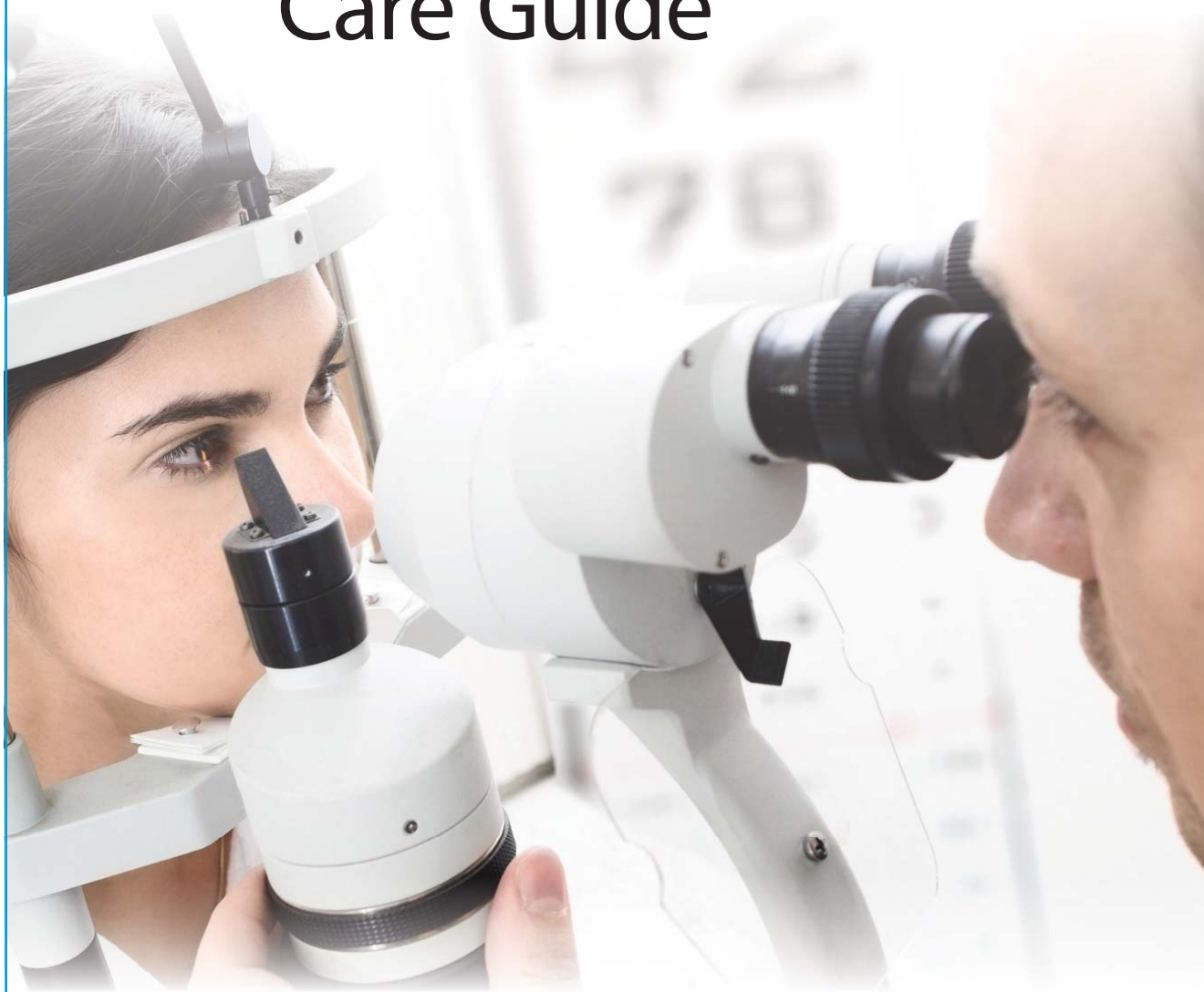


Preparing Optometry for the Accountable Care Era

# The Accountable Care Guide



American Optometric Association



## Preparing Optometry for the Accountable Care Era

### **ACKNOWLEDGMENT**

This strategic guide for optometrists involved input through interviews with and participation by AOA staff and volunteers. We are grateful to Julian D. (“Bo”) Bobbitt, Jr., J.D., of the Smith Anderson law firm, who has many years’ experience providing physicians and allied providers with strategic counsel regarding integrated care, for compiling the information in this non-technical “blueprint” format. The purpose of this paper is to arm you with knowledge and confidence as you consider joining or forming an accountable care organization.

# Preparing Optometry for the Accountable Care Era

## INTRODUCTION

A key component of the Patient Protection and Affordable Care Act of 2010 (PPACA) is the formation value-based care delivery models. The most common model seen today is the Accountable Care Organization (ACO). The AOA has made the elimination of barriers to full participation in ACOs by optometrists a top priority. The result has been important gains for the profession that are reflected in the regulations implementing the Affordable Care Act and new opportunities being explored by optometrists related to value-based care models and pioneering partnerships with other providers.

A work group coordinated by AOA's Third Party Center was instrumental in producing an ACO resource toolkit that will provide AOA members with educational materials and other resources that detail what optometrists need to know and what to do when engaging with ACOs. We want to help our member optometrists participate fully in these new ACOs and other value-based care delivery models. The information provided in two tandem documents, *The Accountable Care Guide* and *The Optometrists' Guide for ACO Participation* will equip all optometrists to work at a local level for the inclusion and integration of full-scope professional optometric services in ACOs.

The first document contains elements for a successful ACO and implementation that transcend specialty or facility and apply equally to all ACO stakeholders.

*The Optometrists' Guide for ACO Participation* applies the principles and processes of the Guide specifically from the perspective of an optometrist.

