

Engaging High-Performing Health System Attributes to Deliver Value-Based Care

Acclaim Award Honoree
HealthTexas Provider Network

In September 2014, HealthTexas Provider Network (HTPN) was named an honoree of the American Medical Group Foundation's 2014 Acclaim Award for its initiative, "Engaging High-Performing Health System Attributes to Deliver Value-Based Care." HTPN was also an honoree in 2012¹ and 2011.²



Founded in 1994, HealthTexas Provider Network (HTPN), an affiliate of Baylor Scott & White, was formed as an innovative partnership between a physician group and one of the largest hospital systems in their market. At a time when many physician consolidation efforts were failing both locally and nationally, HTPN emerged as one of the premier physician-hospital alliances in the nation by aligning with a common vision: *to demonstrate excellence in the delivery of quality, cost-effective, accessible health care and customer satisfaction, which delivers value to patients, providers, payers, and the communities we serve in partnership with our hospital system.*

External and Internal Prompts for Change

Meet John, a 73-year-old male patient with multiple chronic conditions, including coronary artery disease, hypertension, diabetes, chronic obstructive pulmonary disease (COPD), renal insufficiency, and a history of lung cancer with related pain issues. He has a defibrillator in place as a result of a heart attack. This year he called 911 14 times, resulting in four inpatient admissions and three emergency department visits.

Meet Edna, a 67-year-old, healthy woman who is caregiver for her husband with Alzheimer's. One day she finds herself in the emergency room, presenting with new trouble breathing. She assumes it is stress. Diagnosed with heart failure, she is admitted to the hospital for a four-day stay. During this time she receives three new diagnoses—heart failure, hypertension, and high cholesterol—and is prescribed five new medications. After one week at home, her weight starts to increase (she still loves salt), unclear of its significance. Edna continues to minimize her symptoms, concerned that another hospitalization will mean leaving her family unattended again. Unfortunately, Edna collapses and 911 is called. She is intubated and admitted to the intensive care unit. Within days, it is determined that she will need admission to a skilled nursing facility along with her husband, who requires 24-hour care.

The patient experiences outlined above confirm that despite efforts at healthcare reform, the mitigating factors remain the same: the U.S. population is still aging, chronic disease prevention and treatment are still in the spotlight, cost of health care is still a major concern, and patients like John and Edna are increasingly making up a significant portion of patient panels. There is no skirting the fact that health care in this nation remains in crisis. The quality of care is not what it should be. Patients commonly receive too little care, too much care, or the wrong care. In many communities,

these quality and cost problems are associated with care being delivered in the framework of non-integrated physicians and hospitals operating in silos.

HTPN realizes that an opportunity exists for physicians and hospitals to work together in order to successfully meet these current challenges and is motivated to create a care system that is more integrated, coordinated, and accountable—one that delivers the right care at the right place at the right time.

IOM Aims Integration

In 1999, HTPN embarked on a journey to improve care delivery for its patients using the Institute of Medicine's (IOM) six aims for improvement (safe, effective, patient-centered, timely, efficient, and equitable) as its guide. It aligned with the IOM aims and rearranged the six characteristics into an acronym that it trademarked as STEEEP™, which stands for Safe, Timely, Effective, Efficient, Equitable, and Patient-centered care. STEEEP is woven into HTPN's corporate culture, consistently introduced in new employee orientations, taught in process improvement classes, and presented at its Leadership Development Institute. In addition, both the President and Chief Administrative Officer (CAO) of HTPN serve on the STEEEP Governance Council formed by the group's hospital system, assisting in oversight, setting strategy and direction, prioritizing initiatives, and operationalizing functions that fall within the six domains of STEEEP.

HTPN's Best Care Committee (BCC) oversees the clinical implementation of STEEEP objectives across the organization and its network of care sites. The BCC is chaired by a physician leader and consists of patients, executive stakeholders, and physicians from various care sites within the network. It strives to improve the quality of patient care by monitoring the development and implementation of quality improvement projects.

