Changing Directions: Planning and Executing the Shift from a "Fee-for-Service" to a "Pay for Value" Medical Group

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AMGA IQL
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Agenda

1. Snapshot of “today”
   - The *status quo*
   - The new challenges
2. PriMed’s journey to date
3. Reflections on our transition from volume to value
   - What worked?
   - What didn’t work?
   - What do we wish we knew then?
4. An outline of 5 essential factors for group success

About PriMed and MediSync

PriMed Physicians

- Physician owned and led multi-specialty medical group
- 52 physicians
- Largely primary care plus Cardiology, EP, Neurology and Endocrinology specialties
- Greater Dayton, OH
- Largest independent group in Southwest Ohio
- Historically strong financial performance

MediSync

- Provides complete management team to PriMed and 2 other Cincinnati based groups
- Provides all IT including Practice Management, EHR, network, VOIP, etc.
- Performs all “back end” processes (i.e. billing, accounting, finance, HR)
- Responsible to PriMed Board, physician President and all physicians
- Management solutions sold to 120 groups around the nation

The Medical Group World Of **Today**

- Most patients have health benefits (until recently)
- Explosion of new technologies since 1965
  - Pharmaceutical
  - Diagnostic
  - Interventional (i.e. surgical, etc.)
- More money every year for healthcare
  - Increased our revenue opportunities
- 75+ years of compensation “by the piece”

In Today's Fee Based World:

- Volume is essential to financial success
- Perverse incentives:
  - Improving quality decreases profit
  - Why spend money measuring outcomes or improving outcomes?
- Result: Groups don't invest (much) in improvement
  - Dollars "saved" go to the doctors

What Does Your Group Track Today?

Volume Related

- Tracking RVUs
- Tracking encounters
- Track average charge/visit
- Tracking and encouraging referrals
- Physician compensation based upon code revenues
- Tracking costs per RVU
- Frequency of financial reports

Quality Related

- Track outcomes for chronic diseases?
  - How many conditions? How often? Process or outcome?
- Track Wellness/Prevention outcomes?
- Track admissions and re-admissions?
- Track generic utilization?
- Money spent on quality improvements?

The Shift to Pay For Value

- A radical departure from speed and volume to *performance*:

  - ✓ Quality matters
  - ✓ Cost matters
    - Total cost of care
    - Cost of providing care

- This changes *everything*

What Groups Need to Change (A Partial List)

1. Information systems (i.e. for population management)
2. Vastly improved chronic disease outcomes
3. Increased Wellness and Prevention outcomes
4. Case and care management
5. Alternative methods for providing care
6. More effective options for patient engagement
7. New payment models and other contractual changes
8. Internal quality improvement abilities

Volume To Value Summary

- Current group infrastructure and attitudes shaped by fees

- Changing to value requires:
  - New infrastructures
  - New skills and competencies
  - A ton of change (over a long time)

PriMed's Particular Situation

- Independent group = no subsidy or deep pocket
  - A little hospital support for physician recruitment
  - MediSync can help to bear some costs
- Our doctors expect(ed) to earn top 10% regionally
- Physician buy-in essential
  - Physician owned medical group
  - There is no "boss" who could mandate changes

The Launch of PriMed's Journey

1. Leadership made the case for ***strategy***
   - Discussed, processed and passed by the entire physician membership
2. Adopted ***Strategic Plan*** in 2003: **Excel in "quality of care**"
   - Plan designed to increase group revenue
   - Assumed that, as payments go from volume → value, we would be well positioned
   - PriMed wanted to be preferred by employers and patients
3. First projects:
   - Improve revenue/visit through accurate E&M
   - Improve ***chronic disease outcomes***
     - Prioritized list (i.e. HTN → Lipids → DM → Asthma, etc.)

