Trends in Health Care Delivery in the United States-2014

By Bruce Bagley – December 17, 2013

> Year-end is a time for reflection and for talking about the future. The mission of TransforMED is to transform health care delivery to achieve optimal patient care, professional satisfaction and the success of primary care practices. As we go about our daily work with practices we can get a sense of what works and what ideas or interventions will have high leverage for change. Here are a few thoughts about trends in health care delivery for contemplation as you develop your strategy for 2014.

Trends in Health Care Delivery in the United States 2014

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The Need to Change Your Stripes-The most difficult challenge for most health professionals is the need for changing roles, responsibilities and relationships with others on the team. There is no place for the guild or silo mentality in the future of health care delivery. Patients deserve a seamless process from one point of care to another and should feel a sense that the team is connected, coordinated and working together for the best possible outcomes for them.

Focus on Wellness and Prevention-The real long-term contribution of primary care to the health of our nation and to those we are trying to serve will be more emphasis on wellness, prevention and a comprehensive approach to the everyday needs that cause people to seek our help. Our nation can no longer afford to wait until people are hobbled by preventable chronic illness or end stage disease to act.

The Community of Care-The health and wellbeing of our people is more dependent on cultural, social, economic and educational issues than it is on our ability to rescue them from death near the end of life. Our communities must be able to support and promote healthy lifestyles, behavioral health and chronic illness care that enable people to function and contribute to family, work and community.

Access Redefined-For far too long, access in health care has been equated to the availability of a face-to-face visit with a healthcare provider. We need to redefine access so that when someone calls the healthcare provider, the conversation changes from a negotiation about appointment availability to a conversation that starts with… "How can we help you?" Access for patients is the ability to have their questions answered, fears allayed or to gain a clear understanding of the

implications of their health problem to everything else in their lives. If we are to optimize our effectiveness, we must fully engage in the common communication modes of our age…texting, email, video calls, social media and internet based education and support.

The Cultural, Social and Economic Context of Health-Seeing patients in the isolated vacuum of the exam room is no longer good enough. If our goal is optimal outcomes for the patients we serve, we must begin to incorporate the social, cultural, economic and human relational context in which they live. We must inquire and comprehend what matters to the patients if we truly want to be able to help them. We must work to fully engage patients, families and care-givers if we expect the best outcomes from our "care."

Strategic Distribution of the Work-Most of our daily work in health care could be divided into standard work, complex work and innovative work. Our current model presumes everyone has the potential for serious illness and therefore it is all complex work and must be diagnosed and delegated by our most highly trained professionals. Clearly a good part of our everyday work relates to "rules-based" decision making and thus could and should be moved from physicians to other members of the care team. Care maps, algorithms and standing orders along with the acknowledgement that this is our collective game plan would go a long way to increasing our capacity to care for people by spreading the responsibility to the entire team.

Care is About Relationships not Locations-Healthy living or care of the injured, ill and infirm are best supported by continuous healing relationships with providers and care teams. If we are to maximize outcomes for patients, we must promote and enhance these relationships and reduce the barriers inherent in our fragmented care system. Face-to-face conversations, phone calls, email, social media, texting and video calls all contribute to enhancing relationships in our society…they must be part of our care for patients.

Risk Stratified Care Management-Risk stratified care management and care coordination will be the new required competency for most primary care practices. Identify those in your care who need the most help in navigating their chronic problems or navigating the health system. Registry systems, care coordinators and support for high risk patients will be the new standard for primary care practice.

Consolidation, Integration and Market Forces-The tremendous pressure for consolidation and aggregation of healthcare providers and services will continue in the near term. Integrated health systems will see the imperative to control the health care costs of their own employees and devise creative solutions that they will then bring to market.

The Ultimate Imperative-Someone else is already succeeding in everything that you think is not possible.

Bruce Bagley

13 Comments

David Lynch said 4 months ago

This is a wonderful summary, that is also concise and very useful, as we try to help ourselves and others understand how health care needs to change. Thanks!

Glenn Kotz said 4 months ago

Brillant thought process. reading the ABFM recent posts on redefining FM and combining that with this summary you are creating the philosophical foundation. Bruce you continue to challenge us in the "how".

can / should we work together to answer the HOW?

John Frey said 4 months ago

Agree with others Bruce - you have broadened the terms of discussion to include our recognition of all the forces our patients face beyond what we can do in the office and clinic and, in doing that remind us and challenge us to be creative and fearless in thinking about the social systems in which we live and work. There is help out there if we open ourselves to finding allies in the communities where we work if we adopt the attitudes you outline. Thanks so much for reflecting on this - I believe that young docs as well as some old ones like me will find your thoughts hopeful I this paw year and beyond.

Tripp Bradd said 4 months ago

Bruce,

I very much appreciate your thoughful comments. Catching the "wave of change" and staying in the tube will be the challenge for all of us going forward. Otherwise, we stand to wipe out. Your 'ultimate imperative' could also include, 'if we don't step up, someone will fill the gap and leave us out'. It is daunting to stay abreast of all the innovation but 'do it we must' (as Yoda would say!). We are blessed to have you at the helm.

