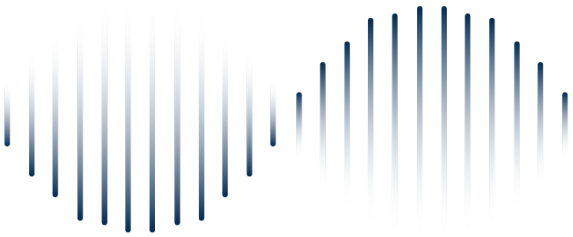
the future of MEDICINE



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MSMS
MICHIGAN STATE MEDICAL SOCIETY

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Introduction

The health care system is complex. Just consider the diversity of tasks involved in the delivery of patient care; the diversity of patients, clinicians, and other staff; continuous implementation of new technology; the number of people and organizations involved in care delivery; the wide variety of reimbursement models and incentives; and the increased specialization of health care professionals, to name a few.

In 2005, the Michigan State Medical Society (MSMS) interviewed more than 60 health care leaders for their insights on what was needed to ensure high-quality, cost-effective care in Michigan over the ensuing five years. MSMS found consensus around key features and changes needed to achieve that goal, which shaped the medical society's policies and platforms for years to come.

Since those interviews, the state of health care has greatly changed. Highlights include the passing of the Affordable Care Act (ACA) in 2010 and the subsequent expansion of Medicaid eligibility to Michigan adults with incomes up to 133 percent of the federal poverty limit, which dramatically increased the number of Michiganders with health care coverage. The 2009 passing of the Health Information Technology for Economic and Clinical Health (HITECH) Act prompted a majority of health care providers to adopt electronic health record systems. New health care payment models and practice models aimed at reducing health care costs while improving quality have proliferated. These developments, along with many others, align with several of the ideas promoted by health care leaders 15 years ago. However, there are continued opportunities for change and improvement. And, beginning in 2020 the world experienced its first pandemic in 100 years. The novel coronavirus (COVID-19) accelerated medical advancements and innovation, while also shedding light on existing challenges in health care and public health.

In 2021, MSMS spoke with about 60 health care leaders to update its study of the future of medicine. This new study, *The Future of Medicine: 2021,* emphasizes the voice of physicians—both those who currently treat patients as well as those who have leadership positions in health systems, health plans, and provider networks (e.g., accountable care organizations), among others—but includes other stakeholders, such as the Small Business Association of Michigan, the Michigan Chamber of Commerce, state legislators, and other nonphysician leaders.

Leaders were asked where medicine should be in five years, both generally and related to specific issues, including practice models, payment models, technology, universal coverage, and Medicaid. Leaders were invited to comment on how to control costs while paying providers fairly, increasing access to health care and insurance, and improving quality; how to reduce administrative costs without undermining accountability; the role of the medical community in addressing social determinants of health (SDOH) and health disparities; the role of medicine in reinforcing public health; and what physicians, payers, and patients must do differently to transform health care in the next five years.

Even in the midst of the COVID-19 pandemic—and, in many cases, informed by the pandemic—interviewees offered ideas for strengthening patient care, increasing the delivery of consistently high-quality care, simplifying reporting and documentation, and returning the joy of practice to physicians who often report feeling burned out by the demands of health care administration and documentation. Key themes and areas of consensus are provided below, followed by summaries of the responses to each question accompanied by quotes that capture the interview participants' overarching sentiments.

Key Findings and Major Themes

1. ***Team-based and integrated care models.*** Participants expressed broad support for these physician-led models, which promote patient-centered care and allow practices to address their patients' needs more holistically and allow all team members to practice at the top of their license.
2. ***Value-based and risk-based contracting.*** Participants often described the need for more aggressive evolution toward value-based and risk-based contracting. Many noted that these types of contracts would help decrease variability in care (e.g., by encouraging evidence-based practices and guidelines) and promote good patient outcomes.
3. ***Electronic health record (EHR) improvements.*** Respondents emphasized the need for EHRs that support clinical decision-making regarding diagnoses and evidence-based treatments. They also said EHRs must be interoperable so health care information can be shared across providers and health systems.
4. ***Social determinants of health (SDOH) and health equity.*** Health care leaders often pointed to the ways proposed advancements to practice models, payment models, and technology would also enable medicine to better identify and address SDOH and health disparities. Many interviewees noted that more work is needed to address these issues.
5. ***Physician leadership.*** Participants articulated a call to action for physicians to lead in multiple areas of the health care system (e.g., health systems, physician organizations [POs], payers) and to actively lead at the practice level in team-based care settings as well as at the community and state level (e.g., policy discussions).
6. ***Payer alignment and transparency.*** When asked how to improve quality and reduce administrative burden, interviewees frequently mentioned the need for alignment among payers regarding the metrics they use to monitor quality of care and the payment models they use to incentivize value-based care. They also advocated for reduced prior authorization requirements.
7. ***Multidisciplinary and cross-sector collaboration.*** Participants frequently noted that no single sector or discipline can transform health care. Physicians and other health care providers need to work directly with payers, purchasers, businesses, and patients to move health care forward over the next five years.

Questions and Responses

The first half of the questions focused on the role of physicians and medicine in health care. Respondents were asked where medicine should be in five years in general and where medicine should be on specific issues: payment models, practice models, adherence to evidence-based guidelines, public health, universal coverage, Medicaid, and the use of technology to support medical care. Participants were also asked how physicians are assets to both their patients and health care and how they can become greater assets; what physicians, payers, purchasers, and consumers need to do differently to transform health care over the next five years; and how MSMS can support health care transformation.

All bullet points are respondent quotations that provide compelling perspectives in addition to representative answers. The parenthetical numbers indicate the number of health care leaders who gave a particular response.

Q1: Where should medicine be in five years?

Interviewees highlighted several areas where medicine should be in five years. Key topics include improved care delivery models, including team-based and integrated care; increased access to care; more patient-centered care; greater awareness and action to address social determinants of health and health equity; revamped payment models and increased payer alignment; and improved technology that supports patient care.

Improved care delivery models (22 responses)

Interviewees want a care delivery model that is characterized by physician-led teams at the practice level, integrated care across settings, a focus on prevention, strong relationships between patients and providers. Several interviewees expressed concern that without improved care delivery—especially the patient-physician relationship—there will continue to be significant physician burnout.

- I would like to see physicians leading the team and being able to better practice medicine. Oversight of the team can be diffused under team-based care. When it does not have a clear leader, it can create more fragmentation. The physicians, the primary care physician, needs to be seen as the leader of the team.
- We will continue to be in the business of treating patients; medicine may be pulled in different directions–public health, advocacy—but it all comes back to treating patients. This is the key to addressing physician burnout, so much of their time is spent not treating patients. We need to recapture the fundamental nature of what medicine is about and for—treating people and staying patient centered.
- We should be well on our way toward no longer treating physical and behavioral health issues separately.
- Care needs to be more focused on preventative care instead of remedies.

Increased access to care (21 responses)

Interviewees want increased access to care for all people. While some did not have a suggestion on how best to achieve this, others proposed moving toward a universal or single-payer health care system, expanding Medicaid and Medicare, or reducing health care costs to increase affordability. Some also believe continued use of telehealth services will increase access to services.

- We have to have improved access in a measurable and a marked way. The ability to receive the right care at the right time in the course of someone's illness. Anyone can go to the ER now, but we need access to primary care and disease management. We need to focus on access to help people stay healthy.
- Universal coverage came up 15 years ago and we are still not there. We need more people covered. This is more realistic than it was 15 years ago. We have tried things and we've gotten closer with the ACA and expanded Medicaid. While we didn't accomplish it yet, we might get closer and have universal coverage at some level in five years.
- We need to have health care coverage for everyone. I am not necessarily an advocate for Medicare for all or any particular plan, but I think we'll need to have a combination of private and public insurance. Whatever the mix is, everyone needs to be covered. Have to find a mechanism we all can live with that covers everyone. Insurance shouldn't be part of reward system; it should be a right to have basic access to health care.
- Focus on health care quality and the cost for the patient. Care and insurance have to have more options for affordable health care. We need to reduce high-deductible plans and increase accessibility of care. Deductibles and premiums make it really expensive. We need to make it more affordable and ensure we have access to primary care, in particular.
- We need to embrace telehealth and not fear it. Telehealth needs to be a part of the routine and not the exception. In this way, it will increase accessibility.

More patient-centered care (19 responses)

Several interviewees expressed that medicine should be more patient-centered, with personalized care that is easier to access and navigate.

- We need a more personalized approach to medical care that is individualized for patients, where patients and providers work together with patients as the driver of their medical care, including in addressing SDOH and behavioral health needs.
- We are heading to a more consumer-driven marketplace in medicine. Solutions that are more convenient and easier for members and patients to use and to access care in new and different ways are already happening and important they continue. Easier to apply for insurance, labs come to your home, home-based solutions—especially for aging population. Millennials do all their banking on their phone; they want to access their health care through their phones too.
- It is hard to maneuver through the system when there is a problem. I know how to get through the system, but I still find it difficult. We need expedited ways to get them to the right provider instead of hoops of referrals.
- Should be more consumer friendly and, patient-centric. It is still too physician and health care facility centric. If people need something, we make them come to us. We can use and expand community-based care, home-based care, and telehealth more over the next five years.

Healthier, more equitable communities (17 responses)

Many interviewees expressed support for advancing health equity, addressing SDOH, reinforcing public health, and promoting population health.

- I hope that we're now starting to look at health beyond the individual patient and looking at health through the prism of a healthy community and really trying to create opportunity for that emphasis to be sustained from neighborhood to neighborhood, city to city, etc.
- Medicine needs to be in a new place in national and global activism. We've been afforded a preeminent place in society. People trust we'll do what is right for them. Yet our data tells us that sexism and racism are deeply entrenched in our societies, which leads to inequities in the care people receive and the services they can access. Until we can overcome these challenges and create equitable opportunities, we will miss our calling. That is one of the biggest imperatives. We can be well on our way to this in five years.
- Obviously, we need a stronger public health sector with collaboration between direct health care and public health efforts. More integration with public health is essential.
- Physicians need to be equipped with the tools and resources to confront and dismantle racism and inequities within the health care system. We need a better trained and equipped workforce that needs to know how to do this, and to advance equity and has the resources and tools to do so.

New payment models (16 responses)

Several interviewees stated there should be changes to the payment model in the next five years to support more affordable quality care that achieves desired outcomes. Many highlighted the importance of increasing payments for primary care physicians and their concern with an overreliance on advanced care practitioners because they are less expensive providers. Some interviewees did not recommend a specific payment system, some want to have less fee-for-service (FFS), and others want to move toward value-based payments.

- We have to tackle health care costs in a real way. We need comprehensive health care: medicine, public health, and behavioral and physical health–we need all things. We need to have payment systems and incentives in the system to do all the things. The payment structures should reflect the full scope of work that physicians do. Focus on patients, not paperwork. Lean in heavily on the cost of medicine. Medicare should negotiate prices. People can't sustain the costs.
- Medicine should be out of FFS and into a value mode for patients. There are a lot of ways to get there. We need more innovative care models that align with the reimbursement model. We need drastic major changes in how we are reimbursed.
- Shift in payment to make primary care more appealing for physicians. Need higher reimbursement, loan repayment, or other financial incentives.
- I have always believed that strong primary care should be our foundation. When you look at models that really work across the US and the world—high quality care at a reasonable price and value—it's primary care. Concerned about losing primary care physicians: NPs and PAs are growing and we're way overpopulated with specialists. When you're talking to a well-trained family doctor, need to be very smart to deal with all of the diseases to know how to deal with them and where to send people. Need a to create a model that supports primary care.

Data and technology advancements (11 responses)

A few interviewees said technology and data advancements should increase over the next five years. These advancements include increased use of technology to understand individual and population health needs and to engage patients in their own care. Interviewees would like to see improvement in EHR interoperability and artificial intelligence (AI) decision support aids.

- How can we use tech advancements to advance community and population health? I am hoping we will see the ability to integrate information from wearable technology to the patient chart and larger dashboards for the community.
- I would hope that there would be more integration of the various digital health systems for more seamless exchange of information among providers and patients.
- Medicine has the opportunity to integrate technology and AI, but we continue to deliver care without leveraging that capacity. Data estimates that 40 percent of medical diagnostic decisions are actually made in error. I can't think of another sector that would tolerate such an error rate. And yet here we do it with living people. We need to continue to advance care delivery models.

Q2a: Payment models that support the sustainability of independent practice while promoting integrated care

Value-based payment models, including risk-based contracts and capitation

(19 responses)

Incentivize quality and value (15 responses)

- The payment model has to move. If we build one that benefits patients, it will support physicians too. As it relates to equity, one that is more focused on value and not on volume. The more we drive and push towards this, it is where medicine needs to be. And it needs to incentivize value and addressing the social needs of patients and have the infrastructure to do so.
- The payment to support this [integrated PO/scale up] approach is value-based payment models. We have to go to value-based aligned incentives and products for insurance and aligned with the physician organization. The PO is then in a value-based arrangement, so the physician isn't concerned with an individual code, they are looking at preventing ER and getting people more upstream in their health and wellness journey. Need to be value based to be sustainable.
- There has to be a push/pull there with physicians being encouraged to provide optimal care to patients, but also thinking in terms of an integrated model of care. There should be some incentivization of care. To be fair, it can't happen without there being a corresponding potential for risk if you're not optimizing your care and not giving care that creates those outcomes that are being desired for whatever population you're dealing with.

Capitation-based payment models (4 responses)

- I think it's a better model to reimburse globally. I'd rather negotiate on the value I provide than whether there is a code for the service I provide. We need to incentivize specialists to see patients, so if you put them on capitated models, they won't be incentivized to see as many people. But we need much more broadly based payments especially for primary care so we're not trying to get paid specifically for using a tobacco cessation counselor. Hold me accountable for good outcomes.

- Independent practices need to have the team to be sustainable and viable. The payment methodology needs to be population-based payment instead of FFS. The population-based payment may not even require an insurance company. Our history of insurance and fee schedules, all of the middle vendors only add costs, not reduce it. The physicians who are savvy with their data, the value they bring to a population value-based payment is focused on quality.

Direct contracting (2 responses)

- Organized entities led by physicians willing to take on the challenge is what is needed. Health plans get between physicians and employers, who actually have a lot in common in terms of what they want. "What needs to happen to make this work?" It's the physicians. If we came together and said this is how we're going to take care of patients, then it could work. The best example is Kaiser and it's physician led and it's part of their culture.
- They're going to see a transition from third-party payer models to employer-driven models of payment which will help sustain independent practices. Employers pay increasing premiums but aren't seeing increasing value. So, they're transitioning to self-funded programs.

Independent practices need to participate in integrated care models (16 responses)

With a shift to value-based, risk-based, and direct contracting, health care leaders acknowledged that independent practices would need to join forces with each other and/or other health care providers to share risk and resources.

Connections for contracting (10 responses)

- I don't think the independent small practice can survive based on what is being required of them unless they are in a medical services agreement or physician organization group structure. This is the only way to have the independent survive. For risk-based management, you need a large group. Otherwise, you need reimbursement or funding mechanism to support independent practitioners to manage these challenges of patients.
- Integrated care doesn't mean the extinction of small private practice, it means integrating though. Michigan is blessed with specific organizations dedicated to that purpose—helping private practices thrive but connect them through an integrated entity.
- Small practices have a harder time negotiating payment models with health plans when they don't have the infrastructure or population to drive risk bearing models. In five years, it would be good if independent practices can band together to create a bigger mass to negotiate more directly.

