# Transformers:

## Enabling Physicians to Lead Healthcare Delivery System Reform

> "It is not necessary to change. Survival is not mandatory."
>
> — W. Edwards Deming

**There is near-unanimous agreement that our current healthcare delivery system, built upon a fee-for-service foundation, is unsustainable. The system must undergo – and now is experiencing – fundamental change to ensure continued access to essential healthcare services without placing our country's economic health at grave risk.**

**The success or failure of continued healthcare reform depends on the willingness and ability of physicians to transform how they practice medicine. Today, the practice of medicine is, for the most part, an individual sport. New care models, however, envision teams of providers working together to maintain the health of a population.**

**These models assume physicians will step into the role of team captain. With their clinical expertise, physicians will be asked to lead initiatives to decrease per-capita cost, improve quality, and coordinate services across the care continuum.**

## trans·form·er

noun /tranˈ(t)s-ˈfor-mər/

1. **A device that changes the voltage of an electric current**
2. **A person or thing that transforms**

But are physicians prepared to assume these new leadership roles? Are they ready to be the spark that ignites systematic reforms? And is the industry providing the resources physicians need to become transformers?

Based on a 2013 survey of chief medical officers, the American Hospital Association's Physician Leadership Forum identified transformational competencies necessary for physicians to truly become "team captains":

- Leadership
- Systems theory and analysis
- Use of information technology
- Development of multi-disciplinary teams
- Working knowledge of population health management
- Understanding of resource management, medical economics, health policy, and regulation
- Interpersonal and communication skills

However, medical schools' curricula often do not address these competencies. A comprehensive study of medical school curricula[1] revealed significant gaps in traditional medical education with regard to the following:

- Leadership and management skills
- Continuity of care
- Procedural skills
- Office-based practice competencies
- Clinical IT meaningful use skills
- Care coordination
  - Inter-professional team skills
- Systems thinking
  - Population management skills
  - Reflective practice and continuous quality improvement skills

Through our work with thousands of physicians in different practice settings – from solo practitioners to physicians who are part of large, integrated delivery systems – we have identified a near-universal need to develop physician core competencies to drive systemic change. Based on our observations, the physician competencies needed most in our evolving healthcare system are **leadership, consumer engagement, and population health.**

## Leadership

The traditional physician group practice is often a collection of individual practices, sharing overhead costs and call coverage – and little else. Each physician frequently works independently, assisted only by support staff. Most doctors believe they control their own destiny, both in terms of financial and clinical success. Physician colleagues, even partners, are viewed as having limited impact on an individual doctor's practice.

In this traditional setting, leaders are enlisted by their colleagues to represent local physician interests in negotiation with the outside world. Such negotiations usually involve securing resources, entering into contracts, or rallying the group to take advantage of an opportunity or to face a real or perceived threat.

In the new age of accountable care, however, success will be tied more to collaboration with colleagues than to individual effort. An individual physician's compensation will depend on how efficient all physicians are in delivering care that meets pre-determined clinical quality and cost metrics.

The physician leader will no longer merely represent his or her colleagues' interests in dealings with third parties. Instead, the leader's primary role will be enabling those colleagues to meet those standards and holding them accountable for their performance. Additionally, physician leaders will assume responsibility for building collaborative partnerships with other community providers and payers.

While physician leaders in traditional settings split their time between clinical practice and management responsibilities, physician executive positions in integrated delivery systems are often full-time. Physicians who take on these roles will find themselves having to lead physician colleagues and other clinicians through turbulent changes in practice patterns and reimbursement. Additionally, physician executives will have to deal with broader business issues facing their organizations.

While there are certainly those with natural aptitude for leadership, there is an acute need to increase the investment in leadership training and resources offered to physicians aspiring to be executives. Providers and payers seek opportunities for physician-oriented leadership training, and are often not pleased with the programs available.

As a result, many integrated delivery systems and payers now are offering internally-sponsored leadership training to physicians, utilizing third-party resources and firms to provide training, or choosing to grow their physician leaders in-house through an investment in the production of leadership materials and the development of leadership academies, discussed later in this briefing.

