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TRANSCRIPT - GR 03 04 22 "Improving Health through Primary Care Investment and Value Based Payment" ***Russ Phillips, MD,*** **from Beth Israel Deaconess Medical Center**

- 00:34:06Okay alright everyone we're going to get started with grand rounds for today, so today we have this year's Brody scholar Dr Russell Phillips, giving medicine grand rounds.
- 00:34:18Dr Phillips trained at the Beth Israel hospital in Boston Dr Phillips, has been a part of the clinical faculty at Harvard Medical School.
- 00:34:25And Beth Israel hospital since 1983 and is currently the William apple bond professor of medicine at a staff attending and the Beth Israel deaconess medical Center.
- 00:34:33Dr Philip has enjoyed numerous roles within the health system, including chief of the division of general medicine and primary care, but currently is the director of the Center for primary care.
- 00:34:43he's involved at all levels of leadership within the health system and Medical School but his main focus through the Center for primary care is to research and identify ways to strengthen primary care, education.
- 00:34:52clinical practice and innovation and Community engagement, given his expertise in this field is the perfect speaker to give us an overview of primary care and the impact of primary care and the patient centered medical homes on help out with that I'll hand it over to Dr Phillips.

Russ Phillips

00:35:49Okay, thank you I'm sorry I can you hear me now.

- 00:35:53Okay, great.
- 00:35:55Thank you very much, I first want to say what a pleasure it is for me to be here.
- 00:35:59i've been spending the week I here at university of Virginia and I've been incredibly impressed by the exceptional people I've met I've met students resonance faculty.
- 00:36:09And uva leadership and everybody I've met has been you know really extraordinary I've been especially impressed by the commitment to education educational research.
- 00:36:20and patient care and have really enjoyed the week I'm also impressed by both you know the offerings in primary care, but also the future of primary care that I think uva is thinking about and envisions with that I'll proceed to my talk.
- 00:36:38improving health through primary care investment and value based payment.
- 00:36:47I do want to just disclose that I'm our primary care physician I also advise several for profit companies that are play a role in supporting primary care both telemedicine.
- 00:36:59company that cares for patients with opioid use disorder and grow therapy which tries to improve access to behavioral health services, and then I also am an advisor to the maven project that provides telemedicine consultations to safety net clinicians.

- 00:37:18The learning objectives and agenda for today's talk is first to define primary care, the impact of primary care and health outcomes.
- 00:37:26And then talk about patient centered medical homes and why patient centered medical on transformation is necessary but not sufficient by itself, and what I believe is the importance of primary care investment and value based payment as we move into the future.
- 00:37:41Now first primary care is defined as high quality primary care is the provision of whole person integrated accessible and equitable health care.
- 00:37:50By into professional teams that are accountable for addressing the maturity of an individual's health and wellness needs.
- 00:37:56Across settings and through sustained relationships with patients families and communities, and this is the most recent definition by the national academies of science, engineering and medicine in their report and.
- 00:38:11What the report also concluded is that primary care is a common good, to its unique impact on life expectancy equity quality of care and health care costs.
- 00:38:24And some of the language in terms of a common good, is actually based on some work that we've done in the Center for primary care.
- 00:38:31For instance, we showed that increasing primary care physician density at the county level by 10 per hundred thousand individuals.
- 00:38:38increases life expectancy by 52 days, this was published in JAMA internal medicine and we were able to show that primary care was actually only specialty that was associated with increase in life expectancy.
- 00:38:51However, sadly, the meantime density of primary care physicians decreased between the period that we studied from 2005 to 2015.
- 00:39:00And I suspect, if we were to be able to update this to 2020 that decrease would be continuing over time, but it's gone from 47 per hundred thousand population to 41.8 and those the last primary care physicians has been more acute in rural communities and it has been an urban communities.
- 00:39:19We also in a subsequent publication showed that counties, with fewer than one primary care physician per 3500 people, and this is really the definition of an underserved community.
- 00:39:30Had a life expectancy that was almost a year shorter or 310 days shorter than those living in counties above that threshold.
- 00:39:38So primary access to primary care and underserved counties can actually if we provide physicians primary care physicians in those counties.
- 00:39:48We can extend life expectancy almost by a year, and these are in studies, by the way, that adjusted for every factor that we know to be important to life expectancy, including, including social factors demographics and other others as well.
- 00:40:06As I mentioned primary care itself is associated with quality and this study shows that quality.
- 00:40:13Across the United States is actually related to the density of primary care physicians and in states that have more primary care physicians generally the quality of care that's provided.
- 00:40:24is actually improved, this is not working at the Center but working Barber starfield and associates, that is, that was done earlier but I suspect the same would be true today.

