Primary Care Transformation:
The Changing of a Culture

Exploratory Paper

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The current model of healthcare delivery in the United States reinforces the unsustainable rise in the cost of medical care. The Patient Protection and Affordable Care Act (ACA) was introduced in 2010 to attempt to reform the healthcare delivery system by providing more Americans with affordable quality health insurance and by curbing the growth in healthcare spending in the U.S. The ACA places an emphasis on the restructuring of healthcare business models to promote innovations in care delivery, reduction in overall cost, and an increase in the quality and value of care for patients.

As a result, the integration of primary care physicians in healthcare delivery is a major strategy for many hospitals, health systems, and other health-related organizations across the country. While these health-related organizations are typically highly structured with a well-defined organizational strategy, barriers working against this integration strategy exist within steadfast cultures. For integration to be successful the culture and strategy of stakeholders must be closely aligned; if the focus is purely on strategy, it is unlikely that true integration will occur.

Primary care practices personify unique and distinct cultures. Whether a solo physician clinic or a large multi-physician practice, cultures vary widely and unique subcultures often emerge among larger groups. Based on the concept established by Peter Drucker that “Culture eats strategy for breakfast”, a common primary care culture must first exist if there is any of aligning Primary Care physicians with organizational strategy.

The transformation of Primary Care to a common culture will occur if a large enough group of stakeholders decide that old ways are not working, figure out a vision for change, act differently, and then enlist others to do the same. It is imperative that physician leaders be included as stakeholders of this group. Given the engrained cultures of primary care physicians and limited physician leadership capacity, transformation to a common culture is a slow and arduous process. Moving to a common primary care culture enables the strategic alignment of physicians with
organizations and provides standardization of new care delivery methodologies that address evolving strategies like Population Health.

The purpose of this paper is to bring to light several of the cultural changes that stakeholders face during primary care transformation. In addition, a framework for healthcare leaders identifies changes affecting management in the following key areas: leadership, care delivery, patients, metrics, and technology.

The context of this paper is based on literature review and personal experience.

**Background**

Culture, as defined by John Kotter, “is group norms of behavior and the underlying shared values that help keep those norms in place. It usually comes from the founders of the group. For whatever reason, the founders value certain things and behave in ways that seem to help the group succeed. Success is key; it seeps into the group’s DNA.” Over time, group norms become the foundation of a physician-centric care delivery culture.

**Physician-Centric Culture**

Deep-rooted norms define the physician-centric healthcare culture; it began with medical school training, was stimulated by physician-friendly competition, and was incentivized by a perverse payment system. Medical school culture focused on the health professional as an individual. In time, friendly competition amongst providers shifted to include competitive organizational stakeholders. Providers and organizations frequently worked against each other to obtain a competitive advantage for themselves; often at the expense of patients. Finally, the volume-based reimbursement model resembled a manufacturing production methodology, which had not changed since inception. The physician was the focal point of medicine.
Within a practice, the physician was typically both owner and care provider. As an owner, physicians delegated the management of the organization to a business professional in charge of managing and directing the administrative functions of the practice. Responsibilities included legal, regulatory, financial and human resources management of the organization. Major business decisions were limited to the owners of the organization due to the potential personal risk involved; consequently, many decisions made by physicians were from a personal rather than business perspective.

The management structure, if any, was comprised of supervisors mainly utilized to oversee staff with a direct reporting relationship to a Practice Administrator. In a culture where change was limited, the function of a manager was to maintain the status quo and conform to standards and boundaries established by the owners. Leadership, as recognized today, was virtually non-existent.

The majority of Care Delivery was provided directly by the physician in the exam room, with a nurse providing limited, acute patient ailments and preforming vaccinations and injections. Documentation of each visit was cryptic, brief and typically consisted of hand-written notes or dictation that varied greatly by physician. In addition to regular office hours, primary care physicians would round on patients in a hospital, deliver babies, perform various procedures and take call 24 hours a day, 7 days a week.

