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

Presented By:
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PriMed Physicians & MediSync
AMGA IQL
October 4, 2012

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

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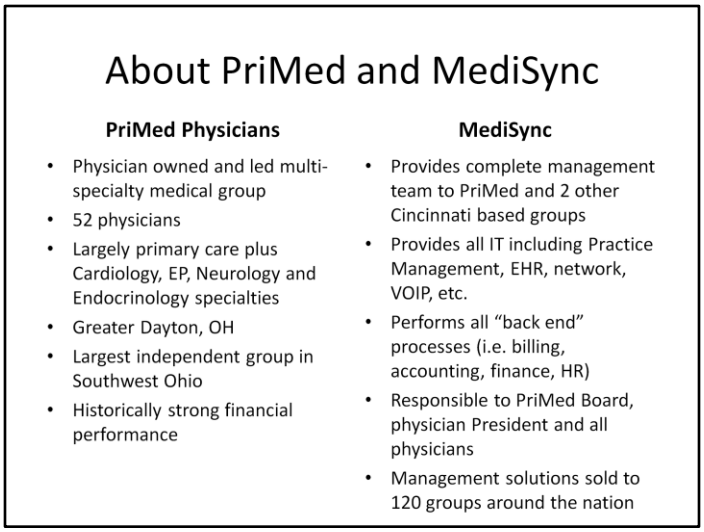


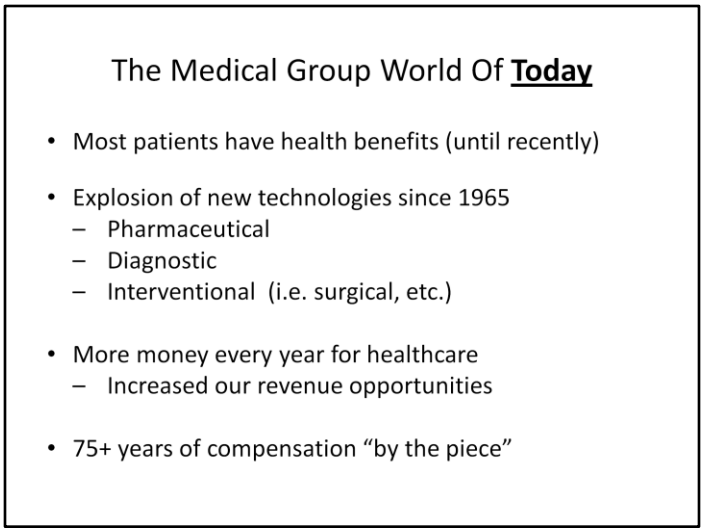
About PriMed and MediSync

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**

Different groups come from different levels of experience in change:

- Some groups have been involved in serious quality and cost improvement for 5 or 10 years – some more successful, others less successful
- Some groups have been publicly reporting outcomes results, others not yet
- Some groups have yet to start the journey from volume to value or have just started
- Some markets have value based contracts, others do not

General statements about the conditions in which we operate today:

- Most patients/citizens have health benefits (until recently)

- There has been an explosion of new technologies since 1965 and these have allowed us to do more for our patients:

  - Pharmaceutical
  - Diagnostic
  - Interventional (i.e. surgical, etc.)

- In the US there has been more money for healthcare every year
  - Which increased our revenue opportunities

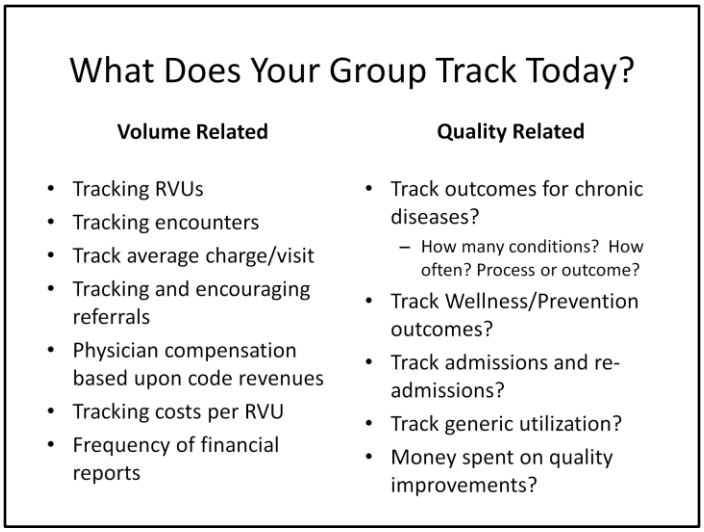
- For almost all of us, we have had 100+ years of compensation "by the piece"

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

In Today's Fee Based World:

- Volume is key to financial success
  - Medical groups have necessarily focused on volume as the major marker
  - Individual docs or groups may be concerned about clinical quality historically but the traditional approach to improvement was personal, not corporate
- Perverse incentives:
  - Improving quality decreases profit
    - Spending money on tracking data increases overhead
    - Slowing down to do a better job costs revenue or extends the work day
  - Why spend money measuring outcomes or improving outcomes?
- Result: Groups don't invest (much) in improvement
  - Dollars "saved" go to the docs
  - Any overhead not incurred typically increases physician income



What Does Your Group Track Today?

