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

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Presented To

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Agenda

1. Where we've been; where we're going
2. Leadership
3. Planning
4. Solving the problem of group affordability
5. Identifying the "pieces" inside value
6. The role of quality theory and practices
7. Lessons from our journey

About PriMed Physicians

- Community based, physician owned and governed
- Greater Dayton, OH
- PCP Based Multi-specialty Medical Group
  - – Family Practice, Internal Medicine, Pediatrics
  - + Cardiology, Electrophysiology, Neurology and Endocrinology
- 70 physicians; ~150,000 patients
- Started prepping for value agreements in 2004
- November 1, 2012 - almost all value contracts

About MediSync

- Management team for PriMed Physicians and multiple other groups since 1997
- Spent lots on R&D to improve medical group performance
  - Elevate *operations* performance
  - Elevate *“value”* performance
- 150+ medical groups use one or more MediSync service lines

PriMed's Situation

- Independent group = no subsidy or deep pocket
- In a historically low paying market
- Our doctors expect to earn top 10% regionally, above average nationally
- Physician buy-in to changes essential
  - Physician owned medical group
  - There is no "boss" who could mandate changes

Disclaimer:

In healthcare, all facts are local.

Seattle vs. Miami, Florida

Assumptions Baked Into This Talk

1. Payments will be based on ***value*** in the future
   - Different “value” formulae and contract terms by region
   - The speed of change will vary by region

2. Many commercial insurers will propose disadvantageous terms to groups and health delivery systems

The World We Grew Up In

- Most patients have health benefits (until recently)
- Explosion of new technologies since 1965
  - Pharmaceutical
  - Diagnostic
  - Interventional (i.e. surgical, etc.)
- More services for groups and systems to bill
- We submitted claims into an unlimited pool of money
  - Increased group/system revenue opportunities
- 75+ years of compensation “by the piece” without accountability for cost or quality

In Today's Fee Based World:

- ***Volume*** is essential to financial success
  - And, keep your overhead down
- Perverse incentives:
  - We could not charge more money for better quality
  - There were no fee reductions for mediocre or poor quality
  - Quality improvement could cost a group $
  - "Why spend money measuring outcomes or improving outcomes?"

What Next?

- If you believe that volume is the answer to tomorrow's challenges
  - You're there…

- If you believe that value is necessary to your success;
  - DO NOT assume that your colleagues agree, understand or know how to get there

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

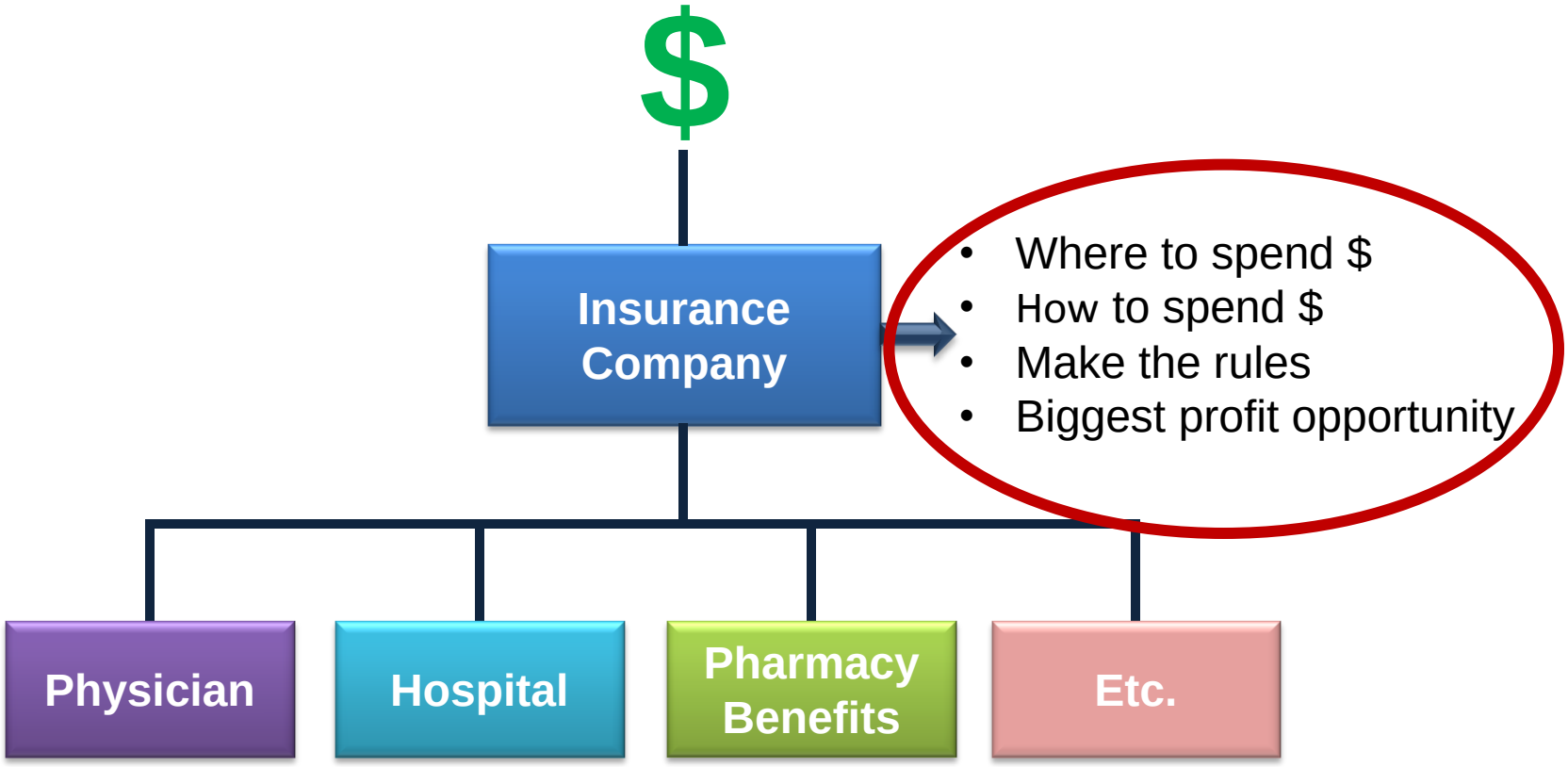
In Business…
(And Healthcare IS a Business)

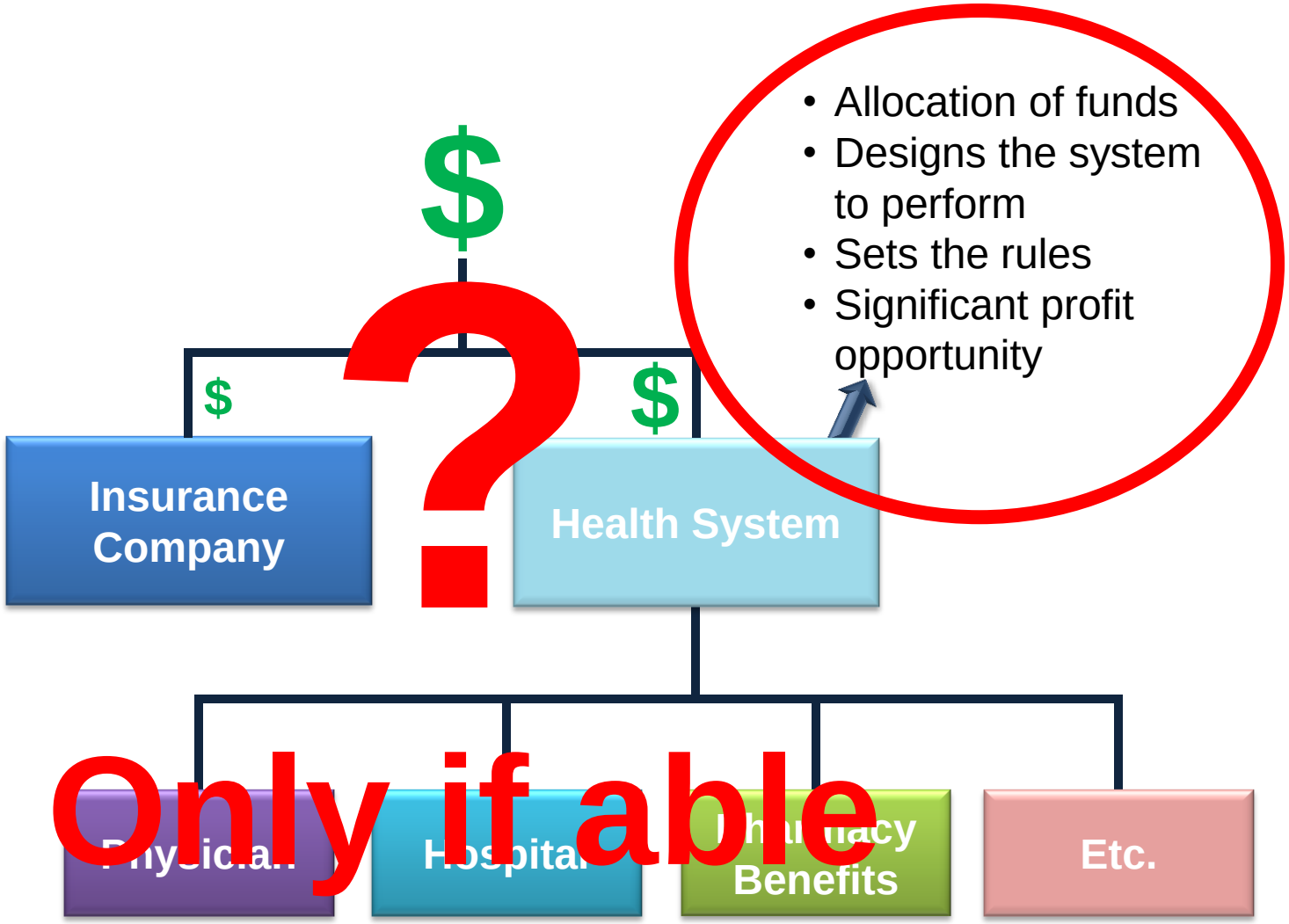
Those who create (the most) **value**
win the prize:

Profit
Market Share
Margin
Brand and Visibility

Defining the Stakes:

The next five years will define who gets to handle the money and set the rules in healthcare!


$
Insurance Company
Where to spend $
How to spend $
Make the rules
Biggest profit opportunity
Physician
Hospital
Pharmacy Benefits
Etc.


$
$
$
Insurance Company
Health System
Physician
Hospital
Pharmacy Benefits
Etc.
Only if able
• Allocation of funds
• Designs the system to perform
• Sets the rules
• Significant profit opportunity

Volume → Value
Four Biggest Challenges

1. The cost
2. Not knowing when you can get contracts that pay for value
3. Learning new skills
4. Changing physician habits and group culture

A Prerequisite:

LEADERSHIP

Leadership

- Takes vision to see what is not obvious to most
- Leadership is a learned skill; not an endowed or natural skill
- Some leadership skills are more critical
  - Planning
    - See the destination AND the journey
  - Communication → engagement

Leadership's Role and Tasks

- Big change requires leadership
- 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

- 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?"
- You ***<u>will</u>*** make mistakes.
  - Not moving is the biggest possible mistake

The Launch of PriMed's Journey

1. Leadership created a strategy and made the case to the doctors
   - Discussed, processed and passed by the entire physician membership
2. Adopted ***Strategic Plan*** in 2004: **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 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 until 2013
- Process based EHR implementation
  - Full productivity in <14 calendar days

What Worked

- Board shifted focus to strategy >80% of its time
- Good ***group*** of physician leaders
- Learned and adopted Six Sigma and Lean quality methods
  - Management good at creating processes
  - Doctors appreciate value of process; willing to use process
- 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

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

If You Don’t Know How To Lead…

- Be willing to learn

- Consider learning as a group
  - We find that a group of physicians with average leadership ability
    - who *learn* how to lead
    - who *collaborate* well
    - who are *committed*

    are often more effective than a single great leader

After Leadership…

Planning


P&G


GE imagination at work

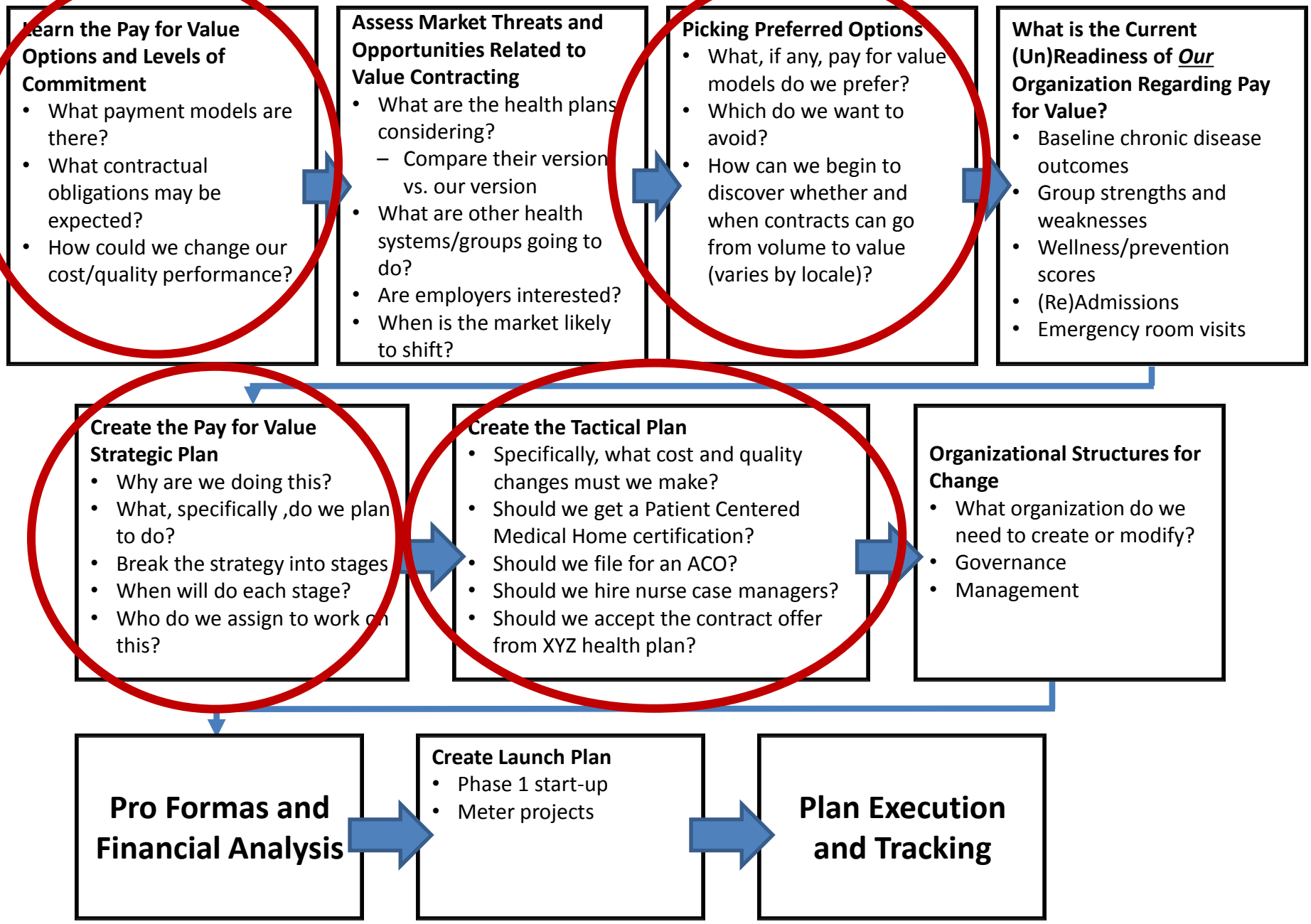

the magic of
macy's


Kroger


TOYOTA
Let's Go Places


2014
AIVGA

Volume ➔ Value Road Map



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?

Volume ➔ Value Road Map

Learn the Pay for Value Options and Levels of Commitment
- What payment models are there?
- What contractual obligations may be expected?
- How could we change our cost/quality performance?

Assess Market Threats and Opportunities Related to Value Contracting
- What are the health plans considering?
  - Compare their version vs. our version
- What are other health systems/groups going to do?
- Are employers interested?
- When is the market likely to shift?

Picking Preferred Options
- What, if any, pay for value models do we prefer?
- Which do we want to avoid?
- How can we begin to discover whether and when contracts can go from volume to value (varies by locale)?

What is the Current (Un)Readiness of *Our* Organization Regarding Pay for Value?
- Baseline chronic disease outcomes
- Group strengths and weaknesses
- Wellness/prevention scores
- (Re)Admissions
- Emergency room visits

Create the Pay for Value Strategic Plan
- Why are we doing this?
- What, specifically ,do we plan to do?
- Break the strategy into stages
- When will do each stage?
- Who do we assign to work on this?

