Building a population HEALTH strategy that physicians LOVE

Healthcare as an industry is under enormous pressure to change. U.S. per capita healthcare spending is more than twice the average of other developed countries. Commercial and government payers increasingly are partnering with providers to build value-based care reimbursement models as a solution to this crisis, following the direction and targets set by the Centers for Medicare & Medicaid Services (CMS) to enroll 70% of Medicare beneficiaries in a value-based program.

These network contracts represent a key shift in thinking from volume to value, but they require much deeper collaboration between administrators and physicians. Ensuring mutual trust and success under value-based arrangements has never been more important.

Successful value-based programs require a deeper focus on population health and care management. Caring for the patient as a whole works best when data is shared freely among all stakeholders: payers, administrators and every provider involved.

The ultimate goal is to create a new patient-centered culture and organizationwide initiatives that transform care through better management of high-risk and rising-risk patients, while also optimizing health system performance as defined by the Triple Aim.

Providers, of course, must be central players supporting this transformation. The angst of all leaders who are held accountable for population health success is the process of getting physicians on board and eager to be active participants amid the growing prevalence of burnout due to increasing administrative and reporting requirements.

Physician success under a population health program is highly dependent upon communication, coordination and resource sharing.

Physicians champion the value revolution

While financial incentives provide motivation for a shift to value-based care, helping physicians understand the benefits to their work lives and patient care that come from more meaningful and focused interactions requires changing their perspective. Some doctors may struggle to see the value of new payment models amid pressure to do more with less, but savvy leaders will create an infrastructure and strategy that ensures their success and creates champions for population health management.

Physicians will be drawn to a plan that transcends traditional cost reduction to focus on long-term outcomes — specifically, a strategy that appeals to their hope for a healthier community. The following three-step strategy implemented at several large-scale networks summarizes a multiyear approach to engage physicians in the shift to value.

1. Introduce (and reintroduce) population health and analytics over the first six months.

A value-based care initiative must be incorporated into the existing organizational governance and information technology (IT) infrastructure, where leaders create a strong sense of team identity and vision. Leaders should reinforce the long-term benefits of population health management, its goals and the power of data to inform change.

Aggregation of data across the patient’s entire healthcare experience is a critical foundational step to enable fully informed decision-making. Physicians must be able to see what care has been delivered outside the network (tests, procedures, specialty providers); through home care; and through long-term care services, prescription fulfillment activities, and so on to manage outcomes reliably.

For physicians, this is a period of self-learning, self-evaluation and self-realization as they appraise the effects of care provided across the entire patient experience based upon health outcomes. Successful models design a framework to enable physician achievement of three specific goals:
• Have visibility into their specific patient care patterns and resource utilization trends.
• Understand the overall health of the network’s patient population and identify high-risk, high-cost members and associated care gaps.
• Make more informed, evidenced-based decisions for each identified patient’s care.

2. Attain practice transformation at the six-month mark and beyond.

At the six-month mark, administrators can use early successes to refine benchmarks and use risk-stratified peer comparisons to drive further performance improvements. Practices that embrace the interdisciplinary team approach then can track the effectiveness in managing outreach activities, conducting social assessments and addressing needs, providing education, coordinating access to community health resources and identifying the need for a physician office visit to avert an acute episode — especially for the practice’s sickest patients. Providers who resist such change early in the process may be driven to participate in the program by their competitive nature to meet or exceed quality metrics, their desire to offload nonessential tasks or the improved patient experience.

At a time when physicians are overwhelmed, practice leaders can empower providers with easy access to data, tools, strategies, guidance and resources to meet target population health goals. Teach them about the value of relevant data and help them become comfortable with analytics.

Physician success under a population health program is highly dependent upon communication, coordination and resource sharing. Value-based program leaders can use the data to identify patients who need more focused care and offer each physician advice that is relevant to their practice. For example, provide a primary care physician with compliance rates for flu shots and a list of patients who they should see more often based on risk stratification, while talking to an orthopedic surgeon about inpatient versus outpatient procedure volume and infection rates. Present them with small, manageable steps to move in the right direction and summarized, action-oriented information.

Continue the evolutionary process by revisiting physician performance at an agreed-upon frequency and reflecting on successes. Progressively expand the focus to other improvement activities and management of specific chronic disease conditions by exploring barriers to care and gathering physician ideas to address them.