- 00:40:37And this actually shows another factor so it's with primary care and it's a similar kind of figure, which shows that the more primary care physicians, the lower the cost, so this is really the argument to primary care.
- 00:40:49Both improves quality and reduces costs which are central to the future of healthcare in this country.
- 00:40:58In a way, the burning platform is there are several factors, but one is that payment for primary care visits undervalues the role and skills of primary care.
- 00:41:07results and lower salaries and prestige and other specialties and limits the ability of primary creator realize its potential for improving health outcomes.
- 00:41:16Now this first statement I think refers and addresses why it is that many of our students are not going into primary care they see what we're doing they see that we're underpaid in that role.
- 00:41:27There we're under supported and oftentimes the tools that we give them as they are doing primary care limit their ability to fully help our patients and examples, for instance, are not being able to address social determinants of health.
- 00:41:42You know, as one example, when our patients have food insecurity housing insecurity and we have little resource to actually direct them to additionally primary care professionals experience a difficult work life as a consequence of.
- 00:41:58The work we do high rates of burnout this is related sometimes to our inability to provide to meet the needs of our patients, as well as excessive loan burdens resulting in severe work for.
- 00:42:11Work for shortages and although I won't speak a lot about the pandemic clearly that's made all of these worse, you know and studies have.
- 00:42:20work life, Sir, clearly, things have gotten more difficult, those who are practicing primary care getting many more portal messages many more sort of.
- 00:42:33Hearing much more about our patients needs, especially in their here of social determinants but also in the context of managing patients with Kofi.
- 00:42:44There are several innovations that have been developed that enhance the value of primary care.
- 00:42:49And the first was the development of patient centered medical homes, a second that i'll talk about is enhanced investment in primary care.
- 00:42:56And by investment in primary care, I really mean spending more of the healthcare dollar on primary care I'll mention shortly, you know in this country, the average spend.
- 00:43:08Prime what we call the primary care spend, which is the portion of total here at health, health care, spending that goes into primary care.
- 00:43:14is about five or 6% So if you think of the average spending of, for instance, to Medicare patient of being $10,000.
- 00:43:22Only $500 are flowing to primary care, and when you think about what we do in primary care, you can understand that that's not really adequate.
- 00:43:30Now, in primary care we're asked to address all preventive health needs for us to be first contact and accessible were managing patients with multiple chronic illnesses and.
- 00:43:40In Medicare patients that the her patients with Medicare these the Crimea city and the complexity is even greater and $500 you know per year.

- 00:43:51You know, barely covers two visits to primary care when it's not only those visits, but really continuing population health needs that we need to be addressing as well, and then, finally, the payment for primary care services using value.
- 00:44:06The other innovation is payment for primary care services using value based payment in the form of a monthly payment based on panel size, so another innovation that's now being explored as a way to further advance the way that we can provide primary care.
- 00:44:23First, in terms of defining patient centered medical homes, when these refers to introduce they were an alternative approach they were based on five.
- 00:44:31attributes, and these are really attributes that are common to primary care and the patient centered medical home is a construct that helps to support these for those who are doing them.
- 00:44:43we're working on them one is providing comprehensive care, the second is patient centered care, the third is coordinating care having services that are accessible and then an emphasis on equity quality and safety.
- 00:45:00Medical home implementation has actually though been shown Dev inconsistent results on cost quality and utilization based on Meta analyses that have been done.
- 00:45:09And, as I mentioned, and you know I think this relates in part to the fact that much repentance patient centered medical home transformation is not resulted.
- 00:45:18In additional resources to primary care it's changed the way primary care is organized, but not necessarily provided the resource that allows us to deliver on the promise of a reduced cost improved quality.
- 00:45:30And some high comorbidity populations, there has been a lower cost of care in one study, there is increased breast cancer screenings in general populations.
- 00:45:41Patient centered medical homes and stem studies have been shown to reduce specialty visits and increased cervical cancer screening.
- 00:45:49But then, a systematic review show decreased emergency department usage better clinical outcomes and greater adherence and follow up care amongst low income.
- 00:45:58populations, so it just you know I mean to give a sense that, depending on what studies you look at their variety of outcomes and there's not really a consensus.
- 00:46:07That patient centered medical home by itself, although incredibly important to those who practice and the bringing resources together and organizing us into teams by itself it's important but not sufficient.
- 00:46:22And this is a medical home initiative that included a shared savings invented incentive for primary care physicians.
- 00:46:30And the initiative was founded decrease hospitalizations and emergency department visits, as well as improved quality.
- 00:46:36So there are certainly ways to get there, higher performance was also measured on for exam and measures of diabetes.
- 00:46:43Care quality and breast cancer screening and those who are also shown to be involved, improved by patient centered medical home and the difference here was that there was some value based payment in terms of incentive surround better quality care.
- 00:47:01I want to talk a little bit about the academic innovations collaborative and this refers to work that's really has been led by the Center for primary care I mentioned some of our research as the Center opened in 2010 2011.

