

PRESCRIPTIONS FOR EXCELLENCE IN HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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EDITORIAL

Health Care Transformation: Fiction or Fact?

David B. Nash, MD, MBA
Editor-in-Chief

When planning the content for *Prescriptions for Excellence in Health Care (PEHC)*, we generally try to achieve a healthy balance between the macro and micro aspects and this year is no exception. With an overarching theme of *Practical Strategies for Transforming Health Care*, we identified and convened a meeting of leaders who are fully engaged at either end of the spectrum. Some of them were involved in transformation at the 30,000 foot level (ie, understanding the dynamics and complexities, channeling their findings into practical solutions) and others were drawn to transformation at the ground level (ie, innovating and pioneering hands-on, replicable projects). Each agreed to author an article for publication in this year's cycle of PEHC.

As in previous years, the meeting was organized around presentations by each participant, but something set this meeting apart from previous years. As they shared their learnings and experiences, there was a

perceptible, collective mood swing. During the wrap-up, one participant described the phenomenon as a gradual shift from feeling weighed down by a sea of challenges to feeling buoyed by optimism.

Admittedly, much remains unclear; however, we all agreed that a few elements will be critical to the success of a health care organization in the environment of health reform:

1. It must be ambidextrous (ie, highly innovative while relentlessly pursuing better quality at lower cost).
2. It must be both patient-centered and population health based.
3. It must recognize that the frontline workforce is crucial and maintain a focus on organizational culture.

This is a daunting assignment but, as the articles in this issue make clear, transformation is becoming a fact. Although I am certain that

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some will prefer to fight against change, I suspect that many readers will find the insights and creative spirit of these leaders to be contagious.

The title of the lead article, “Transforming Health Care from the Ground Up: The Iora Health Experience of Building a de novo Model of Primary Care,” sums it up very objectively. What it fails to convey is the sheer magnitude of the transformation and the impressive outcomes Iora Health is continuing to achieve. Next, “Measuring the Integration Experience Through Patient Satisfaction” challenges us to make use of patient satisfaction data to understand how patients perceive

our effectiveness as health care delivery systems and to prioritize improvements accordingly.

The remaining 3 articles focus on different but equally important aspects of health care transformation.

- “Community Connectivity and Accountable Care: The Patient-Centered Professional Model” is revelatory in the way it relates medical professionalism to practice redesign and value creation.
- For an eye-opening account of the ill effects of a widening gap between the supply of clinicians and the demand for population

health care, look no further than “Provider Supply, Demand, and Burnout: Barriers to Caring for Our Populations.” The article suggests good remedies as well.

- A concise yet comprehensive article, “The Demand for Health Analytics and the Affordable Care Act,” serves as a reminder that health analyses and predictive analytics can play key roles in managing “at risk” patients and understanding and addressing disparities in care that are related to socioeconomic factors.

As always, I welcome feedback from our readers at david.nash@jefferson.edu.

A MESSAGE FROM LILLY

The Uncertain Future of ACOs

Ora H. Pescovitz, MD

For health care providers, change has become the “new normal.” Physicians across the country are experimenting with a wide range of new accountable care models, and many report feeling uncertain about what the future holds. In a recent survey, 75% of physicians said they are participating in at least 1 value-based model; however, only 60% believe they will continue, and fewer than 30% believed their model offered good reward for risk.¹

In the course of my career – both as a physician and as chief executive officer (CEO) of Riley Hospital for Children and, later, the University of Michigan Health System (UMHS) – I have experienced the same change and uncertainty expressed in that survey. On one hand, I am convinced that changes are needed to improve the quality and lower the cost of health care; on the other, I am equally convinced that more time and experimentation are needed to determine the most effective ways to achieve those goals.

Among the most significant experiments with value-based care are Accountable Care Organizations (ACOs). My own experience with one of Medicare’s first ACOs may help illustrate why, despite some demonstrated successes in select settings, I believe the jury on them is still out.

Pioneering Accountable Care

UMHS is one of the premier integrated health systems in the country, made up of nearly 1600 faculty physicians, 3 hospitals, and 40 health centers. When I became its CEO in 2009, UMHS was already 4 years into the 5-year Physician Group Practice (PGP) Demonstration, Medicare’s first experiment with value-based reimbursement.

Participants in the demonstration were given 2 primary tasks: contain cost increases for Medicare fee-for-service beneficiaries, and improve on 32 quality measures. In addition to receiving bonus payments for quality improvements, participants were eligible

to receive shared savings payments if they reduced Medicare's costs by at least 2% in a given year.

At the conclusion of the demonstration in 2010, UMHS had saved Medicare more than \$22 million and had received a grade of 98% on quality measures. Moreover, of the demonstration's 10 participants, UMHS was one of only 2 to earn shared savings payments in each of the 5 years.

