Payer/Provider Partnerships Enable Value-Based Reimbursement

by Jay Sultan

Historically there have been huge challenges between payers and providers trusting one another and sharing valuable financial and clinical information. These have been caused by incentives of the “zero-sum, I win you lose” contracting reality of the fee-for-service world and technology barriers created by the almost exclusive use of claims and encounters as an information exchange medium. However, value-based reimbursement methodologies, such as bundled payments and shared savings, are taking a firm hold on the managed care, commercial and government markets. New types of partnerships must evolve between health plans and providers for these initiatives to work and deliver on the “increased quality with lower costs” promise.

Value-based reimbursement (VBR) describes new methods of delivering and paying for healthcare that reimburse for the value of services, not just volume. While people criticize the waste, poor quality and perverse incentives laden in our fee-for-service world, the reality is that the current system works exactly as designed—only rewarding volume. VBR, or payment reform, changes how providers are paid, making them accountable for the value of services delivered and sometimes transferring a portion of the financial risk held by payers to providers.

The word “partnership” has been abused in describing past and present payer/provider relationships, but it is the right word and concept as the industry proceeds with VBR. A new partnership dynamic is necessary for any type of VBR methodology or new care delivery model to be successful.

Accountable Care Organizations (ACOs) can’t be established with the expectation that they will generate savings and improve the health of their membership without changes to the way payers interact with providers.

Transitioning Physicians to a Performance-Based Compensation Model

by Phyllis Floyd, M.D.

A recent scorecard from the Catalyst for Payment Reform, a national organization which tracks the transition from volume to value based-payments, indicates that in 2014, 40% of all commercial in-network payments are now value oriented—up from 11% in 2013.1 As a result, physician compensation models that are still primarily volume-based must quickly migrate to performance-based plans that reward the “triple aim” of improved population health, better patient engagement and lower per capita cost.

This is no easy task. To help health systems navigate the complex road to a new physician compensation plan and better align employed physicians with system strategies, hospital systems should consider this six-step process to transition compensation plans successfully to valued-based models:

1. Begin by creating a physician compensation committee.

Typically, this committee includes physician executives whose compensation is not affected by the medical group’s compensation plan, such as the chief medical officer who is salaried as a system executive, a human resources executive, a senior member of the legal department and the director of physician compensation. If the latter is not a current position in the organization, the director or vice president of compensation and benefits could serve on the committee. This group will evaluate the physician compensation market, review options and then approve the physician compensation plans and policies.

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Making a Case for Population Health

A Selected Case Study in Population Health Management...

Achieving ‘Breakthrough’ Outcomes in Hypertension

Program Objectives:

1. Achieve optimal blood pressure per Joint National Committee-7 (JNC-7) for >90% of all patients with hypertension.
2. Use a process for hypertension to introduce formal Six Sigma, a well-recognized quality methodology, and Lean quality processes to a physician-owned medical group and achieve acceptance.
3. Change the culture of the medical group from individual-oriented to process-oriented.
4. Establish a process model for the group to address additional chronic diseases and other quality and cost objectives.

The Population Health Challenge

In 2000, approximately 30% of hypertension patients had achieved blood pressures ≤139/89, a minimal level of blood pressure control. At that same time, JNC-7 blood pressure goals were at ≤129/79 for patients with diabetes and/or renal disease so the national achievement of the JNC-7 goals was <30%.

Since then much attention has been given to improve blood pressure outcomes, including the American Medical Group Association’s (AMGA) Measure Up/Pressure Down campaign and the Centers for Disease Control and Prevention’s (CDC) Million Hearts campaign, both presently underway. In 2014, CDC reported that fewer than 50% of patients with hypertension achieved target BP outcomes at ≤139/89. The Integrated Healthcare Association published data showing that blood pressure control in diabetics across all medical groups in California except Kaiser Permanente was 44% in 2013. For the other major chronic disease outcomes, such as LDL and HbA1c, the best groups in the nation generally showed less than 60% success in achieving the evidence-based, national standards for each measure.