Create the Tactical Plan
- Specifically, what cost and quality changes must we make?
- Should we get a Patient Centered Medical Home certification?
- Should we file for an ACO?
- Should we hire nurse case managers?
- Should we accept the contract offer from XYZ health plan?

Organizational Structures for Change
- What organization do we need to create or modify?
- Governance
- Management

Pro Formas and Financial Analysis

Create Launch Plan
- Phase 1 start-up
- Meter projects

Plan Execution and Tracking

$$\text{VALUE} = \frac{\text{QUALITY}}{\text{COST}}$$

Quality

- WRAP (Wellness, Risk Assessment, Prevention)
- Chronic disease outcomes
  - Percent of A1c to goal
  - Percent of LDL to goal
  - Percent of BP to goal
  - Percent of asthmatics with correct prescription and an Asthma Action Plan
  - Percent of CHF optimally managed
  - Percent of CKD with < GFR
  - Percent of diabetes process measures (eye exam, foot exam)
- Depression screening percentage
- Re-admissions per 1,000
- Complication rates post procedure
- Percent of patient care preferences documented
- Etc.

Cost – Easiest Cost Accomplish

- Pharmacy (generics)
- Unnecessary diagnostic costs (MR/CT/PET)
- “Big Events” (strokes, MI, renal failure)
- Cancer – optimal care
- Better managed care for most expensive 2% (frail elderly, etc.)
- End of life care against patient wishes
- Cost per case – procedure
- Complication percentage rate per procedure
- ER visit rate
- Chronic disease “success”
- Preventable admissions
- Re-admissions

Cost – Greatest to Least Easiest to Accomplish

- Pharmacy (generics)
- Unnecessary diagnostic costs (MR/CT/PET)
- “Big Events” (strokes, MI, renal failure)
- Cancer – optimal care
- Better managed care for most expensive 2% (frail elderly, etc.)
- End of life care against patient wishes
- Cost per case – procedure
- Complication percentage rate per procedure
- ER visit rate
- Chronic disease “success”
- Preventable admissions
- Re-admissions

Cost Groups Most to Accomplish

- Pharmacy (generics)
- Unnecessary diagnostic costs (MR/CT/PET)
- "Big Events" (strokes, MI, renal failure)
- Cancer – optimal care
- Better managed care for most expensive 2% (frail elderly, etc.)
- End of life care against patient wishes
- Cost per case – procedure
- Complication percentage rate per procedure
- ER visit rate
- Chronic disease "success"
- Preventable admissions
- Re-admissions

Value

Quality

- WRAP
- Chronic disease outcomes
  - Percent of A1c to goal
  - Percent of LDL to goal
  - Percent of BP to goal
  - Percent of asthmatics with correct prescription, asthma action plan
  - Percent of CHF optimally managed
  - Percent of CKD with < GFR
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Cost

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- Cost per case – procedure
- Pharmacy (generics)

Building a Plan

- Specifically how are we going to achieve value?
  - How much value will we get for each step?
- What can we afford to do NOW?
- What is our plan to generate revenue?
  - When will that revenue come online?
- What are the dependencies?

Example: PriMed's Plan

- Do chronic diseases first
- Our goals:
  - Learn how to do quality work
  - Change physician culture
  - Use higher outcomes to leverage better fee contracts

- NB: Chronic disease work is virtually all 99214 visits and we make money on those

Example: PriMed's Plan - 2

- Later on, when we get additional revenue opportunities (i.e. shared savings) ***THEN*** work on:
  - Case/care management
  - Reducing other healthcare costs

Absolute Necessity of Using Quality Theory and Practices

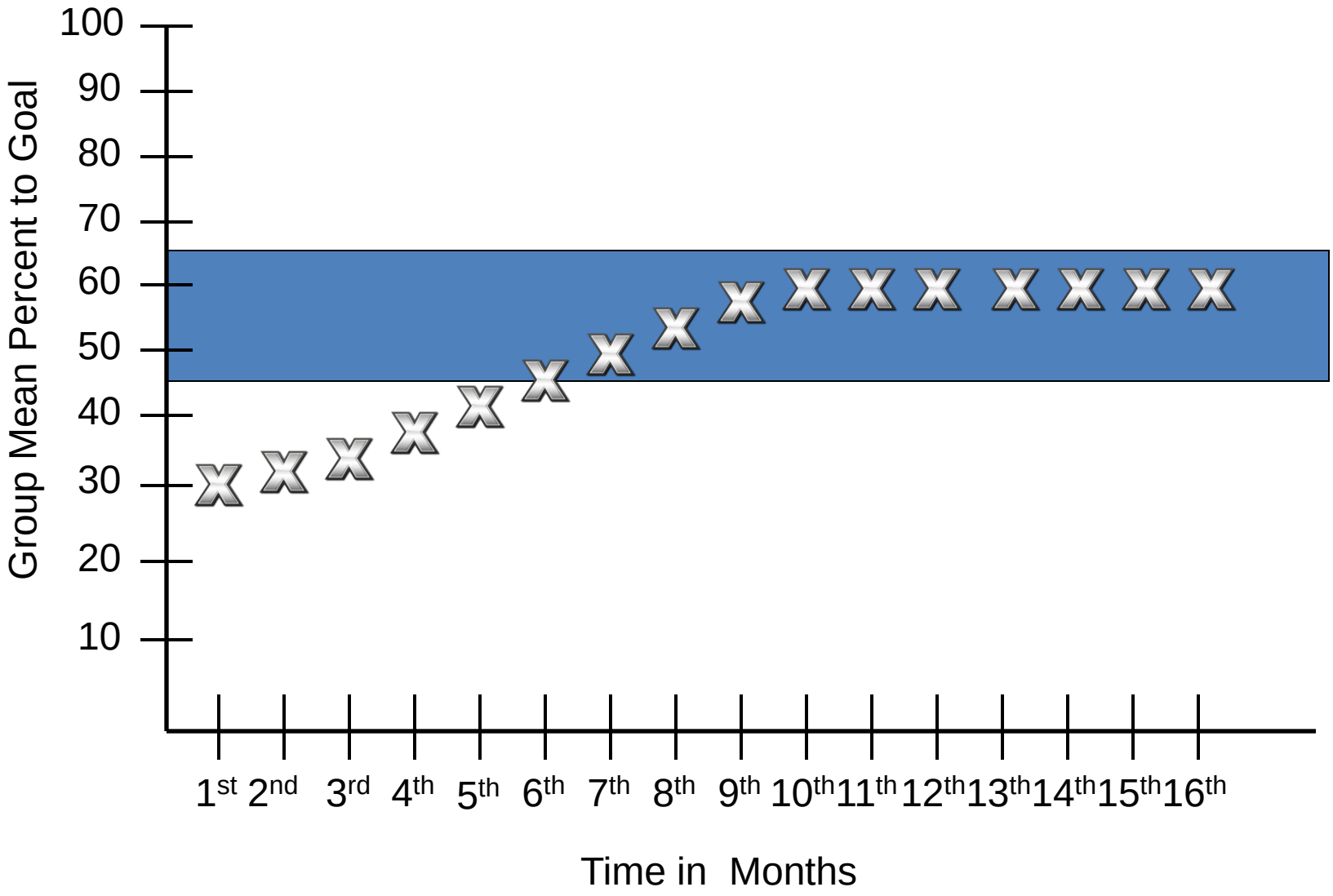
- Most other businesses have far higher quality than medical groups
  - They use Six Sigma and/or Lean
- ***Process*** is essential
  - Process is a set of defined steps to a goal
- ***Statistics*** are essential
- **Is it more expensive to have Six Sigma/Lean or to not have Six Sigma/Lean?**
  - **Not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

What do the “average” quality steps achieve?