Motivational methods inspiring physicians to act and stay the course

To motivate physicians to engage in any shared pursuit of health reform, start with the same steps common to building organizational consensus. At the onset of, and throughout your population health journey, these methods can help inspire physician buy-in:

• Host monthly or quarterly meetings to communicate the organization’s strategic objectives and review protocols and clinical utilization.
• Compensate physicians for their time and engagement throughout the first six to 12 months. Consider paying a stipend to every physician who attends the meetings and an additional incentive if they are able to reach a short-term goal, such as comprehending analytics education. Did their quality care measures increase and why? Can they demonstrate use of an interpretive dashboard or flowchart? This simple strategy can have a substantial effect on provider engagement and their efforts to improve their patient panel’s compliance with metrics.
• Select specific patient populations or quality measures for initial focus to drive early wins and buy-in, and then grow the program incrementally. Present data snapshots over time to demonstrate changing patterns and results (or lack thereof).
• Empower physicians with detailed data on individual and organizational performance. Present each physician with his or her key clinical quality metrics, and collaborate on strategies and panel-specific tasks to improve performance.
• Encourage providers to provide regular feedback on what is working and what is needed to improve performance.

By staying focused on data sharing and milestone achievement, physician buy-in will continue to grow.
Building an interdisciplinary team to support population health

Comprehensive, integrated data serves as a foundation for re-engineering and workflow redesign efforts. Administrators and early physician adopters partner with data experts to identify quality measure gaps, as well as the high-risk and rising-risk patient populations across the organization. Armed with relevant data analysis, practices can develop strategies to tackle overarching value-based care goals such as the following:

- Reduce avoidable and expensive encounters for targeted chronically ill patient populations.
- Address Medicare or Medicaid beneficiaries’ social and behavioral barriers to improve long-term health outcomes.
- Schedule wellness exams and preventive screenings to avoid or reduce the impact of disease.

3. Compare data benchmarks year over year and continually refine processes

Into the second and third years of population health management, physicians are accustomed to reviewing data benchmarks and results derived from effective care intervention strategies regularly. They equate care and costs from the perspective of both the patient and practice. At this juncture, physicians become comfortable with continuous improvement processes to refine population health strategies and services based on evolving disease management needs. They also are open to new opportunities to improve care and are strong advocates of reducing variability and spending.

To sustain momentum, administrators can expand focus beyond initial chronic care management targets to other disease-based activity or social determinants of health categories. As the program evolves, so too will the strategies to resolve healthcare barriers and perhaps the need to hire additional clinical staff to further offload nonphysician activities. By staying focused on data sharing and milestone achievement, physician buy-in will continue to grow. Eventually, providers will begin to ask their own questions of the data and bring other improvement opportunities to light, such as collectively determining referral patterns based on surgical rates, outcomes and costs across providers.

Provided with the right knowledge and know-how, physicians are indispensable allies in leading value-based care reform. Contact Ann Marie Edwards at aedwards@alliancecancer.com. Contact Sanjay Seth at sanjay.seth@healthec.com.

Population health management for specialty groups: Lessons learned at Alliance Cancer Specialists

For small-sized specialty care practice networks embracing an accountable care organization (ACO) model, the path to value-based care can sometimes lead outside their domain. This was the case for Alliance Cancer Specialists, the largest community oncology group practice in southeastern Pennsylvania with 21 oncologists in 11 locations. Alliance credits the CMS Oncology Care Model (OCM) as its chief impetus in moving toward value-based care.

An established physician network focused on a singular episodic condition, Alliance’s transition to value meant understanding patient treatment and conditions outside its oncology domain. The specialty network needed more information to manage cost and quality holistically, including care provided outside of the practice for comorbidities, chronic conditions and emergencies.

Alliance worked to integrate claims and pharmacy fulfillment data with the information in its EHR to improve understanding of population risk and identify patients who may have adverse consequences based on comorbid conditions. For example, a breast cancer patient with congestive heart failure taking multiple vasoactive medications may be flagged for more intensive case management to avoid dehydration and an emergency department visit post-chemotherapy.

To secure successful physician buy-in for value-based care initiatives, Alliance empowered providers with data that encompassed a patient’s entire healthcare experience collected from within and outside their network, including social determinants of health. Leaders initiated meaningful discussions with physicians emphasizing the benefits of evaluating patient care from a holistic point of view.

Alliance also strove to reshape oncologists’ perceptions and increase their comfort with the use of data to drive care and decision-making. Alliance is using its population data in conversations with commercial payers to negotiate contracts, being empowered by its ability to compare care utilization with other providers in their payers’ network. Above all, Alliance considers itself a more-informed advocate for its physician members.

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