For the minority of medical groups that have actually undertaken formal programs to improve chronic outcomes, almost all use one or more of the following four components:

1. Reminders for physicians that can be in the form of communications, electronic health record “pop-ups,” registry systems and other means.
2. Publishing comparative data within the group and, in some instances, external to the group. Data can be published “blinded” or “un-blinded” based upon whether or not provider names are revealed to all viewers.
3. Hiring additional staff. Many groups have started to hire care and case managers, health coaches, educators, additional pharmacists and various other staff.
4. Linking outcomes to physician compensation. The percentage of medical groups that have done this is unknown but thought to be smaller than the other three interventions described above.

Data reported from a variety of states demonstrate that even for groups deploying three or all four of the above described methods, rates of success terminate at between 55% and 70% per measure, and the majority of groups fall well below 60% success per measure. The AMGA has set a goal of 80% of patients at their blood pressure goal, and the CDC is encouraging >70% success. PriMed considers success >80% of patients for any one measure, including BP, lipids and A1c, to be a “breakthrough” accomplishment.

Program Description

In 2004 PriMed Physicians, a physician-owned and led, multi-specialty group serving the Greater Dayton Ohio region, embarked on a major transformation to lead the nation in medical outcomes. PriMed wanted to shift its payer reimbursement from 100% volume-based to some combination of quality scores, total cost of care and patient satisfaction. The group also wanted to be able to grow market share based upon superior quality.

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A multi-year plan was adopted. Because at the outset, there was no value component in PriMed’s payer contracts, the group’s leaders elected to focus first on improving chronic disease outcomes. That decision was based in part on research showing that chronic diseases drove 75% of all medical costs. Improved chronic outcomes were linked to reducing co-morbidities and the total cost of care.

Aware that the group would see some compensation for improvement efforts from conducting additional visits—as required to achieve better outcomes—Primed chose to invest money in the development of its process for hypertension. Other improvement options required changes in payer contracts that carriers were not prepared to offer at the start of PriMed's quality and cost endeavors.

PriMed partnered with an external organization, MediSync, medical management consultants based in Cincinnati, to provide all management, back office operations (i.e. billing, accounting, human resources) and IT infrastructure. MediSync agreed to train Primed’s management team as “black belts” in Six Sigma. The group chose hypertension as the first chronic disease to address and identified physicians to join a hypertension task force. MediSync provided the quality improvement, analytics and operation management staff to create a hypertension process.

From the outset, the process quality leader decided that it was essential to develop a true quality method guiding physicians as they went in and out of a treatment room. The emphasis on “process” was based on the knowledge that in all other industries and economic sectors, all high-performing organizations use process as the key element of their quality and cost improvements.

Additionally, PriMed’s team noted that all major quality methods, such as Six Sigma, Lean, Total Quality Management and Continuous Quality Improvement, have the concept of quality process as their foundation. If PriMed had not decided to adopt process at its core, that would defy both the theory and practice of quality science.

The concept of quality methodologies and process was essential to PriMed’s future plans for improvement and for achieving its strategic goals. If a quality process methodology had not gained acceptance by physicians, the entire quality and cost strategy would have failed. From the start, the group planned to apply the hypertension process template to other major chronic diseases, such as asthma, diabetes and congestive heart failure.

At the beginning, many physicians attributed the failure to reach standard hypertension measures to patient non-compliance with treatment. Using the Six Sigma analytic device called an Ishikawa, or “fishbone diagram,” which visually displays the potential cause and effect of a certain problem, the task force assembled a detailed list of all the ways that hypertension treatment could possibly go wrong. There were a surprisingly large number of ways to achieve sub-optimal outcomes.

Once the task force created a prioritized list of causal reasons for treatment failure, it produced a first draft of a hypertension process to improve the most critical areas of failure. The process required that every time patients with a history of high blood pressure visited their primary care physicians or cardiologists, their hypertension was assessed. Whenever a patient’s blood pressure was not at goal, the hypertension process also recommended the use of impedance cardiography (ICG), a technique of using sensors to detect the properties of the blood flow in the thorax. ICG results were translated to preferred drug choices for the physician’s consideration. In addition, if blood pressure was not at goal, follow-up care was required within 30 days at the physician’s discretion.

Evaluation Process

At the start of its hypertension process development, PriMed Physicians was using paper medical records. The group quickly discovered that physicians needed very rapid feedback about both the degree of process participation and outcomes. PriMed began a manual process to audit 50 randomized patient records per physician per month and capture hypertension data reflecting both process compliance and clinical outcomes. These results were published unblinded every month. Once a patient had the diagnosis of hypertension, the record was eligible for audit whether or not the patient presented for management of hypertension. Eventually the group adopted an EHR, and the data collection process was expanded to all patients with the condition.

