute care setting)</td>
<td>Any patient that is contracted by the patient himself or caregiver</td>
<td>Services range from home health aide, nursing, physical therapy, respiratory therapy, alternative health therapists, geriatric care managers. Patients and caregivers often hire to meet services that are not considered a “skilled need” under Medicare.</td>
<td>Not covered under insurance. This may be a formal contract which is through a licensed agency and meets regulations (and restrictions to scope of practice) or a personal contact (informally labeled as the “gray market”). Some patients may have long-term care insurance which assists with the cost of a private home health aide. NJ State average is $20 to $25/hour for an aide. Most agencies require a minimum number of hours.</td>
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<tr>
<td>Durable Medical Equipment</td>
<td>Provided to patient home or ALF</td>
<td>Any patient that has a physician order</td>
<td>Examples include: walkers, wheelchairs, power scooters, hospital beds, home oxygen equipment, diabetes self testing equipment (and supplies), certain nebulizers (and medications)</td>
<td>Medicare will cover if the DME meets the following criteria: Medically necessary. Appropriate for home use. Likely to last for 3 years or more. Provided by Medicare approved supplier. Additional rules may apply. Contact DME supplier for current regulations. If patient qualifies for home health, Medicare may cover intravenous, wound care, catheter, and ostomy supplies.</td>
</tr>
</tbody>
</table>

**Medicare does not consider constant supervision, assistance in feeding, dressing, or medication management a skilled need**

**“Benefit period” is also known as “spell of illness”**
Services:
› Impedance cardiography (ICG), also known as thoracic electrical bioimpedance (TEB)—a non-invasive method of measuring changes in blood flow in the heart and lungs over time.
› Acoustic cardiography—a non-invasive technology that enables clinicians to integrate heart sounds and echocardiogram data to measure heart function and blood flow.
› Cardiopulmonary metabolic exercise stress testing (CMET)—a non-invasive test that measures heart, lungs and functional capacity at the same time, providing more comprehensive data than the standard treadmill stress test.
› Remote Fluid Status Monitoring—via telemonitoring or implantable cardiac monitoring surveillance
Transplant and VAD Evaluation
Referrals to Device Optimization
HF Research Trials
EKGs
› Extensive diagnostic services provided in collaboration with Gagnon.

Contact Information:
› Atlantic Health System Heart Success Program:
  973-971-4179, 8:00am to 4:00pm,
  Monday through Friday

Care Providers/Functions:
› Nurse Practitioners—Advance practice nurses, who have a dedicated personal relationship with patients to ensure adherence to treatment plan. Provide heart failure screening and manage patients accordingly. Assist with medication management. Perform urgent visits for symptomatic callers, which prevent hospital admission by interventions such as administering IV diuretics. Educate patients regarding disease process. Maintain communication with PCP and other specialists.
› Registered Nurses—Serves as the first line of communication with the patients and families and prioritizes needs to be addressed by the appropriate providers. Provides tailored education at each patient/family encounter and assesses for gaps in knowledge and barriers to adherence.
› CNS—The Clinical Nurse Specialist functions as an advanced practice nurse (APN) with advanced assessment skills. The CNS has an expertise in process management and functions as our transitional care facilitator.
› Telehealth—Works in conjunction with Atlantic Homecare to monitor patients in their home and notify MD as needed.
› Implantable Cardiac Monitoring Center—RN/APN monitors ICD readings of Thoracic Impedance, Daily HR averages, HRV (etc)
› Discharge Clinic—Patients at high risk for readmission are followed by an NP until patient is seen by the PCP.

Suggestions for Referral to Heart Success:
› Patients readmitted within 6 months for heart failure
› Knowledge Deficits regarding disease process and medication/dietary management
› Failure to respond to diuretic therapy
› NYHA Class III/IV patients requiring more intense monitoring
› Patients being considered for chronic inotropic therapy

Performance Measures:
› NYHA class
› KCQL/ MLWHF
› Readmission rate: 5-7% for patients under long-term clinical management by Heart Success
› 6 minute walk distance
› ACEi/ARB use
› β blocker use
› Use of ICD/CRT
› MVO₂ on select patients
Valley Hospital Heart Failure Program

Services:
› Cardiac MRI—non-invasive test to look for tissue viability and evidence of scar/old MI as well as tissue analysis (Amyloid, Sarcoid etc.)
› Blood Volume Analysis—determination of intravascular fluid status to help gauge diuretic and hematologic therapy in Heart Failure patients
› Remote Fluid Status Monitoring—via telemonitoring or implantable cardiac monitoring surveillance
› Referrals to Device Optimization/ AICD/CRT
› HF Research Trials
› EKGs
› Extensive diagnostic services provided in collaboration with Gagnon.
› Outpatient Heart Failure Program for those patients with multiple readmissions or at high risk for readmissions for early intervention and ongoing education
› Transitions program with Van Dyk subacute facility to provide rehab as well as early intervention to reduce 30 day readmissions in the cardiopulmonary population

Contact Information:
The Valley Hospital Heart Failure Program:
201-447-8284 or 201-448-2621, 7:30am to 4:30pm Monday through Friday

Care Providers/Functions:
› Nurse Practitioners (Inpatient and Outpatient Program)—Advanced practice nurses who have a dedicated personal relationship with patients to ensure adherence to treatment plan. Provide heart failure screening and manage patients accordingly. Assist with medication management. Perform urgent visits for symptomatic callers, which prevent hospital admission by interventions such as administering IV diuretics. Educate patients regarding disease process. Maintain communication with PCP and other specialist. Much attention to Medication reconciliation. Partnership with Valley Home Care creating cardiac specialist that perform home visits, communicate with APNs via email, phone, or telemanagement program for early intervention
› CNS—The Clinical Nurse Specialist functions as an advanced practice nurse (APN) with advanced assessment skills. The CNS has an expertise in process management and functions as our transitional care facilitator.
› Telemanagement—Works in conjunction with Valley Homecare to monitor patients in their home and notify MD as needed.
› Valley’s Electrophysiology Center—works in conjunction with the Valley Heart Failure Program to provide state of the art Heart Failure therapies
› Transitions Program—close the look for patients from Hospital to Subacute to Home with Home Care with goals to reduce all cause 60 day readmissions for the Cardiopulmonary patient population by way of APN, RN and MD communication and early intervention at all transition points along the continuum of care

Suggestions for Referrals to the Heart Failure Program:
› Patients readmitted within 6 months for Heart Failure
› Knowledge Deficits regarding disease process and medication/dietary management
› Failure to respond to oral diuretic therapy
› NYHA Class III/IV patients requiring more intense monitoring
› Patients being considered for chronic inotropic therapy

