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FREE SUMMARY REPORT

APRIL 2014

The New Primary Care Model: A Patient-Centered Approach to Care Coordination

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NEW
HealthLeaders Media Intelligence Report

The New Primary Care Model:
A Patient-Centered Approach to Care Coordination

This report reveals the keys to primary care redesign—team-based care, patient engagement, and adaptation to at-risk reimbursement schemes.

- Discover how Atlantic ACO has incentivized physician engagement in primary care redesign by offering its physicians advance payments on future Medicare Shared Savings Program awards.
- Learn which physician compensation measures are preferred overwhelmingly in primary care redesign efforts.
- Find out how the use of embedded case managers coordinating care at Taconic IPA has reduced 30-day readmissions.
- Uncover which patient engagement tactics are best—today and in the future—at supporting primary care redesign.

PLUS! Get actionable strategies and analysis, segmented peer data, and a meeting guide for your organization.

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About the Premium and Buying Power Editions

This is a summary of the Premium edition of the April 2014 HealthLeaders Media Intelligence Report, ***The New Primary Care Model: A Patient-Centered Approach to Care Coordination.*** In the full report, you'll find a wealth of additional information, including the results of all the survey questions. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by David J. Shulkin, MD, Vice President of Atlantic Health System, President of Morristown (N.J.) Medical Center, President of Atlantic Accountable Care Organization, and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Oregon Health and Science University in Portland, Ore.; Taconic Independent Practice Association in Fishkill, N.Y.; and Atlantic Accountable Care Organization in Morristown, N.J.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Methodology

The 2014 *Primary Care Redesign Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In January 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 317 completed surveys are included in the analysis. The margin of error for a sample size of 317 is +/-5.5% at the 95% confidence interval.

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The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

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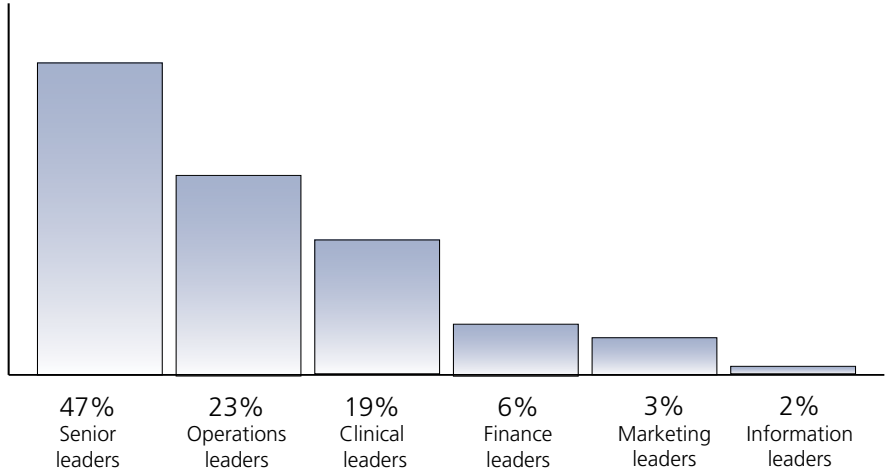
Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

Title

Base = 317



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Type of organization

Base = 317

Hospital	44%
Health system	35%
Physician org.	21%

Number of beds

Base = 138 (Hospitals)

1–199	49%
200–499	33%
500+	17%

Number of sites

Base = 111 (Health systems)

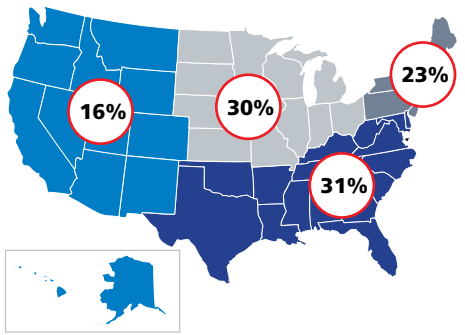
1–5	14%
6–20	34%
21+	52%

Number of physicians

Base = 68 (Physician orgs)

1–9	26%
10–49	31%
50+	43%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, DC, Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Staying Focused on the Objectives of Transformative Change

MICHAEL ZEIS

Transforming primary care is a complex set of interrelated tasks with a wide range of choices. It is important to remember that we have many primary care practice types and no shortage of approaches to transformation. As we try to sort out what to pursue and with how much vigor, we should never lose sight of the objectives of primary care redesign.