Buoyed by our experience with the PGP demonstration, in 2012 UMHS agreed to participate in one of Medicare's original 32 Pioneer ACOs, partnering with an Ann Arbor-based provider group of 175 physicians to serve more than 23,000 Medicare beneficiaries. The parameters of the Pioneer ACO program were similar to those of the PGP demonstration, with 1 major difference: in addition to sharing in the savings if Medicare's costs decreased more than 2%, Pioneer ACOs also agreed to share in the losses if Medicare's costs increased by more than 2%.

At the conclusion of the first year, the UMHS Pioneer ACO saved Medicare 0.3% (\$47 million) while improving on all 15 quality measures. It did not receive a share of those savings, however, because it did not reach the required savings threshold of 2%.

Having already saved Medicare at least 2% in each of the previous 5 years under the PGP demonstration, it became evident that achieving significant additional savings under the Pioneer program would require one of 2 things: either the ACO would need to make major investments in new personnel and resources to drive greater population health improvements, or it would need to gain access to those resources by joining an even larger network of providers.

UMHS chose the latter course. In 2013, with the permission of the Centers for Medicare & Medicaid Services (CMS), UMHS left the Pioneer program and joined an even larger ACO within the Medicare Shared Savings Program (MSSP) – a program with the same goals of lowering cost and increasing quality but a different process for measuring those goals. Today, the Physician Organization of Michigan ACO includes 5700 providers from 12 physician groups, and cares for more than 120,000 Medicare beneficiaries in Michigan. It reported no cost savings for 2013, and has yet to release results for 2014.

Lessons in Accountable Care

My experience with the Pioneer ACO program taught me 3 important lessons:

Success in an accountable care model requires several strengths that not all provider groups possess.

- An existing infrastructure;
- A history of providing coordinated care;
- The ability to reward physicians for team-based work.

Not all quality improvements generate savings.

According to data released by CMS, 81% of the total savings in the Pioneer and MSSP programs were generated by only 26% of the ACOs (53 out of 204) even though most of them demonstrated improvements in quality.² Moreover, making significant improvements in patient outcomes over time likely will require providers to increase their spending substantially, which is very difficult in the absence of additional revenue.

Even for established and successful integrated health systems, there are many challenges associated with working in an accountable care model. Among them are:

- Higher administrative costs associated with measuring, tracking, and reporting cost and quality data;
- The need for workflow tools and real-time access to data for health care professionals across multiple sites of care;
- An unpredictable revenue stream and complex revenue cycle.

For all of these reasons, and despite their ability to improve health care quality and lower costs for Medicare, ACOs may not prove to be a sustainable model of value-based care delivery for all health care providers.

I remain optimistic that we will find a way to deliver and pay for health care more efficiently

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and effectively, with improved outcomes for patients. However, it is likely that experiments with accountable care and value-based payment will need to continue for some time. For the foreseeable future, then, the only thing we can be certain of is that change will continue to be the “new normal” in health care.

Health care providers should embrace that change... but not without scrutiny.

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Transforming Health Care from the Ground Up: The Iora Health Experience of Building a de novo Model of Primary Care

Rushika Fernandopulle, MD, MPP

Patient-Centered Medical Homes (PCMHs), Accountable Care Organizations (ACOs) and most other efforts to transform health care delivery have been incremental; that is, they have made a series of small changes to existing practices or delivery systems. At Iora Health, we have taken a wholly different approach—to simply start from scratch and build a new model of primary care delivery from the ground up. This radically new “operating system” changes everything:

- **The payment model.** Instead of using the dominant fee-for-service model with 5%-6% of total health care spending usually allocated to primary care,¹ we generally accept a risk-adjusted primary care capitation rate that is roughly double the typical reimbursement for primary care.
- **The process model.** This sort of care requires a fundamentally different process of care than

typical practices. Instead of a doctor and medical assistant seeing a stream of patients face-to-face in a reactive manner, we build robust teams organized around caring for an identified population of patients who are our responsibility and doing whatever it takes to improve their health status and keep them out of the hospital and the emergency room.

- **The technology platform.** Proactive, population-based care is not well supported by currently available electronic health records, which are little more than fancy cash registers that allow doctors to document, code, and bill for a higher intensity of services.² After years of trying to adapt existing systems or convince vendors to modify them for us, we decided to build a wholly new platform.³
- **The people and culture.** Perhaps the most important difference is not the payment, process,

or platform but rather the very culture of our practices. There is a huge crisis in primary care with high levels of unhappiness among physicians and other team members.⁴ We have built a culture of service and teamwork that focuses not only on achieving the usual triple aim (ie, better patient experience, clinical outcomes, and affordability of total care) but also on joy in practicing medicine.

The Culinary Extra Clinic

Building practices like ours requires working with sponsors – usually self-insured employers, union trusts, or health plans that have assumed financial responsibility for the health care of a population, and that are willing and able to pay us differently. Over the past 3 years, we have a dozen of these de novo practices across the United States that serve very different populations, ranging from Dartmouth College faculty and

staff in Hanover, New Hampshire⁵ to Medicare beneficiaries in Phoenix, Arizona.