Clinical office workforce consisted of nurses, who supported the office visit, provided phone triage for medications, and delivered lab results; Medical Assistants (MA) were utilized for setting up patients in the exam room, taking vital signs and patient transport. Front office workforce included schedulers, who worked patient visits into a standard template at the convenience of the physician; and reception staff who verified insurance coverage, collected co-pays and performed patient appointment reminder calls. Billing and coding staff performed back-
office functions to support the financial flow of the business. Office workforce was often considered a direct expense to the bottom line of the physician.

Patients were reliant on their physicians for healthcare knowledge and direction. Office visits were scheduled because of patient illness, injury, or for a follow-up visit at the request of the physician; proactive visits for routine or preventative services were rare. The patient relationship was that of accommodating to the physician and revolved primarily around the physicians’ schedule, their approach to care delivery, and their preferences of office flow; often with little consideration for patient needs.

Technology consisted primarily of Accounts Receivable (A/R) programs for billing purposes and scheduling systems used to ensure the volume-based business model. Medical equipment technology for office use was limited. As computer technology evolved, so did software applications and equipment; however, lack of standards and protocols did nothing more than further fragment information.

Metrics that defined the success of the organization were financial in nature and viewed in terms of gross charges, net collections and average days in A/R. Clinical success was productivity-related and measured around appointments; how many days out a physicians’ schedule was full, the no-show rate, and the number of visits performed in a given time period. Consequently, key indicators for a practice focus on the physicians’ schedule and Accounts Receivable.

As Kotter suggests of culture, success is key. In an environment where the physician primarily performs care delivery, patient care is the sole responsibility of the physician, the purpose of the workforce is to support the functions of the physician, patient behaviors are influenced by the physician, technology limitations restricted information, and volume-based reimbursement enables a physician to control income; success thrived in a physician-centric culture.
Body

Culture is demonstrated in a variety of ways, including how an organization treats customers and employees, the extent to which freedom is allowed in decision-making, the development of new ideas, the manner in which power and information flow, and how committed employees are to an organization’s objectives. In the context of cultural change, personal transformation of stakeholders also occurs and organizational leaders have the greatest influence on shaping that change. The transformation of culture requires leadership to objectively assess the existing corporate culture, understand its impact on execution and results, and then take necessary steps to navigate change.

**PATIENT CENTERED CULTURE**

A Patient-Centered Care model emerged that supersedes the traditional physician-centered model. The Institute of Medicine (IOM) defines patient-centered care as: "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." In this new model, the primary care physician is responsible to lead an interdisciplinary care team and encourage cooperation and collaboration between the patient and providers.

Two solutions have migrated to the forefront as leading the Patient-Centered Care model. The most widely known concept is the Patient Centered Medical Home (PCMH) which is an evolving and widely accepted model that sets the current standard for how primary care should be organized and delivered. Second, the Virginia Mason Medical Center developed a solution based on the Toyota Production System of continuous process improvement to enhance the delivery process across their system. The appropriately named Virginia Mason Production System (VMPS) aligns healthcare culture with patient-centered care at an organizational level.
**Patient-Centered Medical Home**

PCMH, while not a new concept, has advanced as a model of primary care that is patient-centered, comprehensive, coordinated, accessible, and committed to quality and safety.

The PCMH is a model that aims to strengthen a health care delivery system by reorganizing the way primary care practices provide care in the following manner:

1. **A patient-centered orientation** toward each patient’s unique needs, culture, values, and preferences; support of the patient’s self-care efforts; and involvement of the patient in care plans.

2. **Comprehensive, team-based care** that meets the large majority of each patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care and is provided by a cohesive team.

3. **Care that is coordinated** across all elements of the complex health care system and connects patients to both medical and social resources in the community.

4. **Superb access to care** that meets patients’ needs and preferences, including care provided after hours and by e-mail and telephone.

5. **A systems-based approach to quality and safety** that includes gathering and responding to patient experience data, a commitment to ongoing quality improvement, and practicing population health management.

