

Delivering *Value*: Primary Care's Opportunity for Greatness – but only if...

William Coleman Lecture

UAB SCHOOL OF
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The Winds of Change

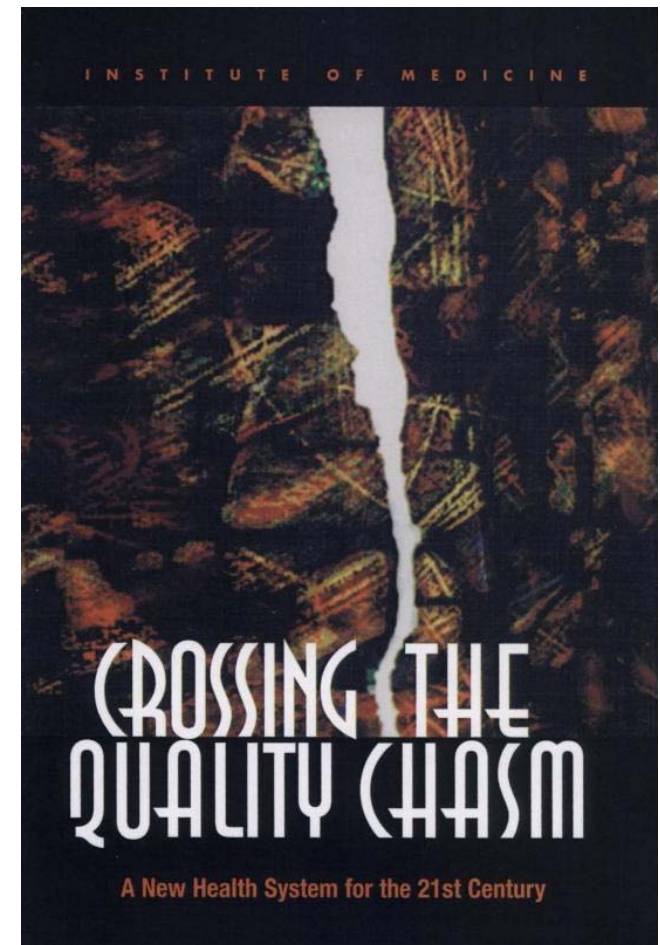
- Health care reform
- Safety and quality
- Aging
- Consumerism
- Technology
- New care delivery models
- Information technology
- Community accountability
- Workforce shortages
- Declining revenue



Value – IOM Six Aims

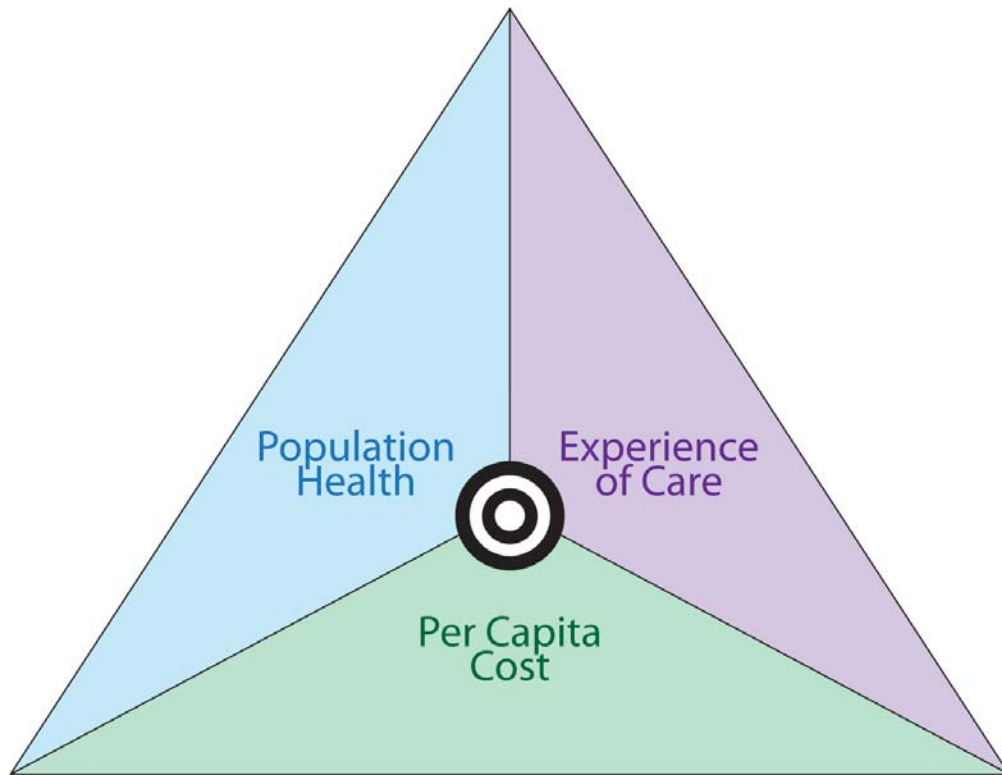
Health care should be:

- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable



Source: Corrigan, et al (eds.). *Crossing the Quality Chasm*. Committee on the Quality of Health Care in America. National Academies Press. Washington, DC. 2001.

The Triple Aim



Clint MacKinney, MD, MS



Value Equation

$$\text{Value} = \frac{\text{Quality} + \text{Experience}}{\text{Cost}}$$

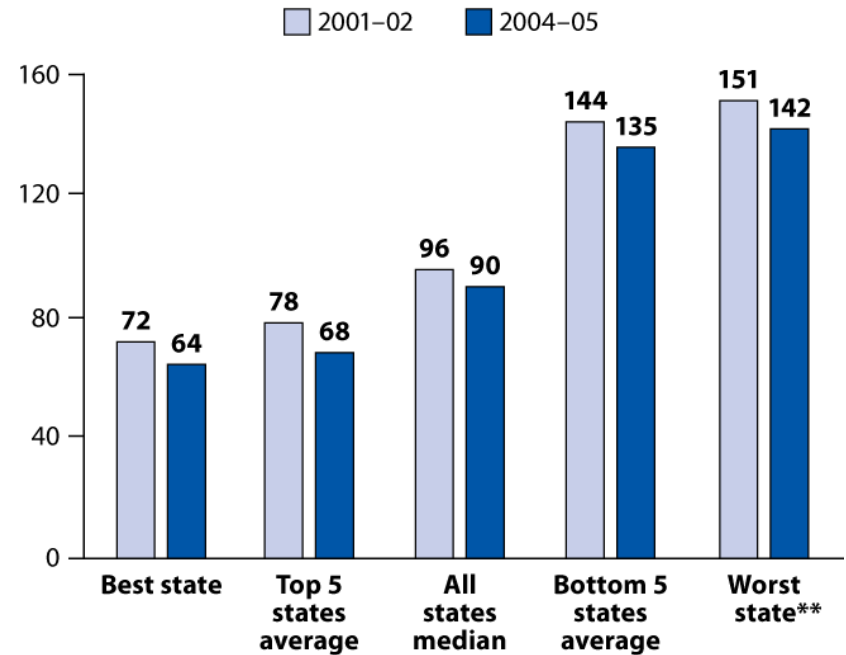
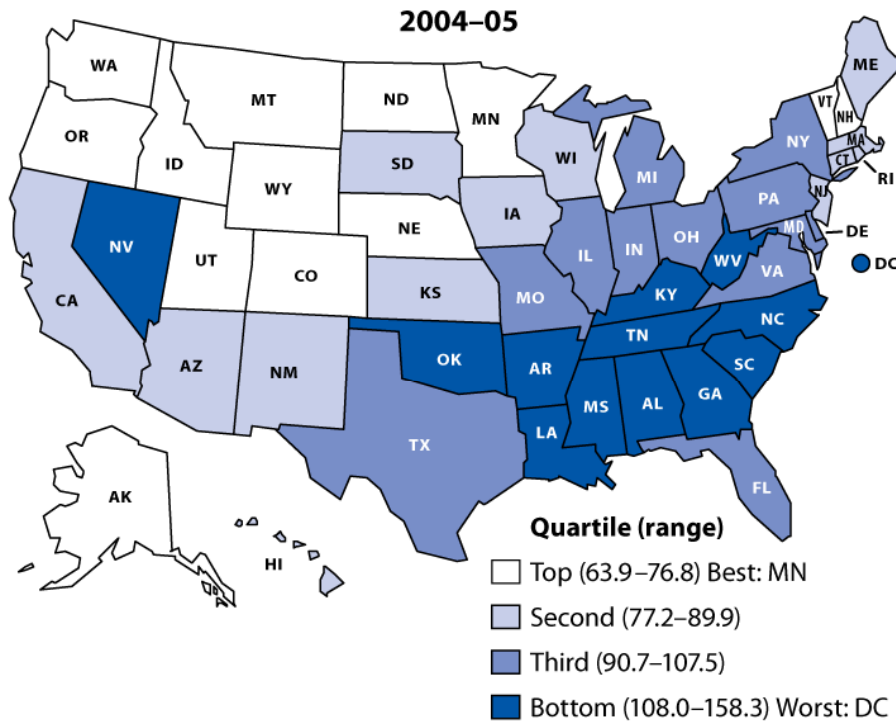
- Safe
- Effective
- Patient-Centered
- Timely
- Efficient
- Equitable

"Triple Aim"

- Better care
- Better health
- Lower cost

Quality

Mortality Amenable to Health Care by State Deaths* per 100,000 Population



* Age-standardized deaths before age 75 from select causes; includes ischemic heart disease.