To explain the model in more detail, I will describe our oldest practice. The Culinary Extra Clinic⁶ was launched in January of 2011 to serve the sickest and most costly participants of the Culinary Workers Union Trust in Las Vegas, Nevada – largely low-wage, non-English speaking, back of the house hotel and casino workers (eg, maids, dishwashers, kitchen staff). Working with the Culinary Union Trust, we built a new practice on the Strip to serve their participants exclusively. The practice is paid a fixed fee per patient and is not required to submit procedure codes or encounter-based bills. The Culinary Union Trust helps recruit patients who opt to receive primary care from the practice.

The team comprises:

- 2 Physicians whose job it is to make diagnoses and develop individualized care plans for patients.
- 8 Health Coaches – members of the community who speak the language of the patients – whose job it is to help with all the “blocking and tackling” of executing on the care plans. The only skill we require is empathy. Indeed, our first Las Vegas health coaches included a paralegal, a manager from Target, a yoga instructor, and a food and beverage server from a casino.
- 1 Nurse Innovator (a registered nurse) who helps with triage and workflow and who supervises

and helps coordinate the health coaches.

- 1 Social Worker who helps to integrate mental health services and address social issues that present barriers to patients receiving optimal care.
- 2 Operations Assistants who help with scheduling, the flow of paperwork, and other administrative tasks in the practice.

The team’s day begins with a 45-minute huddle during which patients are discussed – those who are coming in that day and, more importantly, those who are not coming in but are likely to be getting into trouble. This enables the team to make plans to proactively reach out to these patients rather than waiting for them to come in. During the day, the practice uses a “teamlet” model⁷ for in-person visits. About half of our time is spent on non-visit-based interactions such as e-mail, phone, text messages, and video chats. Each day, the practice runs several groups that allow patients to learn from and support each other. For instance, a diabetes club helps patients learn to cook and eat better.

Because the practice is freed from the tyranny of the billable visit, it can serve patients’ needs in creative ways; for instance, having a health coach take a patient and his or her spouse grocery shopping to learn what to buy, or having one of our doctors visit the patient in the hospital to make sure they are being cared for optimally. We also build a de facto narrow network of specialists, including hospitalists,

based on insights from claims data and clinical experience.

Note that this model is all we do – it is not a side project while we continue to see fee-for-service patients. In sum, the practice is not slightly different than typical practices, it is completely different.

Fulfilling the Quadruple Aim

This all sounds great, but does it work? Not surprisingly, patients love the care. We track net promoter scores weekly by asking patients how likely they are to refer the practice to a friend or colleague using a 0-10 scale with 10 being very likely. Most of the best rated traditional health care providers score in the 30%-50% range; our practices routinely score between 85%-95%.

The practices also deliver much-improved clinical outcomes. For instance, although only 55% of our patients with hypertension enter our practices with their blood pressure under control (close to the national average), almost 90% are under control within 6 months.

Independent analyses of practice outcomes show 40% drops in hospitalizations, almost 50% drops in emergency room visits, and 13%-20% net drops in total spending – all relative to well-chosen control groups.⁸

Finally, we have been able to do all this with much happier teams and extremely high retention of team members for more than 4 years.

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Conclusion

Although there is certainly value in incremental efforts such as PCMHs and ACOs, it is not clear that these alone will achieve sufficient change in the short term. We believe that de novo models such as ours can provide the “laboratories” to test more radical innovations, help demonstrate a vision for the future, and allow patients to vote with their feet thereby exerting pressure for more rapid and comprehensive change from the existing delivery system.

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Measuring the Integration Experience Through Patient Satisfaction

Ronda Christopher, M.Ed, OTL, PCMH-CCE

Introduced in 2008, the Institute for Healthcare Improvement's "Triple Aim"¹ spawned a nationwide effort to improve patient experience as measured by patient satisfaction scores. A parallel movement toward integrated health systems has further underscored the critical role of patient experience as an indicator of patient population loyalty to a health system.² Patient satisfaction metrics now serve both as a key element of payment designs, including Medicare Shared Savings Programs,^{3,4} and a strategic priority for health systems and provider groups seeking to enhance their ability to build strong networks. For these reasons, patient satisfaction measures are often elevated to system-level dashboards for monitoring.³ Unfortunately, traditional dashboards may not be designed to effectively leverage the strength of these parallel paths or accurately depict patients' perceptions of integrated care.