AMGA High-Performing Health System Goals Integration

Over the past two years, HTPN has engaged in implementing population health strategies, prompting its hospital system, physicians, and other stakeholders throughout the care continuum to collaboratively and accountably engage in patient-centric models of care to deliver "right care at the right place at the right time and at the right cost." Committing to a population health strategy required HTPN leaders to define what population health meant for the organization, prioritize key strategies, and create an investment plan that could build the necessary infrastructure to support it. It also meant empowering staff at all levels and then



HealthTexas Provider Network team accepting the 2014 Honoree Acclaim Award (from left to right): David Winter, M.D., M.Sc., MACP, President and Chief Clinical Officer; Cindy DeCoursin, M.H.A., Chief Operations Officer; and Michael Massey, M.D., Medical Officer

linking organizational goals to achieve population health management. To further confirm its dedication to the Triple Aim framework, HTPN finalized a substantial investment in data analytics, continued the expansion of its care coordination department, and further enhanced its patient-centered medical home initiatives within its care sites.

In addition, HTPN and Baylor Scott & White have joined together to form Quality Alliance, an accountable care organization bringing physicians, hospitals, and other organizations together with the aim of delivering value-based care to patients and the community in a collaborative manner.

Critical components to the success of HTPN's journey to becoming a high-performing healthcare system have been:

- A thoroughness in ensuring patient satisfaction
- The network-wide installment of an electronic health record (EHR)
- The redesign of its primary care sites to support a patient-centered medical home (PCMH) model
- A solid history for monitoring adult preventive health services and chronic disease management
- The formation of a population health infrastructure providing a strong capacity for care management and clinical integration

The recalibration of HTPN's organizational infrastructure to include patient-centered medical homes, care coordination, and a suite of data analytic solutions serves as the basis of its population health strategies and the development of new models of care focused

on clinical integration and accountability. With substantial investments in PCMH, care coordination, and data analytics, HTPN has built the population health infrastructure deemed necessary for successful clinical integration and care delivery focused on predictive, preventive, and personalized care (Figure 1).

Changes and Challenges

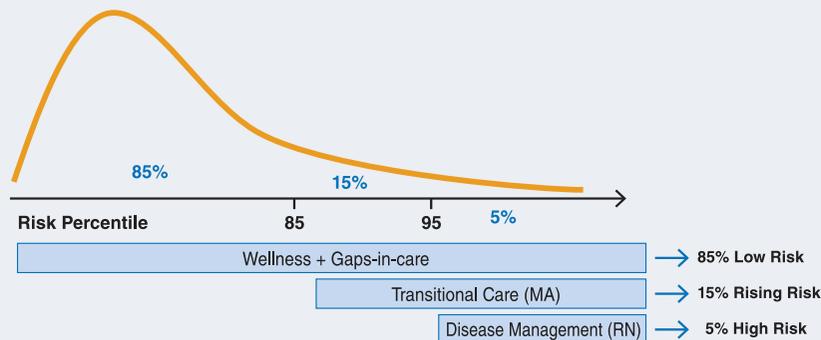
A significant component of effectively and successfully coordinating care for HTPN's patients is to track where its patients are at any given point across the continuum. With this in mind, coordinating in-network referrals between primary care physicians and specialists is receiving increased attention. However, because the medical group is a collaborative organization built on trust and open communication, it feels it cannot mandate that its physicians refer to each other. To overcome this challenge, HTPN has focused on making the process easier. Over the past several years, HTPN has put processes in place to streamline in-network referrals, establishing a centralized referral coordinator department, enhancing EHR functionality to include drop-down lists of all specialists, and publishing a standards agreement between primary and specialty care physicians outlining referral expectations.

Before the 2013 merger of Baylor Health Care System and Scott & White Healthcare, HTPN was not associated with a health plan, creating a claims data visibility challenge. It also did not have the analytics to make the data actionable. Three things have changed the scope of this challenge:

- HTPN entered into several managed care agreements giving it insight into claims data.

FIGURE 1
Risk Stratification

Allocating Care Models in Accordance to Risk



- Physicians are now part of the preferred physician network for its hospital system's employee health plan, allowing insight into commercial claims data.
- It made a substantial investment in a suite of data analytics tools, giving it a longitudinal view of individual patients and patient populations and allowing for functionality that includes automated patient identification, workflow analysis, risk-stratification, and predictive modeling.

