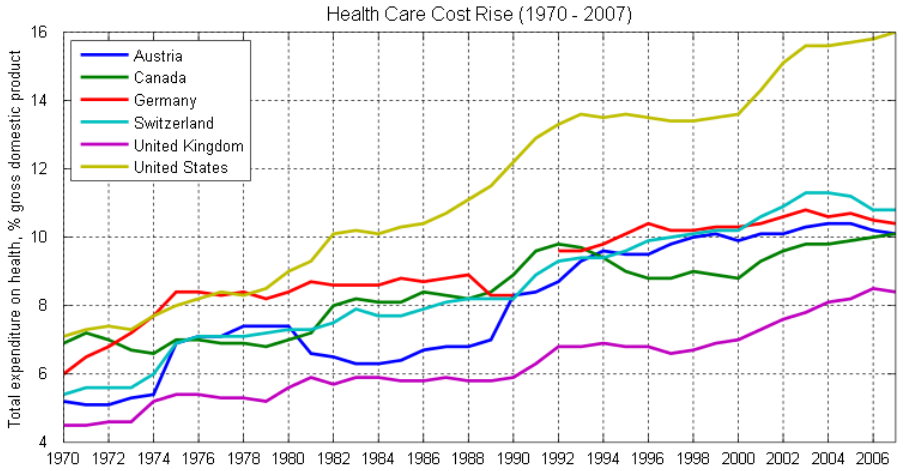
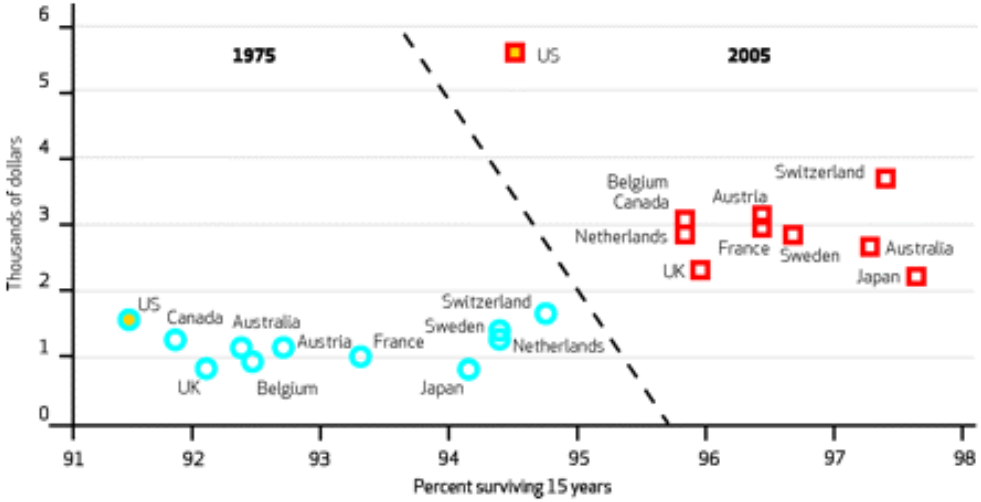
PRIMARY CARE IN THE ACO

PREPARED MINDS SEMINAR—ERICA BRODE, MPH

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.





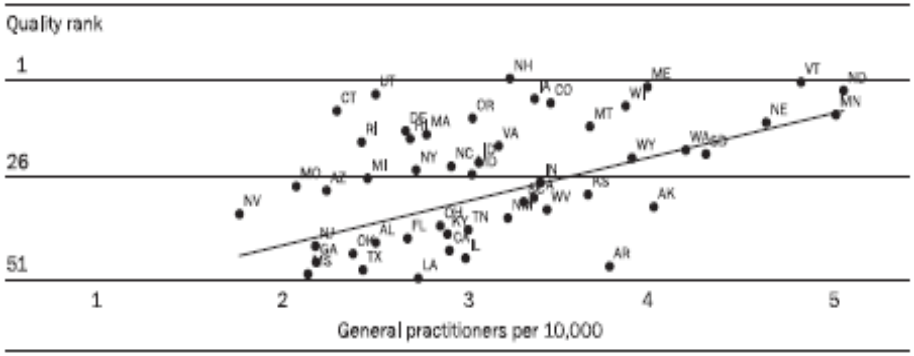
Ranked 42nd in life expectancy, the US receives the lowest value when compared to other industrialized countries and that disparity is growing.

This graph shows per capita health spending and 15-year survival for 45-year-old women in the US and 12 comparison countries, 1975 and 2005.