** Excludes District of Columbia.

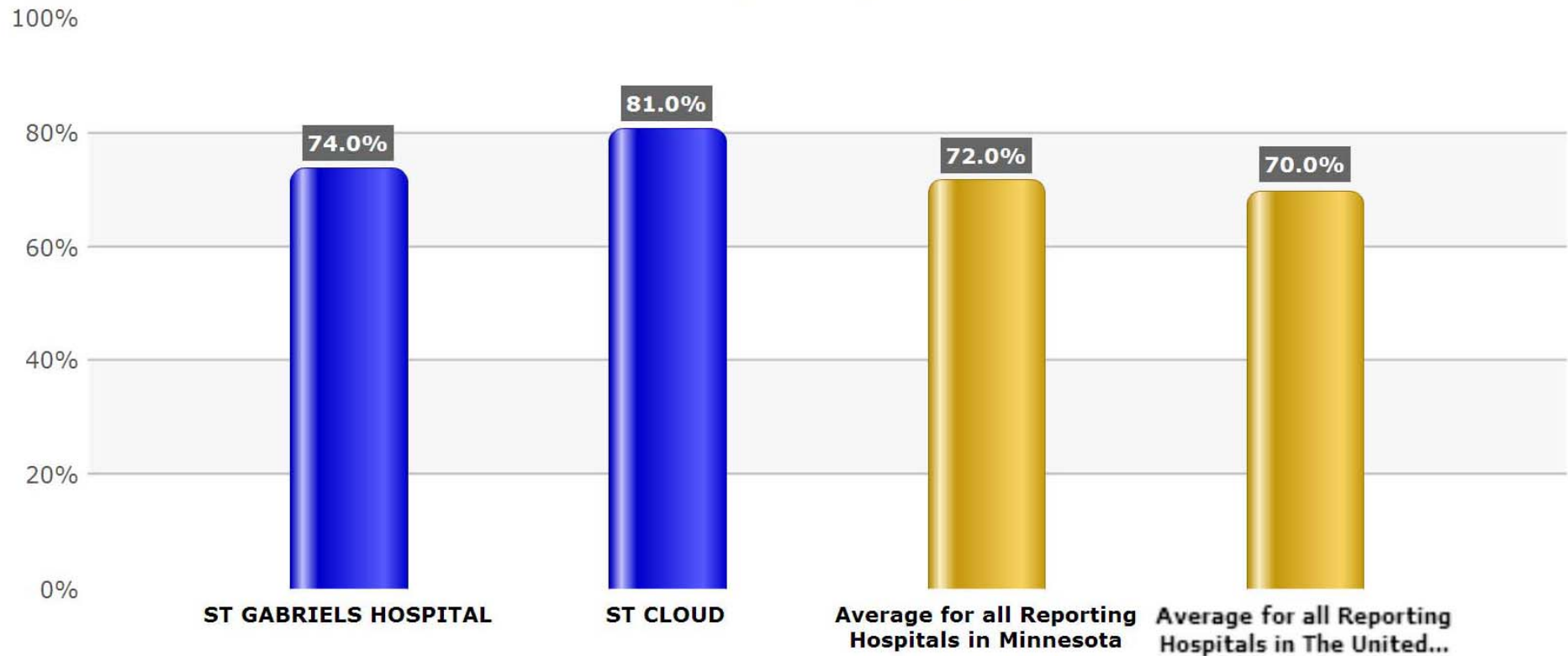
DATA: Analysis of 2001-02 and 2004-05 CDC Multiple Cause-of-Death data files using Nolte and McKee methodology, *BMJ* 2003

SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2009

Patient Experience

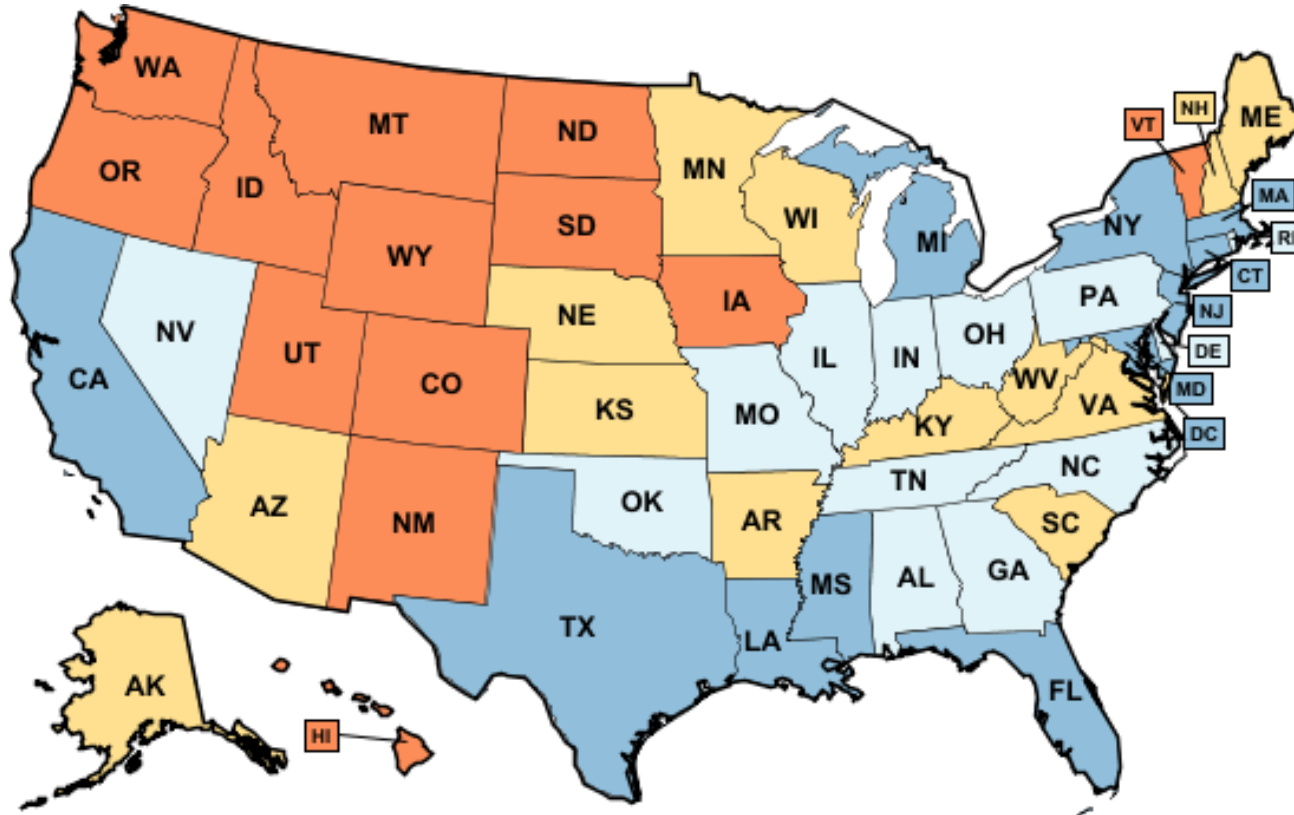
Patients who reported YES, they would definitely recommend the hospital.

Why is this important?



Source: www.hospitalcompare.hhs.gov. Accessed August 8, 2012.

Cost (Medicare)