Further Six Sigma statistical evaluations were performed and demonstrated that use of the process and ICG technology contributed significantly to better outcomes.

Results

For the twelve months concluding Sept. 30, 2014, PriMed had a 90.6% success rate in achieving blood pressures ≤139/89 in a population of 12,473 patients diagnosed with hypertension. The percentage of PriMed’s adult patient population diagnosed with the condition is 41.9%, slightly higher than the national average. During some measurement periods, PriMed’s success rate has been as high as 93%.

PriMed has its expanded disease management processes to include diabetes, lipids, osteoporosis and asthma and is currently working on a process for congestive heart failure. Outcomes for the other disease states are at or above the best published outcomes in the nation.
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Lessons Learned

- Using quality theory and tools and following processes result in better outcomes. Conversely, not using quality methods and tools reduces success rates by 20% or more.
- It is difficult, but possible to help a large group of physicians adopt process as a core operating principle.
- A very good process can outperform even the most intelligent and dedicated physician.
- Processes are also critical in other aspects of group management, including improvements in financial performance and market share, reducing medical costs.

4. Ibid.

Bob Matthews is currently president/CEO of MediSync and vice president of quality for PriMed Physicians. He formerly served as quality leader of PriMed's hypertension process team, as well as for the teams targeting diabetes, lipids and asthma, and as executive director of PriMed. For information, contact Bob at bobmatthews@medisync.com.

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To assure physician input in the design, a second committee is needed—the Physician Compensation Advisory Committee—comprised of physician leaders from the medical group. This second group advises the Physician Compensation Committee and not only provides valuable input into the design, but its members become the physician compensation “experts” in the medical group to help with communication and adoption of the new model. Both committees should start with education sessions on physician compensation market data, regulatory issues related to achieving fair market value and the options in physician compensation models.

2. Move to a flexible compensation plan.

Once the two compensation committees have been formed and both educated on the market data, their first item of business is to inventory the current plan models and the resulting compensation and then compare the results to the market. The Physician Compensation Committee will need to research compensation model options and decide how to best move the employed physician group to a more consistent plan that is fair, equitable (especially inside a specialty), aligned with system goals and easy to administer.

In view of current changes in provider payment reimbursement, the new compensation plan will need to be capable of evolving over time. The physician compensation plan should parallel payer reimbursement changes by having the physicians paid increasingly on clinical outcomes and efficiencies in care as productivity is “de-emphasized.” Flexibility to increase the percentage of incentive and other non-productivity dollars as payer reimbursement moves to more value-based payments is essential to achieving physician-system alignment and must be part of the new plan. For systems that are not yet involved in value-based contracting, adding a pay-for-performance incentive plan is still a good way to start the transformation.


As primary care physicians move to a team-based, coordinated care model with patient-centered medical homes and medical neighborhoods,2, 3 the need to eliminate productivity-based compensation models is most acute. The compensation model for primary care physicians should promote “teaming” and outcomes, not independence and volume. To achieve good outcomes, primary care physicians will need to work proactively with the patient and specialists to coordinate care and provide improved value for patients. The compensation plan for a primary care physician needs to strongly support these changes.

To promote this focus on coordinated team care and chronic disease management, compensation plans for primary care physicians should include: (1) a guaranteed salary based on years of experience; (2) incentives for access, clinical quality, service quality, efficiency, productivity and citizenship; and (3) a panel management fee.

4. Take advantage of metrics already available.

There are numerous Health Care Effectiveness Data and Information Set (HEDIS) and Physician Quality Reporting System (PQRS) metrics that are currently defined and benchmarked that can be applied as early incentive metrics for the clinical and service quality components of the incentive portion of a plan. The panel management fee compensates a primary care physician for the additional time spent working with the care team to provide evidenced-based, coordinated care for the more severely ill patients, as well as assuring that all appropriate preventative care measures (immunizations, well visits, cancer screening) are completed for all patients in the physician’s panel. As the medical group and health system move to increased value-based and fixed payment reimbursement, this new reimbursement model will most likely be based on the population size and severity of disease.

