

A close-up photograph of a hand holding a bright green apple. The apple is the central focus, with its stem visible at the top. The hand is positioned behind the apple, with fingers visible on the left and right sides. The background is a soft, out-of-focus white.

Primary Care in an Era of Health Care Reform

*Strategies for Reorienting the
Health Care Delivery System
Toward Primary Care*





The passage of the Affordable Care Act (ACA) confirmed what many health care providers, practitioners, payors, legislators, and academics have long believed — that reorienting the health care delivery system toward primary care is the best approach for making health care affordable and accessible for all Americans, while slowing down the rapid and unsustainable rise in health care expenditures. Primary care physicians (PCPs) are in the best position to expand access to appropriately coordinated health care, particularly health promotion/wellness; prevent and manage hospital admissions; and minimize unnecessary hospitalizations and readmissions. Primary care can also serve as the centerpiece for management of chronic health conditions that account for more than 95 cents of every Medicare dollar and 83 cents of every Medicaid dollar.¹

For health care organizations, the path forward in a post-reform environment is now much clearer. As PCPs assume a new role as care managers, rather than simply care providers, a robust primary care foundation is key to successful positioning and performance. Evidence of what the primary care foundation will look like under health care reform can be previewed in the patient-centered medical homes, which are moving toward payment for quality and outcomes, and accountable care organizations (ACOs), which are serving as risk-bearing provider organizations.

“Health reform in the absence of strengthening the primary care base is not likely to succeed. When people have access to primary care, health care costs are lower, health status is better and health disparities are fewer.”

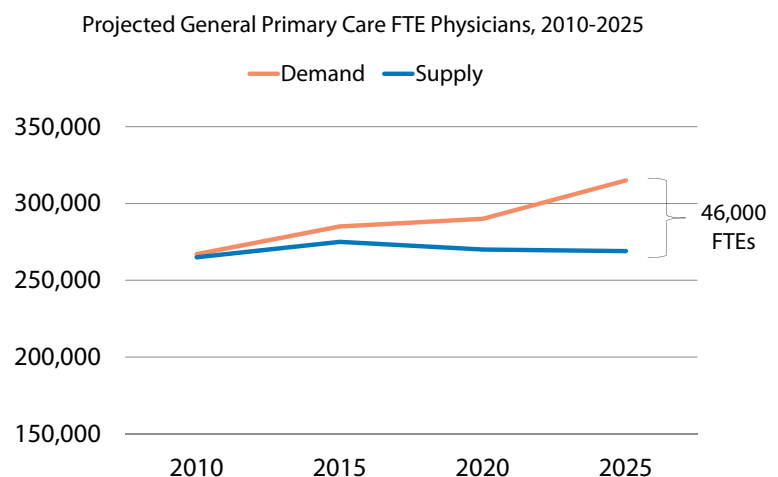
- Dr. Allan H. Goroll,
professor of medicine,
Harvard Medical School
Boston, Massachusetts

Who Will Provide Primary Care to Meet the Growing Demand?

One of the pivotal challenges in creating the necessary primary care infrastructure is determining who will provide the care within the centerpiece of the new patient care delivery system. Even before passage of the ACA, the Association of American Medical Colleges (AAMC) estimated that an additional 46,000 PCPs would be needed by 2020 to keep up with demand, as noted in Exhibit 1.² Add to the equation the roughly 36 million additional individuals expected to be covered under the ACA and that research suggests that all things being equal, insured patients consume twice as much medical care as uninsured patients, and the full depth and breadth of the PCP shortage is apparent.

A portion of the increased demand can be offset by improved attention to prevention, management of chronic diseases, and alternative approaches to care delivery, including use of advanced practice clinicians or new models and approaches for care (e.g., group visits, team visits, e-visits, telemedicine visits), but these approaches alone will be insufficient to keep up with increased demand. Innovative models of care, particularly ones that leverage physician resources by using new approaches for care management, focus on health promotion/wellness and patient empowerment, and optimize the use of advanced practice clinicians are imperative.

Exhibit 1 Projected Primary Care Shortage



Note: General PCPs include internal medicine, family practice, and general pediatricians; FTE refers to full-time equivalent.
Source: American Association of Medical Colleges, 2008.

Exhibit 2 Traditional Role of the PCP versus Future Role

Other market dynamics, including a rapidly evolving commercial payor environment, along with the physician shortage, leave health care organizations with the daunting challenge of building a robust primary care foundation under difficult circumstances. The challenge for health care organizations is twofold: increase the base of primary care providers aligned with a hospital or health care delivery system and support the evolving role of PCPs from caregivers to care coordinators and managers with new multifaceted responsibilities as illustrated in Exhibit 2.

Traditional Role		Future Role
Care provider	➡	Care coordinator
Episodic care	➡	Health and wellness across care continuum
Treatment	➡	Treatment and prevention
Supervising staff	➡	Managing a team
Individual practitioner	➡	Team-based patient care
Face-to-face patient care	➡	Group visits, telemedicine, and e-visits
Managed care interaction and contract negotiation	➡	Provider – payor partnering
Payment for service	➡	Payment for performance
Production	➡	Accountable for quality and outcomes
Patient treatment	➡	Patient empowerment

Source: Health Strategies & Solutions, Inc., 2012.

Benchmarking the Transition

In 2011, Health Strategies & Solutions, Inc. (HS&S), researched primary care to examine the implications of reorienting the health care delivery system toward primary care and gain a better understanding of how health care organizations should approach this transition in their markets. Our research, including interviews with industry thought leaders and innovators at hospitals and systems, led to the identification of six imperatives that health care executives must address as they plan and develop their primary care infrastructure and strategy.

These imperatives were researched by HS&S to understand their influence on primary care delivery and identify approaches health care organizations should use to be successful at delivering primary care services to their communities.

The six primary care imperatives are:

1. Managing risk payments

2. Achieving performance improvement and financial viability for employed PCPs
3. Determining primary care network size, mix, and geographic distribution
4. Implementing primary care recruitment and retention strategies in highly competitive markets
5. Reorganizing primary care delivery models to manage care
6. Selecting PCP-hospital alignment models and approaches

Descriptions of the six imperatives, successful approaches for managing them, and short- and long-term initiatives that health care leaders should consider as they plan their organization's primary care strategy for the next three to five years are presented in the remainder of this report.

Imperative #1: Managing Risk Payments



In 2008, the Medicare Payment Advisory Commission (MedPAC) presented a *Report to Congress* that set the tone for payment reform. MedPAC recommended replacement of the current Medicare fee-for-service (FFS) system with one that would achieve the goals of medical homes, bundled payments, and ACOs. This redirection toward value and integration would maximize tools such as pay for performance and resource management.

With these payment reform initiatives in mind, physicians and health care systems are now charged with forming partnerships and working collaboratively to address quality and efficiency concerns to avoid being penalized. Ultimately, this market shift will require health care organizations to improve cost management and focus on outcomes to receive higher reimbursement, otherwise, both providers and health systems are likely to be at risk for penalties.

Changes in payment methods are a critical component of health care reform at the federal, state, and regional level to ensure the shift of the payment curve from FFS to provider accountability for the full continuum of patient care. While many health care organizations have explored the ACO concept in preparation to apply for the Medicare Shared Savings Program, more health care organizations have pursued other payment approaches that leapfrog future Medicare payment systems. These innovative payment approaches involve commercial payors and state-funded Medicaid. Some markets are far ahead; in Boston, of the three most prevalent commercial payors, two are currently using global risk with providers, and the third is moving to global risk. Southern California and other select markets also have a large portion of the population included in global risk payment.

PCPs, with the support of their practice or hospital employer, must be prepared to invest in sufficient infrastructure beyond information technology to develop and implement improvements and greater care coordination, according to the American Hospital Association (AHA). Both health care organizations and affiliated physicians stand to benefit from the efficiencies achieved by increasing clinical integration, particularly with the physicians on their medical staff or those they have aligned with in the community. Nevertheless, joint physician-hospital leadership will be required to address organizational and cultural changes and gain support from payors to achieve full clinical integration and be well prepared for health care reform.