The new challenge is extracting the right data and making it not only readable, but actionable. The last thing HTPN wants to do is overwhelm its physicians with data that they cannot understand and/or cannot take action on. To overcome this challenge, a number of physician champions, administrators, and hired statisticians are currently being trained in four data analytic solutions: Optum One, Crimson Real Time, Explorys, and Crimson Care Management. The data is showing strong evidence of and confirming HTPN's capacity for effectively managing the health of patient populations as observed by a downward bend of the healthcare cost curve for many of its cohorts.

HTPN also is creating a new compensation model based on performance and rewarding value-based care, a challenge in a fee-for-service market. A compensation redesign plan was recently approved by senior leadership. Targeting the primary care physicians to start, the redesign is the beginning step for promoting a more holistic, corporate-wide view of financial performance that reinforces physician performance based on delivering value-based care.

Population-based care requires staff and resources

beyond what individual physicians do. These challenges often include planning and implementing care for groups, working with patients outside of the office visit, and monitoring effectiveness. Resolving some of these challenges has led to critical changes that include:

- Refocusing its recruitment plan to include goals for deploying quality advanced practitioners within care sites to support the team-approach and provide the care necessary for managing patient populations
- Establishing a new, physician-led committee to study and implement work-flow redesign efforts at the primary care level
- Continuing to invest in its care coordination department focused on promoting wellness, closing care gaps, and assisting physicians in the health management of high-risk patients using a single plan of care

Measuring Success

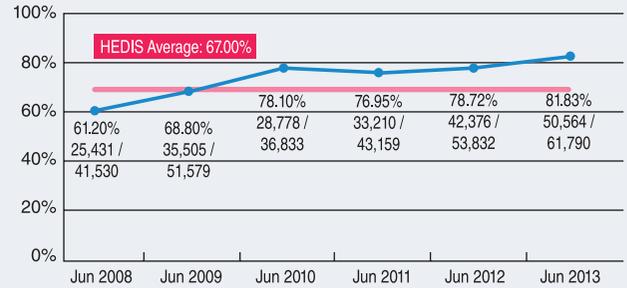
To monitor performance, HTPN conducts a series of active audits which include patient satisfaction, patient safety, clinical quality, preventative health services, chronic disease management, emergency department (ED) visits, inpatient admissions, and readmission rates. The data from these surveys and audits allow HTPN to track successes, identify care gaps, and develop initiatives that lead to improvement. All results are made transparent at individual care sites and posted on the intranet site in the form of improvement reports, as well as a physician dashboard allowing physicians, administrators, and support staff to conveniently view performance results online or in the office. In addition, HTPN captures data and sets benchmarks for its

