# IssueBrief

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## Ten lessons for the path forward:

### What fosters sustainable primary care transformation? What stands in the way?

The Center for Medicare & Medicaid Innovation[1] (CMMI) has helped foster primary care transformation and shined a spotlight on successful programs. But innovative approaches to comprehensive primary care emerged before CMMI came into being, and ongoing success demands moving beyond what CMMI currently offers.

Lisa Dulsky Watkins, MD, knows this inside-out. Formerly with the Vermont Blueprint for Health, she now leads the Milbank Memorial Fund-supported Multi-State Collaborative[2] (MC), which comprises representatives of state-based primary care collaboratives.

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Each member collaborative is different, but all endorse some common core beliefs, she says. Delivery system transformation is predicated upon access to high-quality primary care and supportive services, and high-quality primary care is more likely to occur in a consistently supported and formally recognized patient-centered medical home setting. Moreover, primary care transformation can succeed only in a uniformly applied multipayer model coupled with collaborative learning and team-based care. Only through such a multipayer model can transformation efforts foster cost containment and affordability.[3]

The MC participants have gone a long way toward meeting these aspirations, but there's much left to do. The lessons—the ones learned and those still to be learned—have profound implications for primary care transformation, especially state-convened and/or multipayer payment reform initiatives. They are particularly important for federal organizations—from the Center for Medicare & Medicaid Services, to the Substance Abuse and Mental Health Services Administration, to the Office of the National Coordinator for Health IT—as they craft primary care initiatives.

Likeminded experts with firsthand experience have identified 10 lessons for achieving comprehensive primary care transformation.

[1] http://innovation.cms.gov/

[2] *Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative,* published in 2014, describes the efforts in states to take on these challenges.

[3] *Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative, op. cit.*

Also offering their insights:

- **Patrick Gordon** is associate vice president at Rocky Mountain Health Plans; he currently serves on the State Innovations Model (SIM) Advisory Board in Colorado, and the Accountable Care Collaborative in Western Colorado, an initiative to transform Colorado Medicaid.

- **Lisa Letourneau,** MD, is executive director of Maine Quality Counts, a regional health improvement collaborative committed to transforming health and health care in Maine by leading, collaborating and aligning improvement efforts.

- **Jenney Samuelson** leads the Vermont Blueprint for Health's Expansion and Quality Improvement Program.

## Leadership and engagement: Lighting the fire, fanning the flame

Stable leadership provides the structure necessary for sustainable change. Leadership and engagement at all levels—federal, state, community and practice—is essential to sustainable primary care transformation.

### *LESSON #1*
### Nurture effective and stable leadership

"Understand and foster leadership at the local level. That appears to be one of the magic bullets," says Dulsky Watkins. "There's no question that although participation in demonstration projects is very important, choice of local leadership is where rubber meets the road."

Samuelson stresses the importance of leadership at the practice, community and state levels. Each feeds the others, she says. For example, Blueprint leaders helped cultivate leadership and support among local health systems, primary care providers, hospital CEOs, etc. They also fostered support among Vermont's executive and legislative branches. So much so, in fact, that in 2008 the legislature required payers doing business in the state to participate in the Blueprint. One of the keys to generating that sort of support is transparency. "Show them the good *and* the ugly," she says.

### *LESSON #2*
### Gather together

Never underestimate the value of—literally—being together around the table. Face-to-face time has proven extremely valuable. Just sitting down in a room to grapple with the issues is a crucial step. Taking the time and effort to share data, ideas and experiences is hugely important: It builds relationships.

What's needed is an infrastructure that can build a bridge between what's happening at the policy and payer levels, and what's happening in practices, says Gordon. Convening at state, local and regional levels allows for more flexibility. "One reason Rocky's programs work is because we're small and close to the ground. That means we have access to intelligence; these programs are free to promote and 'chase' value."