The Four Stages of Development

There are four major stages of development affecting payment to primary care providers. As payment systems evolve, physicians are paid for:

- Stage I: Performance/Quality
- Stage II: Outcomes
- Stage III: Care Coordination Per Member Per Month
- Stage IV: Global Risk and Bundled Payments

Historically, the base of a PCP's compensation is relatively fixed. As the responsibility for care management increases, the portion at risk increases and evolves to reflect increasing accountability for care, not just simply providing care.

Stage I: Performance/Quality

FFS or pay for production is the predominant payment approach in the United States. In more evolved markets, pay-for-performance systems apply a bonus beyond the base payments for FFS utilization, with bonuses typically in the range of five to 10 percent plus of the base amount. The bonus is primarily earned for quality performance. Pay-for-performance programs were developed principally by health plans to address the poor quality of health care provided in the United States as documented in the 1999 Institute of Medicine's report *To Err is Human: Building a Safer Health System*. In the last few years, more than half of commercial payors used pay-for-performance systems, and new health care legislation will require the Centers for Medicare & Medicaid Services (CMS) to adopt this approach for Medicare.

The American Academy of Family Physicians supports pay-for-performance programs that adhere to these principles:³

- Focus on improved quality of care
- Support the physician/patient relationship
- Utilize performance measures based on evidence-based clinical guidelines
- Involve practicing physicians in program design
- Use reliable, accurate, and scientifically valid data
- Provide positive physician incentives
- Offer participation to voluntary physicians

Imperative #1: Managing Risk Payments

Stage II: Outcomes

A more advanced payment method for PCPs is to pay for outcomes. With this approach, the majority of physician compensation continues to be derived from FFS payments. Modest additional bonuses are paid to PCPs for quality and outcomes performance.

Geisinger Health Plan initiated a pay-for-performance program in 2005 and has demonstrated significant positive outcomes. With a Physician Quality Summary (PQS) program as its centerpiece, Geisinger Health Plan posts performance results of participating PCPs on their public website and offers financial incentives to those receiving high marks. Physicians are rated on a three-star scale based on a composite score of clinical quality, service, and resource utilization metrics; one star is equivalent to a score that is equal to Geisinger's basic standards whereas a three-star level is equivalent to significantly exceeding the basic standards. Overall success of the program is determined by the percent of the plan's total membership that is cared for by high-performing PCPs as determined by their star rating. High-performing groups can earn a reward of up to \$4 per member per month based on their scores on patient and population level metrics, as well as efficiency metrics compared to their peer group. From 2005 to 2008, the percentage of patients cared for by high-performing PCPs rose from 22 to 55 percent, with physician performance, website transparency, and increased consumer responsibility cited as the sources for this jump in improvement. A slight improvement in generic drug utilization and emergency department use rates was demonstrated as well.⁴

In 2010, Pennsylvania-based Independence Blue Cross (IBX) announced a shift toward pay for outcomes to incentivize primary care doctors and encourage increased utilization of preventive services. Projected to spend an extra \$47 million a year, IBX will increase base pay by an average of 10 percent for in-network services and double incentive programs that are already in place to encourage primary care doctors to deliver higher quality and less costly care. Ultimately, a doctor with 850 Keystone HMO patients could earn up to \$150,000 more a year.⁵

Stage III: Care Coordination Per Member Per Month

In more advanced markets, PCP compensation is at risk as care management becomes a greater role for the physician. This entails payment for care management that would not be paid under a FFS model. The management fee (typically fixed per member per month) is intended to pay PCPs for the facilitation and coordination of primary care, as well as any

infrastructure investments needed to execute this role (e.g., information systems, staff training). Reimbursement for care coordination is commonly used within the patient-centered medical home model. This concept is still evolving, but its goal is to have patients see their PCP to meet their urgent and immediate care needs, as well as wellness and chronic care needs. Productivity-based compensation systems ensure that PCPs and physician extenders are rewarded for their shift in roles as care coordinators and managers.

Unlike Stage II, payments for care coordination and quality/outcomes performance represent a far greater component of compensation. Adirondack Health Institute (AHI), headquartered in the North Country in New York State, is in its fourth year of operation as a medical home pilot. AHI consists of more than 70 physicians in over 30 practices, (and two hospital partners) who have negotiated an innovative payment approach with commercial payors and New York State Medicaid. AHI providers receive payments for care coordination, as a per member per month payment, and are currently quantifying the savings accrued from three categories: decreased preventable hospital readmissions, reduced emergency department utilization, and decreased pharmaceutical costs. These savings are within the context of quality performance in accordance with the National Committee for Quality Assurance guidelines.

Research shows that medical homes can lead to higher quality and lower costs, and improve patients' and providers' reported experiences of care. Emerging evidence of success with the medical home model is shown in Exhibit 3.

Stage IV: Global Risk and Bundled Payments

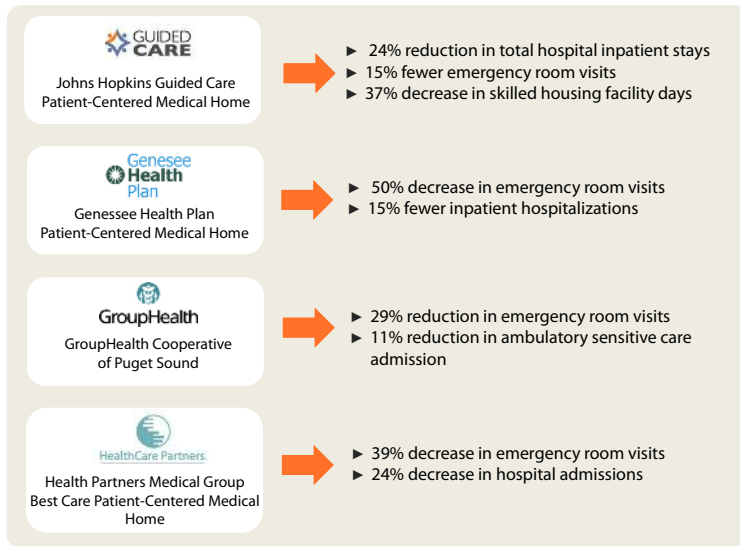
The FFS payment system is credited with contributing to the lack of care coordination across providers and patient care settings, and incentivizing provision of services irrespective of the relative value gained in terms of health benefits. One alternative payment method is capitation where an entity receives a fixed payment to provide an individual's care over a defined time period (e.g., per member per month); however, three key concerns about this approach exist:

1. The incentive to provide fewer services than needed
2. Disparities in cost across varying levels of illness
3. A lack of initiative for long-term change when enrollees can switch health care plans on an annual basis

Capitation is essentially a model to divide fixed payments to providers; thus, it addresses cost allocation, predominantly, but poses other challenges.



Exhibit 3 Demonstrated Outcomes of Medical Homes



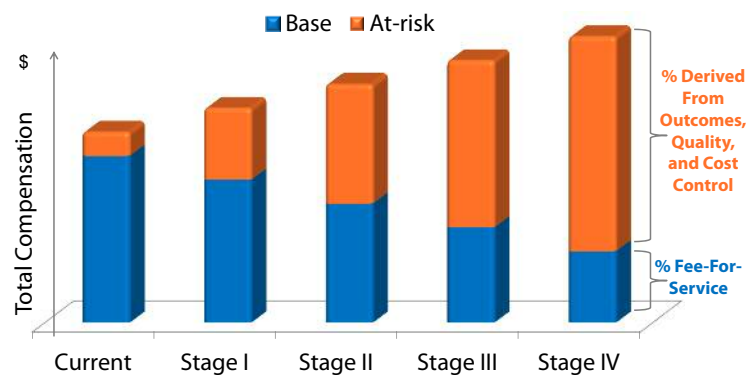
Source: *The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access, and Costs from Recent Prospective Evaluation Studies*. Updated November 16, 2011.

In comparison, bundled payments or global risk, reimburse providers on the basis of expected costs for episodes of care, typically defined on the basis of select conditions or major procedures, and are termed as such because multiple provider payments are combined into a single payment or are bundled.⁶ Costs for both the payor and the providers are fixed in the aggregate, but incentives and requirements are built into the model for achievement of quality and outcome metrics. Bundled payments may also be adjusted for severity of illness and performance on quality outcomes, with providers assuming financial risk for the cost of services for a particular treatment or condition, as well as those associated with preventable complications. In theory, a provider should be incentivized to reduce unnecessary treatments. Furthermore, providers with higher costs would be penalized financially while providers with lower costs would profit.