Orange: \$7,576 - \$8,727

Light Blue: \$9,692 - \$10,615

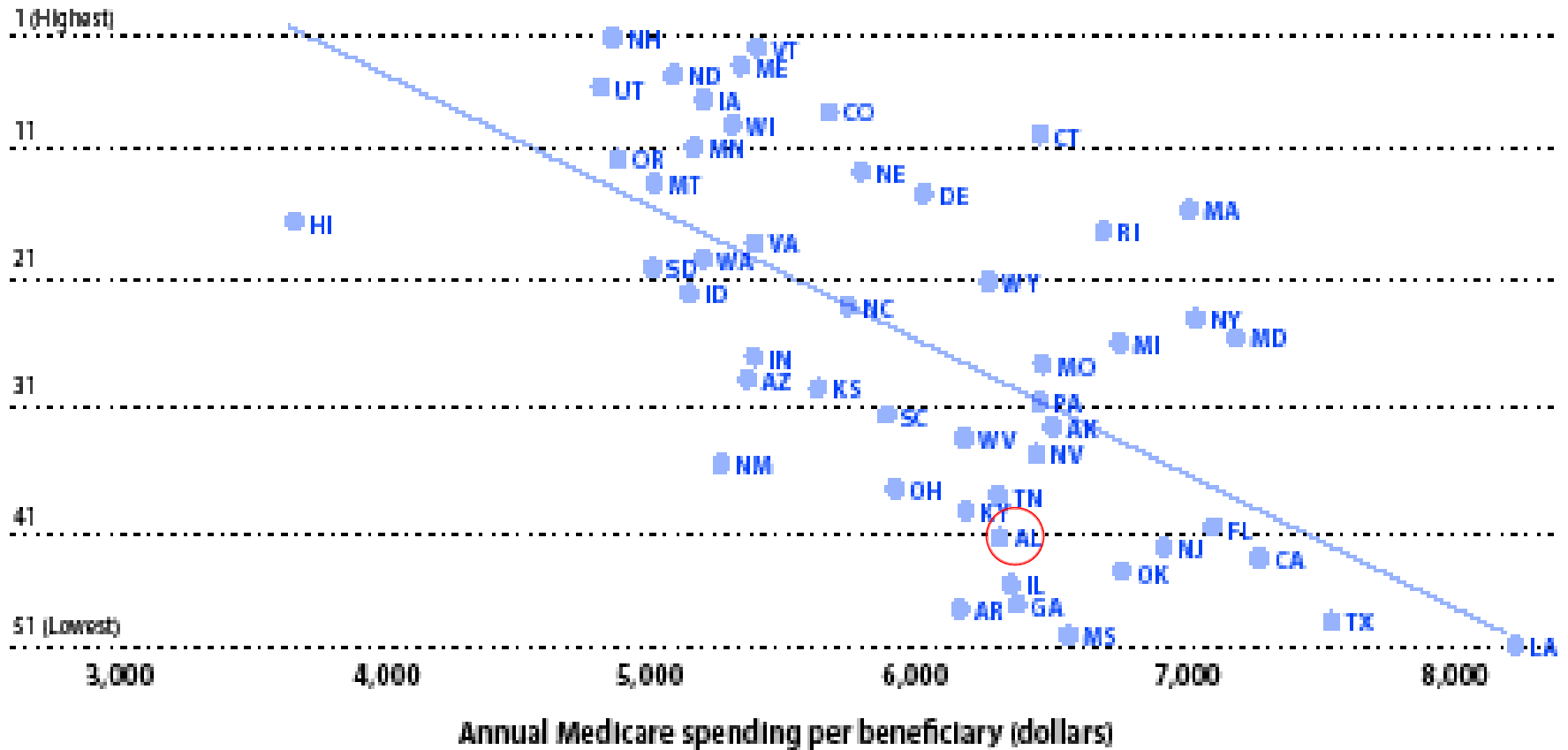
Yellow: \$8,763 - \$9,634

Dark Blue: \$10,667 - \$11,903

Source: Kaiser Family Foundation. 2009 Data

Quality/Cost

Overall quality ranking



Sources: K. Baicker and A. Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs* Web Exclusive (April 7, 2004).

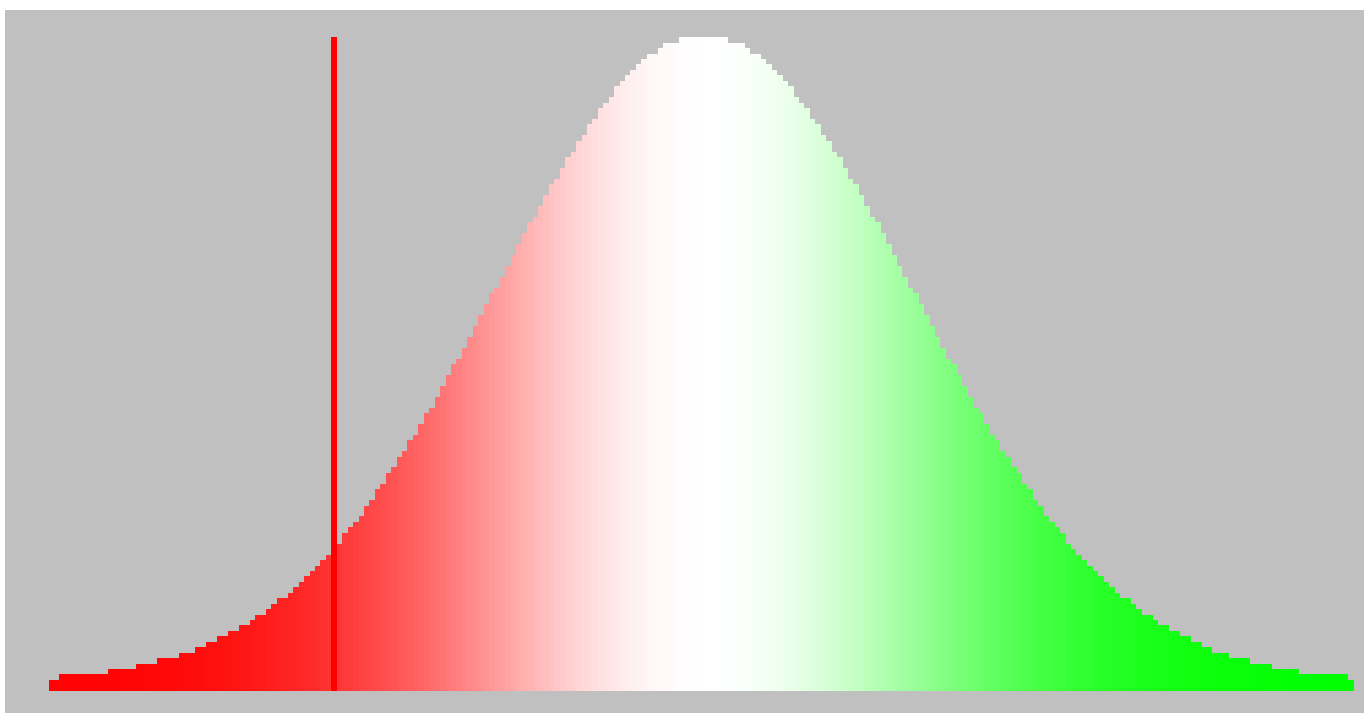


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Variation = Risk = Opportunity

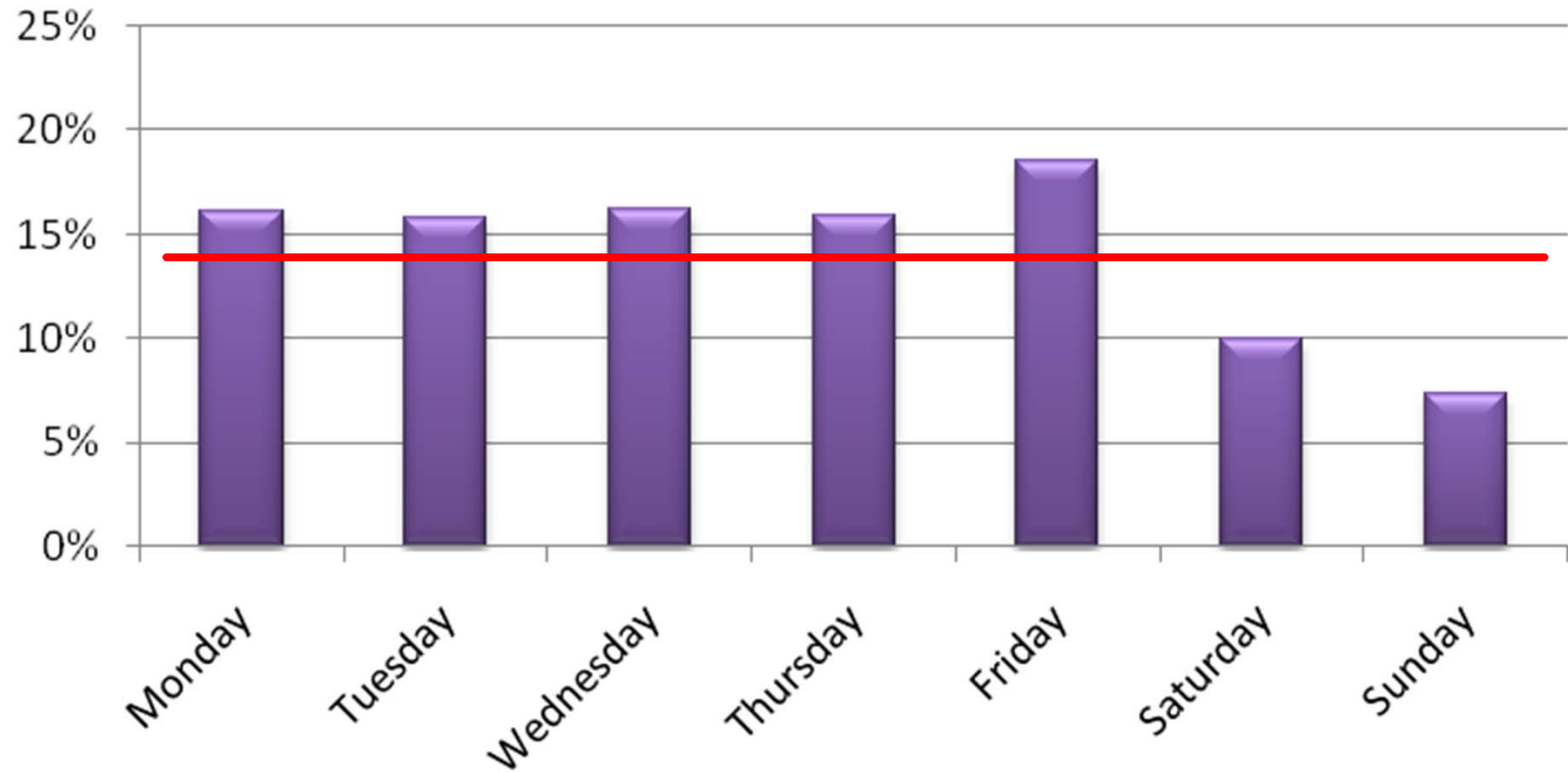
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Variation suggests a risk for underperformance,
but also an opportunity to excel