- 00:47:16We recognize that, in order to provide optimal teaching sites for our.
- 00:47:20Students, we really need to convert our academic practices into patient centered medical homes our students need see into professionals working together to see how teams working together to.
- 00:47:33understand the focus on population health all kinds of things that we can optimize within patient centered medical homes.
- 00:47:41And we work with 19 AMC affiliated primary care practices six of these were hospital based and then 13 with Community health centers and private practices.
- 00:47:52And what we actually did is we provided resources in the form of money to our academic hospitals asked them to match those resources and then to use those resources to drive improvement in primary care.
- 00:48:06we're also including 11 residency program seven of these for internal medicine one was family medicine one was a MED peach residency and two were pediatrics So this was also an effort, where we brought our.
- 00:48:21Our different specialties together for the purpose of really transforming primary care.
- 00:48:30And our aims at that time were to establish team based care so we were talking about patient centered medical home transformation, but we were trying to focus on the things that we thought would be.
- 00:48:40The bring value managed population prospectively and so you know really thinking about population health about how we can keep people patients healthy, without necessarily coming into visits.
- 00:48:52How we can find and manage high risk population, so the role of care managers and these were not care managers that were.
- 00:48:59At the health system level or at the insurer level but we're rather in within the practice improve physician workforce and satisfaction and then improve the patient and the training experience these really were the goals of what we're trying to accomplish.
- 00:49:14And the components were to create a learning collaborative, and this was based on the Institute for healthcare improvement breakthrough series which.
- 00:49:22has developed learning collaborative to focus on such things as reducing readmissions, and you know number of things in healthcare and we applied this to our primary care transformation, by creating.
- 00:49:34Learning sessions monthly webinars and our friend practice coaching as well, that really helped practices transform and this slide is picture is really one of a learning session, of course, these were times when.
- 00:49:47We could come together and not wear masks, and this is reminding us that hopefully this world will get back too soon, but we've actually now we are continuing to do all this work and a virtual way.
- 00:50:02We built this on a change model, there was really developed from was called the safety net medical home initiative, and it was had been supported by the Commonwealth foundation.
- 00:50:13And the reference to this as below, but you can see what the Foundation is and the Foundation is really engaged leadership and we actually had a leadership engagement strategy which I'll.

- 00:50:27Talk about, but you know briefly what we did is we first of all, in order to participate there needed to be a commitment by leadership to moving practices forward in the way that I just mentioned.
- 00:50:38But then we also had leadership come to our learning sessions, so that teams could present the work that they're doing and leaders could.
- 00:50:47support that they could help overcome barriers and help to move practices forward, in addition, the other part of the Foundation is a quality improvement strategy, you know we can only get there through some strategy we actually use the ihi strategy of pst pdsa cycles and.
- 00:51:07And you know that worked well for us, but certainly there are other quality improvement approaches as well.
- 00:51:12Now, building relationships really required, and what we call an annulment and i'm panel means panel men is really a you know hallmark of primary care and that it links patients two.
- 00:51:24Teams or two primary care physicians and our academic practices, where you know, sometimes, as many of 30% of patients were being cared for by resonance.
- 00:51:35And with resident turnover, we found that in panel meant was really a challenge and practices need to set up better systems so that as residents.
- 00:51:44Left and new residence came, then those patients transition so that patients were never without physicians that they could call on and see.
- 00:51:54and building relationships was also important to continuous and team team based healing relationships and, obviously, making connection to practices.
- 00:52:02Changing care delivery was around patient centered in your actions and communication and then organized evidence based care, which was really.
- 00:52:10Around population health and making sure, for instance, we could reach out to patients and make sure they're getting their cancer screening and their colonoscopies their mammograms there and, if not colonoscopies other form of colon cancer screening.
- 00:52:27You know, and the variety of things that we do to prevent cancer or to treat patients with chronic illness such as manage hypertension and diabetes.
- 00:52:37And then, finally, reducing access to care, and that was really thinking about enhanced access, how we can be available to our patients and how we can serve a role.
- 00:52:47Coordinating care, each one of these change concepts were things that we went through sequentially in the context of building patient centered medical homes.
- 00:53:03This slide shows changes and patient experience and shows that we did document improvement and patient experience we improve communication with patients, we improved.
- 00:53:13clinicians knowledge of patients and have the ability to have information about patients when they were seeing.
- 00:53:20And then we also increase the likelihood that patients would be recommending their practice to family members and others, you know these are you know relatively small changes their else statistically significant, though, and then and important factors.
- 00:53:36We also use a tool, called the tcm ha, which is also always also pioneered as part of the safety net medical home initiative.
- 00:53:45And you'll see on the X axis are the different change concepts that I mentioned so engage leadership quality improvement strategy and panel men.