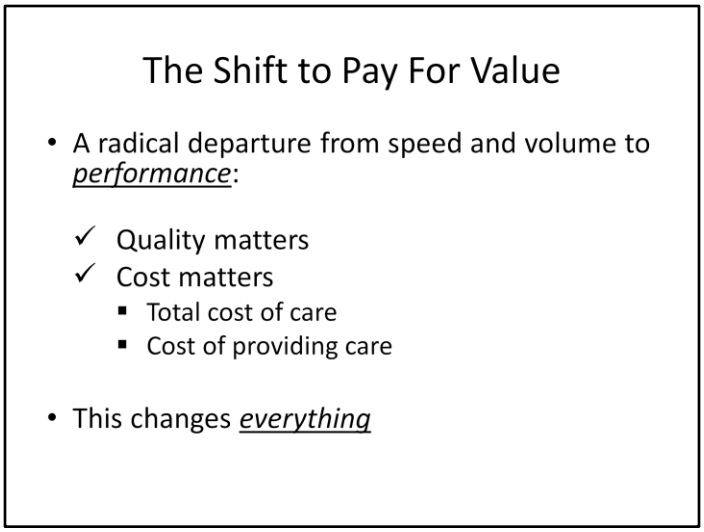
Most medical groups track a lot of data related to volume very closely while only a few track quality data or total cost of care data extensively or regularly:

Volume Related

- Tracking RVU's
- Tracking encounters
- Track average charge/visit
- Tracking and encouraging referrals
- Physician comp 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*

Medical groups do well to understand that the future "value based" world is **not an adjustment, it is a revolution** – over time we will need to change virtually everything we do.

Because it is such a major change, there is a need for a sophisticated plan and careful consideration about how to proceed.

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

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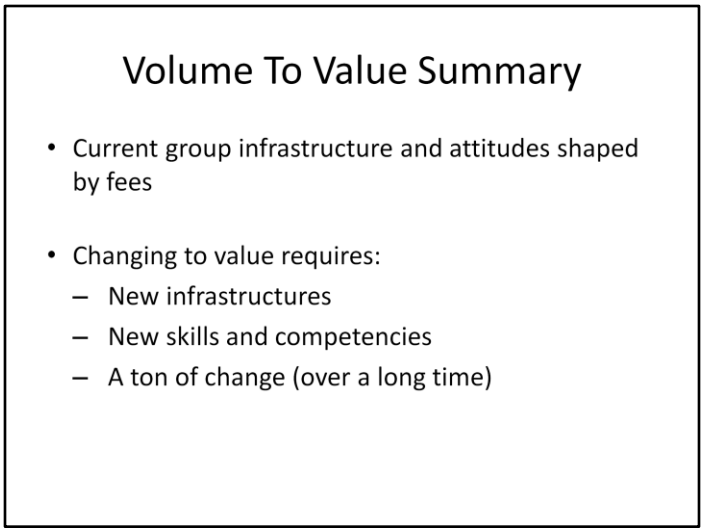

Volume to Value Summary

- 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)

Given the dimensions of change that the shift from volume to value involves, it is wise not to underestimate the dimensions of the challenge.

Many groups do not adequately plan for the changes that they want to achieve and their results can be very disappointing.

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

PriMed's Particular Situation

When starting the journey from volume to value it is a good idea to consider the particular circumstances that define your starting point and the essential "facts" about your organization.

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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.)

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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 Did Right

- Board shifted focus to strategy >80% of its time
  - Previously the Board got involved in a lot of operational details and "mini" decisions
- Lots of physician leadership development *as a group*
  - Sending people away to leadership development was not as successful as a group approach
  - We had 2 or 3 leadership sessions per year for years; each session was a 2 day off-site
- Learned and adopted Six Sigma and Lean quality methods
  - Quality improvement is a science….not knowing the science will weaken your results a lot
- Dedicated a lot of time to communication within group about goals and methods
  - More about communication later
- Developed a multi-year plan with 3 major elements:
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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
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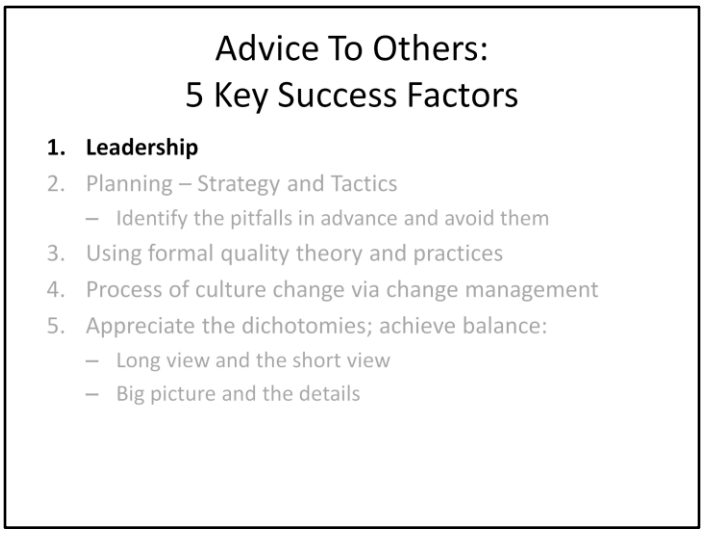
What We Wish We Did