[1] Gaps in Residency Training Should be Addressed to Better Prepare Doctors for a Twenty-First-Century Delivery System, HEALTH AFFAIRS (November 2011).

## Consumer Engagement

The second transformative competency for physicians is engaging the patient as a consumer of healthcare goods and services. As we have explained previously, the rise of consumerism is one of the forces reshaping our healthcare system.[2]

Physicians' roles in this transformation include supporting patients in evaluating costs associated with treatment options, counseling patients to avoid unnecessary or unproven treatments, and embracing pricing transparency.

### Cost of treatment options

One of the key reasons the cost of healthcare has grown exponentially is the fact that most patients do not pay out-of-pocket for healthcare services. Without "skin in the game," consumers have not made healthcare decisions based on price. And without the consumer exerting downward pressure on prices, they have risen far in excess of the inflation rate.

Now, with the rise of high-deductible health insurance products, more consumers want cost information as they evaluate treatment options. As a result, physicians find themselves pushed into a new, uncomfortable role, helping patients make cost-benefit analyses about treatment options and locations.

Some argue that physicians should voluntarily assume this role, noting the relative cost of treatment options often has more relevance for a patient than potential side- effects. As Dr. Peter Ubel asserts:

*Take, for example, a patient with colon cancer whose oncologist is considering prescribing Avastin. Most physicians would go out of their way to warn that this drug could harm a patient's heart; the data show that it carries a 2% risk of cardiovascular toxicity. But few physicians would discuss the price, even though Avastin can cost more than $50,000 per patient, and a Medicare patient without supplemental insurance could be responsible for nearly $9,000 of that.*[3]

### Unnecessary or unproven treatments

Medical societies have also come to grips with the need to decrease the per-capita cost of healthcare. Since 2011, the American Board of Internal Medicine Foundation has led the *Choosing Wisely* campaign in which more than 50 specialty societies participate. The goal of the campaign is to ensure patients receive the right care at the right time at the right place.

To this end, each specialty society has identified "Five Things Physicians and Patients Should Question." Some groups, like the American Academy of Family Physicians, have listed more than five tests and therapies to avoid. AAFP's recommendations, for example, include the following:

- Don't screen adolescents for scoliosis.
- Don't routinely screen for prostate cancer using PSA test or digital rectal exam.
- Don't screen for carotid artery stenosis in asymptomatic adult patients.
- Don't do imaging for low back pain within the first six weeks unless red flags are present.
- Don't order annual EKGs for low-risk patients without symptoms.

Working with *Consumer Reports,* the *Choosing Wisely* campaign has developed patient-focused materials to support informed decisions about treatment options. This trend toward "parsimonious medicine" holds promising results:

*Medicine practiced leanly, consistent with a professional responsibility to use resources wisely… limiting the use of wasteful tests and treatments… ineffective and inappropriate services, could produce major savings of both public and private dollars.*[4]

### Pricing Transparency

The Centers for Medicare and Medicaid Services' (CMS) recent release of pricing data – including 2012 data showing total Medicare payments to individual physicians[5] and individual hospital inpatient

[2] Gaps in Residency Training Should be Addressed to Better Prepare Doctors for a Twenty-First-Century Delivery System, HEALTH AFFAIRS (November 2011).
[3] http://www.nytimes.com/2013/11/04/opinion/doctor-first-tell-me-what-it-costs.html
[4] http://jama.jamanetwork.com/article.aspx?articleid=1656264

and outpatient charges[6] – will be a game changer. Physician groups and integrated delivery systems alike will encounter opportunities and challenges in responding to the increased transparency. Many healthcare policy experts believe that greater price transparency will become an important tool for empowered healthcare consumers to help bend the cost curve.

The public, employers, health insurers, and fraud investigators have welcomed the release of individual physician data. A *MedPage Today* survey of 6,500 readers, for example, found 57% believed the data release was a good idea. It is hard to argue taxpayers do not have the right to know how much money is paid to federal contractors – in this case, physicians participating in the Medicare program.