- 00:53:55And what the show is sort of is there's a validated measure that teams would complete and you can see that on these validated measures there's improvement in each area over time.
- 00:54:07This does refer to the years you know we began in 2012 it goes through 2014 it was a two year initiative, and you can see that they were improvements in all areas, as we move forward in the collaborative.
- 00:54:24And this is aligned with that, and this we had a measure of team dynamics and I asked about whether the team said the right skills blended stability, whether they shared goals understood one another's roles, where they.
- 00:54:38held each other accountable, where they respected for and trusted one another's work and whether the team itself is effective and you can see again there's improvement over time in each of these team measures.
- 00:54:51And then, finally, what we also did was a difference in difference analysis to compare the intervention in control practices between.
- 00:55:01The intervention practices, where the 19 practices that we worked with their about almost 84,000 patients that were included in those practices.
- 00:55:11And we had mentioned it was two years we then extended it by another two years, so this comparison looks at four years.
- 00:55:19I should mention that the investment that was being made was relatively small.
- 00:55:23So although you know the Center committed substantial dollars to this, and they were matched by substantial dollars, given the number of patients who are included it only amounted to about $3 per Member per month.
- 00:55:36Which is about $40 per year in the first two years and then emphasis less so, less than that in the next two years, so this is, you know relatively small.
- 00:55:45Compared to let's say you know the $500 per year, that is, should be flowing to primary care, based on the 5% primary care spend so we're only increasing the investment in primary care by about 10%.
- 00:56:01We you know later i'll talk about where we really need to be is increasing investment in primary care by 100% so we were going up a little in terms of investment, but not a lot in my own practice and enabled us to.
- 00:56:14Bring lpn into the practice which played important roles and supporting the team providing immunisations really a number of things that.
- 00:56:23I floated the primary care physician, so they could focus more on caring for patients, chronic conditions.
- 00:56:31And then, also for patients with two or more chronic conditions there was just logistically significant.
- 00:56:36Reduction in hospitalizations nearly 20% reduction hospitalizations at 25% reduction in emergency department visits.
- 00:56:44And 6% reduction ambulatory care sensitive emergency department visits So these are visits that were prompted by.
- 00:56:52diabetes, hypertension asthma, you know the kinds of things that good management and primary care should potentially avoid So you can see that, at least in our intervention, you know we're able to do that we actually didn't reach or significant reduction overall costs.

- 00:57:12Among our patients, but it was really isolated to our patients with two or more chronic conditions and I there's this thing points out that.
- 00:57:19Those are really the patients that are likely to be hospitalized your show up in the emergency room so that's where we are able to show significant changes.
- 00:57:29The keys for us to learning transformation really were several and they included both the change strategy, which was a change concepts and, by the way, all of these change concepts are available on the web.
- 00:57:41Under the safety net medical home initiative and there's how to in terms of web based support for this.
- 00:57:49drumbeat of action and reflection, I know this is a little bit poetic, but it was really monthly reports structured time for team discussion and planning.
- 00:57:58And what happened at the learning sessions is teams would come together they'd review what they've accomplished, and then they plan, the next segment of work.
- 00:58:05And each of the learning sessions are oriented towards another step in the change package, which I showed you and be in the curriculum which we move forward.
- 00:58:17I didn't actually show you but there's also was a companion curriculum that we developed for residents, so that residents, based on their PGI level where.
- 00:58:26were offered a curriculum as well and residents were very much part of what we call transformation teams within the practices.
- 00:58:34The way that change actually occurred was a transformation team was identified which was into professional would champion the changes in the practice and then would.
- 00:58:44be responsible for helping to scale these changes across the practice, there are resonance on those because of the way our.
- 00:58:54Students rotation worked it was harder to engage students in this, but there were students who are engaged during what we call it hard for their fifth year who were committed to working on this or helping to study it.
- 00:59:07There was also cross pollination across teams which really meant the teams came together and learn from each other so.
- 00:59:15The team, we got from my own practice at Beth Israel deaconess was learning from the team at the Brigham or for mass general.
- 00:59:23The other thing you know we, as I mentioned, we included both academic centers but also Community health centers and oftentimes the Community health centers were leading the way and so their results, so a lot of.
- 00:59:37Learning from what was going on Community health centers.
- 00:59:40And then we had regular and meaningful engagement of senior leaders we had what we're called leadership brands were leaders, actually, as I mentioned, would have here presentations by the teams would be able to apply to the progress that was being made and that would also help overcome.
- 00:59:59Barriers the teams were facing.
- 01:00:03So the question becomes, why are patient centered medical homes not sufficient, and it really does relate to medical spend, I think, and, as I mentioned only 5% of the medical spend.
- 01:00:14In this country goes to primary care well in comparison countries that do a better job at providing better care, often the spend is two to three times what we do.

