Primary care in the ACO: The role of primary care in the future healthcare system

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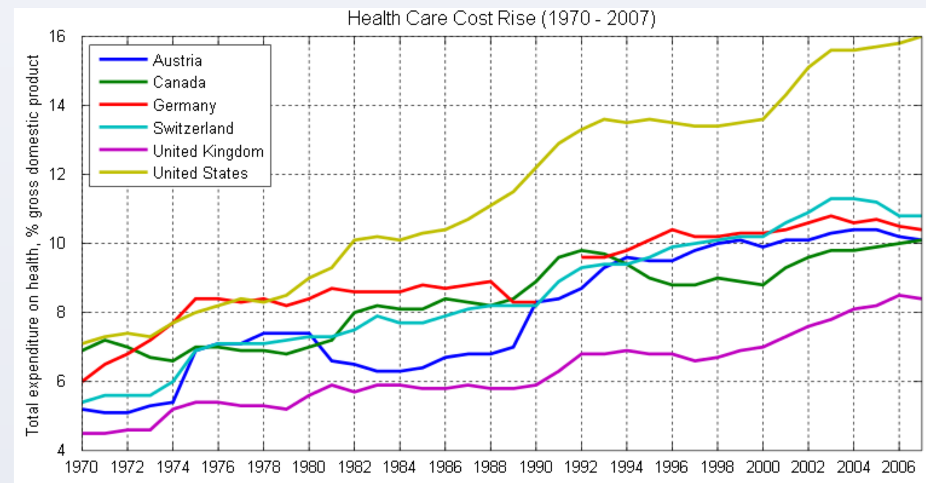
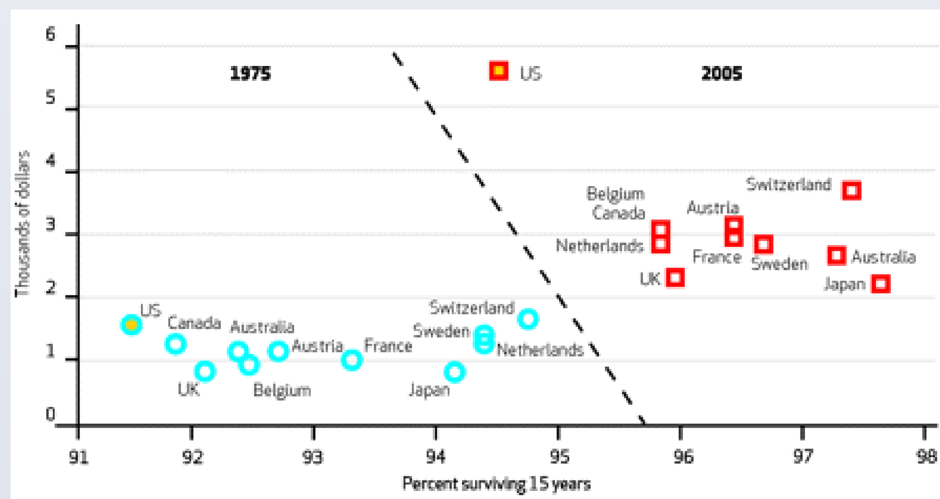
BACKGROUND

THE PROBLEM

Healthcare spending has been growing faster than the economy for many years, projected to reach 25% of the GDP in 2025 and 49% in 2082. This trend far surpasses any other nation.

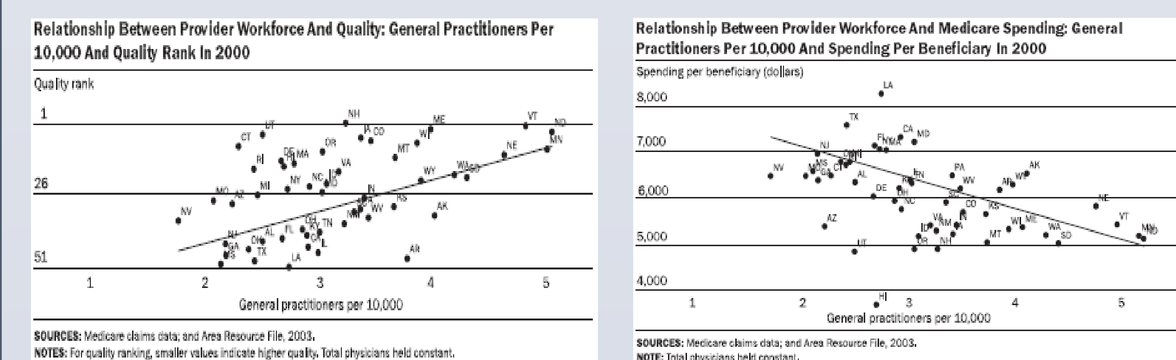


Ranked 42nd in life expectancy, the US receives the lowest value when compared to other industrialized countries and that disparity is growing.



