Accountable Care
A New Era for Primary Care

UNECCOM
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October 10, 2014
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Objectives

By the end of the session the participant will:

- Understand the key elements of an Accountable Care Organization (ACO)
- Understand the concepts of population health management, the advanced medical home and the medical neighborhood
- Understand the opportunities for clinical transformation and the role of primary care in Accountable Care
What is Accountable Care?

- Affordable Care Act (ACA) mandated health care reform – both in how care is paid for and how care is delivered
- Goal: to meet the “Triple Aim”
The root of the problem in health care is that the business models of almost all US health care organizations depend on keeping these aims separate. Society on the other hand needs these three aims optimized (given appropriate weightings on the components) simultaneously. Tom Nolan, PhD.

Source: IHI.org
The Accountable Care Organization

An Accountable Care Organization (ACO) is a set of health care providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.
"The Accountable Care Organization is like a unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one."

California Healthcare Foundation President and CEO Mark Smith
Characteristics of an ACO

- A strong Primary Care Foundation
- Ability to manage patients across the care continuum and across different institutional settings
- Advanced Care Coordination and ability to identify high risk patients
- Advanced IT systems: including EHR’s, Patient Portals, ability to exchange health information, and Data Analytics
- Ability to manage cost and quality despite a variety of
- Different payment models (fee for service, episode payments, bundled payments, global payments, etc)
ACO : Focus on Primary Care

- Based on patients/beneficiaries attributed to a primary care physician (PCP)
- Patients/families have a strong, longitudinal relationship with their Medical Home
- Team Based Care; all team members work at their highest level
- Population Health Management – including prevention and chronic disease management
- Emphasis on Care Coordination and Care Management
- Right care at the right place at the right time
- Move from the hospital to care in the ambulatory setting
That’s What I do!

- That’s what I was trained to do
- But that is not what they pay me to do right now…
- And, I can’t do it alone
Primary Care Challenges

The Workload

Complexity
- Typical PCP must coordinate care with:
  - 229 other physicians
  - 117 practices \(^{(1)}\)

Time
- A primary care physician with might spend:
  - 7.4 hours per day doing recommended preventive care \(^{(3)}\)
  - 10.6 hours per day doing recommended chronic care \(^{(4)}\)

Knowledge
- To stay current, an internist would need to read
  - 20 articles a day
  - 365 days a year

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\(^{(3)}\) Yarnall et al. Am J Public Health 2003;93:635
Our Challenge is to Move

From

Physician centered system

Volume-based reimbursement

Price focus

To

Patient Centered system

Value-based reimbursement

Total Medical Expense
Requires Behavioral Change

“I am accountable”  →  “We are accountable”

From Accountable Care Organizations, Marc Bard and Mike Nugent, 2011
Moving to the New Canoe

Hospital and physician providers must address how to optimize performance in the current environment while also preparing to “jump” from Curve #1 to Curve #2.

Curve #1: FEE-FOR-SERVICE
- All about volume
- Reinforces work in silos
- Little incentive for “real” integration

Curve #2: VALUE-BASED PAYMENT
- Coordinate care
- Shared Savings Programs
- Bundled / Global Payments
- Value-based Reimbursement
- Rewards integration, coordination, quality, outcomes and efficiency
- Blurring lines between payors and providers?
Physician Compensation and Practice Transformation Process

**Current State (Volume)**

- **Productivity/Service**
- **Efficiency**
- **Quality**

**RVU**

**Future State (Value)**

- **Patient Experience/Access**
- **Total Cost of Care**
- **Population Outcomes**

**Operations:**
- Care Team

**Services:**
- Integrated behavioral health

**Infrastructure:**
- Advanced Information Systems

**Culture:**
- Minimum work standards
The Patient-Centered or Advanced Medical Home

- A continuous relationship with a personal physician coordinating care for both wellness and illness

- Whole-person orientation

- Physician-directed team

- A system of care, not a place

- Care is coordinated and integrated across all elements of the health system and community
Key Attributes of The Medical Home

1. Relationship with a personal physician
2. Team-based care
3. Whole-person orientation
4. Coordination and integration of care across all settings
5. Quality and safety as hallmarks
6. Enhanced access to care
7. Payment that appropriately recognizes the added value to patients of a patient centered medical home
1. Relationship with a Personal Physician

- Continuous
- Mindful clinician-patient communication; trust, respect, and shared decision making
- Patient engagement
- Provider/patient partnership
- Culturally sensitive care
- Whole person care
2. Team Based Care