What We Did Right

- Board shifted focus to strategy >80% of its time
- Lots of physician leadership development *as a group*
- Learned and adopted Six Sigma and Lean quality methods
- Dedicated a lot of time to communication within group about goals, methods and progress
- Developed a multi-year plan with 3 major elements:
  1. Prioritized list of chronic diseases to improve
  2. Prioritized list of new technologies and tools
  3. Prioritized list of changes to the way we operate

What We Achieved

Clinical Results

- Best hypertension outcomes in the nation
- Among the best diabetes outcomes in the nation
- Best pediatric asthma outcomes that we know of
- Lower cost of care through reductions in major events and admissions

Operational and Financial Results

- Negotiated higher rates with carriers based upon our quality
- Value contracts Q4 2012
- All of the above with no additional staff *yet*
- Process based EHR implementation
  - Full productivity in <14 calendar days

What We Wish We Did

- Even more time spent on communication
  - Section meetings in addition to group meetings
- More and better formal change management
- Understood cumulative cost of improving multiple diseases
- Been able to get into a comprehensive pay for value earlier
- Had a shorter discussion period with physicians who didn’t agree with the group’s direction and eventually left us

Advice To Others:
5 Key Success Factors

1. **Leadership**
2. Planning – Strategy and Tactics
   - Identify the pitfalls in advance and avoid them
3. Using formal quality theory and practices
4. Process of culture change via change management
5. Appreciate the dichotomies; achieve balance:
   - Long view and the short view
   - Big picture and the details

Leadership's Role and Tasks

- Big change requires leadership
- The leadership job is big
- Leaders assure that all the critical questions are addressed:
  - Why are we changing?
  - What specifically are we changing?
  - How are we changing it/them?
  - Who is going to do all this?
  - When do we do all this?

The Emotional Side of Leadership

- Leadership skill is ***learned***, not genetically endowed
- You ***will*** make mistakes.
  - Not moving is the biggest possible mistake
- Let the leadership ***team*** compensate for ***individual*** leader weaknesses
- Recognize the greatest ***fear*** of physician leaders:
  - "What will I/we do if they won't follow?"

PriMed's Top Leadership Learnings

- OK if there is no one, highly gifted leader
- A team of leaders with various strengths works fine (maybe better)
- Learn leadership together
  - PriMed's leadership learning process
- Build the bench at all times
  - Informal leaders can be just as important

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Strategy and Tactics

Your leadership must evaluate and adopt both:

1. A ***strategy***:
   - "What is our plan to succeed as an organization in a changing environment where our past solutions won't work anymore?"
   - Requires an understanding of what the forces of change are and what options can lead us to success
   - Remember: some people ARE trying to take the cookies off your plate…that is free enterprise
2. And ***tactics***:
   - Your specific plans to be capable to do what you defined as necessary to succeed.

Strategy vs. Tactics

Strategy

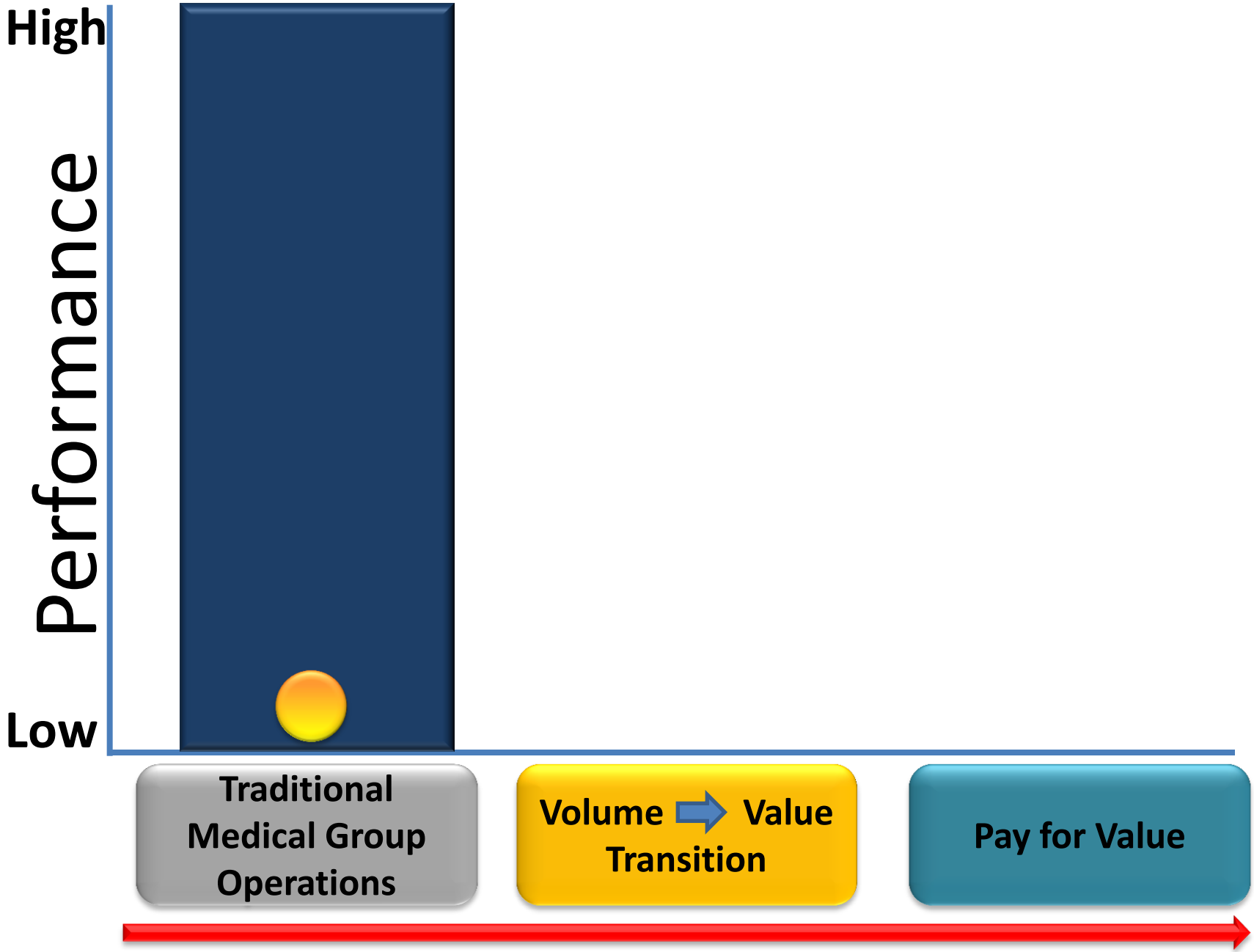
- What are the forces of change?
  - Which are for us? Against us?
- What options are there?
- Which options can we pull off? Which not?
- Which give us the best shot at winning success?
- Where do we get the resources we need?