Performance Measures:
› NYHA class
› Readmission rate: 60% reduction in overall readmissions and a 39% reduction in 30 day readmissions over 3 year period for patients under long-term clinical management by The Valley Outpatient Heart Failure Program
› ACEI/ARB use
› β blocker use
› Use of ICD/CRT
› HF Education provided by Valley Hospital Staff, 100% compliance
› Flu/Pneumonia vaccine for all qualifying Heart Failure patients
Ms. A. is identified on Gagnon 1 as a patient who meets the criteria for a Heart Success consult. The nurse navigator contacts the primary MD on Ms. A.’s case to discuss if they are agreeable to a Heart Success consult. The decision is made to have the Heart Success NP meet the patient in consultation and the nurse navigator contacts Heart Success with the official referral. The Heart Success NP meets the patient within 24 hours of the initial consultation and makes recommendations related to the patients’ care. The Heart Success NP then requests an education consult with a specialized heart failure RN. Discharge planning is addressed with the multidisciplinary care team and a plan is made to send the patient home with home services to include telehealth monitoring. The patient (when medically appropriate) is then discharged home with an appointment to see the Heart Success NP within 5-7 days post-discharge in addition to their follow-up care with the physician and home care services.

As an outpatient, Ms. A. is seen in follow-up with the Heart Success NP and is found to be 5 lbs overweight since hospital discharge. The NP assesses the patient to be volume overloaded and adds additional oral diuretics over the next 48 hours. Multidisciplinary services including (but not limited to) the PharmD and Registered Dietician provide further reinforcement of medication regimen and dietary modifications adherence. After the visit, the Heart Success NP sends a copy of their clinical visit note to the primary/referring physician.

Case Study: Nurse Practitioner Interventions

› Ms. A., admitted for exacerbation of heart failure, is identified on Gagnon 1 as a patient who meets the criteria for a Heart Success consult, having been discharged one month prior for heart failure.

› The nurse navigator contacts the primary MD on Ms. A.’s case to discuss if they are agreeable to a Heart Success consult. The decision is made to have the Heart Success NP meet the patient in consultation and the nurse navigator contacts Heart Success with the official referral.

› The Heart Success NP meets the patient within 24 hours of the initial consultation and makes recommendations related to the patients’ care.

› The Heart Success NP then requests an education consult with a specialized heart failure RN.

› Discharge planning is addressed with the multidisciplinary care team and a plan is made to send the patient home with home services to include telehealth monitoring.

› The patient (when medically appropriate) is then discharged home with an appointment to see the Heart Success NP within 5-7 days post-discharge in addition to their follow-up care with the physician and home care services.

› As an outpatient, Ms. A. is seen in follow-up with the Heart Success NP and is found to be 5 lbs overweight since hospital discharge.

› The NP assesses the patient to be volume overloaded and adds additional oral diuretics over the next 48 hours.

› Multidisciplinary services including the PharmD and Registered Dietician provide further reinforcement of medication regimen and dietary modifications adherence on the same visit.

› After the visit, the Heart Success NP sends a copy of their clinical visit note to the primary/referring physician.

› Follow up phone call is made to the patient the following day by Heart Success RN and case is discussed with homecare.
Services:
› Pulmonary Function Testing and Screening
› Tobacco Use Assessment and Intervention
› Tele Health Monitoring (not Valley)
› Home Care Service
› Six Minute Walk Tests
› Pulmonary Rehabilitation (not Valley)
› Cardio-Pulmonary Stress Testing
› High Altitude Studies (not Valley)
› Arterial Blood Gas Testing
› Radiographic Studies
› Computerized Tomography (CT) Screening Scan
› Sleep Disorder Testing
› Vaccines – Flu and Pneumonia
› Flexible and Rigid Bronchoscopy
› Brachytherapy
› Bronchial Stents
› Genetic Testing
› Support Groups for Lung Cancer and Pulmonary Fibrosis (not Valley)
› Support Groups for Sleep Disordered Breathing and Chronic Obstructive Pulmonary Disease (COPD)

Hours of Operation:
› Atlantic Health System: 8:00am to 4:00pm, Monday through Friday
› Valley Hospital: 8:00am to 4:30pm, Monday through Friday

Contact Information:
› Atlantic Health System Pulmonary Center of Excellence: 866-961-8006 pulmonarycenter@atlantichealth.org
› Valley Hospital: 201-447-8673

Care Providers/Functions:
› Nurse Navigator—Guides pulmonary patients through various components of care in a timely and efficient manner, linking patients and their families with the appropriate health care providers and services.
› Respiratory Therapists—Performs diagnostic testing and treats patients with breathing or cardiopulmonary disorders. Ensures patients and their families have sufficient knowledge of their pulmonary disease, educates on the proper use of medication and equipment. Visits patients in their homes to evaluate the home environment.
› Registered Nurses—Delivers patient focused holistic care including assessment, diagnosis, planning, intervention/implementation, evaluation. Provides health care to patients, families and communities. Educates patients on their disease and provides services designed to promote a health, prevent illness, and achieve optimal recovery.
› Nurse Practitioners—Registered nurses who have advanced education, skills and training in caring for pulmonary patients.
› Registered Polysomnography Technologist—Performs overnight sleep studies on patients with suspected sleep disorders. Provides education and support with CPAP therapy.
› Clinical Social Workers—Works with patients and families to meet short and long term care needs; provides counseling and resources to meet physical and emotional needs.
› Nutritionists—Plans programs and educates patients about healthful eating habits and ideal nutritional intake.
› Physical Therapists—Works with pulmonary patients to restore their physical mobility. Develops and executes exercises that improve range of motion, muscle strength, coordination, endurance and motor skills.
› Case Managers—Works with pulmonary patients and assesses their conditions and needs to develop personalized care plans and discharge planning. Educates patients and their families on how to follow their care plans and addresses psychosocial needs based on family, individual and environmental factors.

Suggestions for Referrals to the Pulmonary Center:
› COPD Population Screener given to patients > 40 years old with a 10 pack/year smoking history with a cough and/or dyspnea. Screening score of ≥ 5 triggers a spirometry test
› Spirometry results of FEV1/FVC of <0.70 requires further workup
› CAT Assessment score (done on known COPD patients) of ≥ 10 triggers intervention
› STOP BANG Sleep Apnea Screening score of ≥ 3 yes answers triggers a sleep disorder assessment

Performance Measures:
› Reduce/eliminate preventable/avoidable COPD readmissions
› Reduce COPD length of stay below the national benchmark
› 80% of eligible patients screened for COPD using population screener
› 75% completion compliance of enrolled smoking cessation program participants
Complex Patient Care Management
Pulmonary Case Study

Mr. J.S. is an overweight 65 year old male who has had a history of cigarette smoking dating back to age 15. Although he was becoming aware of increasing episodes of shortness of breath and cough, he had not been able to stop smoking on his own and was reluctant to seek further evaluation. Mr. J.S. is still working and has not been to a doctor in several years. He was somewhat surprised and frightened to see that when he developed what he felt was a routine upper respiratory infection, that he rapidly became troubled by increasing shortness of breath, worsening cough and sputum production. He was evaluated by his primary care physician who found him to be in significant respiratory distress with wheezing and low grade fever. Hospitalization was recommended with which he was in agreement.

