Implementing Primary Care Change in California

To Advance Primary Care in California, the Question is Not Merely What Do We Do, but How Are We Going to Do It?

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As the United States health care system undergoes its most dramatic transformation since the advent of Medicare almost fifty years ago, there is a clear sense of what needs to be accomplished – lower costs, higher quality, heightened consumer focus – and a far more tenuous grasp on the processes and mechanisms for achieving such sweeping changes. Policies created by the Accountable Care Act (ACA) and other health care market dynamics only provide the broad outlines for these changes, making the final details of the system that is emerging now unknowable. Despite this uncertainty, there are fundamental elements that will undoubtedly be part of the future health care system and these elements provide insight into the transformation process.

Future Health System Characteristic	Implications for Current Work
Less costly as a percentage of gross domestic product	Care delivery model innovations and changes for every type of service from primary to long-term care (limiting access or reducing payments are not enough)
Higher quality care	Care model changes that improve overall quality of processes and outcomes
Consumer focused	Care and system changes that satisfy the needs of consumers at the individual and corporate levels and are focused on delivering value to customers, rather than serving the needs of suppliers and providers

The Call for Change in Primary Care

Key to such a transformation is the re-configuration and re-positioning of primary care services as a part of the overall health care system. To date most of the active consideration around primary care change has focused on the implementation of the Patient Centered Medical Home (PCMH) – important parts of the ACA drive the system in that direction, including integration of care into systems, use of health information technology, payment reform and support for primary care education[i] – and while these developments have become increasingly specific and detailed at the federal and state level, there remains uncertainty as to how to move these needed changes into operation at the clinic and practice level.[ii]

Moreover, the complexity of this undertaking as an organizational change activity has been largely underestimated by most assessments. The process reengineering required for substantive alteration of primary care in a clinic or private office is complicated, involving the financing of care, business model of the clinic, professional prerogatives of the physician, physical make-up of the clinic, adequate information systems and tools,

adequately trained and motivated staff and the expectations of the patient/consumer.[iii,iv] While health reform and market dynamics provide the broad framework for change efforts, more detailed supports around developing a substantive program of the new primary care and the process skills to drive the change to success are needed.

The Change Process: Six Dimensions of Support

There are six dimensions of support for the change process that are needed by entities that provide primary care if they are to be successful with a care delivery reconstruction process. Some of these require policy or legal changes while others can be accomplished at the practice level.

Policy	Practice
• Scope of practice • Finance • Metrics	• Leadership • Information systems • Change selection and process

Scope of practice

Challenge: Most health care workers and professionals are regulated directly or indirectly by the states that issue a great variety of licenses, certifications and credentials to practice the various medical arts.[v] While these ostensibly exist to protect the public's health and safety, they are also viewed as tools to serve the guild interests of the professions, protecting brand, income and market control.[vi] Very few serious reformers believe that significant change can occur within the confines of the existing practice models, but few policy makers – with the notable exception of former Pennsylvania governor Ed Rendell – view scope of practice regulations as a tool by which to promote change and advance health reform.[vii,viii]

Opportunity: Fortunately, California has a long standing process for waiving the practice restrictions for demonstration projects aimed at improving quality, expanding access or lowering costs.[ix] However, the California Office of Statewide Health Planning and Development (OSHPD) sponsored process is seen in the field as slow and cumbersome. This process could be streamlined in a way to facilitate primary care innovation and also encourage more standardization of data collection and sharing. Enlarging the number of experimental practices and standardizing their assessment would also generate a richer evidence base for making policy and political decisions regarding long-term changes in the various practice acts. The process of bringing clarity and definition to scope of practice will in itself help promote change. Today many innovations are not considered because they wrongly are seen as violating existing regulations, when in fact they can be safely and effectively tried. In many instances, the psychological boundaries limiting practice change halt innovation long before the legal boundaries.

Finance

Challenge: There is perhaps no greater rate limiting reality to significant practice change then the various impacts of the ways in which care is financed. Payment for clinical procedures carried out by MDs, NPs and other licensed providers ties them to episodic

care, reduces their value to exam room exchanges, devalues other workers that could add value and locks care into the physical environment of the clinic and practice. While the return to a global financing system would be ideal, bundled payments may be easier to advance in hospital and specialty settings where a specific episode of care is being managed than in the primary care setting where comprehensive well-being and outcomes are at risk and a great variety of services are needed and expected by patients.

