



ASHP Policy Analysis

Pharmacists' Role in Accountable Care Organizations

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Health systems and physician groups are grappling over how to create accountable care organizations (ACOs) that will improve patient outcomes while reducing health care costs. To achieve that goal, ACOs will need to improve medication and chronic disease management, as well as reduce hospital readmissions. Pharmacists have the clinical expertise to help meet this challenge. The types of ACO models tested will be limited only by the creativity of the individuals designing them. ACO models can be tailored to the Medicare patient population they serve and designed by the health care providers who work in them under the Patient Protection and Affordable Care Act of 2010, hereafter referred to as the Affordable Care Act (ACA).¹ ACOs that reach established performance measures will be allowed to keep a percentage of the savings generated. By accepting greater accountability, ACOs could keep a greater share of the savings, although any ACOs that do not meet savings targets will not be financially penalized.²

Research points to numerous areas for cost savings. The health care system incurred more than \$177 billion annually in mostly avoidable health care costs to treat adverse events from inappropriate medication use.ⁱⁱⁱ The proper use of medication becomes even more important as treatment of chronic diseases costs the health care system \$1.3 trillion annually, about 75 cents of every health care dollar.³ Pharmacists are uniquely positioned to help patients optimize appropriate medication use, reduce medication related problems, and improve health outcomes through the delivery of patient care services, such as medication therapy management (MTM), health promotion and education, and disease prevention and mitigation. Pharmacists should be included in ACOs because of their proven ability to improve medication therapy outcomes while reducing costs. For example, pharmacist-provided care can reduce “drug expenditures, hospital readmissions, lengths of hospital stay, and emergency department visits.”⁴

To prepare for ACO involvement, pharmacists should first educate themselves about ACOs and then educate hospital administrators and other decision makers about the need to incorporate pharmacists' medication and chronic disease management skills into ACOs.

Although establishing an ACO is voluntary, ACA requirements may make creating an ACO a necessity for

hospitals and health systems. The ACA creates a hospital value-based purchasing program, establishes provider-level outcomes measures for hospitals and physicians, and adjusts hospital DRG payments based on readmissions.¹ The ACA also creates an Innovation Center in the Centers for Medicare & Medicaid Services (CMS) that will test new models of patient care and delivery.¹ If proven effective, CMS will expand these models nationwide.¹ Establishing an ACO to improve patient outcomes, coordinate care, and lower costs could help hospitals meet these new requirements and avoid reduced reimbursements. The ACA also establishes grant programs to create medical homes, provide MTM services, and manage chronic diseases.¹ Participating in these programs can contribute to an ACO's success.

This paper will explain what an ACO is, provide examples of how some health systems and a physician group are implementing ACOs, explain the importance of incorporating pharmacists' clinical services into an ACO, and discuss how pharmacists can get involved.

What Is an ACO?

An ACO is a group of “providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth.”⁵

Physicians, nurses, pharmacists, and other health care providers in in-patient and ambulatory care settings would be included in an ACO that would be held accountable for the care patients receive. “Hospitals should be encouraged to participate, because improving hospital care is likely to be essential to success,” notes former U.S. Department of Health and Human Services Secretary Mark McClellan.⁵

There are many possible ACO arrangements that can include a variety of payers, such as government (e.g., Medicare and/or Medicaid), insurance companies, or even large employers. This review will primarily focus on Medicare-related ACOs, although ACOs with other payers will have similar attributes and goals for improving the health of the patients that are covered.

Hospitals can effectively coordinate ACOs because their physician affiliations give them access to Medicare patients.⁶ It may be difficult for an ACO to reach the minimum 5,000 Medicare patient threshold without the cooperation of hospitals and health systems and their affiliated physicians.⁶ Hospitals have three main technical advantages as ACO providers:

- the ability to measure performance with “larger sample sizes, a broader scope of potential measures, and the feasibility of including all physicians who contribute to the care of a population within the frame of measurement;”
- local accountability for care; and
- the ability to invest in health information technology, quality improvements, and other areas.⁶

ACO Organization

Hospitals are featured in two of the five ACO categories under the Medicare Shared Savings Program—hospital and ACO professional partnerships or joint ventures and hospitals employing ACO professionals.¹ The other allowable categories are ACO professionals in group practices, networks of individual practices of ACO professionals, and other approved provider and supplier groups.¹