FIGURE 2
Adult Preventive Health Service Improvement

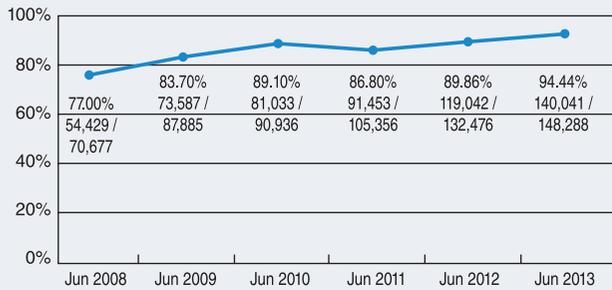
Blood Pressure



Mammogram



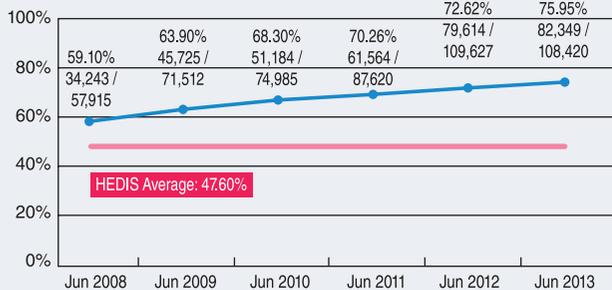
Cholesterol



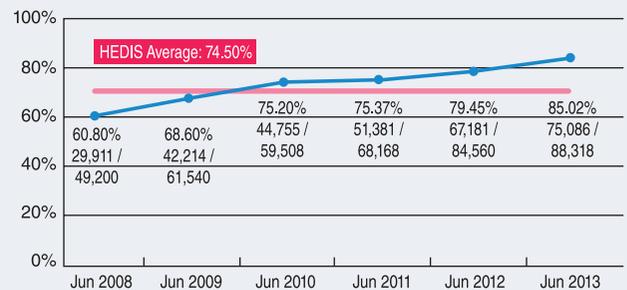
Osteoporosis



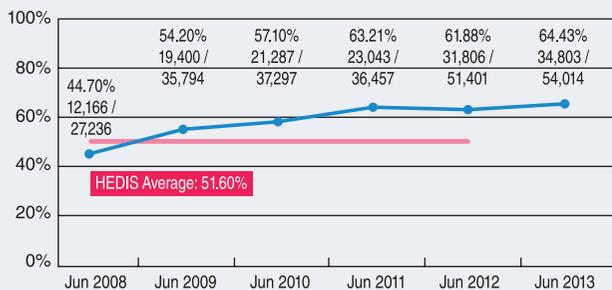
Colon Cancer Screening



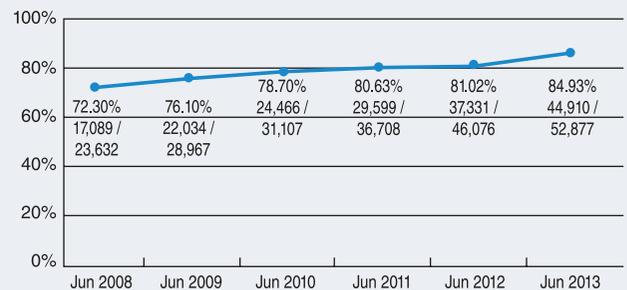
Pap Smear



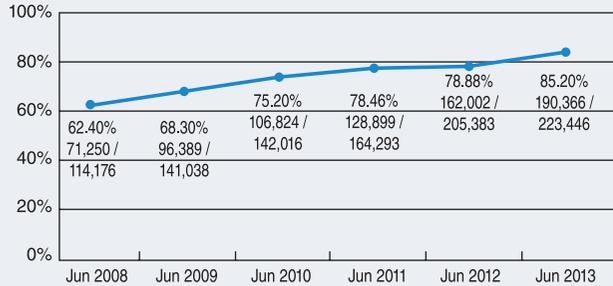
Flu Vaccine



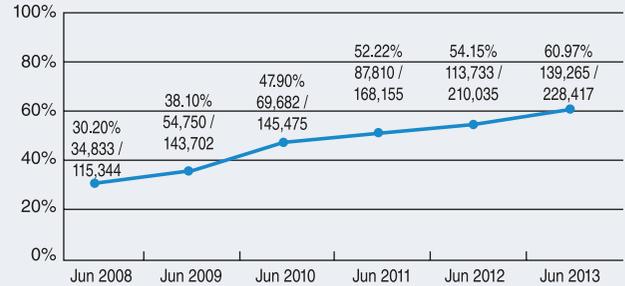
Pneumococcal Vaccine



Td Booster



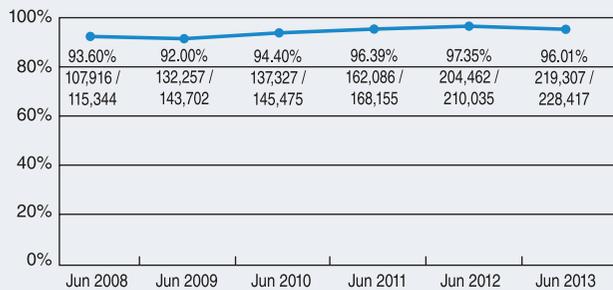
APS Bundle



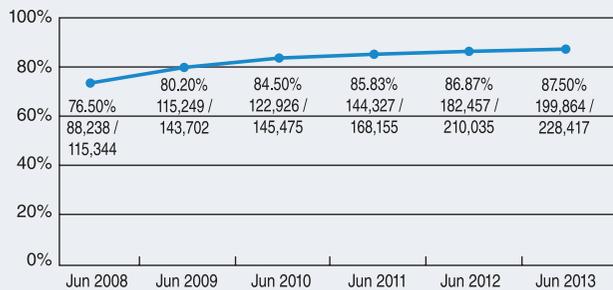
Tobacco Counseling



Tobacco Use



APS POA



initiatives and consistently measures itself against both internal and industry standards.