Connections for data and resources (6 responses)

- The sustainability of an independent practice within a PO requires them to lean in and be in an integrated PO where economies of scale can be helpful. The power of data and computation and having social determinants of health assets to the collaborative of physicians. No individual physicians has the means or the talent to bring all of these things. This is a necessary thing.
- Integrated care requires access to a shared database. Support for the offices for their IT structure so they can remain independent. They need financial support to have an adequate or useful EHR network for ordering and reviewing results and accessing records.

Support independent practices

- I would like to make sure independent practices still have a voice at the statewide level. Independent groups provide less costly care. We do more with less and make fewer referrals. We're not beholden to anyone but ourselves. I would just hope that is kept as a priority at the MSMS level.
- We need to continue to improve upon paying independent practices for care coordination. Paying independent practitioners that are willing to tackle social determinants of health, we need more care coordination options for them to do this. Help their patients address not having transportation, access to food, etc. Payment models for independent practices, they are not incentivized to solve for SDOH problems.

Q2b: Practice models

Team-based care (24 responses)

There is a lot of support for team-based care among the health care leaders who say it allows practices to treat patient needs more holistically, including identifying issues related to SDOH and connecting patients to resources. Several interviewees emphasized that the teams should be physician led. Other respondents said it is important for all team members to practice at the top of their license to ensure everyone does the work for which they are best suited.

- We need to evolve to team-based care that assesses SDOH and takes a broader view, looking at all interactions with health care, and the payment model has to support that. Look at the risk model, look at compensation, track patients through registries, and reach out to patients. Engage in more selfcare for chronic illness. That doesn't exist broadly in medicine because there is no revenue to account for the increased workforce needs.
- Team-based care is huge. We continue to evolve this model and it should not just encompass what our PCPs [primary care physicians] are doing but also what our specialists are doing. When we operate at the top of our license and work with nurses and pharma, you get better quality improvement and we use our resources as efficiently as we can, which we have to do, considering shortages in primary care.
- We need to go towards team-based care, but the physician needs to be the lead, and the staffing model has to fully support this.
- At the state level, we want teams led by physicians, and we want people to practice at the top of their license. If we have NPs [nurse practitioners] leading teams, it threatens the quality of the care. Practice models have to be well thought out.

Integrated care models (12 responses)

- Someone should be able to go to one provider and have their care coordinated across physical, mental, and social needs. Ideally, no one would have to get in multiple lines to get the services they need.
- In our practice, we have really driven hard to build a multidisciplinary team: social work, behavioral health, care management, and quality experts built into infrastructure in our clinic. But I think we need a whole lot more of that. If we're going to adopt new models, we need to reach outside the clinic. Practice model of the future is community integrated. Live, direct communications with multiple philanthropies so we can drive grants into areas that need it. Engage with local political leaders. Have liaisons to grocery stores and work

with grocers and political leaders to identify food deserts and we champion and actively politicize the need for transformational change. Partner with builders and fortune 500 companies to create affordable housing.

- It's got to be more integrated. Our competition is Amazon, Walmart, CVS. I don't believe they can provide better care than we can. We know the people and places where care is delivered, and minute clinics are completely separate from the clinical ecosystem. We need to be much more highly integrated, including with the community elements that drive better outcomes. So, if people have food, housing, or other needs we can drive patients to those resources to help them be healthier. Those things do not happen in for-profit retail health care world. We have to be more integrated.

Patient-centered and patient-driven care (7 responses)

- We need to expand our vision and embrace other models of care and greater flexibility on how to engage with patients. Our systems are set up for the practice, not for patients. Models need to come to people—not patients to physicians.
- Patients have different desires and, as much as we have put patients into a system that was designed by facilities and systems and physicians, the things that will be successful are models of care that are designed for and by patients.
- We need some diversity of options. I think for most complex care you need teams; for people who are otherwise healthy, you need decentralized home care. Not a lot of reason for me as an internist to drag people in for six-month blood pressure check. Could have done that by telehealth. As we get more decentralized, remote technology for things like diabetes is relatively easy to do. The whole remote patient monitoring world makes care at home possible and makes it easier for physicians to see more people.

Maintain independent practices (4 responses)

- We should protect independent practices but support them in working with others. The days of the solo practitioner are gone, except for some specialists, those that don't need to be on call. We have to protect access. So, you have to protect those that want to provide services in the community or where there is no large hospital nearby. Competition is good for the cost of medicine and good for patients to have a choice.

Limited support for concierge medicine (14 responses)

Health care leaders had mixed opinions of concierge medicine. Very few expressed strong approval of the model. Some said it can simplify the practice of medicine for physicians experiencing burnout and provides individualized care to participating patients. However, most acknowledged that it is only available to people with greater levels of disposable income and expressed concerns that it could create further distinctions in access to care based on personal finances.

- Physicians are done going through hoops. They see this as the only way to not lose their mind. They have to charge flat fee, and by having patients pay out-of-pocket, they have control over the quality of care and the amount of time they spend with patients.
- Concierge is great for those that can afford it. Bringing services to patients' homes is great, but it is a high cost of care delivery model.
- Concierge medicine is last-gasp effort at being a single shingle practitioner. I think it's a terrible, impossible job for providing care for someone when they get sick and need a health system. For health maintenance, it works well, but if someone is significantly ill, a concierge physician is ill-equipped to support their care.

Q2c: Adherence to guidelines and use of evidence-based practices

Interviewees highlighted overwhelming support for using evidence-based practices and adhering to guidelines. They reported that the use of evidence-based practices would be easier and, presumably, more widespread if guidelines they were built into workflow systems such as their electronic health record (EHR) and supported through incentives. However, interviewees also cautioned that these practices can be challenging when payers have misaligned metrics and incentives. Many also emphasized that guidelines should be developed by physicians and by and for diverse populations.

Favor guidelines (23 responses)

- If we have strong specialty and subspecialty organizations with good evidence-based guidelines, it makes everyone's life easier. It helps practitioners know what resources are important. It makes accountable care easier.
- I am a firm supporter of individuals using evidence-based medicine. I am a strong believer that variance in health care outcomes has to do with the variance in use of evidence-based medicine.
- Research and technology should help us look at guidelines and evidence-based practices as the standard. Physicians tend to think their patients are all unique and they fear cookbook medicine, but guidelines should be the dominant practice. If someone isn't following evidence-based practices, there should be concern and questioning as to why not.
- I don't know a physician that doesn't value evidence-based medicine; it should be the cornerstone in any practice. Evidence-based medicine is critical, and we should thrive from learning from one another through case conferences and peer review.

Favor with IT support (17 responses)

- Should make it easy for me to do the right thing. The path of least resistance. If I see someone with a UTI [urinary tract infection], I go to EHR and it says that the best antibiotic is X, then I would have to go through extra steps to order something inappropriate.
- Evidence is an overwhelming element, there is so much of it, and no one can track it all. There has to be the deployment of mechanisms to make it easier, so things are up to date through better use of real technology and AI.
- Many guidelines are the work of experts and societies, which should be embedded into the EHR and workflow. They should not be an external thing to look up. The EHR needs to be configured for common chronic conditions to make sure providers are practicing appropriately and not using low-value care.
- We should be AI-embedded. If AI can build accurate algorithms that drive and direct marketing, there's no reason we can't have it drive diagnoses. When a patient comes into the office, they could input their primary symptoms and AI can pre-populate a list of probable diagnoses. Because I know the patient, I know which diagnoses I can rule out, and then try the recommended treatments. We don't have anything close to that now.

Favor with flexibility (16 responses)

- These are important, but the evidence changes and is not black and white. Science is supposed to keep investigating and changing. If held to guidelines that aren't nimble enough for changes, it creates a new barrier.
- We should move forward with evidence-based medicine and the use of guidelines, as appropriate, but there is concern with physician autonomy and being too tied to them. You can't put everything into a square box; there is a tradeoff between providing evidence-based care, the physician experience, and the patient's desire for care.
- I believed in evidence-based medicine, but over time, I have struggled to see the utility in it. It is more a practice in what not to do and what to avoid based on large population groups. When someone comes to see you, they see you for an individual problem, and they expect something to be done, even if there isn't evidence to help guide you. That is an unfulfilling way to practice, and patients don't like it. Plus, sometimes the evidence says something doesn't work, but it is clear it does for some people.

Favor with payment incentives (15 responses)

- Compare the quality of care to established evidence-based practices and use that for reimbursement; reward people who are doing high-quality care.
- You can't be paying for things that aren't evidence-based. With new technology and treatments coming out that cost a fortune, we need something to protect the bottom line.
- We know how to treat diabetes, infectious disease, and sickle cell. We should be doing these in a standardized way, based on patient needs, and without a lot of variation. There should be an incentive around this.

Favor, but physicians must lead (12 responses)

Interviewees added that consideration for who creates the guidelines needs to be given. Interviewees report that guidelines should be created by physicians, and specifically by those who will be implementing them, and that they need to represent and consider diverse populations and include the underlying drivers of health and health inequities.

- Our medical journals that we pool evidence from need to be more diverse, our editorial board must be diverse. We need to appreciate how to evaluate health inequities and systematic oppression, classism, ableism, racism, and sexism on how they impact health. If these are the root causes of bad health, then our evidence base has to improve and evolve. No journals do a good job with this. There are plenty of researchers collecting information, but they don't have an opportunity to get published because of the gatekeeper at the journal level.
- There are a lot of medical organizations developing guidelines and standards. But more and more you have guidelines set by institutions and payers. These need to be developed with physicians and others who have to effectuate them.

Favor, but need payer alignment (8 responses)

- Most physicians are aligned with one institution, so they get one set of guidelines and have one EHR. But I work with three, so I have to remember which guideline to follow based on the institution.

- I would like to see uniformity among payers in terms of incentives. Right now, all goals and quality measures each is asking for are completely different: Blue Cross Blue Shield, Blue Care Network, Medicare, etc., they are all different. Chasing the carrot is different for every payment model. I think alignment is coming because people will realize this is crazy.
- We had some guidelines and evidence-based practices, but it was up to the American Medical Association and others to determine the performance measures based on those guidelines. There is no clear translation into what should be measured to base payment on. Pain was highlighted as the fifth dimension of care and that helped lead to the opioid epidemic.

Q2d: Reinforcing public health and promoting population health

Interviewees tended to respond to this question as two separate ideas. They spoke of the role of medicine in reinforcing public health as one topic and the promotion of population health as another. Thus, the responses below are separated into two topics. Broadly, interviewees see public health as responsible for the community's health and well-being and an avenue to address underlying needs that impact health care outcomes. While participants confirmed medicine's role in partnering and promoting public health, many were wary of assigning public health responsibility to medicine. Conversely, many respondents viewed population health as dovetailing with medicine, since it segments the population by risk factors to provide targeted care, which is key to improving their work with individual patients.

Reinforcing public health

Many interviewees cited the COVID-19 pandemic as a call to action for stronger relationships between health care and public health, noting the challenges faced by the public health system, which were amplified by the pandemic. They described various ways physicians and the medical community could build stronger partnerships with public health, including increasing communication with public health, promoting public health messages, and advocating for public health policy. Some highlighted the need for more education and training on public health for physicians and the medical community, and others see only a small public health role for physicians, who should make their patients their first priority. A few want public health agencies do more to support physicians in their efforts to support public health.

Partner in communication and message promotion (26 responses)

- With COVID-19, I've been working closer with our health department than ever before. We are coming up with all kinds of ways to get people vaccinated. Those relationships in every community at every level are going to pay off. They can help with opioid abuse, suicides, teen pregnancy, anything. I can see this as a real plus of the pandemic.
- For too long, public health and medicine have been isolated and separated from each other. But that's ridiculous, if we're going to make meaningful change in things like maternal health, we need interaction between these two worlds.
- It took big education efforts to get people to use seatbelts. Macro effort included billboards and PSAs. But on micro level, physicians reminded their patients. MSMS can guide which things physicians focus on each year. For that to work, the message has to be the same, consistent, and not too many at once. MSMS can help decide what is at the top of the list.

Support increased funding for public health infrastructure (14 responses)

- We need to strengthen the public health infrastructure. When the public health infrastructure is supported, they are organized, they know what their work is and how to do it, but it is not funded to do this to scale and can't be coordinated appropriately. When this doesn't happen, there is added burden on the health care system.
- It is evident by the pandemic, the underinvestment in public health is troubling. I would hope that [in five years] we doubly invest in public health as time allows. We need to be thoughtful at the state and local level of what investment in public health means.
- From the COVID-19 pandemic, we've seen not only a bright light on public health, but that we have been underfunding it for decades. The public health infrastructure that could respond to this crisis was not there. That has put us in a scrambling situation.

Identify and address health disparities (10 responses)

Interviewees shared their understanding and recognition that health disparities exist across populations and that more needs to be done to address this and the social determinants of health that contribute to these disparities. Many see public health as key to supporting this work.

- The health disparities exposed by the pandemic show how much work we have to do. People are not being adequately served and they are suffering from comorbid conditions and increased mortality rates across the US. How are we going to fix this? How are we going to undo what we have? I'm not a policy expert, but something has to be done.
- We need to shift resources to where disparity and diversity of disparity is there.

Improve physician education and training related to public health (6 responses)

- We need to move beyond clinical science and embrace public health and social science in medical student education. This will drive changes down the line, but not immediately. We need medical school faculty trained in public health areas, emphasizing degrees between MPH and MD. And more medical schools need to partner with health departments so people can graduate with joint degrees. Some schools have some public health curriculum, but it would be more meaningful if partnerships were established between the two. Some models exist, but every med student needs to be able to do this.

Public policy advocacy (4 responses)

- We should, as medical societies, partner with public health explicitly. We should be in connection with public health on many levels, including advocacy. We need to advocate for issues beyond just the halth care system. Create agendas that address the social and structural drivers of inequity. Transportation, housing, and anything explicitly discriminating. This needs to be advocated for at the state and national level.

Limited role for medicine (9 responses)

- We don't need to give physicians more work to do. They should be connected to it, but not responsible for it. Public health should be managed by the community.

- Physicians are trained to treat individuals and others are better trained to look at population-based interventions. Physicians could have a role in public health, but it is not our focus. It is hard to take care of an individual patient and be responsible for the broader population. Taking care of individuals helps improve overall public health.

Public health should support physicians (4 responses)

- Public health should support the medical community by making sure physicians have access to immunizations and that they are being recorded properly and that there is an easy mechanism to refer patient to services at the health department. They need to be a part of a referral system.
- There is no good communication back and forth between public health and medical systems. Nothing comes back to the practices. I have to look for when I should start flu testing. Why isn't the local health department sending notices to primary care providers about what is going on their community. I know they don't have resources, but I should know about emerging infections in my community, where lead and radon are high. Widespread issue across the U.S.

Promoting Population Health

Interviewees described many ways in which population health is promoted by physicians and others in the medical community, including at the individual practice level, in integrated systems of care, and with support from technology and data.