VALUE OF PRIMARY CARE

In Medicare data, states with more PCPs have higher quality and lower cost



THE TRIPLE AIM

The Patient Protection and Affordable Care Act of 2010 suggested that healthcare providers meet this Triple Aim through Accountable Care Organizations (ACOs) through the Medicare Shared Savings Program

RESEARCH QUESTION

What is the impact of the ACO Final Rule on the role of primary care in the ACO?

OBJECTIVES

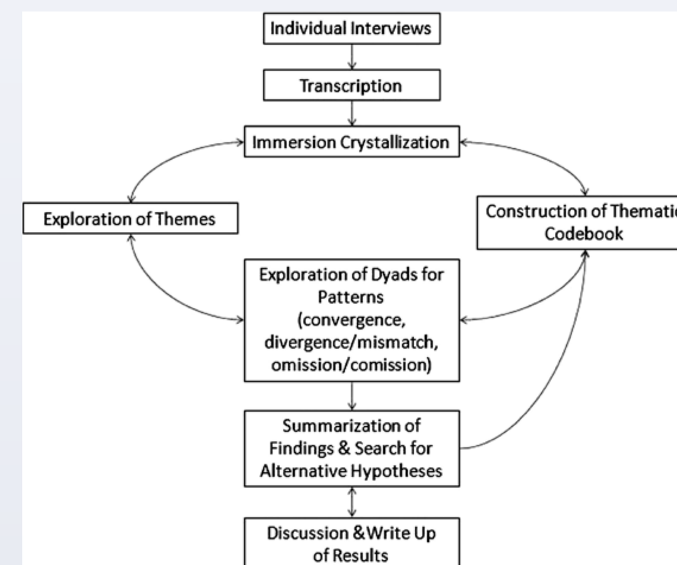
- If the goal of the ACO is to meet that Triple Aim and Primary Care has been shown to increase value, to what extent does the ACO Model promote Primary Care?
- How can primary care best take advantage of this opportunity?

ACCOUNTABLE CARE ORGANIZATION DEFINITION:

"Providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth."

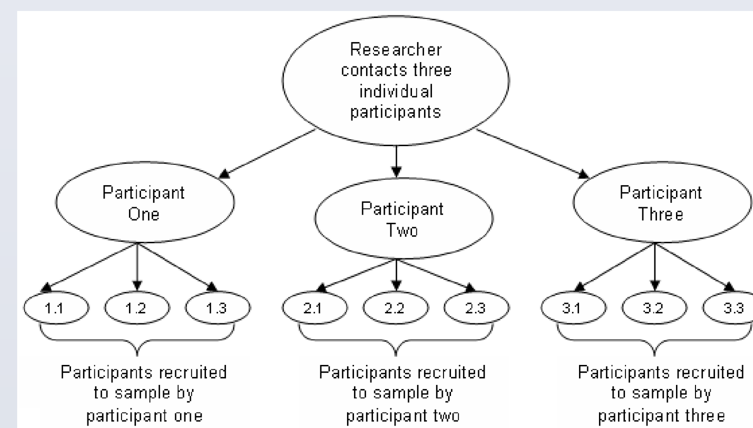
MATERIALS & METHODS

SEMI-STRUCTURED INTERVIEW DEVELOPMENT: IMMERSION CRYSTALLIZATION



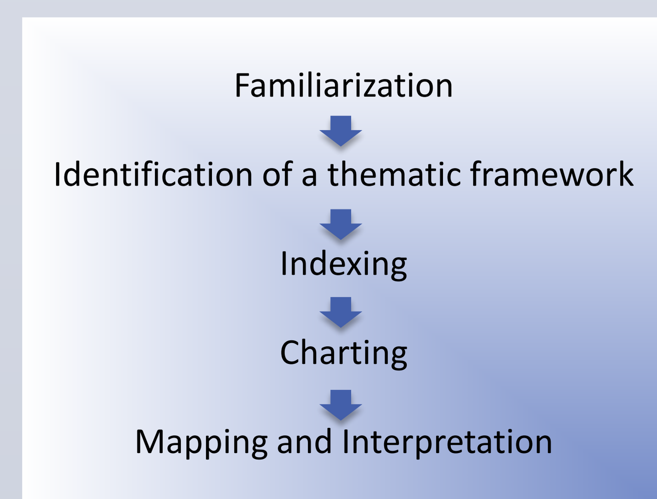
Allegretti A et al. Family Practice 2010;27:676-683

PARTICIPANT RECRUITMENT: SNOWBALL SAMPLING



Stakeholder Group	Done	Upcoming
Thought Leaders	4	3
Government Agencies	2	1
Provider Groups	3	3
Purchasers	1	1
Payers	0	1
Producers	1	0
Policymakers	0	2
Consumer Groups	0	2

DATA SYNTHESIS: FRAMEWORK ANALYSIS



RESULTS

KEY THEMES

THERE ARE REGULATIONS IN THE FINAL RULE THAT PROMOTE AND INHIBIT THE FOUNDATIONAL ROLE OF PRIMARY CARE IN THE ACO

"Primary care should be the foundation of the ACO because primary care is the core function of any well-functioning deliver system—a personalized, medical home is the most fundamental component of all care"