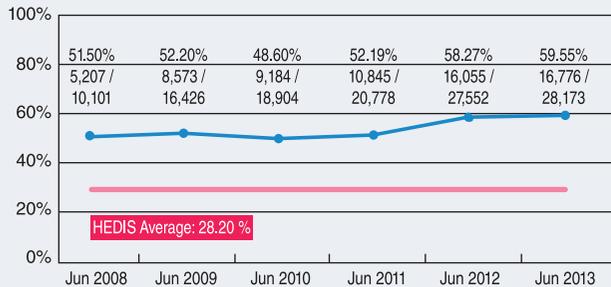
Continuing to Learn, Innovate, and Spread Best Practices

Their most innovative work today is centered on population health management specifically related to care coordination and risk-stratification. The genesis of HTPN's population health strategies focused on establishing a care management infrastructure, prioritizing collaborative care initiatives (working with patients, payers, and employers to enhance care and reduce costs) and analytics.

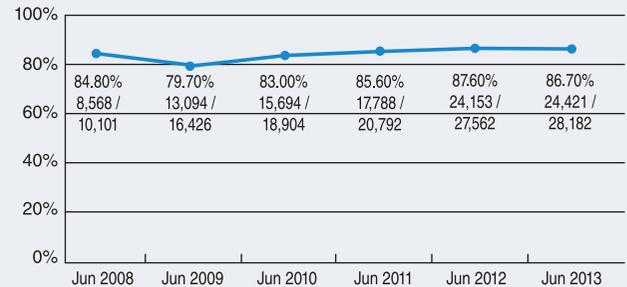
HTPN has learned that to get the best performance from its care management infrastructure, it needed to focus its attention on rising-risk patients and stop its migration to high-risk. Sophisticated risk stratification models allow the group to identify patients by risk and allocate the appropriate level of care management, minimizing or altogether preventing an occurrence before it happens. Patients in the greatest 5% (high-risk) are enrolled in complex disease management, medication reconciliation, and transitional care protocols through a RN Care Manager. The next highest 15% (rising-risk) of patients are enrolled in a patient-centered medical home utilizing transitional care services and gaps-in-care protocols through a MA Health Coordinator. The lowest risk (85%) are offered wellness and gaps-in-care services (Figure 1).

