HealthLeaders Media LIVE From Dean Clinic

Primary Care Redesign
New Physician Compensation Models, Care Teams, and Seamless Care Coordination

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Dean Clinic | Madison, Wis.

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The American system of primary care became broken by a payment system that rewarded what you could do to a patient that generated a charge. Without pretending that this dysfunctional payment system is a thing of the past, a few innovative health systems such as Dean Clinic in Madison, Wis., have set out to redesign primary care in its network of 28 primary care offices across the region.

Redesign may not be the most accurate term, as to some it suggests not much more than putting a fresh coat of paint over an old wall. What the team at Dean has done is a frame-up demolition and reconstruction of primary care. The goal is no longer to drive PCP visit volume but to invite the patient to participate in his or her healthcare again.

The work began with a couple of key foundations. First was the quality, accountability, and data exchange components of patient-centered medical home pilots. At the same time, a fundamentally new physician compensation plan was implemented that shaved away at full DRG models and embedded incentives for keeping Dean’s population of patients healthy, as well as service, financial, and quality metrics.

A scant couple of years into the PCMH journey, the leadership team recognized that the scope of the program was not big enough, so they expanded the redesign concept to rework some broken processes, particularly in access to care. For example, physician scheduling templates were so variable that there was no way for a patient or even a referring physician to easily schedule an appointment. Shrinking the variations down to a handful allowed patients to use a secure Web portal to book their own appointments, and access grew substantially. Patients who used to show up at urgent care centers because they assumed that their PCP could not see them are now triaged and scheduled with their PCP, often for the same day.

The team at Dean understood a couple of key tools that would be required to make primary care redesign more than cosmetic. One was implementation of a rigorous Lean

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value stream process and continuing analysis of the results. Lean allowed for the team to eliminate non-value-added steps that often occurred between providers where confusion about accountability or missing communication left the patient in the middle. Finally, Dean also understood that for primary care redesign to have the lasting change value across the care continuum, the goals of primary care redesign had to be matched and measured against a series of systemwide true north metrics.

Mark Kaufman, MD, chief medical officer for Dean Clinic, says rebuilding primary care is a first step in larger healthcare transformation.

"I think primary care redesign is one of if not the most critical pieces of clinical redesign that a health system has to undertake if you're going to get to that goal of flipping the paradigm from a sick model of care to more of a wellness and maintenance model of care."
One of the beauties of running an integrated delivery system that has physicians, a health plan, and affiliated hospitals is the ability to look at influencers of healthcare costs in a systematic way. Craig Samitt, MD, president and CEO of Madison, Wis.–based Dean Clinic, says a few years ago he asked the organization’s health plan to pull some data on primary care.

“We asked our health plan what percent of total cost of care goes to pay primary care, essentially to pay primary care physicians,” Samitt says. “We were shocked to hear that it was only 6% of the total cost of healthcare. And then we asked our health plan to what degree does the work of primary care—referral patterns, prescribing, everything that they do—influence the remaining 94%. And the health plan said our primary care physicians directly and indirectly drive another 80% of the costs. So if you’re going to start some place to catalyze value-based transformation, primary care is the best possible place to start.”

In 2009, Dean Clinic was not getting the kind of quality and experience results it wanted from primary care, says Mark Kaufman, MD, chief medical officer for Dean Clinic. At that time, Dean’s primary care network was not unlike others across the country—somewhat fractured, with difficulty in recruiting physicians and keeping patients happy.

“We said we really needed to make this a major effort,” Kaufman says. “I think primary care redesign is one of if not the most critical pieces of clinical redesign that a health system has to undertake if you’re going to get to that goal of flipping the paradigm from a sick model of care to more of a wellness and maintenance model of care.”

The first step was to concentrate on six primary care pilot sites in a
patient-centered medical home pilot project with TransforMED, a subsidiary of the American Academy of Family Physicians.

“It was a way to get started,” Kaufman says. “It was a bit messy. In retrospect it wasn’t data-driven enough, but a couple of really good things came out of that.”

The pilot sites—which included 30 physicians at five Dean Clinic locations and one that is part of Dean’s joint venture with St. Mary’s Hospital—reached Level 3 PCMH certification for the National Committee for Quality Assurance program, which includes such foundations as access and communication, use of paper or electronic charting tools to organize clinical information, and adoption and implementation of evidence-based guidelines for three chronic conditions.

The other real benefit was a new physician compensation formula meant to align physician performance with the goals of value-based care, and not by volume. Five years ago, Dean’s PCPs were compensated on the industry standard relative value unit (RVU) formula, in which a standardized dollar amount is given for each encounter or procedure. Dean initially had introduced a 2% incentive for patient satisfaction, but as part of the PCMH pilot, leaders radically redesigned the formula, Kaufman says.

