Paul Woods MD MS CCFP

It’s all about ~~Me~~ Primary Care

Outline

1. Journey: What did I really see and feel?
2. What challenges do we all face? Boolean nightmares
3. Advanced Primary Care: Components
4. APC Models
5. Making them successful

Chapter 1: Paul Woods MD Family Physician

Loved:

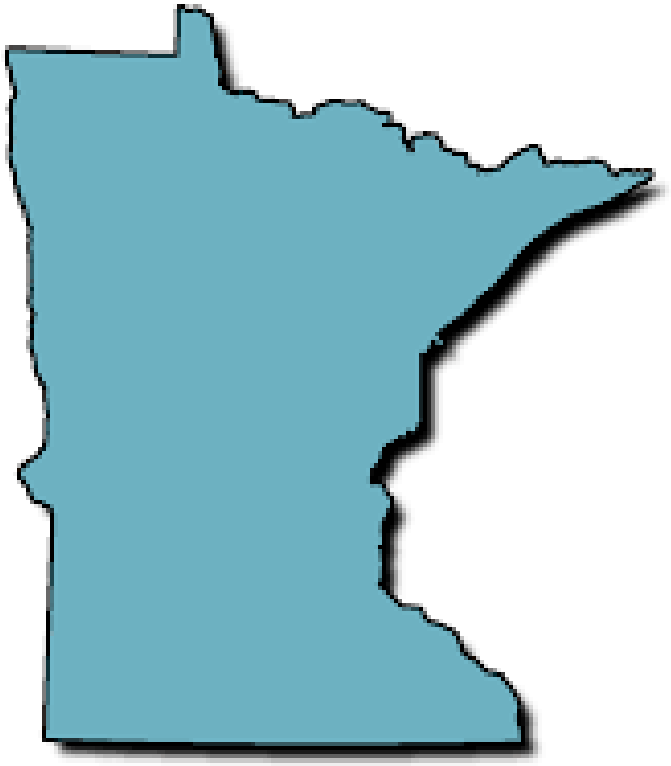
Patient Care

Autonomy (?)

Not so Much:

- Increasing Burden of Care in PC without incremental resources (behavioral health), quality, care coordination
- Diminishing income (productivity) in PC due to increasing demands
- Administrative burden and complexity in PC
- Quality demands in PC
- EHR in PC

Chapter 2: Paul Woods MD MS, Associate Medical Director CDM



Loved:

Quality (-ish)

Leading Change

Not so Much:

- Recognizing Increased Burden of Care in PC without incremental resources (behavioral health)
- Not really P4P (less P if less P)
- Administrative burden and complexity of managing and reporting requirements in PC
- Quality demands were scattered and growth limitless, especially in PC
- Huge care gaps anchored in PC

Chapter 3: Paul Woods MD MS Medical Director DFM

Loved:

- Calgary
- Leading Change (-ish) in care model
- Got on speaking agenda with Barbara Starfield
- Inter-professional Resources

Not so Much:

- Physicians' resistance to change
- Payment models that incentivized volume but not quality
- Lousy EHR
- No integration of care pathways
- Huge care gaps anchored in PC
- No standardization of how resources used
- Very archaic care model

Chapter 4: Paul Woods MD MS Department Chief of Primary Care

Loved:

- Well resourced IDS
- Chance to build advanced PC model
- Exposure to integrated care

Not so Much:

- Physicians' resistance to change
- Payment models that incentivized volume but not quality
- Lousy EHR and terrible rollout
- Difficulty rolling out demonstrably better model
- Huge care gaps anchored in PC
- Administrative burden for docs
- Focus on Finance

Chapter 4: Paul Woods MD MS Department Chief of Primary Care

New Issues: Corporate Accountabilities

- Provider Burnout (see #2)
- Lousy EHR and terrible rollout
- Quality Incentive revenue
- Aligning Compensation
- Recruitment and Retention (see #1)
- Upfront Capital Expense of Scale
- Upfront Operating Expense
- Difficulty finding the ROI (although there)
- Culture: P & L accountability of Medical Group
- Volume to Value

Chapter 5: Paul Woods MD MS
SVP Provider Network Organization

Loved:

- The People
- The Mission
- The Vision we had

Not so Much:

- Physicians' resistance to change
- Payment models that incentivized volume but not quality
- Lousy EHRs
- Finance and focus on productivity
- Huge care gaps anchored in PC
- Administrative burden for docs
- Pushing a burnt out dispirited group of providers who hated me
- Terrible data

Chapter 5: Paul Woods MD MS
SVP Provider Network Organization

Issues: Corporate Accountabilities

- Provider Burnout (see #2)
- Multiple Lousy EHRs EHR
- Volume to Value
- Achieving performance targets in value models (misalignment of incentives)
- Aligning Compensation with wide variation in business needs
- Recruitment and Retention (see #1)
- Upfront Capital Expense of Scale
- Upfront Operating Expense
- Insufficient Data
- Difficulty finding the ROI (although there)
- Culture: P & L accountability of Medical Group

Chapter 24: Paul Woods MD MS President and CEO

Love:

- Single payer system: Everyone gets care!
- Clarity of Mission
- Administrative simplicity (Not really)

Not so Much:

- Physicians' resistance to change
- Payment models that incentivized volume but not quality on both hospital and physician side
- Lousy EHRs
- Prolonged underfunding
- PC dispirited, disenfranchised, disinterested
- Terrible data

Chapter 24: Paul Woods MD MS President and CEO

Corporate/MesoSystem Challenges:

- Access to specialty care
- Readmissions
- Length of Stay
- Inadequate Funding
- Quality of Care across Continuum (good transactionally)
- Primary Care Attachment/Access
- ED Overcrowding
- Hallway Healthcare
- Value?