Medical Quality Goal:
Move One Variable (i.e. BP)



Three Goals @ 60% Each

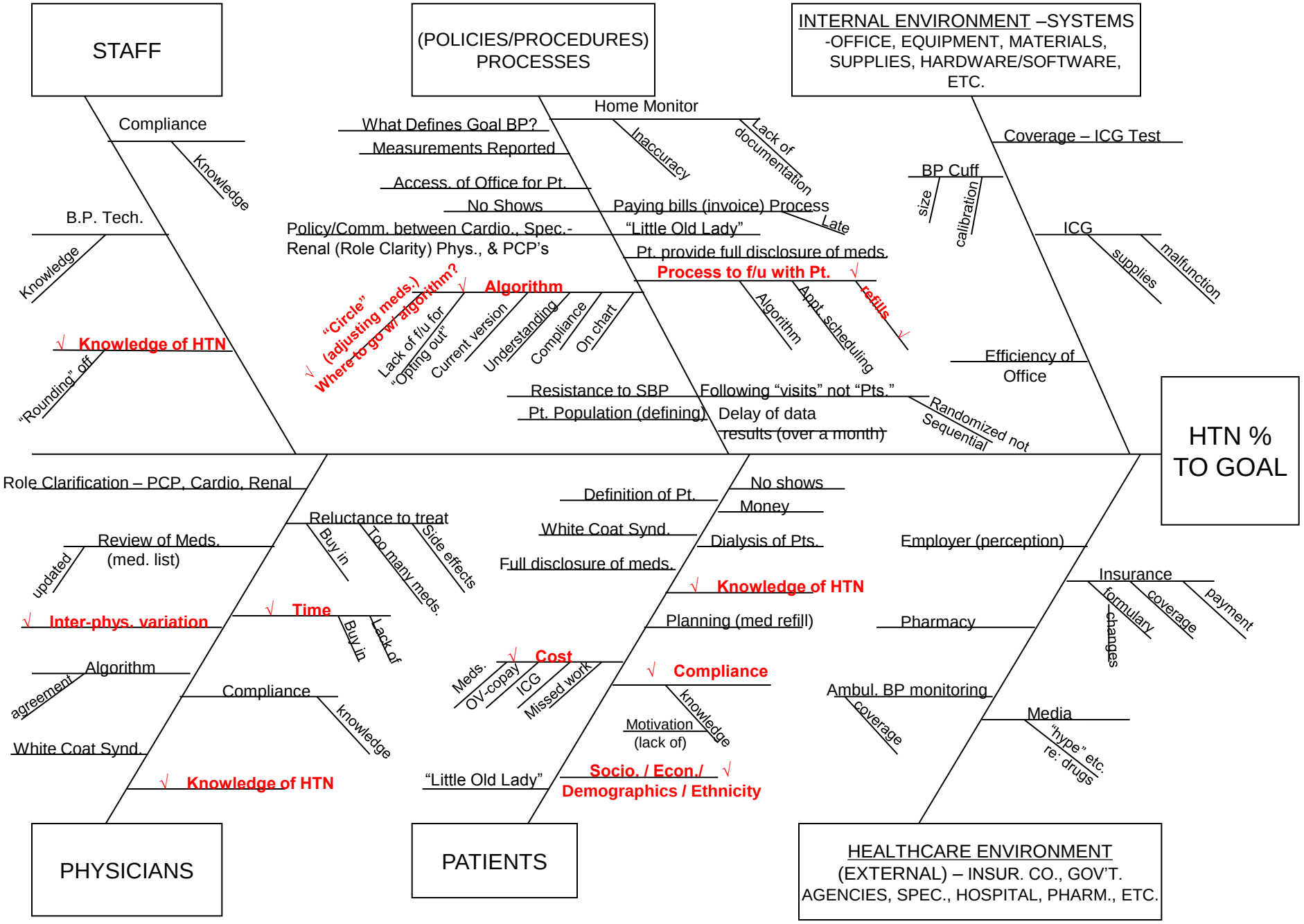
»1st Goal	70%
»2nd Goal	42%
»3rd Goal	24%

Six Sigma and Lean

- ***Better*** problem solving methods
- Emphasis on ***process for everyone***
- ***Statistics*** better than opinion
  - What is / is not working?

How Six Sigma and Lean Work

- Tools to identify problems and create solutions


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

How Six Sigma and Lean Work

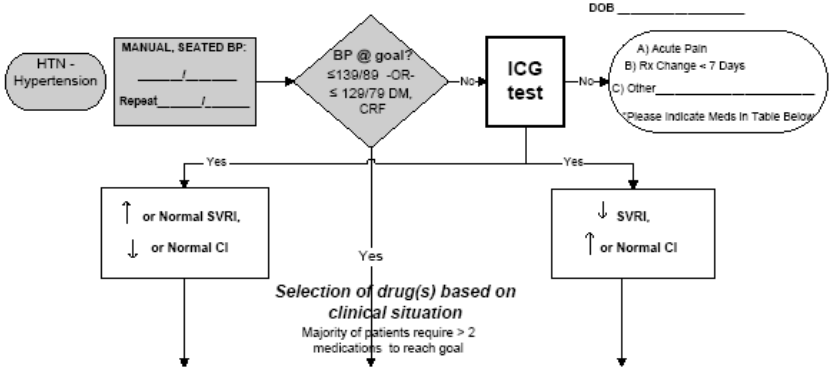
- Tools to identify problems and create solutions
- Fundamental concept: process
- Definition of Process:
  - A series of steps specifically designed to achieve the desired outcomes
- Process doesn’t work if staff uses them, but the doctors do not

DATE _____

NAME _____

DOB _____

HTN - Clinical Process Flow

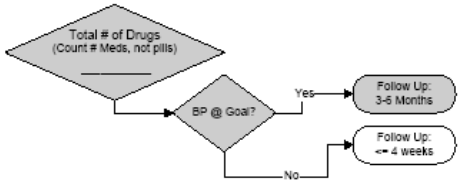


Med Adjustment			Current Meds	Med Adjustment		
Add New Rx	D/C	Change Dose	** JNC 7 guidelines recommends all Pts w/out a contraindication be on a Thiazide Diuretic	Change Dose	D/C	Add New Rx
		↑	☐ **Thiazide Diuretic**** *HF, CVD risk, DM, Recurrent stroke prevention*	↑		
		↑	☐ **ACEI** *HF, Post MI, 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

One Little Problem…

- Physicians generally not familiar (or enthused) about ‘process’
- Thus, the leadership challenge
  - Can our team get doctors to use/accept process?
- If we can’t get ‘process’ to happen; we are going to get stuck at low outcomes

