OPINION

Back to the Future: The Way Forward in Health Care Reform

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It's 1995 all over again. Let's get it right this time.

So much of what is happening in health care today is eerily similar to what was happening in the mid-1990s. If that period were a movie, we would have called it *Capitation*, and this current feature would be called *Return of Capitation*. At the end of the first, the dead monster's eyes would begin to glow again faintly, letting the audience know that a sequel would be a real possibility. Now he's back, and he's angry.

Recently, I re-read a 1995 article about how family physicians should respond to changes in health care written by William J. (Terry) Kane, MD, and published in *Family Practice Management*.[1] (You can download the article at http://www.aafp.org/fpm/2012/0500/fpm19951100p38.pdf.) Kane, a family physician, had held high-level executive positions with Sharp HealthCare in San Diego and with various health plans. I was on the American Academy of Family Physicians (AAFP) Board of Directors at the time, and I remember Kane delivering a fascinating talk on managed care and macroeconomic trends in the industry and in our specialty. He later presented it as the keynote address at the AAFP Scientific Assembly; his article was based on that talk.

On the heels of the Clinton health care reform proposal, Kane discussed the need for transitional leadership and new and innovative thinking. He eschewed "raging incrementalism" and encouraged us to consider this era of "transitional chaos" as an opportunity for family physicians to lead the new system. His words were bold and inspiring. He gave no quarter to timidity as he exhorted us to accept the challenge. "We need physician leaders at all levels of health care willing to bring about dramatic change in how we practice medicine and committed to marked improvement in outcomes and efficiency," he wrote.

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Although his words were directed at those of us practicing family medicine in the mid-1990s, they are no less relevant today.

What is the same in 2012 as it was in 1995?

Market forces tend to build energy akin to that pent up in tectonic plates. Then, when the time comes, they move suddenly and violently. In health care, the trigger seems to be what I call a "policy event." Although the Clinton health care bill did not pass in the 1990s, it was the catalyst for seismic shifts in our practices in the subsequent era of managed care.

The Patient Protection and Affordable Care Act of 2010 is another such policy event. Whether it is fully

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implemented, fully repealed, or (more likely) partially implemented, it has already triggered seismic activity in the private markets. The buzzwords are *patient-centered medical home (PCMH)*, *accountable care organization*, *value-based reimbursement*, *meaningful use*, and others – all of which can be summarized under the rubric of *accountability.*

What happened between 1995 and 2012?

Quite simply, physicians dropped the ball and lost the opportunity to lead:

- We continued to look to the federal government to pay us what we're worth.
- We ignored the fundamentals of business in running our practices.
- We looked to hospitals, health plans, specialists, and government to subsidize our practices rather than taking responsibility ourselves.
- We let our attitude of victimization and helplessness turn our efforts into the "raging incrementalism" of which Dr. Kane spoke.

So what is different now?

Our country is out of money. For the last 50 years since the passage of Medicare, health policy has shaped health economics, but now health economics are beginning to shape health policy. Three years ago, the unfunded commitment of Medicare and Medicaid was $30 to $60 trillion. Now it's $120 to $150 trillion. The cost is unsustainable, and policy cannot control it. As a result, economic factors are heavily favoring primary care physicians, who provide higher quality care at lower cost, to become both the clinical and economic leaders in a revolutionary new health system. Fortunately, this time around, we have at our disposal a number of tools that will allow us to assume leadership in the new era.

The Future of Family Medicine report: Probably the most prescient work I have seen in my career, this document, a joint effort of seven sister organizations of family medicine, gave us a roadmap to the future and gave us the first glimpse of a "medical home."[2]

The Patient-Centered Medical Home (PCMH): The concept, while generic, has been operationalized with specific parameters by a number of credentialing bodies, most prominently the National Committee for Quality Assurance. Becoming a PCMH turns a practice into an accountable facility that measures patient satisfaction and outcomes, thereby greatly enhancing the demonstrable value of our work. The literature is replete with pilot studies confirming the global cost reduction when patient care is delivered by a PCMH.[3]

It should be noted, however, that while PCMH certification is the capstone of a successful practice, it is not the cornerstone. It is not the solution but the mark of a solution. Healthy practices require five things: 1) simple, appropriate technology that works for the physician, 2) operations that solidify efficiencies, 3) sound and profitable financial management that opens doors to innovation, 4) an infrastructure and management team that capitalizes on billing, contracting, and credentialing, and 5) a group of physicians who are optimistic, productive, and committed to success. Without these foundations, primary care architects relying on PCMH certification are in danger of building a house upon sand.

Organizations such as TransforMED (http://www.transformed.com, a subsidiary of the AAFP) and the Patient-Centered Primary Care Collaborative (http://www.pcpcc.net, an advocacy organization of which the AAFP was instrumental as a founder) provide us with deep resources in PCMH creation and adoption.

Lean Six Sigma: Tools of operational excellence have long been used in manufacturing and are now commonly applied to service industries, including health care. Lean Six Sigma is a term that refers to a vast array of quantitative tools and techniques that standardize processes, creating efficiency and driving higher quality by eliminating variability. Having delved for two years into these transformational techniques in our clinics, I am convinced that a clinic that has achieved PCMH status and makes the most of Lean Six Sigma can deliver approximately twice the quality of a PCMH without Lean Six Sigma.

Let's seize the opportunity before us this time. Collaborative strength in time-tested business models using the tools that we now have available will allow our specialty of family medicine to both thrive and lead. FPM

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About the Author

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