According to the *New York Times*, the public release of data revealed that "in 2012, 100 doctors received a total of $610 million, ranging from a Florida ophthalmologist who was paid $21 million by Medicare, to dozens of doctors – eye and cancer specialists chief that year."

For example, Jean Malouin, MD, the female doctor with the highest payments on the list, won that dubious distinction because she leads a demonstration project where the work of 380 primary care physicians caring for a million people are billed under her name. Likewise, salaried Mayo Clinic pathologist Franklin Cockerill is listed as having billed Medicare over $11 million, which makes sense when one appreciates his name was listed on bills for 23 million laboratory tests.

PYA Analytics, an affiliate of PYA whose focus is the integration of clinical, financial, claims, services, public and consumer data records, is performing sophisticated analytics on the entire Medicare physician database (9 million rows of payments covering more than 888,000 providers who billed under Medicare Part B for 2012) to provide correlations that can help physician groups and integrated delivery systems respond to the inevitable questions that arise from such news stories, and leverage this resource for strategic considerations such as recruiting.

More importantly, using analytics tools, the data can identify opportunities for physician groups and integrated delivery systems to provide better care at a lower cost by benchmarking against other providers. The opportunity for competitive benchmarking to effect healthcare costs will be even greater in the future, as more granular information is made available.

Physicians will need tools, training, and ongoing support to effectively engage with patients as consumers. As demand for information and transparency continues to grow, physicians must be prepared to meet those needs or risk being marginalized.

### Population Health

The current emphasis on population health approaches will require physicians to expand their reach beyond the office and the hospital to embrace the community.

The results of recent studies show how important population health has become:

1. Life expectancy can vary by 14 years based on one's county of residence.
2. Life expectancy increases by nine years when one travels on the Blue Line of Washington, D.C.'s Metro system from downtown D.C. to Fairfax County, Va.
3. Medical care accounts for only 10% to 15% of preventable early deaths.
4. College graduates can expect to live five years longer than those who do not complete high school.
5. Middle-income people can expect to live shorter lives than higher income people, even if they are insured.
6. People who are poor are three times more like to suffer physical limitations from a chronic illness.

[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier.html
[6] Inpatient data is available at https://data.cms.gov/Public-Use-Files/Inpatient-Prospective-Payment-System-IPPS-Provider/xpsg-6hup.
Outpatient data is available at https://data.cms.gov/Public-Use-Files/Outpatient-Prospective-Payment-System-OPPS-Provide/tr34-anpb.

Some experts now say that physicians should pay more attention to a patient's zip code than to their genetic code. However, few physicians now have the capacity or capability to link patients with support services and other needed resources. Again, physicians will need new skills to lead the transformation of healthcare from reactive sick care to proactive population health management.

Specifically, physicians will need to develop three critical capabilities within their practices: (1) the ability to identify and classify high-risk and rising-risk patients; (2) processes to develop and track individual care plans for these patients based on their unique circumstances, and (3) the capacity to link these individuals to supportive community resources needed to improve and maintain their health.

Regardless of a physician's practice setting – independent or employed by a health system – emerging payment and delivery models will demand new competencies, especially in leadership, consumer engagement, and population health management. In most cases, on-the-job training will not suffice: physicians will require outside assistance to help develop and hone these new skill sets.

## Physician Leadership Academy

In response to requests from physician clients who want to stay independent and physician clients who are facing new challenges as employees of expanding integrated delivery systems, PYA has organized a Physician Leadership Academy under the direction of PYA Principal, Kent Bottles, MD.

The PYA Leadership Academy can be delivered over a long weekend, quarterly, or monthly at your organization. By offering the instruction at your location, travel costs are kept to a minimum.

The PYA Leadership Academy usually contains twelve modules, but the program can be customized to fit individual organization's needs. The twelve modules include:

- Quality and Patient Safety
- Leadership
- Communication
- Regulation: Federal and State Transformation Programs
- Cross-Disciplinary Team Building
- Population Management Skills
- Systems Thinking
- Finance
- Information Technology
- Payment Reform
- Strategic Planning
- Project Management

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