Dr. Kendal Williams: Welcome everyone to the Penn Primary Care podcast. I'm your host, Dr. Kendal Williams. So, thus far on the podcast, we've done clinical topics, but there's a major movement in Primary Care that's happening all over the country that is termed Value-Based Primary Care. And it's happening here at Penn. And it's time to talk about it because it impacts the practices of all primary care physicians across the country. I Invited on the podcast, two prominent members of this movement at Penn to join me in discussing this topic, Dr. Matthew Press is the Physician Executive of Penn Primary Care.

Dr. Press trained at Penn and I had the bounty of knowing him as a medical resident before he left, and did a master's degree in healthcare policy and financing. He then joined the Senior Leadership Team at the Center for Medicare and Medicaid Innovation at CMS. During that time, he published in the New England Journal, JAMA, Health Affairs on Healthcare Policy and Healthcare Financing Issues, and then returned to Penn as the head of the primary care service line as a Physician Executive at Penn Primary Care. Matt, honored to have you here.

Dr. Matthew Press: Thank you, Kendal. Great to be here.

Dr. Kendal Williams: So I'm also honored to bring in one of my own personal wonderful mentors, Dr. Kevin Kosnocht who also has a storied history at Penn as a leader and mentor to many. He started his career as the Director of the Primary Care Residency Program at Penn and then evolved into the inpatient service chief at Penn Presbyterian, doing a lot of quality and safety. Running the residency program at Penn Presbyterian, and then became the CMO of Penn Presbyterian. He then left Penn to join Tandigm and then left Tandigm to be the VP of Clinical Network and Strategy at Time Healthcare. He now has returned to Tandigm in its partnership with Penn as the CMO. So Kevin, welcome back to the Penn Environment.

Dr. Kevin Kosnocht: Thanks very much Kendal. Really great to be here talking with you and Matt.

Dr. Kendal Williams: So we wanted to talk about value-based primary care and how it's impacting all our lives. I recognize that you know, many listeners to this podcast don't have a background in health policy and healthcare financing. And so we wanted to start really basic and then sort of build to this more general topic of value-based primary care. I want talk about the structure of the healthcare system generally. I do a lecture on this for the healthcare systems course at Penn and basically the healthcare system breaks down to people, us, who finance our healthcare through insurance companies, often

through our employer or through Medicare and Medicaid and other insurance options.

Then there are the major player of the insurance companies who take our money and then pay the providers, that's doctors and others to take care of the people. So, we have this sort of three major players here in the whole healthcare financing paradigm, and I actually wanted to start within that paradigm to talk about how primary care physicians have historically been paid. So Matt, maybe I'll start with you. What's the traditional model of healthcare payment for primary care physicians?

Dr. Matthew Press: Sure. So it, it looks a lot like the rest of the healthcare system is traditionally being paid and that is what we call fee for service. Meaning for each test, procedure, office visit, a bill is submitted to the payer, whether it's a private insurance company or a government payer, and that provider of the service is reimbursed for that service. And so, over time, one result of that system has been that specialties that are more intensive with respect to procedures and more complex interventional care, have done better in terms of overall reimbursement from payers for the services they provide.

And specialties like primary care that are less intensive when it comes to interventions and procedures and are more typically billing for services that are mostly office visits with some ancillary services; have not done as well. So if you look at total payment to primary care in this country, for every dollar that we spend on healthcare in this country, primary care gets about five or 6 cents. It varies a little bit from state to state. Whereas if you look at other developed countries, the investment of the healthcare dollar in primary care can be upwards of 10, 11, 12 cents on the dollar.

So that's the sort of historic framework for the way primary care has been paid for, and I think has contributed to some of the issues and challenges that we've been facing now in primary care for several years.

Dr. Kendal Williams: And I think that has led to some discontent among primary care providers, both because of the comparatively low salaries, but also because of the heavy workload. Caring for patients is more than just seeing in them in the office and delivering a service. It's following up on labs. It's having conversations about the direction of their healthcare that are more substantive and don't always fit in within office hours and so forth. And so we have primary care physicians who are really being pulled and pushed in different directions to try and achieve care in this model, right?