Practice-level efforts (10 responses)

Several interviewees think that the daily work of individual physicians, provider practices, and health systems is managing population health. They report that physicians and health systems use health care data to effectively identify high-needs patients and specific risk factors.

- The PCP does population health every day, they are managing the health of their population. The challenge is adding resources and data to help understand who will need your services next. Use technology to predict who will get sick and wrap resources and services around those people. Need to figure out how to have the PCP be the driver of that patient's journey
- And [physicians have a role] definitely in managing population health. We can't address the needs of the community if we aren't looking at what is going on in specific populations and tailoring the approaches to reach those groups.

Best managed by integrated systems of care with value-based payment models (7 responses)

- Health care systems should be held accountable for outcomes in the communities they serve. When you see money associated with outcomes, you'll see partnerships formed and improvements in health. We can't just increase pay for widgets, we need to look at community successes and outcomes.
- The most cost-effective way to deliver medical care is to focus on prevention and have to have payment model favor prevention. Every primary care physician could spend a week to identify every patient in their practice who is within 5 years of full-on diabetes and bring in ten of those every week to provide preventive care. But this isn't incentivized right now. It would be infinitely cheaper to prevent diabetes than to treat it.

Technology and data (4 responses)

A couple of interviewees shared that new technology and data will better help identify population health trends and needs.

- Technology can support population health. We can use wearables to track metrics at a population level. We have SDOH data, how can we incorporate this into practices. What does continuous data mean on a population level? We need to pull out what is meaningful.

Q2e: Universal access and health care coverage

Everyone deserves health care access (41 responses)

The majority of participants fully supported universal access and health care coverage; many stated that health care is a human or basic right.

- Everyone should have coverage; it is a basic right to be able to see a provider and get medications covered.
- We have an obligation toward the health of everyone in the society. We used to say you can be wealthier and have nicer things, but you shouldn't live longer because you're wealthier. I don't know what the right model is, but universal access is the right thing to do.

Tiered health care coverage (10 responses)

Several respondents supportive of universal access said coverage should have at least a basic level of care available to everyone.

- Everyone needs to have access to basic health care. Not in a position to say what that basic care is.
- I do think some sort of tiered system could work with a basic level of coverage that everyone has access to and if they need specialty care they can get it. People can pay for fuller coverage if they want.

Health care coverage does not ensure access to care (6 responses)

A few interviewees emphasized that although increased health care coverage is essential, it does not ensure access to care, including behavioral health and rural health care services.

- I struggle with the irony that health care coverage does not equate to access.
- Rural communities don't have access to OB/GYN care; it doesn't exist. We need vertical integration, especially in rural communities. There are sensitive matters in terms of licensed parameters and who can do what and independence of practice, but under some circumstances there has to be flexibility. We need family doctors doing OB.

Universal access already exists (5 responses)

A couple of interviewees said that they believe universal access exists in the current health care system in at least some capacity.

- Ultimately, there is universal access already, but it isn't great access. The ER is open, people can show up. Universal access to what is the question.

Strategies for expanding coverage and access (24 responses)

Interviewees had a range of ideas on the best model to support universal access and health care coverage. Some thought that Medicaid and Medicare expansions were an avenue for expanding access. Some recommended moving towards a single-payer or Medicare for All plan, whereas others wanted to increase the affordability of health care to expand access. Several others, however, did not endorse any specific model, cautioned against single-payer or government-sponsored coverage, and provided other options.

Expand and strengthen Medicaid, Medicare, and the Affordable Care Act (15)

Many interviewees thought the best way to partially or fully achieve universal coverage is by expanding and strengthening of the current system, including increased Medicaid and Medicare eligibility and/or improvements to the Patient Protection and Affordable Care Act (ACA).

- We need to tweak the ACA to make sure people enroll and to make it affordable.
- In the interim, we could start moving in that direction by lowering the Medicare age, expanding access to Medicaid, or providing a public option.
- In this country we will not have single payer. We will have a public-private partnership with public programs delivered through private partnerships. We can expand on the current footprint and get closer to our universal access goal.

Implement single-payer coverage (9)

A handful of interviewees believed a single-payer option is the best way to get to universal coverage.

- I don't understand why people don't understand the benefit of Medicare for All. It has much lower overhead costs. If you want private insurance, you should be able to buy private insurance. We're the richest country in the world, it's stunning that we don't have universal access.
- I hear people say that the problem with single payer is that it is government run, and they can't run anything. But our admin costs are so much higher, and we aren't getting the best health care outcomes. Can the gov't possibly do worse than what we have now? We are highly inefficient and have a lot of waste.

Decrease health care costs (5 responses)

A few interviewees wanted decreased health care costs, including through the removal of low-value care. Lowering the cost of care, they argue, will make health care coverage more affordable to everyone.

- It is easier to cover everyone when the costs are lower.
- If we take out the 20 to 30 percent of low-value care cost out, it lowers the cost of care and lowers accessibility and gets us closer to universal access while retaining a patient's ability to choose their system and what they want to be aligned with rather than a government entity.

Unsure about universal health care coverage (9 responses)

A handful of interviewees were opposed to a single-payer system, but did not recommend an alternative option, while others did not have a clear preference or recommendation for a specific model.

- Other countries are straining under the weight of their single-payer system. People need coverage and that should be a goal but paying for it is the challenge.

- I have mixed feelings about universal coverage. I've worked with the VA and it's a mess; they're slow and inefficient. Until and unless they're going to integrate and pay for it, I guess it will be some kind of hybrid model to start. Right now, VA is the model and it's not pretty.

Q2f: Medicaid

Many interviewees were generally supportive of Medicaid and said it is an essential piece of the health care system because it provides access to care for those who have no other avenue for acquiring health care. However, many also identified several problems with Medicaid, including low reimbursement rates, the fee-for-service (FFS) payment model for some populations and services, and limited resources to address SDOH. Additionally, other interviewees expressed that Medicaid should be expanded to additional populations and include more services, such as dental care and behavioral health care with physical health care.

Important component of access (21 responses)

- We have to have a way to care for those without insurance, and we have this. Medicaid works very well to ensure people are covered.
- Medicare is a critical piece of care in our state and in our society. Medicine should position itself so that the neediest people have access to all the services they need.
- Michigan has been on the forefront of offering Medicaid and providing value through Medicaid. We've demonstrated with our Medicaid program and the Healthy Michigan Plan that it is absolutely a lower cost of care, creates access, and stimulates the economy. We need a healthy and robust Medicaid program. We need it as a part of our solution to increasing access to care. I certainly see this as a chief component to the health care ecosystem.

Medicaid Challenges (43 responses)

Low Reimbursement (27 responses)

- The reimbursement is so low that providers do not want to accept or invest their time and energy on this population. This needs to change.
- Funding needs to be appropriate, so my office doesn't have to subsidize care for people who have Medicaid while providing appropriate level of care.
- Funding is an issue. We have a funding parity issue between Medicare and Medicaid. Reimbursement is not on par, so physicians don't want to take it. I think we should all take a some [of these patients], but on the other hand, physicians have to look at the sustainability of their practice and it is hard to see them when reimbursement is so low. We have to adequately fund Medicaid and bring it to parity to Medicare. At Michigan level and at the federal funding level.
- Needs to pay appropriately and fairly. We need Medicaid reform. More physicians needs to participate in Medicaid. A lot of physicians don't because it costs more than they are reimbursed.

Ineffective and short-sighted payment models (16 responses)

- The patients on Medicaid have complex social situations, which impacts their physical and mental health. If we keep Medicaid, it needs to be broader, it doesn't get enough focus or attention, bare bones basic coverage is all it does and was all that was covered in the ACA expansion. We need more services covered and more reimbursement.
- There aren't many dollars available in Medicaid to get upstream and deal with upstream risk factors. There's a big disconnect between everybody gets everything at end of life, but at the beginning we prevent a lot of people getting the care they need. We know 80 percent of health problems are not related to clinical care. We won't have meaningful impact if we don't get to that earlier.
- With respect to payment models, Medicaid FFS is not productive. We should evolve the payment model and almost entirely get rid of FFS in Medicaid within five years. The rates are not sustainable, and they do not encourage anybody to see Medicaid patients.
- The biggest impact on population health is on the Medicaid population. Quality and risk-based models are still only in Medicare commercial payers, but this has to be in Medicaid too.

Expand eligibility and services (15 responses)

- There has to be a true up in who qualifies. The federal poverty level needs to be reevaluated to make sure it is actually livable. $10 per hour is not a livable wage.
- We need to work to broaden coverage further. In the U.P. the expansion of the Healthy Michigan Plan was huge. We saw so many of the working poor get coverage as a result. They came out of the woodwork and got all sorts of care. We need this if we aren't doing something more basic and more universal.
- We are one of 12 states that has separate medical and behavioral health and I think there needs to be integration in this system. We should not have one set of providers serving Medicaid clients and others commercial. We need integrated and holistic care. The benefit has to be better.

Q2g: Use of technology to support medical care (e.g., health information exchange, data interoperability)

Interviewees shared their opinions on electronic health records, use of telehealth, and other health care support technology.

Electronic health records (49 responses)

Interviewees shared that electronic health records (EHRs) were supposed to improve care, increase data sharing, reduce duplication, and lower costs. But they report, this has not happened to the extent expected. Many interviewees are frustrated by the lack of EHR interoperability. They also highlighted that EHRs are expensive to implement and built for billing and auditing purposes instead of for patient care, which has led to increased administrative burden and increased costs without patient benefit.

Make Interoperable and standardized (29 responses)

- One big gap is interoperability, where each system has its own EHR that are incompatible with each other. We have two hospitals in our community, and they have their own EHRs that aren't compatible with each other. If patients go to one and then the other, the information on the previous visit isn't available without making phone calls or repeating procedures.
- We should be much further along on data interoperability than we are today. We are better on connectivity and better than where we were 20 years ago when people across organizations were not willing to share. Now it is the ability to share and the messiness of the data to be shared. Without a national system or a universal structure for health care our data all looks different. We need a Health Information Exchange. We need standardized definitions on the data.
- EHR companies need to drop the barrier of every EHR having a protected, encrypted way to share and save data. Like the electric plug, same across the us, but different in other countries. We need to have the same thing to reduce barriers. We need to penalize companies if they can't make data sharable and able to talk to each other.
- Physicians have invested a lot of money in their EHR, but to keep it up, more and more money dumped into it. Looking backwards, if there had been one HIE, it would have saved a lot of time and grief, but that is not how we did it. Instead, we have 100s of operating systems, and physicians all have different ones. We need to align them through standardization.

Support clinical care (14 responses)

- The number-one cause of physician burnout is the medical record. The EHR is a barrier to interacting with patients and it is for billing and insurance. A visit is 15 minutes, and you spend eight minutes on the EHR.
- The problem is the EHR is the cash register. If I don't push the right button, the transaction doesn't go through. At the end of the day, what I did is what's shown in the EHR, but that's probably not the right thing. It should be, 'Did I keep someone healthy or address issues in the right way?'
- I was one of the biggest promoters of EHRs and I've been one of the most disappointed. It's just a way to control patients, data, and money by vendors and payers. They have taken away personal care; I'm too tied up trying to make a machine work.
- It is easy to insert technology for the sake of technology, but it has to be for the sake of improving patient care. EHRs were forced on doctors and are an interruption of patient care and not an enhancement. When you grow up on technology and learn it in medical school it is more natural in practice, but it is not the entire issue. We should not dismiss a consistent and persistent claim that EHRs get in the way of patient care.

Reduce administrative burden (6 responses)

- For me to help my patient, I have to be a proxy on his chart, so I have to walk my patients through on how to do this work. This is a terrible use of my time and skills. That is what technology has done, takes our time, and takes our resources on things that don't help patients. Every physician should have a scribe, if forced to use the systems someone else can do that data entry.
- The top dx is a well visit code, why doesn't the computer know that already? Then I have to choose that it is a well visit and then I choose the code. Why doesn't the computer know it is an existing patient and that it is a well visit? In Surescripts, I have to look at someone's allergies in one screen to find out if they have an allergy. But when I am prescribing meds, I am in a new screen and I can't see their allergies, even though it is all in same system. I don't want to click back and forth, this is an encumberment.

Telehealth (32 responses)

Telehealth use among providers significantly expanded during the COVID-19 pandemic. Interviewees noted that the expansion was largely positive by improving access to care and providing more patient-centered care. Interviewees also stated that telehealth reimbursement policies need to be established to ensure telehealth continues post-pandemic. Some also highlighted that access to telehealth is not available to everyone due to limited internet or broadband access.

Improved care (18 responses)

- The pandemic pushed telehealth and helped us reach more patients. A benefit of telehealth is that with our limited ICU bed capacity and working in a rural ED or critical access ED, we were able to provide tele-stroke, tele-pharmacy, and tele-respiratory care. Physicians can get the patient into the system and talk to them before they are even in the hospital, which has improved the timely delivery of care and access to specialists. Tele-psyche is also great for expanding access.
- Telehealth is fantastic, the more the better. Some is clunky still, and some is too competitive about which system you are using. Can't do everything virtual, but you can do an awful lot. The more you expand that and are comfortable using it, the better.
- My adult children all prefer to do medicine with their smart phone. They prefer to send a picture of their rash and do a televisit than to drop what they are doing, call and make an appointment, get cleaned up, sit in a waiting room, wait for a five-to-ten-minute encounter, wait for a prescription, drive home, etc. They do not want that; they want to snap a picture and discuss it on the phone. Priority Health and Spectrum have rolled out a program to provide homes with Bluetooth-enabled scopes for ears and eyes, tongue depressors, and stethoscopes so patients can stay home and do virtual visits because that is what they want.

Potential telehealth barriers (14 responses)

- They removed administrative barriers, financial barriers, and legal barriers to telehealth, and it has given people a taste of what you can do with it. Both providers and patients will be excited to keep this around and keep it as a part of their care. After the pandemic it might not be as critical, but it should stay around. We need to make sure reimbursement supports telehealth regardless of where a person lives, and we want it on parity with comparable in person visit. Need to secure this.
- Telehealth is a must, we need more broadband access.
- I hope we continue to innovate in that space, but always concerned about who gets left out. But we need to move forward in a way that increases equity as well.

Technology in General (22 responses)

Interviewees shared that while technology can support patient care and patient engagement, it does not always add value, even as it still adds cost.

Support patient care and patient engagement (11 responses)

- We should be using resources to better stratify risk. We should know days before someone needs a hospitalization based on predictive analytics. We have to use technology to get further upstream. Right now, we're focused on having smaller cameras or more advanced joint implants, but we need to be thinking upstream.

- We have a lot of information but we're not using it to target interventions as much as we should or could. We need to target mobile-based, community-based interventions and screenings. We need to integrate more wearables for monitoring health. We should use the information we have to know where there are problems and take targeted approaches in those communities. There's no reason why a pharmacist can't manage basic hypertension medication when small adjustments in blood pressure have a huge impact on long-term health.
- The tools that we have should be continually expanding and creating opportunities for patients to engage with providers. Applications, phones, virtual capabilities, and through telemedicine, there are a variety of ways to use technology.