While in the hospital, he was assessed by the respiratory therapy team and started on nebulized medication. He required antibiotics, nicotine replacement and corticosteroids. He was also placed on the hyperglycemia protocol and his blood glucose was well controlled. He had a bedside spirometry done that categorized him as GOLD 2 – Moderate. He was gratified to see that within several days his symptoms were improving. He was able to be switched over from nebulized medications to a meter dose inhaler. This technique was taught with return demonstrations from the patient. It was noted that he had episodes of obstructive snoring and nocturnal desaturations. The patient was given the STOP BANG test and the decision was made for him to have an outpatient sleep study. Mr. J.S. also had episodes of decreased oxygen desaturations with dyspnea while walking in the halls. He admits to a sedentary lifestyle due to dyspnea so he was referred for pulmonary rehabilitation. He had further evaluation by the smoking cessation specialist and although skeptical, agreed to enroll in the upcoming smoking cessation outpatient program. A CAT score was completed at discharge and although his symptoms improved, he was classified as a GOLD 1-2.

Mr. J.S. was discharged to home with prescriptions for medications along with referrals for a sleep study, pulmonary rehabilitation, and smoking cessation. He was also instructed to make a follow up appointment in 5 days with his primary care provider. Based on his COPD staging of moderate, he was placed on home monitoring.

The Homecare nurse visited Mr. J.S. two days after discharge and discovered that he did not fill one of his prescriptions and he forgot to take the evening dose of two meds. He was taking the steroids but since he lives alone, he hadn’t gotten out to grocery shop and has been eating pasta, ice cream and cookies. The nurse checked his glucose and found it to be elevated. Mr. J.S. expressed feelings of isolation and has resumed smoking. A depression screen was performed with Mr. J.S. showing evidence of depression. He had not made his follow up appointment with the doctor.

Case Study: Nurse Navigator Interventions
› Receives notification that Mr. J.S. is in the hospital from the dedicated Inpatient Care/Case Manager
› Meets Mr. J.S. in the hospital and collaborates with the attending physician to ensure a clear discharge plan and appropriate follow-up.
› Collaborates with Home Care that home monitoring (Tele Health) will be instituted with appropriate follow up.
› Receives contact from the visiting nurse that Mr. J.S. missed doses of medication and did not fill a prescription, has elevated blood glucose, has resumed smoking and show evidence of depression.
› Collaborates with the visiting nurse to review medication management, dietary teaching, depression management, and physician follow up appointment.
› Identifies that Mr. J.S. may not follow up with smoking cessation, sleep study, or pulmonary rehabilitation
› Case conference with the PCP to review goals of care and assist with any issues concerning care coordination.
STOP BANG Questionnaire

Height _____ inches/cm Weight _____ lb/kg
Age _____
Male/Female
BMI _____
Collar size of shirt: S, M, L, XL, or _____ inches/cm
Neck circumference* _____ cm

1. Snoring
Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes  No

2. Tired
Do you often feel tired, fatigued, or sleepy during daytime?
Yes  No

3. Observed
Has anyone observed you stop breathing during your sleep?
Yes  No

4. Blood pressure
Do you have or are you being treated for high blood pressure?
Yes  No

5. BMI
BMI more than 35 kg/m²?
Yes  No

6. Age
Age over 50 yr old?
Yes  No

7. Neck circumference
Neck circumference greater than 40 cm?
Yes  No

8. Gender
Gender male?
Yes  No

* Neck circumference is measured by staff

High risk of OSA: answering yes to three or more items
Low risk of OSA: answering yes to less than three items

Adapted from:
STOP Questionnaire
A Tool to Screen Patients for Obstructive Sleep Apnea
Anesthesiology 2008, 108:812-21 Copyright © 2008, the American Society of Anesthesiologists, Inc. Lippincott Williams & Wilkins, Inc.
COPD Population Screener™ (COPD-PS)

This survey asks questions about you, your breathing, and what you are able to do. To complete the survey, mark an X in the box that best describes your answer for each question below.

1. During the past 4 weeks, how much of the time did you feel short of breath?

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2. Do you ever cough up any "stuff," such as mucus or phlegm?

<table>
<thead>
<tr>
<th></th>
<th>No, never</th>
<th>Only with occasional</th>
<th>Yes, a few days a month</th>
<th>Yes, most days a week</th>
<th>Yes, every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

3. Please select the answer that best describes you in the past 12 months. I do less than I used to because of my breathing problems.

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

4. Have you smoked at least 100 cigarettes in your ENTIRE LIFE?

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

5. How old are you?

<table>
<thead>
<tr>
<th>Age 35 to 49</th>
<th>Age 50 to 59</th>
<th>Age 60 to 69</th>
<th>Age 70+</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

How to score the survey: In the spaces below, write the number that is next to your answer for each of the questions. Add the numbers to get the total score. The total score can range from 0 to 10.

\[ \#1 + \#2 + \#3 + \#4 + \#5 = \text{TOTAL SCORE} \]

If your total score is 5 or more, your breathing problems may be caused by chronic obstructive pulmonary disease (COPD). COPD is often referred to as chronic bronchitis and/or emphysema and is a serious lung disease that slowly gets worse over time. While COPD cannot be cured, it is treatable.

Please share the completed survey with your clinician. The higher your score, the more likely you are to have COPD. Your clinician can help evaluate your breathing problems by performing a simple breathing test, also known as spirometry.

If your total score is between 0 and 4, and you experience problems with your breathing, please share this survey with your clinician. Your clinician can help evaluate any type of breathing problem.

The COPD Alliance advocates using this and other validated screeners for the early detection of COPD in at-risk populations.
How is your COPD? Take the COPD Assessment Test® (CAT)

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your wellbeing and daily life. Your answers, and test score, can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, place a mark (X) in the box that best describes you currently. Be sure to only select one response for each question.