TABLE 1: Alignment of Domains across Patient Satisfaction Surveys

<u>General Domains</u>	<u>CG-CAHPS*</u>	<u>PCMH*</u>	<u>Health Plan*</u>	<u>Hospital*</u>	<u>ACO**</u>
Timely Access and Care	✓	✓	✓	✓	✓
Communication From Healthcare Providers	✓	✓	✓	✓	✓
Helpful, Informative, Courteous, Responsive Staff	✓	✓	✓	✓	✓
How People Rate Overall	✓	✓	✓	✓	✓
Discuss Medications/Adherence		✓		✓	✓
Coordination of Care/Transitions		✓		✓	✓
Providers Support Self-Care/Health Promotion/Education		✓			✓
Providers Attend to Mental/Emotional Health		✓		✓	
Information About Recovery				✓	
Pain Control				✓	
Cleanliness				✓	
Quiet at Night				✓	
Discharge Instructions				✓	
Access to Specialists					✓
Shared Decision-Making					✓
Between Visit Communication					✓
Stewardship of Patient Resources					✓
Health Status/Functional Status					✓

*Surveys come from AHRQ5

**Survey comes from CMS6

ACO=Accountable Care Organization; CG-CAHPS=Consumer Assessment of Healthcare Providers and Systems, Clinical and Group Surveys; PCMH=Patient-Centered Medical Home

The traditional satisfaction dashboard tracks and measures episodes of care; that is, ambulatory care and acute care experiences. Although surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) have domains for patient-centeredness and shared responsibility, they are not designed to measure multiple aspects of integrated care.^{5,6}

Some domain themes are common across surveys and settings (Table 1); however, the questions relate to a single point in time. Traditional interpretation of these data by improvement teams focuses closely on improving experiences at the location of treatment.⁷

In an integrated health delivery system configuration, the measure of “integration” often defaults to how the system is organized electronically versus how a patient feels when using services across the system. This implies that interoperable data exchanges between health care touch points alone will result in the patient receiving coordinated care.⁷ Patient perception of integration goes beyond communication and data exchange operations; in fact, patients assume this functionality is in place, a perception that may be intensified when patients seek and receive care from a comprehensive, branded health system.⁸

It is important to recognize that “the user experience is shaped more by how service providers work together and with the ‘customer’ than by organizational arrangements.”⁷ Although systems and provider groups continue to pursue the loyal patient as a strategy to advance

the value-based care model,² administrators and physician leaders must understand how to measure and use loyalty as a way to define system-level improvement opportunities. Monitoring domestic utilization provides a quantitative measure of patient loyalty but not the experiential view needed to build loyalty.

Administrative leadership’s willingness to prioritize patient experience to build loyalty as a key initiative will drive success toward improvement.⁵ Understanding the patient’s view of care – at both the point of service and across a network – will help inform leaders’ decisions regarding the resources necessary to build cohesive networks of care. Similarly, comprehensive Improvement strategies should take into account patient experiences with multiple services within the network as well as patient experiences during distinct episodes of care.

Some national efforts are under way to measure the experience of integration as our nation strives to improve the business model for integrated care. Harvard’s Patient Perceptions of Integrated Care study focuses on measuring patients’ perceptions of integration across a system or network through patient satisfaction surveys.⁹ The distinction in this survey is the attempt to capture patient impressions of organization operations in addition to the experience of care. The goal is to identify provider networks that feel more integrated from the patient’s point of view.⁹ Similarly, Scripps Health has developed a leadership dashboard and balanced scorecard that includes measures

of patient perceptions in clinical, administrative, and community service domains to help provide a global view of the “systemness” of the organization.¹⁰ Although the Harvard example elevates the need for surveys that provide this view in 1 measure set, the Scripps model shows us that leveraging traditional CAHPS or related CAHPS scores also can help build a view of the integration experience.

Acknowledging the widespread adoption of CAHPS and CAHPS-related surveys, the Scripps model may be the most resource-efficient approach to initiating integrated patient experience measurement efforts. Building an integrated experience dashboard requires looking at a set of measures and strategies that considers the experience of care before, during, and after an episode. Figure 1 illustrates how an organization might build a new dashboard using a common measure across all settings, and more focused measures within each care setting. For example, a system might consider communication as a common measure, with an added emphasis on “access” for primary care and “discharge-planning” for acute care. The approach aims to provide a qualitative story about patient experience across the entire system, emphasizing a common satisfaction element while simultaneously addressing key drivers of patient experience unique to each care setting. Likewise, strategies to improve experience would include collaborative improvement across settings. Organizing patient satisfaction data in this manner encourages

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system-wide ownership of the patient's experience, regardless of the setting, and supports the interdepartmental strategies to improve it.

As inevitable changes in national health care continue to spur the development of consumer products and networks that seek to drive consumer choices and patterns, so they impel us to improve our ability to measure those efforts. Traditional approaches and uses of patient satisfaction data should be reconsidered with an eye toward using this rich information to understand how patients perceive our effectiveness as a system and to prioritize resources toward the improvements that will help the patient's experience within the system.