### *LESSON #3*
### Spark physician enthusiasm

Engaging the practice leaders is important, but the clinicians themselves need to be excited, committed and invested. In successful efforts, they serve as champions with a visible commitment to improve care. They take an active role in building a team-based approach, Letourneau says.

Letourneau doesn't talk about "physician engagement." She takes it a step beyond: "Find ways to reignite and nurture the professionalism that drives providers." It's a powerful motivator. Practice transformation efforts should appeal to this sense of professionalism and frame transformation as a set of changes to help clinicians do their jobs better. Her advice to any entity sponsoring

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such an effort: *Clearly communicate a vision for practice transformation that both supports the clinician's sense of professionalism and identifies high-quality patient care as its primary goal.* Doing this involves leadership development to help clinicians identify their personal vision for change and offers support for providers to manage change while developing professionally.

Practices need to commit to an extended process of change, Gordon says. Letourneau warns, however, that the Maine experience shows primary care clinicians and practices—even those engaged in transformation—vary considerably in readiness. Without changes in payment models, some may never be able to take the journey.

Primary care physicians, says Dulsky Watkins, have been bearing the burden of transformation with very little, if any, direct financial compensation. "I'm not saying they are all altruistic, but there is a willingness to make things better for their patients and practice, a willingness to undergo upheaval—and a willingness to do it again if they believe it is best for their patient population," she says. "Remarkably, these practices do see tremendous value in understanding transformation despite the price they pay." But it's an unsustainable burden.

That's why sustainable financial support is essential.

## Meaningful public and private sector support

Success requires coordinated, cohesive and concrete support from public and private payers, including a move away from fee-for-service payment. It also requires better alignment and coordination among the multitude of programs, initiatives and pilots that purport to advance primary care.

### *LESSON #4*
### Demand federal commitment, action and coordination

"The sort of transformation we're talking about won't happen without CMS. Private initiatives work, but the public sector needs to move too, now. CMS should act to recognize advanced primary care as a new provider type," says Gordon. "Ideally, CMS has to act to recognize advanced primary care. [See sidebar on page 4 for one possible approach to recognition.] In addition, the public sector needs to take part in these programs."

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Dulsky Watkins agrees, pointing out that all the members of the MC consider Medicare's participation absolutely essential.[4]

Gordon identifies another change needed at the federal level: Better coordination among programs. Current efforts are siloed. It's not just an issue with CMMI, but across the federal government, he says. What's required is better coherence and coordination among federal agencies and their programs when it comes to practice transformation. "Right now, all these programs are disconnected from one another," he says. "That slows the learning process, and leads to duplication and distraction in policy development."

### *LESSON #5*
### Offer meaningful financial support

Success rests on putting resources—data, financial, human—in place, says Samuelson. Financial support is essential, and it can't be offered in isolated pots of nonrenewable funding. "People spend time chasing grants and other demonstration opportunities, but by definition they are temporary—not sustainable," says Dulsky Watkins. When the funding evaporates, the program is dismantled.

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[4] *Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative, op. cit.*

Such support must involve more than "turning on reimbursement codes," Gordon says. There needs to be more clarity around what constitutes effective financial support. "What works? Per-member per-month payments? Population-based reimbursement? We need further conversation about what constitutes an effective mix of financial supports."

Letourneau offers this one imperative: "Change payment to an alternative model that isn't primarily fee-for service." In fact, primary care transformation activities are essentially at odds with the fee-for-service approach. Transformation requires a substantial investment of clinician and staff time, Samuelson says. Transformation can interfere with the emphasis on high-volume productivity that is required in a fee-for-service model; in effect, transformation could compromise revenue to the practice."[5]

## *LESSON #6*
## Encourage multipayer participation

Because financial support is crucial, multipayer collaboration is essential. When payers align in a community, the opportunities for transformation expand. Conversely, isolated payer-specific reforms often struggle, Dulsky Watkins says. Moreover, she notes that practices resist full-scale practice transformation when payers are not in alignment.[6]

Letourneau agrees. It's not just that "one-off" programs fail to take advantage of the synergy between payers; they also put an even greater administrative burden on providers. Medicare is the single largest payer in the Maine market, but the Maine Patient Centered Medical Home Pilot (or efforts to change primary care payment in Maine) would have failed without the involvement of other major payers.

