ACOs and Population Health Management

How Physician Practices Must Change to Effectively Manage Patient Populations

AMGA

American Medical Group Association

Case Study ***Part 1***

Phytel, Inc.

How Physician Practices Must Change to Effectively Manage Patient Populations

By Richard Hodach, M.D., M.PH., Ph.D.

The advent of accountable care organizations (ACOs) is creating unique opportunities for group practices, but it also presents some major challenges. The three-part series that begins with this article examines the implications of the biggest challenge for physician groups: the shift to population health management, which will require an entirely different way of looking at health care.

This article will explain what population health management is, how it changes the relationship between physicians and patients, and why it will necessitate a change in practice workflow and staff roles. Also covered is the risk profile of patient populations and the need to proactively reach out to noncompliant patients. The article concludes with a summary of current concepts in practice reengineering aimed at improving population health.

ACOs Open Door to New Financial Incentives

The Federal government is promoting ACOs to pave the way for the expected shift from a volume-based reimbursement model to one based on quality and efficiency. It is already clear that the new model will include some degree of financial responsibility—or accountability—on the part of the practice. When Medicare and some private payers begin to contract with ACOs, they will initially reward these organizations on the basis of shared savings; however, the leaders of the ACO movement are predicting there will be other reimbursement methods, including prepayment models such as partial and full capitation.[1]

Capitation, or prepayment, is a fixed monthly payment for a defined set of services for each patient assigned to the practice. Unlike volume-based reimbursement, which encourages the provision of more care, prepayment forces providers to switch their emphasis from merely treating sickness to also maintaining or improving health to prevent costly avoidable illness and unnecessary care. Payment bundling and shared savings—two other payment models for ACOs—also require the improvement of population health. So, it is clear that if physician groups aim to succeed as ACOs or ACO members, they will have to move to a population health management approach that is aligned with the new reimbursement models.

Table 1 compares today's financial incentives to future financial incentives to illustrate the importance of population health management to the ACO.

Table 1: Current State vs. Future Financial Incentives as Population Health Management Drivers

Current State: Volume-Based Reimbursement (Fee-for-Service)	Future State: Risk-Based Reimbursement (ACO/Shared Savings/ Capitation and Quality-Oriented)
Low financial accountability for cost of care	High accountability for cost of care
Defines *population* as patients who present at the doctor's office	Defines *population* as every patient in the provider organization panel, regardless of whether they present at the doctor's office
Minimal infrastructure (technology, staff, data, etc.) to manage more than the sickest/most complex patients	Must have infrastructure to manage the entire population
Culture rewards volume and operational efficiency	Culture rewards optimization of cost and quality

Practice-Based Population Health Is Essential to ACOs

Many physicians are aware of the term "population health" from medical school and associate it with public health programs or other government-sponsored programs. Focused on the total populations of a community, a state, or a country, public health programs seek to maximize preventive care at the primary, secondary, and tertiary levels.[2]

> Most physicians have not adopted prevention-oriented population health in their current model of healthcare delivery.

At the individual practice level, most physicians have not adopted prevention-oriented population health in their current model of healthcare delivery. Traditionally, physicians have been mostly involved in the treatment of acute problems; managing these problems consumes most of the patient visit, leaving little time for the physician to address preventive and chronic care needs. In an ACO practice, however, attention must shift to the management of all patients in a practice across the entire spectrum of health, from those who are well to those with the most complex conditions, including individuals at the end of life.

This will be a major transformation for providers and the healthcare systems they are associated with. Making the transition even more challenging, the Patient Protection and Affordable Care Act of 2011 will extend health insurance to an additional 32 million people and require enhanced coverage for preventive care. At the same time, the aging and growth of the U.S. population will increase the number of patients who need chronic care management.

The implications of this shift are profound when the new population health management model is compared with the traditional model, which is designed to address the needs of patients who are active seekers of care. The traditional model is not structured financially or practically to identify, engage, and proactively address the needs of less-active or disengaged members of the population, many of whom are out of compliance with recommended care. In the ACO population health model, it is the aggregate results across all patients that matter–even if some individuals are not cooperative or engaged, their results still count in the world of accountable care.

