Thought Leadership Series
White Paper

The Journey to Population Health and Risk
While the movement into risk-based payment models is not a necessary result of the adoption of a population health approach, it is a natural evolution once the capabilities are in place, as it is the primary way to recoup the investment needed to provide value-based care. Therefore, in this paper, I have assumed this logical progression. Also, for the purpose of this piece, I will focus primarily on the medical group environment.

The domains of change necessary for successful transition to becoming an effective provider of population-based health care can be divided into the following categories:

1. Cultural Preparation
2. Data Capability Acquisition
3. Care Model Redesign
4. Compensation Plan Changes to Reflect Value-Based Care
5. Payer Contracting Alignment

This list is not intended as a recommended timeline, as there will be (and should be) temporal overlap among many of these activities.

1. Cultural Preparation

The decision to take responsibility for the overall quality and cost of care for a population of patients is, perhaps, the most all-encompassing one any healthcare entity can make. It requires change in virtually every aspect of the organization. Whether a standalone, physician-owned practice or an employed medical group within a large integrated delivery system, the required cultural shift is enormous and should be fully understood before proceeding.

If your organization is like most, you have had all your functions geared towards a care model that is focused on volume-based payment. While delivering the best care you can, you have been urged to provide “more medicine,” and there likely have been no negative consequences for high levels of utilization, even if providers did not follow evidence-based guidelines. Once you begin to see yourself as a value-based care delivery system, your entire perspective needs to change.

Setting the vision for this level of change is the job of leadership. Explaining the “why” is essential. Your rationale should be based on the imperatives of higher quality care, affordability, and the increasing likelihood that payment models will change in the coming years. A carefully designed communications plan that includes every level of the organization is essential.
The required investments in data and expanded staffing models (as described in detail below) do not come with the usual, expected short-term financial benefits. On the contrary, you may see revenue reductions related to decreased utilization of services from the most profitable areas of the group or system. It is precisely for this reason that “selling” this new direction has to be based on more than faith—it has to be grounded in an expectation and an intention to move to value-based reimbursement. The recent announcements from the Centers for Medicare and Medicaid Services (CMS) about the clear directional shift towards value-based payments in Medicare (with a timeline) should be helpful in making the case for the transition.

2. Data Capabilities

The ability to accurately measure and report from a wide range of sources is the only way to be certain that high-quality/low-cost goals will be achieved. The data requirements for this endeavor are extensive and expensive and, for many organizations, may represent the greatest challenge to success.

Some examples of critical data tools and data points include:

A. Clinical Care
   - Common EMR with embedded clinical practice guidelines and alerts
   - Panel size measurement capability
   - Quality reporting tools across primary and specialty care
   - Registries for chronic and preventive care
   - Electronic prescribing with embedded formulary
   - Patient portal with email capabilities
   - Tools for care manager work with individual patients
   - Predictive tools to identify patients at high risk
   - Post-discharge tools to transition care and reduce readmissions
   - Reminder systems to insure proper follow-up
   - External benchmarking capabilities

B. Practice Management/Business Systems
   - Provider-specific data on utilization of high-cost care (imaging, Rx, ED visits, admissions)
   - All claims (inside and out of system) for all attributed patients
   - Cost of care data (including hospital/ASC) for bundled payment arrangements

3. Care Model Redesign

Once the clinical and financial accountability for a defined group of patients has shifted to the healthcare provider, a great number of new processes and capabilities will need to be developed. The new perspective becomes one that basically says, “No matter where the patients reside at this moment, their care and well-being is our responsibility.” It is no longer sufficient to think of the care of the patient as being completely encapsulated within the office visit transaction. Patient care must be broadened to include home, office, hospital, physical therapy, rehab, nursing home, palliative care, and hospice.
The oversight of this spectrum often falls mostly to the primary care provider (PCP) practice and requires a team approach and a very different staffing model. The non-provider-to-provider ratio often increases from the national average of about 3:1 up to 4:1 or higher and may include RN care managers, patient navigators, pharmacists, psychotherapists, social workers, and others. This team-based approach requires the PCP to learn to delegate responsibilities to others on the team so they may perform care management not requiring the physician. This allows the physician to use his/her expertise appropriately for the most complex patients.

While a formally NCQA-recognized Primary Care Medical Home is not necessary to be competent at population health, its basic functionality is and includes the following activities:

- Pre-visit chart scrub to be sure all aspects of care (prevention, acute, and chronic care) are addressed at each visit
- Registry development to isolate those with common chronic conditions so care managers are able to prioritize their efforts and address the needs of those who are least well controlled
- Rapid communication with recently discharged patients to arrange follow-up to avoid re-admissions
- Coordination of home care (in person or electronically) to perform chronic care monitoring and treatment
- Excellent access to the PCP office to avoid unnecessary use of emergency rooms

Close coordination also is needed between primary care and specialty providers, as the latter are responsible for procedures and other expensive aspects of care. This can be accomplished by intentionally organizing interdisciplinary discussions about appropriate thresholds for referrals; agreed-upon workup for common conditions; adherence to established, evidence-based guidelines; and assignment of who is responsible for long-term management of certain disease states. If maximum efficiency is to be attained, it is essential that everyone on the clinical team is working up to the top of her/his license.

4. Compensation Plan Changes

While there are a myriad of physician compensation plans in use today, the vast majority are heavily weighted towards some type of production metric. Revenue-expense and RVUs are the most common ones used. While in a fee-for-service world, this makes perfect sense, medical groups looking to be successful in pay-for-value need to begin to add value metrics into their plan. Financial rewards do affect behavior.

Most evolving plans begin with no more than 5–10% of total compensation based on value. The typical categories of these metrics include:

- Quality
- Patient Experience (satisfaction) scores
- Financial (growth) metrics
- Panel size for PCPs
- Meaningful use
- Citizenship
Two important considerations when beginning to use value metrics are:

1. Insuring the accuracy of the metrics to establish the confidence of the providers. Offering a run-up of six months of reporting before any compensation is at risk is a great way of gaining acceptance of this type of change.

2. Clarifying if the value payments are a withhold from expected total compensation based on national benchmarks, or, if affordable, are a true bonus over and above expected total comp.

Organizations that are more advanced along the population health/risk continuum will often have 20% or more of their comp in value components, and this should be the eventual goal.

5. Payer Contract Alignment

There are many ways to be reimbursed for value-based care. Some are happening outside of provider’s control already and will be accelerating. Medicare has been paying based on meaningful use and the Physician Quality Reporting System (PQRS) for a few years and announced in April 2015 that it expects to have 30% of all payments tied to value by the end of 2016 and 50% by the end of 2018. Some of this will be through the Merit-Based Incentive Payment System and some through Alternative Payment Models (ACOs, Shared Savings Plans, and bundled payments).

It is in the commercial portion of the revenue stream that medical groups may have more control over the pace of change. The movement towards pay-for-value and eventual risk can be guided by how quickly the data systems can be brought into place and how quickly the care model matures. Many groups are finding that choosing a local commercial payer partner can be the best path in this regard, as it is one way to secure accurate claims data—a critical component for success. Payers are increasingly willing to work with providers to set up a path to risk that can take three-to-five years and allows time for both parties to adjust to the new reality.

Summary

The principles behind population health make intuitive sense and should lead us to a more affordable, higher quality level of care in this country over time. The orchestration of the transformation to this new approach is daunting and requires courage, vision, and persistence. Attention to the five domains of change addressed in this article can help assure a healthy outcome for all concerned.

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