- 01:00:26The practice payment using fee for service clearly undervalues primary care, while limiting services, and this includes lack of support for population management activities behavioral health.
- 01:00:37Health coaches to address health behaviors fun to address funds to address social determinants of health.
- 01:00:43In orders example Community health workers and those resources to assist patients with food and security are generally not covered by the fee for service system, so it is the reason that we sort of that we need to get away from that.
- 01:01:01i'm investing in primary care, I mentioned that the national average is close to 5% in Massachusetts it's a little bit higher you know 5.7% among.
- 01:01:11Public payers sexually lower So if you looked at Medicare it's 3.6% it's a little bit higher and uninsured patients in Virginia based on data that's available through the.
- 01:01:24primary care collaborative the primary care spending is about 6% but it's actually decreased since 2017 so it's really going the wrong direction at this point.
- 01:01:37And this gives you just a sense of where prime were spending, you know goes so hospital care is a huge portion of this so to the extent that primary care can reduce hospitalizations and you know there's a clear.
- 01:01:51way to help support the you know any investment that's made in primary care prescription drugs is another you know big area.
- 01:02:02You know, and you can see this in terms of you know other services that are that are being provided, but primary care itself is a relatively small portion at five to 7%.
- 01:02:18And this slide shows that is also from the primary care collaborative and it shows that as primary care spend goes up, and this is across states in the country there's a fair amount of variation that.
- 01:02:32Emergency department visits go down, so you know it does speak to what the connection is between primary care spend and.
- 01:02:41hand and some outcomes you'll note there's not a lot of variation you know the variation here is between 3% and 8% so none of these really get to where I think we should be, which is really a doubling which would be around 10 or 12%.
- 01:02:57And this also shows that as primary care Spencer, because Ben goes up hospitalizations go down again the spend is pretty the variations pretty narrow, you can see Virginia, in the middle here.
- 01:03:12This is percent avoidable hospitalization So these are really hospitalizations that we think result from.
- 01:03:18Inadequate primary care and results from things like diabetes and asthma and heart failure things that we can manage in primary care, and you can see again there's a connection as primary care spends goes up hospitalization hospitalizations decrease.
- 01:03:33we've actually looked at some of the changes that have taken place within different systems and in One example is what's gone on in Rhode island were in 2010 the insurance commissioner who.
- 01:03:47Had the actually the power to increase the primary care spend required that ensures that commercial insurance increase primary care spend between 2010 and 2015.
- 01:03:59Really at a rate of 1% a year, so the they were starting at 5% So the idea is that they would double primary care spend over that period of time.

- 01:04:08And we, in the Center actually evaluated this paper that we published in health affairs where we compared to spending among those commercially insured patients to a similar number of patients from other sites, the changes in primary care spend were really.
- 01:04:27part of what was called affordable affordability standards in Rhode island and they in order to pay for the increase in primary care they impose price controls on contracts between controversial insurers and the hospitals.
- 01:04:40And they didn't actually decrease spending at hospitals, but what they did CAP is the increase that was happening every year so that.
- 01:04:50They could not, you know increase beyond a certain amount, I believe it was something like a two and a half percent increase.
- 01:04:56And so, in there some sort of the sort of the limit on the increase, was what helped pay for the increase.
- 01:05:03In money going into primary care and, as I mentioned it required commercial insurers to increase their spending by 1% per year, they also were told they couldn't raise premiums they couldn't increase the cost of patients so that's why there had to be controls on hospital costs.
- 01:05:22And the result of our study was that, first of all, the intervention control groups were similar that fee for service.
- 01:05:28Spending prior to 2010 were comparable between intervention control groups and we saw that fee for service spending actually declined compared to controls after implementation.
- 01:05:39Of the policy with a primary change actually being the decrease in hospital costs so cost did go down, but it was really through the impact on hospitalization costs.
- 01:05:51and health care quality was unchanged, except that there are fewer low value services being provided for patients seen in primary care.
- 01:06:00We believe that you know, this is because we were studying, you know very soon after the intervention after four years of change, you know what was going on in primary care, and so we didn't see sort of benefits in terms of reduced hospitalizations reduced.
- 01:06:19Emergency room visits, or you know or other, you know factors but and we didn't have the capacity to look at things like patient experience.
- 01:06:28But we actually are very interested in going back into Rhode island now as their spending has continued to level of 10 or 12% just see.
- 01:06:38Where things where things are now and how what the impact has been on patient care we're also interested in knowing what the impact is on burnout.
- 01:06:46and other factors and how primary care practices have changed the initial focus on increased primary care spending was to some extent focused on converting practices to ehr and a variety of things that are really part of infrastructure, some care management support.
- 01:07:06But you know with continued spending at that level we think practice have been able to do more in terms of population health and, hopefully, reducing hospitalizations.
- 01:07:20And the study just show this is just the result of our study that showed that healthcare spending slowed after Rhode island applied affordability standards, and you can see the control group and where we're Rhode island is.

- 01:07:34So the conclusion was that a distributed redistribution of funding toward primary care was achieved without net losses to payers so as an example of how we potentially can increase primary care spend without.
- 01:07:48payers actually you know, having to raise more money from their patients, but it does appear that the reduction in spending was mostly attributable to price controls and the affordability standards rather to increase spending on non fee for service primary care.
- 01:08:09Transition quickly to value based healthcare and value based healthcare, the she also mentioned that in Rhode island they weren't paying for value based healthcare they were just putting more money into the fee for service system.
- 01:08:20And I believe there's too many others that as we increase spending in primary care, we need to really do it through competition.
- 01:08:27The national academies of science, engineering medicine report that just came out actually advocated for increase investment in primary care through capitalization.
- 01:08:38And value based healthcare is an alternative approach to delivering healthcare that basis payment don't evidence based patient outcomes.
- 01:08:45And pays based on covered lives, rather than on the number of visits so rather than.
- 01:08:49being paid fee for service for each patient you see there'd be a monthly payment that would potentially come into your practice or officer, a number of ways to do this, but.
- 01:08:59The most common would be a monthly payment that would be based on uncovered live so proud family care practices, for instance, if payment didn't change.
- 01:09:08I mentioned, it would be $500 a year, so you know that would be $40 per Member per month or so, in terms of a payment that comes to your practice if we increased investment in primary care that would double.
- 01:09:21And it would actually have the serve the purpose of having monies come in that.
- 01:09:27can be spent in a variety of different ways they're not tied for the fee for service system.
- 01:09:31And in the context of covert, by the way, you know it would enable a transition to tell them medicine or non-visit based care without bankrupting practices if those payment of those.
- 01:09:42types of visits couldn't be paid for, and practices wouldn't be bankrupt, but anyway because there'd be sustaining monies that would be coming into primary care through that model.
- 01:09:53And this approach differs from fee for service models which incentivize volume and services, rather than rewarding improving patient lives.
- 01:10:01Value based payment also aims to lower costs by reducing utilization of unnecessary and low value services and.
- 01:10:08We do think from based on research that we've done in the Center that patients will move to a value based approach, with more than two thirds of their patients are paid for using value based payment.
- 01:10:19The challenge right now is that patients are being paid for in a variety of ways summer value based summary not realistically we can't within a practice care for patients in different ways, and so.
- 01:10:31Where we can provide different care based on patients payment.