Traditional Physician Culture

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

Changing Group Culture

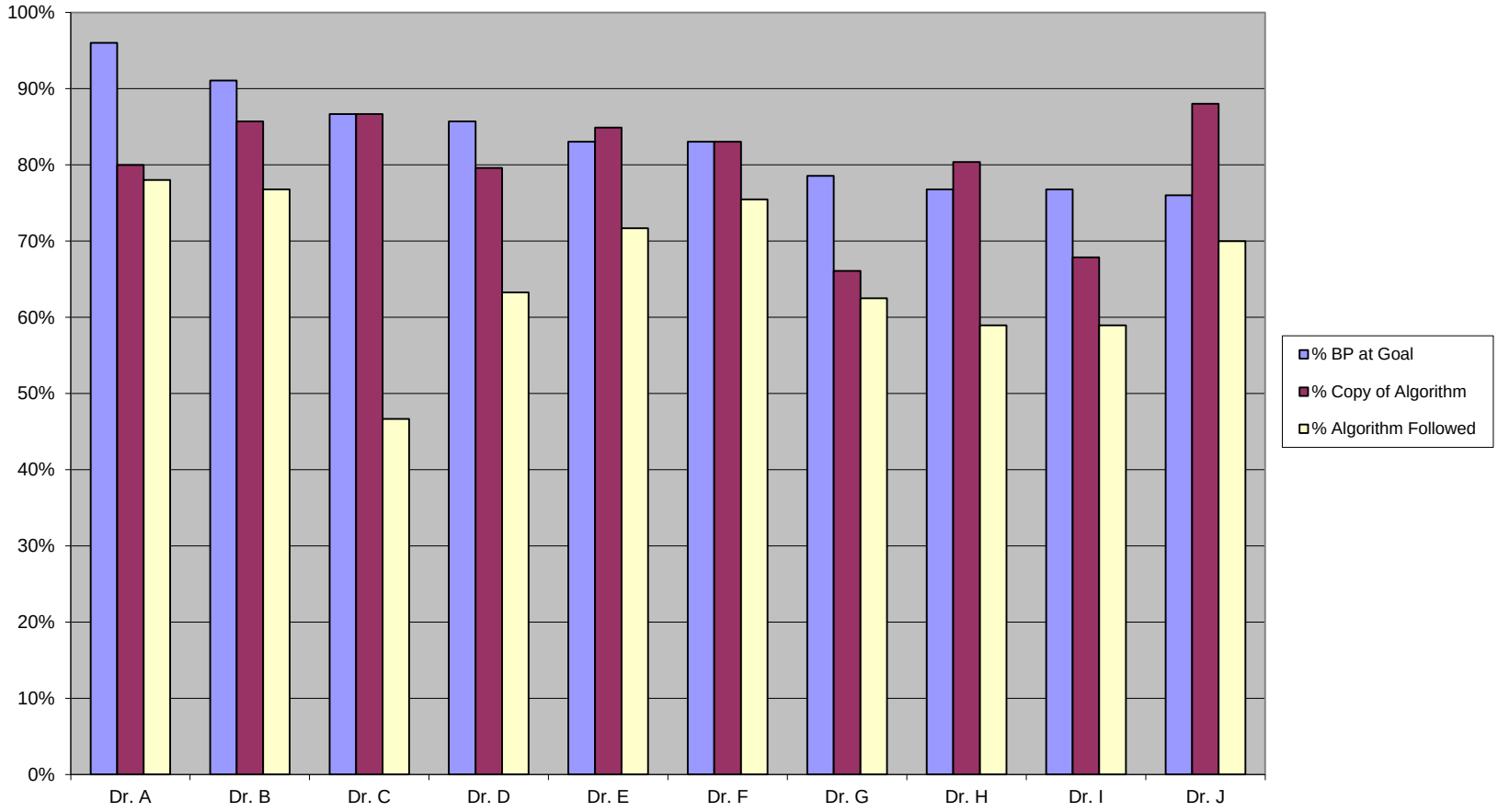
Tradition vs. Quality

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

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

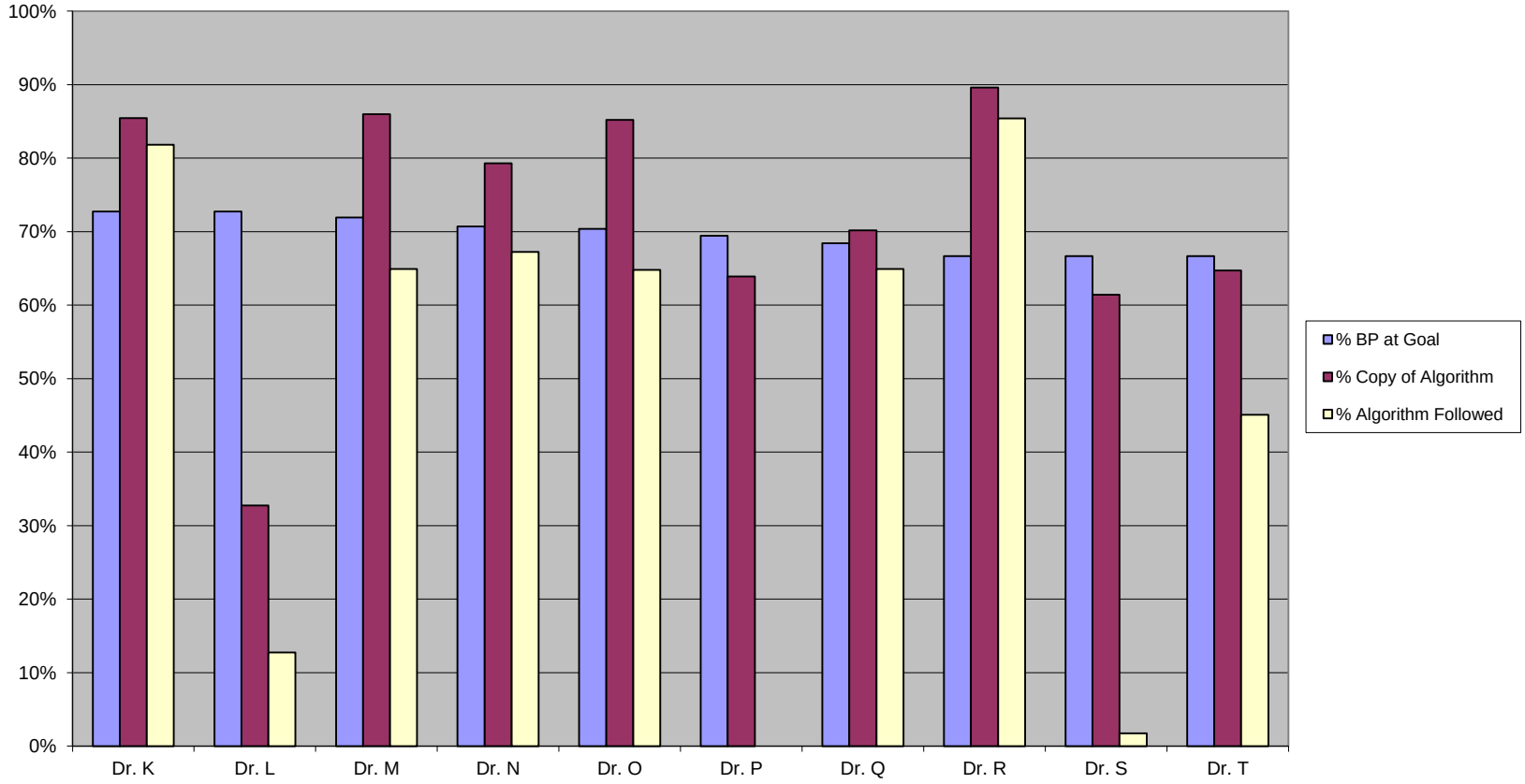
PriMed
% HTN to Goal vs. % Copy of Algorithm vs. % Algorithm Followed
August 2005

Average:
% HTN to Goal = 83%
% Algorithm Followed = 66%



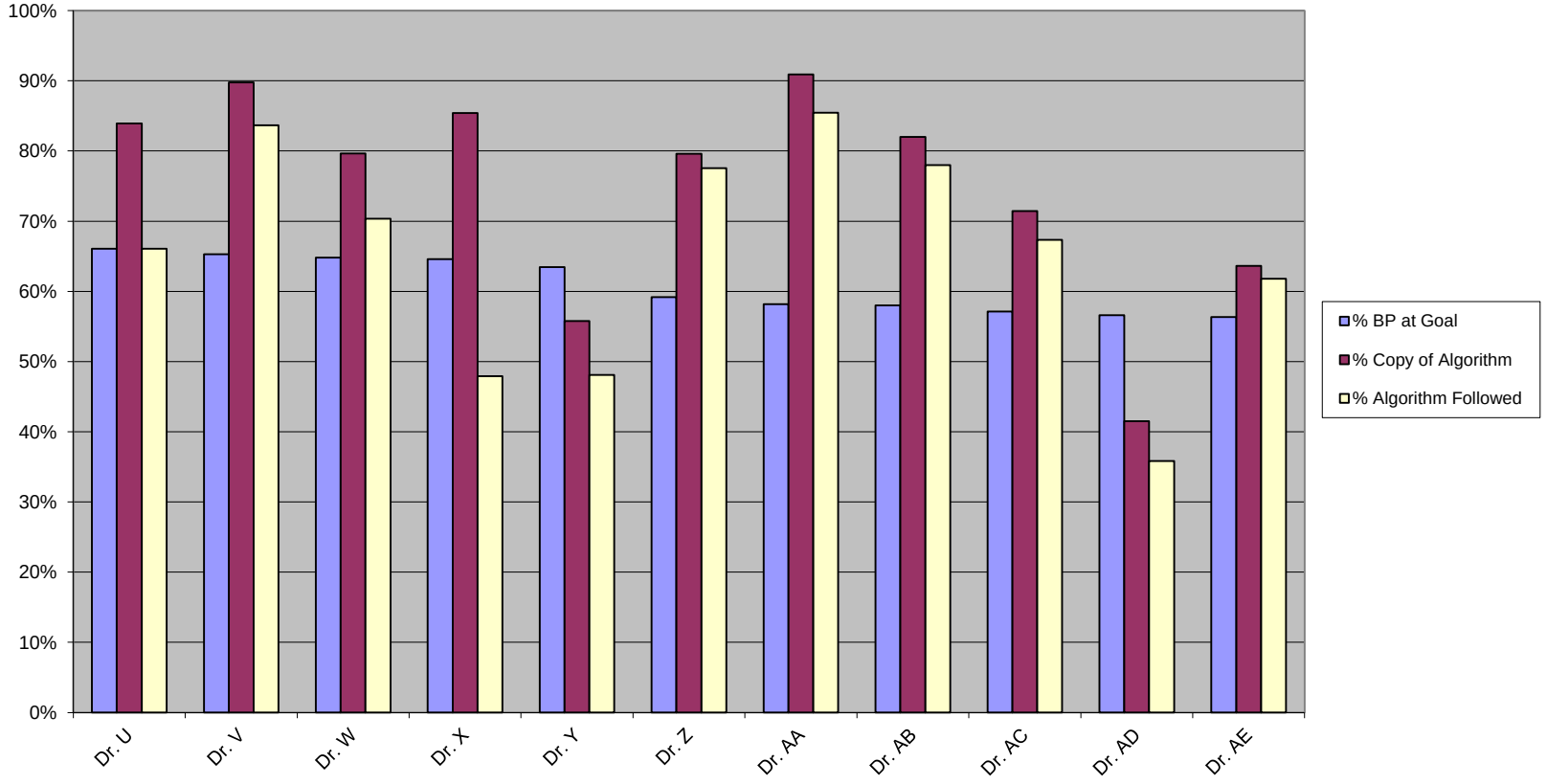
PriMed
% HTN to Goal vs. % Copy of Algorithm vs. % Algorithm Followed
August 2005