Factors that promote primary care
- Safety net clinic involvement
- Prospective beneficiary assignment
- Reduction in number of metric
- Primary care role expansion into population and public health

Factors that Inhibit primary care
- Higher bar for primary care without guaranteed resources to pass this bar
- Upfront investment capitol gives hospitals, multi-specialty groups the advantage
- Overregulation
- One TIN to an ACO may limit access in certain areas
- Specialists can be counted as the primary care provider

THE MOST EFFECTIVE WAY TO BEND THE COST CURVE IS THROUGH PAYMENT REFORM, WHICH REQUIRES ACOS TO ACCEPT RISK AND CREATE INTERNAL INCENTIVES THAT PROMOTE PRIMARY CARE

"When providers are paid a salary they provide little care for few; when capitated they provide little care for as many as possible; when paid for performance they provide as much care as possible for the stuff being measured; and when fee for service they provide as much care as possible for as many as possible."

- Transition from fee for service toward capitation
- Pay based on value created
- Separate performance risk from actuarial risk through stop loss insurance, reinsurance, or risk-adjustment
- Do providers base clinical decisions on incentives?
- Specialists need incentives to link patients to primary care
- Patient incentives to remain within the ACO and to better their own health

THE TRANSFORMATION OF PRIMARY CARE PRACTICES INTO PATIENT-CENTERED MEDICAL HOMES IS CRITICAL FOR ACO SUCCESS

"There is an old Buddhist saying that the best fence is a good pasture."

- Recognize support roles within the PCMH
- The level of quality keeps the patients from wandering
- Learning from the CBO study
- Social and environmental determinants drive costs more than healthcare
- Need partnership with communities of solution
- Need support for non-visit care, metric reporting, interoperability
- Prediction Models (need for technology)

THE ACO MODEL WILL VARY WILDLY BY REGION BASED ON THE PRIMARY CARE POPULATION WITHIN THAT AREA, AS WELL AS THE LOCAL HEALTHCARE MARKET

"The most important geographic differences are between high Dartmouth Atlas spenders and low spenders, like Miami versus Portland. Miami needs the ACO to take full risk to drive down the costs, while Portland can take less risk."

- Resources proportional to the health needs of the population, micro-targeted
- Issues include: demographics, integration of the local system, rural or urban
- Highly Integrated areas may have already managed out extra costs
- ACOs as complex adaptive systems
- Not one solution for all, must adapt to local environment

THE FUTURE OF PRIMARY CARE IN THE ACO IS NOT PRESCRIBED; IT REQUIRES PRIMARY CARE TO SEIZE THE OPPORTUNITY TO BECOME CENTRAL TO THE ACO

"If people in primary care can get organized then when hospitals come they can say that they won't be a part of the ACO unless they run the board of directors. The problem is that we are all nice guys and don't exert power. It is time to stop being nice."

- Primary care should be central to the governance of the ACO
- Primary care should accept risk, access investment capital
- The lone primary care practitioner is a dying breed
- Primary care won't gain power naturally; must organize
- Primary care must negotiate for power, now sought after commodity
- Requires leadership that can make change exciting instead of burdensome

EVEN IF PRIMARY CARE TAKES A CENTRAL ROLE IN ACOS, IT IS UNLIKELY THAT THE ACO MODEL WILL SUBSTANTIALLY IMPACT THE OVERALL HEALTHCARE SYSTEM UNLESS CERTAIN GOALS ARE ACCOMPLISHED

"There will be a small effect because not that many groups will do it, not that much money will be saved, the incentives are not that strong, change is difficult, and we have a paranoid population."

- Less risk and more benefit to get buy-in then in a couple of years put the screws on
- Next Step: let it play out, learn from the early adopters; importance of evaluation
- Patient education and patient buy-in, engagement in ACO model
- Strong primary care leadership and investment in primary care functions
- Less regulation, more innovation
- Payment reform away from fee-for-service

LIMITATIONS

Data Collection
Interviews recorded through note-taking
Possible introduction of researcher's personal bias
Makes verbatim documentation challenging
Defense: Allows influence from interviewee body language and other cues
Total Liking = 7% Verbal Liking + 38% Vocal Liking + 55% Facial Liking (Mehrabian)

Analysis
Inter-researcher variability is inherent in framework analysis
Easily biased by analyst's personal views
Defense: Mindful of possible bias introduction; allowed data to drive the analysis

NEXT STEPS

Secondary Question:
What does the average primary care practice need to be successful in the ACO?

Ideas for publication:
Health Affairs blog: The impact of the Final ACO Rule on primary care
Annals of Family Medicine or *American Family Physician:* An in-depth analysis of what primary care needs to know and what tools will be required for success in the ACO

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ACKNOWLEDGMENTS

A special thank you to The Robert Graham Center for their support and funding through the Visiting Scholars Program. Thank you to the UCSF IRB Committee for their approval. Thank you to my mentors for their support and guidance.

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