# Preparing Optometry for the Accountable Care Era

## I. PURPOSE OF THE ACCOUNTABLE CARE GUIDE

Accountable Care Organizations (“ACOs”) are emerging as a leading model to address health care costs and fragmented care delivery. The purpose of this ACO Guide is to bring together in one source a non-technical explanation of the essential elements required for any successful ACO and practical step-by-step guidance on how to achieve each element. Because a successful ACO must be “win/win”, with every collaborative participant incented and empowered to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payor relationship, or facility type. This Guide works for you whether you are a primary care physician, allied provider, a hospital CEO, or a specialist physician. Although ACOs are still evolving and definitive predictions are impossible at this time, the goal of the Guide is to give any reader a firm sense of the strengths and weaknesses of any ACO model they may encounter and confidence about whether to join one or to create one. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development to be followed.<sup>1</sup>

## II. WHAT IS AN ACO?

### A. Definitions

Former Administrator of the Center for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. described an ACO as follows: “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall, per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”<sup>2</sup> Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs. ...[T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers. ... ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goal.”<sup>3</sup>

Strategic Note: The part of the definition relating to patient populations represents a major shift in practice orientation, and is very alien to a typical physician’s training and day-to-day focus.

---

<sup>1</sup> It is not the purpose of this Guide to provide legal advice. Any person or organization considering participation in an ACO should seek the advice of legal counsel.  
<sup>2</sup> Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.  
<sup>3</sup> National Committee for Quality Assurance, *Accountable Care Organization (ACO) Draft 2011 Criteria*, p. 3. (hereinafter “NCQA”).

## Preparing Optometry for the Accountable Care Era

Without grasping this shift, an understanding of ACOs will remain elusive. It also is important to note what is not in the definition. No definitions specify any particular type of legal entity (i.e., IPA, PHO, employed). There is no mandatory organizational form for an ACO.

