19TH POPULATION HEALTH COLLOQUIUM

LOEWS PHILADELPHIA HOTEL, PHILADELPHIA, PA

MARCH 18, 2019

PRECONFERENCE: THE FUTURE OF PRIMARY CARE

THE FUTURE OF PRIMARY CARE:
Agenda

Mitch Kaminski, MD, MBA
Program Director, Jefferson College of Population Health
8:15am-8:45am

Paul Cohen
Vice President, Strategy and Business Development, **One Medical**,
San Francisco, CA

Alan Cohn
Chief Executive Officer, **AbsoluteCARE** Medical Centers and Pharmacies, Singer Island, FL

THE FUTURE OF PRIMARY CARE: Agenda

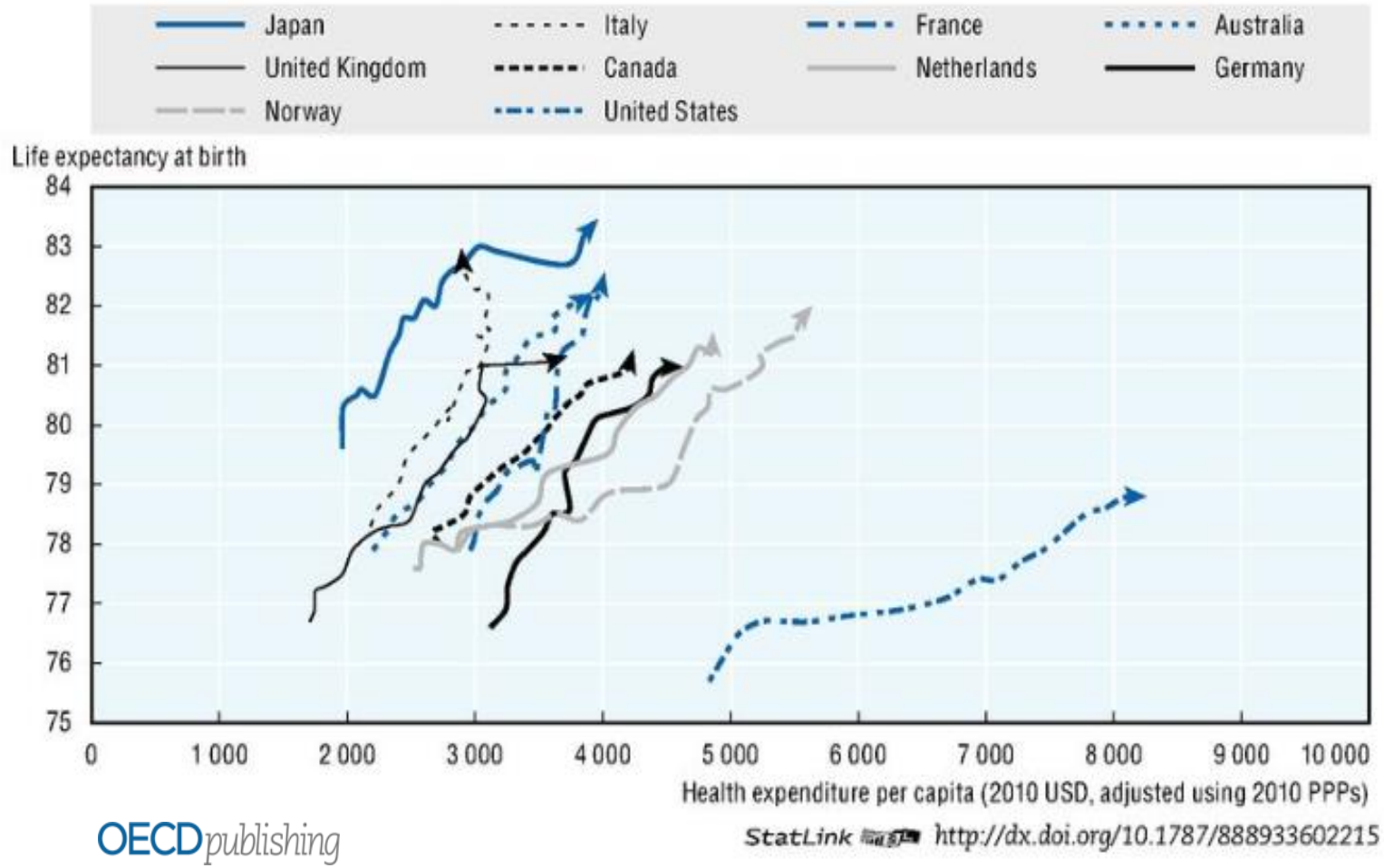
Drew Crenshaw
Senior Vice President, Population Health, **Oak Street Health**, Chicago, IL

Gaurov Dayal, MD
President, New Markets and Chief Growth Officer, **ChenMed**, Miami, FL

Why a Need for Transformative Change?