Dulsky Watkins offers a similar perspective: "It's important to sustain Medicare's participation in multipayer efforts that support primary care transformation." The largest, most influential payer has historically led the way. There's plenty of innovation going on outside of that, but by sheer volume of reach, Medicare—the biggest payer of all—has an "immutable impact on decisions of the others."

## Moving ahead:
## A new provider category?

In a 2015 *NEJM* Perspective piece entitled "Accelerating adoption of high value primary care: A new provider type in Medicare?" Richard J. Baron, MD, MACP, of the American Board of Internal Medicine, and Karen Davis, PhD, formerly of the Commonwealth Fund, call for a new provider category: the Advanced Primary Care Practice (APCP). It would have its own eligibility standards and accountability for performance on patient outcomes, care and resource use, linked to a new payment approach. They describe it as "a bundle of services provided by a team using a technology platform designed to support a variety of visit-based and non-visit-based activities rather than as a discrete cognitive service offered by physicians."

"Everything we are doing aligns with this," says Samuelson. That was also the general consensus among the MC membership. But whether it will really represent a change remains to be seen. Letourneau says the concept is useful inasmuch as it "sets the expectation that we need something different. Primary care is constantly battling its way out of the hold of being undervalued and underpaid. We are dying for better payment models." At the same time, such a move would have to represent a real change. "We have to distinguish the new model from the current broken-down model."

Dulsky Watkins agrees. "The idea is brilliant. What happens is another story."

[5] http://blueprintforhealth.vermont.gov/reports_and_analytics/annual_reports

[6] *Aligning Payers and Practices to Transform Primary Care: A Report from the Multi-State Collaborative, op. cit.*

The issue, says Gordon, is less about the source or even level of payment. What matters is the form—specifically, payment that supports value over volume. Physicians and payers alike are coming to understand how payment drives—or doesn't drive—change.

## Practice transformation that reaches across the continuum

Successful innovation programs offer hands-on support to practices, including assistance with health IT and new team-based work flows. Without such support, the funding won't make a big difference.

### *LESSON #7*
### Offer technical assistance and collaborative learning

Money alone—no matter how much—isn't going to create results. "You can promise me a million dollars if I win the Olympic marathon," says Letourneau. "That would be a great incentive, but it's not going to make me win. You can change the payment all you want; it won't change what I'm capable of doing."

Practice transformation may be a trice easier than winning a marathon, and fortunately there can be more than one winner. But in both examples, nothing happens without coaching. "Too often, we haven't focused on the need for practice transformation assistance—it just hasn't been part of the equation." Successful programs, such as those in Colorado, Maine and Vermont (and others in the MC project), offer technical assistance and collaborative learning, believing that these activities are essential to continued success.

### *LESSON #8*
### Embrace team-based approaches that extend beyond the practice

Transformation efforts should support a team-based approach that frees clinicians to practice at the top of their skill level and relegates administrative tasks to others. Successful practices expand team roles to improve clinical workflows; members see themselves as part of the practice team and can identify their specific roles and responsibilities.

Efforts must be community based: They start within the walls of a primary care practice but move far beyond, across the continuum of care and into the community. In the Maine program, practices identify and refer individuals and families to local community resources and social support services to help them overcome barriers to care and meet goals.

Vermont's community health team accomplished something similar. Community health teams work with primary care providers to assess patients' needs, coordinate community-based support services and provide multidisciplinary care for a general population.