### **B. PPACA Requirements**

ACOs eligible for the Medicaid Shared Savings Program under the Patient Protection and Affordable Care Act of 2010<sup>4</sup> must meet the following criteria:

- That groups of providers have established structures for reporting quality and cost of health care, leadership and management that includes clinical and administrative systems; receiving and distributing shared savings; and shared governance.
- Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- Minimum three-year contract.
- Sufficient primary care providers to have at least 5,000 patients assigned.
- Processes to promote evidence-based medicine, patient engagement, and coordination of care.
- Ability to demonstrate patient-centeredness criteria, such as individualized care plans.

## **III. WHY SHOULD I CARE?**

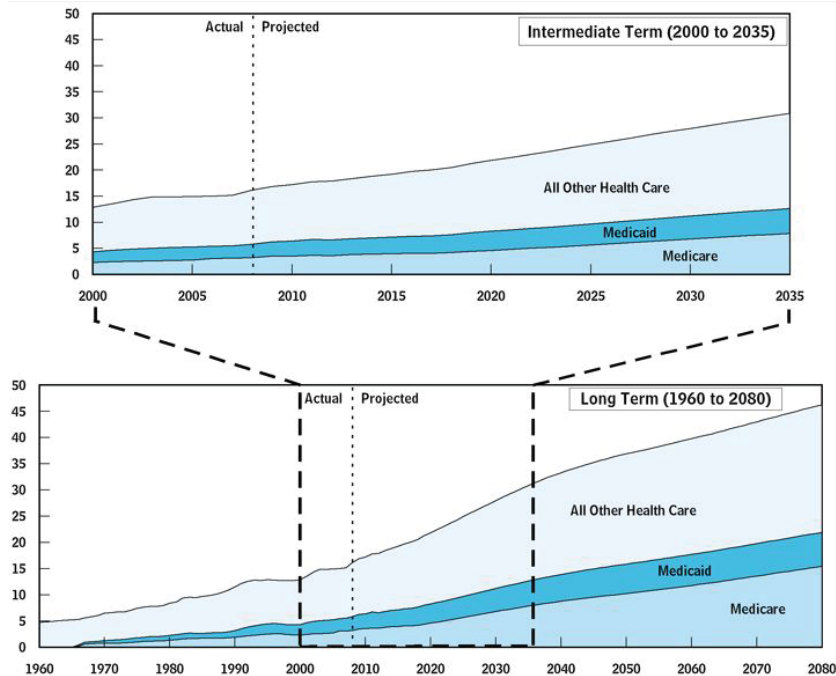
Health spending is unsustainable, even before coverage expansion of the 2010 federal health re-forms. With 19% of Gross Domestic Product (“GDP”) being the rough estimate of the amount the United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are pre-dicted to consume 13% of GDP and health care costs will consume 31% of GDP. In other words, health care alone will cost well over all we collect. The rest, defense, education, roads, etc. we can only pay for by borrowing. By 2080, absent drastic change, Medicaid and Medicare will consume all of our tax and other revenues, and total health spending will claim 46% of GDP.

---

<sup>4</sup>Section 3022 of the Patient Protection and Affordable Care Act of 2010 (amends Title XVIII of the Social Security Act (42 USC 1395 *et seq.*)).

## Preparing Optometry for the Accountable Care Era

### Total Spending for Health Care Under the Congressional Budget Office's Extended Baseline Scenario



There is consensus that much of this is avoidable. The now-famous New Yorker article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. It said: “The real puzzle of American Healthcare... is not why McAllen is different from El Paso. It’s why El Paso isn’t like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone.”<sup>5</sup>



#### Article By Influential Writer Sparks Strong Debate

The Congressional Budget Office Report on the ACO's predecessor, the Bonus-Eligible Organization, includes this rationale: “[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.” These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country’s health care system costing 50% more as a percentage of GDP than any other in the world but ranking only 37th in overall health and 50th in life expectancy.<sup>6</sup>

<sup>5</sup> Atul Gawande, *The Cost Conundrum*, *The New Yorker* (June 1, 2009)

<sup>6</sup> World Health Organization, *World Health Statistics 2009*.