Under the new compensation formula, 60% of primary care compensation was still RVU-based; another 20% was based on an adjustment of age/gender-adjusted panel size; and another 35% was built around incentives for service, financial performance, clinical quality, and growth goals. The formula intentionally totals 115%, Kaufman says. “We purposely made it possible for our physicians to earn above market compensation, but the way our physicians

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did that was by performing well on the incentives that were really all about the
goals of primary care redesign."

The formula has been tweaked in recent years and has been spread beyond
the six pilot sites to the rest of Dean’s primary care system. For 2013 the
package is 50% RVU-based, 30% for panel size, and up to 30% for incentives,
including 10% related to medical cost control and a 20% standard package.

Albert Musa, MD, medical director for primary care, East Region, Dean
Clinic, says the reaction to the new comp plan has been well received by the
primary care staff but is still a work in progress.

"You know, it actually has been good," Musa says. "Our physicians knew it
was aligning them more with the right things."
But there are limits and practical challenges, he says. "When you're doing more non-RVU work and you're getting less for RVU work, you can only scale back your RVU work to a certain point." Other questions leaders found along the way include how best to balance the panel size for each physician, and how to divide that care among different providers who may all care for that same complex patient. And one complication that persists is that—for all the incentives to physicians to encourage patients to use alternate means of contact, other than the office visit—"there are many patients who still want that visit, and so we can't de-emphasize [the office visit] too much."

"And ultimately there is a fear that it becomes a total salary," Musa says. "A salary gives you some comfort, but I think administratively we really worry about taking away people's work ethic, too. So there's a tough balance there."

**Evolving Compensation** The team at Dean Clinic made a commitment to a new primary care physician compensation model as part of the primary care redesign value stream project. However, that's not to say that the model isn't reviewed annually and tweaked to make certain that it is matching system goals and achieving the desired results in physician performance.

**Takeaways:** What Makes it Work?
Two years into Dean Clinic’s PCMH journey, the team decided to take a step back. The leadership team was seeing results from the six PCMH pilot sites, but it wasn’t enough.

“So we started with a pilot methodology for primary care redesign where those six sites absolutely made progress and became high-performing medical homes,” Kaufman says. “But it was problematic because they weren’t everything we wanted them to be. And the other primary care units were asking, ‘What about us?’ It wasn’t conducive to moving the whole organization.”

The Dean team recast the PCMH pilots into a more comprehensive, systemwide transformation labeled primary care redesign (PCRD). The foundational elements of primary care redesign contain five components:

» **Team-based care:** Every patient has a trusted partnership with a personal physician who leads a team of skilled, compassionate healthcare professionals, each performing to the level of his or her training

» **Access to care:** Patients and their families can access care team members according to their individual needs (preventive, urgent, or ongoing) and preferences (in person, electronically, or by phone) and at their convenience

» **Quality care:** Care is evidence-based and delivered to both individuals and groups of patients while being proactive, value-based, and determined through shared decision-making

» **Comprehensive care:** Care is patient-centered, recognizing unique needs including immediate and ongoing medical, psychosocial, preventive, and family care issues

» **Coordinated care:** Care is orchestrated across the delivery continuum, including primary and specialty services delivered in all settings

Case Study // LESSON 2

**Shift From PCMH to Primary Care Redesign and Build Internal Lean Process Improvement Expertise**
Along with that care redesign was a new recognition of the value of Lean process improvement to meet the system goals. "We decided to develop true north metrics [a Lean term referring to high-level goals] aligned with our system objectives of delivering better care at a lower cost," Samitt says. "We committed to cataloging all of the things that each primary care unit needed to redesign to achieve the true north metrics so that 100% of all of our sites are performing at a comparable high level."

As part of the refocus on using Lean tools, the team did a value stream analysis—a tool that employs a flow diagram documenting every step of primary care in high detail. From that analysis some trends emerged, says Michael McGrew, process improvement team lead at Dean Clinic.

"Some general themes that weren’t very surprising were a lot of duplicate work—double, triple, quadruple checks just to make sure everything was right before moving forward because there wasn’t a whole lot of trust in the previous process step," McGrew says. "There were a lot of unnecessary transfers between individuals when one group or one area could have handled it. And there was a real siloed degree of understanding where people knew what they received from the previous step, but they didn’t really understand why they got it that way."

The Lean analysis identified processes that didn’t work for physicians or patients. One example was in appointment scheduling, which fell under the foundation of access. Before the analysis, physicians could customize the length of visits, gaps between them, number, and frequency; that added up to hundreds of variations that made standardized scheduling almost impossible for referrals or for patients themselves.