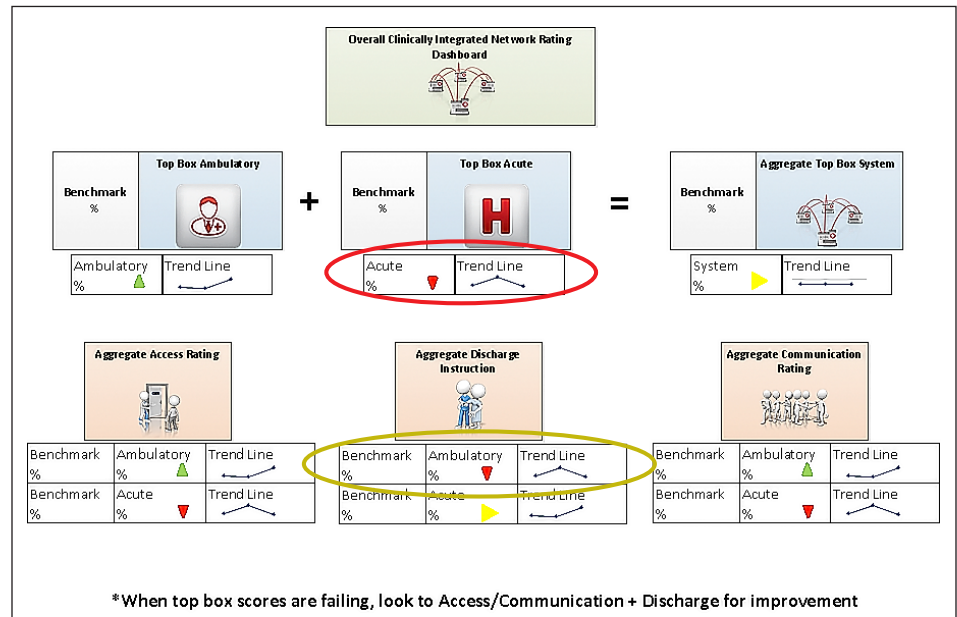
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Figure 1. Clinically Integrated Network Rating Dashboard.

Focusing only on the low-performance area (acute patient experience) provides minimal insight into integrated improvement opportunities. Although top box hospital experience scores are performing below the benchmark, the greatest opportunity for improvement may exist by deploying ambulatory strategies that support patient perceptions of effective discharge planning.



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Community Connectivity and Accountable Care: The Patient-Centered Professional Model

Scott Fowler, JD, MD, FACOG

The universe of successful solutions to value transformation in health care is relatively small compared to the universe of solutions to volume. Although the role of physician leadership

in achieving value is widely recognized as an important component, it often is not understood as the essential initial change element for creating value. Ongoing marketplace debate

regarding the degree of leadership required by individual physicians, if any, reflects this distinction. The physician as skilled laborer versus independent professional, the role of the specialist verses

primary care provider, and the lack of agreement on the essential value of maximizing patient choice all exemplify the complexity of the debate. In addition to providing real-world instructions on achieving value, reports of practical successes are beginning to resolve the debate in favor of understanding physician leadership as both essential and primary.

Physician leadership in the context of value is best understood as the corporatization of professionalism. Thus, understanding the role of enhanced professionalism is essential to understanding value transformation. Enhanced professionalism in medicine strengthens the physician-patient relationship and ties physician behavioral changes to patient behavioral choices. The lens of professionalism also helps us better understand much of what is wrong and guides our efforts in making changes that produce value. Professionalism forms the foundation of an optimized model of care that puts the patient at the center, delivers physician leadership, and provides definitive guidance to maximize the value of health care.

Professionalism

Medicine is a profession for a reason and, in fact, cannot function optimally otherwise. Professionalism as the organizing principle elevates cooperation, engagement, and leadership that is centered on the patient. Professionalism strengthens the relationship with the patient to create a more trusted and clearly articulated path to truth for the patient. Reinforcement

by the exchange of transparent, professionally-protected data and informatics across professional care settings creates a source of trust and truth for providers, dispelling disbelief and empowering action. This is the Patient-Centric Professional Model (Figure 1).

Although the importance of professionalism may seem obvious, it is worth examining what makes it primary to value. The deceptively simple statement, "medicine is a profession for a reason" has broad implications. It suggests that the medical profession is inseparable from its sacred oath to put patients first and to put the needs of patients ahead of the needs of the provider. It means that medical professional colleagues must cooperatively engage in maximizing the care potential of the system for the patients' good, working together toward achieving and sustaining a high standard of practice, and insisting on patient protection when the bargaining position is unequal. It requires avoiding conflicts of interest and the appearance of impropriety. In short, professionalism is the organizing principle of medical practice relationships with patients, colleagues, and communities.

Medicine exists as a profession rather than a vocation because societal goods are maximized with the professional model. Not insignificantly, it is a model that requires active participation on the part of both the medical profession and society – including patients – for support and continual maintenance. Without an understanding of and belief in professionalism as a core value in American health care, the debate

regarding the nature of value becomes unfocused.

In essence, professions are grants of status by society. Documentation of both education and character is required to maintain licensure. The grant is made not only in exchange for capability and knowledge, but also in exchange for an oath (to profess) of duty. This model is adopted by society to maximize the relationships between knowledge and choice, a duty to use the care and skill needed to educate, inform, consent, diagnose, and treat a patient. The oath, as a requirement precedent to the grant of power, is a response to the recognition of the unique ability of providers to use their superior bargaining positions to advantage themselves rather than the patient.