It still makes sense to have a portion of the physician’s incentive based on productivity or panel size to encourage a primary care physician’s alignment with a health system’s financial and market share goals. However, the main focus of primary care physician compensation must reward excellent patient access to high-quality care at the lowest reasonable cost. As systems become more adept at measuring patient-centered outcomes, the incentives will need to move from the more typical process metrics now dominating HEDIS and other commonly used quality metrics to those measuring outcomes that matter to patients.

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Transitioning Physicians to a Performance-Based Compensation Model... continued from page 4

Although metrics and data for incentives are typically more robust for primary care physicians, specialty incentives should be quick to follow. With a recent movement in Patient Centered Specialty Practice (PCSP), there is an opportunity to develop compensation incentives related to referral management and coordination of care or even PCSP certification. Specialty divisions should work with the Physician Compensation Committee to develop specialty-specific quality, cost and service metrics.

5. Maintain continuous communication and an open feedback loop.

It is important to communicate and involve employed physicians in the changes required of their practices by healthcare reform and the changes in payer reimbursement. Their input and willingness to change clinical care models will help in crossing the “crevasse” from volume to value.

Communication can take the form of large “town hall” educational lectures by experts in the field or small practice meetings that allow more questions. Hospital administrators should be transparent with their employed physicians about the multiple pressures that are decreasing revenue streams and the new world of measurement that is driving the need to focus on improvements in quality outcomes and efficiencies of care, which in turn require a change in the compensation model.

6. Consistently move to more performance-based compensation.

As the medical group or health system begins to increase the percentage of value-based contracting, the game changes and there will be more emphasis on the cost savings and quality metrics that should be strategically linked to the payer contracts, as well as to the health system quality and safety goals. When the value-based reimbursement grows to 25-30%, the percentage of the physician’s compensation plan based on performance-based incentives also needs to increase proportionately.

When the group moves to a position where the majority of revenue (> 50%) is from value-based contracts or full capitation, the physician compensation is best managed with a base salary model depending on the physician’s experience and specialty and a performance-based incentive plan that is 30-40% of the overall compensation. This incentive can include a portion based on productivity (to ensure the volume of patients in the medical group is adequate and growing), and the remainder should be based on numerous quality outcomes and efficiency metrics that are aligned with the system’s strategy.

By this time, the group will have the processes in place to report the quality, efficiency and productivity data to the physicians in a timely and accurate manner. With the improved communication plan, the employed physicians should be well versed in the strategy and goals of the health system and comfortable with the culture of measurement and transparency.

Below is a graphic representation of the changes in the compensation plan as value-based reimbursement increases:

The goal of the physician compensation plan is to encourage and support a transformation of the care model that leads to improved health of the patient population and outstanding organizational performance in a value-based environment. The challenges of paying for outcomes instead of volume are many, but a deliberate, steady and evolving approach will allow an employed medical group to transition to a compensation plan that is aligned with value-based reimbursement from payers and supports the strategic goals of the organization. This change in physician compensation culture must start now.

1 “The National Scorecard and Compendium on Payment Reform.” Catalyst for Payment Reform. 2014.

Phyllis Floyd, M.D., is a principal, BDC Advisors, LLC, in Albuquerque, N.M. She can be reached at Phyllis.Floyd@bdcadvisors.com.
Lessons Learned from Consumerism: New Approaches, Opportunities for Healthcare Payers

by Yasmine Winkler

In recent years, there has been an incredible transformation in the healthcare industry, especially in the role of consumers. A decade ago, health plans worked with employers to manage almost all health benefit decisions, leaving consumers relatively unaware of the costs associated with their healthcare needs.

Today, employers and consumers are more frequently choosing plans with higher deductibles; more than 15.5 million Americans are enrolled in such plans. \(^1\) That has encouraged consumers to become more aware of their healthcare costs, as they now have a greater, more direct financial obligation for their care.

This rise of consumerism in healthcare has presented unique opportunities and challenges for health plans. As a result, more effectively engaging with consumers has become a high priority for health plans to remain competitive and maintain customer satisfaction.

Three Areas of Focus to Address Health Care Consumerism

To meet these new challenges, health plans and industry stakeholders should focus on three key aspects of healthcare consumerism: education, administrative and financial. The healthcare industry has made significant progress toward improving the educational and administrative resources available to consumers, especially through new programs, websites and even gaming. To improve the financial side, organizations need to think beyond traditional industry standards and collaborate with healthcare providers and new partners to improve how consumers manage and pay their medical bills.