## Preparing Optometry for the Accountable Care Era

Because of the crisis, drastic efforts at health care cost reform seem inevitable. President Obama stated it bluntly: “So let me be clear: If we do not control these costs, we will not be able to control the deficit.”<sup>7</sup> Private insurers see it, too. The President of Blue Cross and Blue Shield of North Carolina recently stated: “Even if federal health overhaul is rejected by the Supreme Court or revamped by Congress, the market must continue to change. The system that brought us to this place is unsustainable. Employers who foot the bill for workers’ health coverage are demanding that Blue Cross identify the providers with the highest quality outcomes and lowest costs.”<sup>8</sup>

Flattening the cost curve is possible through the ACO’s marketplace incentives without rationing care, imposing new taxes, or cutting provider reimbursement. Doing nothing is not an option, and all these alternatives appear unacceptable. In short, there is no “Plan B.”

### **IV. ARE ACOs REALLY COMING?**

#### **A. If They Repeal Health Reform, Won’t This Go Away?**

No. Federal health reform has three prongs: Expand Coverage (individual and employer mandates, no pre-existing condition exclusions, etc.), Fraud Control, and Cost Controls (ACOs, bundled payments, value-based purchasing, CMS Innovation Center, etc.). Many experts think that expanding coverage into our broken system has made health care even more unsustainable. However, as noted, the cost curves, even without health reform, will bankrupt our resources, and the value-based reimbursement movement was well underway before the federal legislation was passed. Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features of accountability at the medical community level, transparency to the public, flexibility to match local strengths to value-enhancement opportunities, and shifting to paying for value, not volume.

#### **B. Isn’t This Capitation Revisited?**

You may fairly ask, “Isn’t this the ‘next big thing’ to save health care, like capitation? Won’t it fizzle away like that did?”

ACOs with shared savings are unlike capitation in several crucial ways. First, the payments are only bonus payments in addition to fee for service payments. There is no downside risk. Second, vital administrative capabilities, data measurement capability, identified common metrics, severity adjustment, and electronic health information exchange sophistication were not present in the capitation era.

---

<sup>7</sup> President Barack Obama, interview excerpt, July 23, 2009.

<sup>8</sup> Brad Wilson, President of BlueCross BlueShield of North Carolina, *The News & Observer* (January 29, 2011).

## Preparing Optometry for the Accountable Care Era

### C. Can't I Wait Until Things Get Clearer?

As the next chapter describes, successful ACO creation will require deep transformational change. The changes will have less to do with infrastructure and technology than culture. “Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake... Organizations that have not yet started down this path in earnest will need to move much more aggressively to prepare for the post fee-for-service world.”<sup>9</sup>

## V. **WHAT ARE THE ESSENTIAL ELEMENTS OF A SUCCESSFUL ACO?**

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. Because element one is not as objectively verifiable, it is very counterintuitive that the most vital element is by far the most difficult element to obtain will be creation of an interdependent culture of mutual accountability committed to higher quality and patient satisfaction at the lowest cost. “[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change.”<sup>10</sup>

---

<sup>9</sup>Gary Edmiston and David Wofford, *Physician Alignment: The Right Strategy; the Right Mindset*, Healthcare Financial Management Association (December 1, 2010).

<sup>10</sup>Id.



# Preparing Optometry for the Accountable Care Era

## The Eight Essential Elements of a Successful ACO



### A. Essential Element No. 1: Culture of Teamwork – Integration



The most important element, yet the one most difficult to attain, is a team-oriented culture with a deeply-held shared commitment to reorganize care to achieve higher quality at lower cost

### B. Essential Element No. 2: Primary Care Physicians



1. **What Is the Role of Primary Care In ACOs?** As discussed in detail in Section V.G. below, the highest-impact targets identified for ACOs lie in the following areas: (a) prevention and wellness; (b) chronic disease management; (c) reduced hospitalizations; (d) improved care transitions across the current fragmented system; and (e) multi-specialty co-management of complex patients. Primary care can be drivers in all of these categories.

Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, “it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.”<sup>11</sup> He envisions different levels of ACOs, with the core Level One consisting primarily of

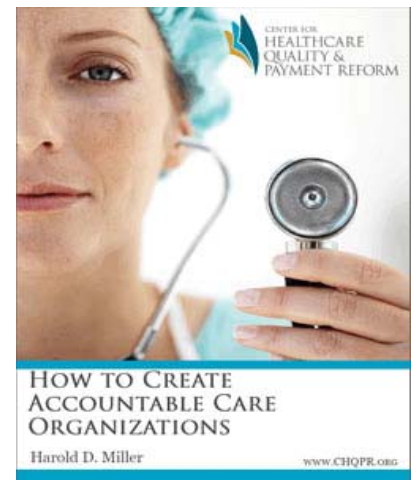
<sup>11</sup> Phillip L. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity, Appendix (November 2010), p. 40.

## Preparing Optometry for the Accountable Care Era

primary care practices. Level Two would include select specialists and potentially hospitals. As the diverse patient populations are included, Level Three expands to more specialists and facilities, and Level Four includes public health and community social services. As noted, primary care is the only provider or health care facility mandated for inclusion to qualify for PPACA's ACO Shared Savings Program. In the Proposed ACO Regulations, CMS proposed "to assign beneficiaries to an ACO on the basis of primary care services rendered by physicians in general practice, internal medicine, family practice, and geriatric medicine.

2. **What Are the Roles of Specialists In ACOs?** It is becoming clear that specialists are going to serve important roles in ACOs. Given the opportunities for ACOs listed in Section V.B.1. above, specialists should see roles in Medical Home coordination on diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and in multi-specialty complex patient management. Inpatient specialists can tackle hospital through-put, minimizing avoidable adverse events and readmissions, and quality improvements. Specialists intent on preserving volume at the expense of best practices have no role in an ACO.

3. **What Are the Roles of Hospitals In ACOs?** Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and HIT infrastructure, ACOs are consistent with their missions, and hospitals are often a medical community's natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, "the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in opposition to one another."<sup>12</sup> A litmus test for hospital membership (or whether to join an ACO that includes a hospital) is whether it is committed to overall increased savings, improved quality, and improved.



4. **What Are the Roles of Other Providers in ACOs?** There is a boom in employment of nurse care coordinators and navigators. As they are so beneficial at engaging the patient who is not in the office, they have been called the "secret weapon" of ACOs. ACO leaders estimate that the "ROI," or return on investment, on employing care coordinators is at least 2:1. The old "silos" are starting to dissolve, and are being replaced with continuums of care. Each provider is encouraged to provide the highest quality at the lowest cost for the patient population in collaboration with others on the team. The quality component promotes practicing up to, but not beyond, each provider's training and expertise level. The efficiency component promotes delegation, supervision,

---

<sup>12</sup>Harold D. Miller, How to Create Accountable Care Organizations, Center for Healthcare Quality and Payment Reform, p.8, (September 2009).

## Preparing Optometry for the Accountable Care Era

coordination, and use of technology. It is truly now about the best care by the best person at the best location, regardless of which door to the system the patient goes through.

In summary, because primary care will drive so many of an ACO's most high-yielding initiatives, it is an essential element of a lasting and successful ACO. "Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs. It must be about proactive and preventive care and not reactive care. It must be about outcomes and not volume or processes. It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home."<sup>13</sup>