Each ACO will be held accountable for the quality, cost, and care of at least 5,000 Medicare patients and must operate for at least three years.¹ An ACO must have a legal structure to receive and distribute shared savings payments and have a leadership and management structure to manage the ACO’s clinical and administrative elements.¹ Each ACO must promote evidence-based medicine and patient engagement, report quality and cost measures, and coordinate care.¹ To do

this, medical homes could be included in an ACO.⁵ Through a medical home, a patient’s care is coordinated by a team led by the patient’s physician.⁷ The team is responsible for ensuring that all of the patient’s health care needs are met. Having both an ACO and a medical home could more strongly encourage care coordination.⁵

The National Committee for Quality Assurance is establishing ACO criteria along seven categories: program structure operations, access and availability, primary care management, care coordination and transitions, patient rights and responsibilities, and performance reporting.⁸ NCQA would establish four ACO levels based on an organization’s ability to improve the quality of care, increase patient satisfaction, and lower costs.⁸ After meeting the criteria, ACOs would be reviewed every two to three years.⁸

ACOs should be conducted in a variety of settings, including small and rural communities.⁹ To get the “critical mass of patients” necessary, rural ACOs will either have to incorporate multiple payers or multiple hospitals.⁹ Another way an ACO can reach a “critical mass” of patients is by applying for a CMS waiver to include Medicaid patients.⁹

Incentive Payments

ACOs will be required to submit data to CMS on clinical processes and outcomes, patient and caregiver care experience, utilization, and quality of care to evaluate whether they are meeting quality performance standards.¹ CMS also may incorporate the reporting requirements for the physician quality reporting initiative and incentive payments into the ACO requirements.¹

ACOs that reduce Medicare spending will be eligible to keep a percentage of the savings to be determined for each individual ACO.¹ To receive an incentive payment, the ACO must reach the estimated average per capita Medicare expenditures for fee-for-service patients for parts A and B services, adjusted for patient characteristics.¹ The benchmark set for each ACO will be based on the ACO’s most recent three-years of per-patient expenditures for parts A and B services for assigned patients, adjusted for patient characteristics and other factors.¹

Much of the program’s details are yet to be revealed in regulations. However, there are suggestions for establishing three ACO levels with a progressively increasing degree of responsibility, reward, and risk.¹⁰ For example, an ACO could keep a greater portion of the Medicare savings it generates as it

moves away from fee for service toward capitation and bundled payments and from reporting basic performance measures to reporting more comprehensive performance data.¹⁰

ACOs and Medical Homes

Although ACOs are not required by the ACA to include medical homes, they are “synergistic models of delivery-system reform that, together, promise to redirect the U.S. delivery system toward reduced cost growth and improved quality.”¹¹ An ACO needs the patient-centered primary care provided in a medical home to reach its performance goals.¹¹ As physicians establish medical homes, pharmacists have an opportunity to become involved as part of the health care team by providing MTM services to patients, especially patients diagnosed with multiple chronic conditions. Those patients have a greater need for medication selection, dose adjustment, laboratory monitoring, drug interaction identification, and patient medication counseling, all of which are also key requirements of a medical home. In the June 2008 *Report to the Congress: Reforming the Delivery System*, the Medicare Payment Advisory Commission stated that a Medicare medical home’s responsibility for patient medication reviews should be coordinated with a pharmacist.¹²

A medical home needs an ACO’s structure to coordinate patient care and manage costs across in-patient and ambulatory care settings.¹¹ Further, primary care practices likely need an ACO to manage the arrangement with Medicare that would allow them to share in savings generated by the ACO if performance objectives are met.¹¹

Pharmacists’ Roles in ACOs

Pharmacists can be key players in guaranteeing an ACO’s success by ensuring appropriate medication use, reducing medication-related adverse events, preventing hospital readmissions, and helping patients manage chronic conditions. MTM services should be provided to hospitalized patients as well as to patients visiting a clinic or a primary care office. Pharmacists as part of an ACO could select or recommend initial medication therapy, review patients’ medications, and recommend any medication changes to the patient’s physician. Pharmacists should counsel patients on their new medication regimens and be available to answer patients’ questions.