Dr. Matthew Press: Absolutely right. To me, the biggest piece that's missing

with the traditional reimbursement system is paying for what I think of is the glue of the healthcare system, helping that patient navigate the healthcare system, trying to anticipate what their needs are and bring additional services to help meet those needs. Following up with them after they have an episode of more intense care, whether it's a hospitalization or a procedure. All that work that happens in between visits, all that glue that for any of us who have had family member or ourselves have experienced a chronic illness or a complex condition, you know that to have a good outcome, you need that glue. You need the dots connected, and the traditional reimbursement system just hasn't provided funding for the glue.

Dr. Kevin Kosnocht: And even if we were to just look at the number of healthcare visits for primary care versus other specialties; Matt mentioned 5% of expenditures going to primary care for primary care services, but they represent 35% of healthcare visits in primary care. So right away you see an imbalance that's captured by things that have just been mentioned.

Dr. Kendal Williams: So there's been a lot of energy I mean, in my career it's been since probably the 1990s to try and revisit this system of how healthcare is financed in this country, how we can achieve better outcomes because there's this, the elephant in the room is that the US healthcare system is the most expensive in the world and doesn't really have the public health, at least, outcomes that are comparable to other countries. Including countries that spend a significantly less amount of money. So we're a high expense, high procedure based system that rewards that and really does develop tremendous technology.

But the value, and this is where we're gonna get to value, is really in what a lot of primary care physicians do in preventing disease and death. So, let's talk about value now and how we achieve value. Value for me, it means the same thing. It means in every other area of our lives, right? We want to buy a car that gives us good value. It's more for your money, right? You want to use your money to get more value. So how do we achieve that in care, in just in our system generally?

Dr. Matthew Press: Well, I think actually, this starts with the clinical model and what for many decades in primary care, we've envisioned as a more ideal clinical model that does provide the glue, that has team-based care. Teams with from dis different disciplines, mental health, social work, pharmacy, nursing, that can meet patients where they are, whether it's in the home or in the office or virtually. Whether that patient is healthy and their needs are purely preventive, as you said, Kendal, or that patient has a chronic illness or other complex illness that needs really focused care and helping them get through that problem.

So, when we think of what's the ideal model and we go back over the decades, there have been efforts to try to invest some more in primary care, but it was always piecemeal investment, layer something on top. The whole concept of the patient-centered medical home that is that ideal clinical model. But different attempts to pay for that have not delivered the outcomes we wanted to see. And so the idea of the last 10 years or so, five, 10 years, is really a more fundamental shift in the payment model so that we can equip primary care practice with the resources, the financial resource s to build that ideal clinical model.

Dr. Kevin Kosnocht: Yeah. Just back to agree with everything Matt said. Just back to your question Kendal, about how to define value. This is where a concept that maybe our listeners are familiar with, maybe they're not. But one expression of that, that has been kind of a compass for defining value in value-based care circles is the quadruple aim. And the quadruple aim of healthcare is to have better outcomes, clinical outcomes, an improved patient experience, number two, number three, lower costs. And the fourth aim, really important, especially as we're talking about primary care, is an improved clinician experience. So, achieving these four aims, having measures for each of those aims as a way to define value that can be paid for in a different way, is part of the journey we're on in value-based care.

Dr. Matthew Press: I couldn't agree more. And just to emphasize the last of those four aims and paint a bit of an even starker picture of what's going on in primary care across the country. We know that burnout among primary care physicians is at levels not seen before. Certainly increased challenges over the last few years related to Covid, etcetera, but it predates that because of the traditional payment model really puts the primary care physician on a hamster wheel of seeing as many visits as you can, to sustain your practice financially.

And it's dissatisfying to the clinician and oftentimes has not allowed us to take as good of care patients as we should. So, that fourth aim is to me, is why this shift to value-based care is not just helpful to primary care. It's essential to primary care to sustain our and grow and strengthen our primary care workforce. We have to make this change. We have to address that fourth aim. If we don't, I'm concerned about not just the future of primary care, but the future of the healthcare system.

Because we know, and there are now several studies that show that a strong primary care system is associated not only with better clinical outcomes, associated with lower cost of care, but also associated with lower mortality at a population level. So, we know the power of primary care and our primary care community has struggled now for years. And this really is, I think, a leap forward that will help us reinvigorate and grow primary care for the future.