Difficult to quickly adopt (11 responses)

- I expect we will have more and more technology. I am hopeful that the technology will be selected and used based on its capacity to make a difference in people's households. Not all technology is generating benefit, how many gamma knives do we really need? We see incredible investments in expensive technologies that help a few people instead technology that will help a lot of people.
- Health care tech will explode in five years. It is at a point that the pace of change is exponential. It is hard to keep up with the pace of change when it comes to the use of technology, mind numbing and unaffordable. It will drive competition in areas we don't understand. This force will benefit patients and increase costs across the country. Force that will be disruptive.

Q3: How are physicians assets to patients and health care in general?

Health care leaders indicated that physicians are assets to patients and health care in various ways, including acting as patient advocates, advisors, and system navigators; having extensive training and a unique skill set; leading health care teams; being a primary access point for health care services; and having a unique understanding of the health care system.

Patient advocates, advisors, navigators (32 responses)

Nearly half of the health care leaders described physicians as patient advocates, advisors, and/or system navigators. They noted that physicians form relationships with patients, advise them on health care decisions, advocate for them to get the treatment they need, and help them navigate the complexities of the health care system.

Form relationships with patients (12 responses)

- I can't tell you how many patients start talking to me about other things because I develop trust and a relationship . . . which [enables me to] have an influence over patients' willingness to follow medical advice.
- When we think of health care, we think of patient as customer and the care provided as the service. The person that walks along with the patient is the physician. Without the physician, you lose the greatest ally and advocate and resource that the patient has.

Advocates (11 responses)

- Every physician is an advocate for their patients; they fight to get access and coverage, including prior authorization to cover medications; help patients secure disability when they need it. Taken to a broader level, physicians are assets because we advocate to make everyone's health better.
- Physicians have the ability to be patient advocates, helping to ensure they are receiving appropriate care. They also look at social determinants of health and advocate for social services and are connecting patients to community resources.

Patient advisors and educators (10 responses)

- Patients should be able to go to them and get an answer they trust. Things that seem obvious to physicians can be confusing to patients, so the physician have to be able to communicate easily to the patients.
- Physicians in the individual realm can be absolute assets in terms of coaching, making wise recommendations regarding the patient's general health, vaccinations, screening, judicious advice.
- With so much information online, physicians are no longer the owner of the body of medical knowledge. Their role now is making sure the information patients find online is correct and then helping them with a real diagnosis and having the communication talent to discuss the care plan with the patient.

Highly trained, unique skill set (14 responses)

14 interviewees said that physicians' level of training provides a unique level of expertise and makes them especially skilled diagnosticians and health care providers.

- Physicians are very important. We have more advanced practice providers in the system, but they are trained differently. Physicians need to be considered the gold standard of care; they are critically important.
- Our training background is broad and deep, creating a unique skill set and knowledge base that is used in patient care.

Leaders of the health care team (9 responses)

Nine interviewees said physicians are assets when they serve as health care team leaders, which some acknowledged is not always a comfortable role for physicians and some said can be difficult to put into practice. A few expressed concerns that this role is being minimized for some physicians in favor of expanding the roles of advance practice providers.

- They are the captain of the ship. What they can't do is control everything. They have wanted in the past to do everything for the patients, but they have no way to manage that. They only see the patient when there is an illness. Physician needs to lead the team, but they can't be the deliverer of all that care. They need to allow others to deliver the care. They need a line of sight and see how it all interacts but cannot be the doer of all.
- Physicians increasingly work in broader health care teams, where physicians bring health care leadership to the team and coordinate the care to the whole team. Team-based care is important, but someone needs to be captain of the ship and that is the role of the physician best served.
- Physicians are assets when they are giving guidance and oversight to the team. That's something that has been eroded in some parts of our profession along the way, e.g., in anesthesia and some primary care practices where you can have physician extenders taking an out-sized role in things.

The backbone of the health care system (9 responses)

Some interviewees described physicians, particularly primary care physicians, as the essential element to health care provision. A few said physicians' unique perspective on the health care system makes them assets, because they understand how a patient's needs fit within and are affected by other forces in the system.

- There is no health care if there are no physicians. There are a lot of moving parts, but it comes back to primary care and the prevention model. Early identification of disease is key and that is done through being evaluated by your provider. Most people's journeys in health are driven by the physician. They are the lead in all things health care.
- We are the access point for everything related to people's health, including social determinants of health. The primary care workforce, we are the first step for lots of things to happen, accessing specialists, social programs, people will first go to their family doctor.
- No one understand the needs of the patients and the resources available to meet those needs as well as physicians. I don't think anyone understand the opportunities for waste and waste reduction and cost reduction as well as physicians. No one has a leadership perspective both within health care and in politics like physicians have. It is a unique perspective.

Not enough of an asset (4 responses)

- They are a tool in the toolbox of health care, only valuable when and if the patients see them as having value. When you get an appropriate diagnosis, you can plug in an evidence-based regiment and the physician is not valuable in that scenario. What patients see now, physicians are conduits to the surgery and the pharmacy they need, it is how they get to what they need next.
- It used to be that the physician and the hospital was the hub of the wheel. And now it is the patient. I think of the patient as the center and spokes going around and the physician is one of the spokes. They are on par with the hospital, and access, technology, they are all in the same boat. Our physicians have to recognize that they are only a piece of the system. If they see this, they are a bigger asset if they don't, they are a detriment.

Q4: How can physicians become greater assets in the next five years?

When asked how physicians can become greater assets to patients and health care, interviewees emphasized the need for physicians to take on leadership roles and engage in policy advocacy. They also said physicians should broaden their view and understanding of health care, work to preserve the physician-patient relationship, support and engage in team-based care, embrace change, and promote the use of guidelines and evidence-based care.

Lead and advocate (19 responses)

Interviewees said physicians will need to increase their influence in the health care system by taking leadership roles in health systems and health plans and by being vocal advocates for policies that promote good patient care.

Take on leadership roles in health care system (6 responses)

- Physicians need to lead the conversation and it should not be led by purchasers, attorneys, or politicians. Physicians should be at the forefront of the conversation on outcomes, quality, and cost. If we don't get ahold of it, it will be done for us and to us instead of by us and with our input.
- Hospitals should be run by physicians; health insurance companies should be run by physicians. In U.S. there is relative minimization of physician leadership in health care system overall whether corporate, private, or public. We have to train our young doctors in leadership and public advocacy and emphasize to them our expectation that they take a leadership role in health care.

Engage in policy advocacy (6 responses)

- Physicians need to better acknowledge, own, and use their capacity to be extraordinary leaders and drive positive change. You have power; if you want things to change, you have opportunity to do so. If they stood up and used their power constructively to be change agents, they would put us in a better situation. My observation is that the very best points of light you see in health and health care are always when physicians are in the lead.
- Expand advocacy to higher levels. Some think physicians shouldn't be in politics. When it comes to seeing patients, you don't want to express political views. But at the higher levels, we don't want agnostic physicians. We need physicians to be involved and speak up.

Get organized (4 responses)

- They could become greater assets if they have a more organized approach to their role in health care moving forward. Within independent physicians that's been very siloed. I don't think MSMS has assisted physicians in developing that role. MSMS has an obligation to be that organizing body.
- They could be more organized and have some more structure. MSMS could help provide the organizational structure and make it easy for physicians to be involved. I want the organization to help me focus on what to talk about, focus on patient care. Provide more training in how to be advocates and offer a more streamlined process for advocacy.

Promote the quadruple aim (2 responses)

- They need to be the architects and organizers and managers of the systems, dedicated to helping people with their healthiness. They'll need to take responsibility for the quadruple aim and develop relationships with patients that are built on trust.
- They should be promoting and basically directing patient care, working toward the quadruple aim. Driving care from most expensive place to lower price cost centers. Providing higher, better quality care by spending more time with patients. Promoting capitation so we can focus on patient care.

Take a broader view of health care (8 responses)

Some health care leaders said physicians need to think more broadly about health care, including understanding issues affecting the health of people living in their communities, gaining an awareness of SDOH, and considering how systemic racism affects care delivery.

- Step out of the office and develop relationships in their community. It is better if they really understand the needs of their community. They have to look at their data, especially of those with low health outcomes. There needs to be a curiosity about why this is happening.
- Garner a greater awareness of social determinants of health and help patients connect to community resources. At all levels, even specialty care. They need to understand the drivers of health.
- Learn about and understand public health and systemic racism. This wasn't part of training for a lot of physicians. It's now only starting to become training for current students. Physicians have to be willing to look at things in a new light and to keep learning. That will help our patients in lots of ways.

Focus on patients' needs (7 responses)

Several health care leaders said it will be important for physicians to be steadfast in their focus on meeting patients' needs. This includes being advisors, advocates, and responsible stewards of resources.

- They need to be better listeners. The more you listen, the more you understand people and what they really want to know. We make a lot of assumptions about people because we don't listen well. Find out what patients really want to know about and what they want to address.
- As providers of health care services, the doctor means being an educator and making health care more accessible and the kind of access that patients want (virtual or face to face).
- Physicians can explain to people what is valuable and what isn't. Some patients don't want to buy their inhaler because they have a copay. But we have to explain the importance of the inhaler and help them weigh the costs. Physicians can help explain value of things to patients.

Support and participate in team-based care (7 responses)

Some interviewees asserted that physicians could become greater assets by embracing team-based care, which would allow them to better meet the needs of patients and focus on the aspects of care for which they are best suited.

- Provide team-based care. Lessen the hierarchy with the physician at the top and people deferring to them for their answer. In order for you to be a leader and serve the needs of the patients, you can't have that hierarchy.
- Become stronger team leaders, learning how to better leverage the components of health care better. We would do better at that if we were better team leaders.
- They should do what they do best. Recognize that others could do some of what they are doing; use a team-based approach. They don't have to do everything. The pharmacist can do some of what they do better.

Embrace and even lead change (6 responses)

Another handful of health care leaders indicated that physicians should embrace change and—if they want to have a say in that change—step out in front and lead.

- We have to collectively transform ourselves. We have to lead those transformations and not be reluctant followers. It is not easy and not intuitive. In most physician practices, it is about how to get a paycheck and get to the end of the day, not thinking two to five years down the road and trying to beat trends. But transactional approaches to running businesses are not going to be rewarded. Transformation will be rewarded.

- They have to understand where the puck is going and not where they want it to stay. The physician offices they spend the most time in may become remote and in their home. They may have to check on their sickest patients more frequently. See them through the digital world, and don't require them to get in their cars to go to their office. They need to embrace this. They have to lead in this effort.

Promote evidence-based medicine, high-quality care (3 responses)

A few health care leaders emphasized the need for physicians to embrace and deliver evidence-based care.

- Embracing evidence-based care from cross-utilization and quality perspective. Don't treat a condition the same way you did 20 years ago if science has advanced. Use decision support, evidence-based care.

Q5. What should be the role of the medical community in addressing social determinants of health?

Conduct assessments and connect patients to resources (28 responses)

Many interviewees said the medical community's role in addressing SDOH includes identifying patient needs through a conversation or assessment and knowledge of available resources and how to connect patients with the resources that will best address their needs. Several respondents noted that this type of support is best provided through a team-based care model that includes a social worker or care manager, who are best suited to support patients in addressing social service needs.

- Our role should be a pivotal one. We are meeting patients where they are on a daily basis. If we aren't and just treating all patients exactly the same way, we're missing important opportunities to improve outcomes. Our patients are not all the same. It's about their circumstances. Frankly if you don't ask, patients won't tell. If you have a patient where you can't explain why they're experiencing symptoms that don't make sense. You have to be willing to ask them if they have other things they need (food, shelter, etc.). It makes an entirely different interaction with that patient.
- We need to work with patients to talk about individual barriers. Lack of insurance—work with financial navigators. We have transportation assistance support. Need to know and use the resources available to leverage concerns.
- On an individual basis, discuss openly with the patient. Know the concept of living in a food desert or where it's not safe to exercise outside or working multiple jobs. Acknowledge difficulties and help problem solve.
- The medical community needs to support care management; driving the tools that help address SDOH. We need use a team approach to create the care management that allows these things to happen and to be on the lookout for risk indicators necessary to create better health.
- I think that our physicians need to be routinely screening for SDOH and their responsibility is connecting patients to community services. There is a lot of complexity under both of these things. But we know SDOH drives outcomes, if we want to improve the health of our communities, we can't ignore this.

Increase understanding of SDOH (15 responses)

Interviewees indicated that while there is a growing recognition of SDOH and their connection to health care access and outcomes, more education is needed to broaden awareness, increase recognition of how factors like racism that contribute to these outcomes, and identify how to best address the challenge.

- We need to acknowledge SDOH; we need to understand what barriers our patients might have, like picking up their medicine or affording their prescriptions. And understand the higher level, like air and water quality. We need to be doing the research that reveals the connection between social issues and how they impact health and then continue the research on how best to address them. We want to make sure we are effective at correcting them. We don't want to create programs that just add cost and make things work or don't work. We need more understanding of what we can do that works.
- The medical community has to draw a clear line in health care outcomes and people having access to resources. Your health won't improve if you do not have consistent housing, heat, electricity or enough to eat. I can't help you care for your health if you don't have the basic needs met.
- Education and continuing education. Medicine has started to embrace the idea that there is more that impacts health beyond the care provided within their office walls. They understand that SDOH impacts this and that some people don't have equitable access to care. But that doesn't address the root causes like gender oppression and racism. We can treat the social needs but if we don't treat the root cause of why these inequities exist in the first place, we aren't doing enough. We need to evolve our language and understand the root causes of these issues.

Increase advocacy (12 responses)

Several interviewees also said that the medical community should be advocates for increasing awareness of SDOH as major drivers in health care access and outcomes and advocates for policies to help address SDOH factors.

- Health disparities are multidimensional and interconnected: food, housing, healthier lifestyles. Physicians can emphasize these connections in the political arena. We should be vocal and more pertinent in our insistence on drawing connections to structures that effect people's lives. Need to be politically involved.
- The medical community has to be leaders in this discussion. They have to be humble enough to say I only contribute to 20 percent of the outcomes of my patient. For my patient to be successful, we have to address the other 80 percent. They have to be public advocates.

Develop a payment model to support SDOH (8 responses)

A few interviewees shared that changing the payment model to support the medical community would help to address SDOH, and a couple added that billing codes are needed to track these activities and support reimbursement.

- Physicians need compensation to build the infrastructure to do this. Historically physicians have done this work. They want to do this work. But they don't have the ability to do this with the construct of the FFS structure and how their time is demanded today in a 15-minute patient visit.

Addressing SDOH is Not Physicians' Role (8 responses)

Some interviewees questioned how large a role physicians and the medical community should have in addressing SDOH. The interviewees emphasized the limited time providers have available with patients, their responsibility in handling medical issues, and that the community should be working to address SDOH needs.

- I think our role should be limited at best. We should be involved as members of our community, but we didn't go into medicine to become experts on access to food and social isolation. So, every doctor is supposed to devote time to go sit with nursing home patients? No, we need to be taking care of sick patients now. I think it's hubris on our part to think we should do these things. I don't deny it's a major part of health care, but it shouldn't be the primary responsibility of physician. They should be a part of the system.
- We can't address factors of poverty, so we do what we can, which is medical intervention. We have a good heart in this, but I am not sure what we can do about it. A physician's job should be to deal with the patient with where they are at and help them get through that episode. We need to have a broader approach to the societal issues.