All medical school applicants must complete year-long undergraduate courses with labs in biology, general chemistry, organic chemistry, and physics; some medical schools have additional requirements such as biochemistry, calculus, genetics, psychology, and English. Many of these courses have prerequisites, so there are other "hidden" course requirements. All medical schools conduct background checks on applicants and these are repeated upon licensing. The years of education for physicians at the time of completion of certification range from 22 to 27 years. According to the National Center for Education Statistics, the average patient has not completed college and has little if any significant understanding of the math,

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physics, chemistry, or biology that form the foundations of medicine. Patients, however intelligent and capable of maximizing value, must have access to a highly-educated and experienced trusted advisor with credible data acting by duty on their behalf.

Lastly, professionalism supports an important argument for having the monopolistic allowances given to physicians. Why are nurse practitioners challenged when they request the right to independent practice? Why can't pharmacists write prescriptions? Why isn't it better to let the patient decide, just like shopping? Education and skill alone cannot support the outcry against monopoly. It is professionalism that makes the case.

Figure 1. Professionalism Protects Choice. Patient-Centric Professional Model.



Prepared by Scott R. Fowler, JD, MD, FACOG, Presentation, "Practical Strategies for Transforming Healthcare" (Fowler, JD, MD, FACOG, 2012)

"The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head."

- Sir William Osler

Practical Health Care Value Creation

Professionalism relies on data collaboration within a professional model to create value. Measuring quality outcomes and cost management reinforces physician leadership and engagement, and enables professional peer review and monitoring to build accountability and strengthen professionalism. Once measurement processes are in place, it is possible to fine-tune medical teams and protocols and to react to measured success or failure.

Data collaboration is currently a stumbling block for professionals and, although needed to protect and enhance the patient relationship and create practical solutions to health care value, it is rarely available in a purely professional model. Financial barriers to investing in infrastructure, high cost, and lack of familiarity with accessing capital are additional obstructions that must be removed. Because data collaboration in a patient-professional-centric system is essential, professionals must work together with society and one other to create economies of scale and lower the barriers to success.

The fundamental tenants of the data model necessitate the creation of a very low-cost provider-patient-centric common (clinical and cost) data set - actionable data that can be used by professionals in caring for patients as well as specific data required to measure and manage value-based contracts. The model

requires real-time, workflow-sensitive feedback to improve collaboration between providers caring for the same patient at the point of care. Secondly, the model requires the ability to subdivide specific information into data sets on a per contract basis as purchased by or for the patient and to allow application of analytics to the segregated data set with feedback into the more general point-of-care workflow such as the OnePartner HIE (a healthcare enabling system dedicated to professional accountability for population health. www.onepartnerhie.com) currently used by the 500 physicians of Qualuable Medical Professionals, LLC, in their successful Medicare Shared Savings Program Accountable Care Organization (www.Qualuable.com).

"A good physician treats the disease; the great physician treats the patient who has the disease."

- Sir William Osler

Practical Tips for Building Health Care Value-Based Contracts:

- Stratify patients by complexity of disease burden and treat the patient, not just the diseases.
- Identify the most complex patients currently receiving care in multiple disconnected care settings.
- Anchor the system of care with a high-performing independent professional medical group to create a nidus of professionalism.

- Insist on inclusiveness and access to all available quality and cost data at the point of care in an environment that maximizes provider workflow. Understand that data is the “currency of exchange” in value contracting.

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RECOMMENDED READING

Centor, R. M. (2007, March 26). To Be a Great Physician, You must Understand the Whole Story. *The Medscape General Medicine*, Volume 9 (1), 59.

Provider Supply, Demand, and Burnout: Barriers to Caring for our Populations

Matthew M. McCambridge, MD, FCCP, FACP

Providing high-quality health care for our communities requires a well-coordinated effort. Preventive medicine, ambulatory care, inpatient services, home care, and long-term care must function together seamlessly with a consistent patient-centered focus; and the health care team – physicians, nurses, behavioral health providers, social workers, case managers, and many others – is central to achieving success.

The Patient Protection and Affordable Care Act (ACA) brings additional patients into the system, stretching limited resources ever tighter. Two barriers exist with regard to providing high-quality care across the continuum:

- An insufficient supply of providers, especially in primary care.
- The large percentage of the provider workforce that is experiencing burnout.

In 2006, the Association of American Medical Colleges (AAMC) proposed increasing the number of medical students in the United States by 30% to

accommodate an increasing and aging population.¹ By 2014, the gap between supply and demand for providers was approximately 40,000 physicians and the AAMC projected a continued imbalance in the physician workforce through 2025. Specifically, the estimated baseline supply of physicians in 2025 is 734,900 compared with the estimated baseline demand of 859,300 – a gap of 124,400 physicians.²

A similar shortage is projected in the nursing workforce, with a gap of 918,232 registered nurses predicted by 2030.³ These imbalances in supply and demand will continue to place a heavy burden on existing providers and directly contribute to burnout in the workforce.