- 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

What We Wish We Did

- Even more time 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
  - It is very expensive to start to do large quality improvement without pay for value contracts…we did too much without those agreements
- Had a shorter discussion period with physicians who didn't agree with the group's direction and eventually left us
  - In our market we were the only group working on quality
  - Some physicians did not like our change in direction for various reasons
  - They let us know and we spent almost two years discussing and discussing
  - The Board eventually called the question: "Are you with us or not?"
  - Some left shortly thereafter and, in retrospect, we think we should have called the question earlier



Advice to Others: 5 Key Success Factors

1. Leadership

2. Planning – Strategy and Tactics
   - Identify the pitfalls in advance and avoid them

3. Using quality theory and practices

4. Process of culture change via change management

5. Appreciate the dichotomies; achieve balance:
   - Long view and the short view
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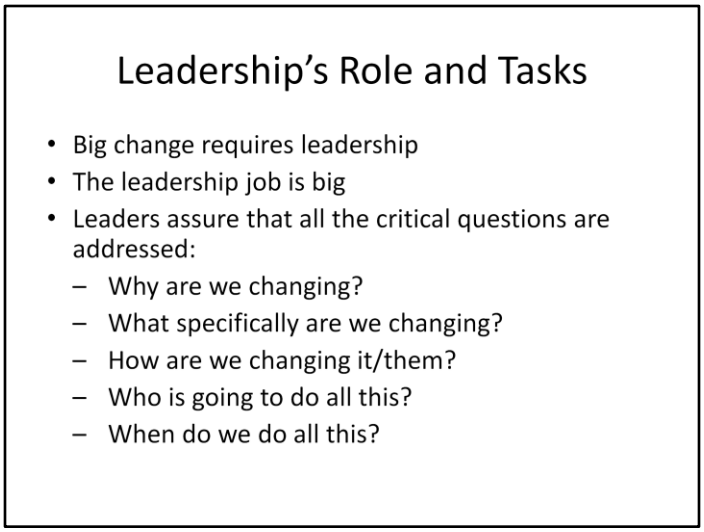


Leadership's Role and Tasks

Leadership is one of the critical factors in group success. Without leadership the change from volume to value cannot be achieved.

The following slides discuss some leadership tips:

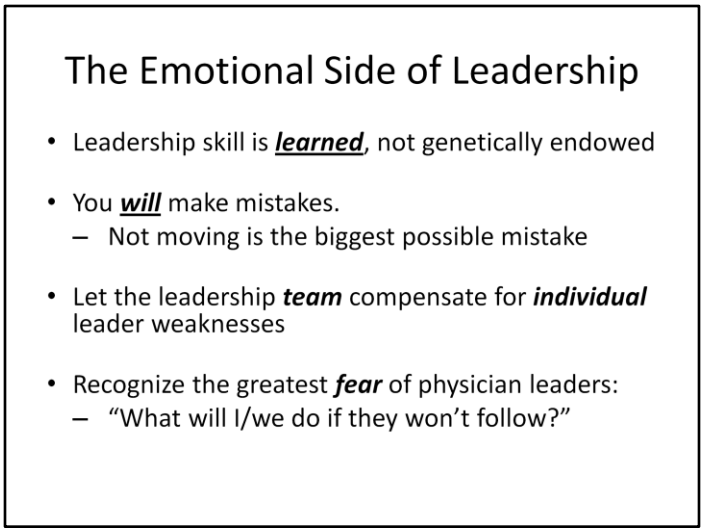
- Big change requires skilled leadership
  - It can't happen any other way:
  - No group of 100 docs (plus 500 additional managers and staff) is going to spontaneously read the tea leaves, see that the future requires change, plan and execute a major change …they ***must*** be led

- Leadership's role is big
  - See Strategy, Change Management and Culture, etc. There is lots to do

- Leadership must address it ***all***:
  - The Why? The What? The How? The Who? The When?

However, one person does not need to do it all.

Few groups have lots of available, highly skilled leaders.