With global risk, the role of payors evolves from enrolling patients and determining the terms and amount of payment for each unit of service into one of providing data and analytics, selling/negotiating with enrollees, providing downside and catastrophic risk protection, and other traditional insurance company roles. PCPs are better positioned under global risk and bundled payments because they have more experience than their peers in assuming risk, dealing with accountability, and managing outcomes.

As shown in Exhibit 4, under the four stages of payment development, the portion of compensation derived from FFS will decline as the portion from achieving profit, outcome, and cost control targets increase.

Exhibit 4 Physician Compensation Under the Four Stages of Payment Development



Source: Health Strategies & Solutions, Inc., 2012.

Short-Term Initiatives for Managing Risk Payments

- Partner with payors to assume more accountability for quality and outcomes so that PCP compensation increases by 20 to 30 percent or more
- Implement new care delivery models (see Exhibit 13) to be organized to assume risk for quality and outcomes
- Consider alternative alignment models if not using employment to align with PCPs (see Exhibit 15); for example, recruitment assistance, professional services agreements, and co-management agreements
- Incorporate an integrated electronic health record to facilitate coordinated care
- Use evidence-based clinical protocols/pathways for highest utilization patient conditions

Long-Term Initiatives for Managing Risk Payments

- Become the hub for global risk payments with commercial payors
- Structure payor contracts as value based (quality and cost)

Imperative #2: Achieving Performance Improvement and Financial Viability for Employed PCPs

According to the Medical Group Management Association's (MGMA) Physician and Compensation Surveys, approximately 60 percent of PCPs were employed by hospitals in 2010, an increase of 10 percentage points since 2007.⁷ Yet the economic model of PCP employment is often unsustainable. Current practice subsidies for employed PCPs are substantial, averaging \$150,000 per physician per year according to MGMA's 2009 data. For health care organizations with 100 or more employed physicians, subsidies can reach upwards of \$15 million annually, which is untenable for most organizations over the long term, particularly in light of declining reimbursement. Even networks considered advanced in managing practice subsidies typically experience modest losses that range between \$30,000 and \$50,000 per employed PCP per year.

With physician employment on the rise once again, as noted in Exhibit 5, opportunities to improve financial performance to tolerable levels and establish compensation models that contribute to sustainable financial performance must be identified and pursued. As budgets continue to be constrained, learning how to employ physicians at lower subsidy levels is a necessity, and improving physician performance is key to reducing the financial drain.

Exhibit 5 Physician Employment On The Rise

Data Year	Hospital-Owned PCPs	Not Hospital-Owned PCPs	Total	% Employed
2007	6,775	6,791	13,566	50%
2008	5,266	4,449	9,715	54%
2009	6,660	5,431	12,091	55%
2010	7,164	4,787	11,951	60%

Note: PCPs include physicians who identified their specialties as general internal medicine, family practice without obstetrics, and general pediatrics; totals vary due to changes in sample size and revised survey completion process. Source: MGMA Physician Compensation and Production Survey, 2008-2011.

Start-up costs, amortized acquisition costs, contractual agreements, long-term leases, and practices in locations to meet charitable mission commitments fall into the category of unavoidable expenses. But there are employed PCP inefficiencies that can be eliminated or mitigated, such as compensation higher than production levels, ineffective accounts receivable and revenue cycle management, excessive bad debt, burdensome overhead allocation, and excess practice staff — all of which can be addressed by performance improvement and the following high-return initiatives.

- **Revised compensation plans.** Critically evaluate compensation plans to ensure that productivity, quality, and satisfaction measures are incenting physicians to work as efficiently as possible. As payment to primary care physicians evolves from predominantly FFS to pay for quality and outcomes, bonus and risk pools should be based increasingly on metrics for achievement in these newly important categories.
- **Revenue capture.** Explore adding new revenue streams by expanding service offerings and improve billing and collections practices. Examples include encouraging same-day entry and coding. Another high return approach is to use the bargaining power of a large network of PCPs to negotiate favorable reimbursement rates with payors. New revenue streams could also include ancillary services to benefit the practice's financial performance, and subsequent compensation for physicians.
- **Practice promotion.** Look into multifaceted promotion of any PCP practice through direct mailings, Internet advertisements, event promotion to generate practice site traffic, and relationship building. Practice promotion should be directed toward practices that are new, not meeting productivity benchmarks, or have unmet capacity.
- **Revised medical practice delivery models.** Use advanced practice clinicians to better leverage physician time and decompress physician time so that physicians can handle the more complex, acute patients; advanced practice clinicians can handle patient callbacks and walk-in visits, as well as (in many states) their own patient panel. Other examples include group medical visits for chronic disease patients, and care provider teams, where patient educators, pharmacists, social workers, behavioral health professionals, physician assistants, nurse practitioners, and/or nurse midwives complement the PCP to manage and coordinate care.
- **Operations improvement.** Evaluate patient flow and practice efficiencies such as appointment scheduling, access to physicians, and pharmacy utilization. Improving practice efficiencies will increase productivity among all caregivers.



In reviewing practice performance, performance targets must be evaluated and benchmarked against desired targets. Benchmarks can include productivity (e.g., visits, relative value units), quality, financial (e.g., outstanding accounts receivable, clinical and clerical staffing per physician), and satisfaction (both physician and patient) measures, and should be adjusted to reflect part-time providers, mid-level providers, and the specialty-specific provider mix at individual locations. Benchmarks for private practice physicians should be used as targets, since hospital-owned practices are not the performance level to aspire toward.

"A cornerstone of our employed network performance improvement effort is to reward not just productivity, but (increasingly) effectiveness. This includes four to five dollars per member per month for every PCP in our medical home initiative, but also significant rewards for achievement of quality metrics."

- Will Groneman, executive vice president of system development
TriHealth
Cincinnati, Ohio

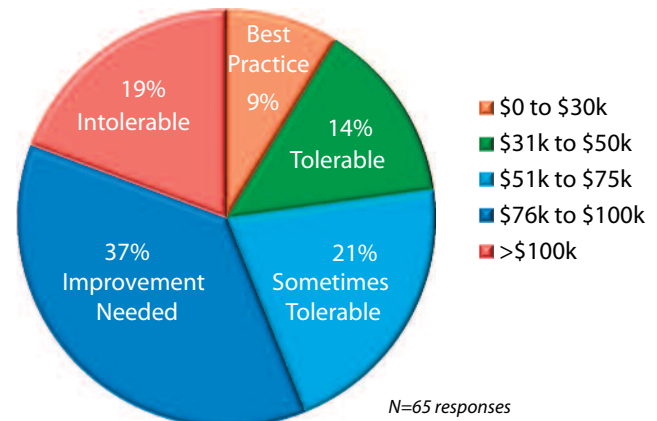
Compensation Models

Health care organizations and physician practices often struggle with providing physicians an attractive compensation plan that avoids excessive subsidies while incenting appropriate levels of productivity and quality performance. Concerns about the quality of patient care, patient and physician satisfaction, and physician productivity can be addressed by instituting compensation components that ensure results.

Improvements to performance and subsequent reduction in subsidies are most often achieved through restructuring the compensation methodology. Organizations that are aggressive in monitoring performance and have proactively managed compensation approaches have achieved subsidy levels of \$30,000 to \$50,000 per physician.

Exhibit 6 shows responses from HS&S' 2010/2011 survey of select health care organizations throughout the United States that actively employ physicians. Of note, 56 percent of physicians require subsidies greater than \$76,000.

Exhibit 6
Annual Subsidy Per Employed Physician



Source: Health Strategies & Solutions, Inc. Survey of health care providers, 2010-2011.

The study also identified that the preferred compensation model among respondents was productivity based and the favored methodology was \$/work relative value unit (WRVU). Of the respondents using productivity-based compensation, fewer than one-third are currently using percent of collections as the basis for establishing compensation.

In the survey results, a minority of respondents report that rewards for quality are key. Only 34 percent of organizations polled in the survey incorporate rewards for quality performance, although this is a much higher percentage than evident a decade ago. Rewards for quality are expected to increase significantly as payors shift to risk-based payment based on the achievement of performance targets. Commercial payors, however, are moving toward rewarding high quality and favorable outcomes.

"We use a number of innovative practice delivery models to achieve quality and outcome targets since we receive PMPM payments from our health plan for our medical home model. As a result our panel sizes are larger, due to group visits, e-visits, telephone visits, extenders, care managers, and patient care coordinators."