Because burnout is a current and very real issue among US physicians, assuring their well-being and emotional health has emerged as one of the biggest challenges in managing the health of a population and successfully implementing the ACA.⁴ Characterized by emotional exhaustion, depersonalization (treating patients as objects), and

a low sense of accomplishment, burnout has been linked to reduced quality of care, increased medical errors, and decreased empathy. Substance abuse, stress-related health problems, and marital and family discord are among the personal ramifications.⁵ A large study published in 2012 evaluated the rates of physician burnout, explored differences by specialty, and compared physicians to US workers in other fields.⁶ This study surveyed more than 27,000 physicians with a 26.7% response rate. When responses were assessed using the Maslach Burnout Inventory, 45.8% of physicians reported at least 1 symptom of burnout, such as emotional exhaustion or depersonalization. The highest rates of burnout were observed in emergency medicine, general internal medicine, and family medicine. Interestingly, the physician groups that were least likely to experience burnout symptoms and most likely to be satisfied with their work-life balance included preventive medicine, occupational medicine, and environmental physicians;

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however, even these physicians reported more burnout than the general US workforce. A comparison of physicians and the general US workforce revealed that physicians were more likely to have symptoms of burnout (37.9% vs 27.8%) and to be unhappy with work-life balance (40.2% vs 23.2%).⁶

How can physicians and other health care providers prevent burnout and reverse the symptoms in providers who are already experiencing burnout? A good starting point would be to recognize burnout and acknowledge that it is all too prevalent and can affect any health care provider. Preventing and treating burnout requires change at the administrative and personal provider levels. Administrators must ensure adequate provider-to-patient ratios and encourage breaks throughout the day. For example, a hospitalist caring for 30 patients on a regular basis or a floor nurse who is assigned to care for as many as 8 patients has little chance of preventing or treating burnout. However, if that hospitalist and nurse care for 16 and 5 patients, respectively, the chances of developing burnout will be less. Moreover, providers already experiencing burnout can recover and regain their emotional well-being.

The life of a health care provider is marked by stress, time pressures, distractions, and hyperstimulation (ie, pagers, hospital cell phones, personal cell phones, text messages, and often more than 100 e-mails received each day on smartphones, tablets, and computers.) It seems that physicians are almost always

“on” and “plugged in.” It is difficult to work long hours while being constantly connected and pulled in many directions. Hospital administrators can encourage development of and participation in mindfulness-based stress reduction (MBSR) programs. MBSR was developed by Jon Kabat-Zinn, PhD, at the University of Massachusetts Medical Center in 1979. The meditation aspect of MBSR helps health care workers to reset on a daily basis and enables them to view stressors differently, respond rather than react to pressures, and be more present for patients.

Many major corporations have incorporated MBSR programs into their businesses, and Silicon Valley corporations have been leading the way with respect to mindfulness. For example, Wisdom 2.0 is an annual, well-attended mindfulness gathering for technology leaders in San Francisco. Health systems are discovering the usefulness of MBSR as well. Lehigh Valley Health Network in Allentown, Pennsylvania, has been offering MBSR programs to its employees and community members for more than 15 years. Along with exercise, yoga, and other intentional stress-reducing activities, MBSR can help health care providers improve resilience and prevent burnout from occurring.

The future success of medicine hinges on achieving balance. Quality health care requires an appropriate balance between the number of patients seen by a provider and the quality of the care given. Administrators will need to balance their supply of care providers with the growing demands of the aging population.

Physicians will need to be attentive to their own well-being and work-life balance. These equilibriums are interrelated; upsetting one will negatively impact the other. However, successfully balancing certain areas will help to stabilize the others and eventually enable us to take better care of our populations.

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The Demand for Health Analytics and the Affordable Care Act

Byron C. Scott, MD, MBA

The Patient Protection and Affordable Care Act (ACA) was initially passed by Congress in 2010 and upheld by the Supreme Court in 2012 with much controversy initially and continuing into the first quarter of 2014 after the first open enrollment.¹ Much of the initial debate involved the cost of implementing the Act, how to fund it, mandates for individuals and organizations, and the perceived government intrusiveness on health care decisions. Despite the politics, the ACA has created more accountability and access to health care for individuals in the United States. Beyond its effect on individual patients, the ACA has impacted health care companies, government agencies, and a broad range of organizations including life science companies (eg, pharmaceutical and medical device manufacturers), federal and state governments, health plans, employers, and providers (hospitals and physicians). Fast-forward to today; with the shift in control of Congress after the 2014 elections, the debate continues on whether to repeal the entire Act or parts of it. No matter what happens, one thing that is clear; the demand for big data and health analytics to improve health care for individuals and to help organizations improve health for the members they serve will continue to accelerate.²