The broadest objective is to improve patient health, of course. The patient-health objective has two manifestations: First, we are fostering relationships with patient populations so that patients use a combination of self-awareness and visits to primary care practitioners to monitor and maintain their health. Second, we are establishing relationships throughout the care continuum so that patients have a ready path when they have conditions that require skills or facilities their primary care team cannot provide.

Both factors are fundamental to healthcare reform because, for instance, closer contact between patients and the primary care team supports efficient utilization of acute care facilities and EDs as well. Further, more engagement by the population at large in their own healthcare will result in a healthier population, a population that will use all healthcare services in a more efficient way.

WHAT HEALTHCARE LEADERS ARE SAYING

Here are selected comments from leaders regarding the effect of their organization's primary care redesign in other initiatives.

"Awareness has increased regarding patient-centeredness, but clinical and patient experience outcomes haven't yet budged."
—Chief medical information officer for a large health system

"Things are very fragmented within the organization, which is moving to an institute model. We are unclear at this point how that will integrate with population health management, which is presently a small pilot."
—Vice president of compliance for a large health system

"We are rolling out clinically integrated networks in multiple markets as a key alignment strategy with our large base of independent physicians. We are cognizant that a robust base of PCPs is critical relative to patient attribution, risk stratification, and care management necessary for effective population health management and risk contracting."
—Vice president of finance for a large health system

"We are trying to integrate the major practices in our community into a patient-centered medical neighborhood that includes primary care, specialists, and ancillary help such as home nursing, PT/OT, pharmacy, etc."
—Chief medical officer for a medium hospital

"We are working with the population at large and the models/outcomes that resulted are applicable to other 'at-risk populations,' with some adjustments, such as working with the integration of the mentally ill with serious behavioral health issues into a medical treatment environment."
—CEO for a small hospital

Analysis (continued)

The need to collaborate is understood. With 59% of respondents to the *HealthLeaders Media Primary Care Redesign Survey* identifying improving care coordination and collaboration as being among their top three goals for primary care redesign, the industry appears to understand the patient-centered mandate. Nearly three-quarters (70%) say their collaboration is primarily with known partners. According to David J. Shulkin, MD, vice president of Atlantic Health System, with 1,315 licensed beds across four hospitals and a children's hospital in northern New Jersey, "Primary care doctors understand the importance of being part of a bigger system of care and having a relationship with an integrated system." Shulkin also serves as president of the Atlantic ACO and president of Morristown (N.J.) Medical Center.

Coordination is important, and it's not necessarily easy. Nearly half of respondents (49%) include coordinating care with other providers among their top primary care redesign challenges. Shulkin cautions, "This is not a solo effort of a primary care doctor. Respondents clearly recognize that in order to accomplish the redesign goals and the transformation of healthcare, it can't be done by them alone."

John Saultz, MD, professor and chairman of the Department of Family Medicine at Oregon Health & Science University—which between the OHSU Hospital and the Doernbecher Children's Hospital is licensed for 572 beds and operates four clinics in the Portland area—notes that care coordination is more important now because primary care practices are seeing fewer patients with minor health issues and more patients with chronic conditions.

> "Primary care doctors understand the importance of being part of a bigger system of care and having a relationship with an integrated system."
>
> —David Shulkin, MD

"Today the majority of the people we see no longer have acute care problems, they have chronic problems, for which a 15-minute office visit is badly designed," Saultz says. "Seeing a diabetic who's depressed and has chest pain is a much more complicated visit. It's going to require not just the ability to assess that problem in the office, but to empower the patient to engage in checking their blood sugars, eating differently, losing weight, and doing a bunch of other things."

Patient engagement. The patient is a bit of a wild card in primary care redesign. Nearly two-thirds of healthcare leaders (59%) acknowledge that fostering patient engagement in their own care is a top challenge. To that end, 78% include nurse phone calls among the most effective tactics to address patient engagement in their own healthcare (making it the only response to exceed the 40% threshold). While only 25% of respondents include email or text messages among their most effective tools in patient engagement, Shulkin, lead advisor for this Intelligence

Analysis (continued)

Report, acknowledges the potential that alternatives to direct one-on-one contact can offer. "As the economic pressures continue to mount in healthcare, we're going to be looking for technology as a way to make the process more efficient," he says. "Many of today's patients, a group that's relatively older, prefer having face-to-face or phone contact. As the younger generation that grew up with electronic communication enters the healthcare system in larger numbers, we're going to see more electronic outreach."