Darcie Robran-Marquez, M.D.,
Presbyterian Health System
Albuquerque, New Mexico

More mature and advanced networks tend to use percent of collections as base compensation, rather than the \$/WRVU model, supplemented by bonuses for quality or a percentage (minimum 10 percent, but often as high as 30 percent or more)

Imperative #2: Achieving Performance Improvement and Financial Viability for Employed PCPs

withheld for quality and citizenship incentives. Lack of infrastructure (staffing and information systems), business systems (revenue capture and expense controls), and confidence in the revenue cycle performance of health care organizations are often cited as the reasons that more networks are not using the percent of collections methodology.

Employed groups that have not yet moved toward a percent of collections methodology with a certain portion withheld for quality incentives should consider moving in that direction because clinicians are increasingly responsible for elements of revenue cycle (e.g., claims submission, coding). The percent of collections approach will also position networks well for the future payor and compensation environment that will shift away from payment and compensation for production to payment and compensation for quality, outcomes, and utilization.

Additional components can be factored into designing compensation plans such as patient satisfaction scores, access, and citizenship. Citizenship includes meeting attendance, maintaining credentials, chart completion, peer review participation, continuing medical education, committee participation, and educational presentations among others. Incorporating an expense management incentive component may also be considered in the compensation plan.

Short-Term Initiatives for Achieving Performance Improvement and Financial Viability for Employed PCPs

- Place a greater portion of PCP compensation at risk (greater than the percentage currently being paid as bonuses by payors) to be earned by increased productivity and improved quality of care, outcomes, patient satisfaction, and cost control
- Identify and quantify high-return performance improvement initiatives such as revised compensation plans, practice promotion and marketing, and innovative models of care management

Long-Term Initiative for Achieving Performance Improvement and Financial Viability for Employed PCPs

- In advanced markets, base physician compensation on care management for a reasonably sized patient panel (e.g., 1,500 to 2,000 patients) with rewards/bonuses for achievement of quality and outcomes targets and contribution/influence on cost of care provided in other components in the health care delivery system

Health First Physicians Inc. (HFPI) Florida's Space Coast

When formed, HFPI, in Florida's Space Coast region, had approximately 20 employed physicians (mostly primary care) and was losing more than \$150,000 per FTE employed physician. An analysis revealed that the HFPI's compensation structure was not commensurate with productivity. Additional review of HFPI overall revealed:

- Siloed practices failing to leverage the benefits of group practice
- Insufficient corporate practice support
- Subpar billing and collection performance
- Inadequate bonus structure that prevented Health First Physicians from recouping losses

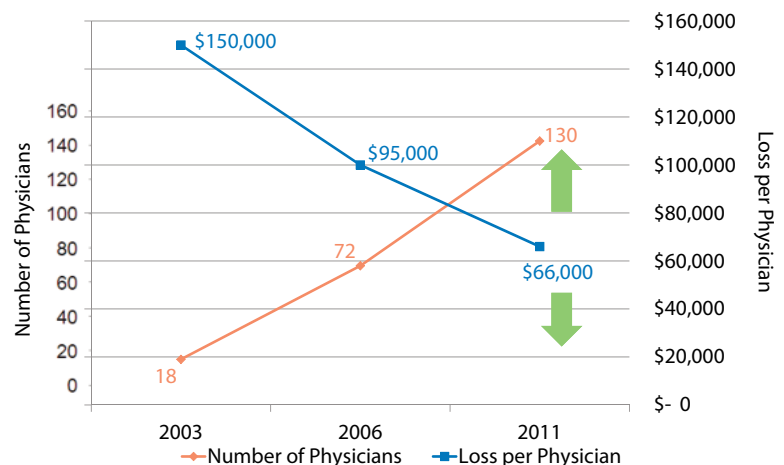
HFPI proceeded to implement an aggressive performance improvement plan including:

- Revising the incentive compensation structure to better align production with compensation
- Further evaluating underperforming practices with placing practices on probation or divestiture available as options
- Improving revenue cycle performance (e.g., fee schedule, billing and collections, coding)
- Establishing accountability for performance on an ongoing fashion (e.g., at least monthly reporting).

These initiatives enabled HFPI to reduce its subsidies by nearly \$100,000 per physician, while growing the network to more than 100 physicians, as illustrated in Exhibit 7 below.

Exhibit 7

Performance Improvement at HFPI: Before and After



Source: Health First Physicians, Inc., 2003, 2006, 2011.

Imperative #3: Determining Primary Care Network Size, Mix, and Geographic Distribution

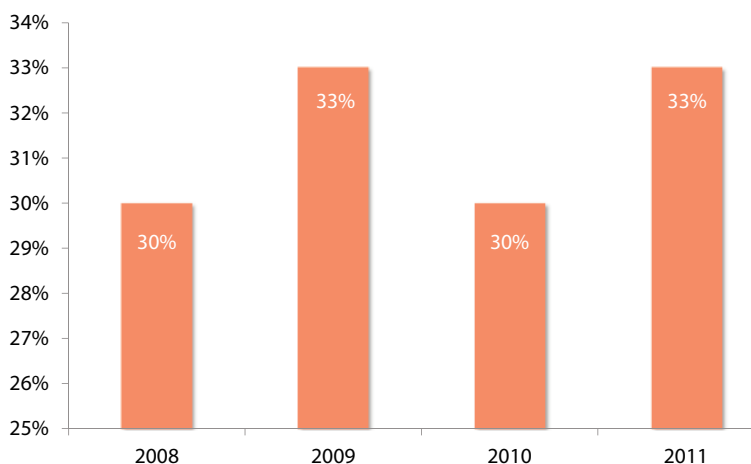


As health care organizations look to the future, several of the paramount questions will be how many primary care providers do you need, what is the right mix, and what is the appropriate geographic distribution?

Need for PCPs

Today approximately 34 percent of physicians are PCPs (i.e., internal medicine, family practice, general pediatrics⁸); in 2010, the Council on Graduate Medical Education recommended that policies be implemented so that 40 to 42 percent of physicians choose primary care as a specialty by 2014. As illustrated in Exhibit 8, the pipeline for new primary care physicians looks grim. In 2011, 33 percent of medical students expressed an interest in going into a generalist specialty — defined as family medicine, general internal medicine, and general pediatrics — up from 30 percent in 2010. The trends are generally favorable particularly compared to the interest levels 10 years ago; however, more progress is needed, as shown in Exhibit 9, since in 1997, 40 percent of students expressed an interest in generalist careers.⁹

Exhibit 8 Interest in Generalist Careers has Fluctuated and Increased

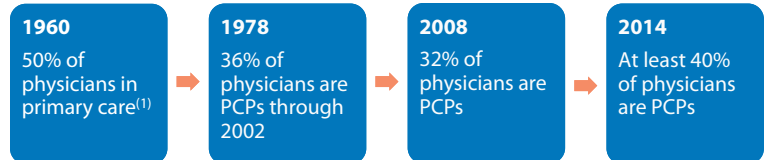


Note: Generalist careers include family medicine, general internal medicine, and general pediatrics.
Source: AAMC Graduation Questionnaire, 2011.

Many factors are contributing to the increased need for PCPs, including, but not limited to:

- Overall population growth and aging (the most significant influence)
- The aging physician workforce, particularly in primary care
- The requirement for the uninsured and underinsured populations to receive safety net coverage under health care reform

Exhibit 9 Past, Present, and Future Recommended Supply of PCPs



(1) Primary care includes general practice, family practice, general internists, and general pediatricians.
Source: COGME 20th Report: Advancing Primary Care, January 2011.

- New models of care delivery in which providers are responsible for care management, health promotion, and population health management, thus reducing the manageable practice panel size and increasing the need for PCPs per capita
- Overall cost of health care and an interest in the role of PCPs in reducing overall costs

New medical schools are opening and existing medical schools are expanding to help increase the pipeline for future PCPs. Unfortunately, a minority (based on the medical student questionnaire) still express an interest in becoming PCPs. In addition to the probable capacity constraint based on the likelihood of students pursuing primary care careers, the number of Medicare funded primary care residency programs and slots represent a significant capacity constraint that cannot be offset by increasing PCP compensation, elevating the status of PCPs, or other initiatives.

