building a value-based primary care network for population health

The experiences of one clinic in Oklahoma demonstrate how a carefully executed plan for population health management can help primary care physicians succeed in a world of value-based care.

Most primary care physicians are uncertain how their practices will be affected by the transition to value-based care. Some are even suspicious of the motivations of policymakers and insurance companies that support the trend. In some ways, they are right to be concerned, particularly if their practices are small, because the population health management strategies that make value-based care possible often require additional staff and technology that few small practices can afford.

But some healthcare providers have a different view. Many, in fact, see value-based care as an opportunity to curb the exponential growth of healthcare spending. In 2013, healthcare spending in the United States grew to $2.9 trillion and accounted for 17.4 percent of the gross domestic product (GDP), according to the Centers for Medicare & Medicaid Services (CMS). Worse, CMS projects that health care’s share of the GDP will rise to 19.6 percent by 2024.

Value-based care holds great promise for helping the United States get a grip on costs. And primary care physicians are at the heart of this effort. Under new models, such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs), primary care practices are a patient’s

front door to the healthcare network. In the future, primary care physicians and their care teams will act as patients’ coaches, working with them to develop strategies for becoming and/or staying healthy (and out of the hospital). They will help patients navigate the complex healthcare system, advising them more closely on which specialists to see and following up to ensure they are doing everything necessary to improve their health. The highest-performing networks in every market will attract more payers, employers, and patients.

Although larger practices with more resources may find it easier to implement some components of value-based care, smaller independent practices also can apply the same principles. These practices can benefit from the transition in terms of cutting waste, managing risk, and improving patients’ health outcomes by adopting PCMH best practices and affiliating with networks or innovation grants in their geographic areas to extend their reach and enhance their capabilities.

How do we get there from here? And who will pay for the additional technologies and staff that will be required to deliver these services?

For Utica Park Clinic—one of the Hillcrest Healthcare System’s 55 clinics in Northeastern Oklahoma—the journey toward building a value-based primary care network for population health management included developing the following six strategies, which helped address both concerns.

Determine Your “Why”
Every great undertaking begins with a purpose. Whether the goal is to land a human on the moon by the end of the 1960s, replace fossil fuels with alternative energy sources, or make a transition from fee-for-service to value-based care, there must be some sort of compelling and shared objective among all stakeholders.

In the case of creating a value-based primary care network for population health management there are a multitude of potential drivers, such as payment penalties and incentives associated with the physician value-physician quality reporting system (PV-PQRS), Merit-Based Incentive Payment System (MIPS), Medicare Advantage (MA) incentive programs, preparation to launch or become part of an ACO, direct contracting with self-funded employers, and many others. If one or more of these drivers is present, and it makes sense from both a financial and clinical perspective, then the healthcare organization can proceed to the next step.

There must, however, be immediate financial motivation to drive successful change. In other words, if providers don’t believe the payment model transformation is imminent and significant, and will affect money in their own pockets, they are likely to push back. Change is always uncomfortable, and the transition from fee-for-service to value-based care represents a significant cultural shift. In Utica Park’s case, leadership saw payment reform coming and took steps to ready themselves for it to maintain a strategic competitive advantage.

Utica Park was fortunate when launching its population health program to be chosen to participate in the comprehensive primary care (CPC) initiative through the Centers for Medicare and Medicaid Innovation. CPC is a four-year, multipayer initiative designed to strengthen primary care through a collaboration between CMS and several commercial and state health insurance plans.

CPC pays fixed per-member-per-month fees to participating providers. Those fees gave Utica Park the seed money and a template to build a chronic care management program. The clinic used the money to revamp workflows, add staff, and acquire population health management and patient engagement technology.

Let Leadership Drive
Whether you’re part of an integrated health system or in a single-site group practice, the pressures of making the transition will take a toll.
A leadership–driven program has two aspects: top-down leadership and horizontal leadership.

Top-down, executive leadership is fundamental for change. Executive leaders must stand firm on their commitment to move toward value-based care and population health management. They also must consistently communicate why the transformation is important to the organization’s mission and its patients, and make certain that the practices take ownership of implementing the change. This alignment of strategies for Utica Park has included revision of provider and leadership compensation, staff bonuses, and on-boarding revisions to reflect value-based goals.

Effective horizontal leadership also is critical. Moving from a provider-centric practice to a team-based care model will challenge the entire team. It is important to develop a leadership infrastructure across clinical practices to ensure support among the clinicians for a lengthy transition. To this end, Utica Park has transformed its monthly clinic meetings to reflect its new values. The meetings begin with patient satisfaction and quality reports before moving into an administrative agenda, sending the message that quality is prioritized over financial performance.

But change takes time, and if clinicians become impatient, the clinic’s transformation will be endangered. Leaders should be developed in each clinic who will echo the messages of executive leadership, participate in a positive way, and share their achievements.

**Educate Staff and Communicate the Transformation Plan**

Once the clinic staff understands the organization’s goals for value-based care, the next priority is to provide ongoing education on how to get there. Staff need to know how to maximize the potential of the electronic health record (EHR), use a risk stratification tool, and use motivational interviewing to improve patient engagement. And they must learn the nuances of hierarchical condition coding if they are to avoid missing out on revenue opportunities, such as for MA members. To help staff gain the knowledge they need, training can be provided in a variety formats, such as videos, webinars, and simple FAQs.

**Find Alignments**

Many healthcare organizations make the mistake of keeping their population health management efforts self-contained. Instead, they should look for alignments within and outside of their immediate networks that can help make the process go more smoothly.

