Chapter 2

Beyond Yesterday's Care

> We don't really have a healthcare delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited microsystems, each performing in ways that too often create suboptimal performance both for the overall healthcare infrastructure and for individual patients.
>
> George C. Halvorson[1]

Policymakers and others have identified 5 elements that define primary care: easily accessible, continuous, coordinated, comprehensive, and accountable to each person regarding their culture, values, and preferences.[2] The scope of primary care is expanding from 1:1 physician office visits focused on acute care to an advanced model that includes the defined elements.

The Patient Centered Medical Home (PCMH) codifies a number of expanded care model features. The National Committee for Quality Assurance (NCQA) and others offer formal medical home recognition to providers that successfully achieve the numerous process measures required to qualify.[3] As noted earlier, this book does not provide a roadmap for PCMH recognition as the topic has been thoroughly covered elsewhere.

The evolving advanced model has a broader range of care services (e.g., chronic illness, preventive, mental health, complex, and coordinated care) as well as group visits and electronic tools (e.g., phone, structured email, and video) that help to improve access. See Table 2.1. Higher performing providers are also delegating tasks that do not require physician skills to others (e.g., mid-level providers, nursing staff, and even patients).

Despite these trends, the fee-for-service payment model that largely limits reimbursement to the volume of discrete 1:1 provider office visits and assigns more value to providing procedures than avoiding them remains the centerpiece of primary care payment.

Table 2.1 Expanding Scope of Primary Care
Traditional vs. Advanced Model

Traditional		Advanced
Acute	VS.	Acute Prevention Chronic Complex Mental health Coordination
1:1 MD office visit		1:1 MD or nonphysician office visit Group visit Electronic visit (email, video, phone) Self-management

The model has many flaws, including short visits and a focus on what's wrong versus improving overall health. Dr. Paul Grundy, Director of Health Transformation at IBM, once commented that he could buy an amputation of a diabetic's leg but could not buy prevention services to avoid the amputation. Grundy also found that the outcomes of care IBM bought lacked value.[4] The predominance of acute, reactive care has also had a negative impact on continuity and longitudinal patient relationships.[5]

Frustration with the current state of primary care has resulted in high levels of physician dissatisfaction with 45% reporting they would quit if they could afford to do so, according to *US News & World Report*.[6] In addition, overall employee turnover rates in healthcare are increasing.[7] One study found a 53% turnover in family medicine practices over a 2-year period.[8]

The do-more, bill-more fee-for-service incentives are similar to the US Department of Defense (DoD) policy of paying for aircraft via time-and-materials. The result? Suppliers billed for materials used and labor time so that the more problems the planes had the more revenue accrued to suppliers. This changed when the DoD adopted performance-based contracting that paid suppliers for the amount of time an aircraft was in service, specifying 95% availability as a threshold for contracts, thus changing the revenue stream to align with the interests of stakeholders.[9]

Unlike most other industries that now bring products and services to consumers 24/7, patients still have to drive to and wait for most healthcare. In addition, patient needs in terms of complexity and risk are not routinely measured or managed. In response to long waits, retail clinics are providing fast access to willing consumers. Over 40% of consumers report they would use a retail clinic for cold and flu symptoms, check-ups for high cholesterol or blood pressure, and lab services.[10]

While foundational to the delivery systems of other industrialized countries, primary care in the US accounts for only 6% to 8% of the total spent on healthcare—almost an appendage in the context of total system costs. A Commonwealth Fund study of care in 11 industrialized countries found adults in the US more likely to go without needed care because of costs. One-third of US adults went without recommended care, failed to fill a prescription, or didn't see a physician when sick.[11]

The contrast in outcomes is also striking; these outcomes include longer life spans, lower infant mortality, and lower costs in other industrialized countries. The US spends over 17% of gross domestic product (GDP) on healthcare, nearly 50% more than the next-highest spender (France at 11.6% of GDP) yet ranks 37th in the world in health outcomes. Rand researchers found that US patients received 55% of indicated care with a "defect rate" in care delivery of about 45%.[12] In addition, the third leading cause of death in the US is medical error, accounting for a staggering 250,000 deaths per year.[13]

