Family Medicine's Leadership Role in Redesigning Care and Training under Value-Based Care

(in the middle of a pandemic, economic crisis and civil rights movement)

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The content, conclusions and opinions expressed in this presentation are mine and should not be construed as the official policy, position or endorsement of my funders, employers or the University of North Carolina at Chapel Hill

This Presentation in One Slide

Perspective as non-clinician researcher and policy wonk

We are in uncharted waters

Data and evidence must be our north star

- **Pre-pandemic period**: shift to value and addressing SDOH
- **Pandemic period** : care disruptions, telehealth, health disparities
- **Post-pandemic period**: financial crisis, building evidence

Family Medicine offices are "Living Laboratories": gather evidence to educate payers, policy makers, health system leaders around value of family medicine and need for payment reform

Need to develop capacity to document,[1] frame and message evidence

[1]Brown LD. 1991. "Knowledge and Power: Health Services Research as a Political Resource" In Health services Research: Key to Health Policy, edited by Eli Ginzberg, 20-45, Cambridge MA: Harvard University Press

My Perspective

- Associate Professor in Family Medicine
- Privileged to work across specialties and professions. Part ethnographer, data geek, policy wonk and diplomat (I'm still working on that last bit)
- 22 years in state, national and international health workforce policy. Direct HRSA-funded Carolina Health Workforce Research Center
- Current Chair of COGME, frequent contributor to National Academy of Medicine and federal policy makers
- Teach and mentor learners from medicine, nursing, social work, and health policy
- Mission is to infuse data and evidence into what are often contentious turf wars

The Pre-Pandemic Context

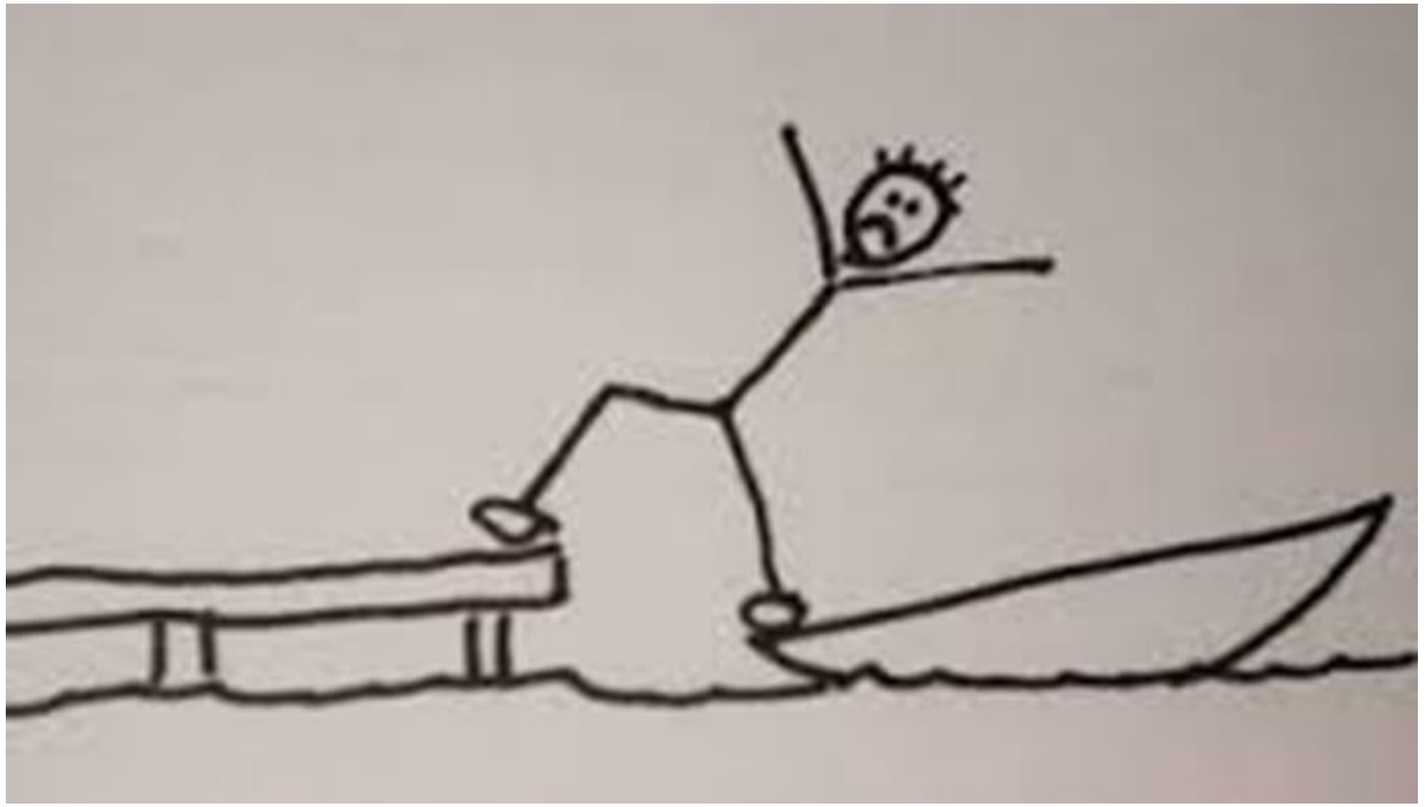
Experimentation re: health care payment, organization, delivery

