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Professional Satisfaction, Payment, & Organizational Resilience

Mark W. Friedberg, MD, MPP
SVP, Performance Measurement & Improvement

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Disclosures

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Employment: Blue Cross Blue Shield of Massachusetts is my primary employer. I worked at RAND 2009-2019.

Research support since 2016: I have received financial support for research from the Agency for Healthcare Research and Quality, American Board of Medical Specialties Research and Education Foundation, American Medical Association, Center for Medicare & Medicaid Innovation, Centers for Medicare & Medicaid Services, Cedars-Sinai Medical Center, Commonwealth Fund, Milbank Memorial Fund, National Institute on Aging, National Institute on Drug Abuse, National Institute of Diabetes and Digestive and Kidney Diseases, National Institute on Minority Health and Health Disparities, Patient-Centered Outcomes Research Institute, and Washington State Institute for Public Policy.

Consulting since 2016: I have received personal payments from Consumer Reports for consulting services, from Wolters Kluwer for co-authorship of an UpToDate article about hospital quality measurement, and from Harvard Medical School for tutoring medical students in health policy.

Travel since 2016: Outside of research, employment, and consulting, I received support to attend meetings from the American Medical Association, Gordon and Betty Moore Foundation, and United States Department of Veterans Affairs.

Clinical practice: I have a clinical practice in primary care at Brigham and Women's Hospital and thus receive payment for clinical services, via the Brigham and Women's Physician Organization, from dozens of commercial health plans and government payers, including but not limited to Medicare, Medicaid, several Blue Cross Blue Shield licensees, Tufts Health Plan, and Harvard Pilgrim Health Plan, which are the most prevalent payers in Massachusetts.

Main topics

Discuss relationship between quality, mission, and professional satisfaction

Review pros and cons of alternative payment models

Discuss organizational resiliency during times of stress

Context for this talk

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COVID-19 pandemic

- Public health catastrophe
- Economic recession
- Dropoff in fee-for-service and similar visit-based revenues for providers
- Rapid adoption of telemedicine

Increased focus on inequities in care

- COVID-19 has disproportionately harmed already-vulnerable communities
- Broader national conversation on structural racism, not just in health care

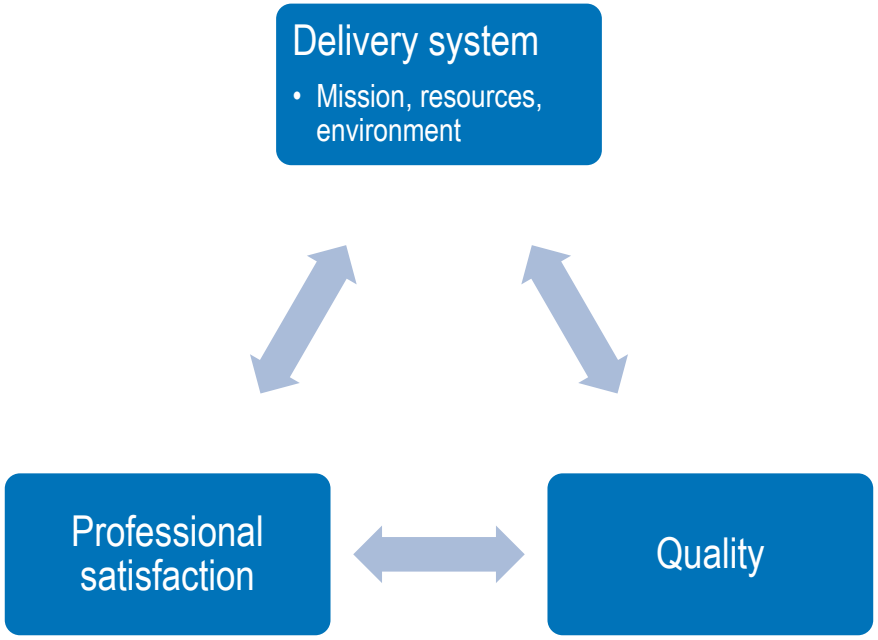
Possible imminent demise of Affordable Care Act

→The importance of Federally Qualified Health Centers has increased

How does professional satisfaction relate to quality?

Is it this?

Or this?