Conversely, several factors are contributing to a decreased need for PCPs, but not to the extent that the shortage of primary care physicians will be mitigated. These factors include:

- Better management of chronic diseases
- Increased use of telemedicine and group visits
- Greater use of advanced practice clinicians and caregivers, as well as patient care coordinators
- Health promotion and wellness initiatives, which can help prevent the need for patients to access physicians
- Patient empowerment



Imperative #3: Determining Primary Care Network Size, Mix, and Geographic Distribution

The Changing Number, Role, and Mix

As PCPs change their role from being caregivers to care managers and coordinators, one goal will be for PCPs and their care management team members to manage larger panel sizes. To achieve this change, a different number and mix of primary care providers will be needed. Other health care practitioners, including nurse practitioners, physician assistants, patient educators, care coordinators, pharmacy technicians, educators, social workers, and others will play a more prominent role to ease the increased demands and time constraints of physicians.

An adequately sized and geographically distributed network of PCPs, nurse practitioners, physician assistants, and other professionals will be an essential component of any health care delivery system. The number of PCPs needed within a geographic region or ACO is best determined using physician-to-population ratios, meaning the number of adult PCPs and general pediatricians needed per 100,000 resident population or 100,000 covered lives.

The number of PCPs needed per 100,000 population currently ranges from 60 to 80, but variables such as geography, practice patterns, and local/regional preferences must be considered. With increased reliance on PCPs as central elements of health care delivery, a 20 percent increase in need for PCPs per 100,000 population is likely to be experienced in many markets.

The need for advanced practice clinicians will also increase in the new care models. One advanced practice clinician for every two to three primary care providers will be required to help PCPs manage the larger care panels and fulfill roles as care managers versus care providers.

Appropriately sized networks will demonstrate standards for accessibility including:

- Ten to 15 minutes (urban/suburban) or 20 to 25 minutes (rural) from a PCP practice

- Routine appointments scheduled within two weeks
- Three to five practitioners per practice to be of sufficient critical mass to enable access

Short-Term Initiatives for Determining Primary Care Network Size, Mix, and Geographic Distribution

- Determine what an adequately sized and geographically distributed network of PCPs and other professionals would be for your service area
- Ensure access standards are being met

Long-Term Initiatives for Determining Primary Care Network Size, Mix, and Geographic Distribution

- Create teams of care managers who are accessible in conveniently located pods/sites throughout the service area
- Begin exploring alternative care delivery models (see Imperative #5: Reorganizing Primary Care Delivery Models to Manage Care)

Imperative #4: Implementing Primary Care Recruitment and Retention Strategies in Highly Competitive Markets



With the demand for future primary care practitioners outstripping supply, recruitment and retention will increase in difficulty and competitiveness as the arms race to build a strong primary care foundation intensifies. Recruitment strategies and approaches must be tailored to candidates and their families, relying on focused and personalized tactics at early stages of the resident's, fellow's, or medical student's career. Health care organization leaders and members of a medical staff must establish connections with future physicians early and often, using various formal and informal approaches that distinguish themselves from the competition since, on average, third-year primary care residents are exposed to over 300 job opportunities.

To help lessen the need to recruit additional physicians, retention of high-caliber physicians is paramount. For health care organizations, proven retention approaches are to provide high-quality and efficient services across the continuum of inpatient, outpatient, and ancillary care so that physician practices are supported. A hospitalist service, high-quality and responsive specialists, market competitive compensation, minimal on-call responsibility, ample time off, practice environments with innovative practice models, inclusion in decision making, and a quality image of the aligned hospital and practices in the market are also key components of physician retention.

Case Study: Lancaster General Hospital (LGH) Lancaster, Pennsylvania

At LGH in Lancaster, Pennsylvania, innovative approaches are used to recruit physicians in a competitive marketplace. A physician recruitment and retention committee including physician executive leaders, key staff, medical staff president, LGH board members, and community leaders, including the president of the Lancaster Chamber of Commerce, has oversight and advisory responsibility.

Three in-house recruiters, including a manager, rarely rely on national recruitment firms because they are less attuned to appropriate candidate fit to the local community and medical staff. While recruiters spend the majority of their time working on filling PCP, specialist, and non-physician clinician positions, they do provide assistance to non-employed practices within acceptable guidelines.

Recruiters attend a variety of national conferences and fairs to generate contacts and leads. Once a prospect is identified, the recruiters, hospital leaders, physician relations staff, and medical office staff participate. The recruitment team recruited 15 physicians and four advanced practice clinicians for the employed physician group and five independent, hospital-based specialists for the hospital in 2011.

LGH uses a number of approaches to foster retention of physicians currently on the active medical staff. As physician leadership articulates, "it is easier to retain our current active staff than spend inordinate resources recruiting new physicians." Examples include:

Leadership education. LGH sponsors a Physician Leadership Academy (PLA), a year-long educational program to groom physicians for leadership positions within the LGH organization. The PLA meets monthly and provides outside speakers on

topics relevant for future decision-making roles. Example topics include health care economics, quality metrics and processes, and reading financial statements. LGH leadership believes that by exposing physician leaders to these topics, physicians will be well informed and able to join in dialogue about emerging issues. Physicians earn continuing education credits for participating and graduate at the end of the year. The program has become so popular that physicians must now apply and write essays as part of the application process.

The chief executive officer roundtable. Formal and informal physician leaders are invited to a monthly discussion session where an agenda of pertinent topics affecting physicians are discussed. The LGH CEO solicits ideas and suggestions for addressing relevant issues. Example topics include payor contract negotiation, affiliations and mergers, and clinical integration. Preparatory articles are sent to attendees by the LGH chief medical officer to help frame and set the tone and level of discussion.

Physician retreat. An all physician retreat is held annually to discuss key strategic issues and gain broad-based input on these issues. For example, one retreat focused on physician integration, and the topics included guidelines for integration, the selection of formal economic models for integration, and development of evaluation criteria for specific opportunities.

Other ways that LGH builds the connection to physicians include:

- A website for physician-focused information
- Monthly newsletter
- Periodic social networking events
- A first-year anniversary dinner
- Golf tournament

Case Study: Hoag Memorial Hospital Presbyterian Newport Beach, California

The president and chief executive officer at Hoag Memorial Hospital has developed an informal kitchen cabinet of physicians that discusses strategic needs and opportunities and options for best meeting those needs and leveraging opportunities. When the hospital's potential development of urgent care centers stirred up physician concern about competitive threats, the kitchen cabinet met to

clear the air and promote dialogue. Determining that urgent care centers were a good strategy for access into Hoag and a continuum of care tool, a primary care institute was developed for oversight of care and referrals. The medical staff is now comfortable with the hospital's urgent care strategy. "Without the direction of the kitchen cabinet and ownership of the process and results, this would have been a fight with the medical staff," reports Richard Afable, M.D., president and chief executive officer.

Imperative #4: Implementing Primary Care Recruitment and Retention Strategies in Highly Competitive Markets

Cultural Compatibility

One of the essential elements of recruitment and retention is to find and retain PCPs who are culturally compatible with a practice or network of hospital-employed physicians. Criteria that assess cultural fit vary, but examples include:

- Embraces clinical integration and patient information integration
- Exhibits team player characteristics
- Has clinical quality at least equivalent to peers
- Is willing to assume compensation risk for productivity and for quality/outcomes/utilization performance

Exhibit 10 presents examples of effective interviewing and hiring techniques. Exhibit 11 presents example selection criteria that may be used when evaluating candidates.

"We place a major emphasis on cultural compatibility. Not only do we use explicit selection criteria, but also I, as president and chief medical officer of our employed physician network, conduct all of the initial recruitment screening interviews for potential new physician hires."