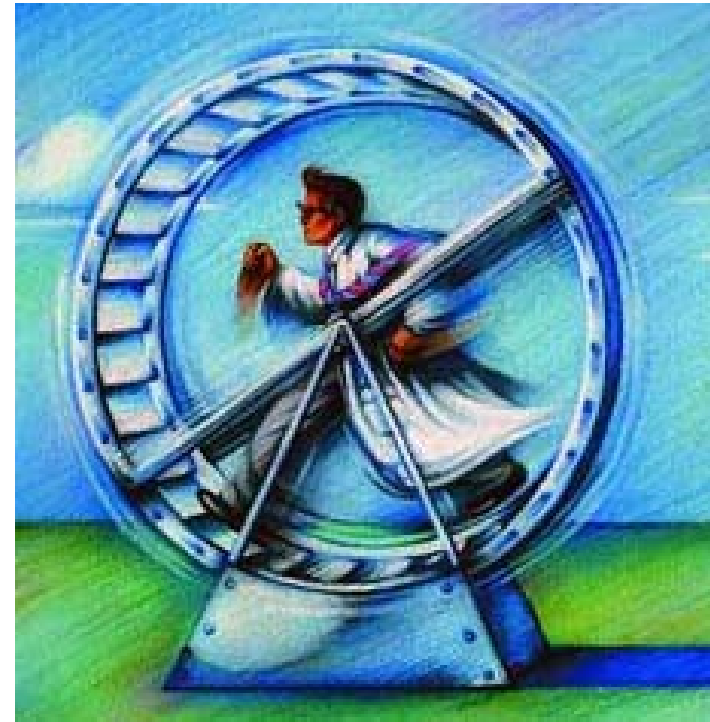
Variation Example

Discharges by Day of the Week



Tyranny of Fee-for-Service

- Current measure of “success” is to maximize:
 - Office visits per day
 - Average daily inpatient census
 - Admissions from the ER
- Is this how you would identify a great physician or a world-class hospital?
- Can we design measures that reward industriousness, yet reflect why we went to medical school?



Unacceptable Healthcare Value

- **Quality** suboptimal
 - Deficient when compared internationally
 - Wide geographic variation
- **Cost** unsustainable
 - Growth in excess of GDP growth
 - Highest cost in the world
- **Waste** intolerable (20%)*
 - Care delivery, care coordination, overtreatment, administration, pricing failures, fraud and abuse.
- **Nobody agrees about what to do!**



*Source: Berwick and Hackbarth. Eliminating Waste in US Health Care. *JAMA*, April 11, 2012. Vol. 307, No. 14.

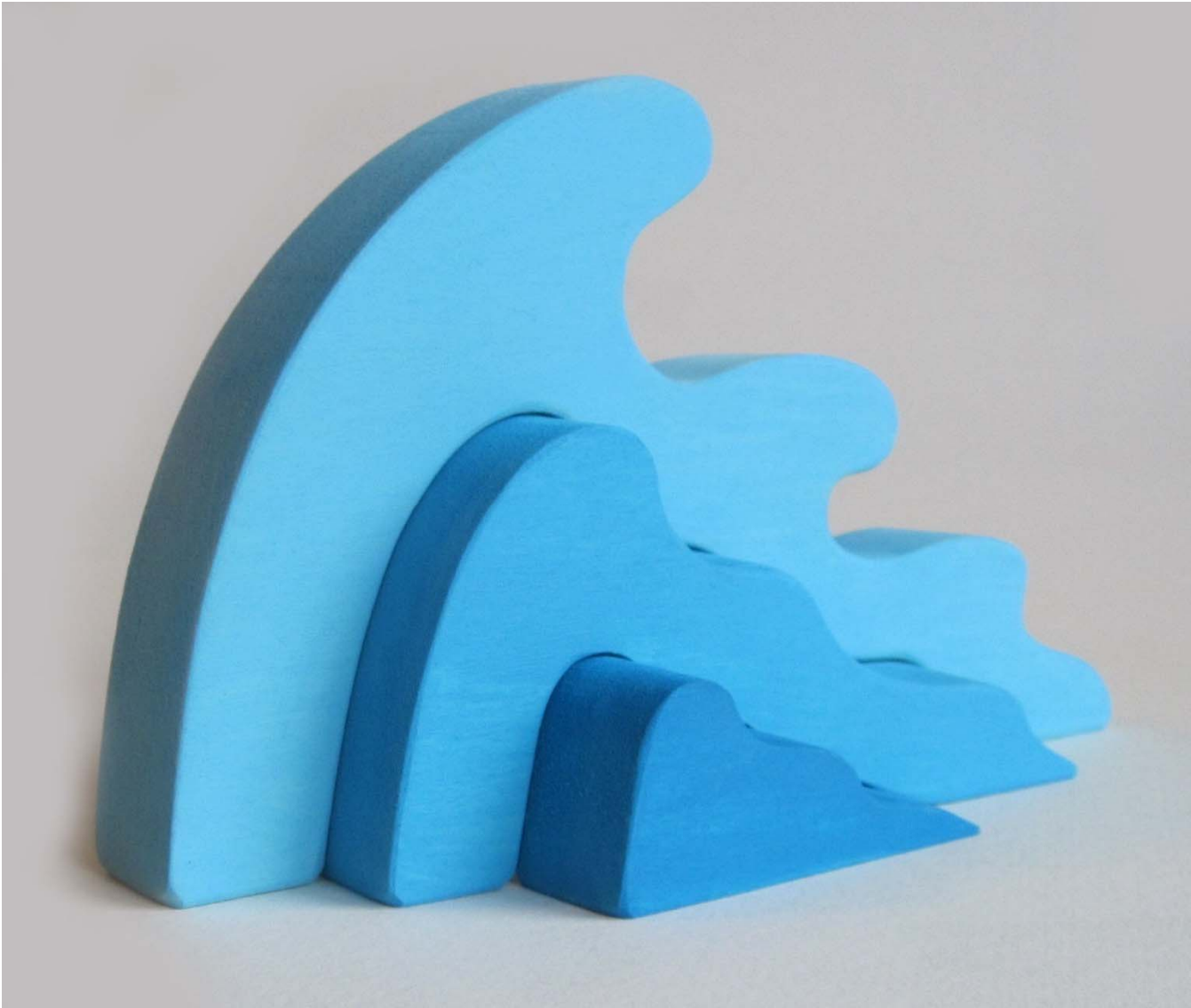
The Value Conundrum

You can always count on Americans to do the right thing – after they've tried everything else.

- Fee-for-service
- Capitation
- Market
- Single payer
- Self-police

- **Pay-for-Performance (P4P)?**
- **Accountable Care Organizations (ACOs)?**
- **Patient-centered Medical Homes?**





Pay-for-Performance

Form Follows Finance

- How we deliver care is predicated on how we get paid for care
- Health care reform is changing both
- Fundamentally, a transfer of risk from payers to providers
- Supreme Court ruling has accelerated change



CMS Value-Based Purchasing

VISION FOR AMERICA

Patient-centered, high quality care delivered efficiently.



GOALS FOR VBP

- Financial Viability
- Payment Incentives
- Joint Accountability
- Effectiveness
- Ensuring Access
- Safety and Transparency
- Smooth Transitions
- Electronic Health Records

Affordable Care Act

- Health care reform predicated on a robust primary care foundation
 - Work force provisions
 - Preventive services focus
 - Accountable care organizations
 - Value-based purchasing
 - Care coordination
 - Medical homes



* See Appendix for ACA primary care provisions and timeline

Accountable Care Organizations

- A coordinated network of providers with shared responsibility for providing high quality and low cost care to their patients.*
- Couples risk-based provider payment with health care delivery system reform
- Accepts *performance risk* for quality and cost



*Source: Robert Wood Johnson Foundation. Accountable Care Organizations: Testing Their Impact. 2012 Call for Proposals.



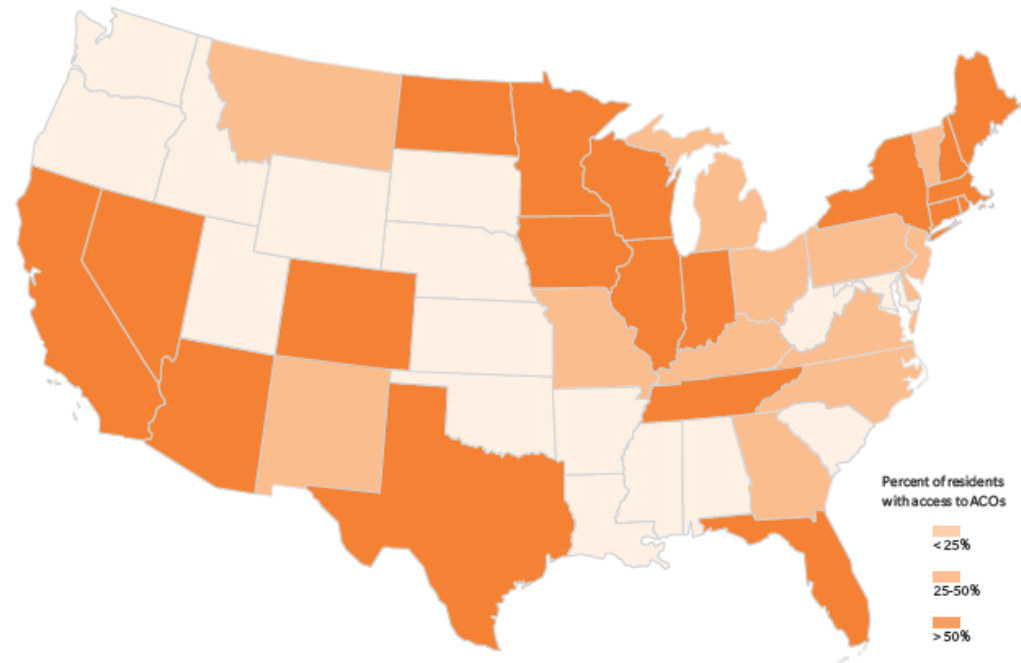
ACOs

ACO Explosion

- 25-31 million US patients receive their health care through ACOs
- ~**10%** of the population
- Remarkably quick growth for a new and complex form of payment and care delivery