Dr. Kevin Kosnocht: Yeah, I couldn't agree more, matt this concept of achieving the four aims better outcomes, improved patient experience, lower costs, and improved clinician experience; can't be achieved on a fee for service model. Fee for service model is exactly what it says. It is paying providers a fee to deliver services as opposed to a model that can fund teams to take care of people. So, delivering services for a fee is not the same as a team taking care of people. And a value-based care model and the journey we're on to get there is about finding a real world way to make that happen.

Dr. Kendal Williams: So when you look at this issue of achieving better outcomes at lower cost, right? And you just look at, we, we are in the business of preventing and treating human disease, keeping people healthy and having them live as long as they possibly can. So, but in order to achieve that, I listed four things that I think are critical. And the first is prevention. So obviously preventing disease before it occurs. Second is early detection, which we've achieved better outcomes with colon cancer and breast cancer, all with early detection strategies at lower cost. So, we're getting better outcomes at lower cost.

Population management. So viewing your patients you care for, not as individuals who are just coming in as clients to receive services, but as a group of people that you're responsible for caring for and making sure that all of them are achieving the best health outcomes. I think the fourth, is really recognition of that in any population, there are certain individuals that require more attention. That's usually folks that have chronic diseases because those are the folks that get sick. And those are the people that have the highest costs.

But they're not going to require the same amount of time as somebody who's otherwise healthy. They're gonna require a lot more time. So you really have to sort of budget your time in order to do chronic disease management. Right? And a part of that, we also wanna reduce costly admissions to the hospital and so forth, but that's really part of the whole chronic disease management paradigm. So those are four things, prevention, early detection, population management, and really chronic disease management; highlighting those folks that are most vulnerable and focusing on those as being strategies that I'm hearing about most often when we think about value-based primary care. Is that right Matt?

Dr. Matthew Press: Absolutely. You hit the nail on the head, Kendal. It all starts with the population and that's something that historically we have not done in primary care. Historically, we've had more of that transactional exchange. Now we've had the benefit of seeing patients over time, but we have typically waited for the patient to come into the office, wait to schedule your

visit for an issue, wait to schedule an annual visit to address preventive care, and we haven't thought about the patients that are not in the office. So the paradigm shift is going from I'm thinking about whoever's in my office that day or whoever's in my office that week, I'm thinking about the population of patients who consider me to be their primary care physician.

And what do I need to do proactively, not reactively, but proactively to address their needs, whether they're preventive, whether they are early detection, whether they are chronic disease management. And once you define the population, then the second step is exactly what you said, Kendal, which is risk stratification. Let's look at our population. So now I know who my population is, let's look at it and let's segment that population based on their needs. And we have different tools and now lots of data to help us predict what their needs are. And let's target the outreach, the intervention based on the need.

So rather than the traditional model where everyone gets a 20 minute visit, my 25 year old with a cough and my 80 year old with 10 chronic medical conditions, they all get a 20 minute visit. That is not tailoring the intervention to the patient's needs. What's tailoring the intervention of the patient's needs is understanding okay the 25 year old with the cough will need a very focused visit on that acute issue, but also we want to use that opportunity to reach out about education and counseling and prevention. Whereas the 80 year old is going to need more time, probably more hands on deck from other types of disciplines and also may not be able to come into the office.

Maybe we need to think about home. Maybe we need to think about telephone engagement in between visits. That's not somebody that we say, okay, thanks for coming in, 80 year old with 10 chronic medical conditions. We'll see you again in six months or 12 months. That's somebody we say, okay, we need to be really proactive. I'll see you again in two months, but in the meantime, my nurse is gonna reach out to you a few times over the next during that interval period.

Dr. Kevin Kosnocht: Yeah, I very much agree with you, Matt and Kendal. I do think you nailed it. I think though there's an important distinction to make here for two reasons. One is just conceptually, but the other is just much more operational. The conceptual distinction to make is population health management and how that differs from value-based care. They're obviously related, but I think the distinction is a helpful one to make. Value-based care as we just spent the first part of this discussion on, is really payment model. It's a financial strategy to achieve the quadruple aim as that referred to earlier.