- William T. Morgan, M.D., president
Health First Physicians Medical Group
Rockledge, Florida

Short-Term Initiatives for Implementing Primary Care Recruitment and Retention Strategies in Highly Competitive Markets

- Develop selection criteria to assess and determine cultural compatibility
- Ensure that interviewing and hiring techniques are carefully vetted and tailored to your organization's unique situation
- Create multiple forums and avenues for physicians to learn about emerging issues and their impact on providers; involve physicians in key decision-making discussions

Long-Term Initiatives for Implementing Primary Care Recruitment and Retention Strategies in Highly Competitive Markets

- Create a recruitment culture that is based on recruitment successes and establishes strong personal connections to future physicians
- Foster a connection to the future direction of the health care organization and its services development through physician leadership engagement

Exhibit 10

Example Techniques for Assessing Cultural Fit

Use effective interviewing and hiring techniques

Use a cross-functional team of physicians trained in behavioral interviewing

Ask standard questions to determine fit with the quality, patient, and behavior norms of the organization

Focus on the candidate's ability to work on a high-performing team, respectfully disagree with a colleague, and provide outstanding patient care

Be realistic about job setting, what the physician will be doing, level of control over the work environment, and available support

Hire physicians with values that are compatible with the organization's stated values

Source: Health First Physicians, Inc., 2011.

Exhibit 11

Example Selection Criteria for PCPs

Perspective

- ▶ Does the candidate understand the clinical, political, and scientific aspects of the organization?
- ▶ Does the candidate value the financial goals of the institution?

Technical

- ▶ Can the candidate evaluate clinical methods to focus on quality improvement or invent new methods?
- ▶ Is the candidate a good presenter or writer who can present quality and credible work?

Human Skills

- ▶ Will the candidate garner respect from colleagues and work as a team player?
- ▶ Does the candidate work to improve patient satisfaction and patient outcomes?

Source: Employees Should "Fit In" Firms As Well As Have The Right Skills, Cejka Search, 2010.

Imperative #5: Reorganizing Primary Care Delivery Models to Manage Care



Primary care delivery models must be restructured to help PCPs fulfill their new roles as care managers. As illustrated in Exhibits 12 and 13, PCPs are moving into a position of care management and coordination, in addition to care delivery, placing them in the hub of practice delivery models. Team care, medical homes, telemedicine, and other new models and approaches will help coordinate the continuum of care for a defined patient population.

The reorganization of health care delivery entails clinical integration as a fundamental platform. Clinical integration is the one common thread that will connect all of the evolving parts of United States health care over the next few years. The American Hospital Association has emphasized clinical integration as an essential component to change the health care system in their *Health for Life: Better Health. Better Health Care*, which identifies critical areas for discussion and innovative ideas for change. Defined as collaboration among health care providers and sites to ensure higher quality, better coordinated, and more efficient services for patients, clinical integration spans several of the initiatives already discussed in this report.¹⁰

The ultimate goal of clinical integration, from the perspective of primary care practices, is a shared and operationalized clinical vision: to build capabilities that contribute to achieving patient-centered, high-quality coordinated care rather than episodic, redundant, and sequential care. Information technology infrastructure and care coordination will be key drivers to achieve these aims.

Information Technology Infrastructure

Sharing clinical information among providers, as emphasized by the AHA, is the gateway to good care. Through the Health Information Technology for Economy and Clinical Health (HITECH) Act and some exceptions to Stark and anti-kickback laws, health care organizations are able to help physician practices install electronic health records (EHRs). The laws do not allow health care organizations to share hardware or completely subsidize software for independent physician practices, but they can begin to form a modest degree of connection between aligned practices and the health care organizations.

Interconnected technology facilitates information sharing between primary care practices and hospital staff and vice versa, opening a new channel of communication concerning patient care. Timely information distribution is vital for PCPs, alerting them to their patients' admission to the hospital, need for follow-up care, and the results of care provided in other settings than in the PCP practice. Some EHRs also permit physicians to contact their patients directly, allowing

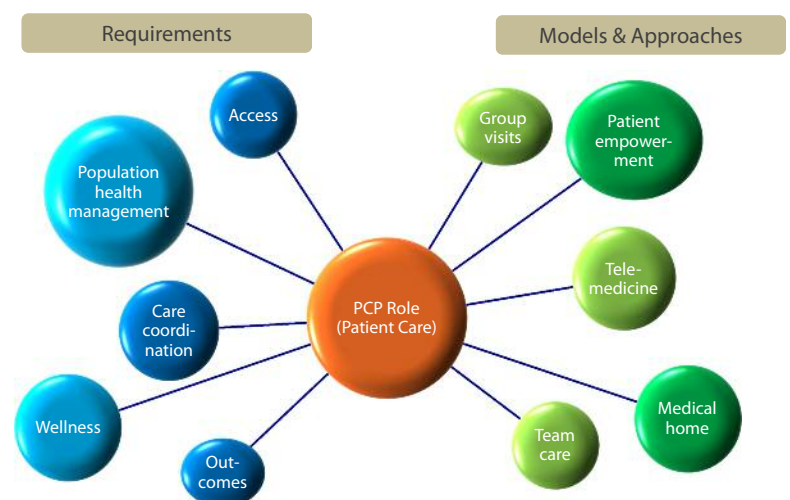
physicians to provide follow-up care or administer medication refills quickly and effectively. Furthermore, an EHR tracks the patient's utilization of health care services and should reduce some duplicative testing, unnecessary costs, and patient hassle. Consequently, patient safety is improved as well.

Exhibit 12: Traditional Role of the PCP



Source: Health Strategies & Solutions, Inc., 2012.

Exhibit 13: Tomorrow's Role of the PCP



Source: Health Strategies & Solutions, Inc., 2012.

Imperative #5: Reorganizing Primary Care Delivery Models to Manage Care

Health care organizations rely on the EHR for data mining and generating reports to consistently measure quality indicators and standardize case and utilization management. Additionally, administrative and clinical peers can share quality indicators within the physician practices to discuss areas of improvement and reach pay-for-performance targets. Clinical decision support software can also aid in the standardization of care as indicated by industry best practices, especially chronic disease management, which is a major area of focus under health care reform.

Clinical integration involves more than patient information and tracking of quality metrics. Financial functions can be linked as well. Health care organizations that employ or have aligned medical staff can provide electronic billing services for their physician practices, many of whom would be directly connected to the EHR. For example, once a physician codes a patient's chart, a bill would automatically be generated, aggregated, and sent to the patient's insurance for processing. With the impending changes in payment reforms, such as bundled payments, expanding automated technology will streamline the billing process and eliminate coding anomalies that previously created numerous inefficiencies.

Without investment in information technology infrastructure to facilitate information sharing, quality tracking, and streamlined finances, providers will miss out on numerous economies of scale that will be vital for sustaining their position in the emerging health care market. However, it is most important to note that the patient stands to bear the greatest burden if these inefficiencies are not addressed because the breadth and depth of health care reform will be compromised.

Care Coordination and Management

Different segments of the health care market have begun to shift their focus to support reform's emphasis on quality. With the increased importance of demonstrating outcomes, private insurance companies have started pursuing methods to promote better care delivery within their markets.

In Pennsylvania, Independence Blue Cross (IBX) announced that it will incentivize PCPs if their patients' health improves as reported by specified quality measures.

The program will reward doctors who:

- Provide greater access for patients
- Follow best practice treatment guidelines
- Educate patients to better manage their own health
- Prescribe drugs via EHR

Examples of evidence of success include:

- Improvement in population health
- Cost reductions
- Improved patient experience
- Decreased length of stay
- Reduction in preventable readmissions
- Better outcomes
- Decreased length of time for specialist access

Similarly, CIGNA is piloting a patient-centered, collaborative accountable care program with several large, hospital-affiliated medical groups. Chronic care patients will receive individualized attention through a registered nurse case manager who will serve as a clinical care coordinator and emphasize wellness, disease management, and health improvement through their direct communication with the patient. If the physician groups are able to improve quality and lower medical costs, they will be rewarded through a pay-for-performance structure.

To further promote care coordination, the University of Pennsylvania Health System and other hospitals are piloting the role of a transitional care nurse (TCN). The TCN demonstration projects are evaluating the use of bachelors-trained nurses to coordinate patient care between an inpatient and outpatient setting. The goal of the TCN is to arm patients and families with the knowledge to identify and address health problems early, provide more individualized high-touch care, and reduce readmission rates. The TCN will

- Meet with the patient in the hospital and collaborate with the members of the health care team to streamline the plan of care and discharge based on patient goals
- Provide home visits within 24 to 48 hours of discharge from the hospital to assess the environment of the patient's home and create a tailored plan for recovery or disease management
- Accompany the patient to the first post-discharge physician visit



These examples represent a substantial cultural shift for most physicians. Far-sighted leaders will be needed to manage and support the dramatic changes required to achieve these steep levels of change.