- 01:10:35And so practices either do a fee for service incentive approach or they do value based, and in order to move to value based two thirds.
- 01:10:44of patients need to be in value based payment systems, we are, by the way, moving to that towards that in Massachusetts, especially within our Community health centers were mass health or form of Medicaid is going to be entirely moving to value based payment come 2023.
- 01:11:02In other states in Maryland they have had initiative we're federally qualified health centers there's a primary care collaborative establish to create an advanced payment model.
- 01:11:13and using value based payment they actually showed that after three years there's a 35% reduction in.
- 01:11:19ED visits and 11% reduction in hospitalizations and a 4.4 million investment or turn 19 $4.4 million So this was actually you know what terrific investment.
- 01:11:33And the primary Maryland primary care program aims to transform primary care delivery get better care for and access.
- 01:11:39Services addressing social needs and the program and objectives include developing more effective infrastructure, providing continuity of care.
- 01:11:48and creation of tools to monitor quality of care and utilization so Maryland is very much moving forward on this and gets resulted, as I mentioned, improve delivery and outcomes.
- 01:12:00Public Health integration, they were able to show that there are fewer guests from covert 19 as well as cost savings to investment in primary care systems.
- 01:12:11And what they've been doing is they've been doing population based payments, the range of $32 per Member per month.
- 01:12:18commitment to sustainable funding and tools for addressing social determinants including linking practices to Community based organizations, which I think is a really important direction to be moving.
- 01:12:30In Oregon they're doing something you know similar they have an Oregon.
- 01:12:34primary care payment reform collaborative created to increase investment in primary care and improve reimbursement methods by investing in social determinants.
- 01:12:43It supports the use of value-based payment provides technical assistance to clinics and payers and integrates primary care and behavioral health care.
- 01:12:51And the state government has outlined steps towards further integration of value based payment with goals for 70% of payment be paid under how your base plan by 2024 so this will get to sort of the key.
- 01:13:07proportion of at least two thirds of patients being cared for in value-based payment by 2024 which we think really will move practices to a value based approach.
- 01:13:19And when I say value based approach it really results in a rethinking of what we do in primary care, you know focuses the attention.
- 01:13:27Of often primary care clinicians and patients with complexity, where we can probably make the most difference enhances population health brings on.
- 01:13:37In certain populations, where this is important Community health workers to address social determinants of health integrates behavioral health care, you know all of these things that we know are part of health primary care value.
- 01:13:51And I think i'll skip over this just in the interest of time.

- 01:13:58And I did want to talk briefly about what we're doing in Massachusetts in Massachusetts we have a primary care payment reform that Center is really front and Center with where we're advocating for primary care payment reform at the state level.
- 01:14:12And our core principles are to decrease the cost of health care to align incentives for all stakeholders to achieve a quadruple aim.
- 01:14:19To increase the percentage of patients in Massachusetts the primary care provider to promote relationship centered care to increase the patient centeredness of care.
- 01:14:29To address social determinants of health and also to increase administrative simplification, making work easier for primary care clinicians.
- 01:14:41We envision a primary care global budget so would not be determined by fee for service billing codes, but really would be based on a.
- 01:14:50On a capitated payment we're advocating for.
- 01:14:54payment system that would start at being equivalent to fee for service payment, but over three years, who would actually double so as I mentioned right now Massachusetts is around five and a half percent we would get to 11 or 12% over three years.
- 01:15:10There would be accountability in our system in that practices don't automatically you know receive this is funding but it's.
- 01:15:19The first third of it comes automatically because we actually believe that primary care practice is under supported for the work that we're doing right now, but the next two thirds would really be based on the integration of what we really think of as value based.
- 01:15:35services within primary care, and this is a list that we put together, each of which is evidence based and suggests that they lead to improvement in value in what we do in primary care.
- 01:15:46And there are no real surprises here one is integrated behavioral health and others addiction treatment so medication assisted treatment for patients with opioid use disorder or treatment for patients with alcohol abuse her or other.
- 01:16:02Problems using care managers to help coordinate care and prevent hospitalizations group visits having health coaches to work with patients around health troublesome health behaviors Community health workers to address social determinants.
- 01:16:16scribes to make the work a little bit easier in terms of documentation for primary care clinicians and reduce burnout, which is part of the focus of our work.
- 01:16:25Integrated palliative care so that we have access to palliative care expertise within primary care providing Tele health.
- 01:16:34additional time to actually spend with patients to make sure we have walked in and urgent care availability, so we can provide the same or as good as X or better accesses some of our competitors like.
- 01:16:48minute clinic are now evening weekend availability, so that we can reduce the use of the emergency room.
- 01:16:55Having a zero dollar copay so there's no restriction in terms of use of primary care by patients linkage to home care as you certainly have it University of Virginia and and and we need to be doing that more in primary care practices patient advisory groups who.
- 01:17:13Review services that are being provided and make recommendations regarding how we can strengthen those services in primary care.