Pressure to contain costs, increase value, address social determinants

Increased competition from corporate players using redesigned workforce, telehealth and house calls (focusing on patient priorities)

Hospitals & health care systems mainly fee-for-service, but planning for value-based future

It Sort of Felt Like This…



Hospitals, health systems and practices see shift ahead but do not have time or expertise to develop roadmap for value-based care

Recognizing Need to Navigate Future Waters, UNC Health Care System Undertook Bold Move. They Capitated our Family Medicine Clinics

On July 1, 2019, began piloting capitated, per-member per month (PMPM) model in our family medicine clinics

Secured funding to evaluate outcomes of this “natural experiment” including best practices and pitfalls in:

- improving patient outcomes and containing costs
- redesigning care delivery models
- reconfiguring the workforce
- training next generation of learners

Offers case study for transition from volume to value

NORTH CAROLINA'S VALUE-BASED INITIATIVE

"No state is moving as far as fast as North Carolina."
Mark McClellan, MD

The New York Times

Inside North Carolina's Big Effort to Transform Health Care

North Carolina is offering payment incentives for doctors like Robert Rosen and Amy Sapp, at Admore Family Practice in Winston-Salem, to play a larger role in managing care.
Jeremy M. Lange for The New York Times

By Steve Lohr

Aug. 26, 2019

RALEIGH, N.C. — North Carolina seems like an unlikely laboratory for health care reform. It refused to expand Medicaid coverage under the Affordable Care Act, and ranks in the bottom third among states in measures of overall health.

Evidence Will Help Family Medicine Lead Nation in Move to Value-Based Care (VBC)

Evidence critical to educate payers, policy makers, health system leaders around value of family medicine and need for payment reform

In January 2020, began collecting data on transition from FFS to VBC

Mixed methods: quantitative and qualitative data

Time frame 2017-2021: two years pre- and post-capitation

Study Site: The UNC-CH Family Medicine Practice

- Multidisciplinary outpatient teaching practice
- Two affiliated rural teaching practices
- Inpatient care in two hospitals
- Full-spectrum care

Measuring Change in Clinical and Cost Outcomes as we Shift From FFS to VBC

- # of empaneled patients
- # of number of virtual and telephonic visits
- # of chronic care, population and behavioral health services delivered
- Quality metrics: cervical cancer screening, colorectal screening, diabetic eye exams, flu vaccines, chlamydia screening
- ED, hospital admission and readmission rates
- Patient satisfaction and engagement
- Cost of care

Measuring Change in Skill Mix and "teamness" as We Shift From FFS to VBC

Workforce outcomes

FTE skill mix, training levels, new roles

Delegation of population health, patient education, patient engagement, and health coaching activities to non-physicians

Provider satisfaction, workload, after hours care|

Team-based care

Barriers and facilitators to team functioning

Resistance to role change and scope of practice expansion

Learner involvement in VBC

Pandemic Struck in March, Posing Significant Challenges but Also Opportunities

Challenges

Dramatic decline in in-person visits

Disruptions in preventive care, chronic care and behavioral health

Many learners removed from clinical sites

Opportunities

Covid-19 acted as "***creative disruption***"

CMS's sweeping changes to telehealth reimbursement fast-tracked shift to virtual care

Workflows and roles changed

Dramatic Changes Occurred Over Night

Redesigned care delivery models

Altered physician decision-making: virtual vs in-person visit, making referrals (or not!), expanding scope of family medicine physicians