The objective of the PCMH is to have a centralized setting that facilitates and coordinates partnerships between individual patients and their personal physicians, and when appropriate, the patient’s family. Care is further facilitated by registries, information technology, health information exchange and other means to assure patients get indicated care when and where they need and want it in a linguistic and culturally appropriate manner.
While there is significant evidence that the medical home model demonstrates noticeable benefits around cost and quality, there is some belief that the PCMH simply reestablishes the primary care physician as the predominant point of care while promoting continuity of care. Notable strides have been made around care that is patient-centered; however, it has been argued that PCMH is really more about the physician and practice than the patient.

**Virginia Mason Strategy**

As PCMH identified the “what” behind this new model, Virginia Mason embarked on a journey of “how” to integrate a patient-centered model within their organization. The Virginia Mason journey of transformation began in the year 2000 when Dr. Gary Kaplan, CEO realized that Virginia Mason was organized not around patients, but around the doctors. As a physician-driven, physician-led place, everything was designed around the physicians. The strategic plan Virginia Mason developed in 2001 was all about the patient, being a great place for doctors, having physicians in leadership roles and built on a management framework to achieve a vision. Their realization of having one system, one common language that everyone could use and one set of tools that all could learn was the foundation needed for changing their culture.

Certainly one the most distinguishing characteristics of Virginia Mason is its mission not only to be a quality leader, but also to transform care. It further indicates that it is not just about a patient, a group of patients or the stakeholders at Virginia Mason; it is about rethinking how health care is delivered. This is a unique differentiator establishing Virginia Mason as the leading provider organization to have made a “visible” commitment to fundamentally transform how care is delivered.

Another differentiator is the management foundation on which the Virginia Mason journey was built. It is a management methodology that enables everything else; that enables Virginia Mason to put the patient first; that allows Virginia Mason the ambition to transform health care. Their
management system creates alignment throughout their medical center; which is seemingly uncommon in the industry. Executive leadership and the entire medical staff are aligned in the pursuit of the organizational mission and goals; successful alignment of strategy and a common culture. Central to this culture is the concept of lean thinking.

**LEAN THINKING**

Much of the lean way of thinking is based on the work of quality guru W. Edwards Deming, who taught, among other things, that managers should stop depending on mass inspection to achieve quality and, instead, focus on improving the production process and build quality into a product in the first place.

Lean thinking is not a manufacturing tactic or a cost-reduction program, but rather a management strategy applicable to all organizations because it has to do with improving processes. All organizations — including health care organizations — are comprised of a series of processes, or sets of actions intended to create value for those who use or depend on them.

In healthcare, both clinical and administrative processes must be evaluated. Thinking lean means that for each process leaders must accurately specify a desired value; identify each step within every process, eliminate non-value-added steps, and make value flow based on the needs of the patient. When applied methodically throughout an organization, the principles of lean thinking can have a dramatic impact on productivity, cost, and quality.

**KEY CULTURAL CHANGES**

The PCMH concept and the Virginia Mason lean journey provide a foundation for transforming primary care to a common culture. Within these and other evolving models across the country, team-based care stands out as the most critical aspect to successfully transform practices to deliver patient-centered care. Team-based care models require some level of change in the roles
and responsibilities of individual professionals, additional training, extensive use of Health Information Technology (HIT), and the expansion of clinical functions.

**Leadership**

With “change” considered to be the core of transformation, leadership plays an integral role at all levels of the organization. As change agents, the behaviors a leader models and the behaviors they reward or punish, both informally and formally, provide an indication of how effectively their initiatives will be executed. If people work in an environment where they do not feel motivated to offer their best, execution will suffer.

Executive leadership transitions to a dyad partnership between an administrative and a physician leader combining responsibilities of both business and clinical functions with a focus on value and quality of care. The executive leadership dyad is collectively involved in strategic planning, direction of the entity, team engagement, improvement of structured care delivery processes, market share expansion, innovation and organizational alignment (both internal and external).