EXHIBIT 1: MORE THAN 40 PERCENT OF AMERICANS LIVE IN PRIMARY CARE SERVICE AREAS WITH AT LEAST ONE ACO



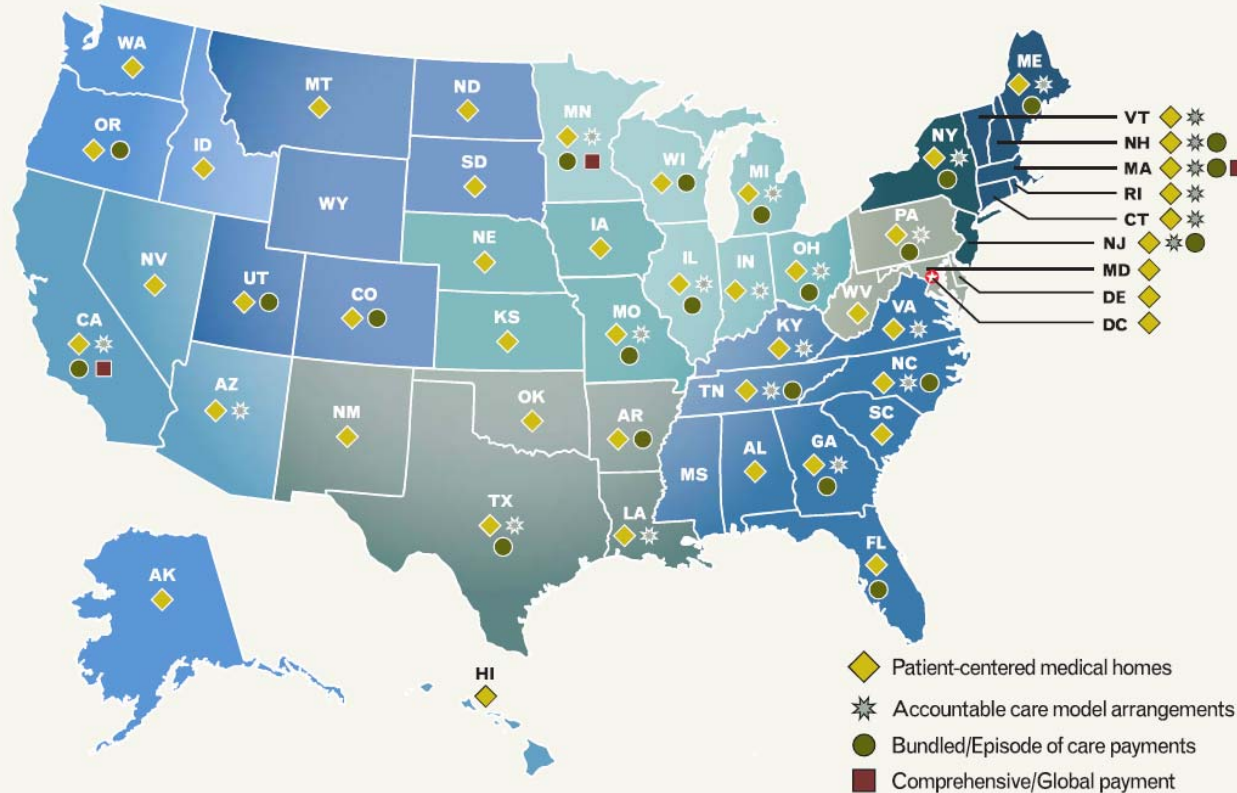
Note: ACOs defined as providers participating in Pioneer ACO, Medicare Shared Savings, a Medicaid ACO, PGP Transition, or in a shared savings/risk arrangement with a commercial payer

Sources: News releases, company websites, Dartmouth Atlas PCSAs, Claritas, Oliver Wyman analysis

Source: Niyum Gandhi and Richard Weil, Oliver Wyman, 2012.

More than Medicare ACOs

Alternative delivery and payment models—Private sector initiatives



Note: Icons may represent multiple partnerships within a state.
 The map is current as of April 2012.
 Source: America's Health Insurance Plans.

Source: Tammy Worth. Saving primary care. Medical Economics. November 25, 2012.

Why Primary Care?

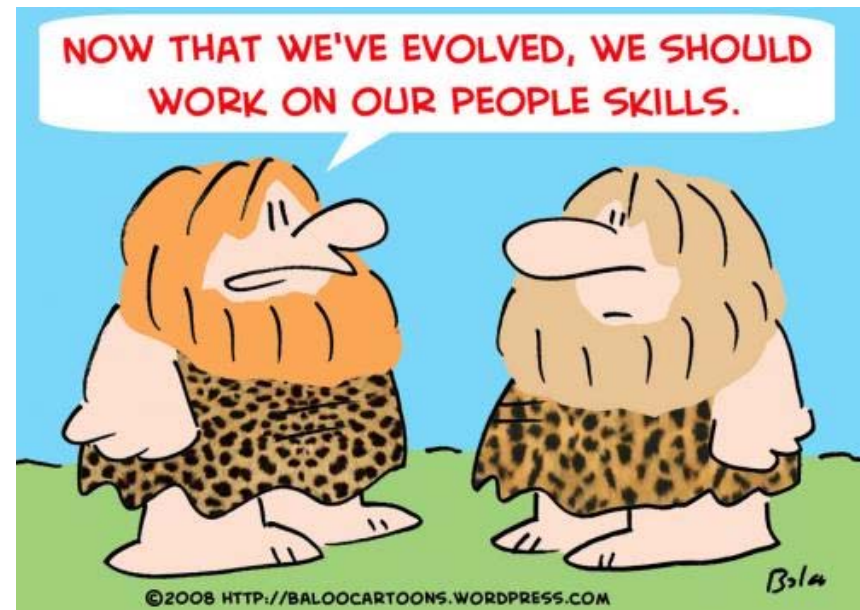
- **Comprehensivists**
- Best and brightest should be rural primary care docs
- Nearly limitless options – ER, sports med, geriatrics, even health care policy (!)
- The beauty of opportunity
- Trusted, and blessed to be invited into the most intimate of people's lives



- * See Appendix for the research case for primary care

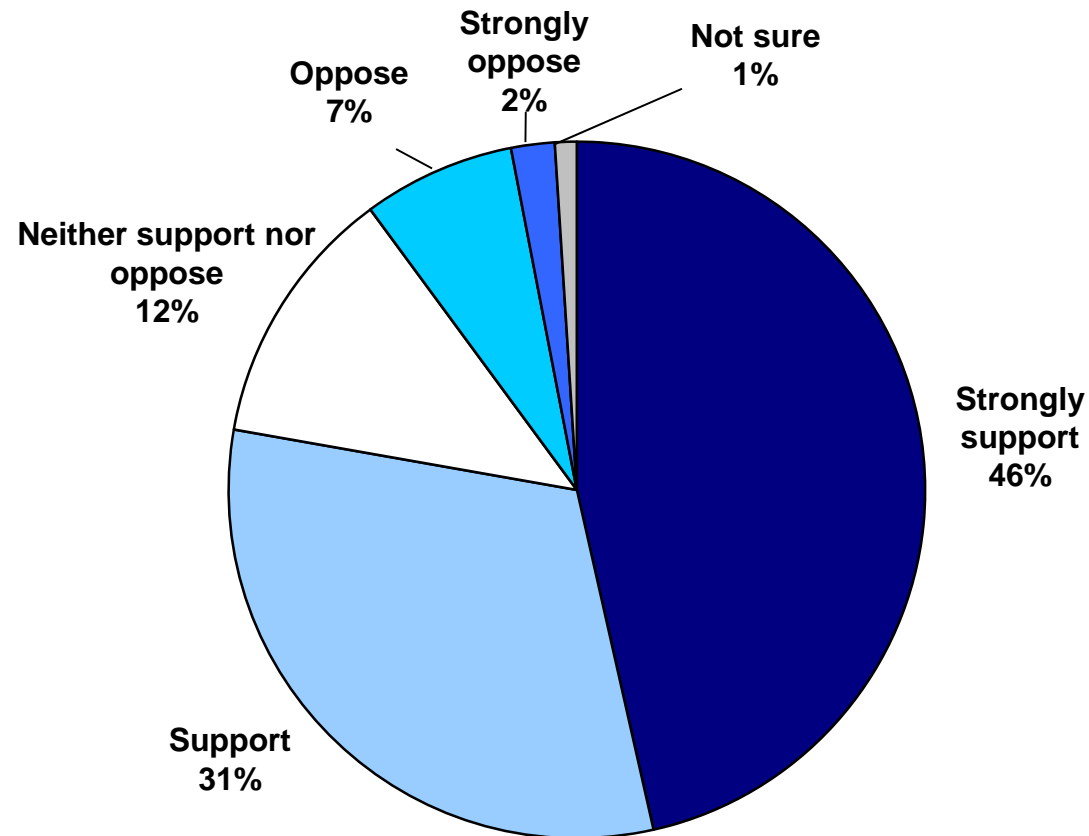
Primary Care offers Unique Skills

- Quality improvement
- Care coordination
- Chronic disease mgmt
- Team work
- Accountability
- Cost control



Primary Care for ACOs

The degree to which you support or oppose establishing standards for primary care capacity as a condition for qualifying for ACO payment."



