Writing about the AMDA – the Society for Post-Acute and Long-Term Care Medicine Annual Conference is always a challenge. I’m going to describe it with a thesis statement:

The individuals we refer to as long-term care patients should be ground zero for our government’s health reform efforts, and their primary care providers are the gateway to that reform.

Many of these individuals also spend part of their year with acute problems that lead to a hospitalization. That event places them in a post-acute BPCI (bundled payments for care improvement) or CJR (comprehensive care for joint replacement) bundle, but those models are ill-suited for individuals with multiple chronic medical and cognitive problems.

If you accept my thesis, the Society’s Annual Conference should be the most important meeting of the year; its attendees include the primary care providers for the long-term care population. Yet some large medical groups reject the Society, saying it’s too focused on medical directorship or continuing medical education, and less focused on management, payments, and population management.

Focus on Education

Neither individuals nor organizations can ignore their DNA, and the Society began as — and continues to be — a medical education organization. Most attendees come for continuing medical education and in support of their certified medical director status; the faculty are the thought leaders in clinical care and the quality indicator/quality measurement process for nursing facilities.

The conference proved that the organization’s nurture can outweigh its nature. Although the conference delivered the usual menu of CME/CMO coursework, it served up a full day’s track on payment reform and individual programs that are changing care delivery. Improvement to break even.”

A viable full-risk model for physician-led LTC, population management. A panel discussing health information technology included presenter Bill Russell, MD, who serves as the chief medical information officer for an unusual geriatric practice — ChenMed/JenCare. ChenMed is a full-risk geriatric medical practice that partners with Medicare Advantage plans. Dr. Russell described how his team had to develop their own electronic health record system to focus on the patient, not the accumulation of their problems. The group is not paid fee for service, so care isn’t delivered through the paradigm of CPT codes. I’d recommend anyone working on a roadmap for their PA/LTC practice to consider the ChenMed model as a high-quality destination. Getting there from FFS medicine is still a problem, but they are a signpost of what the destination might look like.

Cogent discussions about the importance of physician-led care management. One thing presenters agreed on was that PA/LTC patient-centered care required a physician to lead an interdisciplinary team. Beyond that, ideas quickly diverged. Should the physician (or group) share risk, or serve as a clinician/advocate who can manage care delivery without a direct financial interest in the services’ cost? These issues are truly significant to many of us who dwell inside the current and emerging payment models for PA/LTC patient populations; the existing risk adjustment tools and quality measures employed by CMS are defective for the population and lead to perverse incentives. At the same time, MACRA/MIPS is sending a huge signal to physicians: share risk or suffer a death of 1,000 cuts.

Programs from medical groups with hands-on BPCI experience. At least three different programs featured physician leaders from IPC/TeamHealth. Prior to the TeamHealth acquisition, IPC launched a Model 2 BPCI program (http://htcmanagement.com/index.php/blog-categories/85-navigating-ltc-medicine-s-turbulent-waters). Kerry Weiner, MD, IPC’s chief medical officer, related their experience during the first 6 months of the program. The single most sobering slide he used in the presentation stated “Bottom line — 15% utilization improvement to break even.” Regardless of your role in PA/LTC care, pay careful attention to IPC/TeamHealth; they are uniquely positioned to see the entire spectrum of bundled payments based on hospitalizations. They alone fill every niche a medical group can occupy — acute episodic initiator as the admitting physician, hospitalist for someone else’s bundle, and as the PA care attending physician (with or without shared risk).

Growing shift from competition towards collaboration. The days of [IPC’s] rampant acquisitions are over, according to Dr. Weiner, and any PA/LTC network expansion will be increasingly targeted markets. However, IPC/TeamHealth is ready to partner with other groups to create ad hoc PA/LTC networks in many locations. I cited Dr. Weiner’s comments because they are indicative of a newly emerging sense among many attendees that “we are all in this together.” The sweeping changes in payment reform are going to upset years of careful work, and only by banding together can medical groups and facilities create structures that can endure the waves of change.

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