Technology and new staff assignments can support the mechanics of patient engagement, but the concept has to be accepted and supported by the physician as leader of the care team. Report advisor Saultz says, "Now that we're trying to get good at caring for people who aren't in the office, that requires outreach methods and a whole set of behaviors not only on the part of the physician, but also on the part of the whole team, really, in order to get it to work."

Who is paying for this? The financial underpinnings of primary care redesign are being established. Nearly two-thirds (61%) are in payer relationships that reward performance related to aspects of primary care redesign. An additional one-quarter (25%) are in discussions with payers to set up such relationships. Many of the funding mechanisms are not new because primary care transformation activity is decades old, at least. Many practices are moving forward with primary care redesign because they participate in the Centers for Medicare & Medicaid Services' relatively new Medicare Shared Savings Program for ACOs, which went into effect January 1, 2012. The program links shared savings or losses to quality performance and the delivery of coordinated and patient-centered care. Among other things, CMS expects participants to invest in the workforce and the provision of team-based care.

> "Today the majority of the people we see no longer have acute care problems, they have chronic problems, for which a 15-minute office visit is badly designed."
>
> —John Saultz, MD

In an academic environment, much of OHSU's primary care practice transformation work has been funded by grants and participation in pilot programs with payers. Now OHSU's Saultz is trying to institute sustainable business models instead. "It requires more than just grants to study practice transformation," he says. "You actually have to have a business model. If the health system invests $1 million in my practice, what am I going to produce in return that will make their investment worthwhile? That depends on what the ongoing business model is. Otherwise, it's just going to be a question of how much are we willing to lose in order to do primary care well."

Although many are strengthening their relationships with payers and working successfully toward primary care transformation, Saultz has

Analysis (continued)

experienced difficulty as he pursues revenue streams other than grants. "Payers have been shockingly unwilling to be helpful," he says. "They are perfectly happy to encourage us, they are excellent cheerleaders, but they are of little use to the collaborative process." (Saultz concedes that virtually his entire base of experience is in Oregon, and that those in other regions may have different experiences.)

One survey respondent reports that her multi-specialty medical practice is collaborating with its local hospital on population health through an occupational health program, "working with industry, rather than the insurance companies." Despite such provider-payer friction, Shulkin is optimistic when he sees that 61% have some form of performance-related practice redesign relationships with payers, but admits that there is progress still to be made. "Relationships and collaborations with the payers are paramount to success here, but there's still a way to go in developing these relationships," he says. "But without a mechanism for paying for quality, progress toward primary care redesign is going to be much slower."

Physician compensation. Care metrics (85%) and financial metrics (57%) lead the list of measures taken to address physician compensation. "What these two have in common is being paid for performance and paid based upon value," Shulkin says. Incentives based on care metrics and financial parameters are common today. Compensation actions such as reduction of RVU requirements (15%) and removal of volume incentives in favor of salary (also 15%) are selected less frequently, which is an indication that, as with the industry overall, finances in primary care still are steeped in fee-for-service payments. According to A. John Blair III, MD, FACS, president of Taconic Independent Physician Association in Fishkill, N.Y., which has 5,000 physicians, including 1,600 primary care physicians, "we're living with a structure that came into place in the 1960s, has evolved from that, and everybody has built to that. They're not going to let go of that piece of it easily."

> "We're living with a structure that came into place in the 1960s, has evolved from that, and everybody has built to that. They're not going to let go of that piece of it easily."
>
> —A. John Blair III, MD, FACS

Redesign investments. Two-thirds of respondents (67%) say that they expect to invest in coordinated care across the continuum over the next three years. With half (49%) identifying care coordination as a top primary care redesign challenge, a substantial portion recognizes that delivering coordinated care takes some effort. More than half (57%) expect to invest in programs to improve patient access to care. Tracking provider performance (62%) and tracking patients via EHRs (51%) are top

Analysis (continued)

IT investments related to primary care.

Considering that equal percentages of respondents identify clinical quality and patient volume as primary care redesign goals (39% each), Shulkin suggests that the industry has a "dual strategy of maintaining life in the current system while preparing for the future system." To move primary care practices forward on both fronts concurrently will require IT support.

"In order to be successful in clinical and economic accountability," Shulkin continues, "you're going to need information systems that are able to measure and track provider performance. While it may not always be comfortable to be tracked and accountable for your performance, this is where our investments need to be. If you're going to have a payment system, you need to have the ability to measure it and know where you're going to be able to improve."