Utica Park targeted clinical measures that were aligned with its parent organization, Hillcrest Healthcare System. Using EHR data and clinical reports from MA plans in conjunction with population health registries, staff identified underutilization of care by patients with chronic conditions and built outreach strategies around diabetes care, hypertension, hyperlipidemia, preventive care, and Medicare wellness visits, among others.

The clinic also has transitioned this outreach, which was initially manual, to an automated outreach system. This strategy has increased outpatient volumes—driving additional revenue to support the program—while addressing chronic conditions and care gap closures. Utica Park also developed a highly effective hospital readmission reduction program and saw transitional care management visits increase as readmissions penalties at Hillcrest Medical Center decreased three years in a row.

Another improvement was the creation of a previsit planning workflow in Utica Park’s practices to close gaps identified with the population health management technology, the implementation of which has improved rates of immunizations, cancer screenings, and preventive measures across the organization. This workflow has had a positive impact on downstream referrals and has improved the Healthcare Effectiveness Data and Information Set and star ratings of Utica Park’s MA plan partners, which in
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turn increased the quality incentive bonuses received.

That progress has encouraged several additional health plans to embed employees in Utica Park’s quality improvement program to assist in population health initiatives. Today, the clinic’s MA plans are among the highest growth areas for the organization.

As it has generated successes, Utica Park has used these experiences to demonstrate to self-funded employers that it can deliver high-quality care while lowering the employers’ total healthcare costs. By creating high-performing narrow networks of providers and hospitals, the organization has increased market share and improved the financial performance of the entire health system.

To boost momentum and visibility for population health management efforts, health systems should look for additional programs that offer an opportunity to fund their value-based care transition while getting staff and patients more engaged. Utica Park has embraced the new Healthy Hearts for Oklahoma program, part of a larger Agency for Healthcare Research and Quality (AHRQ) initiative, which is aimed at helping prevent heart attacks and strokes. The revenue received and lessons learned through this program will help the clinic further expand its use of population health management across other areas.

Through these and other efforts, Utica Park already has alternative revenue sources in place to continue supporting its population health management program if CMS does not continue funding for the CPC initiative. In any case, the CPC jumpstart has put Utica Park in position to evolve to an ACO and other value-based payment arrangements so the clinic won’t lose the gains it has made.

Get Patients Engaged
A well-designed value-based care transition plan will include a plan for patient engagement. The days of physicians taking a paternalistic approach are being replaced by a partnership between clinicians and patients. The more physicians can get patients actively involved in their own care, the better their chances for success—doubly important in an environment where payment is based on outcomes rather than services.

As it has developed a comprehensive population health infrastructure for its low-risk and “rising risk” patients, Utica Park also has built an embedded care coordination program to assist its highest-risk patients. The care coordination team includes registered nurses, licensed practical nurses, and medical assistants, as well as licensed master’s-level social workers and dieticians.

One of the single most glaring gaps presented by Utica Park’s EHR was the lack of effective care management templates. Care coordinators need effective tools to track and manage high-risk patients, document care time, and generate tasks and reminders. Utica Park was able to add these tools through its population health management technology. Once workflows have been refined, these tools also will allow care coordinators to use the new CMS chronic care management billing codes for Medicare fee-for-service patients ensuring the clinic is capturing all of the revenue due for care coordination efforts.

Building care plan templates, a patient education program, community resources databases, and patient shared decision-making tools enhances engagement and improves patient adherence and outcomes.

Scale the Program with Technology
Many of the tasks involved with population health management and value-based care can be accomplished with a basic EHR and a commitment from an engaged staff. But the staffing required to support a true population health strategy is far too expensive to sustain on a larger scale. So as the program expands, more comprehensive technology for managing population health will need to be added.
Automated tools for patient outreach, a patient-centric registry, and risk stratification (along with care management tools) can be used to scale the program to accommodate broad populations of patients. The software should be capable of identifying patient populations by payer group and by chronic condition or other medical designation.

How and when these tools are implemented during the journey toward value-based care depends on the funding and ongoing support within the organization. With the forward-looking vision of leadership and the understanding that new revenue would be required to fund the technology needed, Hillcrest phased in the technology from the outset.

Utica Park started with automated outreach to patients with preventive and chronic condition care gaps. The revenue from bringing in these patients who had been lost to follow-up yielded a strong ROI. This funding allowed the clinic to add tools that enabled everyone on the teams to see how Utica Park was doing on the quality measures in its contracts, stratifying patients by risk, assigning patients to care team members, and optimizing the visit management process. Each of these tools has accelerated the pace of Utica Park’s transition to value-based care because each team member has the tools to do his or her job more productively and with visibility to what other team members are doing. Each win achieved—for individual patients, for the clinic, and for the health system—has helped keep enthusiasm high during this transitional period.

Going forward, analytics are becoming available to further support population health management. The new field of cognitive analytics will help to draw data from new and previously inaccessible sources such as unstructured data (e.g., provider and care team notes and diagnostic images) as well as mobile apps and remote monitoring devices (e.g., changes in weight, blood pressure, medication adherence). Having this information could help drive a more productive 15-minute visit and intervene effectively between visits to keep patients on track.

Today, Utica Park has the basics of population health management in place but can’t proactively identify who will become the next high-risk patients. Advanced analytics should enable the clinic to move to that next level. Although clinic leadership is pleased with what has been accomplished so far, it’s clear that the clinic will be able to move the needle even further with these new capabilities.

Transitions are difficult, particularly on such a scale as the move to value-based care. But by following the steps outlined here, hospitals and health systems can replace dread with excitement and help ensure a smooth transition. More important, these steps can help organizations prepare to take advantage of what could very well be a golden age of medicine and improved health of the populations they serve.

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