FIGURE 3
Diabetes Improvement

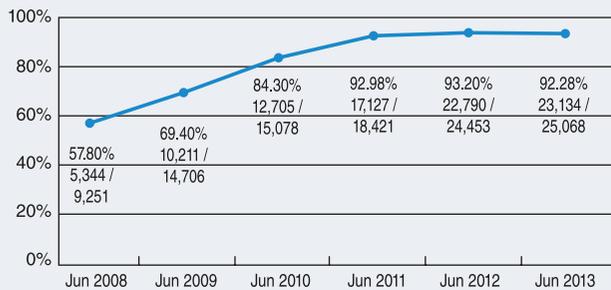
A1C



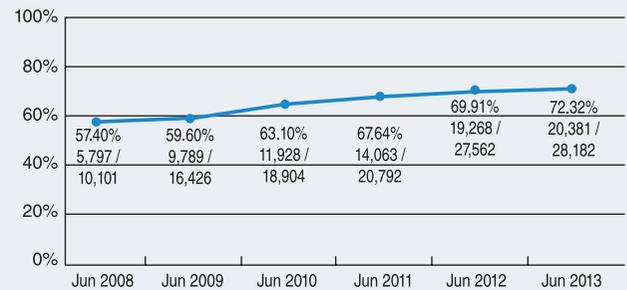
Tobacco Use



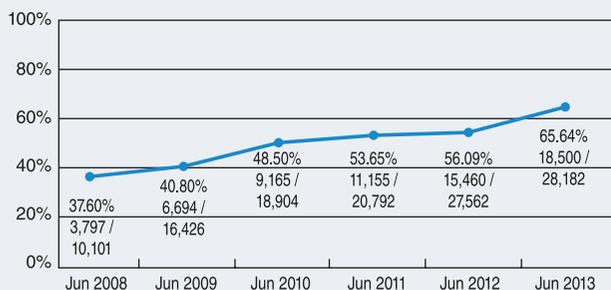
Aspirin



Diabetes POA



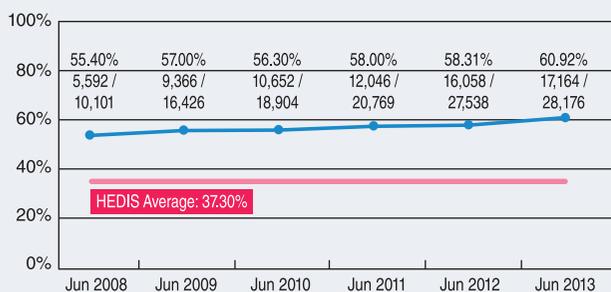
Blood Pressure



Diabetes Bundle



LDL

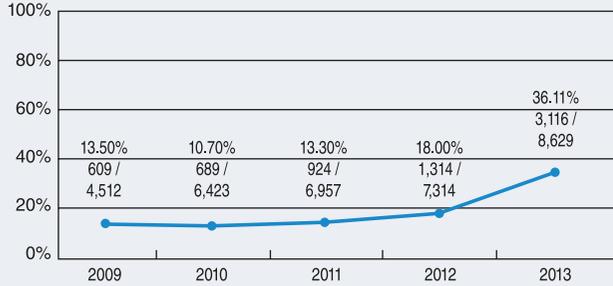


Spreading the "Good Ideas"

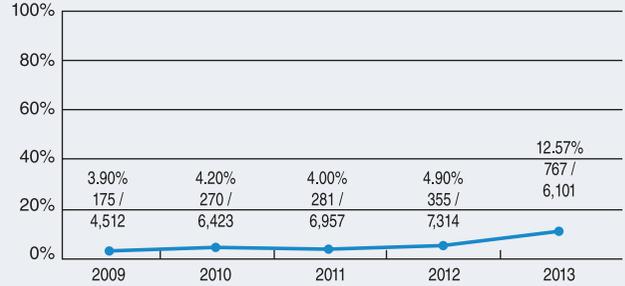
HTPN has a well-woven process for spreading best practices throughout the organization, both administratively through the operations team and clinically through the committee structure of leadership teams, physician champions, and a clinical improvement department. The medical group's operations team is the primary facilitator of strategic and operational objectives at the care site level. Reporting to the Chief Operating Officer is an experienced legion of operations vice presidents, directors, administrators, and managers, all working diligently with physician committees and on-site staff to provide the proper training and resources to