Physicians, nurses, and other health care professionals should be encouraged to collaborate with pharmacists when evaluating patients’ medication regimens. Pharmacists already

work closely with prescribers under collaborative drug therapy management agreements. Pharmacists are authorized “to initiate, modify, or continue drug therapy for a specific patient” in 42 states.¹³ Pharmacists need to engage in collaborative practice with physicians for ACOs to succeed.¹⁴

Coordinating care for thousands of patients will most likely require ACOs to organize patient care through patient-centered medical homes. Pharmacists should be a part of a medical home’s health care team. Medication management is especially important in medical homes that treat patients with multiple chronic conditions.^{12,15} Pharmacists are needed to ensure that patients’ medications and medication doses are appropriate to their conditions and to prevent and manage adverse drug events. Physicians, nurses, and other health care team members will ideally rely on pharmacists’ medication expertise in determining appropriate treatments for patients.

As ACOs place increasing emphasis on patients receiving appropriate primary care and preventing hospital readmissions, many hospital pharmacists may eventually find even more opportunities in ambulatory care settings as they follow the patients.

Case Studies

Three health systems—Baylor Health Care System, Carilion Clinic, and Fairview Health Services—and a physician group practice—CIPA Western New York IPA, Inc.—are creating ACOs that include pharmacists by building on existing chronic disease management programs, medical homes, and health information technology infrastructure.^{16,17,18,19} All organizations consist of hospitals, ambulatory care centers, physician practices, and specialty service providers.^{16,17,18,19} All are focused on improving health care quality and reducing costs now, not waiting for the Medicare ACO initiative to begin.^{16,17,18,19} Baylor, Fairview, and CIPA are establishing shared savings programs with private payers,^{16,18,19} while Carilion is looking to do so once the Medicare ACO program is operating.¹⁷ A Vermont ACO pilot program is also underway, with three ACOs in the planning stages.⁹ Carilion is the largest participant in the Medicare ACO pilot project starting in January 2011.¹⁴ Baylor, Fairview, and CIPA ACOs are expected to start by the January 1, 2012, ACA deadline.^{16,18,19}

Lessons Learned

These organizations’ experiences creating ACOs can be distilled into eight core principles that can be used by other

hospitals, health systems, and physician groups as they consider establishing new ACOs.

- Build on existing programs
- Identify high-need patients
- Develop and expand medical homes
- Collaborate with other health systems, hospitals, physician groups, and health care providers
- Identify patient outcomes data currently collected and expand data collection and analysis (i.e. hospital readmission rates)
- Create an integrated medical record for inpatient and ambulatory care
- Create a personal health record for patients
- Work with private insurers to add patients under the ACO

Existing Programs Form ACO Core

Hospitals and health systems likely have care management programs for certain high-need patient populations. Those programs are the starting point for creating an ACO. Baylor has made chronic disease management a “core competency” that is “anchored by a patient-centered medical home.”¹⁶ Patients will receive preventative health screening, coordinated home and community services, instruction on how they can manage their chronic conditions, psychological and social management of chronic care, and other services as needed, such as weight management and smoking cessation programs.¹⁶

Baylor also operates a medication assistance program for indigent patients who are at a high risk for hospital readmission in which pharmacists help patients apply for free medications from pharmaceutical manufacturers.¹⁶

Pharmacists are involved in Carilion’s medical homes by focusing on specific chronic disease states and “patients with complicated medication profiles. Pharmacists are the go-to health care provider for ongoing maintenance of difficult chronic patients who need intensive time and medication therapy management,” such as diabetic patients with an A1c above 10 and end-stage chronic heart failure patients.²⁰

Fairview is establishing medical homes at four clinics with the goal of reducing costs by 20%, increasing patient satisfaction, placing 50% more patients under a clinic physician’s care, and improving quality-of-care measures.²¹ Early results show that these four clinics, compared to other Fairview clinics, im-

proved quality while either reducing or maintaining costs.²¹ The medical home clinics showed better results for hypertension management, vascular care, and patient experience.²¹