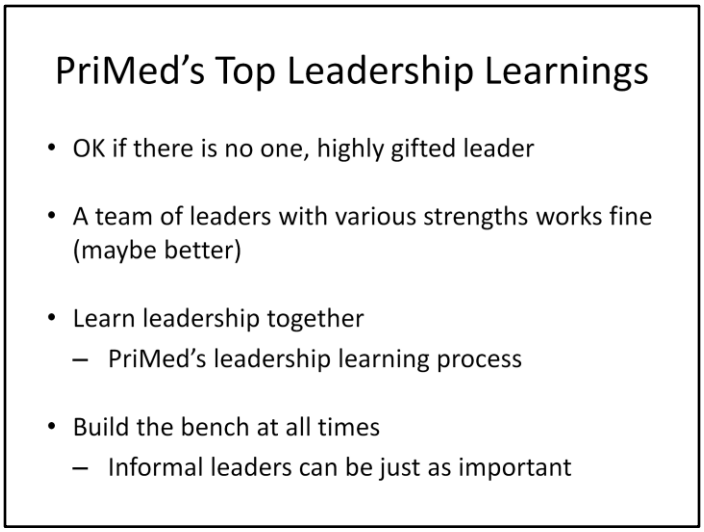
The Emotional Side of Leadership

- 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?"

In most medical groups, leadership can be a team sport. Different people can play different roles, as their skills and interests permit.

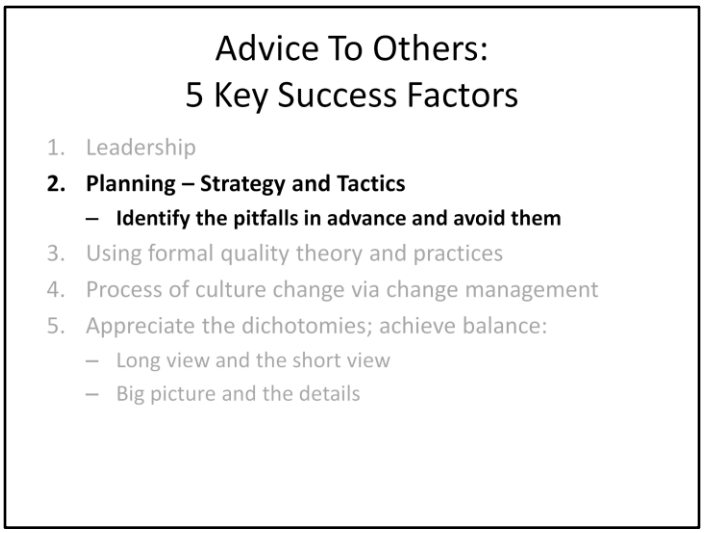
Recognizing the fears that physicians have about leadership helps to free up the team to progress.

In many groups there is no one, highly trained, charismatic leader. The leadership team can compensate well…working as a team various leaders (physician and non-physician) can develop the ability to get the whole job done well.



PriMed's Top Leadership Learnings

- It is 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
  - Leadership sessions 2-3 time per year; 2 days each
  - Leadership timed to the stage of group development
  - Over time covered most of the important topics
    - Strategy
    - Quality
    - Execution
    - Communications
    - Finance and accounting
- Build the bench at all times
  - Informal leaders can be just as important
  - Don't just train the current leaders…train those who may be interested in the future
  - If someone is trained and decides not to lead, s/he will be a better group member
  - Some leadership is down at the site level, on a Task Force, on a Committee



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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.

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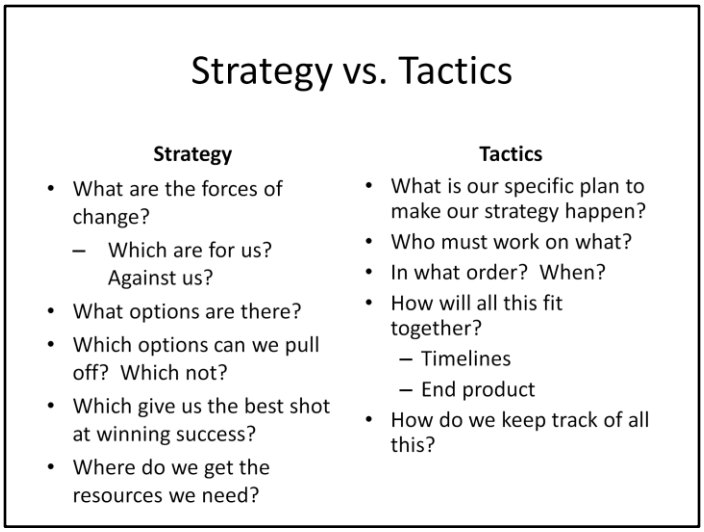

Strategy vs. Tactics

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

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1. **Don't wait** until too late
   - For example, learning how to do chronic disease management takes ***years***
   - You don't want to get into contracts before you know how to do some of this stuff