- National Imperative to re-engineer US Health Care
  - Rising % GDP devoted to health care
  - Low ranking in health of our population
  - The ACA and move to Value-based Care

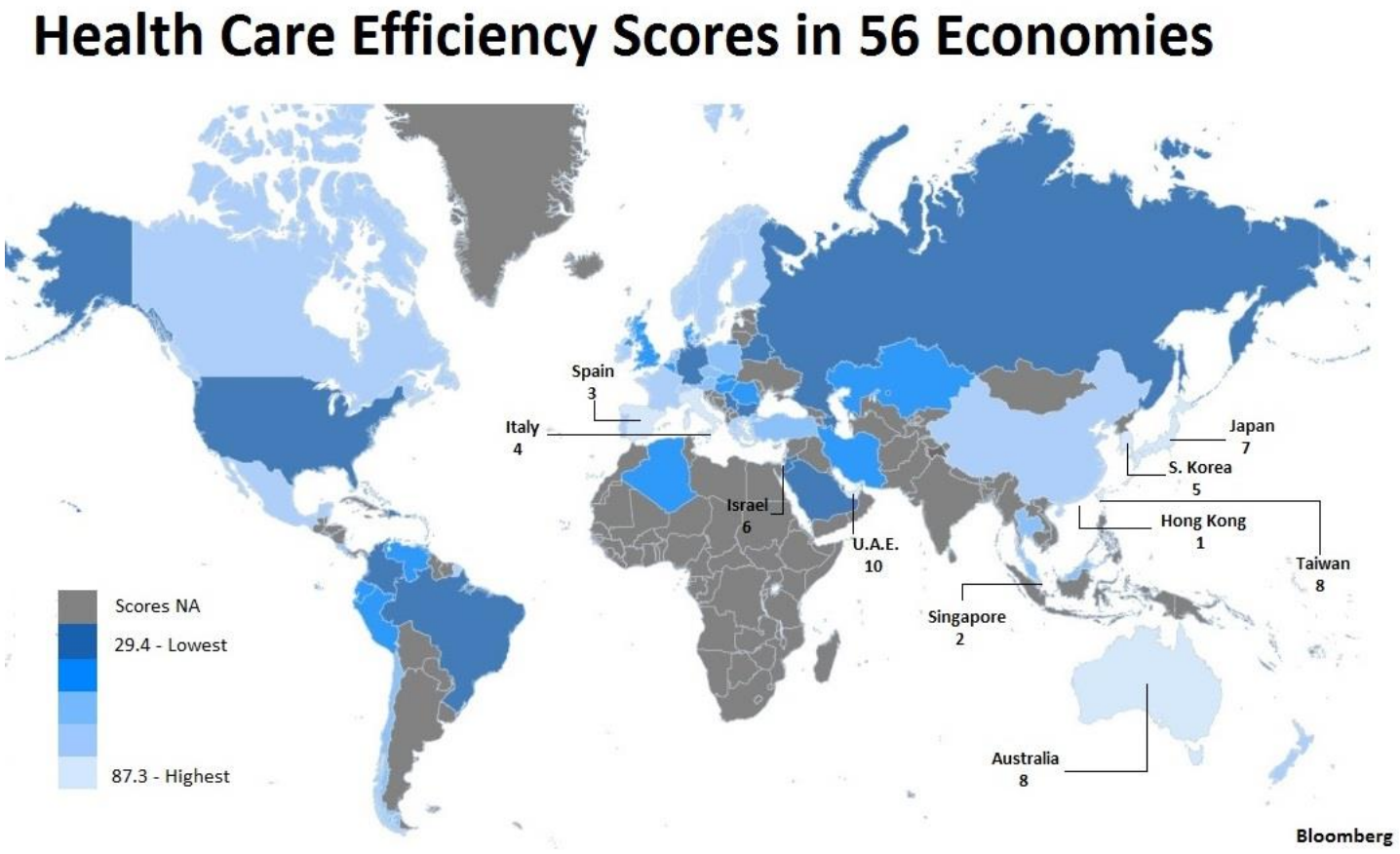
Figure 2.6. **Life expectancy gains and increased health spending, selected high-income countries, 1995-2015**