Redesign goals. As mentioned above, improving care coordination was mentioned most frequently as a top primary care goal. After care coordination, five items fall within a few percentage points of each other as top goals: healthcare leaders want to increase patient volume (39%), improve clinical quality (39%), improve access to care (35%), increase market share (34%), and improve utilization of resources (33%). That's a daunting task list, which, Shulkin observes, "demonstrates how much is being asked of primary care doctors. It's not as if we're asking them to do one thing, like lower costs. They must take a multi-faceted approach to change and redesign."

> "It's going to take years to see results in terms of healthcare value."
>
> —Holly Miller, MD, MBA, FHIMSS

We can see that practice transformation places demands on primary care physicians. They have to drive the transformation of primary care, but nearly half of respondents (45%) say that they lack the time to do so. And new skills are needed, as well. More than one-third (37%) include the lack of change management skills among the top primary care challenges.

"We can't train family doctors the way in which we used to train family doctors and expect them to be facile in this new system," Saultz says. "They have to be more capable of using data to improve their practices, and have to be ready to participate in and lead interdisciplinary teams. On top of that, there is the complexity of taking responsibility for the care of a population of patients. Traditionally, our training has been about the patient that's in front of us. We did not think that it was the doctor's problem if a sick person didn't come to the doctor."

What about motivation? Nearly half (47%) say that motivation to change represents a top challenge. Shulkin says motivation has three facets. "Are

Analysis (continued)

the financial incentives in place today to cause me to change?" he asks. "Are there personal dissatisfiers in my current practice that [drive] me to change? Finally, what's my life situation? If I'm close to retirement, do I really want to change?"

Holly Miller, MD, MBA, FHIMSS, medical director at Taconic IPA and a report advisor, says that early results from primary care redesign efforts will lay the groundwork for future progress. "It's going to take years to see results in terms of healthcare value," she says. "We need to improve quality and control costs so that we're delivering better value. If the programs that are underway now succeed—programs where payers have contributed and have partnered—then more will follow. I am optimistic that these programs will prove that with practice transformation, patient engagement, and all of the other things that are involved, we will start to see great improvements in healthcare value."

The steps toward providing a robust primary care foundation that fosters healthcare reform are difficult because at virtually every turn, one finds that the old way of delivering primary care needs enhancement or overhaul. Generally speaking, primary care redesign means moving toward a more collaborative environment, working as a member of a care team, and supporting patients as they become more aware and more responsible for their own health status.

Because primary care practices must move toward delivering value-based care while the industry's business models are still largely based on performing procedures for a fee, funding mechanisms still are uncertain. That means that investments must be made in an environment of uncertainty. But uncertainty should not be used as an excuse to delay, because practices that are not involved in activities such as establishing strong working relationships throughout the care continuum, developing a system of team-based care, and supporting their patients in their efforts to become more aware of their own health status may find that the industry moves forward without them.

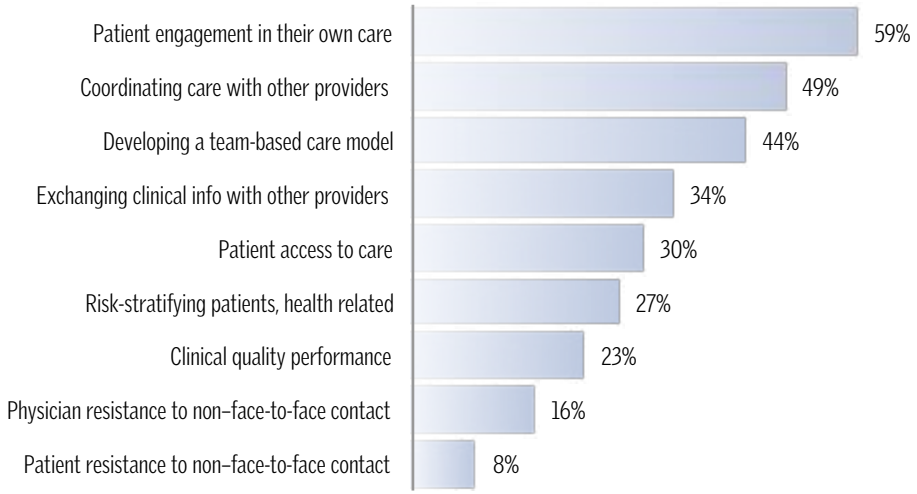
> "As the economic pressures continue to mount in healthcare, we're going to be looking for technology as a way to make the process more efficient."
>
> —John Saultz, MD

Michael Zeis is research analyst for HealthLeaders Media. He may be contacted at mzeis@healthleadersmedia.com.