**Example:** I am very happy 0 1 2 3 4 5 I am very sad

<table>
<thead>
<tr>
<th>I never cough</th>
<th>0 1 2 3 4 5</th>
<th>I cough all the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have no phlegm (mucus) in my chest at all</td>
<td>0 1 2 3 4 5</td>
<td>My chest is completely full of phlegm (mucus)</td>
</tr>
<tr>
<td>My chest does not feel tight at all</td>
<td>0 1 2 3 4 5</td>
<td>My chest feels very tight</td>
</tr>
<tr>
<td>When I walk up a hill or one flight of stairs I am not breathless</td>
<td>0 1 2 3 4 5</td>
<td>When I walk up a hill or one flight of stairs I am very breathless</td>
</tr>
<tr>
<td>I am not limited doing any activities at home</td>
<td>0 1 2 3 4 5</td>
<td>I am very limited doing activities at home</td>
</tr>
<tr>
<td>I am confident leaving my home despite my lung condition</td>
<td>0 1 2 3 4 5</td>
<td>I am not at all confident leaving my home because of my lung condition</td>
</tr>
<tr>
<td>I sleep soundly</td>
<td>0 1 2 3 4 5</td>
<td>I don’t sleep soundly because of my lung condition</td>
</tr>
<tr>
<td>I have lots of energy</td>
<td>0 1 2 3 4 5</td>
<td>I have no energy at all</td>
</tr>
</tbody>
</table>

COPD Assessment Test and CAT logo is a trademark of the GlaxoSmithKline group of companies. © 2009 GlaxoSmithKline. All rights reserved.
Care Coordination
Inpatient Care Transitions

ACO Patient Transitions to Inpatient Care From:

Home to ED:
› ED MD obtains and reviews patient’s previous medical records
› ED MD verbally communicates with PCP
› Medication Reconciliation completed
› Patient admitted to inpatient care

PCP Office to ED:
› PCP verbally communicates to ED MD
› ED MD verbally communicates with PCP re: admission
› ED MD obtains and reviews patient’s previous medical records
› Medication Reconciliation completed
› Patient admitted to inpatient care

Home Care to ED:
› Visiting Nurse verbally communicates with PCP re: patient’s acute needs
› Visiting Nurse verbally communicates with ED MD re: patient’s acute needs
› Universal Transfer Form completed sent with patient to ED
› ED reviews Home Care records and Universal Transfer Form
› ED obtains and reviews patient’s previous medical records
› Medication Reconciliation completed
› Patient admitted to inpatient care

Post-Acute Facility to ED:
› Facility MD/RN verbally communicates PCP within 24 hours.
› Facility MD/RN verbally communicates with ED MD re: patient’s acute needs
› Universal Transfer Form completed and Facility records sent with patient to ED
› ED reviews Universal Transfer Form including medication list
› ED obtains and reviews patient’s previous medical records
› Medication Reconciliation completed
› Patient admitted to inpatient care

Nurse Navigator-Emergency Department
› Collaborate with PCP, emergency physician and case manager to identify complex patients. Assist complex patients in the transition back to the community including: medication reconciliation, referrals to appropriate community resources, and follow-up with PCP.

ACO Patient Admitted to Inpatient Care
› Attending Physician verbally communicates with PCP
› Dedicated Inpatient Care/Case Manager receives notification of ACO patient admission
  - Communicates and coordinates with Attending Physician and multidisciplinary team to ensure daily coordination of care to meet patient’s identified acute care needs.
  - Utilizes established criteria/triggers to refer patient to Centers of Excellence (Heart Failure or Pulmonary) for patient/family education
  - Facilitates completion of transitions assessment to determine readmission risk
  - ACO CM and SW (unit-based) collaborate with Nurse Navigator to develop and facilitate the Discharge/Transition Plan
  - Refers High Risk/complex care patients to Nurse Navigator for ongoing follow-up post discharge

› Nurse Navigator communicates/collaborates with PCP, Attending Physician and multidisciplinary team to develop and facilitate transition/discharge plan for high risk/complex patients
  - Ensures follow-up appointments are scheduled prior to discharge
  - Ensures accurate and complete Medication Reconciliation
  - Ensures completion of patient discharge education/instructions

- After case conference with PCP the following services may be provided:
  • Comprehensive Geriatric Assessment
  • Complete Medication Reconciliation
  • Home Visits post discharge
**ACO Patient Transitions from Inpatient Care To:**

**Inpatient to Home with PCP Follow-up:**
› Upon Discharge patient/family given:
  - Actionable Discharge Instructions including complete & accurate Medication List
  - Scheduled Follow-up Appointments
  - Transportation for follow-up appointments addressed before discharge
› Follow-up Phone call (initial & ongoing based on acuity) to assess self management and answer questions related to care management within 48 hours
› Attending Physician communicates verbally with PCP to review hospitalization.
› Attending Physician dictates problem oriented Discharge Summary within 24 hours of discharge
  - Discharge Summary available to PCP before patient’s scheduled follow-up appointment

**Inpatient to Home with Home Care Follow-up:**
› Upon Discharge patient/family given:
  - Actionable Discharge Instructions including complete & accurate Medication List
  - Scheduled Follow-up Appointments
  - Transportation for follow-up appointments addressed before discharge
› Follow-up Phone call (initial & ongoing based on acuity) to assess self management and answer questions related to care management.
› Attending Physician communicates verbally with PCP to review hospitalization.
› Attending Physician dictates problem oriented Discharge Summary within 24 hours of discharge
  - Discharge Summary available to PCP before patient’s scheduled follow-up appointment

**Inpatient to Post Acute Facility:**
› Upon Discharge patient/family given:
  - Actionable Discharge Instructions including complete & accurate Medication List
› Attending Physician communicates verbally with PCP to review hospitalization.
› Attending Physician dictates problem oriented Discharge Summary within 24 hours of discharge
  - Discharge Summary available to the Post Acute facility at discharge
› Attending Physician signs Face-to-Face form prior to discharge
› Universal Transfer Form completed and available to the Post Acute Facility at discharge
› ACO CM ensures verbal handoffs to Post Acute Facility to answer questions related to the patients post acute needs and enhance continuity of care.

**Inpatient to Post Acute Facility:**
› Prior to discharge Home Care Liaison contacts patient/family to ensure continuity of care
› Attending Physician signs Face-to-Face form prior to discharge
Atlantic ACO
Examples Of Specialists

• Anesthesiology
• Cardiology
• Dermatology
• Emergency Medicine
• General Surgery
• Hospitalists
• Nephrology
• Neurology
• OB/GYN
• Ophthalmology
• Orthopedics
• Pathology
• Pediatrics
• Plastic Surgery
• Podiatry
• Psychiatry
• Pulmonary / Sleep
• Radiation Oncology
• Radiology
• Rheumatology
• Urology
Nurse Navigator

Goals: Remove barriers to care; coordinate care; facilitate in the transition between care centers.