- 01:17:21And the collaboration is pharmacist it's not meant to be a complete list but it's on the list of things that as practices.
- 01:17:29Add on Thursday actually would be additional payment to practices that would more than cover the cost, but allow practices to get to a real doubling of of payment and primary care.
- 01:17:43And I know there are ongoing efforts in Virginia and not you know expert on those i'm sure there are those in the audience that know more about this than I do, I know there's been a change in governor so i'm not sure how that's going to be sort of impacting that.
- 01:17:56But there is a Virginia Center for health, innovation, where the goals include accelerating the adoption of value driven models of wellness and health care to oversee and facilitate I demonstration models.
- 01:18:08According to you know the information I could find 45% of primary care patients are value oriented, this is commercial and I’m sure it varies substantially by system.
- 01:18:19In Medicaid 41% of payments are value oriented, so you know about, so it doesn't appear that you've gotten to the threshold of two thirds of your patients being.
- 01:18:31Value bit being paid and evaluated based way but you're getting there and more than 50% of Virginians experienced health affordability problems in the past year.
- 01:18:40So it just suggest the importance of reducing health care costs or managing health care costs and way that provide that include access for patient and improve access for patients.
- 01:18:51And then finally there's a governor's Task Force on primary care and the aims include defining payment models to better support primary care.
- 01:19:00Identifying needed infrastructure and promoting innovations until the health and population health management.
- 01:19:06So there is a structure that actually hopefully will help to lead transition and primary care and I focused on the States just because a lot of the changes, rather than occurring at the national level are really occurring at the state level So these are opportunities to get engaged.
- 01:19:28So in conclusion, just in order to save and strengthen primary care, we do need to convert our payment system to global payment with financial incentives to support that move.
- 01:19:38Payments need to be adjusted for social severity, this is what we are doing age and gender as well as quality and scope of services provided.
- 01:19:47And then, over time, to increase payments for primary care to enable added services, these are all elements of the of the Massachusetts model, and I think could be helpful to others.
- 01:19:59And finally, I hope, you've gotten a sensor I should be you know, be clear that primary care itself is in crisis, it is the foundation of our health care system.
- 01:20:09Healthy system of primary care is really critical to address and cost quality equity all the things that we really value in healthcare.
- 01:20:17and supporting it adequately is key for to have high value health system primary care itself is divert deserving of advocacy, as I mentioned primary care is really a social good.
- 01:20:29there's no other field of medicine that's associated with improvement of life expectancy as primary care is.
- 01:20:35And the data that underserved areas if they have an adequate number of primary care physicians patients who live in those counties.

- 01:20:43can have life its life, their life extended by year is is extraordinary, and an important thing to keep in mind as we think about primary care.
- 01:20:53primary care itself, I think it's ready for innovation and demonstration projects, you know returning to cove it, I think.
- 01:21:00was a pandemic we've just viewed we've demonstrated the capacity of primary care to innovate.
- 01:21:06As we've set up specialized clinics for patients with covert or overt like symptoms as we've transitioned rapidly to Tele health.
- 01:21:13And I think there's also the opportunity to transition in a rapidly to value based care and thinking about how we can sort of put into practice ways that we can.
- 01:21:24Better utilize our primary care teams and physician so is to reduce overall costs and improve quality.
- 01:21:31And then finally primary care itself is a great career for those interested in innovation, leadership and having a major impact on patients lives in the health system.
- 01:21:41Earlier on I you saw a picture I showed a physician taking care of a patient, as I introduced the academic innovation collaborative and that was my mentor Jordan, who at that time was a physician at.
- 01:21:54One of our Community health centers since then she became the.
- 01:21:59CEO of that Community health Center and she's now the CEO of care quest, which is a multi-billion dollar organization which is focused on.
- 01:22:07Integrating oral health their primary care, which is another sort of really important equity issue in primary care and I mentioned her just to demonstrate.
- 01:22:17The opportunities for those of us working in primary care to assume important leadership roles and to have a major impact on patients lives in the health system.
- 01:22:30And I think with that, I will start Thank you so much for the opportunity to speak with you today.

UVA IM Chiefs

01:22:37Thanks so much Dr Bill was excellent, let me unmute Dr Bill lose as the first question.