The U.S. Agency for Healthcare Research and Quality (AHRQ) recently formulated the concept of "practice-based population health" (PBPH), which refers to the responsibility of primary care groups and networks for the health of their patient populations.[3] (By extension, this could also refer to multispecialty groups and independent practice associations [IPAs] with strong primary care components.) At the level of performance measurement and quality reporting, the population to be managed under PBPH is that of an entire medical group or healthcare organization. This would also be the level at which risk-bearing ACOs would stand or fall on a financial basis. But from a clinical viewpoint, the population to be managed consists of the patients of a particular primary care doctor. This is the basis of the patient-centered medical home, the basic building block of the ACO.[4]

PBPH, by definition, must address the health needs of a total patient population. Thus, ACOs must proactively reach out, not only to patients who have visited their doctors recently, but to every individual who has a relationship with an ACO physician. Even if somebody is healthy today, he or she may be sick tomorrow—and to the extent that PBPH can either prevent or mitigate that illness, both the patient and the ACO will benefit.

Traditional disease management programs seek to address the needs of complex patients, some of whom have five or more conditions (e.g., diabetes, heart disease, obesity, hypertension, and lipidemia). These patients may be seeing different physicians and taking one or more drugs for each condition, potentially causing adverse interactions. But by just focusing on this group, which typically constitutes about 2% to 5% of a population,[5] the care team is missing the opportunity to prevent other patients from developing advanced disease. Because health status is fluid, the real challenge is managing and coordinating the care of every patient in a population across the spectrum of health.

Practice-Based Population Size and Expected Risk Profile

As a well-known 2003 RAND study showed, patients receive only 55% of recommended acute, preventive, and chronic care.[6] One reason is their lack of compliance or contact with providers. In any practice, for example, there are likely to be patients with diabetes who have not been in for a year or more, or have an A1C value > 9.0 and haven't been scheduled for the next A1C test. And it's likely that there are patients in the physician panel who are obese because of poor nutrition and lack of routine exercise; these individuals may develop diabetes unless life-style changes take place. In a PBPH framework with ACO financial and clinical performance requirements, patients who have all the precursors of high-cost/high-risk conditions will have to be identified and managed.

Based on the statistics from the most recent census, a typical practice-based population will have large numbers of patients with chronic diseases. Table 2 below estimates the numbers for certain common chronic diseases for panel sizes of 2,500 patients.[7]

Table 2: Prevalence of Common Chronic Diseases for Physician Panels of 2, 500 Patients

Chronic Conditions	Prevalence Census Data*	1 Physician 2,500 Patients	10 Physicians 25,000 Patients	100 Physicians 250,000 Patients
Hyperlipidemia	0.204	511	5,110	51,100
Hypertension	0.189	472	4,720	47,200
Depression	0.047	118	1,180	11,800
Asthma	0.073	183	1,830	18,300
Diabetes	0.058	145	1,450	14,500
Arthritis	0.152	381	3,810	38,100
Anxiety	0.112	279	2,790	27,900
Osteoporosis	0.056	140	1,400	14,000
COPD	0.052	131	1,310	13,100
CAD	0.048	120	1,200	12,000

* Prevalence data is from recent U.S. Census data. Most likely, these conditions have higher current rates, but these figures are used to illustrate the magnitude of conditions in physician groups of different sizes.

All of these conditions have established guidelines and standards of care. But as the RAND study and others have shown, there are huge gaps in care. The annual report of the National Committee on Quality Assurance (NCQA) on health plan quality has indicated improvement over the years in many areas, but the trend has leveled off recently.[8] For patients with multiple chronic conditions, the number of "care gaps" increases significantly. Overall, a PBPH practice will have thousands of care gaps to identify, manage, and close to achieve compliance across its population.

The health risks in a practice population are much greater than many physicians suppose. Validated Health Risk Assessment (HRA) instruments have been incorporated into the health benefits packages of many employers and third-party insurers, producing a lot of data demonstrating the magnitude of health risk in our populations. For instance, HealthMedia, a Johnson & Johnson company, has developed benchmark self-reported data based on more than 2 million individuals taking its HealthMedia® SUCCEED HRA over the past 10 years. Assuming that a typical panel size for a primary care physician is about 2,500 individuals, Table 3 shows the expected health care risk profile of a primary care physician's population.