Source: Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey, July 2010.

ACO Physician Recruitment

- Desirable physician traits for ACOs
 - Team-oriented
 - Motivated by quality incentives
 - Technologically savvy
 - Evidenced-based approach
 - Comfortable working with PAs and NPs



* See Appendix for job interview insights

Source: Survey of 200 health care employers and hospital systems by the Medicus Firm, 2012.

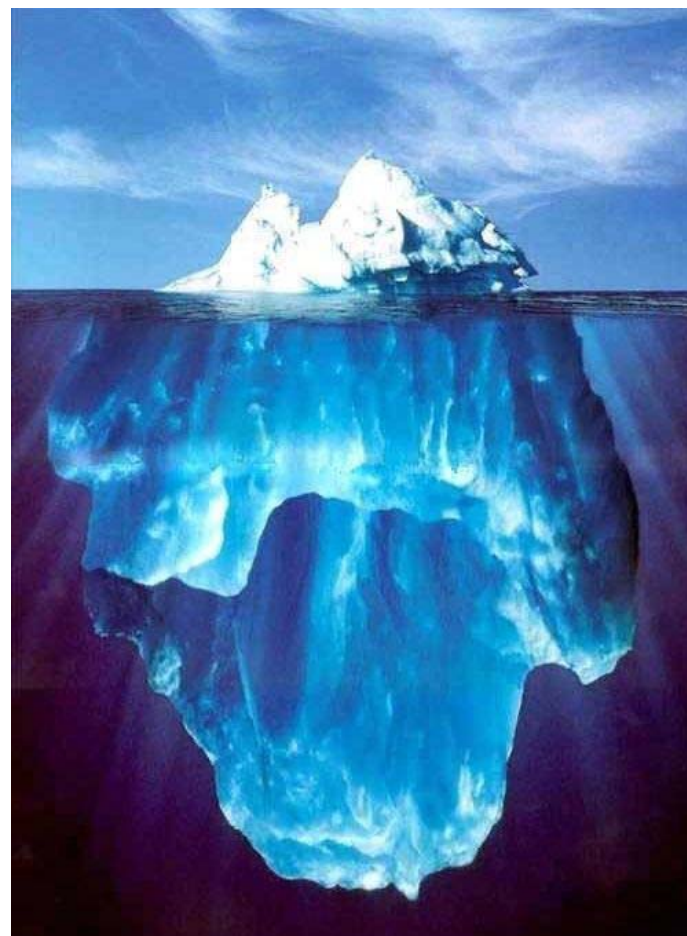
Primary Care's Future

- Primary care is fundamental to almost all health care reform strategies
- Enviable position
 - PCMH leaders
 - ACO darlings
- **Primary care is the answer**
- Greatest job in the world, and it's going to get greater if...



Culture

- Culture is the residue of success.*
- An environment of behaviors and beliefs
- **What we do becomes what we believe.**



* Source: Edgar Schein, 1999

Challenges

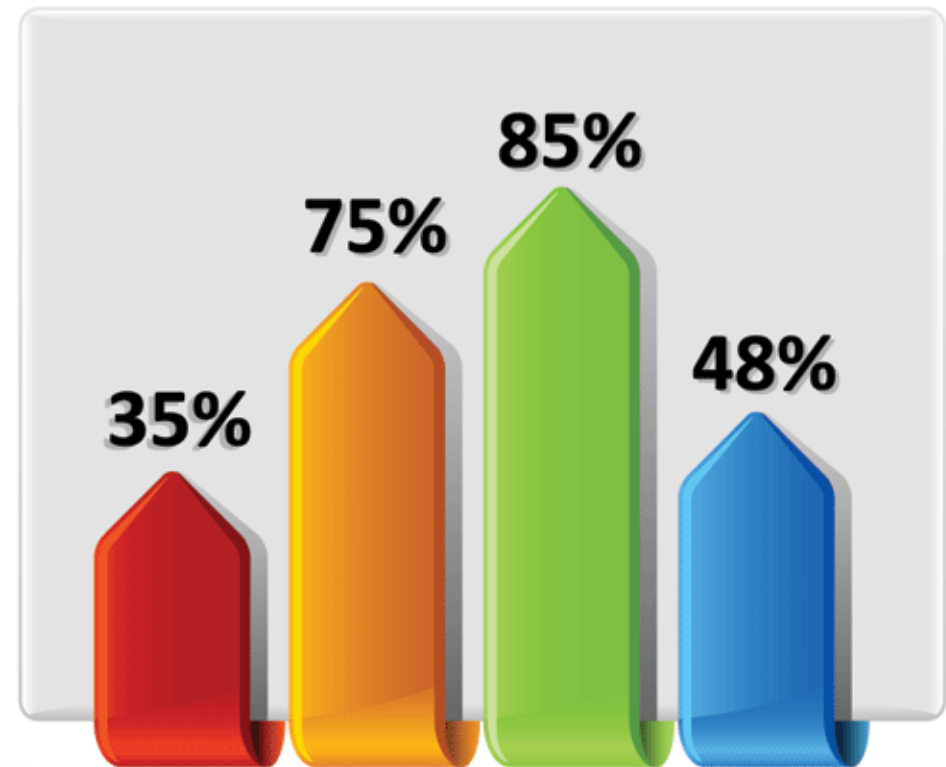
- Perverse payment system
- Body-part medical education
- Data and improvement poor
- Linear thinking
- Autonomy and independence
- Demand for control
- Inertia



Data and Improvement

The Value Equation

- Quality
 - Physician Quality Reporting System, Value Modifier, etc.
 - Many – so “harmonize”
- Experience
 - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Cost
 - To the payer



- * See Appendix for list of performance reporting sites

Non-Linear Perspective



Source: Roland A. Grieb, MD, MHSA - Health Care Excel and Premier, Inc.

Team-Based Care

- Fewer Chuck Yeagers
- More John Glenns
- Fewer cowboys
- More pit crews
- *Independence* as an archaic concept



Our Own Demons

- Nutting et al – small primary care practices are:
 - Physician-centric
 - A hindrance to meaningful communication between physicians
 - Dominated by authoritarian leadership behavior
 - Underserved by PAs/NPs cast into unimaginative roles
- * See Appendix for details



"Characteristics so ingrained in the primary care practice culture that they have become virtually invisible, along with their implications."

Source: Nutting, PA, Crabtree, BF, McDaniel, RR. Small primary care practices face four hurdles – including a physician-centric mindset – in becoming medical homes. Health Affairs. 31:11. November 2012.

Medical Home Definition

Patient-centered medical homes are primary care practices that offer around-the-clock access to coordinated care and a team of providers that values patients' needs.

- **Access and communication**
- **Coordination of care**
- **Patient and family involvement**
- **Clinical information systems**
- **Revised payment systems**



* See Appendix for Medical Home Joint Principles

Source: Commonwealth Fund. <http://www.commonwealthfund.org/>

Medical Home Quotes

- All team members practice at the top (optimum) of their license and experience
- Best evidence is the best and only way we deliver care
- Care is the same, regardless of the provider
- Continuous performance improvement of our care is rigorously driven by data
- There are no non-compliant patients, only those we have not reached
- An EHR is critical to proactively managing patient/population health
- Let care protocols do (at least some of) the work (eg, lab orders, med refills, vaccines)



Crete Physicians Clinic
Crete, Nebraska

Practice Transformation

- How do we move toward delivering value when our practice is primarily fee-for-service?
- One foot on the dock and one in the boat!
- But we can test the waters
 - Use Paul Nutting's insights to be introspective
 - Embrace new non-linear perspectives
 - Measure and share performance, then act on it
 - Drive out variation; only the "best" evidence care
 - www.transformed.com



What We Can Do Now

- Control the data
 - EHR and sophisticated data analytics
- Measure and report performance
 - We attend to what we measure
 - *Attention* is the currency of leadership
- Educate all providers and all staff regarding performance
 - We are all “above average,” right?
- Consider self-pay and clinic employees first for care mgmt
 - Direct care to low cost areas that provide equal (or better) quality



More What We Can Do Now

- Manage care beyond clinic
- Negotiate with third party insurers to pay for quality (funds ACO infrastructure)
- Aggressively apply for value-based demonstrations and grants
- Begin implementing processes designed to improve value
- Move organizational structure from physician-centric to patient/community-centric



Collaboration and Value

- ACOs and other “programs” less important
- Collaboration that fosters health care value is key
- Future paradigm for success
- **Good medicine and good business**