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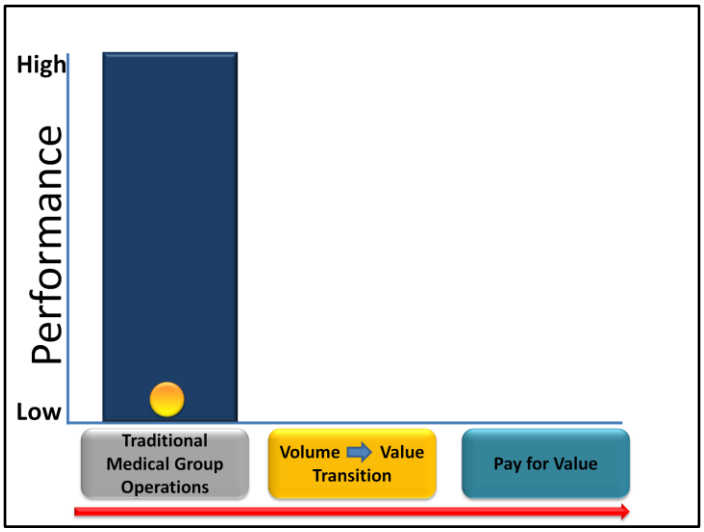
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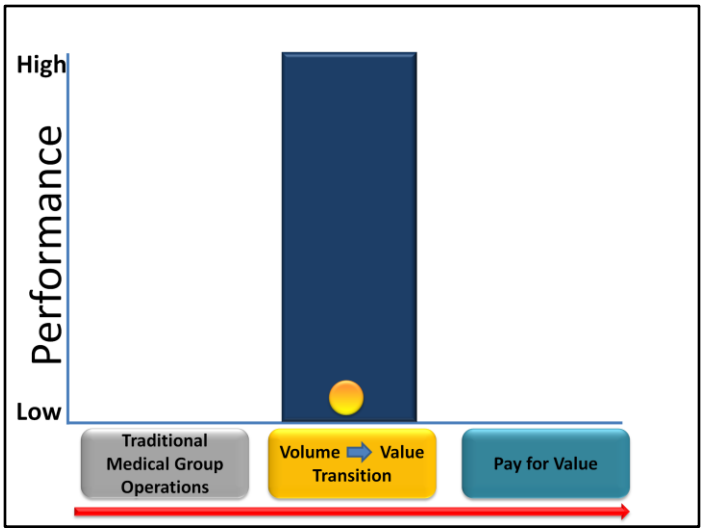
Performance
Low
Traditional Medical Group Operations
Volume Value Transition
Pay for Value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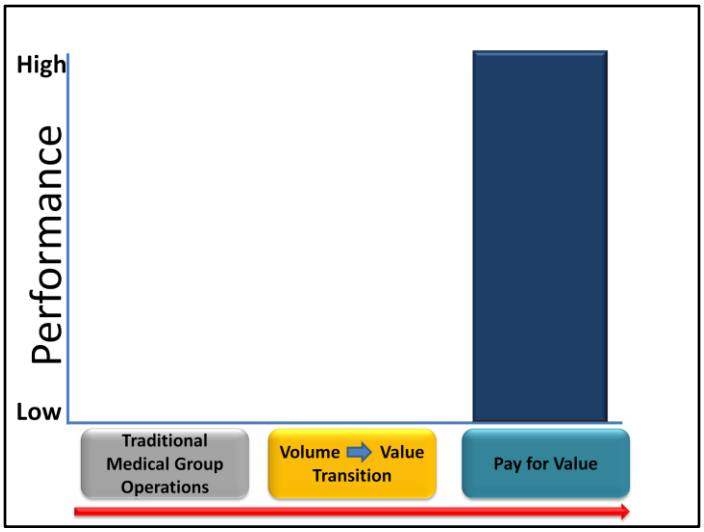
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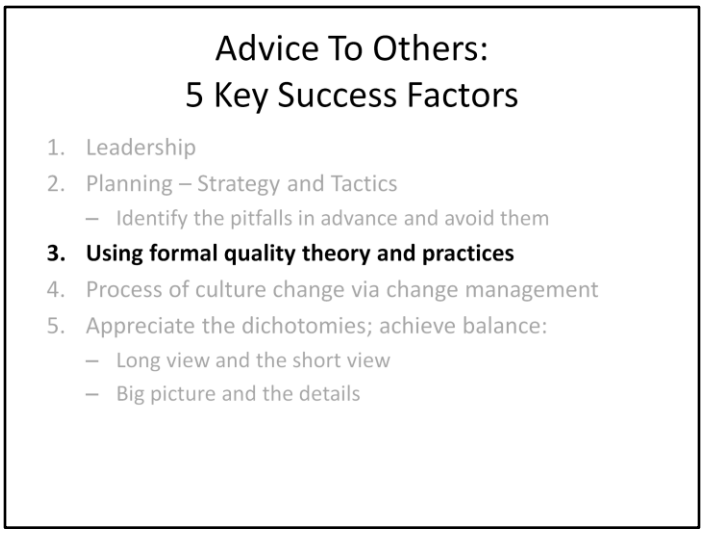

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Absolute Necessity of Using Quality Theory and Practices

- 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?
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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.
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On average these steps result in about 55-65% success on any one variable (i.e. BP, LDL, A1c, etc.)