FIGURE 4
Asthma Improvement

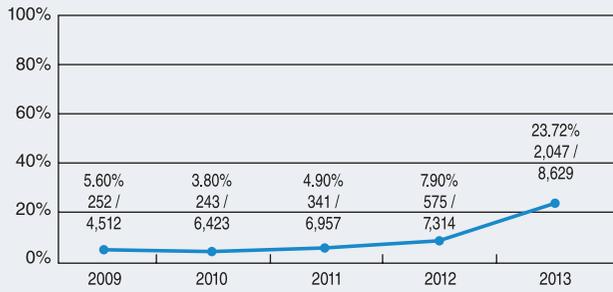
Symptom Assessment



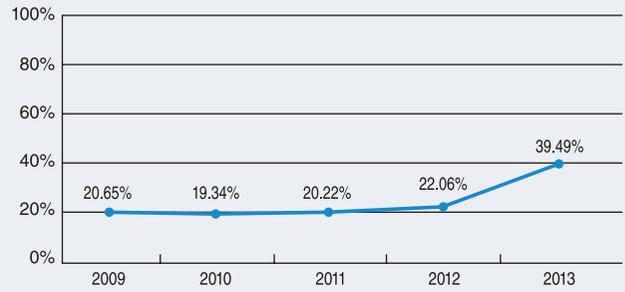
Spirometry



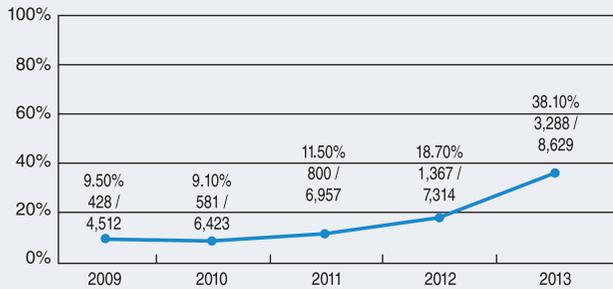
Action/Management Plan



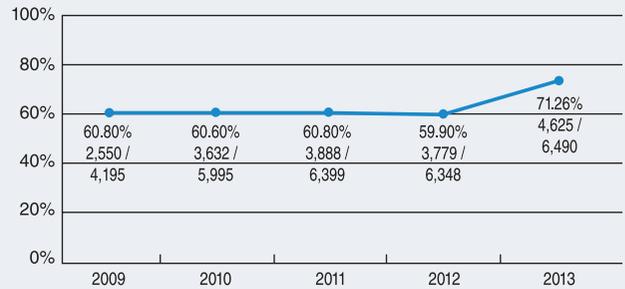
POA



Severity Assessment



Controller Therapy



effectively manage the spread of best practices across the network.

Results for Improving Population Health

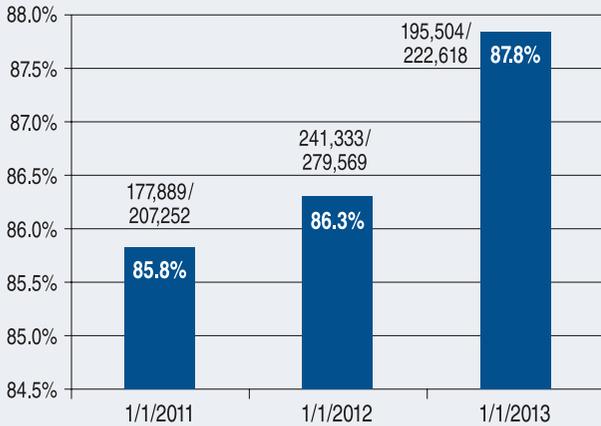
HTPN has been improving the lives of patient populations since the launch of Adult Preventative Health Services (APHS) in 2000 and the Disease Management program in 2006. Year after year, the group has significantly surpassed national Healthcare Effectiveness Data Information System (HEDIS) measures for both the Adult Preventative Health Services and Disease Management programs, as seen in Figures 2, 3, and 4.

From a former study conducted on their APHS and Disease Management initiatives, in the first five years of

launching their program, HTPN has prevented:

- 400 cases of cancer, including 150 cancer deaths
- 1,600 cases of coronary heart disease, including 325 sudden cardiac deaths
- 4,000 cases of influenza and pneumonia, including 110 hospital admissions
- 300 fractures due to osteoporosis
- 48 deaths from breast cancer
- 125 deaths from cervical cancer
- 224 deaths from colon cancer
- 222 deaths related to hypertension

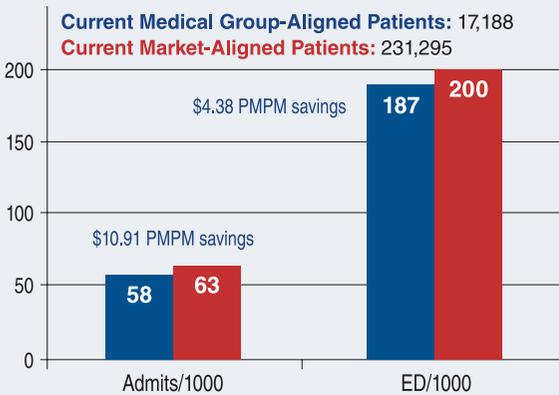
FIGURE 5
Percent of Hypertension Patients in Control



BP < 140/90 less than 60 years old or < 150/90 60 and older

■ % of patients in control

FIGURE 6
2013 Reductions in Admits and ED Utilization for Cigna Population



Risk Score:
HTPN 1.62 (vs. 1.37 for market) indicating HTPN's patient population is sicker

Quality Success Rate:
HTPN 80.0% overall (vs. 77.7% for market) indicating HTPN's quality is better

Total Medical Cost: \$7.39

■ HTPN
■ Market

- 489 deaths related to hyperlipidemia
- 190 deaths from tobacco use
- 110 hospital admissions due to pneumonia
- 130 hospital admissions related to influenza
- 1,030 hospital admissions related to osteoporosis

Extrapolation has predicted that 1,500+ lives will be saved over the following five years and that this will increase further thereafter.

Three specific protocols/metrics highlighted below have contributed to significant cost savings to HTPN's patients, payers, and the hospital system.

