Accountable Care Organizations

Assessing Infrastructure

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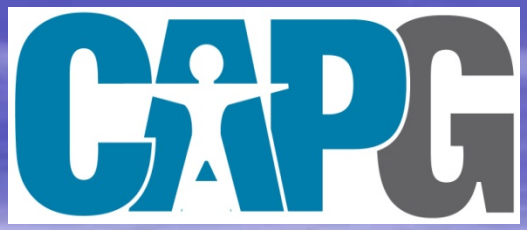
What’s Under the Hood?

Messages

1. CAPG's Standards of Excellence has evolved into a checklist for ACO functionality for ambitious medical groups

2. Effective to stimulate and respond to group, purchaser, and governmental audiences

3. Eventual formal criteria for CMS should incorporate this 4 year experience as a road-tested "pilot" of >10M covered lives



- 150+ Medical Groups in CA
- 12-13 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”
- “Fertile Crescent” for the ACO model

Philosophical Basis: Group View

- 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 avoiding risk or obstructing care
- Pts are “ours” long term
- Respect administrative competence
- Culture of accountability—Quality and Finance

Matryoshka Doll concept: “Home, Neighborhood, City”

- High functioning Medical Homes, inside…
- Accountable, administratively capable group with population focus (“medical neighborhood”), inside…
- ACO…”municipal utilities”…fire, police, roads, education, and light

Medical Group Mandate

- Using “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

How do we do that?

- Public Relations claims not enough
- Many ranking & reporting systems incomplete or off target
- Power of peer-developed criteria much greater than top-down regulation (ICSI lesson from 1990's)

Standards of Excellence

- CAPG Board Initiative 2006
- Annual surveys 2007-10
- Executive attestation *(i.e. Casalino & Shortell)*
- Voluntary participation—groups caring for 90+% of our lives.
- Scored with detailed feedback to groups
- Scores published in “star” format—1 to 4

Four Domains

1. Care Management Practices
2. HIT
3. Accountability and Transparency
4. Patient Centered Care

Care Management

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

HIT

1. Preventive & Screening registries
2. Chronic care registries—bi-directional flow, accurate, updated, incorporate with work
3. BP capture
4. EMR support
5. Secure electronic communications
6. E-prescribing

Accountability & Transparency

1. Clinical measures public reporting—P4P
2. Patient satisfaction—in-house or external
3. Provider satisfaction
4. Resource use & variability—individual MD
5. Performance incentives—individual MD
6. Authorization TAT
7. Financial standards: Strict CA SB 260
8. Publish Standards of Excellence

Patient Centered Care 1

1. Secure patient-to-MD communication
2. Same day access
3. After hours, Sat, & convenience access
4. Time lag to appointments
5. Cultural education
6. Interpretation services (useful ones)
7. Staff with proficiency multiple languages
8. Ethnicity/language info accessible

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9. Personalized reminders
10. Advice line
11. Home visits for hardship/complex pts
12. Shared decision making protocols
13. Website with expanded profiles of MDs

Harder Every Year

- Higher bar for “points”
- Increasing scalability & specificity
- Increasing documentation requirement
- New criteria as environment changes
  - *(i.e. Meaningful use, ACO, timely access, culture & language, ER & readmits, resource consumption)*

Complementary to P4P

- Analogy: SOE is “sticker” list of equipment on car
- P4P is “Consumer Reports” on function, satisfaction, repair experience

- Wise purchaser will pay attention to both

Challenges we faced pre ACO… Likely to stay with us a while

- Primary care workforce shrinkage
- Trust between parties—govt, insurors, groups, hospitals, medical associations, employer/purchasers, advocacy groups
- Misaligned incentives will persist
- Geographic variability in behavior and resources
- Capital for systems development
- Takeways will not be peaceful

Must Bolster Primary Care

- Income improvement—parity with England
- Lifestyle improvements
- Scut abatement
- *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*

Several Ripe Opportunities

- Define Health Disparities as clinical and business challenge well-suited for systematic approaches
- Employer outreach to reinforce chronic care interventions
- Schools
- Community organizations

Questions?

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