Population health management is a clinical strategy that is necessary to be successful in value-based care. And I would include all of those four domains

actually under population health management, at least as I think about it, Kendal. Which is very much as Matt said about really understanding your population and then having these other features. The operational consequence of this is, that Matt just talked about the 20 minute visit versus all what all the patient needs and how to tailor it. That can't happen just with the doctor or even just with the NP.

This requires population health management and value-based care, requires team-based care, which I think we'd all agree is a real fundamental component to high quality primary care. So, when I come back to this theme of a payment model that pays for teams to take care of people as opposed to paying doctors to deliver services. That team-based care then, the other major consequence here, it requires a real re-engineering of what a primary care practice looks like. And this is where it gets hard and the journey that we're on both from nationally, a payment model down to locally, and the experience that Tandigm is having with its practices over the years.

And now with the Penn partnership, really requires kind of re-engineering. You can't have a proactive model tailoring services to a cohort of patients that are identified without a team and a multidisciplinary team that is functioning in a very coordinated and continuous way to deliver this kind of care.

Dr. Matthew Press: And I think Kendal, people might think, okay, well then if we're doing this and this is here now, why haven't things changed more dramatically? And I think there's a couple big things that are holding us back that hopefully will be unlocked over the next a couple years. So, one of those is that most of primary care is still paid by fee for service. So in some ways in order to continue to run your practice, you do need to see patients and that's seeing patients and giving patients access, by the way, is, doesn't just work on the fee for service model. It's really critical in the population health management model.

You want patients to be able to access the primary care practice, particularly for acute needs, so that they can have those needs met in the primary care setting. That's a good thing. But financially, when most of payments of primary care remains in the fee for service methodology, it's hard to start to invest some of the team-based care that Kevin is talking about. I think that's one challenge. I think the other challenge is that while most payers now have some form of value-based payment program, they often look a little bit different.

And so, for the practice or the health system or the provider group, it can be challenging to figure out how are different value-based programs working and what do I need to do to be successful. There are definitely common elements

and philosophically, everything Kevin is saying is spot on in terms of what the clinical model needs to look like. But when you get down to the day-to-day, what do I need to do to hit the mark on value-based payment program metrics? They're gonna look at different from payer to payer.

So my hope is over the next couple years that number one, more of our payers and our providers make this shift towards value-based payment. And number two, our payers really get aligned on what the model looks like, or you work with a company like Tandigm that we have the pleasure to work with now since their partnership launched in January, who can help sort of aggregate and consolidate and present a more unified version of different value-based payment programs to the primary care practice.

Dr. Kevin Kosnocht: Yeah, that's clearly the goal. Matt, as this has been referred to as having one foot in two canoes and you're trying to get down the stream and the effort just to keep your feet in the canoes is hard. And that's just value-based payment versus fee for service. But what you're talking about is the actually value-based payment has multiple canoes and now you're trying to get four canoes down with two feet. And that really requires an effort and you can end up spending so much energy in just keeping your feet in the canoes that you're really not actually, that the stream is moving you rather than you guiding it to beat that metaphor.

That challenge of the, there's the varied measures that are part of value-based care packages, depending on the payers. Then there's also the payment models are really separate. So the actual funding for these efforts is really varied. And with that then comes a different and challenging way to bring kind of a coherence to the environment we're in right now. The importance of increasing the total number of ones patients panels that are in a true value-based care arrangement, is very significant for these reasons.

The more patients that you are, are being paid for to deliver team-based care, in your practice, then the less energy spent in trying to manage them too. And that's certainly a mission of Tandigm to increase that number of patients that are in given practice's population that are in a value-based care agreement that can help fund the work necessary to deliver this kind of care.

Dr. Kendal Williams: So I want to spend a moment and just sort of summarize what you said and also build a little bit for the next part of this discussion. And so if I look at my own practice or just a typical practice, we're mostly still fee for service. We have our heads around this idea of ensuring prevention and early detection and taking a population management approach, but frankly, we're not paid to do a population management approach. Right? So you might

like to do that, but it's not like primary care physicians already have a lot of free time on their hands.