- **Low-Back Pain:** The medical group developed a low-back pain protocol. After just four months of physicians utilizing this protocol, they observed an increase in appropriate use of MRI lumbar spine from 37.4% to 79.8%.
- **Hypertension:** Hypertension is a major contributor to cardiovascular disease and stroke. Adopting the Measure Up/Pressure Down® campaign guidelines coupled with the development of a hypertension protocol (based on a modification to the Kaiser Permanente algorithm), HTPN has reached an average 86.6% of patients within high blood pressure control over the past three years (Figure 5).
- **Generic Prescribing:** Participating in the Blue Cross Blue Shield (BCBS) generic prescribing program, HTPN has contributed to generic drug cost savings. Participation in this program resulted in an increased generic prescribing rate for BCBS patients from 62% to 77.3%, saving them approximately \$1 million on prescription costs.

Healthcare Cost Reductions

Utilizing key tools for population health management has resulted in a reduction in ED utilization and inpatient admission costs totaling almost \$2 million over two years for HTPN's Cigna population. FY13 marked a \$7.39 per member per month (PMPM) improvement over market, while managing a patient population risk score of 1.62 vs. market score of 1.37 (Figure 6).

Measuring Patient Experience

In FY13, Press Ganey results show that the medical group ranked in the 91st percentile for both Likelihood to Recommend Practice and Standard Care Provider among the nation's 873 practice groups, which include 12,160 individual practice sites and 43,331 providers.

In addition, HTPN completed its second year of Service Pay-for-Performance with an impressive 99.5% of eligible physicians meeting the benchmarks set at a mean score of 90 for two metrics: Likelihood to Recommend Practice and Standard Care Provider.

Lessons Learned

The greatest lesson HTPN has learned throughout its healthcare transformation journey is that small changes throughout an organization can add up to real results in improving care. Steps to improvement do not always have to be monumental to make a difference.

- **Put your patients first.** HTPN's philosophy to do right by patients and do it well has always been its guide when developing initiatives.
- **Encourage and empower employees at all levels.** Help them to identify and implement techniques to improve healthcare quality. Give them the training and the tools they need to be successful. Reward them.
- **Teamwork and communication are crucial.** The committee structure allows for leaders, physicians, patients, administrators, and staff to all come together as a team, work collaboratively on initiatives, and develop a true sense of partnership and trust. The committee structure is also instrumental in the dissemination of information throughout the care site network.
- **Measure results.** Track progress and performance through evidence-based research/tools. Make results transparent throughout the organization, share information, and learn from each other.
- **Use Data Analytics.** Data reporting only tells half the story. You need data analytics to build the full patient story. Data analytics identifies the "why" behind the "what" and helps you to learn "how" to make things work.
- **Engage technology.** Information technology continues to astound HTPN with the boundless opportunities it offers to improve communication, patient experience, and process automation.
- **Coordinate Care.** Integrate advanced practitio-

ners, health coaches, and referral coordinators in your care team. This team-approach to care increases efficiency, streamlines practice workflow, and retains your patients in their medical home.

- **Partner with Payers/Employers.** Partnering can improve care coordination for targeted patient populations across all care settings. HTPN accomplishes the same population health goals as accountable care organizations (ACOs) and is an excellent example of how health plans and physicians can work together to achieve a healthy, productive workforce and create an ideal healthcare system.
- **Track Referrals.** Industry experts agree that a strong referral network improves the patient experience and promotes quality, timely access, safety, and patient-centered care. In-network referrals can also lead to financial benefits and a source of new patient volume for both the medical group and physicians.
- **Stay ahead of the competition.** Retailers such as Walgreens, CVS, and Walmart are successfully entering the healthcare market to provide for the simple, acute care needs of our patients at their convenience. As a means for achieving their access strategy, HTPN finalized an agreement with Walgreens. HTPN physicians will oversee nurse practitioners in new Walgreens clinics located throughout the area, offering quality, affordable, convenient services with a focus on acute illness, wellness, and prevention.

References

1. Transforming Healthcare Delivery Through Patient-Centered, Value-Based, Quality Care: 2012 Acclaim Honoree Health-Texas Provider Network. *Group Practice Journal*, 62(9): 10-21. Available at <http://www.amga.org/wcm/PI/Acclaim/2012/healthTX.pdf>.
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Adapted from the HealthTexas Provider Network Acclaim Award Application submitted by Jean Sullivan, marketing manager.