Services:

1. In-patient/acute care (Referred by the dedicated in-patient ACO Care/Case Manager)
   a. Collaborate with PCP, Attending Physician and multidisciplinary team to develop and facilitate discharge plan. For these complex patients the NN will
      i. Ensure follow-up appointments are scheduled prior to discharge
      ii. Ensure accurate and complete Medication Reconciliation
      iii. Ensure completion of patient discharge education/instructions.
   b. After case conference with PCP the following services may be ordered:
      i. Comprehensive Geriatric Assessment
      ii. Complete Medication Reconciliation
      iii. Home Visits post discharge

2. Emergency Department
   a. Collaborate with PCP, emergency physician and case manager to identify complex patients. Assist complex patients in the transition back to the community including: medication reconciliation, referrals to appropriate community resources, and follow-up with PCP.

3. Post-acute/community care (Referred by the physician or identified by the Care Coordinator as a complex patient)
   a. Telephone conference with all involved parties (may include homecare, community services, Centers for Excellence, specialists) to identify gaps and overlaps in care.
   b. Telephone conference (or meet at patient home if indicated) to discuss patient and caregiver primary concerns. Establish and understand patient’s goals of care. Identify areas of concern for all parties.
   c. Relay findings to PCP and collaborate on appropriate, efficient, safe plan that meets a patient’s unique needs.
   d. Communicate findings with all involved parties and make contact with additional resources if indicated.

4. On-going
   a. Follow-up with patients and/or caregivers depending on Nurse Navigator’s assessment, determined risk of patient acuity and likelihood of readmission. The physician may request that specific patients receive follow up if there is a change in patient status.
   b. Provide essential information regarding the patient to prevent duplication of services, in the event a patient is readmitted to the hospital.
   c. Serve as a community resource for geriatric care delivery and education on geriatric syndromes.
Nurse Navigator Referrals

Dedicated Inpatient Care/Case Manager: Contact Care Coordination Center if YOUR ACO patient has had:

A prior hospitalization in last 6 months (non-elective) AND 2 other risk factors listed below

OR

3 of the risk factors listed below

1. Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin and clopidogrel dual therapy, digoxen, narcotics)
2. Psychological (depression screen positive or h/o depression diagnosis)
3. Principal diagnosis (cancer, stroke, DM, COPD or heart failure)
4. Polypharmacy (> 7 more routine meds)
5. Poor health literacy (inability to do Teach Back)
6. Patient support (absence of caregiver to assist with discharge and home care)
7. Palliative care (Would you not be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either question.

If the patient does not meet these criteria, but you have concerns about patient follow-up after discharge because of the following reasons:

› Noncompliance
› Caregiver overwhelmed
› Patient is unsafe
› Patient leaves AMA

Call the Care Coordination Center at 855-ACO-7171
An 82 year old male, “Mr. Jones” is admitted to the hospital for shortness of breath. Significant medical history includes: hypertension, hyperlipidemia, BPH, and emphysema.

Mr. Jones is diagnosed with a COPD exacerbation and pneumonia. The hospital course is complicated by new atrial fibrillation. Mr. Jones is instructed at discharge to resume all medications; start Coumadin; complete course of Levaquin; and begin oxygen 2 L via nasal cannula continuous. Mr. Jones is told that a visiting nurse will be seeing him at the home and that he should follow up with his cardiologist for monitoring of his INR in 1 week. Mr. Jones is discharged on a Thursday.

On Friday the nurse visits Mr. Jones to complete the admission to homecare. Mr. Jones is taking his medications as prescribed and states that he is feeling much better sleeping in his own home. The nurse observes that the patient is alone with only support from an elderly neighbor. The patient is short of breath walking around the home and the nurse notes that the patient is unable to climb the stairs. The patient states that he sleeps in his recliner chair and he does not need to go up to his bedroom. The nurse follows up with the doctor’s office after the visit, but the office is closed and will reopen on Monday. The nurse leaves a message.

On Monday the nurse speaks with the office staff who arranges an appointment for the patient to be seen by cardiologist on Wednesday for his INR check. The patient is seen by visiting nurse on Tuesday. Lung sounds are clear to auscultation and again the patient states that he is doing well. Patient appears that he may need a bath but otherwise progressing well. Physical therapy should see the patient on Thursday.

The nurse goes to the patient home again on Friday. The patient states that he did not go to his appointment. He insists that he called the office and provided all relevant insurance information so he did not need to go in person. The nurse explains that INR is not related to his insurance and that it is a blood test. The nurse contacts the office and receives orders to check patient’s INR by the visiting nurse on Monday.

On Sunday the patient falls (tripping over his oxygen tubing) and is admitted to the ED. His INR is 6.0 and he is diagnosed with an intracranial hemorrhage. Hospital stay is complicated by delirium. He is placed on 1 to 1 observation and encouraged to stay in the geri-chair for long periods to prevent a fall. Mr. Jones develops a stage 2 pressure ulcer and is ultimately discharged to subacute rehab. After 40 days in subacute rehab, the patient is able to return home. However, he is not safe alone. He cannot bathe himself; he is forgetful and likely to leave the stove on. He has difficulty transferring out the chair independently and is at high risk for further skin breakdown. The patient insists on returning home but states that he cannot afford a private aide. The staff is not sure what do to do next with Mr. Jones.

Case Study: Nurse Navigator Interventions

› Receives notification that Mr. Jones is in the hospital from the ACO Care/Case Manager and at high risk for readmission (determined by the transitions assessment).

› Meets Mr. Jones in the hospital and collaborates with the attending physician to ensure a clear discharge plan and appropriate follow-up.

› Identifies that Mr. Jones is likely to miss follow-up appointments (lack of caregiver support, impaired functional status, low health literacy, and transportation issues).

› Contacts the physician following the INR levels and obtains orders for the visiting nurse to check INR level at the patient home.

› Collaborates with the visiting nurse to begin teaching on oxygen safety and Coumadin.

› Refers patient to community resources to assist with meal delivery, transportation to medical appointments, and programs to prevent social isolation.

› Case conference with the PCP to review goals of care and assist with any issues concerning care coordination and management of geriatric syndromes.
Improving Quality of Care for Medicare Patients: Accountable Care Organizations

FACT SHEET

http://www.cms.gov/sharedsavingsprogram

Overview

On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health & Human Services (HHS), finalized new rules under the Affordable Care Act to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including doctor’s offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

In developing this final rule, CMS worked closely with agencies across the Federal government to ensure a coordinated and aligned inter- and intra-agency effort to facilitate implementation of the Shared Savings Program.

CMS encourages all interested providers and suppliers to review this final rule and consider participating in the Shared Savings Program.

This fact sheet describes the quality measures and the method for scoring an ACO’s performance for purposes of meeting the quality performance standard under the Shared Savings Program.

