Medical Management in California Groups: Macro Implications for ACO’s

Wells Shoemaker MD, Medical Director
California Association of Medical Groups

ACO Summit, October 27, 2010
• 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
Long time to wait for Reform

Wrigley Field
1968
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
Group viewpoint: ACO = Validation of CA’s coordinated systems of care

- Formal assignment PCP
- Contractual care coordination responsibility
- Formal, audited, ethical UM and QI programs
- Sophisticated HIT support for coordination, population awareness, measurement, feedback
- Care management programs & personnel
- Complex financial/admin capability
- Public reporting; internal & ext accountability
- Regulatory oversight in public interest
- Risk bearing → Effective cost control incentive
Local “System” Care Management to Expand Physician Capabilities

- Search for at-risk patients
- Personnel for outreach, coordination, navigation, special interventions
- Identify and patch lost connections
- Catch pharma errors, adherence gaps
- Save money by doing the right thing first …not by dodging risk or obstructing
A Problem: Performance Variability in a Diverse State

- California regional variability in:
  - Provider demographics (> 2X)
  - Patient demographics (income, education, ethnicity)
  - Care management infrastructure
  - Structure, size, & financial capacity
  - Leadership “bench strength”

- Only some of those are “actionable”
California can be a crucible

• All of those variables are manifest between states...we *all* need to solve!
• Identify what can be changed over short term & do those first
• Learn to move “upstream” to community, family, employers, schools...public health thinking...build novel partnerships
OK...What will we have to do?
Inventory

- CAPG’s Standards of Excellence
- Four Domains:
  1. Care management practices
  2. HIT
  3. Accountability & transparency
  4. Patient centered care, and…
  5. Coming 2011—Fiscal/Admin capability
Care Management Domain

1. High risk case management program
2. In-house Disease management programs
3. Hospitalists
4. In-person inpatient concurrent review
5. Post discharge continuity of care
6. ER use
7. Generic Rx
8. Experts for specialized services
Quick Tools for Change (2 yrs)

1. Registries—Population Awareness
2. Channels to deliver PHI for real time decision support + provider measurement & feedback (EHR *not* essential)
3. Personnel & systems for complex patients
4. Cost awareness data down to MD level
5. Collegial engagement for change—Not a part time, passive task! (Beckman exponent)
6. Financial incentives for intended functions
Resources to Build Care Mgt: $  

• Prospective cap payment → enabling
  - *Unclear if CMS flows will be sufficient*

• Loans—not easy for IPA

• Investor capital—not generally avail to IPA

• Bonds—not easy for private sector group

• Grants—stretch for low resource groups, chase butterflies, consume energies

• “Sugar Daddy” relationships tricky
Alliances and Consolidations

• Create larger organization by merger, acquisition, or contracted relationship to reach efficient size...yet retain local connections & ethical leadership
• Hospital affiliation for capital, admin
• Community based consortium
• Health Plan alliance, i.e. Medi-Cal managed care
Primary Care is Number One
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
ACO can Recharge Primary Care

- Care management systems to improve capabilities and outcomes
- Novel, logical payment systems to reward outcomes, team effectiveness
- Scut work abatement
- Admin support for business operations
- Capture the functionality *and* the dollars for HIT meaningful use
- Support for work-life balance & family responsibilities
The Hospital Role
Lots of Permutations

- Hospital Centric—capital & credibility, strong Finance underpinning & admin bench strength…but slow, risk averse
- Group Centric—CA took 2 decades of infrastructure development, seeks risk
- Community Health Center—big gaps
- Plan Centric—Works when integrated, i.e. Kaiser-Permanente, Geisinger
- Governmental structure—COHS in CA
Facts of Life: Hospital & Group

- Hospitals are generally inept at ambulatory care. Docs as “workers” → high maintenance relationships
- Medical groups don’t have grip on complex personnel & industrial functions of hospital. Limited access to capital.
- Neither has time to learn each other’s business
- Classical integrative negotiation opening
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
Questions?
Contact Information

Wells Shoemaker MD
wshoemaker@capg.org

www.capg.org
Standards of Excellence, Health Disparities, ACO presentations from CAPG conference, other information on public access home page