

ACO's, Reform, and the Future of Prevention

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- 150+ Medical Groups in CA
- 13 Million people in HMO delegated model +5-6 M in FFS = 18 Million +/-
- Both private and public sector care
- Trade assoc interests: Lobby & Business
- Push for QI, consistency, affordability
- Collaborator Culture for QI & EBM
- Measurement & performance "culture"
- View ACO as validation of model

Take Home Messages

1. Reform at the delivery system level is crucial—
Costs are a Homeland Security threat
2. Prevention needs to happen upstream, or even
a dream delivery system will be swamped
3. The ACO initiative may finally align financial
incentives, political will, and personnel energy
to integrate Public Health approaches into the
delivery system—especially prevention,
disparities, and creative community action
4. This won't happen passively

“Prevention” —in candor

- Frontline doctors don't do much primary prevention (other than peds). This is not our strong suit.
- Early recognition and better chronic care may delay, diminish, or prevent avoidable morbidity...but rarely prevent incidence
- Real prevention starts long before the traditional office visit

“Upstream” instead of “Up the Creek” — *Do we have the Paddle?*

- Community-wide accountability with ACO could create a business case, finally, to:
 1. Bridge financial interest silos—purchasers, payors, providers, public, private, etc.
 2. Reach and engage disregarded populations
 3. Use smarter approaches where traditional ones fail—doctors and hospitals moving occasionally to a “respect and reinforce” role

Long time to wait for Reform



Really a long time



Two Lessons I Learned Age 22

- There is no sense changing something unless:
 1. What you build is decisively better than what's here now
 2. What you build can support itself once the novelty wears off

The ACO's are Coming...

1. ACO's are specified in ACA. CMS regs to come
2. Start date for rabbits January, 2012
3. CA has been doing large scale "ACO pilots" for 15-20 years → many tests of concept in many settings. Instructive successes and failures
4. It can work...for both Quality & Affordability... for large populations and diverse regions.
 - Locally organized, clinically motivated, technologically sophisticated, administratively competent, fiscally responsible systems
 - Variability is a continuing problem

Editorial Messages

- California has a head start in many aspects. Significant gaps, challenges await. Humility
- At last, we have a chance to align financial incentives with quality & societal goals
- Primary care needs urgent, courageous boost. Without this, it all collapses
- Patient experience will determine whether this floats or sinks. CA has some catch-up to do.
- Local leadership is key, and local experience will guide the country.

The CA Medical Group Mandate

- Use “central intelligence” and administrative innovation: Support primary care and specialty physicians & teams to enable practice at higher proficiency and greater professional satisfaction than achievable in isolation.
- Respond to changing needs of nation’s largest & most diverse population
- Do it with sustainable business model

California Group Viewpoint

- Community-wide systems are foundation for effective care of populations—not small offices
- Group provides critical infrastructure support for connected, Advanced Medical Homes—with accountable “team play” in return
- Save money by supporting timely “right” care ...not by dodging risk or obstructing care
- Pts are “ours” long term
- Culture of measurement & accountability—Quality, Finance, Community, Workforce
- Lines up nicely with ACO philosophy

Wells' Matryoshka Doll concept: "Home, Neighborhood, City"

- High functioning Medical Homes, inside...
- Accountable, administratively capable, supportive group with population focus ("medical neighborhood"), inside...
- ACO... "municipal utilities" ...fire, police, roads, education, light, libraries...and **Public Health**

OK...What Exactly is an ACO?



Quick History of the ACO

- New acronym 2009 → New Law 2010
- Strong appeal from New England insiders —Dartmouth, Brookings, Fisher, McClellan, NEJM, IHI & Berwick—year long dialogue → influenced CMS policy
- Intense interest: 1000+ at June ACO Summit in Washington DC...more in Oct.
- Finally...recognition of CA group model & role of risk. Low cost = notable point

Accountable Care Organizations

Three principles of the ACO mantra 2009:

1. Local organization and accountability
2. Standardized performance measures
3. Payment reform (go beyond FFS)

From Brookings Institute ACO Learning Collaborative Sept, 2009

ACO's—Likely Attributes 2010

- Network offers full continuum of care
- Sufficient size and IT horsepower to measure, connect, apply (>5K MC lives)
- Sufficient administrative capacity (and reserves) to manage complex payment mechanisms (probable minimum 30K)
- Medicare & Medicaid by law...likely will expand to commercial...hazy now

Reform Act Provisions

- HHS designs shared savings model—likely 3 tiers of sophistication, but scuffling now
- Create legal framework for shared dollars
- Wide range of potential qualifying orgs
- Priority to those already “up”
- Medicaid included along with Medicare
- Start date for early birds: January, 2012

California Challenges

- Hospital buy-in with groups & payors
- Public and private sector overlap
- Rural vs Urban
- Regional variation
- Primary care workforce shrinkage
- Remember: Affordability is key promise
- Quality alone is not enough.