Average:
% HTN to Goal = 70%
% Algorithm Followed = 49%



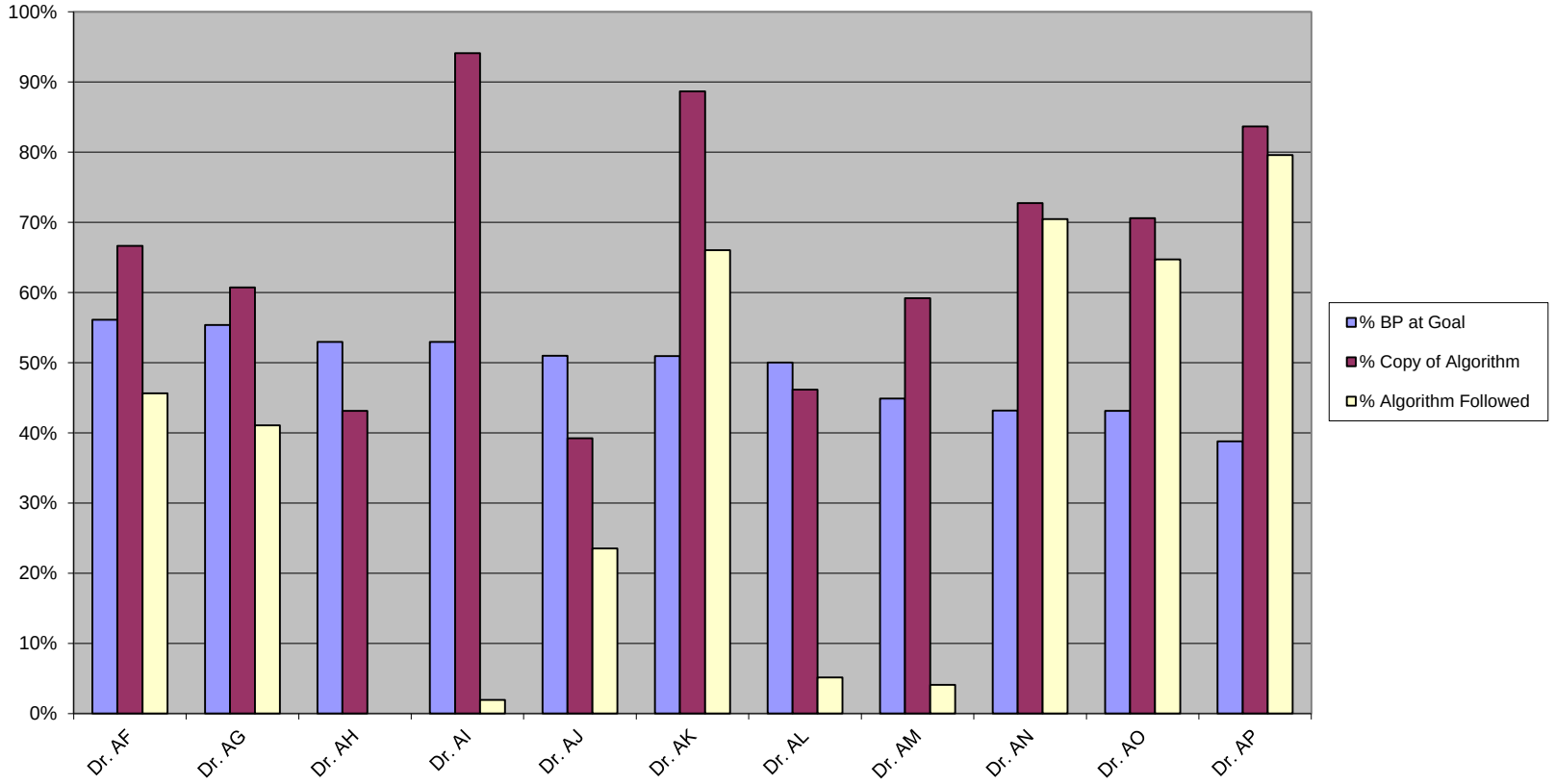
PriMed
% HTN to Goal vs. % Copy of Algorithm vs. % Algorithm Followed
August 2005

Average:
% HTN to Goal = 61%
% Algorithm Followed = 66%



PriMed
% HTN to Goal vs. % Copy of Algorithm vs. % Algorithm Followed
August 2005

Average:
% HTN to Goal=49%
% Algorithm Followed=37%



Changing Medical Group Culture: Quality vs. Tradition

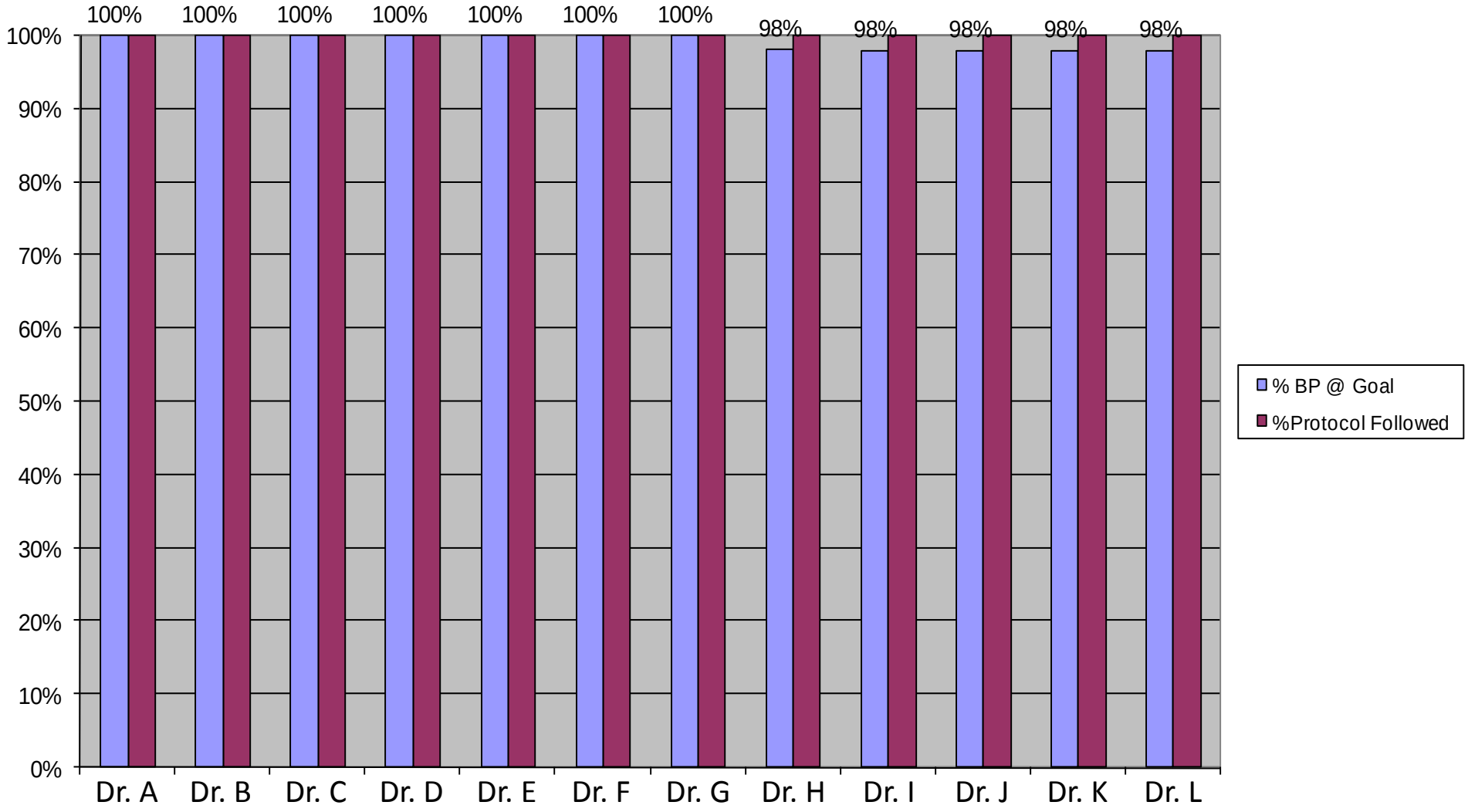
- Changing the group culture requires its own process
- LOTS of time discussing
  - Group meetings
  - Section meetings
  - Site meetings
  - Task Force meetings
  - Board meetings
- Some doctors decided to leave due to differences

What Happened?