The case for robust primary care is compelling. Research by Macinko, Starfield, and Shi has found reductions in low birth weight, as well as infant, stroke, heart, cancer, and all cause mortality rates associated with increased primary care supply.[14] In addition, the supply of primary care physicians is associated with lower total costs of care.[15] Finally, regions of the country with high versus low primary care physician involvement at end-of-life care have lower-cost, lower-intensity end-of-life care.[16]

To make key concepts regarding care and improvement more visible, a number of simple graphics are used throughout this book. Whether a primary care provider is a small independent practice or part of a large, integrated delivery network, the "capacity" of any primary care provider "system" consists of its resources, care activities, and values. Figure 2.1 shows the who, what, when, where, how, and why of provider system capacity.

Figure 2.1 Key Provider Capacity Characteristics

Resources		
People Tools	Ratio, skills, availability Technology & space	Who, when, where, how
Activities		
Scope	Range of care services & ways to access Processes	What
Values		
Culture	Leadership & relationships	Why
Agreements	Rewards & accountabilities	

Provider resources include who's providing care—the skills, ratio, and availability of MDs and staff. Resources also include the where, when, and how care is provided (e.g., physical space, hours, and technology). Activities include the overall scope of care services and ways they can be accessed as well as individual processes. Culture as well as formal and informal agreements regarding how people interact reflect an organization's values.

Table 2.2, graphically summarizes the interaction of patients, primary care resources, and values to generate care activities and the resulting operational (including clinical), financial, and satisfaction outcomes. Based on a modified logic model, the Care Matrix can be used broadly to view system characteristics or to map specific processes (e.g., patient visit activities). For example, a nurse advising a patient regarding diabetes care brings clinical skills as well as professional and

organizational values to the work of completing the activity and resulting outcomes (e.g., expanded patient knowledge and ease in managing their own care).

Table 2.2 The Care Matrix

Inputs	→ Care Activities →	Outcomes
Patients Resources Values	Scope Process	Operational Financial Satisfaction

Developed as a heuristic, hands-on tool versus an academic model, the Care Matrix provides a common visual reference for improvement work. The matrix is designed to make care delivery concepts clear for a variety of users, including physicians, managers, staff, and even patients.

Provider resource issues include a mismatch of provider ratios, skills, and availability with patient need, from physicians providing care that could be delegated to those less trained to wide variation in the number or panel of patients for whom individual physicians provide care. Other issues include insufficient resources to support the expanding scope of care and compartmentalized workspaces that hinder teamwork. Additionally, many processes are inefficient and unsatisfying for physicians and staff as well as patients. Finally, complex regulatory, IT, and administrative requirements consume valuable staff, physician, and patient time.

Challenges related to provider values include entrenched work habits, a hierarchical culture, and physician training to autonomously fix presenting problems—factors that compete with the need for innovative, high-performing teams. Growing accountability to improve value conflicts with reimbursement incentives based on the volume of MD activity.

> We believe the underwhelming results of recent attempts to scale the successes of pioneering medical homes were inevitable, as they focused on transplanting lists of processes (NCQA criteria) into practices with completely different cultures. We are proposing that in addition to learning to modify processes to meet a practice's culture, we must also learn to modify a practice's culture to more easily bind the many new processes that are needed to produce triple aim results.
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Like fee-for-service reimbursement, Relative Value Unit (RVU)-based physician compensation creates perverse incentives by rewarding the volume versus the value of care provided. These factors "trickle down" to impact work processes, how resources are used, and willingness to change. See Table 2.3.

Table 2.3 Provider Capacity Issues

Inputs ➔	Activities ➔	Outcomes
Resources • Frequent mismatch of skills, ratio, & availability with patient needs • Compartmentalized work spaces hinder teamwork & flow • EHRs built around MD & billing vs. team activities, expanding documentation requirements *Values* • Maximize volume of MD vs. team care • Hierarchical culture & outdated agreements slow innovation	*Scope* • Focus on acute 1:1 MD office visit • Cultural resistance & financial disincentives to expand scope *Process* • Little intentional design to be efficient & satisfying	*Operational* *Financial* *Satisfaction*

Despite the numerous challenges, change is slowly and profoundly shifting the traditional paradigm. Pushed by payer and regulatory requirements, technology, activated patients, large-scale improvement initiatives, and real shifts in reimbursement, an advanced, more comprehensive model of primary care is emerging that is changing how resources are deployed and care is provided. See Figure 2.2.