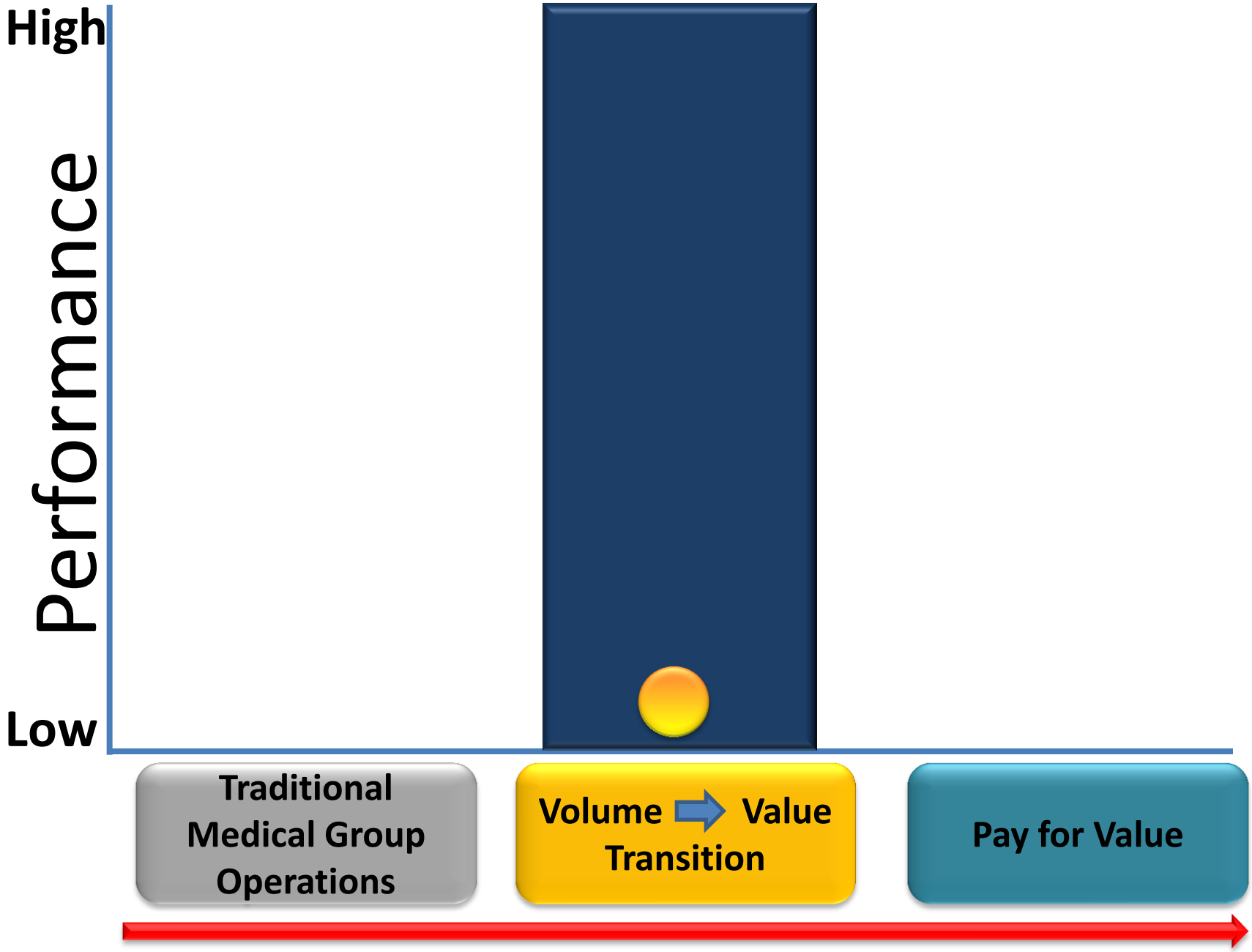
Tactics

- What is our specific plan to make our strategy happen?
- Who must work on what?
- In what order? When?
- How will all this fit together?
  - Timelines
  - End product
- How do we keep track of all this?

Identify and Avoid Pitfalls

1. Don’t wait until too late
2. Plan, plan, plan
3. Plan identifies costs of change ***in stages***
4. Be willing to invest some money in changes before new revenue BUT…
   - You ***must*** get new revenue at some defined point