New workflows to accommodate “drive-through” lab testing and home monitoring

Accelerated outreach to reach vulnerable patients and communities to address health disparities

Reconfigured workforce

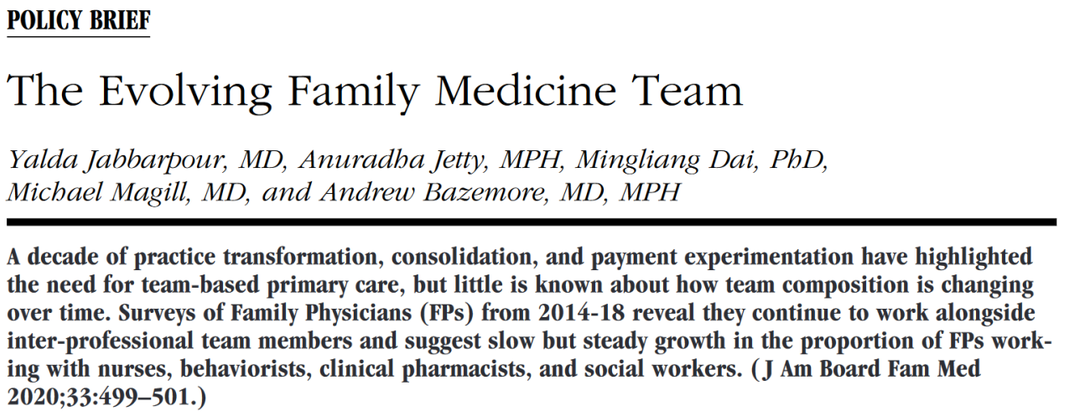
Expanded use of population health specialists to help patients navigate clinical, behavioral health and chronic care concerns

Flexed roles of medical assistants and social workers

Evolving Role of Social Workers in Family Medicine Practices

Integrated behavioral health and primary care models spawning new team structures[1] with social workers acting as behavioral health specialists, care managers and referral coordinators

Jabbarpour et al found growing % of FM physicians working with SWs



POLICY BRIEF

The Evolving Family Medicine Team

Yalda Jabbarpour, MD, Anuradha Jetty, MPH, Mingliang Dai, PhD, Michael Magill, MD, and Andrew Bazemore, MD, MPH

A decade of practice transformation, consolidation, and payment experimentation have highlighted the need for team-based primary care, but little is known about how team composition is changing over time. Surveys of Family Physicians (FPs) from 2014-18 reveal they continue to work alongside inter-professional team members and suggest slow but steady growth in the proportion of FPs working with nurses, behaviorists, clinical pharmacists, and social workers. (J Am Board Fam Med 2020;33:499–501.)

[1]Fraser MW, Lombardi BM, Wu S, Zerden LD, Richman EL, Fraher EP. Social work in integrated primary care: A systematic review. *Journal of Social Work and Research.* 2018; 9(2):0-36.

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Critical Role of Social Workers in Face of VBC, COVID-19 and Health Disparities

Patient Population	How Social Workers Can Help
Vulnerable and homebound	Improve access, obtain insurance
In crisis (e.g. interpersonal violence)	Provide psychosocial care, manage crisis
Preventive care and “worried well”	Educate and encourage adherence
Geriatric patients	Address social isolation
Persons with medication lapses	Arrange mail delivery service

Much work is by telephone, but located within practice for provider access

How Do Patients Feel About Changes?

If the United States intends to pay on the basis of value, it is essential to ask patients what they value, and then deliver on those priorities[1]

Have we asked patients what they want?

- How do patients want to access primary care?
- Are patients more satisfied with accessibility and convenience of tele-visits and drive through lab testing?
- Do they want drive-through services expanded to include other services like vaccines?
- Do patients with hypertension and congestive heart failure want to engage in more home monitoring of their conditions?

[1]Lynn J, McKethan A, Jha AK. Value-Based Payments Require Valuing What Matters Most to Patients. JAMA. 2015;314(14):1445-1446. doi:10.1001/jama.2015.8909

So Where Do We Go From Here?

Family Medicine clinics are “Living Laboratories”: where we can harness, evaluate and build evidence to advocate for policy change

Imagine Power of Evaluating Innovations Underway. What Changes Should be Sustained?

Care delivery: which patients should be seen virtually vs. in-person? Has FM scope increased?

Provider satisfaction: do providers feel they have more or less work-life balance and control over their schedule?