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> **executive director, Maine Quality Counts**

## Realistic evaluation based on meaningful data

Transformation is not once-and-done, and neither is evaluation. "It's important to keep the evaluation rigorous and transparent. What is the connection between the intervention and its impact on value? It may take a while to get it, but there has to be an answer," says Dulsky Watkins. And, she adds, it's important to hold participants accountable for their relative success or failure.

But appropriate evaluation happens only when an initiative is given enough time to succeed or fail.

## *LESSON #9*
## Establish realistic time tables for evaluation

"It's taken a while to get information that helps us learn about whether these programs are working," says Dulsky Watkins. "This is a central statement we've been making: Evaluation periods are too short." Credible evidence is emerging to show that a sustained program—five to 10 years—provides a more realistic basis for evaluation, she adds. Unfortunately, larger programs have expiration dates, and they tend to be just two to three years. That's not enough time to see programs come to full maturity and if investments made are viable. The good news, she says, is that some at CMS are taking these concerns seriously; some programs have received extensions.

Too often, evaluations are based on short-term data—frequently, data collected while the participants were building infrastructure or simply getting up to speed. Such an approach encourages innovations to focus on short-term gain instead of long-term transformation. No one benefits from that, says Gordon.

That's one reason, Samuelson says, that the Vermont Blueprint simply doesn't seek short-term demonstration funding.

It's impossible to tell if a program is working over a short time frame, agrees Gordon. And that prevents meaningful evaluation. "The beauty of innovation center programs is that those that show value can be turned into formal programs without congressional actions. But evaluation cycles are long and clunky—too 'inside the beltway,'" he says. There is need for a more thoughtful and strategic approach to evaluation, both in terms of communication and process.

What's required to evaluate efficacy? Accurate and timely access to data.

## *LESSON #10*
## Obtain timely, accessible and useful data

Data is essential to evaluating patient care and provider effectiveness. The collection, cleaning, analysis and distribution of accurate and timely information are paramount, but even the most advanced practices struggle with complexity and costs, says Dusky Watkins. "We are starting to see it. It's early, but we're getting some traction." All-payer claims databases are huge undertakings and demand the willingness to invest in analysis. She points to Vermont as an example of a success story.

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>
> **— Patrick Gordon, MPA, associate vice president, Rocky Mountain Health Plans**

The ability to rapidly share results is critical to facilitating practice transformation, says Letourneau. Clinicians respond to data feedback, and evidence supports that as an effective tool to improve the quality of care.[7] Many small and independent practices may need significant assistance in developing these systems, and most practices still lack systems that can provide them with timely data on utilization and costs and help identify high-risk patients.

Payers, at a minimum, should provide claims-based reports that include demographics, total cost and resource use per member per month (pmpm) with trends, pmpm by service category, utilization by inpatient, outpatient, professional and pharmacy, and chronic care patient summaries, says Letourneau.

She adds one more point about data: It takes a while for practices to trust the information. Sometimes, the data is just wrong, she says. And sometimes, they are undergoing what's been termed "The 5 Stages of Data (grief)"—denial, anger, bargaining, depression and acceptance. It's never a mistake to question data,

[7] Nutting PA, Crabtree BF, Miller WL, Stange KC, Stewart EE, Jaén CR. "Transforming physician practices to patient-centered medical homes: lessons from the National Demonstration," *Health Affairs,* 2011. 30(3):439–45.

but eventually practices need to act on what they learn. "It can be a big, ugly, messy process, but it's extremely important."

## Moving forward: Progress trumps perfection

Leadership, engagement and collaboration are all essential to primary care transformation, but not all the requirements are quite so lofty. Dulsky Watkins, Gordon, Letourneau and Samuelson all stressed the hard work required. From hands-on practical assistance to accessing and crunching data, it's a heavy lift, and it requires the cooperation of payers, providers, government agencies and the larger health system.

Not all of that will happen at once, and achieving all the goals may not be possible. But that's not the point, says Gordon. Perfection is too often the enemy of the good, he warns. "We don't need perfection. We just need sustainable progress."