   - Have a plan for when/how new revenue will occur
5. Manage your plan’s execution
6. Constant adjustment to plan
7. Communicate, educate, communicate, educate


High
Performance
Low
Traditional Medical Group Operations
Volume Value Transition
Pay for Value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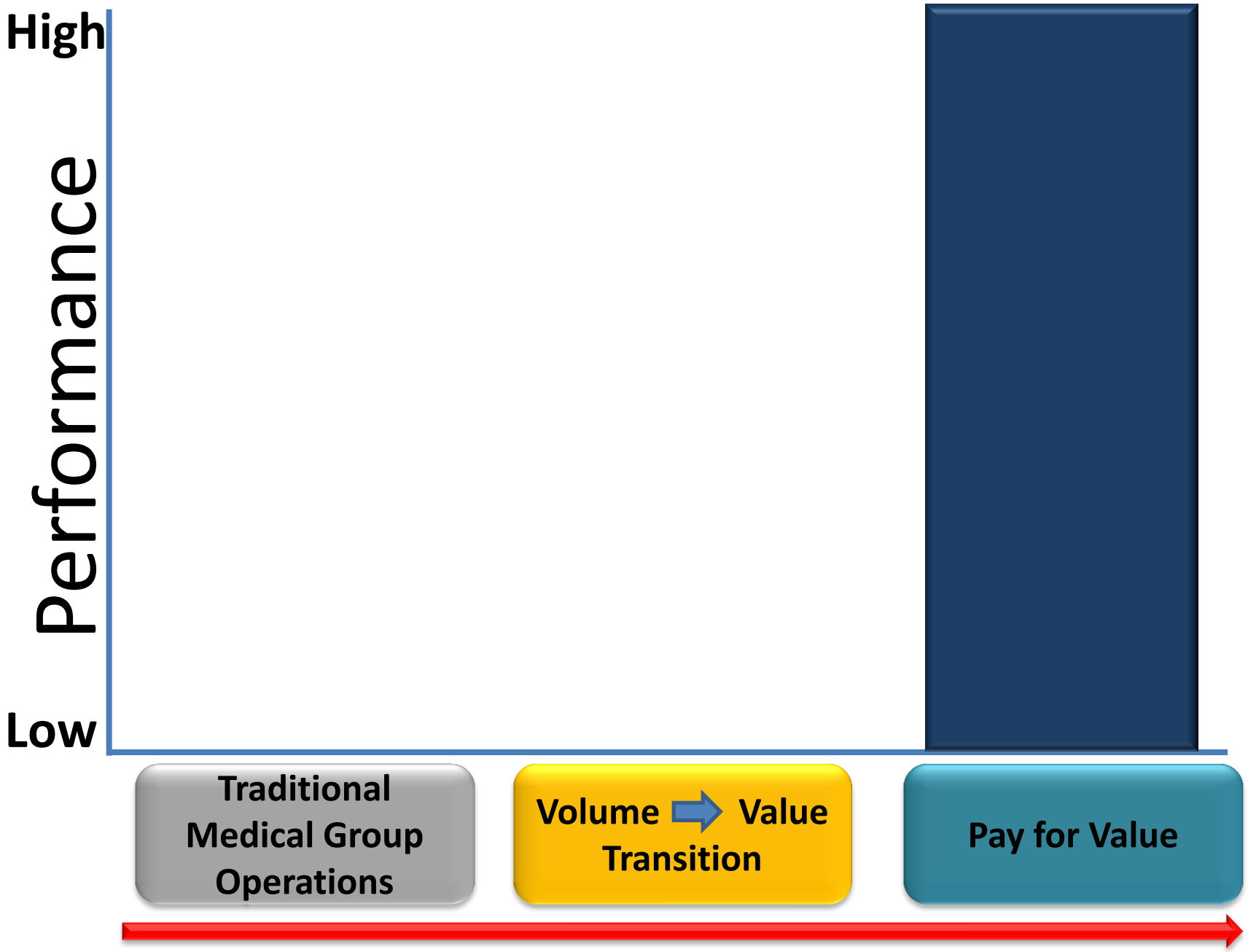
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Absolute Necessity of Using Quality Theory and Practices