Workforce: have changes enabled "share the care" model? What is effect on burnout and provider/staff satisfaction?

Training: are learners aware of, and engaged in, new models of care, workflows, new team configurations?

If the Clinic Is the Curriculum, What Can We Learn from the Pandemic?

The Future of Family Medicine Residency Training is Our Future: A Call for Dialogue Across Our Community

Warren P. Newton, MD, MPH, Andrew Bazemore, MD, MPH, Michael Magill, MD, Karen Mitchell, MD, Lars Peterson, MD, PhD, and Robert L. Phillips, MD, MPH

(J Am Board Fam Med 2020;33:636–640.)

How should Family Medicine residencies evolve?

*"The pandemic has demonstrated the importance of family physicians and their trainees playing many very different roles…What components of our current residencies built **the flexibility and tenacity** so prominent in in the past 4 months?"*

I've Always Been Interested in the Flexibility—aka "Plasticity"—of Family Medicine Physicians

The term **plasticity** is used in neuroscience. Neuroplasticity refers to a brain's ability to change continuously throughout an individual's life.

In workforce, **plasticity** describes provider's ability to **adjust his/her scope of services to** changing needs in the clinic, community, personal preferences, density of other providers with related scopes of practice, and evolving payment and care delivery models.

Related concepts: flexibility, adaptability, generalist practice

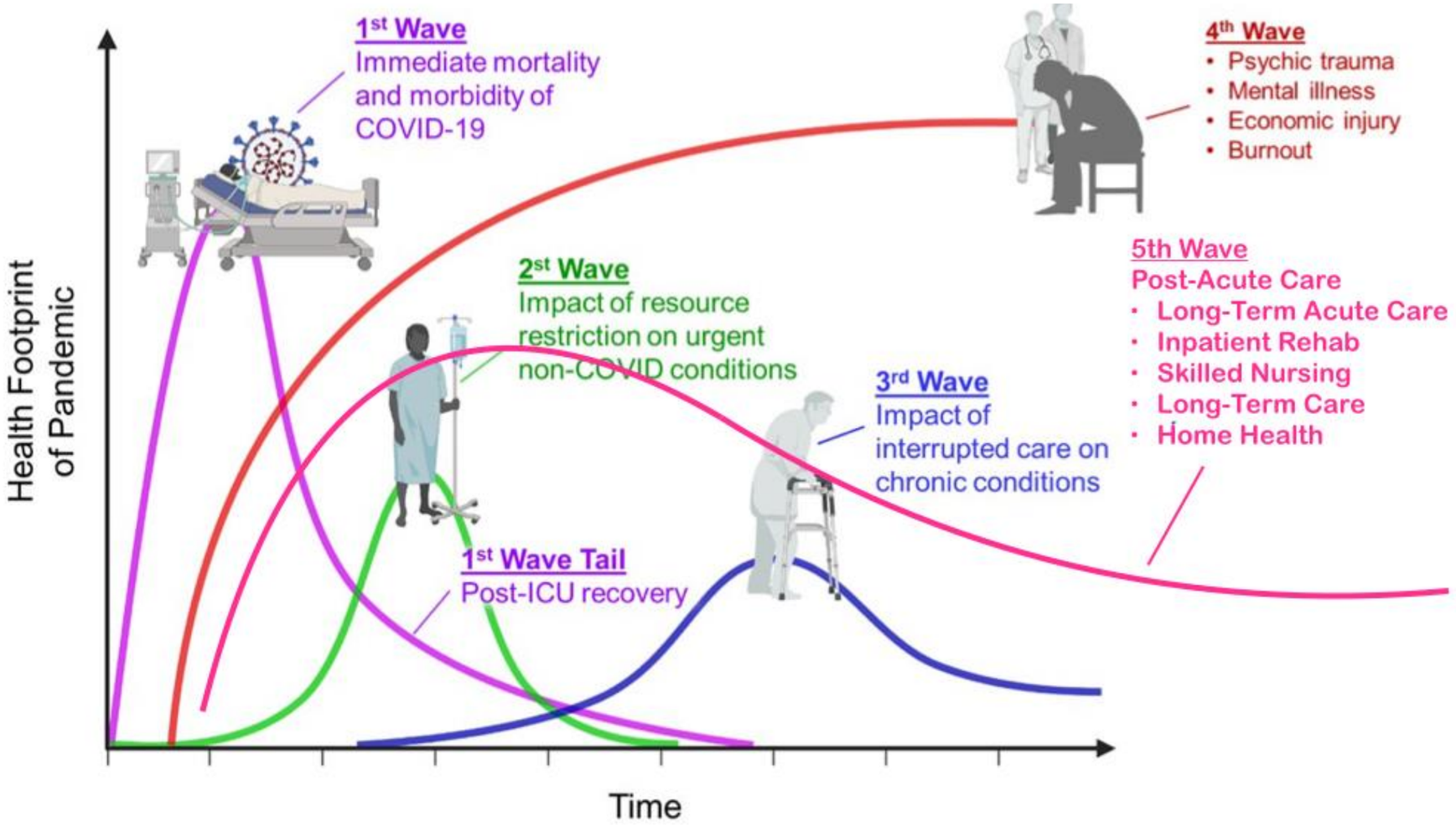
When There Was a Crisis, the System Leveraged the Plasticity of Family Medicine Physicians