Services pharmacists will be likely to provide in ACOs that are part of a Vermont pilot program include MTM, medication reconciliation, acting as a medication resource for patients, and improving patients’ compliance with their medication regimens.²²

CIPA’s ACO is built on its clinical integration plan to improve care coordination.¹⁹ For example, a pilot program that integrated pharmacists’ services within the physician group is being expanded to include additional pharmacists providing more direct patient care and increasing collaboration with other health care professionals.²³ Pharmacists are working closely with approximately 20 of CIPA’s 900 providers that involve direct patient care.²³ The remaining providers have a “broader virtual relationship” with pharmacists.²³ Those providers can call the pharmacists with questions and receive medication information newsletters.²³ CIPA is investigating grants and other funding sources to offer pharmacists’ services to more patients.¹⁹

Measuring Performance

Most organizations creating ACOs “do not yet have sufficiently complete data to produce a reasonable number of standardized, reliable, valid measures for comparison and benchmarking. NCQA believes that until meaningful, comparative performance reports are available, ACOs should demonstrate core capabilities critical to improving quality and reducing costs.”⁸

Reducing hospital readmissions and improving medication management are two areas targeted for measuring performance by the selected health systems and physician group.

Carilion is focusing on reducing hospital readmission rates and emergency room use for patients with chronic diseases, limiting the number of patients who seek care from non-ACO providers, and service referrals to “prevent unnecessary utilization of certain services.”¹⁷ Concentrating on better outpatient management and reduced emergency department visits for chronic heart failure patients and lowering diabetic patients’ A1c levels could easily prove pharmacists’ worth.¹⁷

Reducing readmissions is the “driving force” behind CIPA’s performance measures.¹⁹ CIPA also is targeting transitions of

care between inpatient and ambulatory care settings and improving medication use.¹⁹

Although ACO performance goals have yet to be identified under regulation, many of the existing metrics such as The Joint Commission's National Patient Safety goals and evidence-based guidelines are medication related.¹⁶ Pharmacists can improve medication-related performance goals and an ACO's opportunity to meet targets and share in savings generated.¹⁶

Evidence-based care in Baylor's hospitals will continue as Baylor looks to expand that care to the outpatient setting.¹⁶

Health Information Technology

Establishing an integrated electronic medical record (EMR) that can be accessed in whatever setting the patient receives care is a core component of an ACO. Carilion has a fully-integrated EMR that allows hospital staff and primary care providers to access a patient's record and see what care was provided in the other setting.¹⁷ Fairview is creating a unified electronic health record (EHR) for its system, whereas there were three separate EHR systems being used, and is developing a personal health record for patients.¹⁸

CIPA's consultant pharmacists have remote access to certain patients' EHRs to provide medication management.²³ Remote access allows the pharmacists to help more patients by not requiring the pharmacist to be in the physician's office to provide care.²³ Pharmacists are also available to meet with patients' in the doctor's office.¹⁹ CIPA has access to EHRs for all patients discharged from the hospital and transitioning into other care settings, for all patients in primary care clinics, and for some patients in other practices.^{24,25} CIPA is working toward global EHR integration.^{24,25}

Health Information Exchanges

To expand the available data that can be accessed to assess performance, Fairview is investing in and helping develop the Minnesota Health Information Exchange. The exchange will be "a statewide secure electronic network designed to share clinical and administrative data among providers and between providers and payers."²¹

CIPA benefits from HealthLink, a "virtual cloud" of comprehensive patient health information accessible by health care providers throughout the region.^{24,25} Patient consent is required before health information can be shared through HealthLink.^{24,25}

Working with Private Payers

Although ACOs under the ACA focus on Medicare patients, ACOs can incorporate patients with private insurance to further improve patient outcomes and reduce costs. Fairview and several employers created targeted care packages to improve patient outcomes and lower health care costs for certain types of patients, such as those receiving prenatal care or those who have migraines or hypertension.²¹ Fairview also is moving toward basing its compensation from insurers on meeting patient measures and total costs-of-care thresholds.²¹ Fairview expects that in 2011 its contracts with more than 70% of private payers, representing more than 50% of the system's revenue, will include incentives for Fairview to reduce its total cost of patient care.²¹