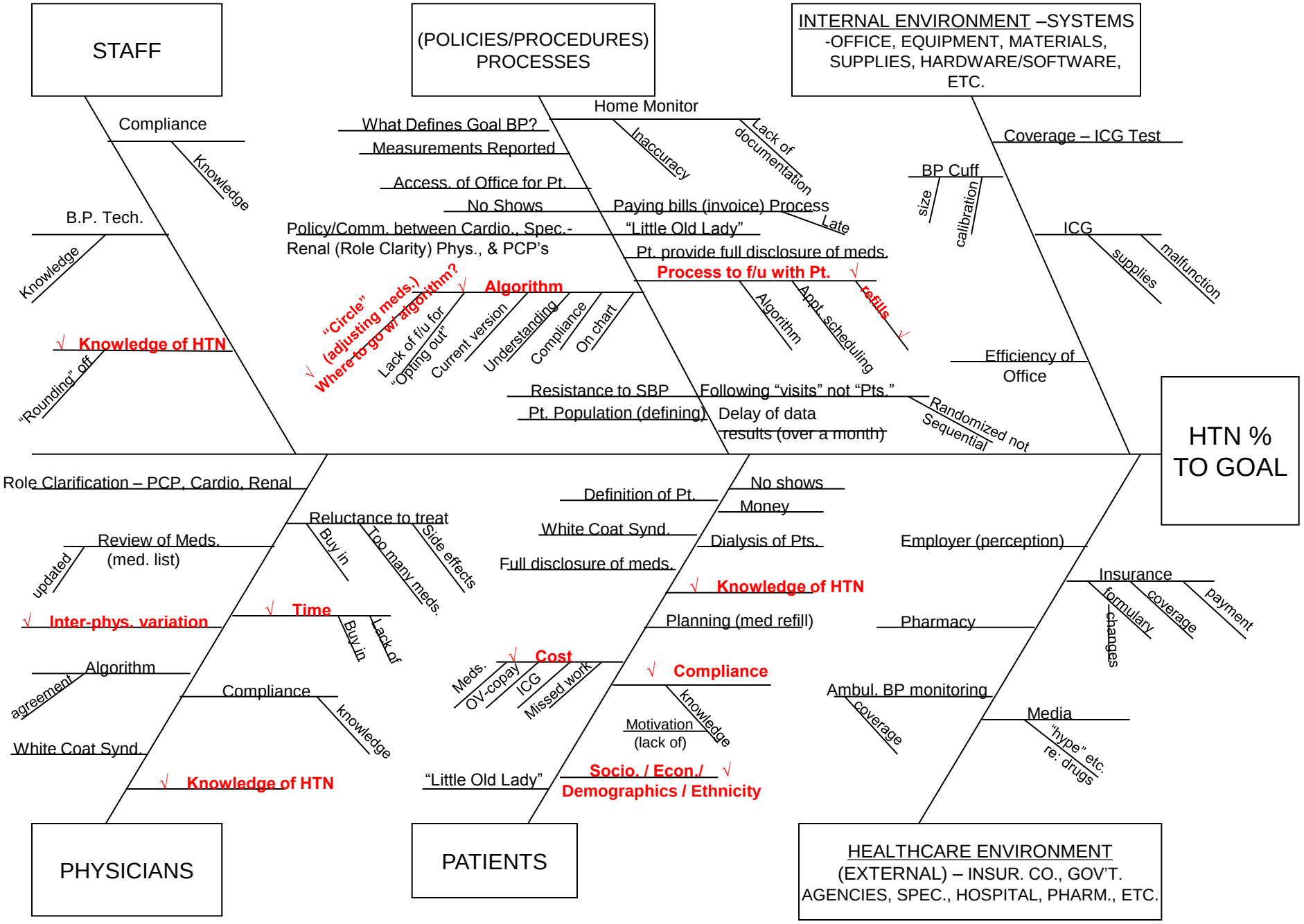
- Most other businesses have far higher quality than medical groups
  - They use Six Sigma and/or Lean
- ***Process*** is essential
  - Process is a set of defined steps to a goal
- ***Statistics*** are essential
- Is it more expensive to have Six Sigma/Lean or to not have Six Sigma/Lean?
  - Not having Six Sigma and Lean costs more