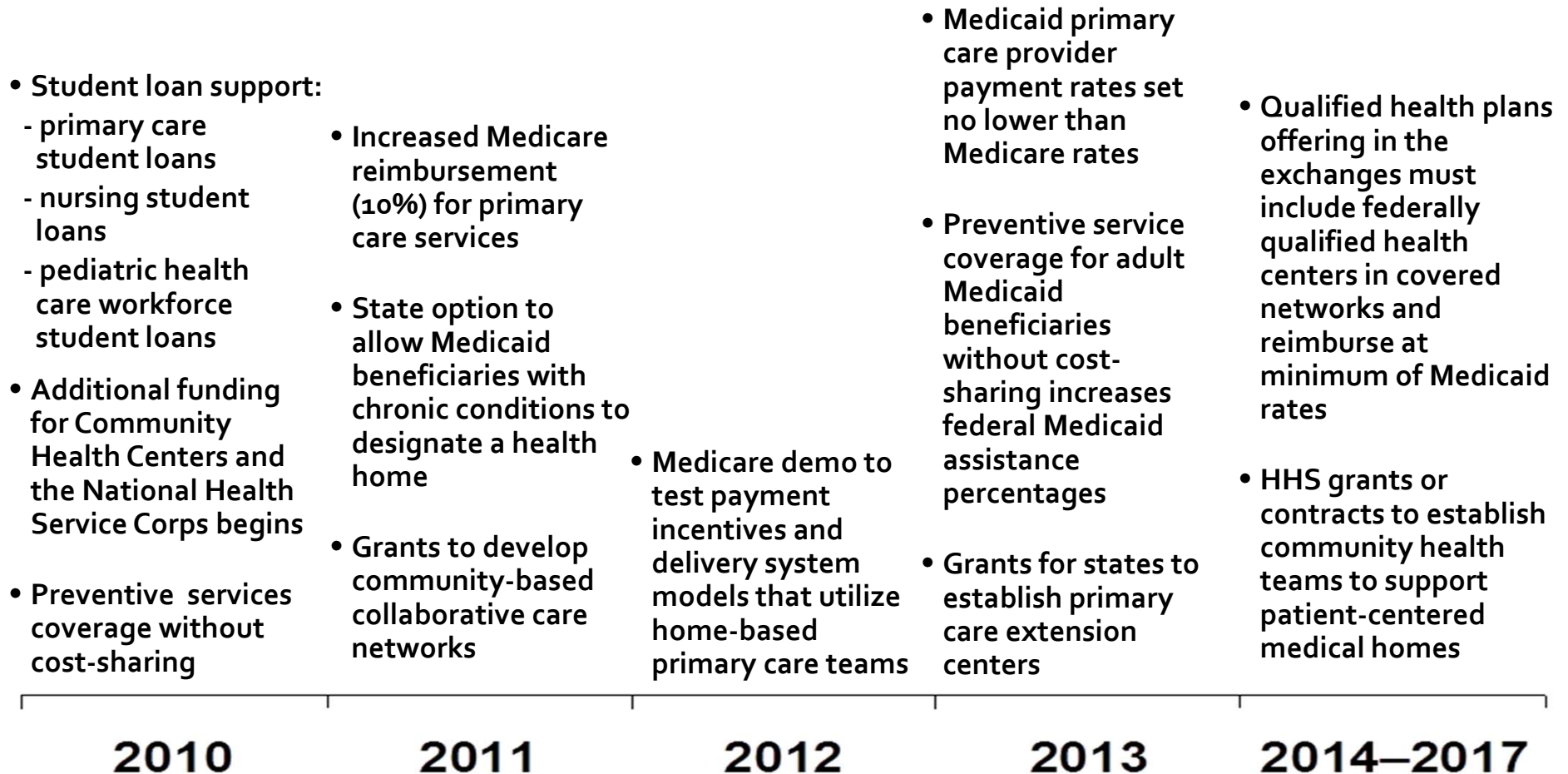
Healthy People and Places



Appendix



ACA Primary Care Provisions



Source: Commonwealth Fund analysis

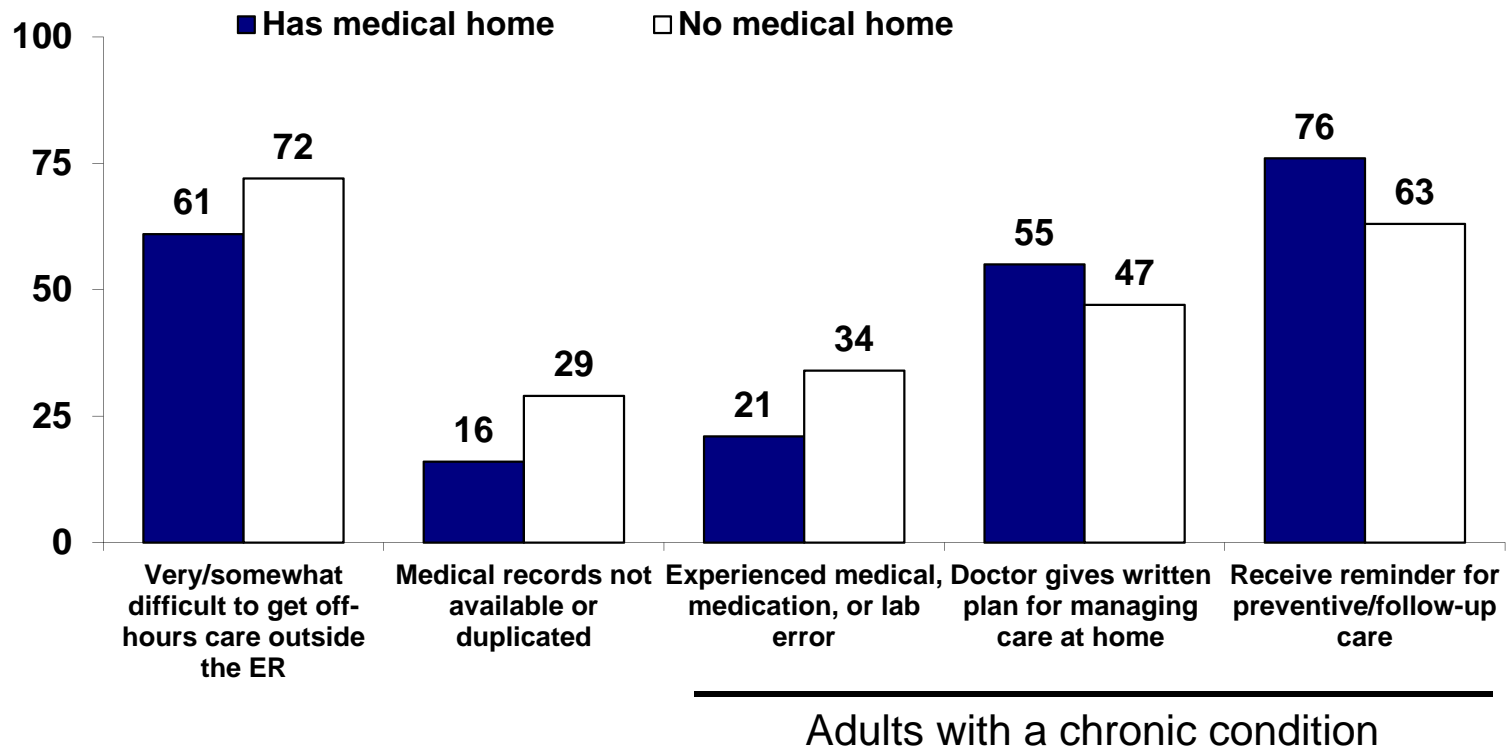
Medical Home Joint Principles

- Improving **access and communication** through policies like advanced access scheduling and e-mail communication between doctors and patients,
- Streamlining **coordination of care** by better integrating data systems,
- Promoting active **patient and family involvement** and culturally sensitive care,
- Adopting advanced **clinical information systems** to reduce errors and expand the physician's access to critical information and guidelines,
- Revising **payment systems** to reward primary care physicians for taking on the role of care coordinator .

Source: Joint principles of the patient-centered medical home. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. March 2007.

Medical Home Quality

Percent of adults reporting

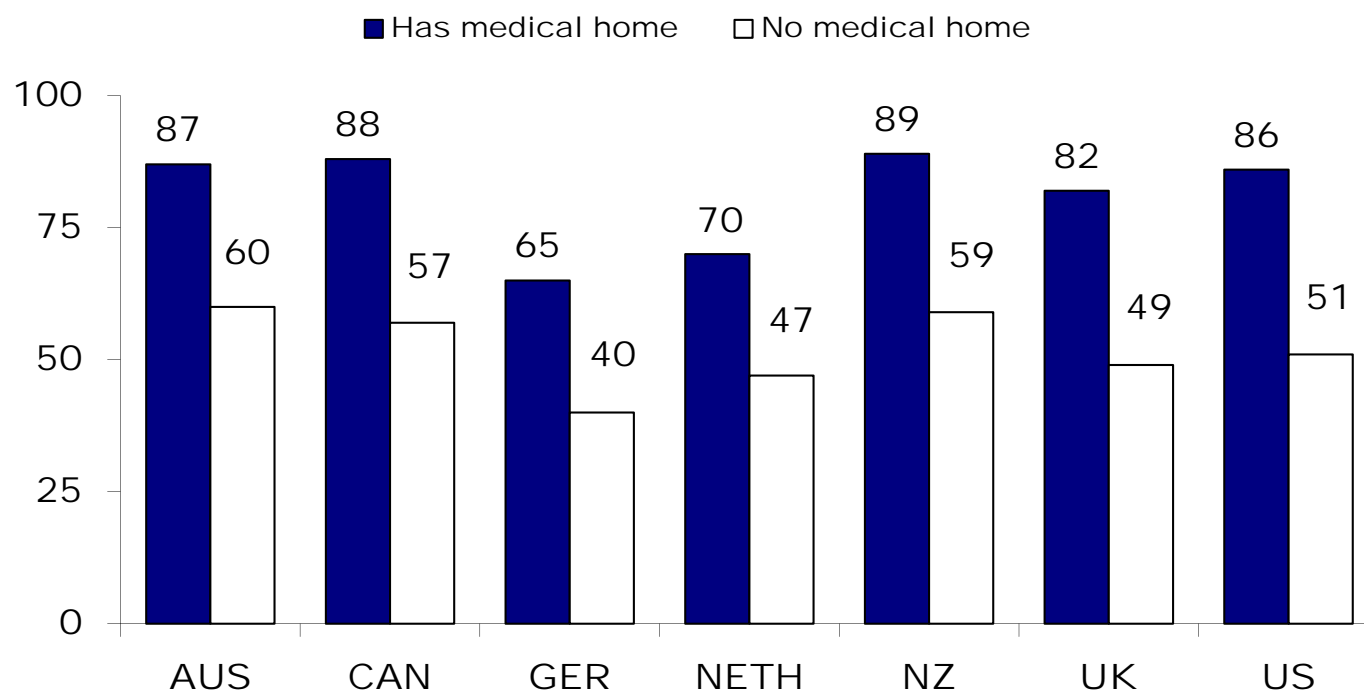


Note: Medical home includes having a regular provider that knows you, is easy to contact, and coordinates your care. Errors include medical mistake, wrong medication/dose, or lab/diagnostic errors.