Chapter 24: Paul Woods MD MS
System Transformation Leader/Stakeholder

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System Transformation Leader/Stakeholder

System Challenges:

- Access to specialty care
- Readmissions
- Length of Stay
- Inadequate Funding
- Quality of Care across Continuum (good transactionally)
- Primary Care Attachment/Access
- ED Overcrowding
- Hallway Healthcare
- Physician Engagement
- Physician Burnout
- Volume to Value

Themes: As a Physician and Physician Leader

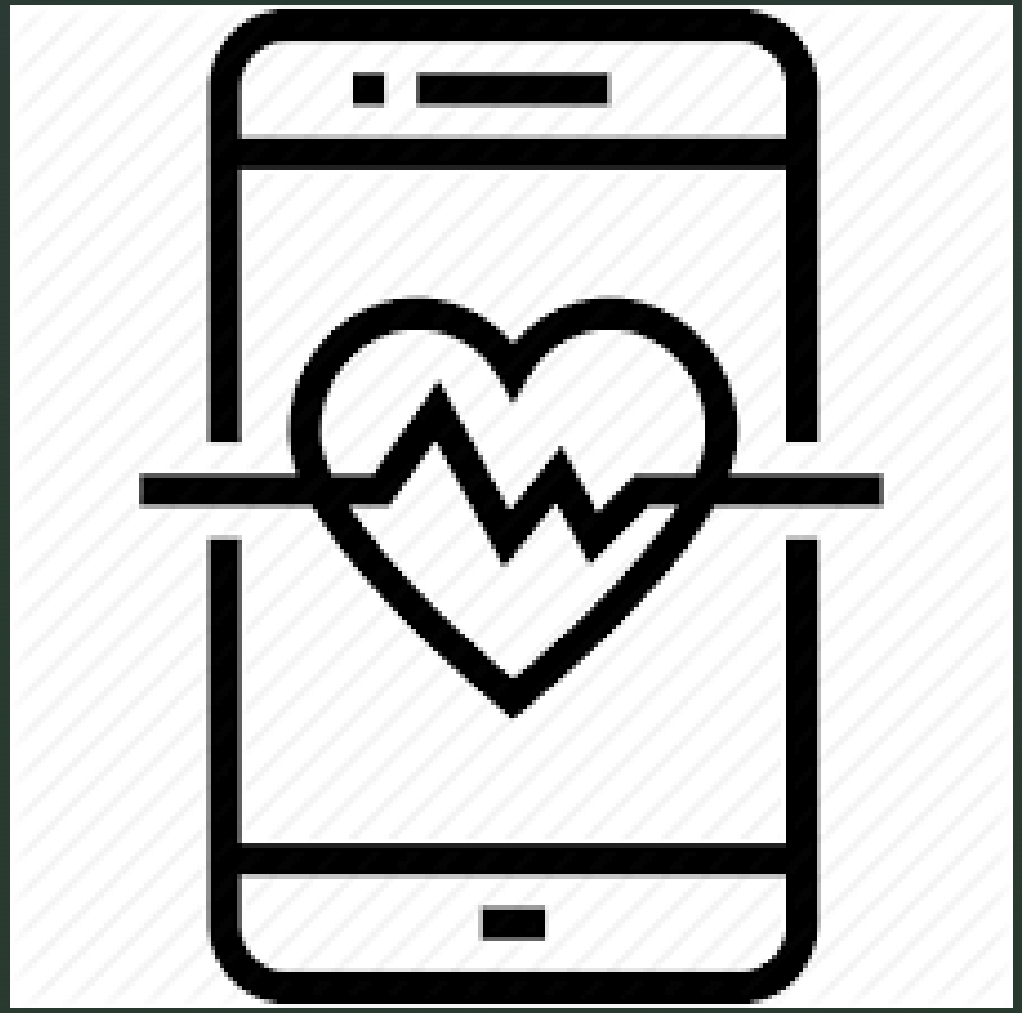
Themes: As a health care executive

People Challenges

Patients/Consumers:

- Access to care
- Rise of Consumerism
- Experience of Care
- Quality
- Cost

Consumerism



Provider Challenges

Providers:

- Administrative Demands
- EHRs
- Quality of care and moral distress
- Eligibility and moral distress

MAYO CLINIC PROCEEDINGS

Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014

Tait D. Shanafelt, MD[a], Omar Hasan, MBBS, MPH[e], Lotte N. Dyrbye, MD, MHPE[b], Christine Sinsky, MD[e], Daniel Satele, MS[c], Jeff Sloan, PhD[c], Colin P. West, MD, PhD[d]

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Abstract

Objective

To evaluate the prevalence of burnout and satisfaction with work-life balance in physicians and US workers in 2014 relative to 2011.

Patients and Methods

From August 28, 2014, to October 6, 2014, we surveyed both US physicians and a probability-based sample of the general US population using the methods and measures used in our 2011 study. Burnout was measured using validated metrics, and satisfaction with work-life balance was assessed using standard tools.

Results

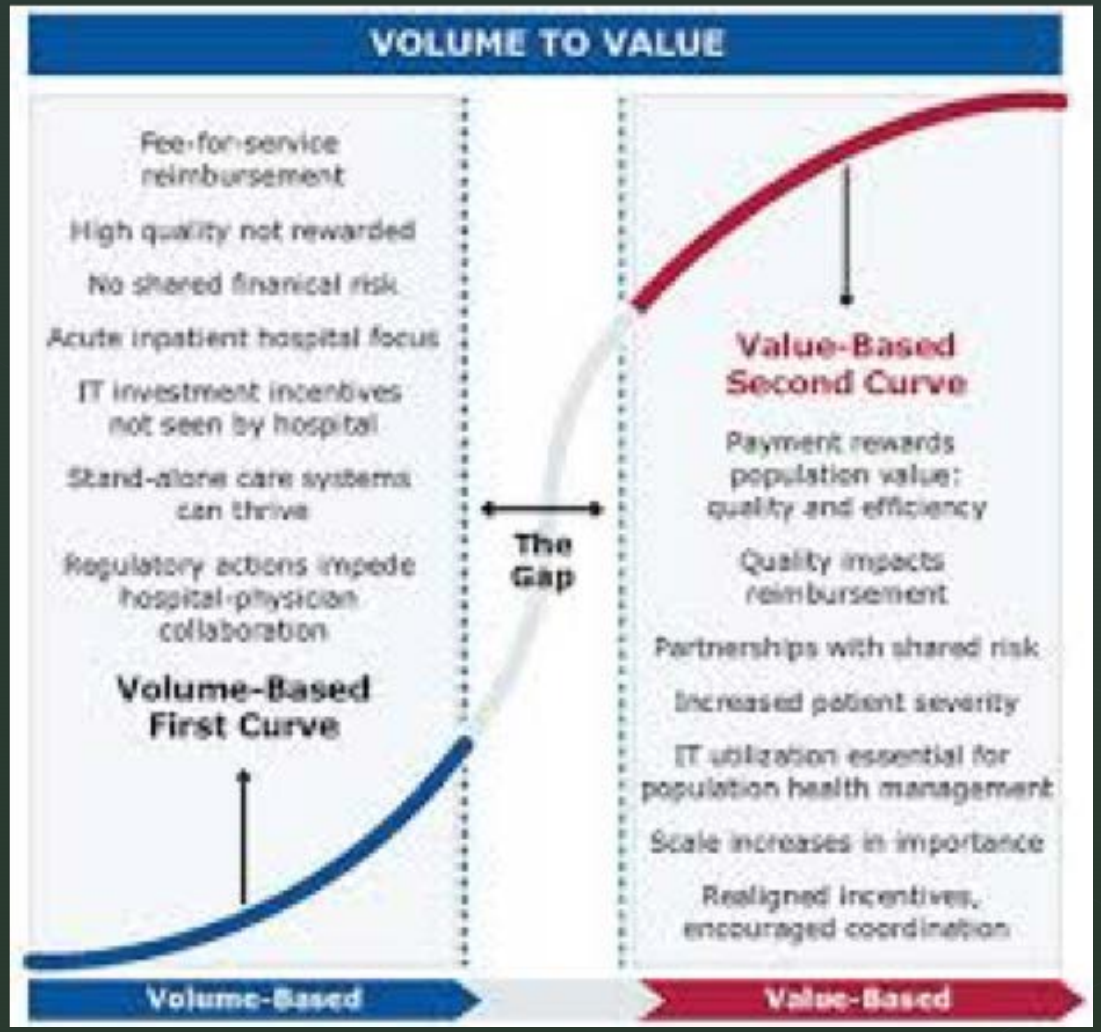
Of the 35,922 physicians who received an invitation to participate, 6880 (19.2%) completed surveys. When assessed using the Maslach Burnout Inventory, 54.4% (n=3680) of the physicians reported at least 1 symptom of burnout in 2014 compared with 45.5% (n=3310) in 2011 (P<.001). Satisfaction with work-life balance also declined in physicians between 2011 and 2014 (48.5% vs 40.9%; P<.001). Substantial differences in rates of burnout and satisfaction with work-life balance were observed by specialty. In contrast to the trends in physicians, minimal changes in burnout or satisfaction with work-life balance were observed between 2011 and 2014 in probability-based samples of working US adults, resulting in an increasing disparity in burnout and satisfaction with work-life balance in physicians relative to the general US working population. After pooled multivariate analysis adjusting for age, sex, relationship status, and