This is good, but not good enough

These interventions are not capable of high levels of achievement

Six Sigma

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

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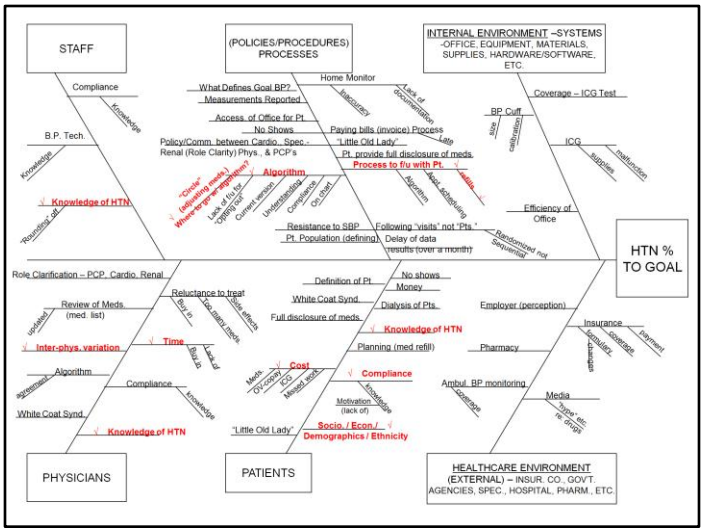
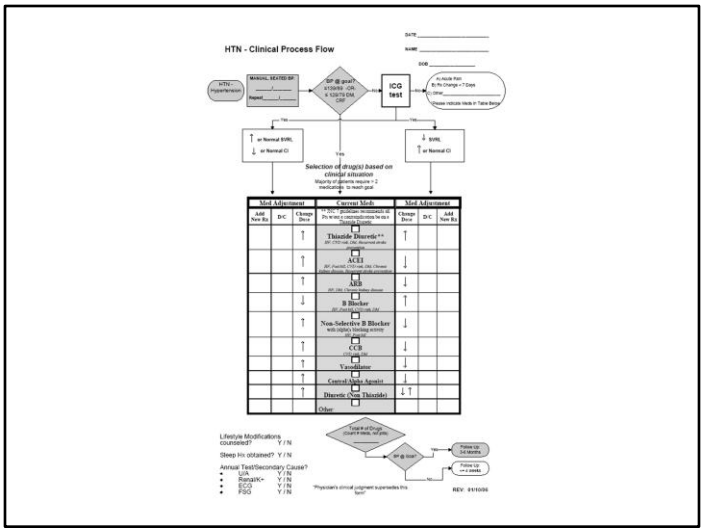
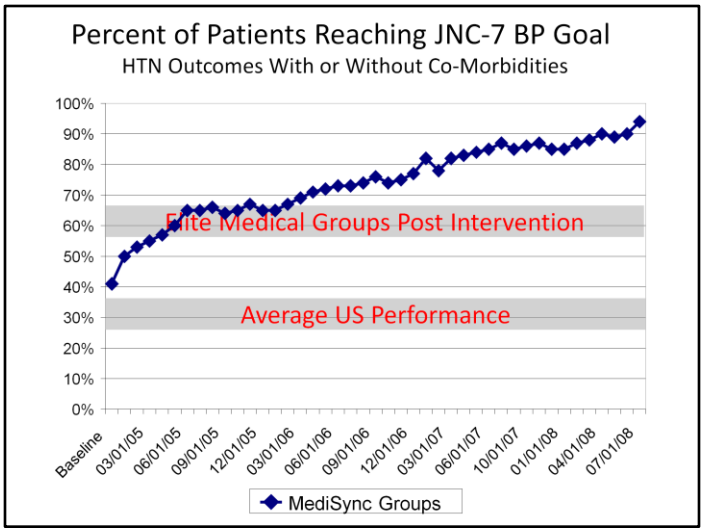


This example of a Six Sigma problem solving tool emphasizes that, at the start of an improvement project, you need to find every single thing that might go wrong in achieving your goal. See illustration above related to all the problems that could inhibit achieving JNC-7 blood pressure outcomes.

Many medical groups just identify one or a few of the problems and their solutions are misguided thereafter.