### C. Essential Element No. 3: Adequate Administrative Capabilities



What Kind of Organization Can Be an ACO? The very label "accountable care organization" tends to convey an impression that an ACO must be a particular type of organization. In retrospect, it probably should have been called "Accountable Care System." It is about function, not form. The NCQA's ACO criteria look to core competencies and infrastructure to implement them, but are "agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association)."<sup>14</sup> There are three essential infrastructure functional capabilities: (1) performance measurement, (2) financial administration, and (3) clinical direction. A legal entity of some sort is necessary, and a number of choices are available. The form ultimately chosen should be driven by what most readily facilitates achievement of the functional needs of the ACO initiatives in your community. The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. The key to achieving this goal is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols and transparent measurement and reporting. "While ACO formation and ongoing structural, operational, and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development."<sup>15</sup>

### D. Essential Element No. 4: Adequate Financial Incentives



**1. Isn't This the Same As Insurance?** No. An insurance company assumes the financial risk of whether a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for higher performance treatment of patients once they become ill. This gets fuzzy when one remembers that the ACO will be responsible for an entire patient population, especially as it assumes more risk, as in full capitation. However, this distinction is why the ACO performance expectations need to be severity-adjusted.

**2. What Are the Types of Financial Incentive Models for ACOs?** There are three tiers:

<sup>13</sup> Terry McGeeney, M.D., The Patient-Centered Medical Home and the Accountable Care Organization, <http://www.transformed.com/CEOREports/PCMH-and-ACO.cfm>, (2010).

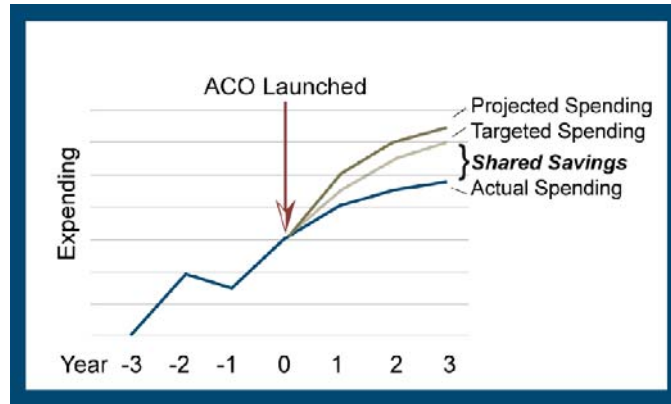
<sup>14</sup> NCQA, pp. 7-8.

<sup>15</sup> Doug Hastings, Accountable Care News (December 2010), p. 6.



## Preparing Optometry for the Accountable Care Era

### The Shared Savings Model



\*Courtesy of the Brookings Institution

b. Savings Bonus Plus Penalty – As with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks, but also will be liable for expenses that exceed spending targets. This model is called “symmetric” or “two-sided” and the bonus potential is increased to balance the accountability for exceeding pre-set goals. Fee-for-service is retained. This resembles the “two-sided” model mentioned in the Final Rule.<sup>16</sup>

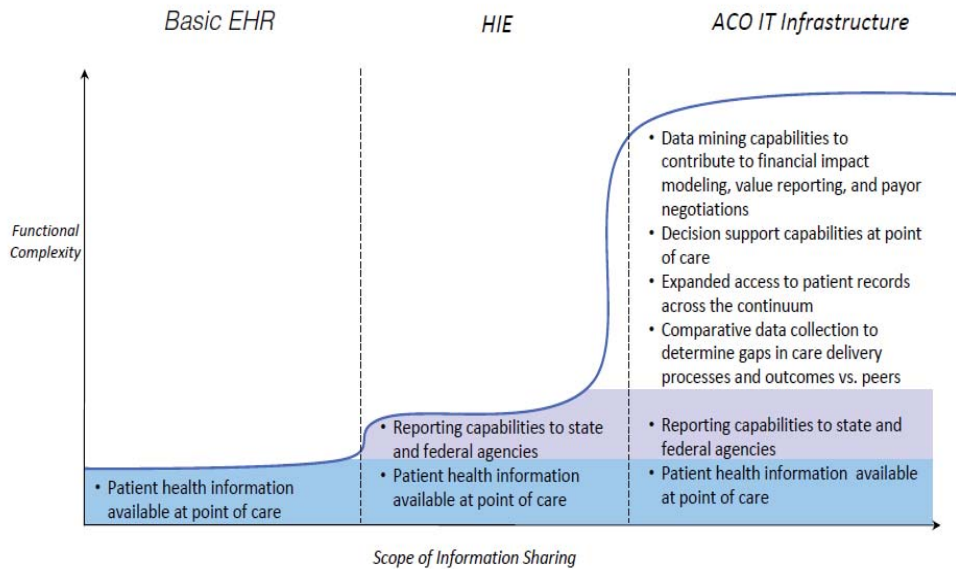
c. Capitation – A range of partial capitation and full capitation models are possible. Fee-for-service payments are replaced by flat payments plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should attempt this level of risk. Yes, the upside is higher, but the disasters of the '90s should not be forgotten.