Evan Heald

01:22:46russ Thank you so much for your thoughtful talk and your impactful visit with us this week, it strikes me that messaging is going to be really important here, obviously, you know we can't give.

- 01:23:02a lump sum to practices and not expect quality, but at the same time, we risk having it sound like you know doctors want nicer cars and they have to be bribed to do a good job.
- 01:23:16Are their thoughts about how we do message this to.
- 01:23:22Patients and politicians decision makers.
- 01:23:28so that they understand that this is about supporting the things that the doctors are trying to do for their patients.

Russ Phillips

01:23:36And it's a really wonderful question and I think you know, there are issues in terms of how we support in our physicians directly I, you know as we've talked about during this week salaries for primary care.

- 01:23:50clinicians that includes nurse practitioners physicians assistants and physicians are 60% of what they might earn in others in the average specialty.
- 01:24:01or some special specialty and raising you know those salaries is important as we compete for medical students to enter the field, so you know that sort of needs to be you know part of the conversation.
- 01:24:13Although I don't think, as you mentioned, you know as you say, I mean primary care clinicians are paid well compared to the average person in this country so.
- 01:24:20We can't be making that as a as a sole argument, and in fact that so you know subsidiary in a way to improving patient experience to reducing the cost of health care, improving quality.
- 01:24:32So I think that's really where the messaging you know needs to be that our goal is to improve the patient experience to improve access to.
- 01:24:40You know, to really be addressing you know patients needs and improving the patient experience and doing more, and as I’ve mentioned, you know clearly in Massachusetts we don't think we could actually achieve investment.
- 01:24:53Without having some accountability in terms of what practices are actually you know doing and so.
- 01:24:59Requiring practices to take on high value services and provide better services.
- 01:25:04You know, to their patients as part of that you know increase we think those are things that primary care practices are going to want to do anyways so these aren't going to be a hard sell.
- 01:25:13But it's important to the messaging as we sort of move this forward we, by the way in the Center do you have a communications lead who works with us on messaging because I think your point is really important one is we do advocacy messaging is critical.

UVA IM Chiefs

01:25:36Welcome

- 01:25:39To find them.
- 01:25:54about it okay.

Andy Wolf

01:25:57Great Russ Thank you very much, that was illuminating and I will attest to the statement that primary care is a very gratifying and satisfying career.

- 01:26:07Despite the obstacles that we face that you're attempting to overcome so I know you said that much of the Innovation needs to come from the State level and change but.
- 01:26:19It does need to come at the federal level two and we were we were hardened a couple of years ago when reimbursement was restructured, you know to favor office based rv use, but they did nix the primary care coordination.
- 01:26:35I think it was a G code that could have offered us more reimbursement for what we do in terms of quarterbacking but can you comment on what might be happening at the federal level to support value based care change and also maybe comment on what's happening at the federal level to.
- 01:26:57Block proposed changes.

Russ Phillips

01:27:00i'm sure if that's a really great question because they're you know, obviously, should be changes at the federal level as well, and certainly through cms and through cmi there are a number of demonstration projects that are going on.

- 01:27:11That are you know sort of examining value based payment and patient centered medical home transformation.
- 01:27:18You know, unfortunately, some of these just haven't gone on long enough to really show improvements in costs or outcomes so.
- 01:27:25The results of those you know, have been mixed so they haven't been you know widely expanded, although there are things like Medicare advantage that you know that cms also provides, which is.
- 01:27:37A prospective payment on that's risk adjusted the I think the most exciting thing that's happening is that, through the report of the national academies of science, engineering and medicine for referred to, they called for a.
- 01:27:53You know primary care leader within hhs dhss hhs who brings together the interests of hearst.
- 01:28:02And HR Q and the different federal agencies and really to make sure that the primary voices primary care voice and interests are being heard and communicated.
- 01:28:12And so right now there are actually two people who are working in the deputy secretary's office with a goal of developing a strategy for primary care.
- 01:28:23And they're actually very interested in hearing from the primary care Community at Trudy Steinberg or Judo Steinberg is leading that effort, who had come over from her so you know to do this and there'll be issuing the report in May and and really would be report.
- 01:28:41For a strategy moving forward on how primary care might be supported and.
- 01:28:48And, and then again and how an Office might become permanent within hhs that focuses on this as well, and I do think that will bring changes at the federal you know level.
- 01:29:01She is looking at things like payment, and you know, a variety of things and but you're really using the national academies report as a blueprint.
- 01:29:11So I do encourage you to look at the national academies report and react to it and.
- 01:29:16You know, be in touch with Dr Steinberg she's also going to be there, a number of public events that she's going to be participating in as well, so to you know, to look for those.

- 01:29:25as well, but it's actually really exciting and I think really encouraging that this is happening at the federal level and.

Andy Wolf

01:29:34Excellent thanks.

UVA IM Chiefs

01:29:37So much Dr Phillips is one o'clock we really appreciate your time and your expertise and thank you to Dr Shield wall for the questions and yeah thanks so much.

Russ Phillips

01:29:47Thank you so much.

- 01:29:49Take care now.