ACO Final Quality Measures and Performance Scoring Methodology

Quality Measures: The final rule adopts 33 individual measures of quality performance that will be used to determine if an ACO qualifies for shared savings. These 33 measures span four quality domains: Patient Experience of Care, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population. The list of measures is included as an appendix to this fact sheet.
The ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System and the Electronic Health Record (EHR) Incentive Programs. The ACO quality measures also align with the National Quality Strategy and other HHS priorities, such as the Million Hearts Initiative.

In developing the final rule, CMS listened to industry concerns about focusing more on outcomes and considered a broad array of measures that would help to assess an ACO’s success in delivering high-quality health care at both the individual and population levels. CMS also sought to address comments that supported adopting fewer total measures that reflect processes and outcomes, and aligning the measures with those used in other quality reporting programs, such as the Physician Quality Reporting System.

**Reporting:** The measures will be reported through a combination of a web interface designed for clinical quality measure reporting and patient experience of care surveys. In addition, CMS claims and administrative data will be used to calculate other measures in order to reduce administrative burden. CMS will also administer and pay for the patient experience of care survey for the first 2 years of the Shared Savings Program, 2012 and 2013. ACOs will be responsible for selecting and paying for a CMS-certified vendor to administer the patient survey beginning in 2014.

While an ACO’s first performance year for shared savings purposes would be 18 or 21 months, depending on the start date, quality data will be collected on a calendar year basis, beginning with the reporting period ending December 31, 2012.

**Quality Performance Scoring:** As required by the Affordable Care Act, before an ACO can share in any savings created, it must demonstrate that it met the quality performance standard for that year.

For the first performance year, CMS is defining the quality performance standard at the level of complete and accurate reporting for all quality measures. During subsequent performance years, the quality performance standard will be phased in such that ACOs must continue to report all measures but will eventually be assessed on performance.

Pay for performance will be phased in over the ACO’s first agreement period as follows:

- **Year 1:** Pay for reporting applies to all 33 measures.
- **Year 2:** Pay for performance applies to 25 measures. Pay for reporting applies to eight measures.
- **Year 3:** Pay for performance applies to 32 measures. Pay for reporting applies to one measure that is a survey measure of functional status. CMS will keep the measure in pay for reporting status for the entire agreement period. This will allow ACOs to gain experience with the measure and will provide important information to them on improving the outcomes of their patient populations.

CMS intends to establish national benchmarks for ACO quality measures and will release benchmark data at the start of the second performance year when the pay for performance phase-in begins. For pay for performance measures, the minimum attainment level will be set at a national 30 percent or the national 30th percentile of the performance benchmark. Performance benchmarks will be
national and established using national Fee-For-Service (FFS) claims data, national Medicare Advantage (MA) quality reporting rates, or a flat national percentage for measures where MA or FFS claims data is not available. Performance equal to or greater than the minimum attainment level for a measure will receive points on a sliding scale based on the level of performance. Performance at or above 90 percent or the 90th percentile of the performance benchmark will earn the maximum points available for the measure.

The diabetes and Coronary Artery Disease (CAD) composite measures will each receive the maximum available points if all criteria are met and zero points if one or more of the criteria are not met. The EHR Incentive Programs participation measure will be double-weighted in order to encourage EHR adoption.

CMS will add the points earned for the individual measures within each domain and divide by the total points available for the domain to determine each of the four domain scores. The domains will be weighted equally and scores averaged to determine the ACO’s overall quality performance score and sharing rate. ACOs would need to achieve the minimum attainment level on at least 70 percent of the measures in each domain to avoid being placed on a corrective action plan.

In addition to the measures used for the quality performance standards for shared savings eligibility, CMS will also use certain measures for monitoring purposes, to ensure ACOs are not avoiding at-risk patients or engaging in overuse, underuse, or misuse of health care services.

**Incorporation of the Physician Quality Reporting System into the Shared Savings Program:** The Affordable Care Act allows CMS to incorporate the Physician Quality Reporting System reporting requirements and incentive payments into the Shared Savings Program. ACO participants that include providers/suppliers who are also eligible professionals for purposes of the Physician Quality Reporting System will earn the Physician Quality Reporting System incentive as a group practice under the Shared Savings Program, by reporting required clinical quality measures through the ACO Group Practice Reporting Option (GPRO) web interface, in each calendar year reporting period the ACO fully and completely reports the ACO GPRO measures.

**Resources**

The Shared Savings Program final rule can be downloaded at [http://www.ofr.gov/inspection.aspx](http://www.ofr.gov/inspection.aspx) on the Internet.

It will appear in the November 2, 2011, issue of the “Federal Register.” The Shared Savings Program will be established January 1, 2012.

For information about applying to participate in the Shared Savings Program, visit [http://www.cms.gov/sharedsavingsprogram](http://www.cms.gov/sharedsavingsprogram) on the CMS website.
## Appendix

### Quality Measures for Accountable Care Organizations

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure #/Measure Steward</th>
<th>Method of Data Submission</th>
<th>Pay for Performance Phase In</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>R = Reporting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Year 1</td>
</tr>
<tr>
<td>AIM: Better Care for Individuals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Patient/ Caregiver Experience</td>
<td>CAHPS: Getting Timely Care, Appointments, and Information</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
<td>R</td>
</tr>
<tr>
<td>2. Patient/ Caregiver Experience</td>
<td>CAHPS: How Well Your Doctors Communicate</td>
<td>NQF #5, AHRQ</td>
<td>Survey</td>
<td>R</td>
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<tr>
<td>3. Patient/ Caregiver Experience</td>
<td>CAHPS: Patients' Rating of Doctor</td>
<td>NQF #5, AHRQ</td>
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<td>4. Patient/ Caregiver Experience</td>
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<td>Claims</td>
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</table>

¹We note that this measure has been under development and that finalization of this measure is contingent upon the availability of measures specifications before the establishment of the Shared Savings Program on January 1, 2012.
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<thead>
<tr>
<th>Domain</th>
<th>Measure Title</th>
<th>NQF Measure #/Measure Steward</th>
<th>Method of Data Submission</th>
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<td>23. At Risk Population – Diabetes</td>
<td>Diabetes Composite (All or Nothing Scoring): Low Density Lipoprotein (&lt;100)</td>
<td>NQF #0729 MN Community Measurement</td>
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<td>NQF #0729 MN Community Measurement</td>
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<td>NQF #75 NCQA</td>
<td>GPRO Web Interface</td>
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<td>NQF Measure #/Measure Steward</td>
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<td>33. At Risk Population – Coronary Artery Disease</td>
<td>Coronary Artery Disease (CAD) Composite: All or Nothing Scoring: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)</td>
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<td>GPRO Web Interface</td>
<td>R</td>
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### MEDICARE SHARED SAVINGS PROGRAM (MSSP)

ACO Measures – Compared to Physician Quality Reporting System (PQRS), Meaningful Use (MU), and Patient-Centered Medical Home (PCMH) Measures