The former “supervisory” layer of administration, while still performing personnel functions, is expected to engage in a higher level of thinking and performance. As a manager, their new leadership role focuses on a management methodology of process improvement by identifying duplicate and wasteful work, balancing the work load of team members, developing standard work, and ensuring appropriate training is provided. These management leaders help to facilitate the implementation of standard work through the use of visual displays, daily staff huddles, and root-cause analysis into their leadership role.

**Care Delivery**

In the team-based care environment, changes to individual roles and responsibilities for care team members typically align with changes in care delivery. Ideally, all non-visit care is handled in a
tightly defined flow process, eliminating the need for the physicians to perform tasks other than spending time with patients. A key element of the new flow system is that doctors get to spend more time with patients as a result of standard work, evidence-based care, and process improvement.

Many primary care staff members have typically been under-utilized compared to what their clinical licensure and personal potential would permit them to do. The challenge with team-based care is to enhance staff skills and roles to do more complex and meaningful hands-on work. Developing this at each licensure level allows less-complex work to be offloaded from the level above, including the physician or Non-Physician Provider (NPP). It also positions providers to manage more patients in the future.

Members of the care team are expected to practice at the top of their license, not just the physician. Leaders should critically evaluate NPP, RN and MA tasks to ensure each member of the team is assigned tasks aligned with their clinical license. Training staff to achieve top-of-licensure practice is critical for change and provides tiered opportunities for advancement within job positions, increases staffing flexibility, and resource capacity.

Retail medicine and tele-health may be considered disruptive to the team concept of care team delivery, especially when considering continuity of care. In a forward thinking organization, these care delivery models are simply an extension of the care team. The key to successful utilization of these models is the integration of clinical data in the primary medical record of the patient.

**Patients**

The role of the patient has shifted from passive to interactive and new levels of patient expectations and responsibilities have developed. Rapidly advancing technology, access to
information, a significant shift in financial responsibility, regulatory changes, healthcare reform and general uncertainty have contributed to profound changes in the way patients view and interact with providers. New key areas of patient expectations include:

- **Access to care**
- **Access to information**
- **Quality of service and care**
- **New alternatives to pay for care**
- **Better coordinated care**
- **Better communication**
- **New and better medications**

Meeting these expectations is more than just accommodating the patient; it is about risk management, effective competition, and improved clinical care. Quality service and care lead to a better patient experience, better outcomes, and an enhanced sense of security and well-being. Exceeding patient expectations must be the goal of any organization today; communicated extensively and demonstrated daily until it becomes engrained in the culture.

The new and evolving role of the patient requires them to take more ownership of their personal health. It is important for them to become comfortable with and assume this new level of responsibility. For patients to be successful in this new role they must possess three attributes: 1) acknowledgement of responsibility for their own health care decisions; 2) impeccable organization of their health information; and 3) they must be their own best advocate.

With this new ownership role in their personal health, the patient must also balance their personal fiduciary responsibility. Growing financial burden on the patient has created a consumer driven culture. Patients are shopping for care based on cost and value. Results of this consumer driven
environment include price sensitivity of fee structures to the market; and a growing demand on convenience and the quality of the patient experience.

Patients have emerged with a significant role reversal in a patient-centered culture as compared to the traditional physician centric culture.

**Metrics**

Measurement of the new processes, roles, responsibilities and expectations, along with the simultaneous convergence of changes for stakeholders, is vital to understanding the pulse and rate of success. The metrics for the patient-centered model are described below and focus primarily on four categories: Clinical Quality, Utilization, Patient Experience, and Finance.

Clinical Quality – Core measurement subsets of primary care include: preventative care, chronic disease management, acute care, overutilization, and safety. A set of standardized and validated technical quality metrics for those subsets was assembled from the following measure sets: Ambulatory Care Quality Alliance (AQA), Healthcare Effectiveness Data and Information Set (HEDIS), National Committee for Quality Assurance (NCQA), and Physician Quality Reporting Initiative (PQRI). To ensure consistency and non-bias, an additional set of supplemental adult measures and core pediatric measures was added to the original set of standard PCMH metrics. The set of metrics and criteria is well-defined albeit extensive and difficult to obtain.