Business/System Challenges

System/Administrative

- Two Curve Problem
- Access
- Cost
- Productivity
- Efficiency

Two Curve Problem:



? Value Proposition of Having a Model Cell

- Skunkworks: Development of what is next and beyond
- Operational: Make it work together
- Develop scalable model components that can be used now and have future utility (understand the business value)
- Prestige

Advanced Primary Care: EPC and IPC (Two very cool models)

- Enhanced Primary Care: Was and IS working great
- Innovative Primary Care (FKA PC^2): Struggles

Advanced Primary Care Models: Biopsychosocial Model

- Anatomy
- Physiology
- Psychology
- Sociology

Enhanced Primary Care

- Grand Rapids MI
- “De novo”
- No specifications and little in the way of constraints
- Took what I had learned at U of Calgary

EPC: Anatomic Components

- Co-location: No offices
- Flow Cells
- Flow Manager and Provider
- Care Team Lead
- Interprofessional Team

EPC Anatomy Themes

- Interprofessional care models
- Co-location
- Clear role definition (not the usual)

EPC: Physiology (Processes)

- Huddles (Daily Management and Patient care)
- Weekly Team Huddles (Education, Improvement, Complex Care Management, SCR)
- Interprofessional Care Models
- Collaborative Care Models
- Compound visits
- Warm Hand-off
- Standard templates in Epic (Dot phrase Queen)

EPC: Physiology (Processes)

- Flow
- Shared patients
- Advanced Access
- The LIGHTS!!!!!
- In Basket Management: Early win
- Systematic Case Review
- Group Visits
- Open Chart

EPC Physiology Themes

- Flow
- Interprofessional Care Models
- In-person communication

EPC: Psychology

- Autonomy: Redefined in light of patient need
- Work to scope of License or training
- Team member: Provider as team leader
- Ownership
- Standardized care pathways: ? Cookbook Medicine
- Patients own their story and their data: Open Chart

EPC: Psychology themes

- Seeing ourselves in the light of a team
- Redefining what “Physician Autonomy” means

EPC: Culture

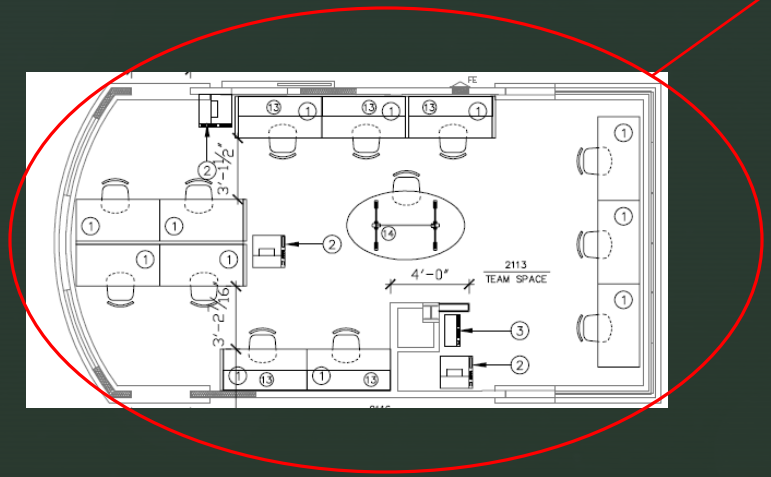
- Shared Accountability
- Respect for all members of the team
- Shared Panels
- SCR
- Care pathways (academic detailing) Just culture
- Teamness
- High reliability
- From ”Cross Coverage” to “Shared Accountability”
- Alignment of Goals