FIGURE 2 | Clinical Challenges of Primary Care Redesign

Q | What are the top three most challenging clinical components of primary care redesign for your organization? (Among those with primary care redesign underway or expected.)

Total responses



Base = 302, Multi-Response

TAKEAWAYS

- With only minor variations by setting and size, engaging patients in their own care is included as a top clinical challenge by 59% of respondents overall, more often than any item.
- Coordinating care with other providers is mentioned as a top primary care clinical challenge by more respondents from hospitals (56%) than health systems (47%) or physician organizations (40%).
- More than one-third of health systems (39%) include health-related risk stratification as a challenge in primary care redesign, compared to only 20% of those from hospitals and 21% of those from physician organizations. One would expect that health systems would be more adept at what can be a data- and analytics-heavy population health activity. We suspect that a higher proportion of those from health systems have firsthand exposure to risk stratification and are therefore more familiar with the difficulties.

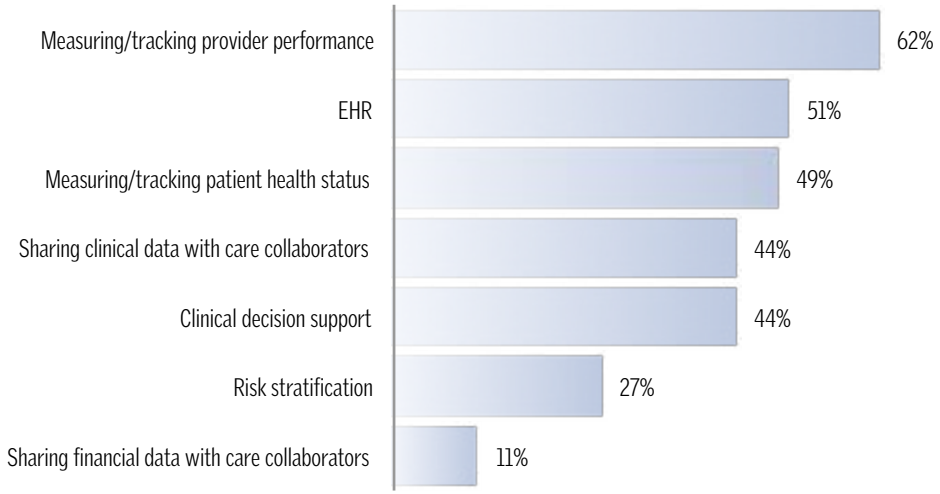
WHAT DOES IT MEAN?

With an engaged patient population, outreach resources can be dedicated to at-risk populations. Also, patients who are engaged in their own healthcare will attend to their health issues earlier in the disease process, when treatment is less complex and less costly.

FIGURE 7 | Primary Care Redesign IT Investments Next Three Years

Q | What are the top three IT investments or developments your organization expects to make over the next three years to support primary care redesign? (Among those with primary care redesign underway or expected and planning to make IT investments.)

Total responses



Base = 294, Multi-Response

TAKEAWAYS

- Measuring and tracking provider performance is cited by 62% of respondents as being among the top three IT investments they expect to make over the next three years in support of primary care redesign, making it the top area of investment. There is little variation in response across settings.
- A smaller percentage of health systems (45%) than hospitals (59%) expect to invest in their EHR in support of primary care redesign.
- In like fashion, a smaller percentage of health systems (36%) than hospitals (54%) expect to invest in sharing clinical data with care partners, perhaps because their systems may be sharing already and their care partners may be part of their system.

WHAT DOES IT MEAN?

Generally speaking, health systems may have more experience than hospitals with EHRs and sharing data with collaborators. We see higher percentages of health systems that expect to invest in risk stratification—an area that can be quite complex. A similar percentage of physician organizations, perhaps not thought of as being on the IT vanguard, expect to invest in risk stratification, probably because they recognize that they need to carefully develop patient panels.

FIGURE 7 *(continued)* | Primary Care Redesign IT Investments Next Three Years

Q | What are the top three IT investments or developments your organization expects to make over the next three years to support primary care redesign?
(Among those with primary care redesign underway or expected and planning to make IT investments.)