So you're talking about extra time that requires you to take these approaches. And so you would want to have a model that compensates you for that because if you do that well, in a fee for service model, if you do that, well, let's say you spend every Saturday morning reviewing your patient populations and making sure that Joe Smith is getting in for his annual and he missed his last hemoglobin A1C measurement. If you do all that; you're actually not getting any more money in a traditional model. In fact, the insurance company is gonna save the money, which may be passed on to the public ultimately, but you are saving someone else money and doing all the work, right?

So, there needs to be some financial adjustment to the value transition that you're doing. This is the two canoes you're talking about, Kevin, right? That we need to live in one canoe that is focused on providing value and doing things a little differently than what we had done in the past. But we're still not paid to do that. Matt, you had highlighted that there are value-based arrangements with primary care practices, but the individual primary care practice may be looking at three or four different programs that they're participating in. Sort of not allowing them to sort of devote themself to one particular approach and one particular focus.

So, it can actually add to the complexity of their situation rather than improve it, even if there is some more money involved. What we want to do though, is to see that we're achieving better outcomes and that our time is well spent and we're getting compensated for our time. So I think that's what we're trying to figure out, right?

Dr. Matthew Press: That's right. And figure out how some of these new activities that are more sort of, air traffic control on the population's care. How do they replace some of the existing activities? Because if they're just added to the existing day, it's as I mentioned earlier, an already taxed workforce in primary care. That will just really, I think, tip folks over the edge. So how do we replace the existing activities with some of these new activities? And a big part of it is payment, and getting more into one canoe as we talked about. The other piece though is the demand for primary care services is massive.

I mean, our population is aging, our population's getting more complex. I think the pandemic showed people that having a longitudinal relationship with a primary care provider is a good thing for your health. And so people want a PCP, people who are navigating some complex illness or new diagnosis, they want to feel like they have that quarterback in their corner. So the really, to me,

looking at primary care at its future, we have to think about how do we meet the demand in an efficient way? And because one of the things value-based care could do, and probably should do, is translate into us maybe taking care of fewer number of patients for each individual primary care provider.

So rather than being on that fee for service hamster wheel and having a lot of patients who you maybe don't know as well; we want to think about some slightly fewer patients who you know really well and you have to spend the time with, but that could worsen our supply of primary care. So to me, the shift to value-based care, what it will do from a big picture, sustainability is bring more resources into primary care, enhance compensation, and enhance the work experience of being a primary care physician, hopefully attract more people into primary care, to use our teams more efficiently so that it doesn't all fall on the primary care physician.

If we can do that, then we can meet that demand that will only continue to grow from here. So it's not just about changing the day-to-day work. It's really, to me, this is a fundamental shift in how we support the workforce of primary care to meet the needs of our population.

Dr. Kevin Kosnocht: Yeah, Matt. Agree. Tandigm has its tagline, to engage, enable, and empower physicians. And this requires many of the things that, that Matt talked about and it's why actually as we're seeing across the country and in a variety of geographies; the practices that are devoting themselves entirely to risk-based, value-based care contracts. They are taking patients only under those models and those number of practices are growing. They are all or most are part of a broader vertical integration of healthcare companies that we're seeing nationally.

But it is a signal in the market that to sustain and attract and provide and deliver high quality primary care; the practice environment needs to evolve and has to meet the quadruple aim. Which includes that fourth aim; the lower panels of patients, team-based care with the physician directing important clinical decisions. But not having to do as Matt said, air traffic control and care coordination efforts. All of us, as PCPs know what it's like to have to get a patient in a complex system after a new worrisome diagnosis, the care they need. And very often you're not the quarterback, only the quarterback around the medical decision making.

You are literally making calls, making it happen, and doing all of the effort it takes to get a patient through the system. That is not the kind of effort that PCPs who do it every single day for multiple patients, themselves would need to do if a system is working the way it ought to in a team-based environment.

Dr. Kendal Williams: Matt, you and I had a conversation a few months ago just about primary care generally, and you have mentioned that most primary care practices that are sustaining their income are doing so through value-based primary care arrangements and actually increasing their income in certain circumstances, right. And nationally, that's been a trend. So these are partnerships essentially between providers, primary care physicians and insurance companies, and the structure of those relationships.