Family Medicine led on many fronts because of their versatility, full scope and systems-level training to:

- care for patients across settings: ED, inpatient, outpatient, nursing facilities and home-based care
- lead and innovate in times of change—developing new workflows, staffing models and systems of care
- address health *and* social care needs
- provide integrated behavioral health and primary care

Martin, Shawn. "COVID-19: Lessons Learned So Far." AAFP *In the Trenches* blog. Posted Apr 28, 2020. https://www.aafp.org/news/blogs/inthetrenches/entry/20200428itt-covidlessons.html

Family Medicine Will Continue to be Needed in Each of the 5 Waves of COVID-19



McMicheal B. (MD) [@brimcmike]. (2020, April 05). Given the emerging COVID-Associated Neuro Morbidity + expected post-acute/post-critical care debility + the ordinary SCI/TBI/polytrauma, etc. I would add the Never-Sexy Post-Acute Care/LTACH/Rehab/SNF/Long-Term Care Post-COVID Wave that will likely overwhelm that system, too. [Tweet]. Retrieved from https://twitter.com/brimcmike/status/1247005625684570113

Despite This Value, Payment System Does Not Reward Primary Care

Authors estimate PC will lose > $65K/FTE physician

Independent and small practices particularly hard hit

RESEARCH ARTICLE THE PRACTICE OF MEDICINE

HEALTH AFFAIRS > AHEAD OF PRINT

Primary Care Practice Finances In The United States Amid The COVID-19 Pandemic

Sanjay Basu, Russell S. Phillips, Robert Phillips, Lars E. Peterson, and Bruce E. Landon

AFFILIATIONS

PUBLISHED: JUNE 25, 2020 Free Access https://doi.org/10.1377/hlthaff.2020.00794

"Our results ultimately highlight vulnerability of primary care practices to financial demise due to fee-for-service and visit-based payment policies, indicating that ***capitation-based payment reforms may be key to ensuring robustness of primary care into the future***"

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Need More Voices, Armed With Evidence and Stories, to Move the Needle on Payment Reform

Larry Green Center survey capturing insecurity, exhaustion, moral outrage, despair, grief, rage, despondency

"Seriously questioning whether to continue to stay and serve a society that doesn't seem to value me, my loved ones, or what we do"

"Primary care leaders and their supporters need to present a united voice to persuade public policymakers and health plan executives to act or US primary care will collapse."

Quick Covid-19 Primary Care Survey: Series 17 Fielded July 24-27, 2020.
https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/5f232458d3f9837f2a5bf19b/1596138585659/C19+Series+17+National+Executive+Summary.pdf

Building the Evidence Needed to Drive Policy

Traditionally, FM research focused on improving patient care and training

Innovation on front-lines of FM practice needs to be harnessed for ***research-based policy change***

New generation of learners hungry for big data, analysis and policy skills needed to advocate for change

Can/should we develop teaching case studies?

Getting This Done

Doesn't have to be "big R" NIH research

Build momentum and relationships ***within*** FM to bolster clinical-research partnerships

Bolster networks ***outside*** FM to health services researchers, public health, anthropology, sociology, economics, other professions

A Caveat: This Isn't Quick or Easy

Difficult to invest time in developing evidence and crafting policy messages with competing clinical and teaching demands

Speaking truth to power can be risky

Policy change is frustratingly slow and incremental, requires patience

But growing an evidence base and persevering in messaging ***does change*** way policy makers understand, and act on, pressing policy issues

Question and Answer

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