Click on these icons to dig deeper

BUYING POWER Who controls the money? Click on the icons to learn how they think

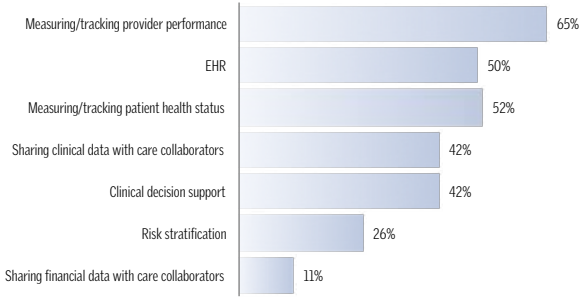
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

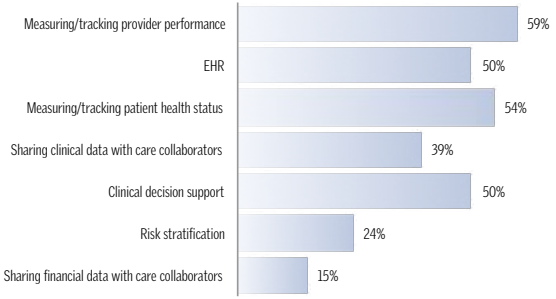
PRODUCTS/SERVICES

Clinical products



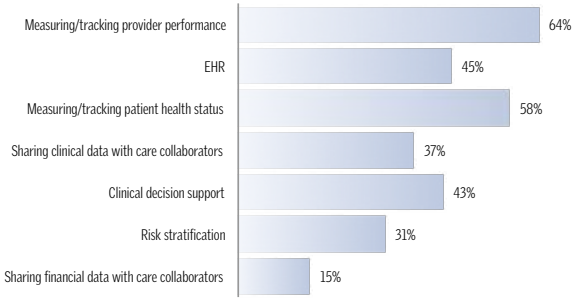
Base = 161, Multi-Response

Financial services



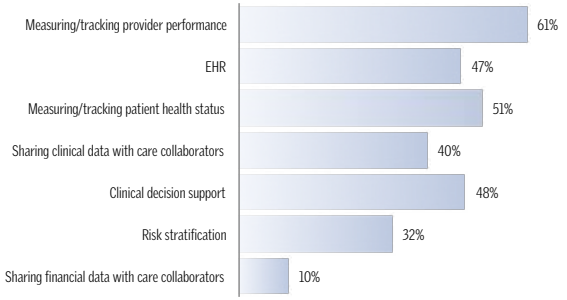
Base = 103, Multi-Response

Executive search



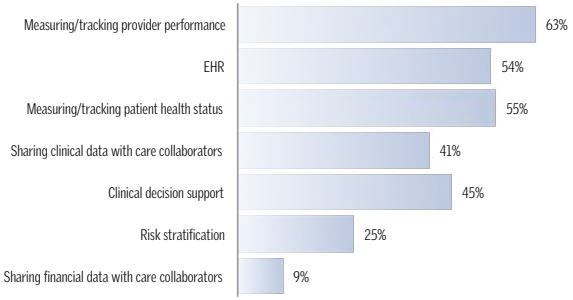
Base = 113, Multi-Response

Consulting services



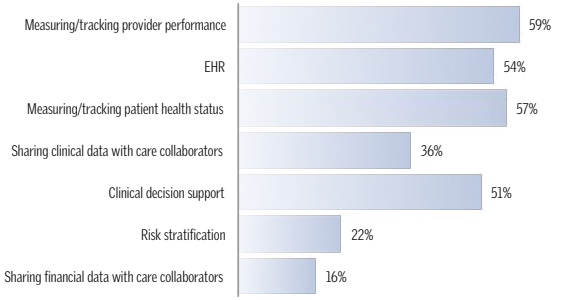
Base = 136, Multi-Response

Outsourcing services



Base = 106, Multi-Response

Legal services



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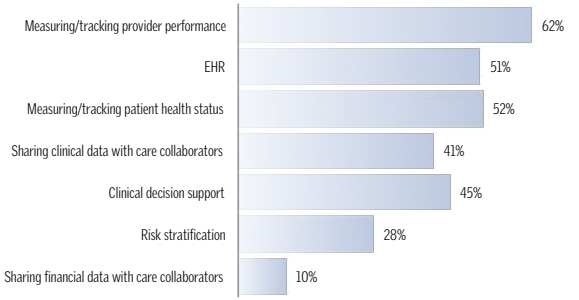
Information technology



Base = 172, Multi-Response

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