But there's a big pot of money there, right? So there's a lot of, money spent on healthcare. If you drop those cost five, 10%, you're talking about an enormous amount of money. And so that's the pot of money that can be then used to make the structural adjustments that primary care practices need to do. But that really has to be done in collaborative partnerships, right, with primary care practices and payers?

Dr. Matthew Press: And specialists too. I mean, so if you, so you're right. The model is, you know, if you can, if you can bend that cost curve, you can drive some of that savings back into primary care to help both individual compensation as well as bring in and support additional resources in the practice. So that's the model and how it looks. But this is, I want to be really clear, at Penn, but nationally, this is not about cutting or depriving care when it should be delivered. This is not about an individual PCP saying, okay, well maybe I don't want to order that test, or I don't want to order that test and that will translate into more money in my pocket.

That's the wrong way to go, clearly. And not at all what the, what this is about and what we want to create. What we want to create is we want to make it easy for the PCP to make high value care decisions. In order to do that, the relationship with the specialists is really critical. So we talked earlier about that, five, 6 cents on the dollar going to primary care, well that means 95, 90 cents are going to specialists and hospitals. So a lot of money is spent there. And what we want to do, and I think real critical pathway to bending that cost curve and driving some of those savings is to get the right specialist input at the right time, to make sure the patient is getting the right care and the right place at the right time.

So depending on the level of acuity of the need, depending on what specialty looks like, there's lots of different ways to do this. There's eConsults, which we're doing at Penn, which is essentially a formal curbside provider to provider. There's work that's in development for patients with more acute issues, getting them into specialists for same day and next day visits to help expedite their care in an efficient way. To Kevin's point, I think there's data that can be leveraged

to identify where there's variation in care where there's care that's not evidence-based. And how do we make it easy for all providers in the healthcare ecosystem, primary care and specialists to make more high value decisions?

Dr. Kevin Kosnocht: Yeah, I very much agree with that, Matt. You know, I will say that certainly this requires a different relationship between providers and payers. I think there is a role towards this evolution. And this is actually the role that, that Tandigm fills, which is there is a way to design value-based care agreements that aligns incentives across the care continuum and then delivers the value created by a change in practice back to the PCPs where it's warranted in some cases back to the specialists where it's warranted. When there's evidence of really achieving, as we said, the quadruple aim, to come back to that.

Totally right to call out that this is not just about cost cutting but cost cutting can't exist in the absence of improved outcomes, improved patient experience, and improved clinician experience. It's kind of the whole point of having a quadruple aim. So that focus is essential in getting this work done. Some of the work that Matt mentioned with regard to specialists within the Penn system also work that Tandigm is doing with its network of specialists. We have what's called a specialty alliance in the five county region. And these are specialists in five high volume, high cost procedural based or in the case of oncology, very costly episode type specialists.

And their, our work with them is about access, care collaboration, improving outcomes and ensuring that the right care is happening at the right place. That right place of care does involve a site of service that has a cost that is optimal. Not necessarily just less costly, but optimal relative to the quality and the patient experience. And we've seen this shift to outpatient in a variety circumstances, but it's one of the areas where there are clear cost savings with a better patient experience and at least equivalent if not better outcomes. This is hard work though. This takes a local approach. It takes a lot of provider engagement. It takes iterative work around designing incentive models that will help promote it.

And Matt, through his experience with CMS, is certainly very knowledgeable about the piloting that Medicare has the largest payer has been doing in this space. So, even now, the Medicare Shared Savings Program, which allows for a gain share of cost savings if you meet quality and patient experience measures. The dollars that come for that don't come until 18 months after the period that is under measurement. So, as a result of that, that's not a sustainable way in itself just to fund the evolution of an office or the evolution of a practice or a healthcare system. So we have to find more creative ways to fund the kind of

population health management and value-based care that we're talking about today.

Dr. Kendal Williams: So I wanted to use this session as sort of establishing the theoretical foundations. You both have alluded to some of the specifics that we want to get to in part two of this discussion. I think we want to understand the role of organizations like Tandigm in this new change and and how that impacts Penn, but also for those listeners who are outside of Penn, understanding this whole environment of value-based primary care and how they can navigate it most effectively. So I want to thank you both for joining us and we will schedule another time to do part two. Thank you everyone for listening to the Penn Primary Care podcast.