Utilization – Utilization measurement is hospital focused and consists primarily of emergency department visits, hospitalization, and readmissions. Access to primary care physicians can have a significant impact on utilization metrics; however, some risk adjustment is necessary to avoid bias due to local constraints and population characteristics.

Patient Experience – Patient measurement is evolving from a standardized means of measuring the patient experience: CAHPS (Consumer Assessment of Healthcare Providers and Systems).
CG-CAHPS is the Clinician and Group survey version of the tool that asks patients to report on and rate their recent experiences with clinicians and their staff. The survey has many questions with several different categories and some level reimbursement is expected to be based on scoring in the near future.

Finance – Volume and cost are important measures of success in the financial measurement category. As the focus of care shifts from volume to value, the patient panel size of physicians is emerging as a new key indicator for patient-centered care.

Panel size was originally defined as the number of unique patients seen by any provider (physician or advanced practitioner) in a rolling 18 month period. Since inception of this definition, there have been multiple interpretations and variations for panel size such as utilizing a 12 month time period. Age and gender are the most significant attributes that can affect panel size. The age and gender of a patient often predicts visit utilization and reflects visit acuity; therefore, it is very imperative to measure panel size by risk-adjusted patients.

For management, panel size plays an important role in balancing appointment supply and patient demand. Additionally, it can help to define the workload, anticipate patient demand, reveal provided performance issues and improve outcomes.

Many new metrics provide a better level of measurement for the patient-centered model and will be obtainable through comprehensive technology solutions that have not previously been available.

**Technology**

The use of technology, more specifically, Health Information Technology provides tremendous potential to enable, support, and enhance, the patient-centered care and future care models.
Ten recommended HIT tools that support the concept of patient-centered care have been established by the Patient-Centered Primary Care Collaborative (PCPCC) as it continues to evolve in the direction of Population Health Management.

1. **Electronic health records**: EHRs document diagnoses, vital signs, tests and treatments, populate registries, and create the structured data needed for advanced analytics.

2. **Patient registries**: The central database of PHM, registries are used for patient monitoring, patient outreach, point-of-care reminders, care management, health risk stratification, care gap identification, quality reporting, performance evaluation, and other purposes.

3. **Health Information Exchange**: Enables effective coordination of care across the medical neighborhood and between care team members. Secure messaging that uses the standardized direct protocol is another way to exchange information from one provider to another.

4. **Risk stratification**: Analytic tools used to classify patients by their current health status and their health risk. Risk stratification and predictive modeling applications enable providers to intervene appropriately with high-risk patients and those who might become high-risk.

5. **Automated outreach**: By applying analytics to registries, organizations can generate automated messaging to patients who need preventive or chronic disease care, according to standardized clinical protocols.

6. **Referral tracking**: Referral management tools help practices keep track of referrals to other providers and make sure that they receive the results back from those consultations.
7. **Patient portals**: Web portals attached to EHRs help providers share records with patients and engage patients in self-management. They are also important to the process of continuous care, an essential component of PHM.

8. **Telehealth/telemedicine**: Remote examination and treatment of patients using audio and video conferencing are another method of engaging and caring for patients between face-to-face visits and can also reduce the need for those encounters.

9. **Remote patient monitoring**: Whether patients are monitored at home or using mobile devices, this approach makes it possible for providers to intervene quickly when high-risk patients show signs of distress. Remote monitoring can also help patients control chronic conditions such as diabetes and hypertension.

10. **Advanced population analytics**: Applied to the data in registries and data warehouses, these analytics can be used to evaluate how different segments of patient populations are doing and to assess the clinical and financial performance of individual providers, sites of care, and the organization as a whole.