Tripp

Edward Shahady said 4 months ago

Well done Bruce. Especially liked "the need to change your stripes" comments. Lot of wisdom and challenges!!

Ed Shahady

FP Nguyen said 4 months ago

I just finished a 4-hour leadership conference sponsored by the hospital. It was formatted in small, round table discussions with each of us given the chance to stand up and voice our concerns. They even went as far as role playing, "if you were a CEO, how would you prioritize these concerns." It spanned 3 days involving about 300 providers and ancillary services. As usual, I'll relate to your many poignant points.

1) I'm not sure about leadership but the passion was still there for me, and it was VERY INTENSE.It's strange to say this after the last 17 years being in the trenches, but I realized that "I STILL DO CARE A LOT," and perhaps more so than ever. When it came to my turn, I stated that as a person, my motto has always been, "I DO, THERE FOR I AM." The "I CARE A LOT" seems to have overshadow any concerns about my own for "REIMBURSEMENT."

The Need to Change Your Stripes

Among doctors as a specie, I find this the hardest part to be changed, if at all. One way is to do what Mayo and Kaiser did, to salary their physicians. We are competitive in nature, but if money is the prize, it is a double-edged sword. Corporations can come and go, change their names, reinvent the game, but not for medicine. The risk of failure sometimes is not an option. If so, it is inhumane and unethical.

Focus on Wellness and Prevention

It was brought up when we discussed a key component of healthcare reform. I said that this is a 30 year plan, with a high uncertainty for achieving actual results (obesity). The good thing from this is it forces those who are in healthcare NOT just for the short-term gain. Not too many companies have a 30 year plan, buthey, the average life-span here is 79.

The Community of Care

Coming from a small agricultural town in the Midwest, I say ditto. This might not apply to southern metropolitan california, however.

Access Redefined

Wait until the registry is fully matured and data for access (wait time, consult, PCP) is defined as a MAJOR metric, to be publicized for all to see, in real-time with blinking red, yellow, and green lights. Yet, healthcare is not manufacturing. It is still labor and mentally intensive with respect to human resources. Of all areas, this is the least touched by managed care in my observation, because much of the early decade the focus was more on "market share dominance." Yet this is a point of most disatisfaction among the patients as consumers, and still is today.

The Cultural, Social and Economic Context of Health

After these mega mergers, the networks are so large that this is a must, because we are a diverse country. Most of the mega-networks are actually concentrated in larger cities (think California and Florida), which are also more culturally, socially, and economically diverse.

This is an area where surveys based only on the patient alone are not good enough, and perhaps something like "my family's stamp of approval" is needed. I see this in Hispanic and Asian communities, as they always bring their families to every grandma's visit.

Strategic Distribution of the Work

It's already here for corporations with robust informational technology with large funds for ancillary staffs. I believe time will also favor the smaller practices as technology will become cheaper yet more powerful, more end-user oriented and more automated. Ultimately, this power will translate to hands of the two biggest end-users: the providers in the trenches and the patients with respect to technology. The governmental involvement will also help to standardize information technology, the same way Medicare has standardized our coding and how the VA was the first biggest EMR in the country at one time.

Care is About Relationships not Locations

One of the slides for the group was that local surveys say 54% of the patients want to use the internet for their healthcare communications, yet only 17% of doctors are doing that. Because of the complexity of healthcare, I would take this with a grain of salt. Ultimately, I don't think this is something that can be achieved with market or legislative forces alone, because healthcare is not only complex but also personal, and in some culture, sacred.

Risk Stratified Care Management

Talk to the up and coming Urgent Care movement. We have been doing this for a long time when access got worse, when the relationship between physician and patients got diluted, when population medicine became the norm and popular based on abundant data but without real solutions and coordination. It takes a certain financial committment because these are not your simple bread-and-butter cases, not your typical patients. It'll take real leadership to bring this to the next level from where we are currently, because it is a group, and NOT just an individual effort. It will become the new culture, but will also take time.

Consolidation, Integration and Market Forces

I used to say every great company, 3M, IBM, Catepillar, always start small, and mature over decades. Now we can have instantly made mega global corporations with some touch of financial wizardry. That's the easy part. Trust, culture, you know, getting along, tolerance, look good on paper but the realities are usually more bitter, as reflected by our political climate. Change is hard, but change is also inevitable, if not more dynamic here in the U.S. I don't think this is hard for the U.S. to do.

Pete Moyer said 4 months ago

Bruce, thank you for formatting these trends in such a way. I'd like to highlight one that is oft left out of our discussions. That is the community of care. If one takes a good look at the communities, regions, countries and contenents that are "healthy" they find out quickly that population health is bi-directionally afftected by (within) the culture of that area. I think *our* culture has recently had the impetus to change provided by the foresight of the unsustainability of our current health culture. Over time that impetus will change from an exterior motivatior (government, payers, employers, financial viability, etc.) to an interior motivation where we collectively internalize our personal health as a big deal. I guess my sentiement is that we are no where near that culture now, but the only way we will acheive that is through the steps we are taking now in each of these "trends" this year. Like retirement planning, we need to do this now- not because of the short-term payoff, but because of our health

culture's future. The steps we are taking now *are* a much bigger deal than we think.