Steve Wilkes, administrator for primary care, East Region, Dean Clinic, says that in the past the physician view of scheduling was, "I want to restrict this or I want to add that so that hopefully if we make the scheduling right, my day will go well," And the more complex we made the schedule; the less likely it was that the day would go well. We just got more complex over time."
In the redesign, the team whittled down to five visit types and limited the selection for length of visits. With the revised scheduling, patients can now schedule their own visits through the patient portal of Dean’s Epic-based platform, and referring physicians and their staff can schedule referrals just as easily. Physician flexibility is not eliminated, Wilkes says.

“So you can have different lengths of time that you want with a patient than your peer because your pace is different, or your ability to cycle through patients is different,” Wilkes says.

Other initiatives during this phase included medication refill protocols, a pre-visit summary at check-in, and replacing voice mail systems in primary care offices with staff. Another particularly successful access initiative was to institute a triage process at Dean’s urgent care centers and large clinics to guide patients back to primary care if appropriate.

“Our patients were sort of trained to go to urgent care because their access to primary care historically was not all that terrific,” Kaufman says. “They got to the point they didn’t even bother to call to see if their primary care provider was available. And so now when people walk into urgent care, we have a nurse who greets the patient and triages the patient. If the patient wants to go to urgent care, that’s fine, but we offer the patient an appointment with their PCP team if it’s available that day and help facilitate that.”

At the end of 2011, the Dean team measured performance of the PCRD pilot sites and compared that with the clinics that were not part of the pilot. Clinical efficiency measures such as 90-day prescription refills rose 29% at the pilot sites compared to 23.8% at the others. Overall service ratings of the pilot PCPs rose 4.3% compared to 0.3%. In general, the conclusion was that while the PCRD sites were doing better than their counterparts overall, there was only marginal difference between PCRD and non-PCRD in total cost of care, inpatient admissions per 1,000 patients, ED visits per 1,000 patients, and overall usual care utilization and cost.

**TAKEAWAYS: WHAT MAKES IT WORK?**

**FOLLOW THE PATIENT** Those familiar with Lean tools will know the benefit that value stream mapping can give to any complex process. In primary care the value stream is particularly useful in identifying where gaps may happen between the primary care clinic, the hospital, or specialists. As with Dean Clinic’s experience, the value stream map is not a onetime document and needs to be evaluated and updated as the redesign evolves.
Dean leadership was committed to the idea of the primary care redesign but was not satisfied with the results. So the team put a new emphasis on the effort. Kaufman says the pilot sites were drawing interest from new physicians, “but on the other hand, the pilot sites were getting tired. We were spreading things from the pilot sites to the rest of the sites, and we were actually starting some initiatives at the non-pilot sites because the pilot sites were fatigued.” Dean moved away from the pilot site concept at the start of 2012 because the distinctions between pilot sites and non-pilot sites were blurring anyway.

“We redefined our true north metrics and aligned those with our corporate goals,” Kaufman says. “We did a repeat of the value stream analysis, which looks at the end-to-end delivery system for primary care and redefined primary care redesign for the next 24 months.”

In May 2012, Dean recast the PCRD vision to unify efforts at all Dean Clinic locations as well as those in the larger regional network that are part of the joint venture with St. Mary’s Hospital, owned by St. Louis–based SSM. The team developed “a reason for action,” which specified that they were not meeting all corporate goals for PCRD, team-based care was still not consistent, and care coordination was not provided. A new “target statement” for the next 24 months was crafted that stated all primary care sites “will meet high level True North PCRD goals, offer a consistent patient experience, provide care coordination services, and deploy a care team model that allows each care team member to use his/her skill set to the greatest extent possible.”

Care coordination came not just through use of a team of care navigators but also by using data mining and using other system resources to engage patients in their care. Jennifer L. Close, MS, vice president of operations, office of
medical affairs, Dean Clinic, says one of the reporting tools in the Epic platform allows a practice to know which patients are missing key preventive services. But how each practice contacted that patient was different and often was handled by clinic staff during the workday when most patients are not at home, Close says.

"We have a nurse call center here at Dean," Close says. "We took a subset of that group and staffed what we called the quality improvement pod, the QIP, which is a group of clinical staff that call out to patients largely in late afternoon and evening hours when we have found our patients are more likely to be at home. The nurses say things like, 'We're calling because we see that you haven't been in for your A1c test or your nephropathy screening. We're wondering if we can help you find a location and time that might work well for you to come in.'"

Dean was concerned that patients would find the intervention too pushy, Close says, but patients responded well.

"Service is our differentiator in the marketplace and this has been so warmly received by our patient community," Close says. "The reaction from patients has been, 'Oh my gosh, you actually really do care.' We weren't quite sure what the receptivity was going to be, you know, if people would feel like we were hounding them. But it has been incredibly well received. And we have seen our success rates soar for these types of tests we're intervening on."