Opportunity: To advance change in primary care will require step-wise demonstration projects that permit global financing, measure clinical and financial outcomes, and build support for general payment reform including pay for performance, bundled payments, and other demonstrations that build new models of primary care. The desire will be for broad sweeping reforms, but as in scope of practice regulation, it will be more realistic to create focused demonstration projects that test a clinical performance and business model for one aspect of primary for a discreet population. These demonstrations must be evaluated in a consistent and rigorous manner in order to glean accurate assessments of clinical, managerial and financial practices and the change process steps that led to the successful implementation of the new practice model.

Metrics

Challenge: Measurement may seem an oddly specific recommendation to move change forward, but it will inevitably be essential to success. Sophisticated measurement means understanding fully how a specific change fits into an overall set of organizational goals. It also means the ability to isolate and understand the impact of a change in the short and long term on finance, clinical outcome, consumer satisfaction and organizational acceptance. In addition, these metrics must be able to be understood and valued by other organizations and patients so that they can determine the value of the innovative practice as potential partners or consumers.

Opportunity: Improving the metrics around primary care has immediate and longer-term implications. In the short run measurement practices should be improved by standardizing data collection and analysis processes. This step will of necessity include focusing data collection on specific items that can be readily assessed, understood and shared across the delivery community and represent good indicators of successful practice. Because the implications of a different type of primary care are also longer term, the measurement scheme must also keep an eye on how the impacts unfold over a longer time horizon. Developing widely shared standards, improving data collection and analysis skills, creating new means of sharing data collection practices and outcomes, demonstrating the value of such commitments will all be a part of a process of improving how metrics can drive change.

Leadership Practice

Challenge: One of the daunting realities of change in health care is that there is no shortage of alternative models for the organization of care services. There are a number of proven models that have been successfully deployed in organizations across the country over the past decade. In each of these settings leadership has been key in understanding the need for change, adapting best practices to current organizational realities, building from strengths, pushing past reservations of special interests and bias and sustaining the change process over an extended period of time. [x,xi] One assessment

of change in the hospital setting found success to be less a function of choosing the best idea and more an outcome of continual adaptation of the change process by leadership.

Opportunity: Bringing about change in primary care will require the same leadership attention. Clinics and practices will need to have leadership that recognizes the change process as multifaceted involving finance, clinical models, information technology, relationship with customers, and radically varied roles for professionals. These leaders will need to understand the macro themes of the health care reform, how these relate to their organizational challenges, how they can be mapped on to other strategic directions and how they contribute to new visions for success for provider organizations. Leaders will also need new skills that include communication, persuasion, political savvy, influencing others, leading change, measurement, financial alignment and working through teams. Finally leaders of such transition will need to have a commitment to break through innovations, but ones that can be shared and taken up widely throughout the organization.

Information systems

Challenge: There is a great deal of attention being paid to the proliferation of improved information management systems for clinical and organization processes in primary care. While these tools are essential for a more effective management of the health of populations, they will not of themselves lead to change. For this to take place it is essential that the information technology be integrated into the strategic re-work of the primary care processes.

Opportunity: To accomplish this it will be important that these efforts not be caught up with the automation of the current care model, but take full advantage of the ways in which information and a communications technology allows knowledge and information to move, engage the patient/consumer more fully, create new models for service delivery, and sponsor new business models and applications. This area of primary care change can be richly influenced by partnerships with organizations that currently use these technologies in creative ways as well as with developers of the technology.

These six dimensions represent ways in which innovation in care can move more quickly into the system. Action by organizations seeking to change their approach to primary care along these lines will lead to a more comprehensive and successful set of changes. Organizations seeking to support clinics and practice to change should consider actions that leverage these six, making them more accessible.

Change selection and process

Challenge: While it is important for those that wish to change primary care to understand the rationale for the change, it is even more essential for them to have easy access to evidenced based studies that focus on the improvement of some dimension of primary care, i.e. management of diabetes or incorporation of behavioral health into pain management. Most individuals and teams leading change efforts in clinical settings do not have ready access to the best evidenced based reviews of innovations, they are not well prepared to be critical of such studies and they need as much discussion of the

process that produced the change as the content of the change which is the focus of most scholarly studies.

Opportunity: To remedy this a compendium of reviewed resources with access to the individual and organizations that led the demonstration would be needed. As most such studies have not been critical of the process that was involved in change, it would be even more helpful to have at least cursory information on the perceived key elements of success in each change project and whether or not the project led to a broader change in the organization. There have been a rich set of public and private change efforts in California in primary care, but this resource is not currently available to help support change going forward.

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