EPC Sociology/Culture themes

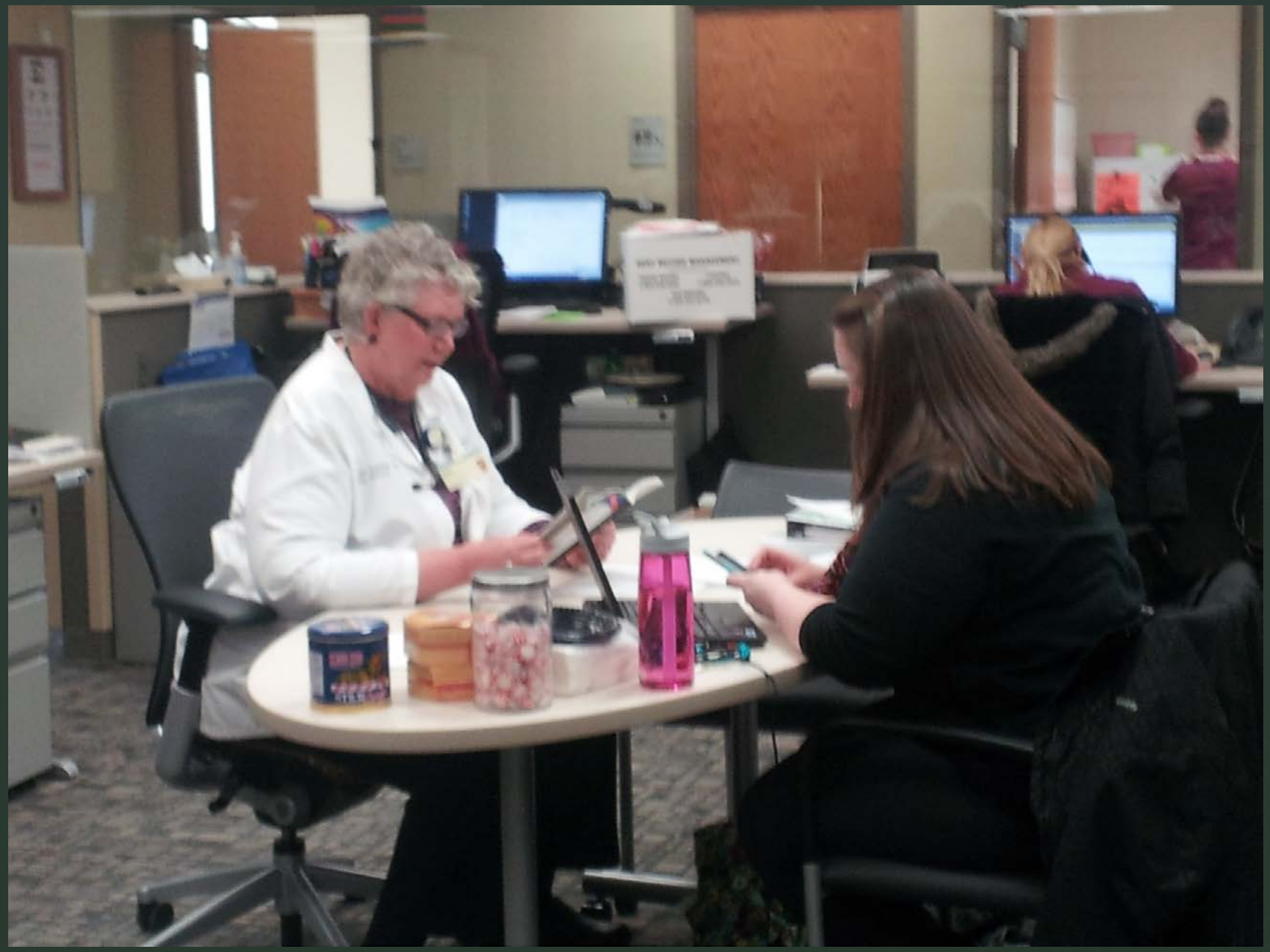
- Changing me and my to us and ours

Vision and Mission: Culture

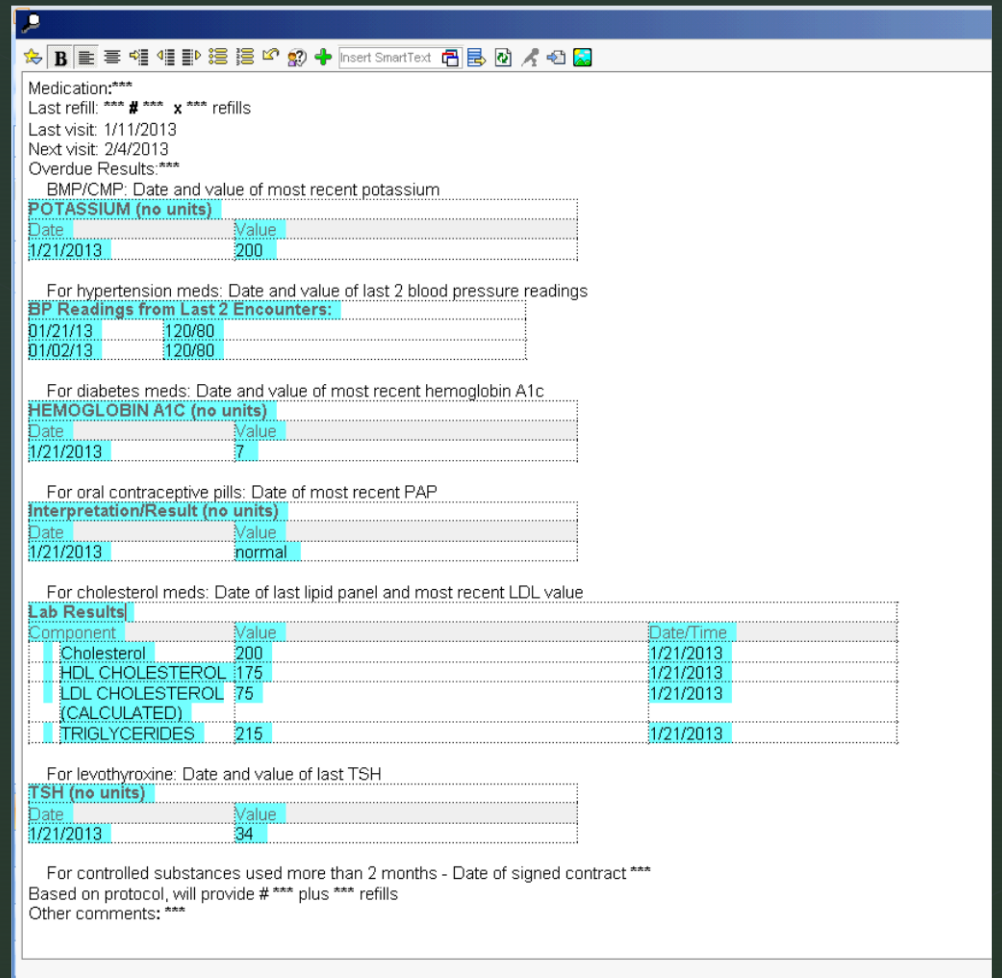
ePC Anatomy: Making do



Created a collaborative area that accommodates 13 employees. This enhanced space previously supported 3-4 employees.