Increase health plan and health system responsibility (6 responses)

A few interviewees reported that as health systems and health plans have more resources and have more responsibility for the health of the broader population they serve, they are well positioned to assume more responsibility in addressing SDOH.

- Health systems are addressing this but can only do so if a large entity. See the spectrum of costs, health systems recognize that their Medicaid population needs transportation and housing. See health systems are building low-income housing and have whole transportation networks together. It is only going to get bigger. Not everyone can build an apartment building. You can scale up and provide more services to address these determinants better.

Q6: What should be the role of the medical community in advancing health equity?

Build stronger connections with patients and communities (28 responses)

Interviewees suggested that the medical community could reduce health disparities by developing patient connections and establishing practices in local communities. They emphasized the need to deliver culturally sensitive care and increase racial and ethnic diversity among medical students. Some noted that Medicaid reimbursement rates can make it financially difficult for providers to serve low-income patients, whose health are more likely to be underserved.

- We need people to work in rural communities to ensure access; we need more primary care practices there. We need to support people working in these needed areas.
- We need to make it financially attractive for physicians to serve underserved populations. Also, it should be a badge of honor, a prestigious honor to serve the most vulnerable and underserved. But it is not right now. It is an honor and privilege to serve the wealthiest and the whitest.

- We need build bridges to engage patients to come in and seek care. Community-based practices are good at this, but we need to reinforce these practices where there are barriers to coming in. Not just about social status, also cultural barriers. Help people who are accessing care make sure they are getting the care they need, but if they don't understand the care, make sure they understand the instructions and can follow the care plan.
- We need to train more providers who look like the communities they are serving. We are training way more women in medicine and this has had a huge impact on health equity, but this is a huge gap with POC.
- We need to advance diversity in medical schools (race, gender, nation of origin, sexual orientation). We need a diversity of people and diversity of ideas in the health care arena.

Increase education and training (16 responses)

To advance health equity, the medical community needs more education and training on identifying health inequities, understanding their own implicit biases, and providing culturally competent care.

- We have a great role to play, but even my colleagues suffer from the same blind spots. Assumptions are made and biases creep into decision making. Physicians have a role, but society has created these biases and tendencies and we have to do some hard work to address these issues.
- The medical community is somewhat uneducated. I think people don't even know how to embrace this yet. Clearly, we have a role, but we need to recognize our own prejudices. A lot of programs have started working on this. I know MSMS had a program. I think physicians personally think of themselves as advocates for health equity, but they may not even be aware of how they are a barrier to health equity.
- As a profession that trains physicians, they have to be trained to provide services where inequities exist and have the appropriate culturally sensitive training to be effective in this area. Vast majority practice in areas that are not socially disadvantaged. We need to structurally talk about this from a training program and entice physicians to work in these other areas.

Recognize and acknowledge health inequity (11 responses)

- COVID-19 is a great example of inequity; many populations were disproportionately impacted from long term disparities. This is something we have known for a long time. But because of the last year, many others know it too. These inequities exist and now we have to really figure out how to close the gaps. Increased emphasis on what the solutions look like.
- Recognizing that health equity is a driver of health outcomes. It is a factor that impacts people's ability to be healthy. The collective and individual voices of physicians are very powerful, and they could speak up on this.

Advocate for health equity (14 responses)

Several interviewees want to see the medical community, led by physicians and the medical societies, to be stronger advocates for health equity.

- Physicians have to be the leading voices on health equity. In a lot of ways medicine enjoys being perceived as less political. Medicine has to be the voice that leads with science and reason when it comes to equity and framing social issues.
- We need to be louder advocates in Lansing saying, 'This is what's going on. This is what you need to do.' Information should come from community forums too. When you can coalesce stories across communities,

they have more strength and power. We're trying to increase our advocacy efforts by having conversations with providers at individual practices that we can share with MSMS, who can help take it to the capitol.
- MSMS would have more success advancing physicians if they spent more time talking about these things than surprise billing and prior authorization which are symptoms of a problem. The good will they are spending needs to go to social justice and inequities and affordability and best practices because that will transform over health care.

Address SDOH (6 responses)

A few interviewees recommended that health equity could be advanced by addressing needs related to social determinants of health.

- Equity is not the same as equality, some people need more or something different. May need to connect to a care manager because they don't have care literacy. Need to identify the needs of the population and connect them to the services they need to drive to better outcomes.

Q7: How can costs be contained while ensuring providers are paid fairly?

Promote value-based payment models (15 responses)

About one-quarter of the health care leaders indicated that implementation of value-based payment models will reduce costs in the health care system and will ensure fair payment for providers who are delivering high-value care.

- We need to continue to pursue value-based payment models. If you double down on value, you will be doing the greatest service for the people at large. You'll get more optimal outcomes, fewer errors, etc. So much will get better.
- I think outcomes matter; I know that's what we're moving toward, but we need a more aggressive approach to some of the capitated models. More meaningful incentives for high quality high value care. The information systems are in place to tell us how physicians are doing. And need disincentives for providers who aren't performing up to snuff.
- We'll be more successful at containing costs if we try some of the payment models out there, like shared savings programs. That's very different than "Your quality can be the worst, but if you keep delivering a lot of services you get paid a lot." Could also move toward more capitation. There are some learnings to be taken from innovative models like concierge medicine.

Focus on prevention and primary care (10 responses)

Several interviewees said that health care costs can be reduced by focusing on prevention and primary care, which in turn reduces the need for more expensive care down the road, including care provided in hospitals.

- One area of cost containment is a focus on prevention. Shift the proportion spent on last-ditch treatment procedures in favor of prevention.

- Historically, medical care has been focused more on widgets and less on preventive care. We need a better balance of reimbursement between primary care and specialty care. If we want these services and better outcomes, we have to reward and recognize primary care.
- Through the minimization of disease so you treat disease in earliest phases.
- The major driver of costs is ER visits and inpatient admissions. Better primary care keeps people out of the ER and the hospitals.

Address other cost drivers (e.g., pharmaceuticals, insurers, hospitals) (9 responses)

Nine health care leaders pointed to health care system elements they believe drive higher costs and which, if addressed, could reduce costs overall. They identified the primary cost drivers as the pharmaceutical industry broadly and pharmacy benefit managers specifically as well as health plans and hospitals. Some noted that physician payment and reimbursement accounts for a very small portion of overall health care costs.

- Drugs cost way too much money. They can't negotiate Medicare drug prices, and this is a huge mistake.
- Cut it out of places that are being way overpaid. Hospitals are overpaid. Third-party payers are taking too much off the table. Let's change that. It's not primary care physicians' six percent or the specialists' 12 percent [of the cost of health care] that's breaking the bank.
- Role of medical insurance industry, $3 trillion per year. That is not something other countries have as a component of what they do, this warps our costs. That warps the cost structure that won't allow us to control those costs.
- There is a lot of excess cost and inefficiencies. Vendor community and predatory profiters off of health care need to be looked at in all areas – pharmaceuticals and device suppliers. People who drive up the cost of construction in health care – facility cost. There is a lot of predatory behavior on health systems.

Improve EHR usefulness and interoperability (7 responses)

Several interviewees asserted that costs could be reduced with more effective EHRs—those that support clinical decision making and are interoperable to allow real-time data sharing among health care providers.

- Use technology to support medical care. Optimize the tools that are being used, the EHR, to better support physicians. There are ways to do this correctly.
- Do more effective care coordination. Share information—true EHR interoperability to remove duplication and wasteful care.
- I think there's a lot of waste in health care. Not being able to access other hospitals labs and records leads to a lot of duplication.

Promote evidence-based care and guidelines (6 responses)

Several interviewees noted that waste can be reduced by increasing the use of guidelines to promote evidence-based care.

- Putting in the standards of care and making sure they are followed. Need to identify outliers and people not practicing to standards. That happened up here where several providers were way outside the standards. Falls on the medical community to police themselves.

- We are going to have to start to think in terms of using our health resources more wisely—more evidence-based. Something, maybe AI, will let you know "I'm not sure why you ordered that test, not evidence based. We told you it wasn't evidence-based when you ordered the test, but you did it anyway and it increased the cost for the patient." I don't like to be second-guessed, but there are opportunities to help with use of guidelines and evidence-based practices. To increase quality of care and likelihood of favorable outcome.

Reduce unnecessary utilization and duplication of services (6 responses)

Others said waste can be reduced through improved communication and coordination and limiting unnecessary tests and procedures.

- There is a ton of inefficiency in the system currently. We have huge complicated systems designed to deliver care and the lack of coordination leads to inefficiency and variation.
- Everything is a department—urology department, orthopedic department. They all have expenses, and so many are duplicated. But if you pulled it all together and had a large multispecialty group, you can reduce those costs and have savings, throw in technology and it is very profitable.
- You'll reduce waste by doing less tests to rule things out for fear of a malpractice suit. We send them blanketly for all the tests. Or order more tests so you don't get sued in case you miss something.
- A huge amount of waste goes back to PAs [physician assistants] and NPs ordering unnecessary tests and referrals.

Reduce administrative burden (5 responses)

A handful of health care leaders said costs could be reduced by reducing some of the administrative burdens associated with health care, especially related to prior authorization and documentation.

- Administrative costs are too high. We have too many FTEs focused on prior authorization.
- Well-intentioned but excessive administrative—we employ 50 people for ten doctors, and many of them are involved in prior authorization and completing forms for different metrics. All of this has its place, but it is also excessive.

Other (5 responses)

Other ideas for reducing costs included implementing a single-payer health care system, eliminating for-profit medicine, centralizing the availability and use of high-tech procedures, and ensuring that money is paying for care rather than facilities.

Q8: How can access to health care be improved?

Respondents offered several ideas for increasing access to care, including improving physical accessibility, ensuring providers are available to offer services, increasing the affordability of care, promoting team-based care, allowing all providers to practice at the highest level their license allows, focusing on the needs of local communities, and increasing Medicaid reimbursement for providers.

Make health care more physically accessible (23 responses)

More than a third of the health care leaders said health care services should be easier to get to, with many promoting continued and increased use of telehealth and other types of nonoffice-based health care services, Several others noted that health care providers need to be available locally.

Offer telehealth and other types of remote care (17 responses)

- Telehealth is huge for increasing access especially for primary care.
- We need more telehealth to help address transportation issues, but also need broadband to help expand access to telehealth. Support for families to care for aging family members stay in their homes longer.
- We need to take care to our patients, including in-home care. In five years, we'll be having a different conversation about what a hospital is or should be.

Be in communities (6 responses)

- It's not just an insurance card. People need services in their actual communities. In Detroit, many people don't have access to a car. You need to be in neighborhoods.
- We need real attention to close-to-home services. From the hospital perspective, there is a lot of interest in moving services to large cities and having patients come to the services. But the sheer geographic distance is often a disincentive.

Ensure providers are available (15 responses)

Many interviewees emphasized the need to ensure that enough providers are available to meet the needs of the population—statewide as well as regionally. Some pointed to a need for more primary care physicians generally. Others offered ideas for incentivizing providers to practice in underserved areas.

Increase the supply of health care providers, especially primary care (10 responses)

- At the medical school level, we need to get a handle on how many people don't choose primary care. We don't need all these neurosurgeons and other specialists. We need to expand the number of highly qualified primary care physicians.
- Primary care physicians are the key to this. We have enough specialists. There are some shortages in pockets, but primary care providers are needed in higher numbers to improve access.
- We're not training enough people to become medical providers. There is a shortage of psychiatrists, children subspecialists, nurses, and other types of providers.
- We need mental health access. We still don't have psychiatrists in our county. We have telepsychiatrists, and there's community mental health, which is overrun by demand.

Incentivize practicing in underserved areas (5 responses)

- There needs to be an effort to look at who practices in rural areas and how to get people there. One idea is loan repayment. Give people from rural areas job-shadowing opportunities.
- In Detroit and elsewhere, we have care deserts; no medical providers or dentists; we need to address this. There are ways to incentivize providers to practice in locations that were previously not sought after or as lucrative.

Increase affordability (14 responses)

More than a dozen health care leaders identified the cost of care as a key barrier to access and offered a few solutions for reducing costs for patients. Several suggested expanding health care coverage and others indicated an overall need to reduce out-of-pocket costs.

Increase health care coverage (9 responses)

Interviewees noted that insurance coverage is a key factor to accessing care and making it affordable. Some suggested expanding coverage through Medicaid and a few said a single-payer model is the best approach to increasing coverage and affordability.

- Insurance coverage is also essential to improving access.
- We need to expand Medicaid and create universal access.
- We need a single-payer system—socialized medicine. We hear complaints of how things work in Canada, but we have the most expensive system in the world, and we don't have the best health in the world.

Reduce out-of-pocket costs (5 responses)

- I'm thinking of cost sharing; care is hard to access if you are always paying out of pocket. Look at how insurance plans are developed and the payment structure of these.
- In the emergency settings, I think the fear of bankruptcy is creates hesitancy because people fear bankrupting their family. So, creating safety for patients around seeking care is important.
- When the ACA came out, it increased access for millions, but it also increased the cost of care for a lot of people. They utilize services and that costs a lot of money. There was no cost side of the equation.

Use more team-based care (9 responses)

Several health care leaders asserted that using a team-based approach to care will increase access because patients would have an increased amount of care providers depending on the type and level of care they need, and it also allows physician practices to see more patients.

- Team-based care will improve this. Most physicians would readily agree that much of what they do could be done by a team member that they are coordinated with. Not free-standing independents, but team care.
- Team-based care is helpful, access to the right provider at the right time and not everything has to go through the physician.
- Ensure those providing care are doing so at the top of their license to expand bandwidth.

Address community-specific needs (6 responses)

Some interviewees promoted the idea of identifying and directly addressing the needs of the community in which care is delivered. This includes working with communities and engaging nontraditional community-based providers, like community health workers (CHWs).

- Community-based care is essential. It needs to be driven by public health with input from physicians in the community. The needs in urban, rural, and suburban communities are very different so that's where we have to recognize there are different needs of care based on where you're located.

- Expand access by having a health care system rooted in the community and controlled by the community; they make decisions best for the community. Move to more local control.
- CHWs are unlicensed trained people with resource connections; they are the ones that support the prenatal care and get patients to stop smoking and take the vitamins and keep their appts; they are trusted by the community. The concept of the nontraditional care provider needs to be taken advantage of.

Increase Medicaid reimbursement (6 responses)

Several interviewees noted that people with Medicaid coverage often have more difficulty accessing care because providers are less likely to accept Medicaid than commercial insurance. They said increasing the Medicaid reimbursement rates would encourage more providers to accept patients with that type of coverage into their practices.

- Medicaid beneficiaries have a harder time than people with commercial coverage. Leveling the payments for each of those products would go a long way to improving access.
- Medicaid reimbursements are too low. If you're not an academic health center or FQHC it doesn't cover the cost of operations.

Be available for patients (3 responses)

Three interviewees said providers should consider expanding their office hours to meet the needs of patients who are not available during the typical workday.

- Having more available hours. We're the only non-urgent care office I know of in the state that is open seven days a week. That makes a huge difference. Making sure everybody in the community has access to a medical home and designated primary care office.

Q9: How can health care quality be improved without significantly increasing costs?