The ACA set in motion some specific market dynamics

such as the shift toward ambulatory versus inpatient care, volume versus value-based reimbursement, and unprecedented engagement of physicians and consumers. The push toward value-based reimbursement also will drive more performance improvement along with better care coordination and management by hospitals and physicians. One health care trend driven by these market dynamics is that large health care systems - already large employers - are beginning to develop or acquire health plans. Taking on more risk and accountability as population health becomes more critical works to the employers' advantage. A recent survey estimated that 20% of health systems plan to launch a health insurance plan by 2018.³

Life Sciences

Life sciences companies such as pharmaceutical and medical device manufacturers and clinical laboratories have always used health analytics to perform comparative and cost-effectiveness analyses for drugs and devices. Provisions included in the ACA have impacted these companies by increasing the demand for data and health analytics for informed decision making and demonstrating value to payers and governments.

Pharmaceutical companies are impacted by new reimbursement models such as Accountable Care Organizations (ACOs) and

bundled payments wherein provider organizations are seeking greater cost efficiency by prescribing fewer, less expensive drugs and devices. Potential benefits for pharmaceutical companies may lie with the closure of the Medicare Part D coverage "donut hole" in 2020. This may result in improved patient compliance.⁴ The medical device tax of 2.3% on sales by manufacturers and wholesalers likely will reduce margins and result in these organizations needing to demonstrate the value of their products. A similar 1.75% year-over-year reduction of payment for clinical laboratory company equipment and reagents also will drive justifying return on investment.

Government

Various provisions in the ACA have impacted both state and federal health care agencies by creating and influencing the need for health analytics. At the state level, there are mandates to create public insurance exchanges, expand Medicaid, and evolve health information exchanges to house data and perform analytics on mandated quality reporting metrics. A few examples of the ACA impacts on federal government health care agencies include Medicaid expansion, increased analytic research on quality and outcomes, and the reporting of data by hospitals to the Centers for Medicare & Medicaid Services as it relates to value-based purchasing.

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Health Plans

Early impacts of the ACA on health plans involved conducting extensive health analytic reviews of their member populations to determine how various mandates would affect them; for example, compliance reporting, evaluating the overall cost and benefit strategy because of coverage mandates for dependents and employers, and assessing the effect of government mandates on margins because of the medical loss ratios. Looking ahead, the expansion of private and public exchanges will likely create a more competitive environment among health plans.

Employers

As a result of changes imposed by the ACA, employers are trying to decide how actively they want to be involved in creating a healthy workforce - especially in the face of rising medical costs. Should they nudge employees toward exchanges by providing a subsidy? Employers are using analytics to quantify mandated benefits, assess the potential impact of the Cadillac Tax (40% excise tax) if benefit plans are above a certain dollar threshold annually, and inform decisions regarding health plans versus direct contracting with providers. These decisions likely will have a measurable effect on the health of their employee populations – and perhaps their business performance.⁵

Providers

Most affected by the ACA, the provider group (ie, hospitals, physicians providing direct care)

has faced challenges associated with the new reimbursement models, the focus on value-based purchasing, and the broader population health initiatives. Robust analytics tools are required to make informed decisions because the new models tie reimbursement to quality and outcomes. Providers must have analytics at their fingertips to perform surveillance monitoring for early detection and infection prevention, clinical decision support for error reduction, and better patient engagement to reduce readmissions, improve compliance, and optimize the patient experience. Creating these changes requires organizational transformation using effective leadership and performance improvement techniques such as Six Sigma or lean. Effective, strong physician leadership will be crucial to the success of ACOs as they make the journey away from fee-for-service payment toward population health.⁶

Population Health

One of the most commonly used terms in health care today is population health. In 2003, Kindig and Stoddart defined it as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.⁷ Population health has gained traction since the ACA spurred the creation of new payment models. Many organizations are obtaining better analytic tools to manage their patients across the continuum of care – from the patient's home to hospital, outpatient, nursing home, skilled nursing, or hospice settings. Although analytic tools are essential

for any organization creating a population health model, the real key to success is a well-defined strategic plan around population health. This entails performing an assessment to evaluate the organization's readiness:

- Defining what population health means to the organization.
- Listing the organization's short- and long-term goals.
- Evaluating the organization's leadership structure (including physician leadership).
- Understanding the organization's processes for clinical integration and care coordination of inpatient and outpatient services.
- Understanding the information technology capabilities and deficiencies within the organization.

Conclusion

Health analytics will continue to be the engine that drives informed decisions with data. In the future, predictive analytics will be the new "norm" in every aspect of health care. These sophisticated tools will use data from various sources to make real time predictions that will help better manage patients who are at risk for chronic diseases, hospital admissions or readmissions to the hospital - all events that consume excessive resources and generate high costs in health care today. Most importantly, predictive analytics will help us understand and address some of the disparities of care related to socioeconomic factors.⁸

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