- Provider leadership
- All staff involved;
  - shared mission and vision
- Patient participation, family involvement options
- Responsibility for care distributed across the team
- Clear roles and responsibilities
- Effective communication; regular meetings to plan care
- Information technology support
Who’s On the Team?
Think Out of the “Box”
3. Whole Person Orientation

- Provide for comprehensive care; acute and chronic conditions, prevention and end of life care
- About 70% of care should be provided by the team
- What is not provided is arranged for and coordinated
- Work is organized around the patient
- Focus on patient needs and convenience
- Sensitive to patient culture and values
- No barriers to access
4. Quality and Safety

- Evidence-based best practices and decision support
- Performance measurement and improvement
  - include patients and families
- Culture of innovation
- Utilization of information technology
- Risk management
- Regulatory compliance: NCQA, other
5. Coordination and Integration Across all Settings

- Collaborative relationships; hospital, behavioral health, specialty care, pharmacy, PT/OT, case management, public health
- Care coordination
- Leverage health information technologies; electronic health records, e-prescribing, registries, population management reports, personal health records, protocols and reminders, evidence based decision support, internet access and email communication
- Community based resources
6. Access to Care and Information

- Same day appointments/expanded hours
- After hours access coverage
- Lab results highly accessible
- Online patient services
  - e-Visits
- Culturally sensitive care
7. Payment that Recognizes the Value of the Medical Home

- Rewards health, not health care
- Relationships with payers and plans
  - Aligned incentives
- Disciplined practice and financial management
- Optimized practice design/redesign
  - Change management
Community Family Patient

**Patient Centered Medical Home**
Provides patient-centered, comprehensive, and coordinated care that supports patient self-care

**State and local public health**
- smoking cessation
- tobacco use prevention
- Infectious disease control
- chronic disease prevention

**Community and social services**
- hospice, personal care services, home-delivered meals, home modifications, assistive technology, accessible transportation, education and support for patient self care

**Acute and post-acute care**
- inpatient hospital care
- rehabilitation
- skilled nursing care
- home health services
- emergency department

**Ambulatory care**
- specialty care
- ancillary services (e.g., physical therapy, podiatry, speech therapy)
- retail clinics

**Diagnostic services**
- lab
- imaging

**Pharmacy**
- medication management
Clinical Transformation

• Why is this so important?
ACOs

- need to provide and demonstrate value to patients/families and employers
- depend on market share and loyalty to be successful
- are collaborating directly with employers to care for populations and better manage the total cost of care
Consumerism in Health Care

- ACA creates a marketplace – forces the market to change, and to provide better value at a lower cost
- “God’s work on Wallstreet terms”
- Employers moving more of the cost to patients; higher deductibles, higher co-pays, move to the healthcare exchanges, more out of pocket
- Payers looking to contract for less cost
- Employers looking for creative, lower cost solutions
What Consumers Want
Advisory Board Study

- Convenience is king.
- Same-day appointments trump walk-in and wait.
- Evening or weekends? Depends on age.
- Clinic near errands or work? They’d rather meet you online.
- A one-stop shop is worth the drive.
- Consumers prioritize convenience over credentials—and continuity.
- High-tech beats high-quality.
- Don’t rely on your brand.
- Talk about money—consumers will trade access for bill info.
- Know your target population—particularly their age.
CVS and Wal-Mart... are Primary Care?

- Disruptive innovation – take from the fringe (flu shots) and add continually services (chronic disease management)

- 42% consumers age 18-24 prefer independent retail pharmacy to primary care

   **WHY?** less wait, nearby, low cost, on demand
The Ten Descriptors of Better Systems of Care

1) Care based on continuous healing relationships:

2) Customization based on patient’s needs and values.

3) The patient as the source of control. Encourage shared decision-making.

4) Shared knowledge and the free flow of information:

5) Evidence based decision making.

6) Safety as a system property.

7) The need for transparency.

8) Anticipation of need.

9) Continuous decrease in waste.

10) Cooperation among clinicians. [“I to we” within practices, across practices, across systems and throughout the community.]

There are many ways to get to a better system of care. Physicians must lead the way.

Crossing the Quality Chasm, Institute of Medicine
Call to Action

- Primary Care is Regaining Strategic Importance
- Participation is Critical
- This is a Team sport
- Clinical Transformation- Move to the Advanced Medical Home
- Have Everyone Work at Their Highest Level
- Focus on Fundamentals
- Foster Community Connections
- Leverage Your Medical Neighborhood - partner with your specialty colleagues
- Be Holistic, use Systems Thinking
- Get Data to Make Good Decisions
Questions?