**3. Is This the Same as Bundled Payment or Episode of Care Payment?** ACO incentives can be aligned with these and other payment experiments under consideration. An “episode of care” is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment covers providers who would have been paid separately under fee-for-service, that is a “bundled payment.” Such a payment mechanism that excludes payment for treatment of avoidable readmission or hospital-acquired infections motivates better care. These approaches do not incentivize prevention and medical-home coordination to avoid the episode in the first place.

<sup>16</sup> 76 Fed. Reg. 67986-67987.

# Preparing Optometry for the Accountable Care Era

## E. Essential Element No. 5: Health Information Technology and Data



1. **What Data?** ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It will usually have outcomes and process measures. Nationally-accepted benchmarks are emerging. There are three categories of data needs for an ACO:

a. **Baseline Data** – This is often overlooked. To compare anything, there needs to be a beginning reference point. Can you collect costs and quality data? Who owns it now? Who collects it? Do you trust them to be accurate and objective?

b. **Performance Data** – In the value-based reimbursement era, it will not be enough to provide exceptional cost-effective care, you must prove it. A practical way to determine your ACO's needed performance data is to start by selecting the ACO's targeted initiatives. Then select from emerging nationally recognized quality and efficiency metrics, if they apply. Even if they do apply, convene a multi-specialty committee of clinicians to vet their clinical validity. This committee will recommend performance benchmarks from scratch if national standards are not yet available for all of the care pathways of your initiative. They should address quality, patient satisfaction, and efficiency. They need to be severity-adjusted. Obviously, if and when a third-party payor, including CMS, sets the performance benchmarks, they should be a part of the performance array. Many payors want to allow local flexibility and clinical leadership in metric-setting.

## Preparing Optometry for the Accountable Care Era

Who collects the data? Are there variables outside of your control affecting your performance scores (i.e., patient non-compliance)? What financial incentives/penalties are tied to each?

c. Data As a Clinical Tool – Once the ACO targeted care initiatives are selected, the best practices across the care continuum will be determined. The appropriate ACO committee will then usually “blow up” each pathway into each component and assign clinical leadership, decision support, data prompts, and relevant clinical data to each step at the point-of-care. ACOs are discussing virtual workstations and data dashboards. Coordination with downstream providers will be optimized with the real-time sharing of upstream care results and scheduling.

Strategic Notes: (1) The ACO should periodically internally grade itself against the performance benchmarks to create a constant quality/efficiency/satisfaction improvement loop. This not only will hone the contributions of the ACO initiatives, but also will prepare it to increase its financial rewards once the performance results drive a savings pool on bundled payments. Gaps in care should be flagged and addressed before your compensation depends on it. Clearly, clinically valid, accurately collected, severity-adjusted, and properly benchmarked data are essential for any compensation model based on performance. (2) Data that reflects a track record of high performance serves as a bargaining tool when reimbursement is being negotiated, even in fee-for-service. (3) Use data first in order to target the “low-hanging fruit,” high-impact, value-add initiatives in your area that are best suited to your specialty or facility. Next, use data to collect evidence of your performance. There will be specific baseline, performance, and clinical data elements needed for each participant to meet objectives, maximize their measured contribution, and thus reap a meaningful reward from the savings pool.