**LISA M. LETOURNEAU, MD, MPH, FACP**
*Executive Director*
*Maine Quality Counts*

**LISA M. LETOURNEAU, MD, MPH, FACP,** serves as executive director of Maine Quality Counts, a regional health improvement collaborative, and as physician champion for several quality improvement efforts, including the Maine Aligning Forces for Quality initiative and the Maine Patient Centered Medical Home Pilot. A board-certified internist who practiced emergency medicine for seven years before beginning her work in clinical quality improvement, she is a graduate of Brown University and the Dartmouth-Brown Program in Medicine. Letourneau holds a master's degree from the Harvard School of Public Health, and has particular interests in helping build connections between public health and clinical care, and the role of physicians in helping to develop and lead health improvement efforts.

**JENNEY SAMUELSON**
*Vermont Blueprint for Health*

**JENNEY SAMUELSON** leads the Vermont Blueprint for Health Expansion and Quality Improvement Program (EQuIP), which consists of a team of 13 highly trained practice facilitators who assist more than 100 adult, family and pediatric primary care practices to implement continuous quality improvement. Samuelson also oversees the statewide implementation of the Blueprint community-based self-management programs, including six evidence-based programs, among them the Stanford chronic disease, chronic pain, and diabetes self-management programs. Before joining the Blueprint, she administered diverse community and statewide public health programs, including leading a four-county health careers workforce development program and directing Vermont's Lead Poisoning Prevention Program.

**LISA DULSKY WATKINS, MD**
*Director, Milbank Memorial Fund-supported Multi-State Collaborative*

**LISA DULSKY WATKINS, MD,** formerly with the Vermont Blueprint for Health, now leads the Milbank Memorial Fund-supported Multi-State Collaborative, which comprises representatives of state-based primary care collaboratives. Dulsky Watkins was in general pediatric practice in Vermont from 1988 until 1997, when she began a career in the public health and health information fields of medicine. She has been a researcher at the Vermont Program for Quality in Health Care, Inc., a medical content reviewer at Problem Knowledge Couplers Corporation and has worked for Vermont since 2006. As operations chief for the Vermont Blueprint, she managed a multi-million dollar budget with over 30 grants, contracts and memoranda of understanding. She served as a central liaison with Vermont's health system community and is a frequent guest lecturer.

**PATRICK GORDON, MPA**
***Associate Vice President***
***Rocky Mountain Health Plans***

**PATRICK GORDON** joined Rocky Mountain Health Plans (RMHP) in 2004 as the director of government programs. He leads the Medicaid Accountable Care Collaborative project in Western Colorado. Within RMHP, he is accountable for the operational, financial and regulatory performance of the Medicaid, Dual Eligible, CHP+ and Medigap programs supported by the health plan. He previously served as executive director of the Colorado Beacon Consortium. He has also led and implemented several strategic projects for RMHP and stakeholders in Western Colorado, including the design and implementation of a performance incentive arrangement with the State of Colorado and participating physicians to achieve Triple Aim objectives; the implementation of a Medicare Part D Prescription Drug program and targeted coverage arrangements for dual eligible beneficiaries; development of Medicare supplemental insurance offerings; and a Medicare service area expansion in 10 Wyoming and two Colorado counties.

Prior to joining RMHP, he held various positions within the Colorado Department of Health Care Policy & Financing related to Medicaid, CHP+ and Nursing Facilities policy development and program management. Gordon earned a master's degree in health policy/economics from the University of Colorado, and has received certification from America's Health Insurance Plans Executive Leadership Program. He also serves as president of the Pinon Institute, a center for thought, leadership and culture change within long-term care.

## About Rocky Mountain Health Plans

Founded in Grand Junction, Colo. in 1974, as a locally owned, not-for-profit organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

## About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health.

We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.
- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

**For more information:**

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