- PriMed leadership and Board proposed to members that following process would be linked to physician compensation:
  - NOT outcomes; process
  - Time to get on board
  - Never expect 100%

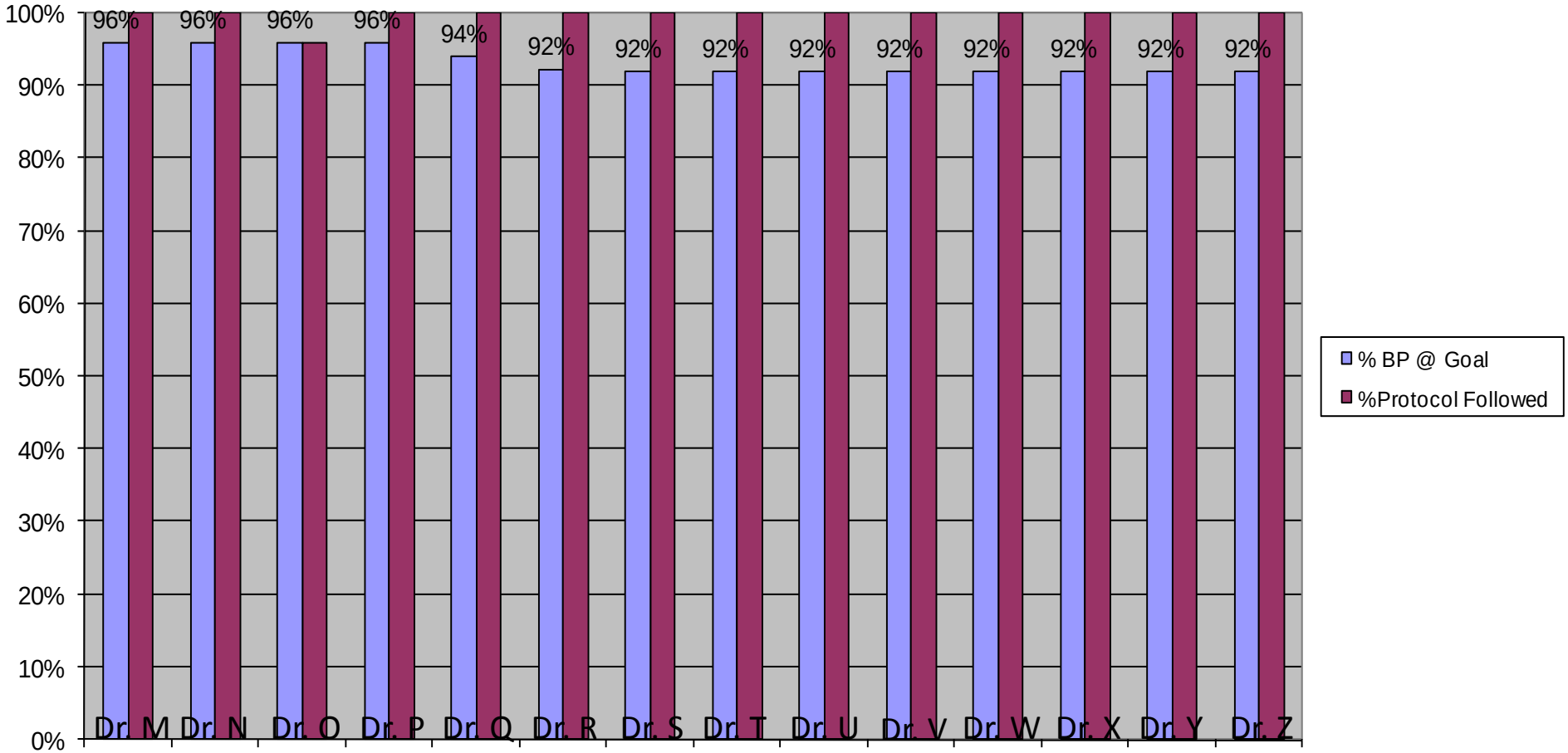
% BP@Goal
PriMed
Quartile 1
September 2009

Averages:
% BP@Goal = 99%
% Protocol Followed = 100%



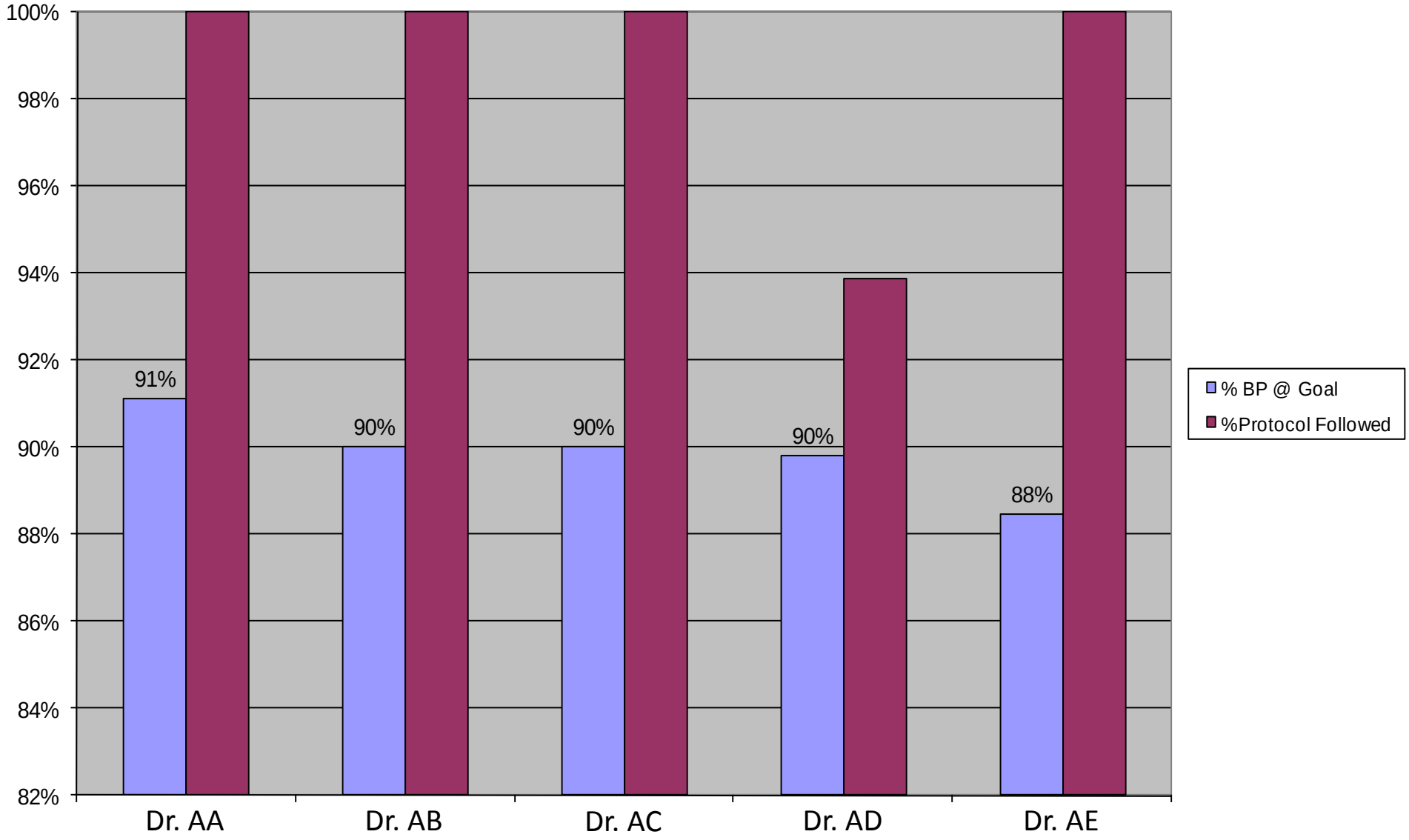
% BP@Goal
PriMed
Quartile 2
September 2009