Source: 2007 Commonwealth Fund International Health Policy Survey. Data collection: Harris Interactive, Inc.

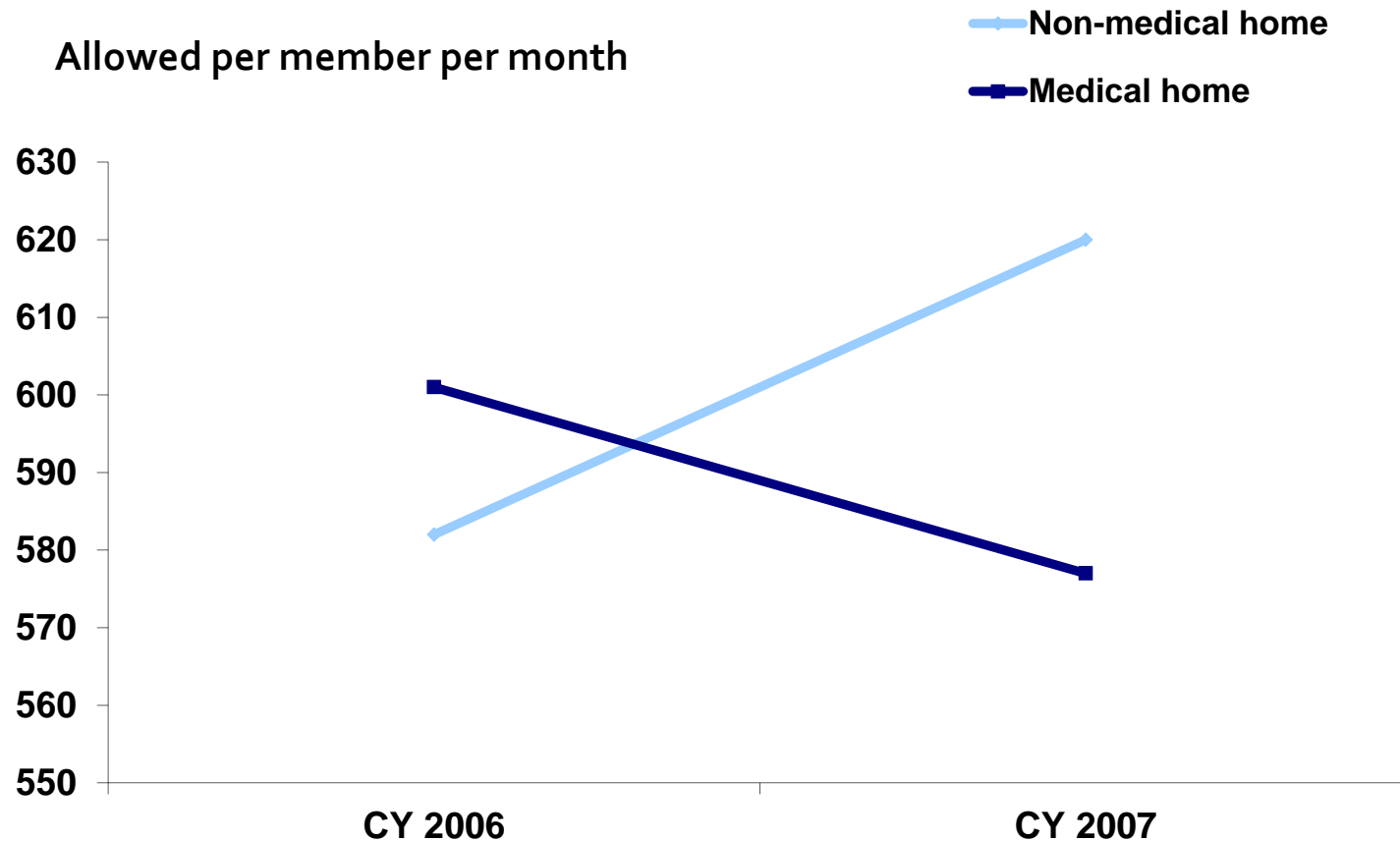
Medical Home Satisfaction

Percent rated care received “excellent” or “very good”



Source: 2007 Commonwealth Fund International Health Policy Survey. Data collection: Harris Interactive, Inc.

Medical Home Costs



Source: G. Steele, "Geisinger Quality—Striving for Perfection," Presentation to The Commonwealth Fund Bipartisan Congressional Health Policy Conference, Jan. 10, 2009.

The Case for Primary Care

- Access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs.^{1,2}
- Primary care physician supply was associated with improved health outcomes.³
- Each increase of one primary care physician per 10,000 population is associated with a reduction in the average mortality by 5.3%.³
- A higher ratio of primary care physicians compared to specialists had improved quality and effectiveness of care, as well as lower health care spending than states with a higher ratio of specialists.²
- Increasing the supply of specialist physicians does not show lower mortality rates and does not improve the population health of the United States.⁴

1. Steinbrook R. Easing the shortage in adult primary care -- Is it all about money? *N Engl J Med*.
2. Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Aff*. April 7, 2004.
3. Macinko J, Starfield B, Shi L. Is primary care effective? Quantifying the health benefits of primary care physician supply in the United States. *Intl J Health Serv*.
4. Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: Assessing the evidence. *Health Aff*. March 15, 2005.

Job Interview Insights

Some of the key factors hospitals are seeking are for team-oriented, technologically savvy, flexible, and evidence-based physicians. This may or may not describe you. And even if it does describe you, you may not be prepared to present these particular qualities in an interview setting -- until now.

Here are a few things you may want to think about before your next interview, so that you are prepared with specific anecdotes of real-life scenarios you can share with your interviewer:

1. Think of a time (or 2-3) when you showed that you provided quality care for a patient as part of a team of providers – how did you lead, delegate, consult, and act as part of the team?
2. Be prepared to share examples of a time (or 2-3) when you've used an evidence-based approach to treat a patient and achieved good outcomes.
3. Be able to express your ability to provide high-quality healthcare and good outcomes, via examples, anecdotes, and/or references.
4. ACOs are evolving, and healthcare is changing as well. Therefore you will need to be able to show that you are adaptable to various initiatives, able to learn new things, and able to change with the circumstances or directives.
5. Keep in mind if you're interviewing for an employment position, you not only need to show that you're qualified as a physician, you also need to convince the executives that you'll be a good employee, in addition to being a good physician. This may be challenging for physicians who have owned their own practices for years, to consider the prospect of reporting to someone else such as a hospital executive, who may not even be clinically experienced.

Source: Stone and Santiago. Recruiting Physicians for an ACO Care Model. *Accountable Care News*. 3:12. December 2012.

Nutting: Physician Centricity

■ Status Quo

- Operations revolve around physician schedules and preferences
- Decisions with little input from others with different perspectives
- Office systems that hinder innovation
- Primacy of patient flow

■ Innovators

- Operations revolve around patient and community needs and preferences
- The entire practice becomes a collaborative care team
- Pursuit of better things to do, not doing the same thing better (or faster)
- Value, not volume, is the desired output

Nutting: Poor Communication

■ Status Quo

- Autonomy and independence within the same practice
- Communication limited to practice operations and administrative issues
- Absent benchmarks from which to direct improvement

■ Innovators

- A shared-learning organization that considers practice vision, clinical priorities, and patient care approaches
- Regular discussions, formally and informally, regarding care team performance
- Rigorous attention to data shared among the care team and used to drive improvement

Nutting: Authoritarianism

■ Status Quo

- Physicians recognized as powerful leaders
- Staff exclusion from clinical and office policy discussions
- Staff reluctance to offer improvement suggestions, even when the most informed

■ Innovators

- Recognition that primary care is no longer single acute illness care; complexity of medical care requires a *team*
- Attention to time and space necessary for team building
- Application of a broad set of individuals and skills to meet patient needs and preferences

Nutting: Unimaginative Roles

■ Status Quo

- Belief that the physician is the best (and preferably only) care provider
- PAs/NPs “fill in” when the physician is absent or too busy
- PAs/NPs employed to enhance revenue, not value

■ Innovators

- Recognize that each care team member potentially unique skills and contributions
- All care team members are challenged to imagine new value-added activities
- Each staff member contributes uniquely to the patient experience

Performance Reporting Sites

- Hospital Compare
 - <http://www.hospitalcompare.hhs.gov/>
- Healthgrades
 - <http://www.healthgrades.com>
- CARECHEX
 - <http://www.carechex.com/>
- Consumer Reports
 - Not just hospital ratings anymore!
- Angie's List and social media!
 - <http://www.angieslist.com>