Quality of Care & Professional Satisfaction: the 2013 RAND/AMA study

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Being able to provide high-quality patient care is satisfying to clinicians and staff

Available for free download: https://www.rand.org/pubs/research_reports/RR439.html

Being able to provide high-quality patient care is satisfying

Obstacles to high-quality care are major sources of dissatisfaction

> *The unrelenting pace of patient care…with 15- and 20-minute visits for people who avoid seeking health care until they have serious problems, not only led to innumerable long hours, but also was an error waiting to happen. … Even though you're trying 120 percent to do the best by everybody, you can't catch everything at that pace.*
>
> *—primary care physician*

Quality of Care & Professional Satisfaction: the 2013 RAND/AMA study

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Being able to provide high-quality patient care is satisfying

Obstacles to high-quality care are major sources of dissatisfaction

Similar results in quantitative analysis

- Significant predictors of better satisfaction:
  - —Feeling like it's possible to provide high quality care
  - —Practice tries out ideas to improve quality
  - —Receiving useful feedback about quality of care
- Feeling overwhelmed by patient needs was the strongest single predictor of worse overall professional satisfaction and greater burnout

Quality of Care & Professional Satisfaction: the 2013 RAND/AMA study

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Being able to provide high-quality patient care is satisfying

Obstacles to high-quality care are major sources of dissatisfaction

Similar results in quantitative analysis

Clinicians and staff as “canaries in the coal mine” for quality

- Sources of dissatisfaction can also be threats to quality
  - Investigate and verify what clinicians and staff are saying
- Solutions not just important to clinicians and staff

General Implications

Understanding the specific factors affecting professional satisfaction is important

When clinicians and staff members report that something is professionally dissatisfying, follow it up: *Is there a quality problem here, and if so, how can we fix it?*

- Identify opportunities to benefit patients, clinicians, and other stakeholders
- Increasing the number of "satisfied clinicians" not the only or ultimate goal

Short AHRQ blog post on this point: https://psnet.ahrq.gov/perspective/relationships-between-physician-professional-satisfaction-and-patient-safety

Implications During COVID-19

Professional satisfaction is likely to take a hit

To ride this out: double down on mission, and make sure front-line clinicians and staff have the support they need to deliver excellent care (e.g., PPE, technology)

If the necessary support isn't available, it's OK to say "no" to putting your clinicians and staff at personal risk, or even at risk of delivering what they perceive to be substandard care. In other words, try to avoid putting FQHC clinicians & staff in an impossible situation. Better to say, *"This is an impossible situation"*—and try to change it.

Intermission

Pros and Cons of Alternative Payment Models

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COVID-19 has interrupted revenue from fee-for-service and other visit-based payments models

Alternative payment models (APMs) look attractive due to

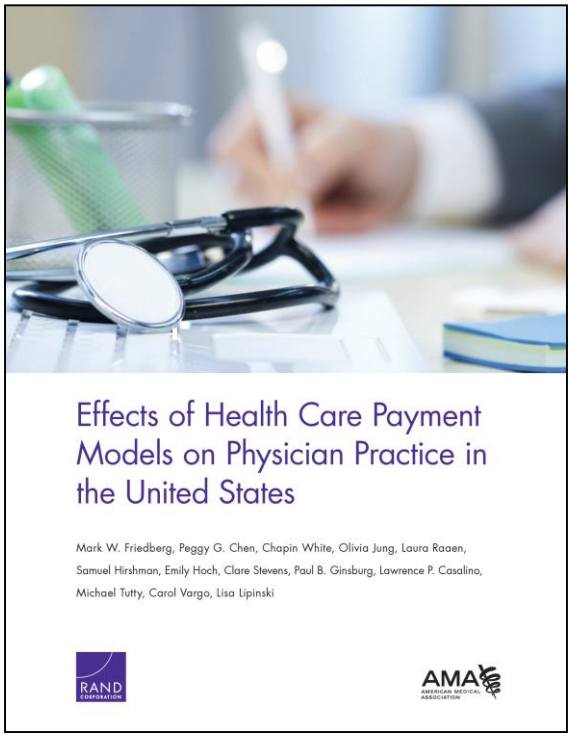
- More predictable revenues, especially in capitation-type models
- Dispensing with fee-for-service minutiae like "*After the pandemic, will telehealth phone calls still be paid?*"