The Dot Phrase Queen



Medication:***
Last refill: *** # *** x *** refills
Last visit: 1/11/2013
Next visit: 2/4/2013
Overdue Results:***

BMP/CMP: Date and value of most recent potassium

POTASSIUM (no units)	
Date	Value
1/21/2013	200

For hypertension meds: Date and value of last 2 blood pressure readings

BP Readings from Last 2 Encounters:	
01/21/13	120/80
01/02/13	120/80

For diabetes meds: Date and value of most recent hemoglobin A1c

HEMOGLOBIN A1C (no units)	
Date	Value
1/21/2013	7

For oral contraceptive pills: Date of most recent PAP

Interpretation/Result (no units)	
Date	Value
1/21/2013	normal

For cholesterol meds: Date of last lipid panel and most recent LDL value

Lab Results		
Component	Value	Date/Time
Cholesterol	200	1/21/2013
HDL CHOLESTEROL	175	1/21/2013
LDL CHOLESTEROL (CALCULATED)	75	1/21/2013
TRIGLYCERIDES	215	1/21/2013

For levothyroxine: Date and value of last TSH

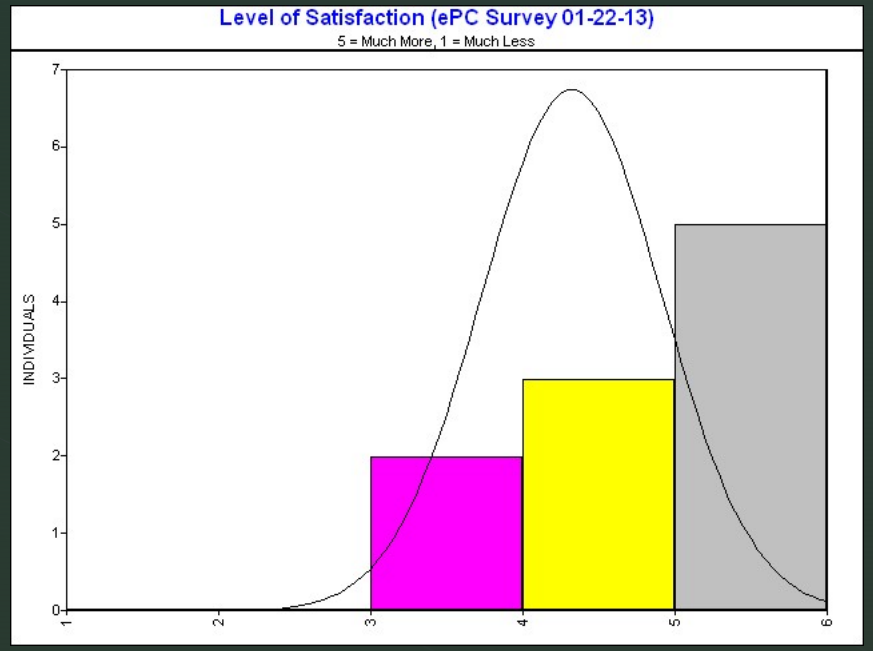
TSH (no units)	
Date	Value
1/21/2013	34

For controlled substances used more than 2 months - Date of signed contract ***
Based on protocol, will provide # *** plus *** refills
Other comments: ***

ePC looks nice; So what?

- Did it solve any problems?

Provider Satisfaction and Burnout

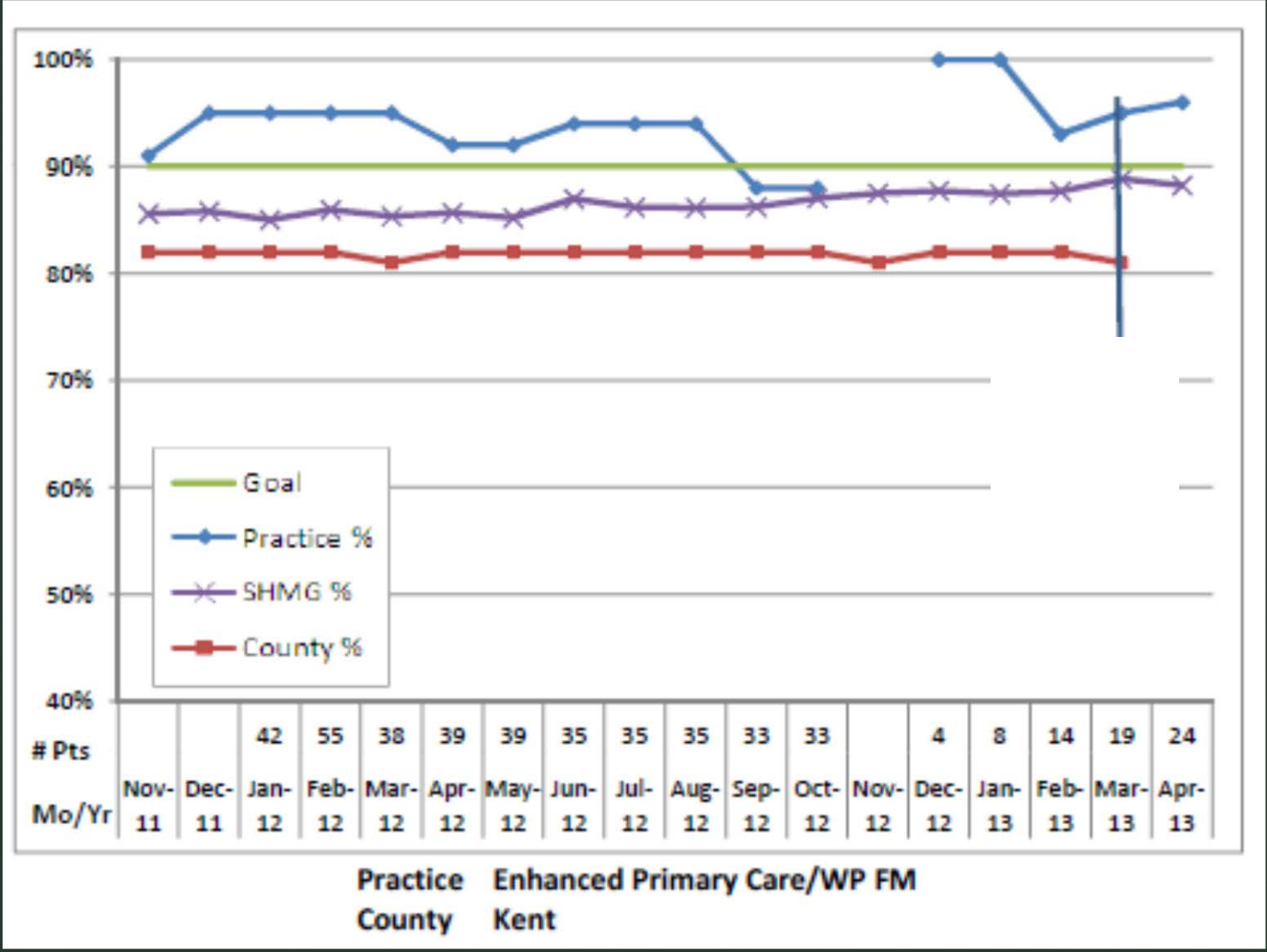


And even more impressive…..