## Preparing Optometry for the Accountable Care Era

### F. Essential Element No. 6: Best Practices Across the Continuum of Care



Another essential element of a successful ACO is the ability to translate evidence-based medical principles into actionable best practices across the continuum of care for the selected targeted initiative or initiatives. An ACO may start out with a single patient population (i.e., morbidly obese patients) or disease-state (i.e., diabetes).

The five identified high-impact target areas for ACO initiatives are:

- Prevention and wellness;
- Chronic disease (75% of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multi-specialty care coordination of complex patients.

“The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today’s delivery system, unnecessary spending relating to substandard clinical coordination, further complicated by the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice.”<sup>17</sup>

As discussed earlier in Section V.B., the richest “target fields” from this array will vary by specialty and type of facility. Looking at these suggested initiatives, it is no wonder why primary care is emphasized as key for ACOs, since they could play a significant role in every area. The ACO should match its strengths against the gaps in care in the ACO’s market to find the proverbial “low-hanging fruit.”

### G. Essential Element No. 7: Patient Engagement



Patient engagement is another essential element. Without it, an ACO will not fully meet its potential. Unfortunately, many of today’s health care consumers erroneously believe that more is better, especially when they are not “paying” for it, insurance is. Patient noncompliance is a problem, especially regarding chronic diseases and lifestyle management. It is difficult to accept a compensation model based on input on improved patient population health when that is dramatically affected by a variable outside of your control, patient adherence. Currently, asking a patient to be a steward of his or her own care puts an ACO at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by PPACA for an ACO to qualify for CMS’ Shared Savings Program.<sup>18</sup>

<sup>17</sup> *Toward Accountable Care*, The Advisory Board Company (2010)

<sup>18</sup> Section 3022 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. §§ 1395, et seq.). See also 76 Fed. Reg. 67976.



# Preparing Optometry for the Accountable Care Era

## What Can an ACO Do to Engage Patients?

Better information at a societal level and also at the medical home point of care.

- The Patient Compact – Some ACOs, such as the Geisinger Clinic, engage the patient through a compact, or agreement. It may involve a written commitment by the patient to be responsible for his or her own wellness or chronic care management, coupled with rewards for so doing, education, tools, self-care modules, and shared decision-making empowerment. The providers will need to embrace the importance of patient involvement and hold up their end of the engagement bargain.
- Benefit Differentials for Lifestyle Choices – The financial impact of many volitional patient lifestyle choices is actuarially measurable. A logical consequence of the patient choice could be a benefit or financial differential reflecting at least partially these avoidable health care costs.

## **H. Essential Element No. 8: Scale-Sufficient Patient Population**



It is OK, even desirable, to start small; to “walk before you run,” so to speak. However, it is often overlooked that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. PPACA's Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to it.

Strategic Note: Some ACOs commence activities through a single pilot, or demonstration project, without a sustainable patient population scale. It can de-bug the initiative and test-run the ACO early enough to fix problems before ramping up. This must succeed, however. If it does, it will be much easier for the ACO champions to gain buy-in from others.



## Preparing Optometry for the Accountable Care Era



## Preparing Optometry for the Accountable Care Era

### **VII. CONCLUSION**

The Accountable Care Organization holds great promise to address many of the ills of America's health care system. However, it will require new skill-sets, collaboration partners, technology, and systems. It will require a radically different approach to shared accountability. It is the goal of this ACO Guide to demystify ACOs for all stakeholders and to provide some tools and confidence to allow health care leaders to take prudent risks for greater success than they otherwise would have.

**For more information on any aspect of this ACO Guide, please contact Julian (“Bo”) Bobbitt at 919-821-6612 or [bbobbitt@smithlaw.com](mailto:bbobbitt@smithlaw.com). ([www.smithlaw.com](http://www.smithlaw.com))**