THE VALUE OF PRIMARY CARE

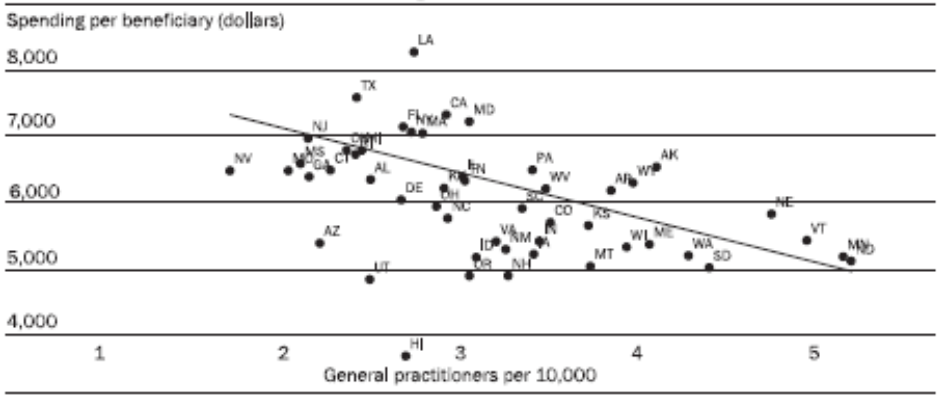
In Medicare data, states with more PCPs have higher quality and lower cost

Relationship Between Provider Workforce And Quality: General Practitioners Per 10,000 And Quality Rank In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTES: For quality ranking, smaller values indicate higher quality. Total physicians held constant.

Relationship Between Provider Workforce And Medicare Spending: General Practitioners Per 10,000 And Spending Per Beneficiary In 2000



SOURCES: Medicare claims data; and Area Resource File, 2003.
NOTE: Total physicians held constant.

THE TRIPLE AIM INITIATIVE

Oct. 2007: Institute for Healthcare Improvement launched the Triple Aim Initiative

- Improve the health of a population
- Improve patients' experiences
- Lower or reduce the rate of increase in per capita costs of care

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

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

ACO TIMELINE

March 23, 2010: Patient Protection and Affordable Care Act passes

Sec. 3022 of the ACA authorizes the Medicare Shared Savings Program

April 7, 2011: CMS Proposed ACO Rule

June 6, 2011: Public comment period ends

August 19, 2011: Pioneer ACO applications due

October 20, 2011: Final Rules published

January 1, 2012: 32 Pioneer ACO Programs Start

The purpose of these Pioneer ACOs is to test the ACO concept in a variety of local markets and learn from these early adopters.

RESEARCH PROJECT

Research Question:

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

Collaboration between UCSF and Robert Graham Center

Kevin Grumbach, MD
Andrew Bazemore, MD, MPH
Robert Phillips, MD, MSPH

IRB through UCSF

METHODS

Qualitative study using in-depth, semi-structured stakeholder interviews. The interview questions were adapted through immersion crystallization

Stakeholders were purposively sampled and identified through the snowball technique

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

Total n=24

Data was analyzed using framework analysis

IMMERSION CRYSTALLIZATION

Data was gathered through open-ended, semi-structured interviews where the interviewer used cues and prompts to help direct the interviewer into the research topic area, while still allowing for a in-depth discussion of the topic

IMMERSION: Process by which the researcher immerses themselves in the data

CRYSTALLIZATION: Temporarily suspending the immersion process to reflect on the analysis experience and attempt to identify patterns and themes

These processes continue through the data collection process until stable patterns emerge from the data

SNOWBALL OR CHAIN SAMPLING

"Snowball or chain sampling involves utilizing **well informed people** to **identify critical cases or informants** who have a great deal of information about a phenomenon. Often a few key informants or cases will be **mentioned multiple times** and take on **additional importance.**"

- The initial list of informants was developed through consultation with my mentors, Andrew Bazemore and Kevin Grumbach
- Initial informants were asked to give suggestions of other informants in their stakeholder group
- Informants who were recommended more often may get higher weight in inter and intra stakeholder group analysis

FRAMEWORK ANALYSIS

Similar to grounded theory, but better suited for applied policy research with specific questions, limited time frame, pre-designed sample (professional participants) and a priori issues.

Conceptual Framework: Not a collection of concepts, but a construct in which each concept plays an integral role. Lays out the key factors, constructs or variables and presumes relationships.

Five Steps:

1)Familiarization
2)Identification of a thematic framework
3)Indexing
4)Charting
5)Mapping and interpretation

Key features of this type of analysis: Grounded, dynamic, systematic, comprehensive, easily retrievable, allows within-case and between-case analysis, and is accessible to others.