Patient Satisfaction?

Provider	July-Nov			Nov-Feb			March			Nov-Mar		
	N	Top Box	% LTR	N	Top Box	% LTR	N	Top Box	%LTR	N	Top Box	%LTR
JR	18	18	100	16	16	100	3	3	**100**	19	19	**100**
ES	29	25	86	8	7	88	0	0	**0**	8	7	**87.5**
AF	36	31	86	19	18	95	9	9	**100**	28	27	**96.4**
KG	52	48	92	42	41	98	24	24	**100**	66	65	**98.5**
Total	135	122	**90.370**	85	82	**96.471**	36	36	**100**	**121**	**118**	**97.5**

EPC: Quality


100%
90%
80%
70%
60%
50%
40%
Goal
Practice %
SHMG %
County %
Pts
42 55 38 39 39 35 35 35 33 33 4 8 14 19 24
Mo/Yr
Nov-11 Dec-11 Jan-12 Feb-12 Mar-12 Apr-12 May-12 Jun-12 Jul-12 Aug-12 Sep-12 Oct-12 Nov-12 Dec-12 Jan-13 Feb-13 Mar-13 Apr-13
Practice Enhanced Primary Care/WP FM
County Kent

ePC Quality: MiPCT

IPC

- Grand Rapids MI: Different (competitor) system
- Additional bells and/or Whistles
- Desire to create a scalable model that could be adapted for 22 markets
- “Health Care Unified Field Theory”

IPC: New bells and whistles

- Design: Human Centered Design
- Lean as Operating, Management and Improvement Systems
- Team documentation
- Patient Activation Measure
- Social Determinants and CHW: Community Hubs USB

Team Documentation

Metric	Baseline	Current	Target
Provider Visits per Week (1.0 FTE)	75	100 **(33% Improvement)**	120
Provider Work Time After Hours (per Week)	7.0	4.5 **(36% Improvement)**	0

- **$99,000 in additional annual revenue (1 Provider)**
- **Increased wRVUs from 65th to 74th Percentile**
- **No additional FTEs**

If APC Models work, so what?

- The Unstated Question:
  - Is it possible to have a win both in volume and value based payment models?
  - Answer: Yup
- Scalable or just a nice demonstration?

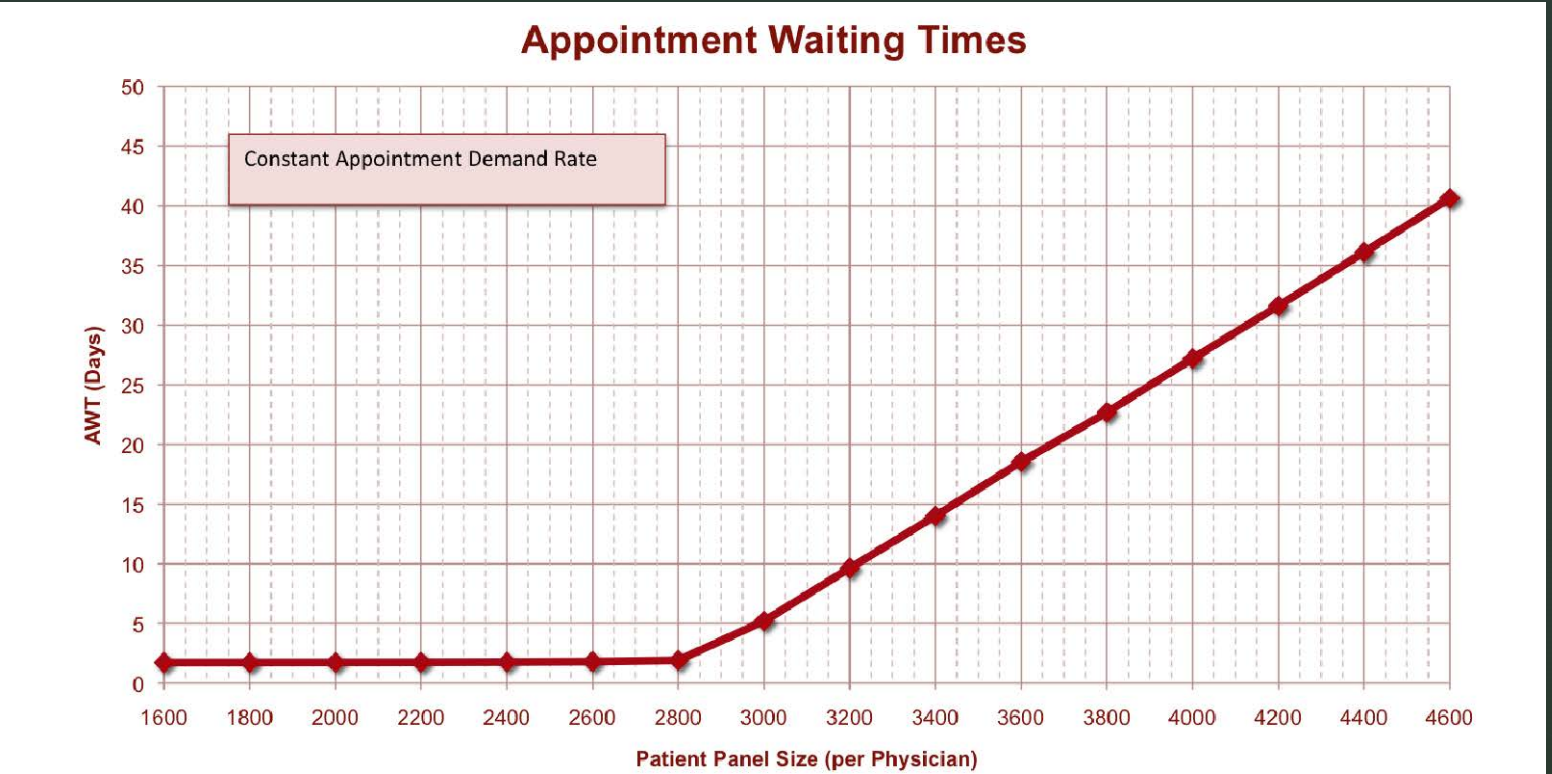
Deployment Strategy

1. Start with No Fail Four
2. Roll out quickly and in standard way
3. Evaluate business case for other bundles
4. Look for synergies
5. Deploy the non- No Fail Four Bundles as business case arises