HTN - Clinical Process Flow
DATE
NAME
DOB
HTN / Hypertension
MANUAL, SEATED BP
BP @ goal? ≤130/85 -OR- ≤ 130/70 DM, CRF
YES
NO
ICQ test
At Acute Pain
By Pts Change – 7 Days
By Other
Please indicate Meds in Table Below
↑ or Normal SVRL
↓ or Normal CI
↓ SVRL
↑ or Normal CI
Selection of drug(s) based on clinical situation
Majority of patients require > 2 medications to reach goal
Med Adjustment
Add New Rx
D/C
Change Dose
Current Meds
Med Adjustment
Change Dose
D/C
Add New Rx
Thiazide Diuretic**
ACEI
ARB
B Blocker
Non-Selective B Blocker
CCB
Vasodilator
Central Alpha Agonist
Diuretic (Non Thiazide)
Other
Lifestyle Modifications counseled? Y / N
Sleep Hx obtained? Y / N
Annual Test/Secondary Cause?
UA Y / N
Renal/K+ Y / N
ECG Y / N
FSG Y / N
Total # of Drugs (Count # Meds, not pills)
BP @ Goal
Follow Up 3-6 Months
Follow Up << 3 MNTH
Physician's clinical judgment supersedes this form
REV: 01/10/05


Percent of Patients Reaching JNC-7 BP Goal
HTN Outcomes With or Without Co-Morbidities
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Elite Medical Groups Post Intervention
Average US Performance
Baseline
03/01/05
06/01/05
09/01/05
12/01/05
03/01/06
06/01/06
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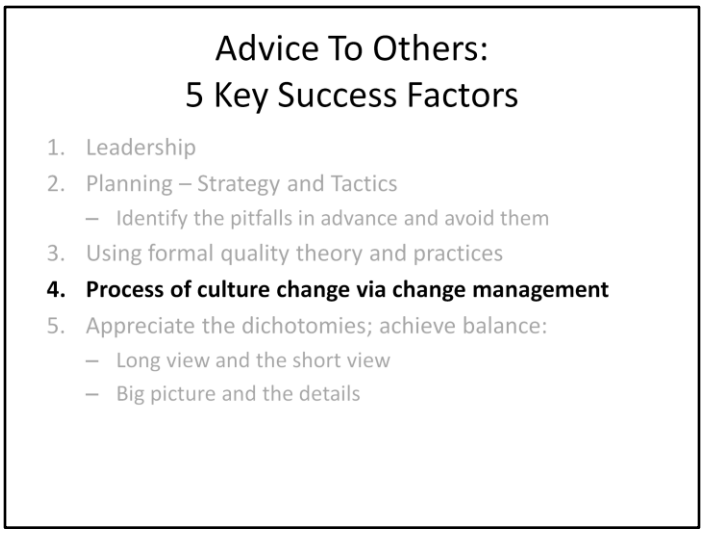
07/01/08
MediSync Groups



Advice to Others: 5 Key Success Factors

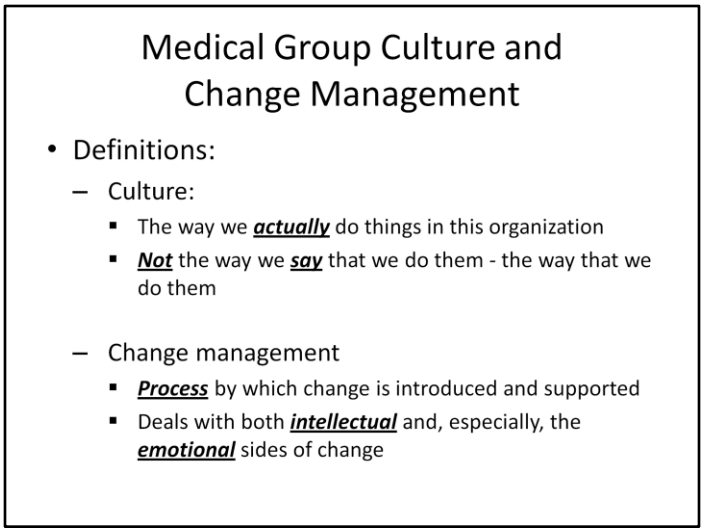
1. Leadership

2. Planning – Strategy and Tactics
   – Identify the pitfalls in advance and avoid them

3. Using 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



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 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"