Table 3: Health Risk Across the Population: Prevalence Estimates by Size of Physician Practice

Health Risk Category	Risk Prevalence (Based on self-reported HRA data of over 2 million individuals >17) Population Benchmark*	1 Physician 2,500 Patients	10 Physicians 25,000 Patients	100 Physicians 250,000 Patients
Alcohol Use	0.22	550	5,500	55,000
Injury Prevention	0.16	400	4,000	40,000
Nutrition	0.96	2,400	24,000	240,000
Physical Activity	0.48	1,200	12,000	120,000
Sexual Behavior	0.01	25	250	2,500
Skin Protection	0.34	850	8,500	85,000
Smoking	0.11	275	2,750	27,500
Stress	0.35	875	8,750	87,500
Depression Symptoms	0.12	300	3,000	30,000
Weight Management	0.64	1,600	16,000	160,000
• Overweight	0.33	825	8,250	82,500
• Obese	0.25	625	6,250	62,500
• Extremely Obese	0.06	150	1,500	15,000

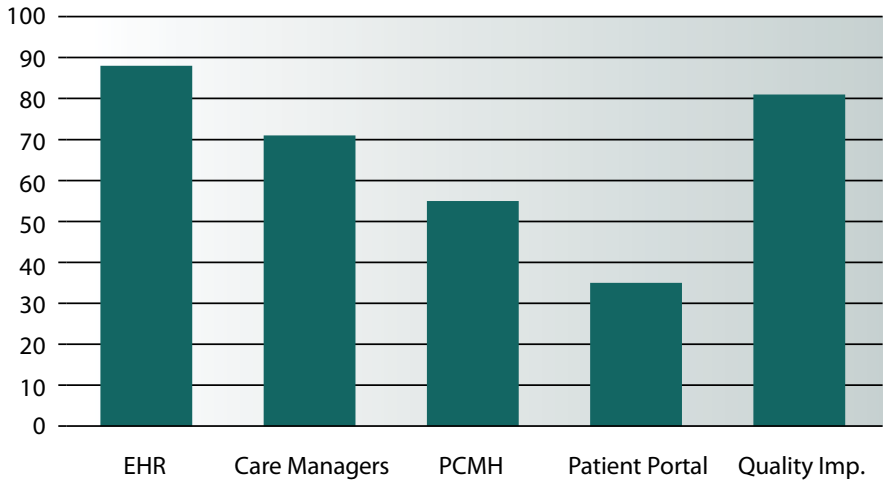
* Population benchmarks are provided by HealthMedia, Inc. The benchmarks are based on over 2 million responses to the HealthMedia® SUCCEED Health Risk Assessment for employees and health plan members over 17 years old across the HealthMedia® book of business. Data updated August 19, 2010, n=2,032,430.

Considering the implications of the data in Tables 2 and 3 in stark terms, how will a physician who has a patient panel of 2,500 patients manage the 511 people with reported high cholesterol, the 145 with reported diabetes, and the 1,600 individuals who say they are overweight or obese? By extrapolation, how will a practice of 100 physicians—perhaps configured as an ACO—manage the risks and conditions of 14,500 diabetics and 160,000 people who are overweight or obese? How will the physicians find out which of these patients are at risk for diabetes but don't know it yet? Remember that in the ACO model, these 100 physicians are collectively responsible financially and clinically for the health of all of these patients, whether or not they have presented at the office.

Gaps in Readiness for the New Model

Many group practices already have some of the tools they will need to build an ACO population health management model, as indicated in Figure 1 below. A survey of Phytel's client practices, mainly large multispecialty groups, shows that most practices have electronic health records. Many have care teams, care managers, and patient portals.[9] Some groups are participating in pay-for-performance programs or are seeking medical home certification. But even if they are doing all of these things, they probably have two crucial gaps in readiness for the ACO environment: they are not proactively reaching out to every patient in their population; and they have not yet automated their care management system to maximize the effectiveness of their care teams both inside and outside the four walls of the practice.

Figure 1: Steps to Population Health
Percent of Practices Implementing Each Initiatve



Source: Phytel Client Strategic Priorities Survey, September 2010

While EHRs are necessary and fundamental to ACOs, they are not sufficient to help group practices achieve population health and ACO goals. In a recent report, AHRQ lists some of the shortcomings of EHRs for purposes of population health management: most EHRs cannot generate population-based reports easily; cannot present alerts and reminders in such a way that providers will use them rather than turning them off; cannot capture sufficiently detailed data on preventive care; or cannot interoperate with other clinical information systems.[10]

The AHRQ report and other studies[11-12] indicate that, with few exceptions, today's practices are unsuited to doing population health management at the practice level across all patients represented by the thousands of charts and electronic records they maintain. Their workflow is organized around a visit-based model of care, and the structure and roles of their staff are designed to serve the needs of providers rather than patients. All of this will have to change if physician groups are to thrive in the era of the ACO and healthcare reform.