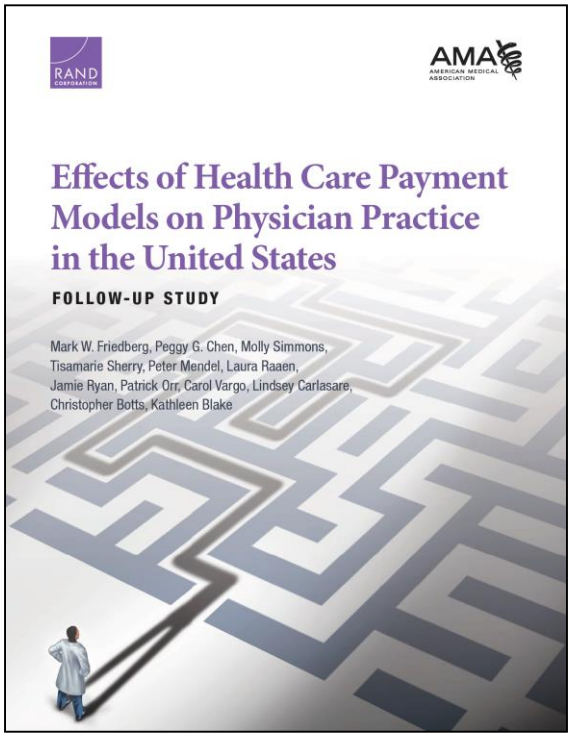
Are APMs right for your FQHC?

- It depends on your FQHC and on the details of the APM
- I'm going to talk through some things to consider
- Bottom line:
  - Don't get into an APM that you don't understand
  - Get help. Consider hiring an actuary to model your risk/benefit likelihoods and advise you.

Findings of two RAND-AMA studies on APMs

Overall take-home in 2015 and 2018: Doing well in APMs requires resources and guidance





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Challenges of APMs

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Overall take-home in 2015 and 2018: Doing well in APMs requires resources and guidance

Challenges:

- Data issues (timeliness, accuracy)
- Complexity of payment models
- Conflicting payment models

Challenges of APMs: Data

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Data issues: timeliness and accuracy

We've had three months in this year…[and] they're supposed to give us a list of what we need to do this year for our patients… [but] we still don't know what we're supposed to do on these patients. Are we supposed to get mammograms on them? Because they're supposed to give us a list of who needs what, and it was supposed to be done two days ago, and they said "Oh, it's not going to be done until the next refresh, which is next month." ***So we're going to go a quarter of the year into the program, without really having the data to actually do what we were supposed to do****. So all we can do is guess. …It just would be nice at the beginning of the year, at the very beginning, the first of the year, or let's say in December of the previous year, if they just said, "This is what we're measuring. So as you're seeing your patients here, why don't you start working on this?"*

--Physician owner of a small primary care practice participating in PFP programs

Challenges of APMs: Complexity

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Complexity of payment models: Practices had to make investments to understand & comply with APM requirements

Finding qualified people to run this program has been awful and especially with what the physicians would want to pay to get that quality. You've got to know IT. You've got to know some medicine. You've got to know how to put documents together. You've got to know how to work Excel. You've got to know how to do presentations. You've got to know how to do all of it, you know, the blah-blah—I mean it goes on and on and on—if you're going to do it right. You have to do budgets for CPC. You have to show them how you spent the money. You've got to make sure you're legal doing this or they can come in and take all of your money back from you that you've already used to pay people…

--office manager of medium-sized primary care practice, discussing CPC+

Challenges of APMs: Conflicting incentives and measures

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Having multiple payers created conflict between APMs and fee-for-service

- APMs incentivize avoiding low-value care and preventing high-cost complications
- Fee-for-service incentivizes the opposite

Cacophony of measures across payers

The PQRS [measures] don't line up particularly well with the meaningful-use ones and, you know, all sorts of other [measures.] ***It's like [having] 50 people shouting their priorities at you, and then trying to prioritize those into some semblance of order****. . . . It does have this, sort of, feeling of "make-work" at some level. . . . You lose sight of [whether] this is really having true clinical impact or is this just, you know, like winning the video game? And that's what it starts to feel like after a while, when you have a list of 50 things that you're chasing.*