Robert Smith said 4 months ago

Bruce,

I agree completely with the direction of where we need to go and how we need to deliver care differently in the future. I am committed to telehealth technologies and virtual care and am already using The Apractis Clinic in order to guide me through that change. What I do not have control over, however, is a business model to care for patients within our current internet age. Until insurance reimbursements change and start paying us for caring for patients, regardless of if they are face-to-face with us or not, my only option currently to stay open as a business is to entertain a Direct Pay model of care.

I would appreciate your thoughts on how this will change with the advent of PCMH and ACOs.

Robert L. Smith, MD

Finger Lakes Family Care, NCQA Level 3 PCMH

John Bachman said 4 months ago

As Deming says I need to think about it... I am not sure what is the way to go with all this. Sometimes the things we do not change are more important then the things we change. What things should we not change...

1. Health is more then the absence of disease. We need to promote health because it leads to resillency. That means we deal with a unique human being in a family.

2. Standardization works great for differentiated processes but not for undifferentiated issues that come our way. We need flexibility in dealing with patients who just happen to have diseases.

3. Fragmentation in care whether from specialist or team members trying to help is not good. We need to make sure that we are not having teams that get in the way of each other.

4. Family medicine is relationship based and there are forces which are trying to change the encounter to transaction based. It misses the whole point of how to care for someone in a holistic manner.

5. Speed kills and harms. Hurried providers are not good for anyone. The most important question we may ask is Now that I know your concerns, what is really worrying you?

6. 30% of health care is waste (That is conservative figure) Harvest that and we are talking some reall money to spend on other things.

It is half baked and I will continue to let things ferment

Last edited by Rhondda Francis - 4 months ago

Donald Brown said 4 months ago

"Family medicine is relationship based . . . Speed kills and harms . . . Standardization works great for differentiated processes but not for undifferentiated issues "

Thank you, Dr. Bachman!

Dr. Bagley has provided us with a fascinating list (though I would add one more trend: the increasing domination of health care by for-profit organizations whose primary responsibility is to increase return-on-investment for their shareholders). But fascinating though his list is, it doesn't have much in common with what my patients say they want from their medical care.

It's striking that physicians are not mentioned anywhere in this list of trends. What we're seeing is the continuing devaluation of the physician-patient relationship, the root strength of family medicine, and the de-professionalization of physicians in general. This is definitely payer-centered and large health corporation-centered, but sure doesn't seem to be patient-centered.

I don't know if Dr. Bagley approves of the direction in which these trends are leading us, but it is dismaying, to say the least, that the AAFP seems to be giving it their tacit approval.

Bruce Bagley said 4 months ago

Don, Thank you for your comments. Let me be perfectly clear, the purpose of a list like this is to get some conversation going about the likely future and how we all might best prepare for it. These are observations based on a daily scanning of the changing landscape of health care and watching trends for many years. It should not be perceived as any kind of approval by the American Academy of Family Physicians or TransforMED.

To best deal with the uncertain future in one's life, it might be helpful to think about being on a tossing sea. Sometimes you are in a small boat with no oars or motor, where there is little value in fretting about the fact that you are going to go where the winds and currents will take you. Sometimes you are in a sailboat where you do not get to choose the vessel but lot can be done with the management of the helm and the sails. Sometimes you are in a motorboat with lots of gas and lots of power and can determine the precise direction of travel. Wisdom will tell you in which of the three boats you are traveling at any given time. In any circumstance, it helps to have a forecast of the weather and the currents.

Christopher Hawley said 4 months ago

Great thoughts Bruce. Thanks for stimulating the discussion. My favorite is the focus on Wellness & Prevention. I think most of healthcare runs on a similar model to the autobody shop. When it's

broke, we fix it.

With >70% of U.S. healthcare $ spent on preventable chronic disease (CDC), it seems like we need much more sophisticated driver's training to prevent accidents. Making autobody shops (healthcare) more cost-efficient, accessible, and with better customer service is not a high-yield strategy for lowering overall spending. The spending drivers (no pun intended) are the accidents that occur before our patients reach us. We are driving very well. We must be inspired, equipped, and encouraged to live better.

Our PCMH has been delivering corporate wellness programs to local companies and have cut healthcare costs by over 30% during the last 7 years. I think integrating corporate wellness (a community-oriented population managment program) with PCMH's is a scaleable model that creates win-wins.

Thanks for being a great weather forecaster during the winds of great change!

Richard Streiffer said 4 months ago

Just returning from Cuba with a group of University of Alabama faculty. These are very parallel to the principles that the Cubans have used to produce a health care system with outcomes and measures very close to that of the US, and in some key areas better than the US, yet at a fraction of the cost And I the face of shortages of resources and technology. Their system is of course based around the geographically distributed family doctor-nurse team, and founded on the principles of prevention and health promotion.

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