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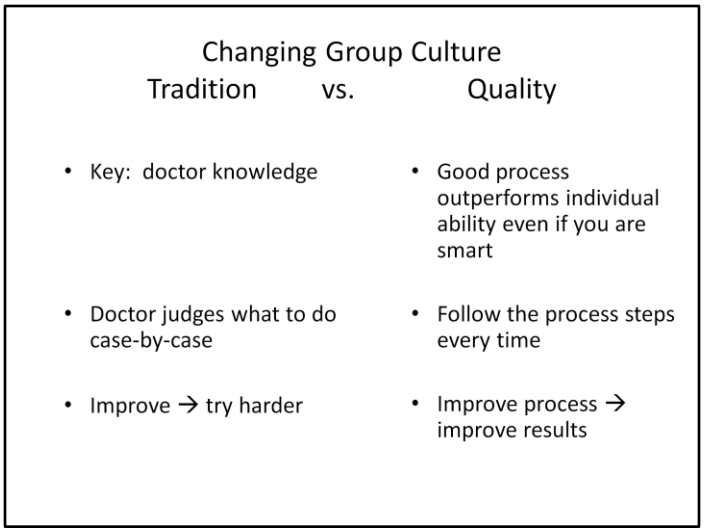
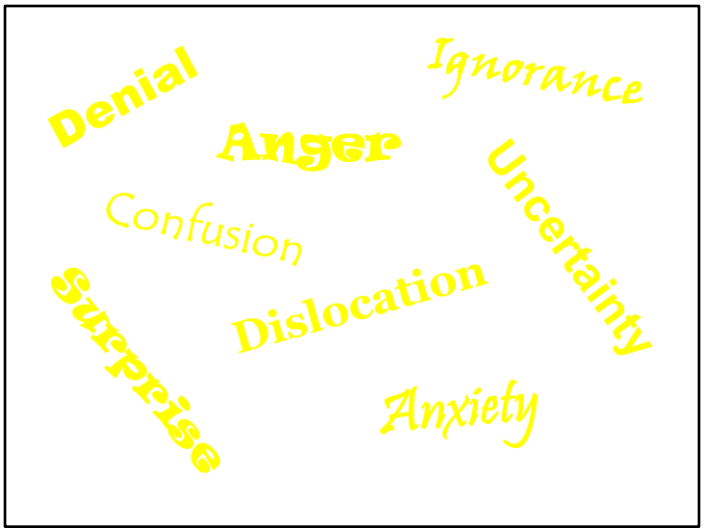


Changing Group Culture
Tradition vs. Quality

Tradition
- Key: doctor knowledge
- Doctor judges what to do case-by-case
- Improve ➔try harder

Quality
- Good process outperforms individual ability even if you are smart
- Follow the process steps every time
- Improve process ➔ improve results



Reactions are Both Intellectual and Emotional

- Just understanding the nature of the changes we face, listing our options, evaluating the options and then planning is a major intellectual effort
- Major changes in the environment that disrupt an organization often evoke strong emotions
  - Leaders have emotional reactions
  - Physicians have emotional reactions
  - Management and staff have emotional reactions
- Denial is not a small factor
- Effective change management takes into account the intellectual/cognitive and emotional needs of the stakeholders in the organization

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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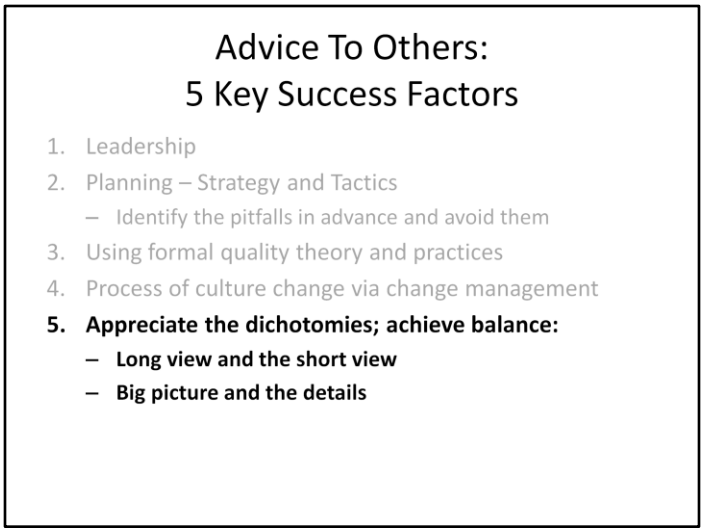

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Appreciate the Dichotomies;
Achieve Balance

- 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

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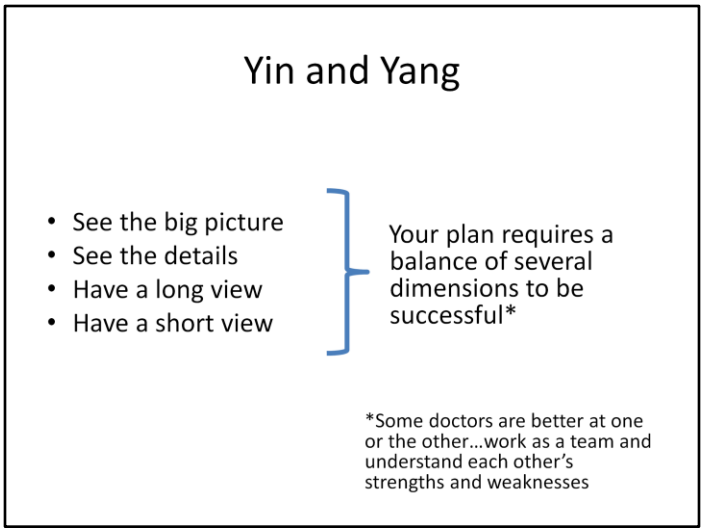

Yin and Yang

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

Your plan requires 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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