Most Groups' Approach To Chronic Disease Improvement

1. Remind doctors about goals, evidence standards, etc.
   - Pop-ups in EHR
   - Registry
2. Measure outcomes for different doctors and publish (un)blinded results
3. Hire additional staff to help
   - PCMH, care or case managers, health coaches, etc.
4. Link outcomes to pay

Six Sigma

- Better problem solving methods
- Emphasis on process for everyone
- Statistics better than opinion as to what is or is not working

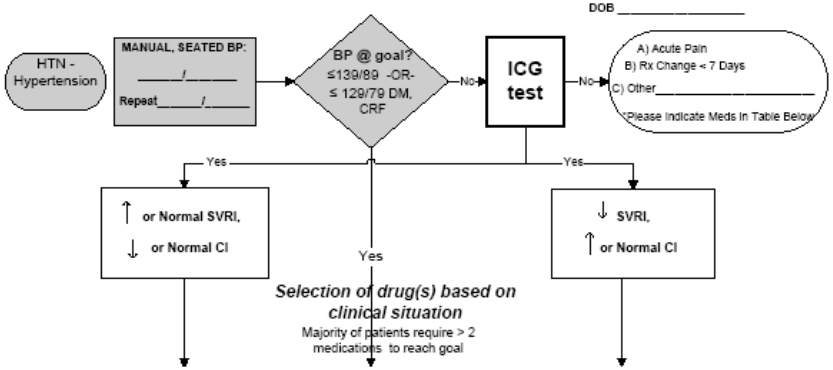

STAFF
(POLICIES/PROCEDURES) PROCESSES
INTERNAL ENVIRONMENT –SYSTEMS -OFFICE, EQUIPMENT, MATERIALS, SUPPLIES, HARDWARE/SOFTWARE, ETC.
HTN % TO GOAL
PHYSICIANS
PATIENTS
HEALTHCARE ENVIRONMENT (EXTERNAL) – INSUR. CO., GOV'T. AGENCIES, SPEC., HOSPITAL, PHARM., ETC.
Compliance
Knowledge
B.P. Tech.
Knowledge
√ Knowledge of HTN
"Rounding" off
Role Clarification – PCP, Cardio, Renal
Review of Meds. (med. list)
updated
Reluctance to treat
Buy in
Too many meds.
Side effects
√ Inter-phys. variation
√ Time
Buy in
Lack of
Algorithm
agreement
Compliance
knowledge
White Coat Synd.
√ Knowledge of HTN
What Defines Goal BP?
Measurements Reported
Access. of Office for Pt.
No Shows
Policy/Comm. between Cardio., Spec.-Renal (Role Clarity) Phys., & PCP's
Home Monitor
Inaccuracy
Lack of documentation
Paying bills (invoice) Process
Late
"Little Old Lady"
Pt. provide full disclosure of meds.
Process to f/u with Pt. √
Algorithm
Appt. scheduling
refills √
√ "Circle" (adjusting meds.) Where to go w/ algorithm?
Lack of f/u for "Opting out"
Current version
Understanding
Compliance
On chart
Resistance to SBP
Pt. Population (defining)
Following "visits" not "Pts."
Delay of data results (over a month)
Randomized not Sequential
Definition of Pt.
No shows
Money
White Coat Synd.
Dialysis of Pts.
Full disclosure of meds.
√ Knowledge of HTN
Planning (med refill)
√ Cost
Meds.
OV-copay
ICG
Missed work
√ Compliance
knowledge
Motivation (lack of)
"Little Old Lady"
Socio. / Econ./ Demographics / Ethnicity √
Coverage – ICG Test
BP Cuff
size
calibration
ICG
supplies
malfunction
Efficiency of Office
Employer (perception)
Insurance
formulary changes
coverage
payment
Pharmacy
Ambul. BP monitoring
coverage
Media
"hype" etc. re: drugs