Interviewees offered several ideas, including implementing better (and interoperable) data systems, investing in prevention, and addressing social determinants of health, delivering evidence-based medicine, eliminating waste, promoting high-quality care, promoting individual patient responsibility, reducing administrative burden, and improving provider training and education.

Invest in prevention and address social determinants of health (12 responses)

Many interviewees suggested that investing in preventative health measures at the individual and community levels would lead to long-term savings.

- Preventative medicine. Better public health measures. A true investment that would pay off over the years. Infant mortality can be reduced. Also, infant injury—things that hold you back and set you up for chronic conditions down the road.

- Up front there will need to be investment, but in long-run we'll see lower cost. In the short run we need everyone to be covered. When people are outside the system, they delay care until it is too late. As long as we marginalize people, our health care costs will be high. If we bring people into the system and invest in prevention, we'll see costs go down because end-stage disease will be less common.
- You have to look upstream. I teach in our residency program here and have been introducing that no matter how much money you throw at health care, there will never be enough to deliver it. We need to structurally look at society to invest in the right places. If we want to change the realm of health care, we will invest in early childhood development opportunities. If we invested in highest quality pre-K care, it would mitigate enormous downstream problems.

Create better, interoperable data systems (11 responses)

Several health care leaders asserted that the quality of care would be improved with better data systems, especially with EHR interoperability. Many also noted that these improvements would likely reduce the cost of care due to reductions in overutilization.

- Everything already exists for the universal EHR and marrying that with artificial intelligence–enhanced decision support. It's already out there, we just have to implement it. If we really move toward leveraging AI to hardwire best practices and evidence-based guidelines, it will immediately improve quality.
- Decision support tools, use registries to identify the population and get them to the services they need, stratifying the population and connecting them to the appropriate care.
- One major factor is our lack of integration of data leading to neglect and duplication. And to me if there was a real policy on integration of data in the long run it would decrease our costs and improve the health of the population.

Adopt evidence-based medicine (10 responses)

Some interviewees indicated that wider adoption of evidence-based practices and care protocols would improve quality by decreasing variation in the care delivered, which they argued should also lower costs.

- Evidence-based protocols that are widely agreed upon with input from more physicians would improve quality and reduce costs.
- Decrease variation. Focus on quality and get rid of variation and increase standards; that will lower costs.

Promote high value and high-quality care (7 responses)

Several health care leaders said consistent delivery of high value, high-quality care will improve health care quality. Some of them suggested implementing payment and/or reimbursement models designed to incentivize this type of care.

- Incentivize people to focus on known quality measures.
- Pay for value and hold people accountable.

Address overutilization (6 responses)

Several health care leaders also said quality would be improved by reducing utilization of unnecessary services, which stem from existing payment models as well as care providers with lower levels of training.

- Look at everything through a value lens and look at utilization. Some utilization has nothing to do with quality or value and is just driven by the market.
- There are a lot of tests that happen to rule out diagnoses because care is delegated out to NPs and PAs. They cast a wider net; we need to watch over that care. Ordering more tests does not mean better care.

Promote individual patient accountability (4 responses)

A few interviewees pointed out that health care providers cannot control patient behaviors, and they are concerned about measuring quality of care based on patient outcomes.

- In medicine, we are making physicians responsible for life choices and that is silly. The quality of care is based on patient outcomes that are being put on the physicians' shoulders, but they can't control the patient. If a patient eats and drinks whatever they want and the physician can't fix the health care problem, it doesn't make it poor quality health care.
- No matter how you define quality, the patient has to be the one who's accountable. The physician and insurer only have so much control. The more the patient can do for themselves, the less time they spend in the medical office. If they are able to quit smoking, we are able to reduce utilization and costs.

Reduce administrative burdens (4 responses)

A few interviewees asserted that administrative burdens placed on physicians by payers contribute to unnecessary costs without promoting quality and, in some cases, reducing quality.

- The thing that costs more is counting things. Every time we need to count more, we need to hire people to do the counting. The hospital wants to see every one of my charts so they can bill as much as possible. They should be confirming I'm doing the right things, not just trying to see how much they can bill.

Increase provider training (3 responses)

A few interviewees emphasized the importance of physician education on quality improvement. They indicated this education should begin in medical school and continue throughout their careers.

- Get the residents involved with this and with safety projects. The more we do this, the more they will see the importance of quality improvement. They have to be trained to think about health care quality and quality improvement.
- Improve the education of physician during training and afterwards. A lot of good online resources for physicians and others that could be made available and supported.

Q10: How can administrative burden be reduced without undermining accountability, quality, or patient outcomes?

Interviewees had several recommendations on how best to reduce administrative burden without undermining accountability, quality, or patient outcomes. Their ideas focused mostly on improving EHRs and required documentation and eliminating or minimizing prior authorization requirements. A few also suggested increasing

physician control of service utilization, aligning payers' quality metrics, increased use of team-based care, and reducing other regulatory burdens.

Improve EHRs and reduce documentation (17 responses)

- Probably can be improved by making the EHR a less obtrusive and almost unworkable object that's in our way on a daily basis. It's one of the largest contributors to physician burnout. If effort was put into making it work for us instead of against us and not just capture minutiae that doesn't contribute to patient outcomes, that would reduce administrative burden and improve quality.
- There is a lot of documenting that is done that seems to be a waste. The insurance industry and the government have created huge hoops to keep people from going down an expensive pathway, you have to keep going through the hoops. The fear is that if there are fewer hoops it will cost more. But the hoops just to get paid is ridiculous, prior authorization and documentation is a burden.
- If you have a way to automate systems through machine learning or artificial intelligence, you won't need bodies to do administrative work. A lot could be automated.
- Physicians – out of the giving of the care and now they are typing in epic and doing administrative work that shouldn't be them. We should want them to be worried about medical illnesses and their patients and not about how to get their chart completed.
- I don't think any of the administrative burden improves quality or outcomes. The buttons we press are related to billing and have nothing to do with quality of care. Physicians should be asked what they find useful to document and what is not.
- We need clinical guidelines embedded in EHR. The utilization management of the payer should be automatic.

Address prior authorization (11 responses)

- The administrative effort to do any care provision is too high. For example, it is no good to have a preauthorization requirement when the physician and the insurer knows that it will get approved because it is appropriate; it just is a delay to the patient receiving care. It adds to the office cost and office staff to deal with it on both sides.
- If the insurer is approving 95 percent of requests for a specific treatment, they shouldn't require prior authorization.
- The biggest administrative hurdle for a lot of practices is the prior authorization process. There is a giant disparity in what different payers will pay or cover based on the patients' plans. Very little universal thought has been put into denials and coverage.

Let physicians take control of managing utilization (6 responses)

- The whole pretense that somehow without those levels of authorizations we won't be held accountable is absurd. Implement risk-based contracting and that will hold us accountable.
- That should be provider driven. Aligning goals and incentives. We spend a lot of time with authorization and utilization management review, if we can find a way to reduce this waste and we don't need that administrative burden.
- If the administration is done by physicians, they will figure out how to minimize the burden and embrace their role in planning, designing, and optimizing the health care system. Administrative burden is high because we've acquiesced to others making decisions and running the system.

Implement single-payer coverage (4 responses)

- Universal health care would help reduce admin burden and would help with population health because the data is all in one place.

Align payers around quality metrics (4 responses)

- The different payer plans have different metrics for accountability and quality and, as a result, there is no efficiency or harmonizing.
- Insurers should have the same quality measures and shouldn't be able to change them more than once a year. It would support continuous quality improvement. Right now, we pick and choose what to focus on because we don't have bandwidth to implement all of the quality measures.

Support team-based care (3 responses)

- It's really sharing the load of patient care across a team of providers. The physician is accountable, but everyone is responsible. Everyone has to be responsible for the outcomes we produce collectively.

Reduce regulatory burden (3 responses)

- Medicine is becoming so regulated, and we keep adding administrators to address regulations. We are now dealing with OSHA [Occupational Safety and Health Administration] from COVID-19, and Michigan makes their requirements more stringent than others, so we have to pay more money to implement MiOSHA requirements. Someone thinks it is a good idea, but most of it is just adding time and barriers and steps, without adding value.

Q11: From your experience, what is the most promising idea, program, or initiative for improving health care in Michigan?

Health care leaders suggested promising ideas, programs, and initiatives that could improve health care in Michigan. They recommended value-based and risk-based models and expanded health care coverage, as well as a greater focus on social determinants of health and advancing technology. A few interviewees recommended other ideas.

Value-based and risk-based payment models (8 responses)

- Probably value-based contracting. It aligns incentives of the hospitals and the community practices around the patient because the patient goes to all of these different sources of health care. Right now, these entities are disjointed. Value-based care allows us to solve for diseases, common pathways patients take.
- Risk-based payment models. A shift to risk bearing contracts will drive behavior change and improve quality.
- Physician groups could be stepping up in accountable care organizations to say we will accept the responsibility for the economics of the patients we care for. That is a huge potential game changer. They are in a position to have a conversation with the patient and explain the relative cost differences, take a generic med, etc.

Health care coverage expansion (6 responses)

Universal coverage (4 responses)

- Universal insurance coverage.
- Universality of health care. Not Medicare for all, which would put us out of business.

Medicaid expansion (2 responses)

- Extending maternal Medicaid coverage from 60 days postpartum to be 12 months. Seeing that effort across the country. We know there are much better outcomes for the moms. A lot of anecdotal evidence that the baby is also experiencing greater levels of health when the mom has coverage herself. Health of other children in the household seems to be better as well. Relatively small expense with huge benefit and lifetime of health impact.

Focusing on social determinants of health (5 responses)

- Appreciating SDOH and understanding that we can manage the health care experience, but we have more opportunity to improve outcomes and reduce cost by addressing the SDOH.
- Focus on SDOH has the greatest potential. Physicians need to broaden their mindset on why patients are ill and share this will policy makers and work with public health. Have a holistic approach to patients as people.

Technology advances (5 responses)

- I have heard rumors of AI programs that are used in the office where the physician–patient visit is overheard by the computer, the AI generates the orders, billing, and notes for the physician to review at the end of the visit. Everything is lined up, not perfect but everything is completed and able to be reviewed. The program is Robin, and some are experimenting with this. It would allow us to examine and talk to our patients instead of our time spent coding, ordering, and entering data. If AI was good enough, it could do pre-charting, where we have to wade through past medical history and have it lined up for us to review.
- I would say MiHIN [Michigan Health Information Network]. It started with just discharges but its evolving into pharmacy lists and more information. They're moving forward with discharge diagnoses which they didn't initially have. It's playing a key role in integrating information between siloes.

Remote medicine (4 responses)

- Telemedicine. Continuing changes in home-based care programs. Hospital home programs.
- We need to support our provider networks and invest in telehealth to have frequent visits. Talk about internet capabilities, make sure patients can connect to care in this way. We have a unique opportunity to take these learnings and translate them to real advancement and change for our nation.

Maternal and child health (4 responses)

- I really like the CHAP [Community Health Access Program] program. It's nurses who work with families and kids to get referrals for things they need. Nurses and social workers getting families into WIC, getting kids to clinicians when needed, getting follow up, immunizations, and testing.

- The AIM [Alliance for Innovation on Maternal Health] initiative, which was a health care innovation initiative to look for ways to improve outcomes. Once you discovered the best approach to something, operationalizing it, creating a way for it to be used by others. Created safety bundles to improve outcomes. When used by physicians and health system, it worked. It's a lot of work that goes into it, but it's physicians who share a belief and they get together and talk about it and figure out how to make it happen and put it into practice.

Physical and behavioral health care integration (3 responses)

- A greater emphasis on behavioral health and mental health. The comorbidity or physical and mental health is around 40 percent and yet this is often ignored. This needs to be a critical focus.

Efforts to strengthen primary care (3 responses)

- MiPCT [Michigan Primary Care Transformation Project] was probably best program for advancing health care to where it is today. Would've liked to see it continue to be funded.
- Advanced primary care and integrated behavioral health. Primary care demonstrates how to control costs. It is not brand new, bread and butter, but it is the best way. Stratifying out the top 3-4% in the complex needs and tailor services and supports to them, longer visits, smaller panels is also a good idea. We know social isolation drives a lot of unnecessary visits, such as with seniors who are alone and without social supports; those models can be very helpful.

Other specific programs (4 responses)

- The Great Lakes Regional Business Alliance worked with MiHIA [Michigan Health Improvement Alliance] to elevate the quality of health care delivery through THRIVE [Transforming Health Regionally in a Thriving Economy]. I've seen systems partner with business entities, but never seen all systems in a region come together with business sector. It's a fascinating, promising initiative that can really improve health in a region. Business is our greatest asset, but we've never leveraged it.
- PACE [Program of All-inclusive Care for the Elderly] programs are excellent, having the structure in place.
- The MIDOCs program provides opportunities for our residents to work in rural and urban areas and helps place physicians in areas they might not have otherwise. It is a small program, but we are trying to grow it from 20 to 26 physicians.
- I like the MIDOCs program that sends people off to work in rural communities.

Q12: What must physicians do differently to transform health care in the next five years?

Interviewees recommended physicians be more engaged in health care, including in leadership and advocacy efforts. Many also wanted physicians to embrace and lead needed changes.

Lead, advocate, and engage (22 responses)

Many health care leaders emphasized the need for physicians to increase their levels of advocacy, leadership, and general engagement in health care transformation.

Just get engaged (10 responses)

- Doesn't matter what you get engaged in, but physicians need to get engaged in something.
- We need to accept the fact that there is more to being a physician than just opening our offices and seeing patients every day. We do have the answer to a lot of other problems, and if we don't speak up, other entities will and that has not gone well. We need to engage and be more involved in these processes.

Engage in health care system leadership (7 responses)

- Physicians need to find a ladder and be more involved as CEOs of health system. The highest-functioning health systems are physician led: Mayo, Cleveland Clinic. It is not about the bottom line; it is about patients and the bottom line. When administrators don't understand what happens in an office and they downsize this without understanding patient type and patient flow, it is very discouraging.
- They need to be leaders and have a voice at the table. Those employed by health systems need to engage the physicians and identify the pain points and give physicians the sense that they are solving problems for themselves and for patients. Get on a hospital committee. Take increasing leadership positions.

Engage in policy advocacy, including through MSMS (5 responses)

- We need to take ownership of health care. We need to advocate for health care. There are enough burdens on us that we think others will do this, but if we want to transform, we need to advocate for what we need to provide patients the best care. We have to leverage our relationships with medical societies, so they can invest in policies that will support us. We need the support of organized medical societies.
- We need to get neck deep into the social issues of our day. Health care systems are incredibly powerful mechanisms for effecting change. This is the richest moment I've seen in my 50 years of living. We can reshape the future because everything is ready for revision, transformation, evolution.

Embrace change (12 responses)

Several interviewees noted that physicians will need to embrace change in general, but also with specific regard to payment models and new technology.

General change (3 responses)

- Embrace the change that is happening. They are wrestling with so many challenges already, but health care will keep changing. There are so many disruptors in the market, it won't stay the same. The model is changing, and they need to embrace change like they did with telehealth.