Effective, meaningful use of HIT promotes efficiency and cost-cutting with the primary intent being the improvement of patient care. The adoption of these technology tools has a direct impact on the success of the patient-centered care model. Technology also plays a significant role in enhancing the patient experience through increased electronic communication with providers, online access to personal medical information and electronic delivery of medical information such as test results.

Physicians often look for technological advances to take better care of patients such as a new technique, procedure, medical instrument, medication, or research discovery. While there is
some sentiment that physicians are reluctant to embrace technology, they normally embrace solutions that bring better information to optimize their time and enhance their decision making related to patient care.

**OBSTACLES TO PATIENT-CENTERED CARE**

Patient-centered care is an excellent concept for providing the framework of where to go and the metrics to get you there. Getting physicians, care team members, patients, and all stakeholders on the same page and moving in the same direction is a cultural challenge, but certainly attainable. Yet, with all of the progress achieved around the PCMH concept and potential success of Population Health, there are still a few obstacles to overcome with the patient-centered care model.

Primary care physicians are paid relatively poorly per patient encounter; unfortunately, the reimbursement model in no way reflects the importance of longstanding relations and personalized care provided to patients. Physicians often become hurried and stressed as they drive to increase patient volumes; thereby, reducing the time they spend with each patient and potentially negatively affecting the patient experience.

The relationship between the physician and patient is crucial as a lack of relationship can significantly influence health-related decisions. A higher level of patient engagement has been shown to provide better outcomes. Physicians not engaged in patient-centered care often order more expensive tests, make unnecessary referrals or prescribe medications as an attempt to appease or connect with patients, giving the illusion of high quality care. Patient-centered care is also about empowering patients by providing an appropriate weight to their opinions about care delivery.
Among multispecialty groups, hospitals and other healthcare entities, primary care physicians are often valued more for the patients they bring rather than for the actual care delivered to patients. Some organizations often hire generalists or create competing entities with goals that may run contrary to patient centrism and relate more to the financial bottom line than patient care and outcomes.

Until a reimbursement and compensation model for primary care physicians is based more on value and outcomes, rather than volume, a barrier to the patient-centered care model will exist.

**Summary**

“We cannot solve our problems with the same thinking we used when we created them.” This quote by Albert Einstein has a direct correlation to the cultural transformation of primary care. Holding on to a physician-centric culture of doing things the way they have always been done and expecting a different result or outcome can be considered insane.

To align culture with strategy, transformation is not optional. Large and small practices alike will need to undergo transformation. Few organizations understand what is needed or are prepared to make the fundamental changes necessary for true transformation.

While change is difficult enough for most, cultural change can be quite painful. Understanding what to expect and the why behind transformation makes change much more palatable. Moving to a patient-centered care model is an evolutionary transition that takes time. Fortunately, the path has already been traveled and it is not a new trail to explore.

Patient-centered care is the retrofitting of a noble idea into an antiquated delivery system. It involves careful and thoughtful process changes that dramatically affect both the workforce and the patient. Realistic expectations of the investment required in both time and resources are imperative. Practices that do not currently function at a high level are likely to have the most
difficulty as they may be resource starved, understaffed, and may feel extremely overwhelmed during the process.

Primary care physicians must adopt new mental models to be able to think in new and different ways about themselves and their practice. It will be necessary for the physicians and their staff to create innovative care teams, become a learning organization, and act as good citizens within the health care neighborhood. Physicians and the public will both require a care delivery paradigm shift to ensure there is a true focus on the patient. Staff will be assigned new roles, responsibilities, and tasks while performing lean thinking processes with new skillsets.

While there are challenges involved in the transformation to a patient-centered primary care model, the rewards provide immense potential. A resulting common culture provides consistency of care delivery, higher standards by which performance and quality can be compared equally, and a platform for continual process improvement. Primary care transformation enables strategic alignment of a common culture with an integrated healthcare delivery system regardless of affiliation.

**Bibliography**