As reform reshapes United States health care, PCPs must rapidly adapt to meet the demands of patients and the government. With a focus on these two areas — information technology infrastructure and care coordination — primary care providers can begin the transition toward accountable, high-quality care management, consistent with the evolution of payment for these new responsibilities.

Changes to Medical School and Residency Curriculum

Leading-edge primary care training programs are incorporating new competencies into their medical school curricula and residency training programs to train PCPs for their new role. Health care organizations should focus their recruitment efforts on innovative programs that are incorporating these changes into their training of future physicians.

- **Significant exposure to multidisciplinary team patient care.** Physicians, physician learners, nurses, patient educators, patient care coordinators, social workers, pharmacy clinicians, and other clinicians working together as a team and ensuring effective communication and decision making will be the standard for patient care delivery. Medical students should be exposed to team-coordinated care experiences early and often.
- **Consistent reliance on and application of evidence-based approaches to patient care.** Evidence-based patient care integrates the physician's clinical expertise and knowledge of relevant clinical research with patient values and preferences to make decisions about patient care that provide the best opportunity to achieve optimal clinical outcomes and quality of life.
- **Training in patient treatment with a strong reliance on advanced practice clinicians.** If PCPs are to serve as patient care managers, many of their former duties and responsibilities must be delegated to advanced practice clinicians. Understanding when to delegate is a core competency for medical students who intend to focus on primary care.

- **Reliance on EHR, computerized order entry, and other electronic forms of communications with patients and other caregivers (e.g., e-visits, telephone visits, telemedicine).** Learning to manage health records and communication at multiple levels electronically should be emphasized in medical school curricula.
- **Exposure to the patient-centered medical home model or other emerging models.** While it is unclear which model or models will become the standard for organizing and coordinating patient care in the future, PCPs are likely to receive additional compensation for assuming responsibility for patient health management and prevention, rather than payment for episodic care delivery. This new perspective on the role of PCPs and their expected reimbursement should be integrated into medical school curricula.

"We adhere to the ACGME (Accreditation Council of Graduate Medical Education) accreditation requirements to train lifelong learners and clinically competent physicians. But further, in light of the evolving role of PCPs, we strive to instill and train our physicians to be clinically and culturally competent, have good communication skills, be caring physicians, and be committed to patients and the community. We call these our 5 C training guidelines."

**Martin S. Lipsky, M.D., regional dean
University of Illinois College of Medicine at
Rockford, Illinois**



Imperative #5: Reorganizing Primary Care Delivery Models to Manage Care

Case Study

The Maine Track

Maine Medical Center, Portland, Maine

Tufts University School of Medicine

Boston, Massachusetts

A Maine-tailored curriculum and reserved and subsidized slots for Maine students are just two of many innovations in place at a partnership between Maine's largest hospital, Maine Medical Center, and Tufts University School of Medicine. Tufts and Maine Medical Center jointly recruit and select students in the co-governed program that awards a combined diploma from both organizations. Twenty of the 36 slots are reserved for legal residents of Maine, students attending Maine colleges, or students from adjacent New England states or other locales deemed similar to Maine to encourage participants to establish medical practices in Maine.

Students attend Tufts for their first two years and spend their entire clerkship period in year three and portions of the monthly rotations in year four at Maine Medical Center. The program's curriculum, called the Maine Track, prepares students for rural and small town practices and is emphasizing the team-based patient care approach. Students also have the option of pursuing dual degrees, such as M.D./M.B.A., M.D./Ph.D., and M.D./M.P.H. "This is not the usual affiliation between a medical center and a medical school," says Vincent S. Conti, Maine Medical Center president and chief executive officer. "This is a true partnership, co-developed and equally governed and managed by the two organizations. It is a unique approach to find a solution for what is becoming a national crisis: a lack of physicians, specifically PCPs in rural areas."

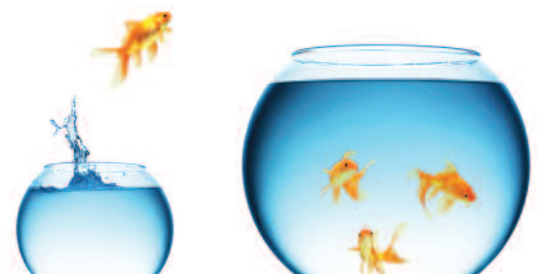
Short-Term Initiatives for Reorganizing Primary Care Delivery Models to Manage Care

- Prioritize information technology infrastructure development, information sharing, and timely distribution of information to ensure outstanding patient care, quality tracking, and streamlined finances
- Prepare for a patient-centered medical home and bundled payment system by putting a greater percentage of compensation at risk for demonstration of outcomes, cost control, and care management
- Move toward best practice levels of care coordination across inpatient and outpatient settings and across the care continuum

Long-Term Initiative for Reorganizing Primary Care Delivery Models to Manage Care

- Establish primary care delivery models that are based on clinically integrated team-based care that is accountable for value-based patient care

Imperative #6: Selecting PCP-Hospital Alignment Models and Approaches



In the recent past, there has been a movement among PCPs to be less involved in hospital operations and systems. The most significant driver of this trend is the emergence of hospitalist programs. Hospitalists minimize the need for physicians to spend time in the hospital environment. Instead of a physical presence, PCPs interact with other providers through clinical information sharing. And without a significant hospital presence, fewer PCPs are involved in hospital leadership roles.

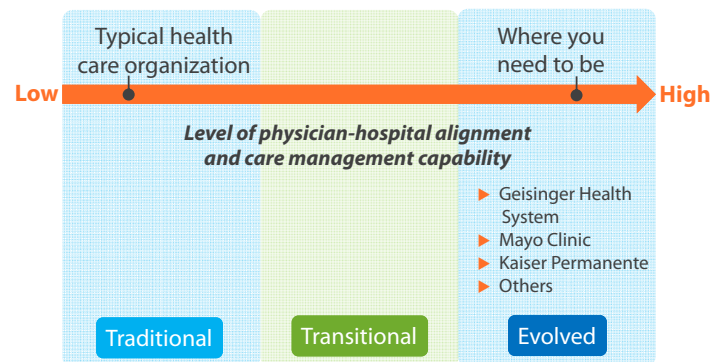
Effective PCP-hospital alignment has never been a more critical strategy for both PCPs and hospitals. Historically, alignment between PCPs and health care organizations has not been a priority except when PCPs are employed or in markets with capitated payments. Only in recent years have accelerated efforts to align the interests of community-based PCPs and hospitals emerged.

Despite the forecasts by some pundits that all PCPs will be employed by health care organizations, it is more likely that both voluntary and employed PCPs will continue to exist and therefore, health care organizations must try to increase the depth and breadth of less formal alignment with primary care practices. Aligning voluntary practices through formal economic relationships (e.g., recruitment assistance, co-management agreements, and real estate joint ventures) and earning referral relationships via a systematic and proactive physician liaison/outreach program will be a key strategy in many markets.

Further, exploring the continuum of alignment between PCPs and hospitals, understanding where the organization and its physicians fit on the continuum, and deciding how to move along the continuum toward more aligned, effective relationships are imperatives that health care organizations must address to be well-positioned under health care reform and more specifically to develop ACOs, medical homes, or other primary care-centric models that lead to eventual full risk or bundled payment models.

As Exhibit 14 illustrates, most health care organizations are in the early stages of achieving physician-hospital alignment; Kaiser Permanente and Geisinger Health System are among the notable highly evolved integrated delivery systems that have been working toward advanced levels of alignment of PCPs for decades, are led by physicians, and have been practicing primary care practice clinical integration – not just talking about it.

Exhibit 14:
Range of PCP-Hospital Alignment and Care Management Capability



Source: Adapted from Grube, M.E. and K. Kaufman. 2010. "Positioning Your Organization for Success in the New Era." *Healthcare Financial Management Journal*.

Identifying where an organization and its PCPs are along the continuum means looking at multiple parameters, including physician-hospital relationships, physician leadership and accountability, and shared information technology. Exhibit 15 represents a snapshot to assess where an organization falls on the continuum, with most health care organizations falling somewhere between the traditional and transitional aspects of PCP-hospital alignment.

An evolved PCP-hospital relationship links the primary care medical practice with the health care organization to ensure commonality of mission, vision, and values between and among the organization and its PCPs. It also ensures effective clinical care collaboration by PCPs with other physicians, other clinicians, and care delivery sites, instead of siloed, redundant, and duplicative care.