Payment model changes (4 responses)

- Embrace value-based contracting. They have to be the leaders and get away from fee-for-service and recognize that it is not serving their patients. We want to take care of our patients, and we have to have a better way to do this. They have to look at other industries and how they have transformed and really embraced the physician's role and show the possibilities. They have to be the designer of their future. Whether you are a primary care practitioner or specialist, how do you become the leader in value-based care.
- They have to be willing to join shared savings and risk programs with payers. Have some skin in the game to understand where money is going and how to be a steward of that. It costs $1,300 just to walk in the door at the ER. That's a lot of money!

Team-based care (3 responses)

- Team-based care. This is now embedded in residency and in school, but many didn't have this. MSMS has been helpful in educating physicians and encouraging adoption of this and seeing patients as people. Continuing this is huge role. PGIP [Physician Group Incentive Plan] and BCBS—practices that have accepted PGIP are transformed, accountability for cost and quality and connecting with community resources.

Become more community-minded (5 responses)

- When I was a physician, I was focused on doing the work within the hospital, without thinking about the patients before they come into the hospital. We have to change this mindset to be more engaged in the community and what are the factors influencing health and what are we doing to address this. People trust their physician. They need to use that pulpit to address the key issues and talk to the community and the leaders in the communities about key issues.
- I think the idea of becoming more community-focused and knowing more about what's going on in their communities. That's how you're going to effect change. Identify circumstances that are affecting people's health. When you ask questions because you care about a patient, they feel safe, and they'll tell you what's going on.

Promote patient-centered care (3 responses)

- We need to move to a sincerely patient-oriented model. Right now, things are very inconvenient for the patient. Clearly, we're not a hotel chain, but we could do so much to make things easier and simpler for them. Stop being enamored of the really fancy (precision health). It's great that your T-shirt monitors your sweat chloride but come on.

Q12a: What will physicians have to give up to accomplish this?

The health care leaders acknowledged physicians would likely need to relinquish some autonomy, time, and/or money if they become more engaged in advocacy efforts. Some also noted that physicians may have to give up some level of comfort if they embrace new payment models or step into new roles.

Autonomy, time, and/or money (14 responses)

- Will have to give up autonomy. That's the main thing is the concept that "I am an island and I know best" needs to evolve toward "I am a leader of a team and there are best practices we can follow."
- Time and money. It takes time to write blog posts and get in front of legislators and to lead or dispel medical information and time away from the practice is money. We have to give up time and money to gain what we want.
- One unfortunate thing, there will be less autonomy of the individual physician. But I think that horse has left the barn. The next generation of physicians is more comfortable with less autonomy. This makes them more likely to take on leadership roles.
- They have to give up money. To have politicians listen to you, you have to buy their time. We can't buy their votes. But if you want to be heard, you have to donate to their campaign.

Comfort (5 responses)

- Some will have to step into uncomfortable roles in order to help do the right thing. We need to be at the table to make decisions that support patient care.
- They will have to be willing to make changes in their approach to patient care and to disease care. When you are confronted with the fact there's a better way to do something, that shouldn't be a deal breaker, if the goal is to improve the health of our patients.

Q12b: What will physicians gain in accomplishing this?

Interviewees said if physicians are willing to step into new leadership roles, engage in policy advocacy, and embrace new ways of delivering care, they will be rewarded with better patient care and outcomes, increased respect from patients and others, and a return to the joy of practice, among other things.

Better patient care and outcomes (11 responses)

- Better patient outcomes. By working with MSMS to set priorities for public health and addressing health care disparities we would have better outcomes and a healthier population.
- With a more collaborative approach to care, we could potentially end up with less sick patients and greater wellness.
- I would hope we would make medicine more efficient and better, and we would provide better care as a result.

Status, value, and respect (7 responses)

- They will retain a position of respect and authority with policy makers.
- The more useful you are, the more people turn to you and the better off you are. The profession is more likely to get more control over what we do and more influence over how resources are used.

Joy of practice (7 respondents)

- They will do more of the things they trained to do and that they are passionate about doing and less of the things that aren't the core reasons for going to health care; and a knowledge that more people are getting the affordable and accessible care that they need.
- What we gain is a return to the actual calling of this vocation as opposed to job. And you'll regain interpersonal delight in terms of, "I am a human being", and "you are a human being", and "I will strive to make your health better" and "through interacting with you, my life is better."
- They get the joy of practice back. And patients don't want to go elsewhere because they're happy. They gain the sacredness of their profession back. These are the most important things to doctors: I'm a good doctor. I take care of patients. I'm respected by my colleagues.

Q12c: What policies are needed to support these ideas?

Interviewees identified several policy changes that would support physicians' efforts to transform health care over the next five years. These include payment reform, policies that support team-based care, policies that remove barriers to innovation, and reductions in administrative burden. Respondents also noted that payers, health systems, and physicians would need to work together in transforming health care.

Payment reform (11 responses)

Pay for value (9 responses)

- The way to make change happen is through payment policy. We need to shift reimbursement policies to align goals and incentives. Fee-for-service payment will continue to make this a challenge; we need to shift payment policy to make real progress.
- Payment reform. Looking broadly at value-based care and what is rewarded, paying for precision health, and supporting social determinants of health.
- Payers need to put incentives in place that will engage specialists. There's been very little work to integrate primary care and specialists.

Pay for nonoffice-based services (2 responses)

- We have to be okay with some health systems dying because we don't need all of these hospital beds if we care for people in the right way. And physicians have to be paid well to take care of patients at home and outside of the hospital. Value-based care models can help with this.
- Rebalance the budget for more at home services instead of nursing home focused services.

Pay for advocacy work (2 responses)

- It would help if we were paid to do this work. It would be a lot easier to participate.
- We have to ensure they are compensated by the practice when they take time away from the practice to do advocacy work. Physician organizations need to support this work.

Address scope of practice barriers (5 responses)

- We need to address scope of practice barriers and implement reimbursement models that support team-based care. We need payment models that support care coordination and physicians leading a team instead of being an n-of-1.
- Address barriers to advanced practice providers practicing at the top of their license. It's not MSMS's mantle, but they could play a role in figuring out what is the compromise and what makes sense and how to bring the value proposition to physicians.

Reduce barriers to innovation (5 responses)

- Telemedicine was quickly accepted, and we had billing codes to support this. We need MSMS and AMA to see the barriers to care related to tech and interoperability and figure out how to help us. Develop the CPT codes, free up barriers to innovation in health care. Help get stakeholders together to work through this.

Reduce administrative burdens (3 responses)

- Reduce the burden of prior authorization. It's a day-to-day challenge. Get rid of nickel and dime barriers.
- The providers' frustration is that payers do things differently; they pay them differently, etc. Payers try to meet customer needs and differentiate themselves in the market but, from a provider perspective, having things the same is helpful—not having to do something different for every insurer. How many ways are there to manage the same process? We need consistency across insurers through multi-payer policies.

Review antitrust laws (2 responses)

- There are antitrust laws that stop physicians from being able to own hospitals. That directly impacts the ability of physicians to direct better care. So, I think allowing physicians to be in charge of and own hospitals is important.
- There are elements of the Stark Law that are not serving the system well at this point. Some of the restrictions they placed on creative relationships to align independent practice with hospital-based medicine are causing more problems than helping at this point. More aligned around patient-centered care

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Q13: What must payers, purchasers, and consumers do differently to transform health care in the next five years?

Health care leaders provided insights on changes they would like to see payers, purchasers, and consumers do differently, including promoting and engaging in healthy behaviors.

Payers

Implement value-based payments (6 responses)

- Government and payers need to look long term at where medicine needs to go, how they can pay differently to do this, and how we support this going forward.
- Payers have to be willing to participate in shared risk. Medicare has done this. Payers need to focus more on outcomes and care management resources. Need to support team-based care, home care. We need flexibility to keep person at home or nursing home rather than hospital. What makes it so difficult to discharge patients back to their home?

Engage physicians as partners (5 responses)

- Listen to physicians; give everyone a seat at the table. Be more willing to work with MSMS on the legislative priorities. Get away from the "us and them" mentality. Be willing to work with physicians to do what is best for people in the state.
- Payers and physicians see each other skeptically because they are on opposite sides, but we need to get on the same page and find alignment to get to the end goal faster. Payers have to be open to more collaboration and partnerships to transform health care.

Incentivize healthy behavior (3 responses)

- Consumers need to be more activated and engaged in the transformation. There are opportunities for us to get that member more engaged through our purchasers or through the payer-led plans. We incentivize the providers for certain activities, so how we tie the accountability with consumers is really important. Advance population health by engaging patients in their care.
- Payers need to figure out how to give consumers real incentives to manage their own health better.

Be transparent (3 responses)

- We have to have data transparency and payment transparency, so that everyone can make the best choices. Payers have way more data than any individual physician.

Use data and technology to promote better care (4 responses)

- Payers can create structures to create personalized care that uses analytics and uses artificial intelligence.
- EHRs have not made my life easier or care better. I mean there's data registries, which is great and cool, which facilitates research. But payers have data on people all over the country. They should be able to leverage that data source to learn and improve care. Bring me real value.

Do not put onus on consumers (2 responses)

- Consumers can only do so much. It's a copout to lay this on consumers. They obviously need to be educated, but it's really hard.
- High deductible plans come at the cost of quality care. When patients are saddled with the high deductible, they avoid necessary care. We have to move away from those plans. Expecting the average consumer to be a wise purchaser of health care is not smart.

Decrease administrative burden (2 responses)

- Payers should decrease administrative burden that isn't effective. If something is approved 99% of the time, they should stop requiring prior authorizations.
- Standardize forms and requests of providers.

Purchasers

Increase engagement in outcomes (6 responses)

- Purchasers always look at the bottom line of the total premium, but they should also look at outcomes. Not just what they're paying, but what outcomes they are getting for that money.
- They need to be able to look at a new model of health care. They look much closer and know much more about who's making the bolts on the cars than they do about health care and the new types of primary care-based models. I think they'd be absolutely flabbergasted if they knew where their money was going.

Promote employee wellness (2 responses)

- Purchasers have to look at the work environment and they have to think about wellness and prevention, encouraging employees, and having incentives to participate in the actions that lead to wellness and being healthy.

Contract directly with providers (2 responses)

- Purchasers need to connect directly with providers of care; develop relationships and they need to accept the notion of narrow networks. There is some limitation of choice, but it's meaningless as long as providers are being held responsible for the care their system is providing.
- The payers need to get out from between health care delivery and the patient. Any insurer gets in the way of making good sound choices. If employers do direct to employer contracts, you get rid of the insurer. All you need the insurer for is the transaction.

Consumers

Engage in healthy behaviors (8 responses)

- As a society, we need to embrace health, embrace wellness, lose our fascination and faith in new technology and medications, and take better care of ourselves not only for ourselves but for those around us.
- Ultimately, people have to want to be healthier. And there is a big segment of the population that doesn't take accountability for their health in a meaningful way. The more educated our consumers of health care are, the better our systems are going to be. People need to be more accountable for their health and demand better value.

Increase understanding of health care costs and quality (11 responses)

- Consumers should be more knowledgeable about where health care dollars are going. The more knowledgeable they are about how much a tonsillectomy costs at one type of facility versus another would help reduce costs.
- Patients need to take more ownership of their health care. People spend more time researching new cars than they do their orthopedic surgeon. There is more information out there than people might realize. Some health care entities will put their costs out front, but the majority of places don't. There needs to be more transparency out there too.
- It would seem as if there's an opportunity for the consumer to demand more transparency about pricing and what are the outcomes of these programs and the dollars I pay.

Q13a: What will they have to give up to accomplish this?

Interviewees recognize that in making changes to shift the payment structure, payers will lose some profits and control and for consumers to be more involved in their health, they will have to lose time to become more educated and engaged.

Payers will have to give up some profits and control (9 responses)

- They have to loosen their stronghold on revenue and share in some of the risk bearing arrangements.
- Control of the data. But they should emphasize value of care and patient experience as the way to keep patients, not just keep them from other systems.

Consumers will have to give up some time (2 responses)

- Just time to gain knowledge. The health care system is probably the most complex thing they could ever endeavor to learn about it. They'll give up a lot of comfortable apathy to get that knowledge.

Q13b: What will they gain in accomplishing this?

The benefits of making transformative changes, interviewees said, will lead to happier, healthier people, employees, providers, and communities.

Better health for society overall (5 responses)

- Better health care for people and a happier population.
- Better care, lower costs, better outcomes.

Payers will have happier consumers and providers (2 responses)

- They'll gain subscriber satisfaction. Patients will be happier.
- They have a real opportunity to gain market share. If they get known as the one that's easier to work with, they'll pick up market share.

Purchasers will have happier employees and manageable costs (2 responses)

- Their employees would be happy knowing that the employers are looking to make sure their health care dollars are being spent prudently and they're getting more for their money.
- Flattening in the level of variability of cost across procedures. As a business you'd be able to manage your business more consistently, which truly is about slimming down the things that don't have value to spend time on things that add value.

Consumers will be healthier and more knowledgeable (3 responses)

- Outcomes can be better if they take better care of their own health.
- Consumers: being better able to navigate the health care system. They can speak up when someone tries to send them to a facility that costs more.

Q13c: What policies are needed to support this?

Although most health care leaders did not have many policy recommendations, those who did mentioned policies that would support many of the themes from across the interviews. Policies that would shift payment models, make care more affordable, require EHR interoperability, among others.

Revised reimbursement methodologies (7 responses)

- Practice reform requires payment reform. Policies that don't support effective practices need to be modified.
- Innovative payments, less regulation, shared risk. Willingness to do things differently. Stop paying FFS; would prefer to pay for the preventive care that avoids the need to more treatment.
- Accountability should not take a policy. It takes commitment and education. Most of the codes physicians are paid for are about sickness, few are for health and wellness, so many things are not even covered. If we went to a population-based system, we wouldn't worry about the codes, and we would be focused on meeting the patient where they are and helping them manage the diseases or sickness. If we had a policy for population-based payment, it seems like more government interference, insurance companies would want to take something out of it, I think it will be undue. We can do it and then scale it without a policy.

Promote EHR usefulness (3 responses)

A few respondents said policies are needed to improve the usefulness of EHRs including mandating universal interoperability and building in clinical decisions supports, including through the use of AI.

Make care and coverage affordable (3 responses)

Three interviewees suggested health care could be made more affordable through reduced deductibles, increased use of HSAs, and expanding Medicaid coverage.

Support evidence-based practices (2 responses)

Two interviewees said greater uniformity of medical care is needed, which can be achieved through increased utilization of evidence-based practices and clinical guidelines.

Price transparency (2 responses)

Two health care leaders emphasized the need for increased transparency related to costs and pricing to promote informed decision making among consumers, providers, and purchasers.

Address prior authorization (2 responses)

Two interviewees recommended policies to address prior authorization, including updating requirements around step edits and step therapies.

Q14: How can physicians lead necessary changes?

Interviewees suggested physicians can increase their engagement across the health care system, including by advocating for policy changes; being involved with medical societies; and by assuming health care leadership positions.

Engage in policy advocacy (10 responses)

- Discuss what policies will help the adoption of value base purchasing and where are the barriers. It is ongoing dialogue to make sure policy makers understand the barriers physicians are experiencing on a day-to-day basis.
- Advocacy is really important. If you want to be proud of something or complain, you need to speak up. Advocate at the state and government level and with your society and with your specialty.
- We have to be advocates; we have to be engaged. It's not good enough for us to practice Monday to Friday 8 to 5. That isn't good enough. You have to get outside of your day to day and be an advocate.