—leader, large multispecialty practice

Common strategies for APMs

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Overall take-home in 2015 and 2018: Doing well in APMs requires resources and guidance

Challenges:

- Data issues (timeliness, accuracy)
- Complexity of payment models
- Operational errors in payment models

Strategies used by practices:

- New capabilities & patient care models
- Investment in data & analysis
- Incentives modified within practices

Strategies for APMs: New capabilities

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Primary care practices have become more comprehensive

*So we have a **medical home care coordinator program** at the clinics, those are expanding, but also their job roles are expanding to include things like social determinants of health assessment and dealing with issues like transportation and referral to agencies. We're **embedding behavioral health providers in the primary care clinics**, so we have an entire training program online and in person for both therapy folks, as well as the pediatricians, to prescribe medications. **We even have a substance abuse program**, where we're prescribing medications for opioid withdrawal in some of our primary care practices, that's like world changing.*

--physician leader of large multispecialty practice

Strategies for APMs: Data & analytics

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Practices have invested in their data infrastructure and analytic capabilities

We follow our own measures… I have the target goals right here …it's in the system. ***We have a scorecard that we're able to look at, and it's updated on a weekly basis****. So I can see where we fall. I can see what measures we're doing really well on, I can see what measures we're still struggling with,* ***and I can dive down to the provider and I can see which provider is struggling with which measure****. I can also identify the missed opportunities that the provider had. So, you know, of these patients that walked in to see you in the month of March, or in the month of February… hypothetically speaking, 200 were in need of these screenings and only 100 got screened. So what happened to the other 100? …I'm able to get that report to that level.*

--clinic administrator within a large multispecialty practice participating in capitation and PFP

Strategies for APMs: Incentives modified within practices

Quality incentives passed through to front-line clinicians, but only after modification in most cases

Cost incentives almost never passed through as individual clinician financial incentives. But other, non-financial techniques can be used…

There's no differential payment of individual member practices, according to their [total medical expenditure] or quality performance, but every one of us got A's in college, at least, and a lot of us got A's in medical school, and if you send me a report that says that I'm a bottom feeder, I'm pretty bent out of shape, and I want to get those A's.

--physician leader and practicing physician in a primary care practice within large organization

My overarching advice re APMs

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Don't get into an APM that you don't understand

- The most critical questions to any payer:
  - —What are you asking us to do differently? *(Check: is this consistent with your mission?)*
  - —How does this APM incentivize those things and enable us to succeed?

Make your decisions about APMs based on congruence with your clinic's mission. And also some cold, hard financial calculations.

- —Trap to avoid: Signing up for APMs because it's cool.
- —Watch the cash flow. When is the payout? Does success require up-front investment? Where will you get the funds?
- —Get help. Consider hiring an actuary to model your risk/benefit likelihoods and advise you, especially if you're substantially on the hook for cost overruns.

Organizational resiliency during times of stress

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Financial resiliency

Crisis as opportunity

This is the part of my talk where the evidence is thin

Financial resiliency

Financial resiliency: Revenues

- Talk with payers. I recommend a straightforward “this is our financial situation” approach.
  - —Distinguish cash flow problems from accrual problems, give clear time horizons (even if these are best guesses)
- Commercial payers have an interest in FQHC well-being
  - —Ask about community engagement resources, foundation grants
- Political engagement, lobbying

Financial resiliency: Expenses

- Distinguish mission-critical from non-critical activities
  - —Cut mission-critical expenses last, due to potential impact on clinician and staff professional satisfaction
- Identify expenses that can be delayed, even if this costs something in the long-term

Crisis as opportunity

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COVID-19 has increased the importance of FQHCs

- In a pandemic, we are all connected. A hot spot in one community won't stay there.

New emphasis on racial and ethnic inequities in health and health care has increased the importance of FQHCs

- Many payers are extremely interested in closing these inequities
- Proposals that target inequities will probably get more traction right now than ever before

Shift to telehealth

- The US health care system seems unlikely to return to pre-COVID rare usage of remote care
- Proposals to address the digital divide are getting some traction

Thank you