Several Ripe Opportunities

- Define Health Disparities as clinical challenge and business opportunity... ideally suited for systematic approaches
- ACO as a Public Health vector
- Move upstream to roots of illness
 - Schools, of course
 - Employer outreach to reinforce chronic care interventions & healthy living
 - Community organizations

Primary Care is Number One



Primary Care Workforce

- This is the loose bolt in the rotor
- The rhinoceros in the bedroom
- The hole in the gas tank
- The iceberg in the Atlantic
- The scorpion in your shoe
- That e-mail you never should have sent
- It will not fix itself.

Primary Care Triple Whammy

- ACO concept is built upon a crumbling foundation, much worse than we think
- 1. 1/3 of CA PCPs will retire in next 5 years
- 2. PCP pipeline running dry. Trainees siphoned to more appealing disciplines. >50% drop in 12 years, getting worse.
- 3. Most PCP's are not working with same productivity as their fathers...good & bad

Crucial Test for the Future PCP

- Will participation enable a physician to practice in a prideful, collegial fashion, concentrating upon the features that attracted him or her to medicine in the first place, in a financially sustainable manner, with a sensibly balanced life?
- *If yes, ACO's will make it.*
- *If not, they will fail*

PCMH vs ACO—Which will it be?

(Both)

- Small offices simply can't afford and staff all WYODI* criteria and 'work them.' The rare exceptions don't move populations
- "Systems" don't do 1:1 communication
- Synergy is the answer, and it IS achievable. (We think that's what we do.)
- No time for turf battles....

* *What You Oughta Do Is....*

The Hospital Role → Another talk



Obstacles and Opportunities



10 Philosophical Quandaries

1. Individual provider vs Group—who's #1?
2. Payor vs Group—who's responsible for population?
3. Hospital vs Group—who's the dog, who's the tail?
4. FFS vs Global capitation—is it “either/or?”
5. Quality vs Affordability—must we choose?
6. Primary care vs Specialists—where's the balance?
7. Fill beds vs reduce total cost of care—either/or?
8. “More is Better” vs “More is Wasteful & Dangerous”
9. Free choice vs accountable network RBO—coexist?
10. California vs Boston—fruits & nuts vs beans and brains? *...or...Birkenstocks vs Red Sox...*

Challenges we faced pre ACO...

Likely to stay with us a while

- Turf & trust—Govt, insurers, groups, hospitals, medical associations, employer/purchasers, advocacy groups
- Misaligned incentives will persist
- Geographic variability in resources
- Population diversity
- Capital for systems development
- Takeways will not be peaceful

Really Thorny Ones

- There are virtually no American models for care which yield BOTH high quality AND moderate cost without network limits.
 - Impossible to sell restrictions in “choice”
 - Incentives to “stay in” crumble under stress
 - Risk bearing foolish if patients can wander
- Evidence based medicine distrusted
- Smearing of all aspects of reform in TP hysteria, anti-governmental backlash

Legal Obstacles: 3-headed dog

- FTC—restriction of trade, price fixing, collusion—clinical integration for community benefit vs monopoly & profiteering?
- DOJ—Fraud and abuse, Stark Law
- OIG—Civil Money Penalty, i.e. incentives to reduce care—how to fit with hospital stay optimization.
- *Crucial test: Does Community benefit in BOTH quality and affordability? If “Yes,” it will work. Public Health Officer will be asked that question.*

Moving Upstream



Moving Upstream: Employers

- Employer based initiatives—dramatic, fast results for chronic illness risk reduction.
- 2080 contact hours/year vs 3 office visits
- \$ value of lost but reclaimable productivity exceeds health insurance costs (epiphany)
- Local customization and coordination essential.

Upstream: Schools

- Health Education, age-appropriate, every school day, every year—braided into curriculum, not separate “capsules”
- Physical Education & Sports/healthy rec
- Screening and minor acute care onsite
- Nutritional support
- Contact avenue to families and elders

Upstream: Families

- Diabetes is a 3-generation illness
- Instead of one PCP for 2000 patients... how about 3, 4...maybe 10 care coaches for one patient...in each household?
- Medication adherence...where is the most effective touchpoint?
- Ditto for diet, exercise, depression
- Invest in the teaching—cheap compared to an MI, CVA, amputation, dialysis, etc.

Upstream: Communities

- Cultural affinity and advocacy groups
- Disease-focused advocacy groups
- Clubs, churches, charities,
- Neighborhood organizations
- Media—huge range
- Recreation all ages
- Educational venues—fairs, gathering points, art, sports...wide open

Upstream: Government

- Public Health (obviously): measure, report, advise, educate, intervene
- But also define one doable PH role for every governmental organization:
 - Law enforcement, Fire, Transportation, Highways, Urban Planning, Food & Agriculture, Media oversight, Education, Utilities...

2010 - 2015

- Should be a golden age of creative thinking and rapid communication
- Tolerance and expectation for disruption in pursuit of greater good—accommodate “great leap” system improvements
- Diplomacy at local, state, federal levels
- Some “Tough Love” and friction coming, too

Bill Bryson's exhortation:

- Do More
- Try Harder
- Start Now



Questions?



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Standards of Excellence, Health
Disparities, ACO presentations from
CAPG conference, other information
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