Baylor is beginning its ACO transformation by working with private payers and large businesses in the North Texas area, which will be the foundation to be more "ACO ready" for Medicare.¹⁶

Carilion is focusing on establishing an ACO for Medicare patients.¹⁷ "However, Carilion is working with private issuers to create relationships that share in the benefits of cost containment, even to the point of capitation in certain segments," says L. David Harlow III, director of pharmacy operations for Carilion's New River Valley Medical Center and Tazewell Community Hospital.¹⁷

Private payers' suggestion to incorporate pharmacists' services into primary care sparked CIPA's interest.²³ The services pharmacists provide has developed to address particular patient needs.²³ Pharmacists began by answering medication questions then added helping patients manage their diabetes and cholesterol to the services they provide.²³

Payment 'Paradigm Shift'

Although ACOs provide pharmacists with an opportunity to improve patient care and reduce costs, there is not an ACA provision to pay pharmacists for their clinical services. Pharmacists are unlikely to receive "direct remuneration from shared savings."²⁰ "However, for the profession, the impact of the ACO could be nothing short of profound and paradigm shifting," Harlow says.¹⁷

In moving away from fee-for-service to tying payment to the quality of patient care, pharmacists are at less of a disadvantage for not having provider billing status under Medicare when working as part of an ACO.²¹ Under the ACO, it does

not matter which health care providers can bill for services, “billing is only important as a way to document patient care,” advises Harlow.¹⁶

Physicians will likely be eligible for a bonus for ACOs that meet performance goals and are allowed by CMS to retain a portion of the savings.²⁰ The remaining savings most likely will be kept by the ACO to make future investments in patient care.²⁰

While CIPA’s performance incentives under its clinical integration program are given to physicians, CIPA sees the potential for rewarding all medical home team members for their efforts under an ACO.¹⁹ Any ACO shared savings CIPA would be allowed to keep would be reinvested in structural improvements.¹⁹ However, contracts with health care providers could be tied to quality outcomes and financial performance.¹⁹ CIPA is focusing on billing for pharmacist-provided MTM under Medicare Part D and will pursue additional billing and contracting opportunities with private payers.^{24,25}

Advice for Pharmacy Leaders

A pharmacy leader who is interested in being part of an ACO “will need to partner with physician groups and work with the administration to raise the level of awareness of what their staff is capable of in the direct patient care arena. By and large, these folks are completely unaware of what pharmacists can do and what the scope of practice of pharmacy is,” Harlow says.¹⁷ A pharmacy leader should make the case for including pharmacists in an ACO by creating clinical protocols and business plans for the organization’s chief financial officer and physician groups.¹⁷

Although a physician may first turn to a nurse to manage a patient with a “time-intensive” chronic disease like diabetes, a pharmacist is more prepared to help a patient with a complicated medication profile.²¹ Pharmacists can help physicians improve patient care which will help physicians’ overall performance as the health care system becomes more transparent under health care reform.¹⁶

Pharmacy leaders should explore which organizations are taking the lead in creating ACOs in their area and reach out to them. Pharmacists also can start learning more about medical homes, which are a “natural extension” of ACOs.²²

Pharmacy leaders should participate in as much of an ACO’s development as possible.²³ For example, pharmacists should review the needs in their practice setting and suggest how a pharmacist could meet those needs.²³ Further, pharmacists should learn what skills other health care professionals bring to the table to coordinate what services physicians, nurses, pharmacists, and other health professionals will provide under an ACO.²³ Pharmacists also should frequently communicate with physicians, nurses, and other health care providers about the services pharmacists can provide.²³ Also, pharmacy leaders should look for a physician champion within their organization who could advocate for including pharmacists’ services in an ACO.²³

Conclusion

ACOs offer hospital and health-system pharmacists an opportunity to leverage their medication expertise in the hospital and ambulatory care settings to improve patient health outcomes and reduce health care costs. Care coordination will be an important element for ACOs and their medical homes and pharmacists are experienced at collaborating with physicians, nurses, and other health care providers.

Pharmacists can help patients better manage their medications and chronic conditions, thereby reducing hospitalizations and rehospitalizations. Pharmacists’ participation in ACOs will help ACOs to reach CMS-determined clinical and financial performance targets that show improved patient results and lower health care costs.

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