OECD publishing

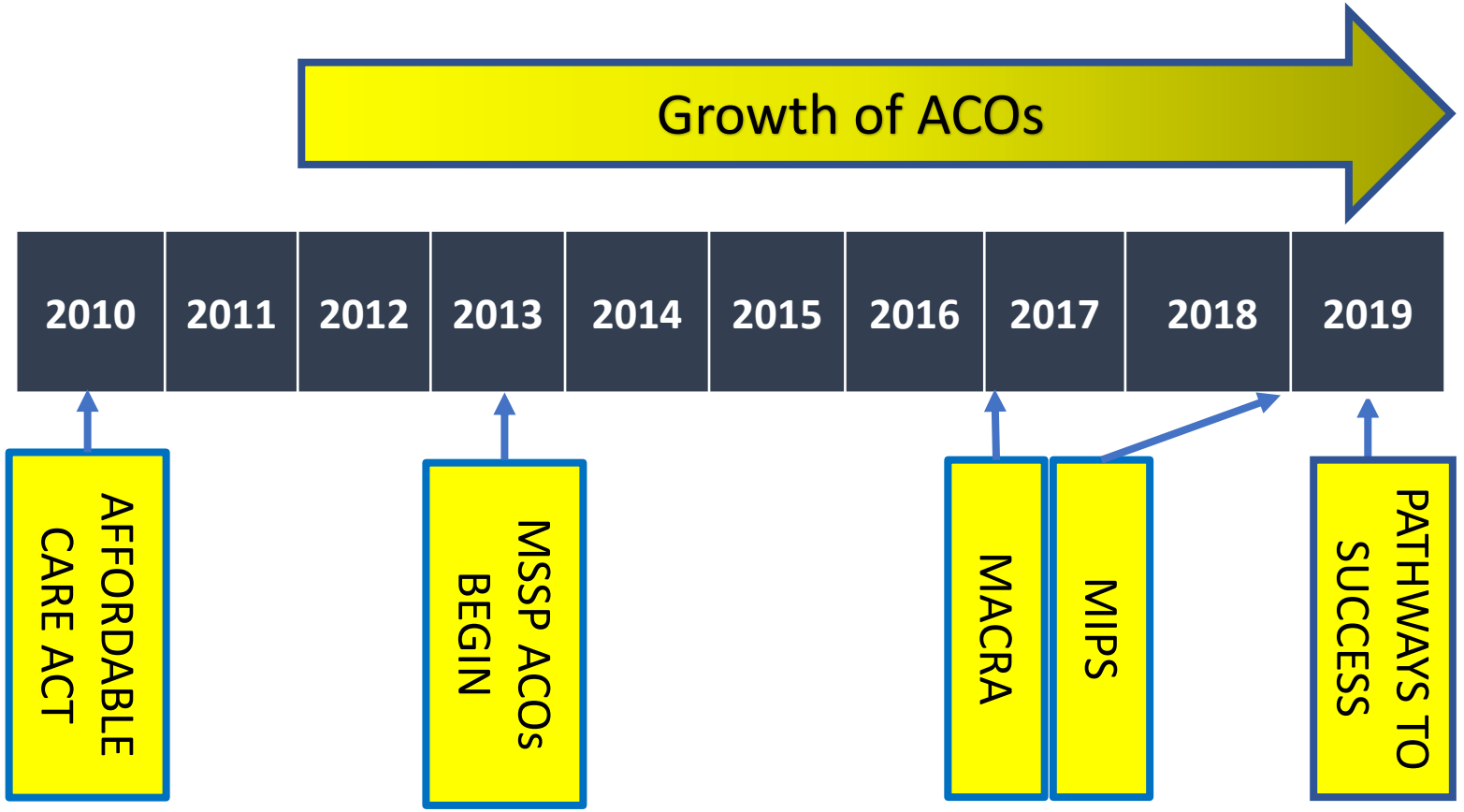
StatLink http://dx.doi.org/10.1787/888933602215

Low ranking in health of our population



America is number 50 out of 56 countries that were assessed

A Decade of Population Health Legislation in the U.S.



The move from *volume* to *value*…
Value-Based Contracts

Alternative payment approaches engage physicians and health care organizations willing to assume ***collective responsibility*** for the ***cost and quality outcomes*** of a ***specified population.***

Medicare MSSP/ACO

Medicare Advantage Contract

Episodic VBC (bundles)

Medicaid Contracts

Commercial contracts

Upside-only vs Downside Risk

key thoughts…

Segmentation

- Cardiologist's approach to reducing CHF readmissions
- Seasoned geriatric PCP struggling to generate RVUs while caring for increasingly complex elderly patients

Incremental change

By Michael E. Porter, Erika A. Pabo, and Thomas H. Lee

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HEALTH AFFAIRS 32,
NO. 3 (2013): 516–525

ANALYSIS & COMMENTARY

Redesigning Primary Care: A Strategic Vision To Improve Value By Organizing Around Patients' Needs

Michael E. Porter is the Bishop William Lawrence University Professor at the Harvard Business School, in Cambridge, Massachusetts.