DATE _____

NAME _____

DOB _____

HTN - Clinical Process Flow

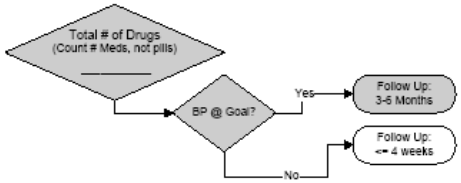


Med Adjustment			Current Meds	Med Adjustment		
Add New Rx	D/C	Change Dose	** JNC 7 guidelines recommends all Pts w/out a contraindication be on a Thiazide Diuretic	Change Dose	D/C	Add New Rx
		↑	☐ **Thiazide Diuretic**** *HF, CVD risk, DM, Recurrent stroke prevention*	↑		
		↑	☐ **ACEI** *HF, Post MI, CVD risk, DM, Chronic kidney disease, Recurrent stroke prevention*	↓		
		↑	☐ **ARB** *HF, DM, Chronic kidney disease*	↓		
		↓	☐ **B Blocker** *HF, Post MI, CVD risk, DM*	↑		
		↑	☐ **Non-Selective B Blocker** with $(alpha)_1$ blocking activity *HF, Post MI*	↓		
		↑	☐ **CCB** *CVD risk, DM*	↓		
		↑	☐ **Vasodilator**	↓		
		↑	☐ **Central/Alpha Agonist**	↓		
		↑	☐ **Diuretic (Non Thiazide)**	↓ ↑		
			☐ Other:			

Lifestyle Modifications counseled? Y / N

Sleep Hx obtained? Y / N

Annual Test/Secondary Cause?
- U/A Y / N
- Renal/K+ Y / N
- ECG Y / N
- FSG Y / N