What works is that the nurses get a "behavioral contract" that the patient will come into the primary care office within a certain time frame, and if they don't, then the nurse will follow up.

As it was with scheduling, Dean’s goals with the makeup of the care teams are to standardize them from dozens “to really identify the one, two, or three ideal models and really get those throughout the organization,” Kaufman says. The idea is to create team-based care that enables the "right people, right work" premise, says Wilkes.
“We’ve gone back through a number of iterations of clinical staffing efficiency and care team modeling,” Wilkes says. The conversations of the team are not just the typical issues of physician support, but a holistic view of the team, including questions such as how best to involve pharmacists in planning medication therapy, or how to incorporate behavioral health into the needs a primary care team might have, Wilkes says. “It’s also nutrition services, chronic disease management, care coordination, and social work. We’re really trying to look at it on all fronts,” he says.

Scalability is an issue in care team redesign, with some Dean Clinic locations in Madison having double-digit providers while a primary care office in a more rural area may have one or two, says John Butler, MD, vice president of medical affairs at Dean Clinic.

“Some of the features of the traditional patient-centered medical home—the expanded care team, the case management, social work, health coach-type resources—are much easier to put into a large practice than a two-person practice,” Butler says. “We want to do the same work in those practices because the way we see it, there is a population of patients out there who we feel accountable for and we want to make the health of this population better.”

Tactically what the team has tried is to place some of the enhanced resources not necessarily in each small clinic but in a regional sharing arrangement.

“So we may not have a case manager or a social worker at a two-physician site, but they would have access to those same resources on a regional level; so the care team includes the same mix of people who are at a larger clinic but perhaps not always at that smaller site,” Butler says.

**TAKEAWAYS: WHAT MAKES IT WORK?**

**TEAM CARE** Dean Clinic leaders took a broad view of the members of the primary care team in crafting a vision for how to engage the patients in new ways. For example, using call center nurses to phone patients who may need more blood pressure monitoring is just one aspect of a familiar theme of using an expanded care team of PCPs, NPs, nurses, and coordinators to engage the patient in ways that match the patient’s needs and the system’s goals for quality and coordination.
For Further Study

Using Lean tools and goals, systemwide metrics, a more value-based compensation model, data mining, care team redesign, and improved care coordination, Dean has set ambitious goals to use primary care to drive down the total cost of care while raising the levels of quality and service. For further study, consider the following resources:

Collaborating to Improve Care and Cut Costs

Initiating collaborative relationships is the key to improved quality, most healthcare leaders say. Many also agree that major increases in HIT spending are necessary, but others are more cautious about spending for technology improvements. And more than two-thirds see transparency as improving quality of care, while a sizable minority has reservations about it, according to the June 2012 HealthLeaders Media Intelligence Report, Collaborating to Improve Care and Cut Costs.

Teamwork is an emerging focus, with nearly three-quarters (72%) entering collaborative care relationships, while 28% say they are not. At the same time, healthcare leaders are reluctant to engage in shared savings programs as a risk-sharing cost-reduction tactic: 63% say they have no plans for such programs, which are a foundation of the evolving accountable care organization models.

Q | Are you embarking on collaborative care relationships with other providers and organizations to form a community of care?

Source: HealthLeaders Media Intelligence Report, Collaborating to Improve Care and Cut Costs, June 2012.

Yes 72%
No 28%
Base=309
About the Host

Dean is one of the largest integrated healthcare delivery systems in the country. Established in 1904 and headquartered in Madison, Wis., Dean provides:

- Medical and health services through a network of Dean or St. Mary's/Dean-owned clinics throughout southern Wisconsin
- Health insurance services through Dean Health Plan
- Ancillary health services within Dean Clinic locations
- Clinical research and education, through Dean Foundation

A privately held Wisconsin corporation, Dean has been a physician-owned and physician-governed organization since its inception. Ninety-five percent of Dean is owned by physician-shareholders. The remaining 5% is owned by the SSM Health Care, a St. Louis-based order that also owns several hospitals nationwide including St. Mary's Hospital in Madison and Janesville, Wis., and St. Clare Hospital in Baraboo, Wis.

Align Physicians and Hospitals in a Non-aligned World

In the post-PPACA era, the only universal truth is that there are no universal solutions to drawing physicians and hospitals into a model that rewards physicians, hospitals, payers, and patients for better care. Get alignment insights and lessons from CEOs and CMOs at Providence Health & Services, Lakewood Health System, MemorialCare Health System, and Baton Rouge (La.) General Medical Center.

Please click here to download a free copy of the HealthLeaders Media Impact Analysis Report, Align Physicians and Hospitals in a Non-aligned World.

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Primary Care Redesign

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