QUESTION FORMATION

Initial set of questions were based on the American Academy of Family Physicians recommendations to CMS for the ACO Final Rule

Initial Question Domains:

Role of Primary Care in the ACO
Beneficiary Assignment
Quality Measurements
Voluntary Assignment
Risk Reduction
Needs Assessments
Governance
Disbursement of shared savings
Geographical variation
Next Steps

Additional Questions Domains added through Immersion/Crystallization Process:

Tools needed for PC in the ACO
Response to CBO study
Performance and Actuarial risk separation
Payment methods
Risk adjustment
Incentives

LIKERT SCALE QUESTIONS

A couple of Likert questions were added for a quantitative hook.

If these questions are used in the analysis, an addendum will have to be added to the IRB

On a scale from 1 to 5 (1 being least supportive and 5 being most supportive), how supportive is the ACO model for primary care under the current rules?

On a scale from 1 to 5 (1 being least supportive and 5 being most supportive), how supportive could the ACO model be for primary care at its full potential?

RESULTS: 6 KEY THEMES

1) There are factors in the Final Rule that promote and inhibit the foundational role of primary care in the ACO

2) 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
   - The impact of metrics as incentives for primary care

3) The transformation of primary care practices into patient-centered medical homes is critical for ACO success
   - Technology Is instrumental to the success of primary care in the ACO, especially relating to population care management

4) The ACO model will vary wildly by region based on the primary care population within that area, as well as the local healthcare market

5) 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

6) 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 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 metrics
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
Need for upfront investment capitol gives hospitals and 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."

Payment Reform

Transition from fee for service toward capitation
Pay based on value created

Risk Acquisition

Separate performance risk from actuarial risk through stop loss insurance, reinsurance, or risk-adjustment

Incentives

Do providers base clinical decisions on incentives?
Specialists need incentives to link patients to primary care and to think about the whole person
Patients need 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."

PCMH
Recognize support roles
The level of quality keeps the patients from wandering

Care Management
Spectrum of provider interactions
There is much to learn from the CBO study

Community Engagement
Social and environmental determinants drive costs more than healthcare
Need communities of solution with the ACO as a community resource

Technology
Need support for non-visit care, metric reporting, interoperability
Prediction Models

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."

Flexibility of the ACO Model

Resources proportional to the health needs of the population, not their desire for care
Population needs assessments should be micro-targeted, not state-based
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 Ascendancy

Primary care should be central to the governance of the ACO
Primary care should receive as much of the shared savings as the amount of risk they are willing to accept
The lone primary care practitioner is a dying breed
There is no reason primary care can't be credible and have access to investment capital
Primary care won't gain power naturally; a lot of invested interest in specialty care
Primary care must organize itself
Primary care must learn to negotiate for power as they are now the 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."

Transition

Smart to make the ACO more appealing with less risk and more benefit to get buy-in
Then in a couple of years put the screws on

Next Steps

Let it play out
Learn from the early adopters; important of evaluation
Patient education and patient buy-in

Goals

Strong primary care leadership and investment in primary care functions
Patient engagement in ACO model, not just healthcare
Less regulation, more innovation
Payment reform away from fee-for-service

FURTHER ANALYSIS

Inter and Intra-stakeholder group analysis of themes

Challenging with n of 1 in some of the sub-groups

Likert Analysis

Overall analysis

Average support for primary care in current ACO model: **3.5**

Average support for primary care in full-potential ACO model: **4.6**

Outlier analysis

Inter stakeholder group analysis

DISCUSSION: 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

I am the sole analyst as I was the sole interviewer, which increases the risk of bias

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:

Possibly break up data to answer separate questions:

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

QUESTIONS FOR THE AUDIENCE

1) What is the utility of intra- and inter-stakeholder analysis with an n of 1 in some sub-groups?
2) My initial question was specifically about the final rule, while much of the data relates more to how primary care fits into the concept of the ACO. Since this more general question has been addressed in the past, how should I frame my themes?
3) What areas of the themes could be more fully elucidated in upcoming interviews?
4) Are any of the themes confusing? Do you feel that any of the themes try to cover too much or could be expanded?
5) Are there any other relevant research questions that this data could answer?
6) What forums should I seek to disburse this information? How should I break up the information?
7) Other comments, suggestions, or questions?

“We need Winston Churchill because he promised blood, sweat and tears. That is what won WWII, not the promise of a quick and easy victory.”

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