Figure 2.2 Shifting Outcome Goals

Outcomes	Pay-For-Volume	Vs.	Pay-For-Value
Operational	Physicians treat acute illness of individual patients		Expanded scope of care, high-performing teams, activated patients, & shifting focus on improving population health
Financial	Maximize physician visit volumes		New models that bundle payments to incentivize better quality at less total cost
Satisfaction	Fragmented, unsatisfying experiences		Improved patient, staff, & physician experience

Qliance, a Direct Primary Care (DPC) model in Seattle, has achieved immediate access to primary care and low patient turnover. The group reports an average total cost of care savings of $679 per patient in ED, inpatient, and specialist care.[18] Appointment times of 30 to 60 minutes allow providers to identify and provide care for problems that previously may have been overlooked. Monthly fees range between $60 and $100 per patient enrolled.

The Centers for Medicare and Medicaid Services (CMS) is gradually moving from fee-for-service to value-based payments with a stated timeline as well as outcome accountabilities to improve care and overall health while reducing costs. Commercial payers that often follow CMS's lead quickly announced support for the shift to value-based purchasing. Structural financial reforms include bundled payments, shared savings programs, and Accountable Care Organizations (ACOs). The Institute for Healthcare Improvement's Triple Aim of improving population health and the patient experience at less cost also reflects this shift in focus to improving outcomes. Some have embraced the Quadruple Aim, which includes the additional goal of improved satisfaction for physicians and staff.[19]

Bundling payments for a complete set of services or even all services for individual patients over a period of time frees physicians from the tyranny of 1:1 MD office visits and allows them to provide more continuous care across time and venues. Innovators like Iora Health have contracted directly with employers and payers, assuming financial risk for outcomes via capitation.

Within the Comprehensive Primary Care (CPC) Initiative, CMS is paying participants in 7 geographic areas fee-for-service payments plus a care management fee for enhanced care coordination to Medicare beneficiaries. Shared savings are being added for primary care providers who achieve better quality and less cost. The Medicare Access and CHIP Reauthorization Act (MACRA) creates several payment models aimed at shifting to value-based care.

The population-based capitation payment model (PBP) differs from traditional capitation in that providers would receive a risk-adjusted monthly payment that covers all necessary patient care. Eliminating HMO gatekeepers and third-party authorizations, the model would put responsibility for treatment costs with providers consulting with patients. PBP would also include quality measures and standards. Independent physicians would receive fee-for-service payments adjusted quarterly based on quality, patient satisfaction, total cost, and care outcomes. The advantage? PBP builds on an existing physician payment system and rewards physicians for improvements in quality and cost. It would also compensate physicians for income lost if care volumes fall due to improved efficiency in how care is delivered.[20]

Growing accountability for population health has also heightened provider awareness about the impact of patient health behaviors. Because their activities drive 50% of health outcomes, patients are increasingly seen and appreciated as a resource versus passive recipients of care. While the pace may seem glacial to pioneers who have labored for years to transform care, profound change is emerging. The end result? A delivery model that is relevant to the daily lives and health of patients versus episodic, body-part-treatment centers focused on disease.

The shift in how resources are used, care processes flow, and outcomes are produced in an advanced model of primary care is a work in progress. Truly transforming care requires a redefinition of how providers, staff, and patients view themselves and each other in care delivery. Innovative providers are cocreating better health outcomes with patients, enabling new care models that complement and even replace old paradigms. *What Works* explores national best practices in care redesign to improve outcomes.

> Transformation to value-based care is not a project. It's not something we'll do this month, quarter or year. It's really a continuous process, a culture change and a lifestyle commitment for the life of that practice.
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