Reengineering the Primary Care Practice

In order to work effectively as ACOs or within ACOs, all medical practices will have to be reengineered so that physicians become leaders of high-performance care teams, take on new roles, and share responsibility for patient care with other members of the team, seeing only those patients who require physician attention. In particular, primary care practices must find a way to increase their patient capacity without sacrificing quality of care or adding more work to already overburdened physicians.[13] This will entail changes in workflow and work processes to delegate clinical responsibilities properly.

A practice dedicated to population health management and care coordination must also undergo a cultural shift. Take patient-centered care, for instance. Extended hours, open-access scheduling, and the opportunity to request refills and appointments online are indications that a practice is patient-centered. All of these initiatives will require changes in staffing, staff roles, and clinician workflow and scheduling. While outreach to patients who need preventive and chronic-care services can be partially automated, it will necessitate changes in the functions of practice schedulers. Close management and care coordination for the practice's sickest patients will require the use of care managers who may not have been part of the staff before.

Practices must begin tracking and monitoring the health status of their entire patient population.

The very concept of the care team will be difficult for some doctors to accept because they're used to thinking of themselves as the providers and the rest of the team as support staff. That attitude has to change because of all the additional functions that will be required by population health management. Medical assistants may take more of a patient's history, allowing doctors to spend extra time working with patients to fill their care gaps. Nurses may triage care-related calls directly, freeing up receptionists to spend more time on patient referrals and follow-up. And the whole staff may "huddle" each morning to discuss strategy for the day's upcoming visits.[14]

Even after a practice has reorganized around a care team, implemented an EHR, and received extra funding for care coordination, population health management may still present hurdles. As will be further discussed in Part 3, EHRs alone are often insufficient for the kind of identification, stratification, and outreach that are required. Registries and other automation tools are needed, as well. And, even with an EHR, it can be difficult and costly to achieve such basic goals as making sure that every chronic-disease patient has a comprehensive care plan and that they follow it.[15]

To summarize, group practices that want to form or join ACOs will have to start making the transition to population health management. Instead of just providing preventive and chronic care when patients come in for acute problems, practices must begin tracking and monitoring the health status of their entire patient population. Unless they do this, they cannot be accountable for the quality and cost of care. To effectively manage population health, practices must reengineer their workflow and adopt health IT automation tools that will enable them to reach out to patients who need services, and keep track of their population in the most efficient way.

References

1. Mark McClellan, Aaron N. McKethan, Julie L. Lewis, Joachim Roski, and Elliott S. Fisher. 2010. A National Strategy to Put Accountable Care in Place. *Health Affairs*, 29:(5): 982–990.

2. B.J. Turnock. 2011. *Public Health: What It Is and How It Works, 2nd ed.* Gaithersburg, MD: Aspen Publishers.

3. U.S. Agency for Healthcare Research and Quality. 2010. Practice-Based Population Health: Information Technology to Support Transformation to Proactive Primary Care.

4. Diane R. Rittenhouse, Stephen M. Shortell, and Elliott S. Fisher. 2009. Primary Care and Accountable Care—Two Essential Elements of Delivery-System Reform. *New England Journal of Medicine*, 361(24): 2301-2303.

5. David A. Dorr. 2009. Managing and Coordinating Health Care: Creating Collaborative, Proactive Systems. *The Bridge*, Winter 2009.

6. Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro, and Eve A. Kerr. 2003. The Quality of Health Care Delivered to Adults in the United States. *New England Journal of Medicine*, 348(26): 2635-2645.

7. Yarnell Ostbye, et al. 2005. Is There Time For Management of Patients With Chronic Diseases in Primary Care? *Annals of Family Medicine*, 3(3): 209-214.

8. National Committee on Quality Assurance. 2009. The State of Healthcare Quality 2009.

9. Phytel, Inc. 2010. Client Strategic Priorities Survey. September 2010.

10. AHRQ 2010. Practice-Based Population Health. Op. cit.

11. David Margolius and Thomas Bodenheimer. 2010. Transforming Primary Care: From Past Practice to Practice of the Future. *Health Affairs*, 29(5): 779-784.

12. Richard J. Baron and Emily Desnouee. 2010. The Struggle to Support Patients' Efforts to Change Their Unhealthy Behavior. *Health Affairs.* 29(5): 935-955.

13. David Margolius and Thomas Bodenheimer. 2010. Op. cit.

14. Ken Terry. 2000. Re-engineer your practice—starting today. *Medical Economics*, January 24, 2000.

15. Richard J. Baron and Emily Desnouee. 2010. Op. cit.

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