Get engaged, especially through medical societies (6 responses)

- Being willing to be at the table and to give of themselves to do it. Not easy to work 12–14-hour days and take time to be part of this. People who are actively engaged in medical society are not the norm. They are a group who see a greater good to being part of the process and pushing for substantive change. And so that's the necessary –the leadership we have to provide for that.
- We lead by being participants, being involved. If we're not directly involved, we need to delegate the participation. We can be represented in the conversations.

Get organized (5 responses)

- They have to be cohesive when they take something on. We have too much splintering. You have to have a unifying message. Especially when you're talking at the level of the MSMS.
- There's a tremendous opportunity for physicians to drive change in health care. It requires us to set aside our individual interests and find the common thing to focus on.

Obtain leadership positions (3 responses)

- Having a voice in the hospitals that they serve in. Getting more involved in discovery and innovation and implementing processes that take out waste. Don't need waste to see when there are too many steps in the process and that by removing some you improve outcomes, patient experience, etc. Every day is a day to ask what I could do differently for my patients instead of cursing the darkness. Figure out how to do it better and then tell people about it.

Practice evidence-based medicine (2 responses)

- We have to practice what we preach. We have to practice good evidence-based medicine. It has to be based in science. We have to be experts and practice that way.

Partner with insurers (2 responses)

- We need physicians in the community to partner with [payers] to help us solve these issues. Develop a care coordination model. Physicians need to get past, "whose dollar is this?" We need to include [physicians], and all drive toward improved patient care. How physicians get paid fairly and drive improvements is through focused population health. We need to take the time to address the whole population health and have physicians lead these discussions and decisions. Opportunity for them in the community to partner

with physicians in health plans and the society to figure out how to push patients' best interests together and how we can all win. Need to include in practice model and payment model conversation.
- Let's work with insurance companies to develop pilot projects.

Q15: What skills or competencies will physicians need to achieve the goals you have described?

Health care leaders identified leadership, communication, and collaboration as the skills most needed by physicians to achieve the recommended health care system changes. In addition, respondents noted that physicians also need to have a robust understanding of the health care system, health care policy, and how to advocate effectively for policy changes.

Leadership, communication, and collaboration (19 responses)

Leadership and team-based skills (12 responses)

- Physicians need really strong interpersonal communication and leadership skills. You have to know how to work within and manage a team. We don't get that training. Medical schools have to do a better job of helping students and residents. We need structured content around interpersonal communication. None of us get any reasonable training in leadership in medical school. Nor until recently were people trained in teams. It's not even a way medical schools think about it.
- We don't teach enough about leadership and how to build effective teams and foster trust. Empower all members of the team to speak up and participate – we've seen tragedies in power differentials and people don't speak up when they see something concerning. Empowering all members of the clinical team to bring their expertise and speak up.
- They will have to be team-based players, consummate collaborators, and effective leaders
- Leadership development. They have to have a formal leadership development. To understand the general direction we are going. There should be a formal training to understand skills they need – using their influence and building a team to make change.

Consensus building, persuasion, collaboration (4 responses)

- They have to bring their understanding of the practice of medicine to the table first and foremost, but they have to have some sense of how organizational change occurs and how you build consensus and how do you create urgency about different issues that are out there.
- We [physicians] have come from historical position of dictating everything around us, especially in the operating room. When we are in board meetings, we need to have better skills on how to communicate with people as equals. We have our patients' best interests in mind, so we have moral argument on all of this, but we need to be better collaborators and better group problem solvers.

Talking with patients (3 responses)

- There's a lot of education that goes into delivering health care, and physicians have to be good educators.

Broader understanding of health care system (9 responses)

Macroeconomics and health economics (6)

- We are very good at the clinical side of medicine. But we don't know how deductibles and copays are handled. We need to know how the system works to advocate for changing the system. We could use CME [continuing medical education] specific to the economics of health care—maybe not for credit, but the content is something MSMS can deliver.
- Being aware of how the system works, understanding the broader policy system. We need more administrative education at residency level. They should go to a CIN [clinically integrated network] meeting so they can understand the concept of value-based contracting vs. more traditional systems.
- Physicians need financial acumen and to understand macroeconomics. Many run their own business, but they need to understand the role they play with the interchange with payers, health systems, and consumers. As more physicians get this, that will create urgency to think differently about our situation and support change.

Population health (3 responses)

- Physicians need to understand population health. When you are in the office, you are focused on that patient and then you go to the next one and you think about them. You need to have a mindset on your entire population—shift to a population mindset. We need access to data and tools to do this, and then analyze and look at the data. We need physician leadership in this space to think about the role of the practicing physician. There are the organizations that help them understand this data and to deploy resources to work on populations.

Policy advocacy skills (7 responses)

- They have to understand how advocacy works. They need to understand that health care policy is driven by congress and understand how to be involved and help that process. Physicians have to be taught to be advocate for their patients, not just within their individual relationship, but also about health inequities.
- They need to be able to state their position in clear terms. They need to understand when there is regulation or legislation prosed and come back quickly with a better or recommended solution. Can't just complain, have to have a solution. Need skills to understand the legislation and policy and understand why something is being considered. Know the context. Political savvy and communicate clear and be diligent and persistent. It takes more than one visit. Support organized medicine.

Business acumen (5 responses)

- They will need a willingness to improve their knowledge base on business approaches and legislative practice.
- Some percentage of us need to get better at business.

Increased comfort with technology (4 responses)

- Doctors are afraid of technology—most of the ones I know. They're afraid someone's going to breech the data or someone's looking over their shoulder. Need to be willing to deal with changes.

Understand implicit bias (3 responses)

- With patients that don't look like me or patients that don't speak English, I have to remind myself that I am at increased risk for misdiagnosing them. The first time I was a med student and interviewing a black patient and asking social history, I didn't understand the term "jumping over the broom." I didn't have that cultural literacy to know they were talking about marriage. I thought there was something wrong with him mentally. It's so easy to do that, and physicians have to acknowledge that we can do better.

Q16: What does MSMS need to do to support Michigan physicians in achieving these goals?

Interviewees recommended MSMS continue to support physicians and changes in health care in multiple ways. They want MSMS to continue its advocacy for physicians, which requires MSMS to maintain and expand its membership base, thus ensuring it remains a leading voice for better health care in Michigan. Interviewees want to see MSMS convene payers, health systems, specialty societies, and other organizations to collaborate on needed changes, including increased support for stronger public health and efforts to address health inequity.

Advocate on behalf of physicians (22 responses)

General (12 responses)

- They need to continue to ensure Michigan physicians are at the table and adapting as changes come about. This will change in health care, and they need to be at the table with the relevant policy makers and have the voice of physicians in it and ensure physician interests are being represented at the forefront of the conversation and that they represent patients. I don't trust insurance lobby to lobby for anyone besides insurance. MSMS has to represent physicians and patients.
- Being a really strong lobbying and advocacy arm with state legislature. Core function. It's not well understood by doctors, but probably core function.
- Advocate on behalf of providers. It's important for society to think about what health care should be in five years. Advocate on grassroots issues, but also advocate based on a five-year plan and priorities. Make it easier to be a provider in five years than it is today.

Specific policies (4 responses)

Three health care leaders would like to see MSMS advocate for specific policies, including better reimbursement, value-based payment models, and flexible practice arrangements. One said MSMS needs to represent independent physicians and support their relationships with insurers.

Support physician advocacy (3 responses)

Three other health care leaders said MSMS should make it easier for its members to engage in advocacy. They said the medical society should make it easy for physicians to know what is going on in the legislature, including using Twitter and Instagram to get information to younger physicians. They also recommended that MSMS point to specific opportunities for physicians to engage in advocacy and provide the messages they need to share with policymakers.

Promote the value of membership and engagement (12 responses)

- They need to persuade those that are not members to join in them. The more members they have the more persuasive they will be. They are not regarded as a "must talk to" organization. The best way to grow the membership is showing value of practice transformation and the resources they have for physicians.
- It can be a little bit difficult for physicians to know how to be involved with MSMS and the AMA. It's easy to be a member; it's harder to be engaged. For the general member, I don't think they know what MSMS can make available for them. It doesn't need to be the physician union, but it's sort of a guild. People who are highly engaged in the society should facilitate membership and education to explain value of MSMS.
- They need to intervene early. Go into medical schools so physicians and med students know the importance of organized medicine. If you asked the average medical student what MSMS does, they won't have a clue. Have a prominent physician talk about what their life has been like and talk about what organized medicine is and why it's important.

Be a convener and a liaison (10 responses)

- MSMS needs to play a role with other sectors. MSMS needs to create that interaction at the higher level. Collaborate with the Michigan Chamber of Commerce and others. Consider how to interact with public health. Are we using those roles and connections to find the wins-wins? Or is it medicine versus public health. We need to find solutions together.
- Bring different groups together to work together to advance initiatives. Physicians are only one part of this. They need other partners too, like the nursing association and MHA. We need to redesign health care; it will be in our benefit to have everyone come together. Those entities need to all band together.

Support physician education (9 responses)

- Some of the resources needed for educating physicians on cost and quality of care, consulting type services, could be provided by or through MSMS. In other states, large hospital associations offer consulting support.
- Can never have enough educational opportunities for physicians to understand policy and advocate well. Specific fellowship programs for physicians to get additional training and experience to understand policy and public health. MSMS could sponsor those opportunities.
- Work with medical school deans to have these things be a part of curriculum and in front of residents

Provide a vision and platform for policy change (7 responses)

- It needs to create a vision, what it stands for, what it's trying to accomplish. It needs to lead and encourage and evangelize on the vision and needs to put in the infrastructure to assist in building it. What I hear is we're going to work on pre-authorization or balance billing and get the legislature involved. Really? The legislature in health care?
- They should be having the hard conversation about who we are as MSMS. Do we believe in value-based care or are we going to continue to support FFS? Do we lead and help design value-based care and move the industry forward or do we want to spend our money on prior authorization? They can be the true convenor of health and citizens of Michigan while protecting the interests of their profession.

Collaborate with county and specialty medical societies (5 responses)

- I think that the society needs to better engage physicians in individual communities and at the county level. The county-level system has degraded and become something else entirely. Physicians in small communities like mine need to see the benefit of joining and see that they are working for them. It is on the MSMS to support the county medical societies and have them thriving and paying dues to the state society.
- The challenge with MSMS is that as medicine becomes more specialized, physicians identify with their specialty societies that also do advocacy and education. MSMS needs to find a way to work with the other specialty societies. May need to find a way to integrate in some way.

Support public health (4 responses)

- We need to up our public health game. MSMS could provide the right body to help us engage in this conversation. We are committed to the state, so how can we reinvigorate our public health system? MSMS needs to get involved in this.

Engage in social justice (2 responses)

- Michigan needs to name racism as a public health issue. Need to have a strategic plan around equity. Need to walk the talk before you influence anyone else. Equity is not stand alone, it is a strategy on how we do all of our work and how all systems are set up.
- Advance a platform of policy change toward addressing social injustice. Disconnect between practicing providers and higher vision of where we could be. We need to effectively build communication platforms with a story that is compelling.

Appendix A: Health Care Leader Interviewees

The following health care leaders participated in interviews between January 7, 2021, and March 31, 2021.

- Kevin Anderson, MD, Family Practice of Cadillac
- Catherine Baase, MD, Michigan Health Improvement Alliance
- Norman Beauchamp, MD, Michigan State University
- Charles Bloom, DO, Health Alliance Plan
- Brooke Buckley, MD, Henry Ford Wyandotte
- Brian Calley, Small Business Association of Michigan
- Betty Chu, MD, MPH, Henry Ford Health System, MSMS Past President
- Seth Ciabotti, Michigan State University Health Team
- Jayne Courts, MD, Mercy Health Physician Partners
- Paula Cunningham, AARP
- Steven Daveluy, MD, Wayne State University Department of Dermatology
- Lisa DeStefano, DO, Michigan State University College of Osteopathic Medicine
- J. Bryan Dixon, MD, Advanced Center for Orthopedics and Plastic Surgery
- Anne Docimo, MD, United Health Care
- Claudia Finkelstein, MD, Michigan State University College of Human Medicine
- Robert Flora, MD, McLaren Health Care
- James Forshee, MD, Priority Health
- Mike Genord, MD, Health Alliance Plan
- Thomas George, MD, Kalamazoo Anesthesiology
- Peter Graham, MD, Physicians Health Plan
- Mona Hanna-Attisha, MD, Hurley Children's Clinic
- Paul Harkaway, MD, MSMS Board of Directors
- Elizabeth Hertel, Michigan Department of Health and Human Services
- Robert Jackson, MD, Western Wayne Family Physicians, PLC
- Theodore Jones, MD, MSMS Speaker of the House
- Courtland Keteyian, MD, Henry Ford Allegiance
- Joneigh Khaldun, MD, State of Michigan, Michigan Department of Health and Human Services
- Mark Komorowski, MD, Chair, MSMS Board of Directors
- Viktoria Koskenoja, MD, UP Health System–Marquette
- Warren Lanphear, MD, Emergency Care Specialists
- James Madera, MD, American Medical Association Chief Executive Officer
- Melanie Manary, MD, Northern Physicians Organization, MSMS Board of Directors
- Nathan March, DO, West Front Primary Care
- Kate Massey, Michigan Department of Health and Human Services Medical Services Administration
- Aletha Maybank, MD, American Medical Association
- Amy McKenzie, MD, Blue Cross Blue Shield of Michigan (BCBSM)
- Christopher Milback, MD, Henry Ford Macomb Hospital
- Christie Morgan, MD, Henry Ford Medical Group
- Bobby Mukkamala, MD, MSMS Past President
- Dennis Ramus, MD, Chair, The Physician Alliance, BCBSM board member, MSMS Board of Directors Ex-officio

- Michael Redinger, MD, Western Michigan University Homer Stryker M.D. School of Medicine, MSMS Board of Directors
- Sasha Savage, MD, MidMichigan Health
- Mark Schweitzer, MD, Wayne State University School of Medicine
- Charles Shanley, MD, Wayne State University—Physicians Group
- M. Salim Siddiqui, MD, Henry Ford Health System
- Mark Smith, MD, Henry Ford Allegiance
- Herb Smitherman, MD, Wayne State University, MSMS Board of Directors
- Peter Sneed, MD, Northern Physicians Organization
- Aron Sousa, MD, Michigan State University College of Human Medicine
- Remington Sprague, MD, BCBSM board member, MSMS Board of Directors Ex-officio
- Debbie Stabenow, U.S. Senator, State of Michigan
- Samuel Stanley, MD, Michigan State University
- Brian Stork, MD, Michigan Medicine–West Shore Urology, MSMS Board of Directors
- Herman Sullivan, MD, Mercy Health Physician Partners
- Karen Swanson, MD, The Physician Alliance
- Noel Upfall, DO, Total Health Care HMO
- Larry Wagenknecht, PharmD, Michigan Pharmacists Association
- Mildred Willy, MD, Central Michigan University College of Medicine, MSMS Board of Directors

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