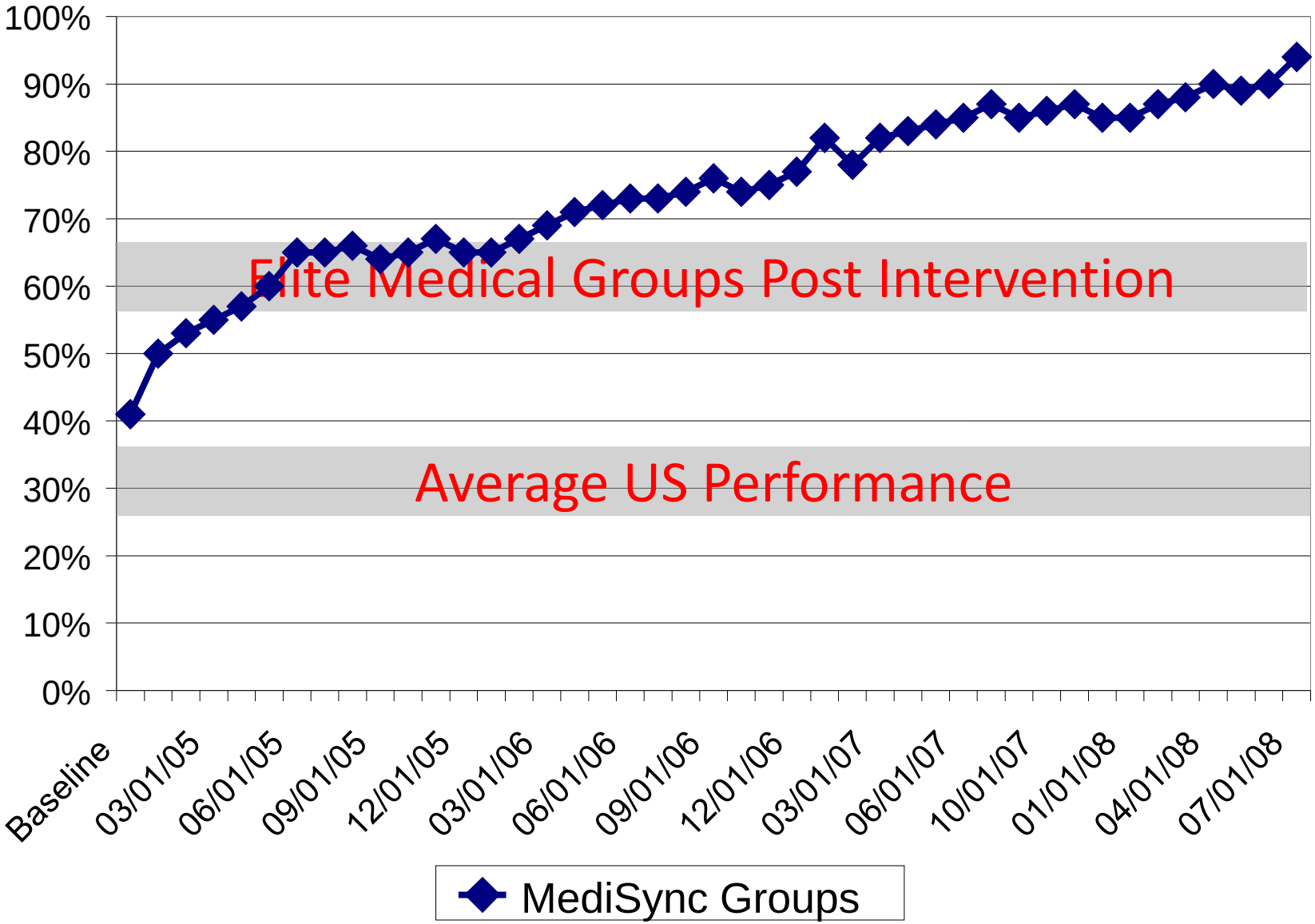


"Physician's clinical judgment supersedes this form"

REV: 01/10/06

Percent of Patients Reaching JNC-7 BP Goal

HTN Outcomes With or Without Co-Morbidities



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Medical Group Culture and Change Management

- Definitions:
  - Culture:
    - The way we ***actually*** do things in this organization
    - ***Not*** the way we ***say*** that we do them - the way that we do them
  - Change management
    - ***Process*** by which change is introduced and supported
    - Deals with both ***intellectual*** and, especially, the ***emotional*** sides of change

Traditional Physician Culture

- I do it my way
- Team flexes around my way
- Clinical ethos around personal responsibility, not process
- Ralph Waldo Emerson:
  - “Foolish consistency is the hobgoblin of little minds”

Changing Group Culture

Tradition	vs.	Quality
• Key: doctor knowledge		• Good process outperforms individual ability even if you are smart
• Doctor judges what to do case-by-case		• Follow the process steps every time
• Improve → try harder		• Improve process → improve results

Denial
Ignorance
Anger
Uncertainty
Confusion
Dislocation
Surprise
Anxiety

What We Learned

- There cannot be enough communication
  - Copy the drug reps: 7 times, 7 ways
- Remember Kubler Ross:
  - Denial, Anger, Bargaining, Depression, Acceptance
- Predict the hard spots and the emotions
- Acknowledge the emotions
- New culture built out of new behaviors
  - If you don’t change behavior, you don’t change culture

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Appreciate the Dichotomies; Achieve Balance

- You need a strategy ***and*** tactics
- The plan needs ***all*** the elements – Why? What? How? Who? And When?
- ***How*** is a very important question
  - Multiple ways to attack chronic disease, some don't help much
  - It is possible to get NCQA PCMH and not move a quality of cost needle
- Plans that sit in binders don't help much
  - The game is to plan ***and execute***
- A ***schedule*** is a good thing

Yin and Yang

- See the big picture
- See the details
- Have a long view
- Have a short view

Your plan requires a balance of several dimensions to be successful*

*Some doctors are better at one or the other…work as a team and understand each other's strengths and weaknesses

Get help where you need it.

Questions?

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