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<tr>
<th>ACO Measure</th>
<th>ACO Measure - Data Source</th>
<th>PQRS</th>
<th>MU</th>
<th>PCMH</th>
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<tr>
<td>1 Getting timely care, appointments, and information</td>
<td>Survey - no action by provider</td>
<td></td>
<td>✓</td>
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<tr>
<td>2 How well your doctors communicate</td>
<td>Survey - no action by provider</td>
<td>✓</td>
<td></td>
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<tr>
<td>3 Patients’ rating of doctor</td>
<td>Survey - no action by provider</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>4 Access to specialists</td>
<td>Survey - no action by provider</td>
<td>✓</td>
<td></td>
<td>✓</td>
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<tr>
<td>5 Health promotion and education</td>
<td>Survey - no action by provider</td>
<td>✓</td>
<td></td>
<td>✓</td>
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<tr>
<td>6 Shared decision making</td>
<td>Survey - no action by provider</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>7 Health status/functional status</td>
<td>Survey - no action by provider</td>
<td>✓</td>
<td></td>
<td>✓</td>
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<tr>
<td>8 Risk-Standardized, All Condition Readmission</td>
<td>Claims - no action by provider</td>
<td>✓</td>
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<tr>
<td>9 Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Claims - no action by provider</td>
<td>✓</td>
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<tr>
<td>10 Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure (CHF)</td>
<td>Claims - no action by provider</td>
<td>✓</td>
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<tr>
<td>11 Percent of PCPs who successfully qualify for an electronic health record (EHR) incentive payment</td>
<td>EHR Incentive Program Reporting</td>
<td>✓</td>
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<td>12 Medication reconciliation after discharge from an inpatient facility</td>
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<td>✓</td>
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<td>13 Screening for fall risk</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>14 Influenza immunization</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>15 Pneumococcal vaccination</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
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<td>16 Adult weight screening and follow-up</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>17 Tobacco use assessment and tobacco cessation intervention</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
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<td>18 Depression screening</td>
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<td>✓</td>
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<td>19 Colorectal cancer screening</td>
<td>GPRO web interface</td>
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<td>20 Mammography screening</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
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<td>21 Proportion of adults 18+ who had their blood pressure measured within the preceding 2 years</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>22 Diabetes Composite: HbA1c (&lt; 8%)</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
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<td>23 Diabetes Composite: LDL-C (&lt; 100 mg/dL)</td>
<td>GPRO web interface</td>
<td>✓</td>
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<td>24 Diabetes Composite: Blood pressure (&lt; 140/90)</td>
<td>GPRO web interface</td>
<td>✓</td>
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<td>25 Diabetes Composite: Tobacco non use</td>
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<td>26 Diabetes Composite: Aspirin use</td>
<td>GPRO web interface</td>
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<td>27 Diabetes Mellitus: HbA1c poor control (&gt; 9%)</td>
<td>GPRO web interface</td>
<td>✓</td>
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<td>29 Ischemic Vascular Disease (IVD): Complete lipid panel and LDL-C control (&lt; 100 mg/dL)</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>30 IVD: Use of aspirin or another antithrombotic</td>
<td>GPRO web interface</td>
<td>✓</td>
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<tr>
<td>31 Heart Failure: Beta-blocker therapy for left ventricular systolic dysfunction (LVSD)</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>32 Coronary Artery Disease (CAD): Drug therapy for lowering LDL-C</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>33 CAD: ACE or ARB therapy for patients with CAD and diabetes and/or LVSD</td>
<td>GPRO web interface</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>

1Definitions may vary.  2Measure often calculable.  3Measures can apply to several PCMH elements and standards.  4Not a composite measure.

Prepared by QualCare, Inc. (April 2012)
Anticipated Data Flow
Accountable Care Organizations and You: Frequently Asked Question (FAQ) for People with Medicare

Your doctors try hard to provide you with high quality care, but it can be a challenge to juggle information. Medicare wants to ensure that all doctors have the resources and information they need to coordinate your care.

That’s why we’re working with many doctors, hospitals, and other health care providers that have decided to work together to provide better, more coordinated health care. They have decided to participate in Accountable Care Organizations (ACOs).

If your doctor, health care provider, or hospital decides to coordinate with other doctors through an ACO, you’ll benefit because the doctors will be part of a better team. They will work together to get you the right care at the right time in the right setting.

**If my doctor’s in an ACO, can I still see whatever doctor I want?**

Absolutely—if your doctor participates in an ACO, you can see any healthcare provider who accepts Medicare. Nobody—not your doctor, not your hospital—can tell you who you have to see.

**Is an ACO a Health Maintenance Organization (HMO), managed care or an insurance company?**

No. An ACO is a group of doctors, hospitals, and other health care providers who work together to provide you with better, more coordinated care. Doctors and hospitals in an ACO communicate with you and with each other to make sure that you get the care you need when you are sick, and the support you need to stay healthy and well.
An ACO isn’t an HMO, managed care or insurance company. Unlike HMOs, managed care, or some insurance plans, an ACO can’t tell you which health care providers to see and can’t change your Medicare benefits. If your doctor participates in a Medicare ACO, you always have the right to choose any doctor or hospital who accepts Medicare at any time.

**How do I know if my doctor is in an ACO?
What should I expect if my doctor is in an ACO?**

If your doctor chooses to participate in an ACO, you will be notified. This notification might be a letter, written information provided to you when you see your doctor, a sign posted in a hospital, or it might be a conversation with your doctor the next time you go to see him or her.

If you aren’t sure if your doctor or healthcare provider is participating in a Medicare ACO, ask him or her. For general information on ACOs, call 1-800-MEDICARE (1-800-633-4227) 24 hours a day 7 days a week. TTY users should call 1-877-486-2048.

Over time, if you see a doctor participating in an ACO, you may notice that:

- You don’t have to fill out as many medical forms that ask for the same information;
- The health care providers that you see all know what is going on with your health because they communicate with each other;
- You don’t have to have the same medical tests done over and over because your results are shared among your health care team;
- The providers participating in the ACO will become partners with you in making care decisions.

Here are things that won’t change because your doctor is part of an ACO:

- What you pay, your Medicare benefits, or the cost of your coverage should not increase;
- Your right to choose any hospital or doctor that accepts Medicare, at any time, will not change even if that hospital or doctor is not part of an ACO.
Some ACOs may hire people to help check on your care. They may call you after an appointment or a procedure to make sure you understand how to take your medicines or schedule follow-up visits. They will also share information with your doctor to make sure you get the right care.