No Fail Four

1. Risk Adjusted Panels
    1. Volume: Utilization/10,000 in FFS
    2. Value: Capitated Lives
2. Access
    1. Volume: Productivity
    2. Value: Keepage and Care Gaps
3. Network Integrity
    1. Volume: Productivity
    2. Value: Keepage and TCOC
4. Production Cost
    1. A winner in any scenario

No Fail Four: Access and panel size problem



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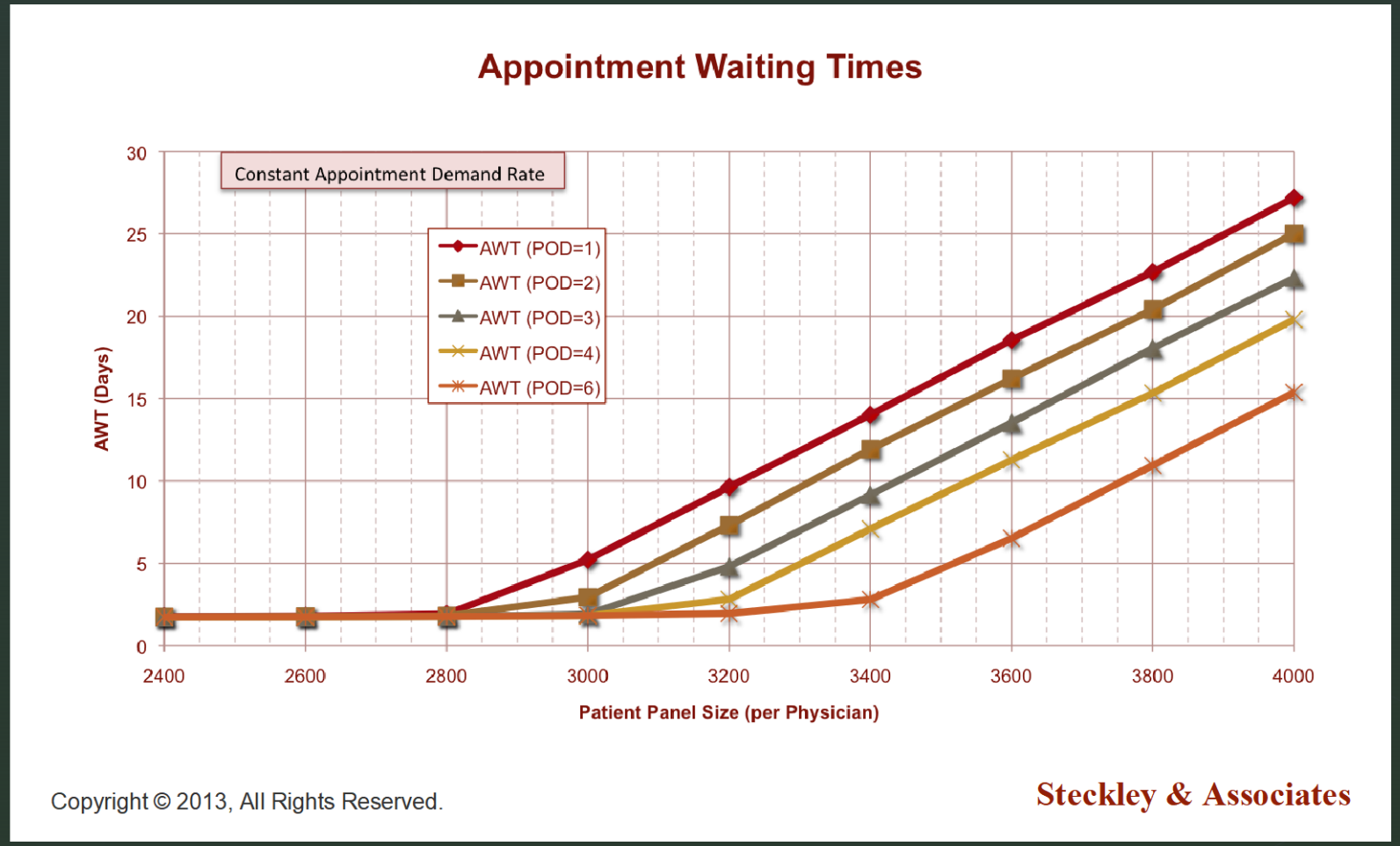
Tactics: Solving Access and Panel Size



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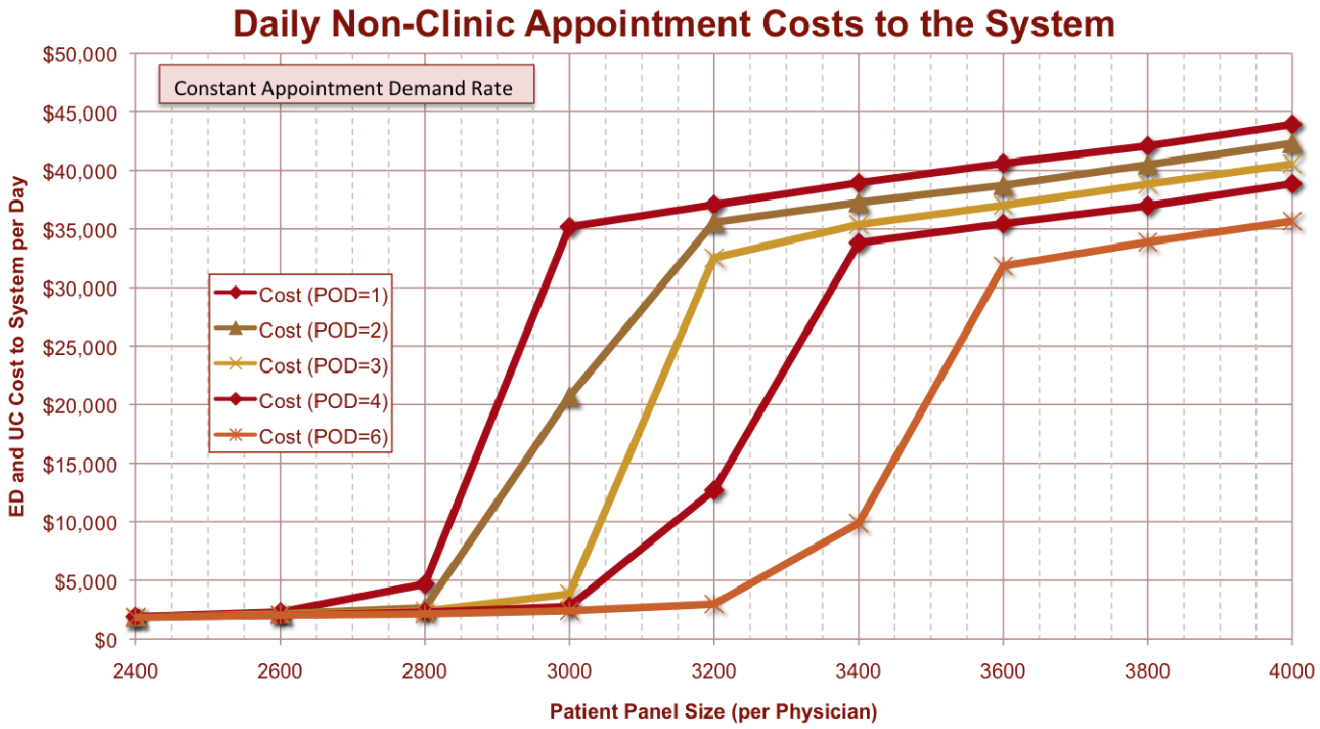
TCOC: Simple rules that help