Imperative #6: Selecting PCP-Hospital Alignment Models and Approaches

Exhibit 15:
Effective PCP-Hospital Alignment Continuum

Parameter	Traditional	Transitional	Highly Evolved
PCP relationships among themselves	<ul style="list-style-type: none"> ► Silos ► High autonomy 	<ul style="list-style-type: none"> ► Moderate interdependencies ► Individual physicians autonomy diminishing 	<ul style="list-style-type: none"> ► Coordinated approach ► Accountable for the continuum of care and standardization of care
PCP orientation toward the hospital	<ul style="list-style-type: none"> ► Practice-focused 	<ul style="list-style-type: none"> ► Shared practice- and hospital-based orientation ► Employed physicians create linkage to institutional vision 	<ul style="list-style-type: none"> ► Shared system vision ► Aligned performance measure (access, quality, etc.)
PCP engagement	<ul style="list-style-type: none"> ► Minimal roles, "in name only" ► Committee members 	<ul style="list-style-type: none"> ► Active participation 	<ul style="list-style-type: none"> ► Engaged leaders
PCP leadership	<ul style="list-style-type: none"> ► Elected volunteers 	<ul style="list-style-type: none"> ► Appointed physician leaders 	<ul style="list-style-type: none"> ► Physician executives in highest roles in the organization
Governance	<ul style="list-style-type: none"> ► A few physicians in participatory roles on hospital board 	<ul style="list-style-type: none"> ► Physicians on hospital board as well as a governing body of the physician enterprise 	<ul style="list-style-type: none"> ► Physicians play major role in governance of all levels of the system
Autonomy in business decisions	<ul style="list-style-type: none"> ► Full autonomy of own practice 	<ul style="list-style-type: none"> ► Loss of some autonomy in business decisions 	<ul style="list-style-type: none"> ► Control in many aspects of the business enterprise
Payment	<ul style="list-style-type: none"> ► Pay for utilization 	<ul style="list-style-type: none"> ► Pay for performance 	<ul style="list-style-type: none"> ► Pay for outcomes
Economic models	<ul style="list-style-type: none"> ► Few and loose 	<ul style="list-style-type: none"> ► More and moderate 	<ul style="list-style-type: none"> ► Few and tight
Typical alignment models	<ul style="list-style-type: none"> ► Few models and few physicians involved 	<ul style="list-style-type: none"> ► Variety of models 	<ul style="list-style-type: none"> ► Majority of physicians in one or two alignment models
Information technology	<ul style="list-style-type: none"> ► Financially based 	<ul style="list-style-type: none"> ► Clinically focused EHR 	<ul style="list-style-type: none"> ► Fully integrated EHR (financial and clinical)

Source: Health Strategies & Solutions, Inc., 2012.

Health care organizations should work with medical staff leaders to help individuals evolve from simply providing input to strategic initiatives to being engaged individuals, serving in more significant leadership positions. In advanced integrated delivery systems (typically the most evolved in terms of physician-hospital alignment), leadership teams, including significant numbers of PCPs, oversee clinical service lines for quality, efficiency, and value, and physicians are co-managers, co-leaders, and co-governors of the organization. Ultimately, evolved PCP-hospital alignment requires the ability to access and share information in an expeditious manner, promoting real-time results reporting and sharing. Measuring and reporting outcomes, facilitating care coordination, and clinical integration in general require sophisticated information technology.

There are dozens of models for the alignment of PCPs with health care organizations. Examples are included in Exhibit 16 arrayed from the perspective of four dimensions: degree of challenge in formation (Y axis), the degree of alignment (X axis), target segment of a medical staff (color of bubble), and relative prevalence in the industry (size of bubble).

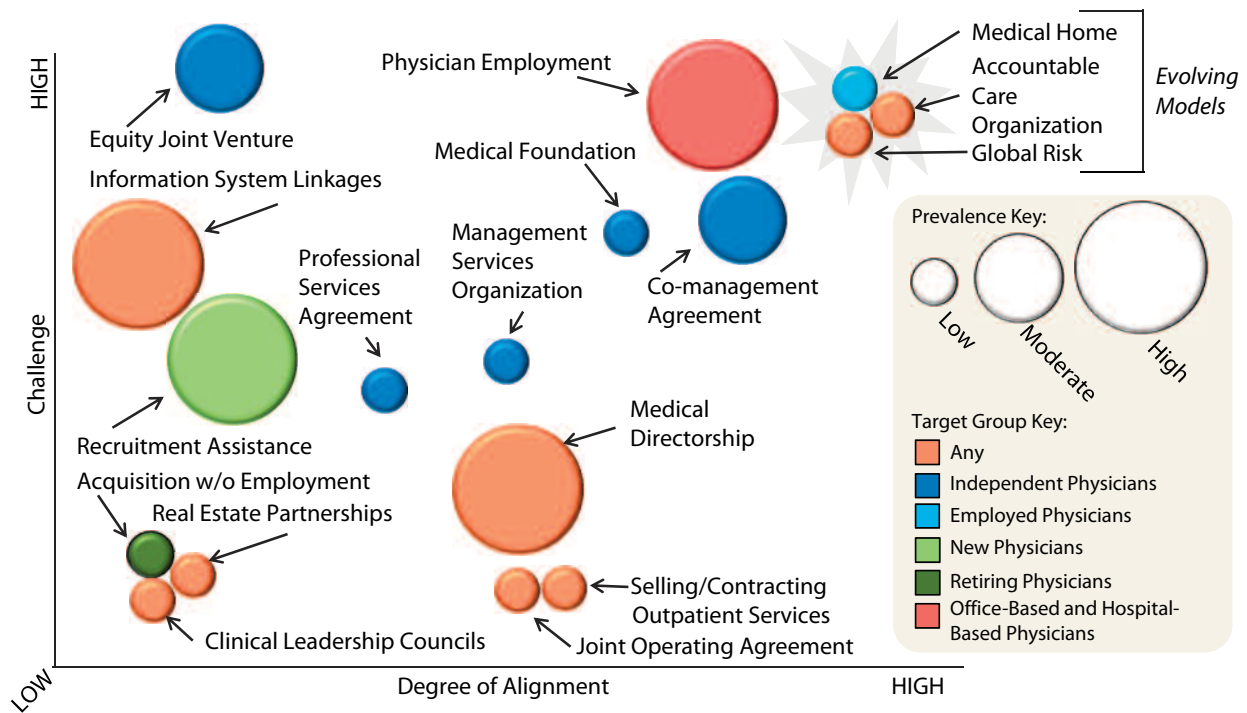
Short-Term Initiatives for Selecting PCP-Hospital Alignment Models and Approaches

- Determine the appropriate models and approaches for alignment; consider using multiple alignment approaches to meet varying needs and interests of PCPs and your organization
- Identify goals for each alignment model and approach; examples include facilitation of access, fostering integration, improving the patient experience, and operations efficiency
- Establish a process for alignment; components of the process include determining strategic priorities for both the physicians and the health care organization, defining core issues or non-negotiables, outlining the guiding principles for alignment, and selecting evaluation criteria to apply to specific models/approaches and practice targets

Long-Term Initiatives for Selecting PCP-Hospital Alignment Models and Approaches

- Focus on the outcomes or goals of alignment, such as quality care, care coordination and management, access to care, and integration
- Continue to push your organization and physicians toward more advanced levels of alignment, physician leadership, and clinical integration

Exhibit 16: The Continuum of Alignment Models



Source: Health Strategies & Solutions, Inc., 2012.

Conclusion

The Supreme Court decision to uphold the major provisions of the ACA launches a new era in health care in the United States. Development of a robust foundation of primary care services must move to the forefront of strategic priorities for all health care providers. Health care organizations that stay entrenched in traditional approaches to delivering primary care and partnering with their primary care physicians will be left behind, while those willing to be pathbreakers, innovators, and alignment partners with PCPs will set new standards for primary care in a reformed environment.

Key initiatives in the post-reform environment will be to

- Grow primary care services in geographic distributed networks
- Partner with payors to share risk and reward under new models of primary care delivery
- Develop new models of accountable care in which population health, patient empowerment, and care management, not utilization, are the hallmarks of success

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