Erika A. Pabo is a resident in internal medicine and primary care at Brigham and Women's Hospital, in Boston, Massachusetts.

Thomas H. Lee (thlee@partners.org) is network president at Partners HealthCare and a professor at the Harvard School of Public Health and Harvard Medical School, in Boston.

ABSTRACT **Primary care in the United States currently struggles to attract new physicians and to garner investments in infrastructure required to meet patients' needs. We believe that the absence of a robust overall strategy for the entire spectrum of primary care is a fundamental cause of these struggles. To address the absence of an overall strategy and vision for primary care, we offer a framework based on value for patients to sustain and improve primary care practice. First, primary care should be organized around subgroups of patients with similar needs. Second, team-based services should be provided to each patient subgroup over its full care cycle. Third, each patient's outcomes and true costs should be measured by subgroup as a routine part of care. Fourth, payment should be modified to bundle reimbursement for each subgroup and reward value improvement. Finally, primary care patient subgroup teams should be integrated with relevant specialty providers. We believe that redesigning primary care using this framework can improve the ability of primary care to play its essential role in the health care system.**

Primary care is widely recognized as essential to any health care system, but the field remains beleaguered.[1] Many primary care practitioners feel frustrated and underappreciated, and fewer than one in ten US medical school graduates enters primary care residency programs.[2] Primary care practices are starved for

believe that the overarching strategy for health care should be to improve value for patients, where *value* is defined as patient outcomes achieved relative to the amount of money spent.

Only through achieving better outcomes that matter to patients, reducing the costs required to deliver those outcomes, or both can we unite the interests of all key stakeholders. Unless primary

Private Equity Acquisition of Physician Practices

Lawrence P. Casalino, MD, PhD; Rayhan Saiani, MD; Sami Bhidya, MS; Dhruv Khullar, MD, MPP; and Eloise O'Donnell, MPH

Acquisition of physician practices by private equity firms has increased dramatically during the past few years (1). Such acquisitions are a significant phenomenon with unknown consequences for physicians and patients, although they have received little attention from researchers and policymakers.

We describe this phenomenon and explore its implications, based on review of the gray literature and the very limited peer-reviewed literature. We interviewed 21 knowledgeable individuals around the United States, including consultants; attorneys; investment bankers; and leaders of private equity firms, physician practices, and health insurers.

Private equity firms invest in many industries using capital provided by pension funds, sovereign wealth funds, high net-worth individuals, and university endowments. These investors anticipate average annual returns of 20% or more (2). To achieve such returns, private equity firms focus on acquiring "platform practices" that are large, well managed, and reputable in their community. The firms sell these practices after augmenting their value by recruiting additional physicians, acquiring smaller practices to merge with the larger practice, increasing revenue (for example, by bringing pathology services into a dermatology practice) (3), and decreasing costs (for example, by substituting physician assistants for physicians) (4). Growth makes it possible to spread fixed costs, exploit synergies across merged practices, expand ancillary revenues, and increase negotiating leverage with health insurers.

Acquisition prices are based on EBITDA (earnings before interest, taxes, depreciation, and amortization), a proxy for operating cash flow. Acquisition of smaller practices provides a major arbitrage opportunity: The private equity firm typically pays 8 to 12 times EBITDA for a platform practice but 2 to 4 times EBITDA or less for a smaller practice. Once the practices are merged, the value of the smaller (as part of the whole) immediately becomes that of the larger–that is, 8 to 12 times EBITDA.

Private equity firms typically take 60% to 80% ownership, although sometimes they accept minority ownership in very large medical practices. The amounts paid to practice owners vary but may be as much as $1 million to $2 million per physician. After the acquisition, physician owners typically receive market rate salaries but cede all or most additional revenue (for example, from ancillary services) to the private equity firm. Firms do not seek 100% ownership because they want physician owners to share their growth objectives. They aim to sell practices within 3 to 7 years in what is known as a "liquidity event" or "second bite of the apple." Such a sale can generate substantial additional cash for physician owners, but it may create a schism between owning and nonowning physicians despite contracts incentivizing the latter to remain with the practice.