Costs to the Overall System Due to ED and UC Visits



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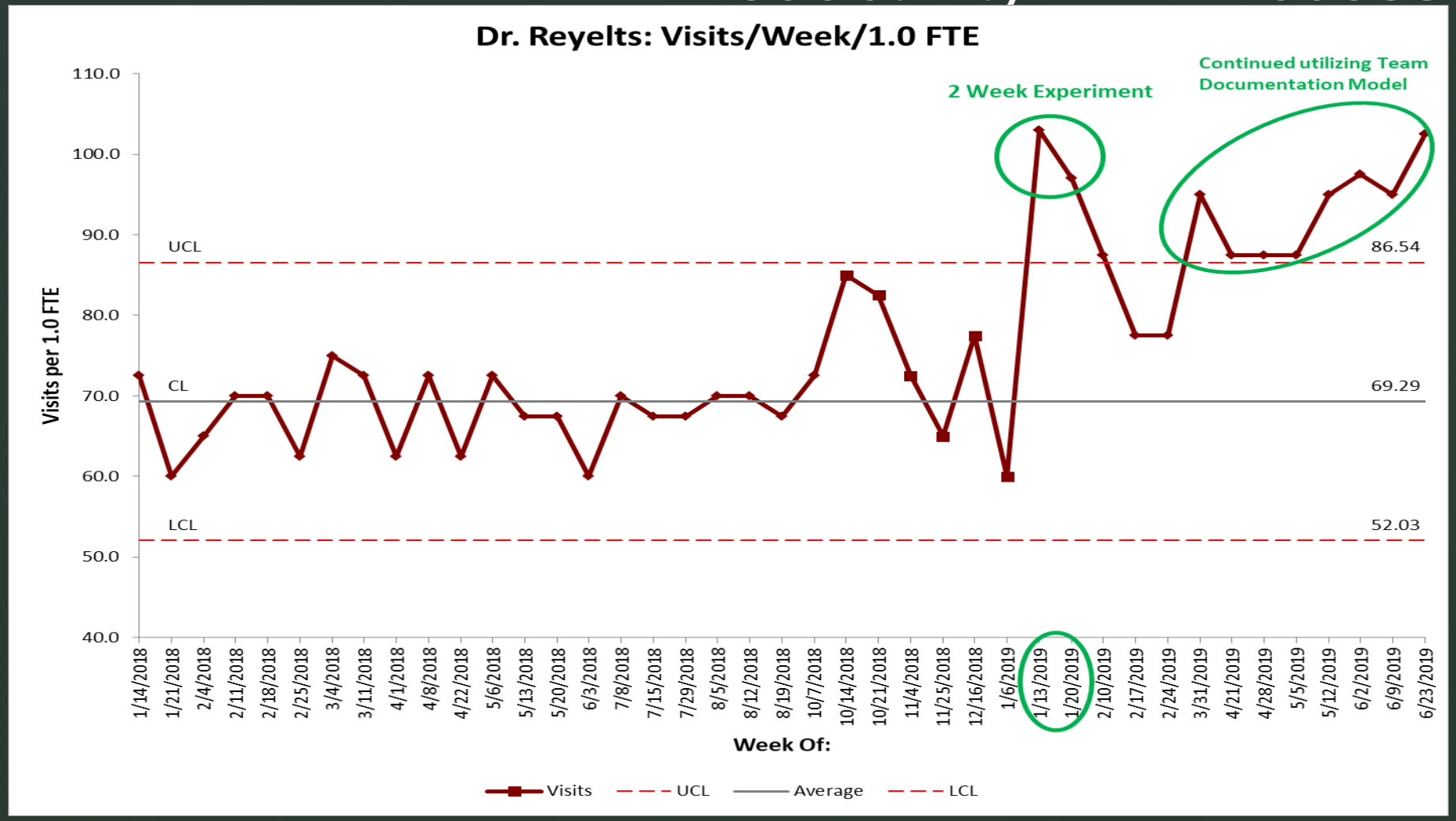
Team Documentation: Provider Burnout AND Productivity AND Access



Critical Success Factors

- Leadership: System
  - Protection
  - Advocacy
  - Intent to scale from the beginning
- Leadership: Team
- Team Culture: Ownership
- Team Culture: Teammate Selection
- Clear Vision and Objectives
  - Throughout the system
- Focus on Principles and vision upfront
- Engaging the team in developing the model
- Care and Feeding: Ongoing support including resources

Failure Modes

- Pilot thinking and Rossi's Iron Law
- Existential Drift
  - Lack of alignment about why you are doing what you are doing
- Lack of Sponsorship at leadership level
- Poor choices in providers and other team members
- Lack of attention to culture
- Starving for resources: Clear business proposition
- Failure to demonstrate ongoing value proposition

Conclusion

- Providers and frontline leaders feel every day the myriad challenges that modern health care has and the burdens that systems have placed on them
- Provider burnout remains a persistent problem; ensuring that solution sets do not make this worse but hopefully improve it will promote long term success
- It is unlikely that tiny technical fixes will deal with these challenges
- **Advanced Primary Care Models hold great promise in driving to many of the required outcomes both future and present**
- Assumptions about what primary care should look like will have to be challenged by all (“Change is hard”)
- It takes a team to get this done