**What rights do I have if my doctor is in an ACO?**

You will continue to receive the same rights enjoyed by all people with Medicare. To help you to get the best-coordinated care, Medicare will share information about your medical information with your doctor’s ACO, including medical conditions, prescriptions, and visits to the doctor. This is important to help the ACO keep up with your medical needs and track how well the ACO is doing to keep you healthy and helping you get the right care.

Your privacy is very important to us, so you may choose to have your name and other personal information removed from the information that Medicare shares with your doctor by doing one of these things:

* calling 1-800-MEDICARE (TTY users should call 1-877-486-2048); or
* signing a form available in your doctor or other healthcare provider’s office, which you may also receive in the mail from your doctor.

If you receive a letter from your doctor, unless you take one of these steps, your medical information will be shared automatically starting 30 days from the date you are notified.

Medicare won’t share information about anyone who has ever received treatment for alcohol or substance abuse without written permission. If you have received treatment for alcohol or substance abuse and want Medicare to share that information with your doctor’s Medicare ACO complete the “Alcohol or Substance Abuse Medical Data Sharing Form” and mail it in.

Starting in 2013, Medicare will also be following up with people with Medicare to ask about your experiences as a patient of a doctor who is participating in a Medicare ACO. As time gets closer, you will get a letter to let you know the survey is genuine. Medicare will use your feedback to help make sure you get high quality care.
Who can read my medical information?  
And will it be protected?

The group of doctors, hospitals, and other health care providers working together in the ACO will be able to read your medical records, along with other office staff authorized to help coordinate your care.

The privacy and security of your medical information is protected by Federal law. Contact your doctor’s office for more information about how they protect your medical information, or call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

How will an ACO lead to better care for me?

When your health care providers have access to your health information and are able to share that information with one another, they can give you better, more coordinated care. Each of your health care providers will not only know about the health issues that they have treated, they will have a more complete picture of your health through communicating with your other health care providers.

If your health care providers are participating in an ACO, over time, you should see better more coordinated health care where you are the center of care and your satisfaction is a goal of the ACO.

Where can I find more information about ACOs?

For more information about ACOs, you can do the following:
- Visit www.cms.gov/ACO/.
- Visit www.Medicare.gov/ACO.
- Talk to your doctor.
- Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048.

CMS Product No. 11588  
October 2011
We are participating in a Medicare Shared Savings Accountable Care Organization (a New Care Coordination Program in Medicare)

**What’s An Accountable Care Organization (ACO)?**

- ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give you high quality service and care at the right time in the right setting.
- Your doctor has agreed to participate in a Medicare Shared Savings ACO and to work closely with other doctors and health care providers in the ACO to coordinate care for Medicare beneficiaries, like yourself, who have traditional Medicare.
- The ACO may share in any savings that result from providing you with high quality and more coordinated care.

**ACOs Don’t Change Your Medicare Benefits**

- An ACO is not a Medicare Advantage plan or an HMO plan.
- If you have traditional Medicare, you still have the right to use any doctor or hospital who accepts Medicare, at any time.
- We may continue to recommend that you see particular doctors for your specific health needs, but it’s always your choice about what doctors you use or hospitals you visit.

**How Will An ACO Help My Doctor Coordinate My Care?**

- You benefit because your doctors will be part of a better coordinated team.
- You may not have to fill out as many medical forms that ask for the same information.
- Each of your doctors will not only know about the health issues they’ve treated, they will have a more complete picture of your health through talking with your other doctors.

**Questions**

If you have questions or concerns, you can talk with us at anytime. You can also visit www.medicare.gov/acos.html or call 1-800-MEDICARE (TTY users should call 1-877-486-2048). Atlantic Accountable Care Organization can be reached at 973-971-7499.
NOTICE TO PATIENTS:
[Name of Doctor/Practice] is participating in an Accountable Care Organization and
Information on sharing your health information

<BENEFICIARY FULL NAME>  <file creation date>
<ADDRESS>  <CITY STATE ZIP>

[Name of Doctor] Is Participating in a New Care Coordination Program

This letter is to let you know that I, Dr. XXX [and my practice] have chosen to participate in a Medicare Accountable Care Organization (ACO).

We’re Working to Improve Your Care

An ACO is a group of doctors and other health care providers working together with Medicare to give you better service and care. The goal of an ACO is for your doctors to communicate closely with your other health care providers to deliver high-quality care and meet your unique individual needs and preferences. The ACO may be rewarded for providing you with high quality, more coordinated care.

You Can Still See Any Doctor or go to any Hospital

Your Medicare benefits are not changing, and you will still receive your benefits through Original Medicare. This isn’t a Medicare Advantage plan or an HMO plan. You still have the right to use any doctor or hospital who accepts Medicare, at any time. [I/we] may continue to recommend that you see particular doctors for your specific health needs, but it’s always your choice about what doctors you use or hospitals you visit.

You Control Your Personal Information

To help us give you the right care in the right place at the right time, on [insert date 30 days after the date of this notice], Medicare plans to start sharing certain health information with us about your care. This information will include things like visits to the doctor or hospital, medical conditions, and prescriptions you’ve had in the past and moving forward. Having this information will help [me/us] and your other health care providers participating in our ACO give you high-quality care, because [I’ll/we’ll] have the most up-to-date information about your health.
Your privacy is very important to us, and you control the use of your personal health information. Like Medicare, we have important safeguards in place to make sure all your medical information is safe.

**You Can Choose to Not Share Your Health Information**

If you choose, you can ask Medicare not to share your personal health information with us by doing one of these things:

- Call 1-800 MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048.
- Complete and Sign the “Declining to Share Personal Health Information” form in [our] [your doctor’s] office.
- Complete, sign, and return the “Declining to Share Personal Health Information” form included with this letter.

If you want to ask Medicare not to share your information with us, you should take one of the three steps described above by [insert a date 30 days after the date of this notice]. Even after Medicare begins to share your information with us, you may always ask Medicare to stop this information-sharing in the future.

Please note, however, that Medicare will not share any information about alcohol or drug treatment without express written permission. If you have received such treatment, it is important that we understand all of your health needs in order to allow the health care providers that treat you to coordinate your care. To give this permission, complete the “Consent for the Release of Confidential Alcohol or Drug Treatment Information” form and give it to [me/us] or mail it to the address indicated on the form.

If you have received such treatment, consenting to allow Medicare to share this information about you with us will not change who you go to for alcohol or drug abuse prevention, treatment or recovery supports, but will help us provide better health care for you. You may withdraw your consent to share this information at any time either in writing or over the phone if you want Medicare to stop sharing this information.

**Questions**

If you have questions or concerns, you can call us at [phone number], or bring it up next time you’re in your doctor’s office. You can also visit [www.medicare.gov/acos.html](http://www.medicare.gov/acos.html) or call 1-800-MEDICARE and tell the operator you are asking about ACOs (TTY users should call 1-877-486-2048).