Private equity firms focus on specialties with high potential for additional income from elective procedures and ancillary services. Dermatology has been a major focus, and attention to ophthalmology, urology, and gastroenterology has recently increased. Firms have not emphasized primary care, although some invest in primary care and multispecialty practices with the objective of profiting from risk contracts in which they manage care for Medicare Advantage patients. A commonly used database (5) indicates that private equity firms acquired 102 practices in 2017; interviewees stated that acquisitions have been increasing in recent years and that the database misses some acquisitions, especially of smaller practices.

Interviewees emphasized that the rapidly changing health care environment–especially movement toward value-based purchasing–has made physicians more interested in selling their practices. Small practices struggle to contend with new requirements imposed by value-based purchasing programs and with the high levels of uncertainty in the current environment (6). Even large independent practices have difficulty finding capital to reach the size and create the infrastructure that they believe are necessary to succeed. Large size also allows negotiation of higher payment rates from insurers.

In addition, independent physician practices find it increasingly difficult to compete to recruit physicians against practices owned by hospitals, private equity firms, and health insurers. These well-capitalized purchasers offer "shelter from the storm" in the rapidly changing environment, as well as the regular work hours and freedom from running a small business that many newly trained physicians prefer.

Critics argue that private equity firms have an intense incentive to increase profitability–perhaps at the expense of patient care–whereas private equity firms argue that they provide practices with more autonomy than they would have if acquired by a hospital or insurer (1); capital to improve care; and expertise in financial discipline, business operations, and acquisitions of other practices. Private equity firms also give physicians a continued share of ownership and leadership in their practice and the opportunity to profit from the future sale of the practice. Interviewees stated that private equity firms vary widely in the extent to which they deliver on these promises. Nearly all physician practice management companies that were publicly traded in the 1990s failed; the ensuing bankruptcies severely disrupted the acquired medical groups (7). However, the health care environment has changed:

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ORIGINAL RESEARCH

Physician Burnout and Higher Clinic Capacity to Address Patients' Social Needs

Emilia De Marchis, MD, Margae Knox, MPH, Danielle Hessler, PhD, Rachel Willard-Grace, MPH, J. Nwando Olayiwola, MD, MPH, Lars E. Peterson, MD, PhD, Kevin Grumbach, MD, and Laura M. Gottlieb, MD, MPH

Background: **A recent regional study found lower burnout among primary care clinicians who perceived that their clinic had greater capacity to meet patients' social needs. We aimed to more comprehensively investigate the association between clinic capacity to address social needs and burnout by using national data that included a more representative sample of family physicians and a more comprehensive set of practice-level variables that are potential confounders of an association between clinic social needs capacity and burnout.**

Methods: **We conducted a cross-sectional analysis of 1298 family physicians in ambulatory primary care settings who applied to continue certification with the American Board of Family Medicine in 2016. Logistic regression was used to test associations between physician and clinic characteristics, perceived clinic social needs capacity, and burnout.**

Results: **A total of 27% of family physicians reported burnout. Physicians with a high perception of their clinic's ability to meet patients' social needs were less likely to report burnout (adjusted odds ratio [OR], 0.66; 95% confidence interval [CI], 0.47–0.91). Physicians who reported high clinic capacity to address patients' social needs were more likely to report having a social worker (adjusted OR, 2.16; 95% CI, 1.44–3.26) or pharmacist (adjusted OR, 1.73; 95% CI, 1.18–2.53) on their care team and working in a patient-centered medical home (adjusted OR, 1.65; 95% CI, 1.24–2.21).**

Conclusion: **Efforts to reduce primary care physician burnout may be furthered by addressing structural issues, such as improving capacity to respond to patients' social needs in addition to targeting other modifiable burnout risks. (J Am Board Fam Med 2019;32:69–78.)**

Keywords: **Family Physicians, Patient-Centered Care, Primary Health Care, Professional Burnout**

In light of a growing recognition that clinician well-being is a foundational component of a high-functioning health care system,[1,2] it is alarming that more than 60% of US family physicians report symptoms of burnout.[3] A new body of research has emerged exploring both clinician- and practice-level risk factors for burnout as potential targets for intervention. Reported clinician-level burnout risk factors include being midcareer[4], spending a higher percent time in clinical activities[5,6], and being female.[7,8] Reported practice-level burnout risk factors include electronic health record (EHR) burden[9,10], work stress, poor team efficiency[6,9,10–12], and poor or misaligned clinical leadership.[9,12,13]

Burnout is of particular concern in United States safety-net practices, where the level of need frequently exceeds available resources.[14–17] In these

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Transformative change

- Segmentation around patients' needs within a *new* structure
- Models representing transformative change which we will learn more about today:

one medical

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Patient Centered Medical Care

OAK STREET HEALTH

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