Averages:
% BP@Goal = 93%
% Protocol Followed = 100%



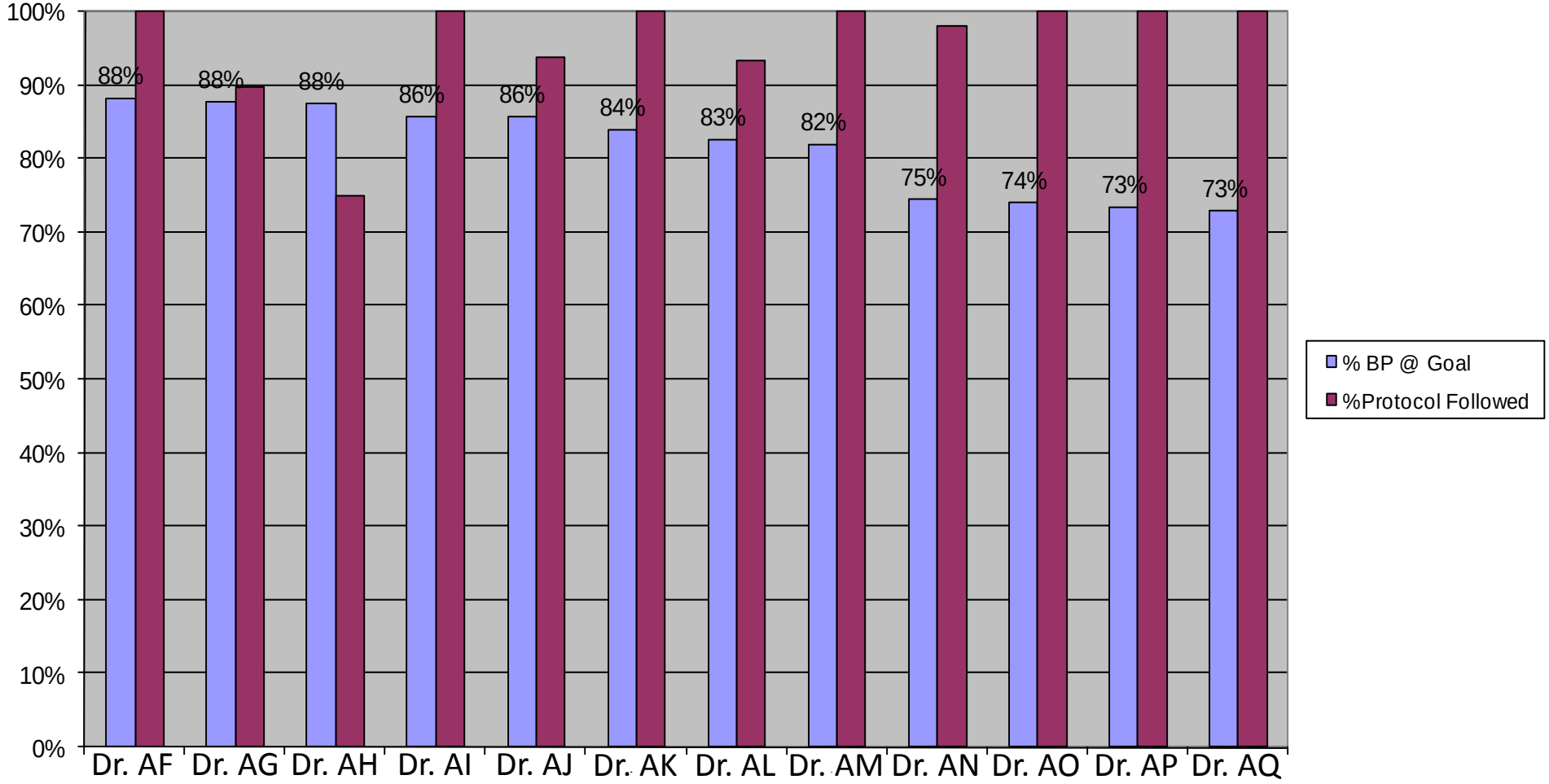
% BP@Goal
PriMed
Quartile 3
September 2009

Averages:
% BP@Goal = 90%
% Protocol Followed = 99%



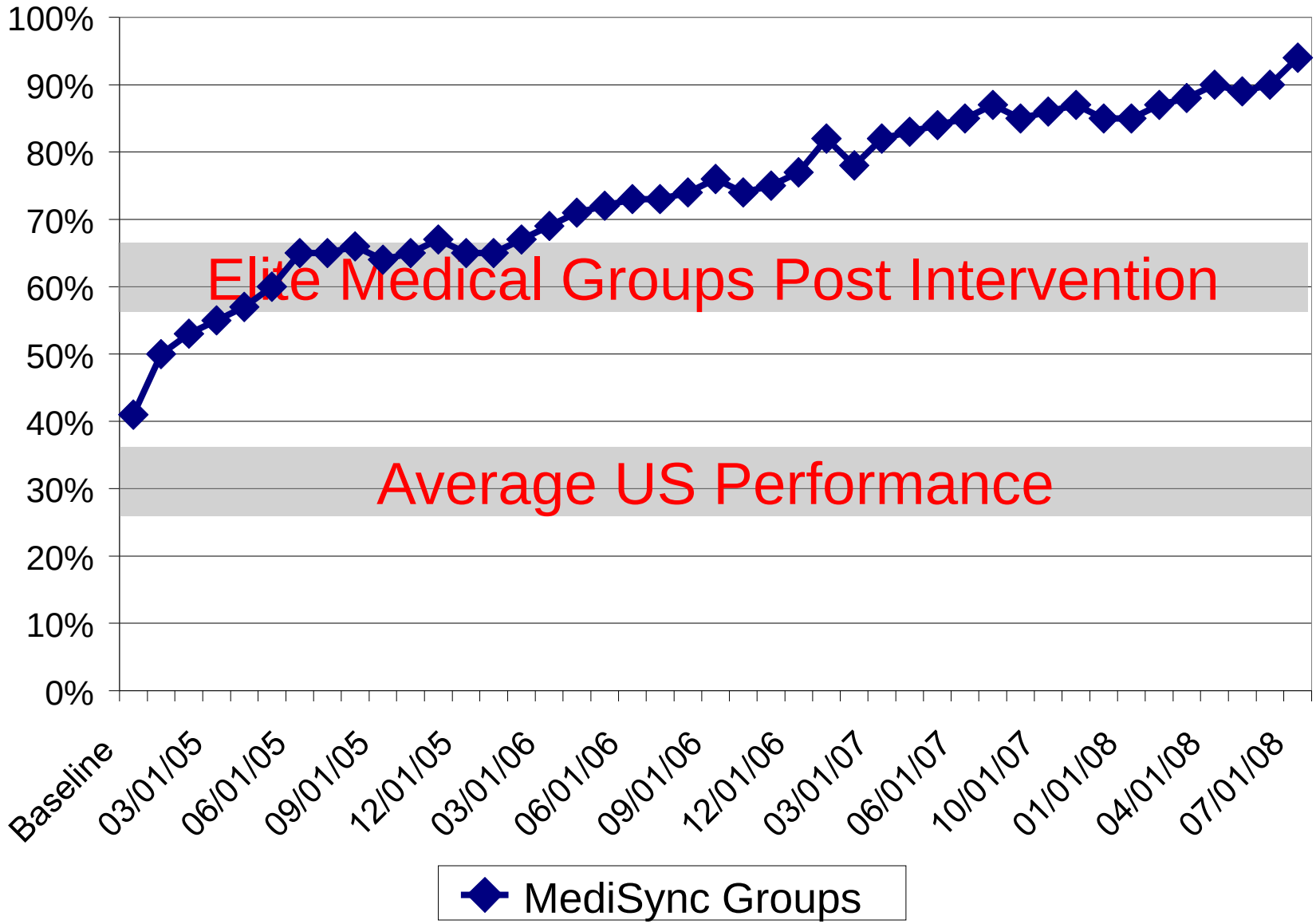
% BP@Goal
PriMed
Quartile 4
September 2009

Averages:
%BP@Goal = 82%
% Protocol Followed = 96%



Percent of Patients Reaching JNC-7 BP Goal

HTN Outcomes With or Without Co-Morbidities



Lessons From Our Journey

- Leadership is essential
- Plan, plan, plan
  - We spend 30 hours per month planning and coordinating
- You cannot possibly over communicate
  - 7 times; 7 ways
- Change management is essential
  - Change is emotional
  - If you don’t address the emotions; you lose
  - Cognition + emotion = experience

Topics We Hope We've Covered

1. Where we've been; where we're going
2. Leadership
3. Planning
4. Solving the problem of group affordability
5. Identifying the "pieces" inside value
6. The role of quality theory and practices
7. Lessons from our journey

Questions / Comments?

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