Educational Aspects

To help improve the decision-making process, consumers need educational materials and resources to help them make more informed decisions around when and where to access care. Through online directories and mobile apps, consumers can now more easily select high-value care providers. Some of these initiatives use national standards to evaluate care providers for quality and local market benchmarks for cost efficiency, including family practice, internal medicine, pediatrics and cardiology.

Health plans are also taking steps with care providers to better engage consumers, including the creation of patient-centered medical homes and accountable care organizations that link care provider reimbursement to quality and efficiency measures. This collaboration puts the patient at the center of the healthcare experience, providing resources and support to help prevent disease and better manage chronic conditions. Already hundreds of billions of dollars in reimbursements to hospitals, physicians and ancillary care providers are paid through contracts that link a portion of the reimbursement to quality and cost efficiency. These reimbursement structures will become more common as additional care providers join the transition to accountable care contracts that reward quality and value-based healthcare.

Worksite wellness programs are another way to help improve the health of consumers and reduce medical costs. The Wellness Council of America states that workplace wellness programs are a wise investment to help address rising healthcare costs and improve employees' health and well-being.

New technologies, such as pedometers and other wearable devices, are making it easier and more interactive for employees to participate in these wellness programs and take charge of their health. For instance, some companies have created voluntary walking challenges and provided free pedometers, as well as enabling employees with Fitbits or other wearable devices to sync their steps to an online platform that allow wireless tracking of daily steps.

The adoption of wearable devices is part of the growing use of corporate wellness incentives, which have doubled in value to $594 per employee since 2009. \(^2\) By providing employees wearable devices and other resources, employers are able to encourage more active and healthier lifestyles and track the actual activity levels of program participants.

Administrative Issues

Many health plans offer member portals to help meet consumers' administrative needs by providing access to personally relevant plan, benefit and network information. These resources also offer information to help health plan participants understand how their benefits are applied to their claims with simple, consumer-friendly explanations of healthcare and insurance terms. Some health plans are even using game play and game mechanics to help engage consumers, helping them to better understand and use their health benefits.

In addition, there are various mobile applications, including Health4Me for iPhone and Android devices, that put crucial health and plan information and decision support at consumers' fingertips, including the ability to comparison shop for healthcare services based on both quality and cost. A recent UnitedHealthcare study \(^3\) showed that price transparency services, which can include quality information in addition to cost estimates, enabled people to more frequently select quality healthcare providers across all specialties, including primary care physicians (7% more likely) and orthopedists (9% more likely).

Industry stakeholders should also take note of the ongoing collaboration between several large health plans and the Health Care Cost Institute, which is developing an online tool that will provide consumers with transparent and comprehensive information about the price and quality of healthcare services. The information will be available not only to consumers, but also to purchasers, regulators and payers in an accessible, comparable and easy-to-use format. Providing healthcare prices could reduce U.S. health care spending by more than $100 billion during the next decade, \(^4\) according to a 2014 report by the Gary and Mary West Health Policy Center.

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It is important to note that there are significant price variations for healthcare services and procedures at hospitals and doctors’ offices nationwide, even though there is little or no corresponding improvement in health outcomes for services performed by higher priced care providers. For example, the total cost for childbirth, including prenatal and postnatal care, at hospitals in the New York City area range from $10,021 to $31,982. For back surgery, specifically lumbar fusion, the cost ranges from $50,617 to $65,154 at area healthcare facilities in San Francisco. Other cities show similarly widespread variation by procedure.

Financial Side

Improving resources that help consumers understand their health benefits is another crucial step, especially to help address questions about claims, explanation of benefits (EOBs), deductibles and more. Although consumers can view benefit and claim information through member portals and mobile apps, health plans can do more to make it easier for consumers to understand, manage and pay their healthcare bills. New systems are enabling consumers to clearly identify their claim and financial obligations, as well as pay their medical bills with their credit card, debit card, health savings account or bank account. These services add convenience for consumers while helping healthcare providers get paid more quickly.

Online bill-payment services are becoming increasingly important as consumers continue paying a larger percentage of their medical bills. Currently, only about two-thirds of physician practices accept credit cards so these services fill an important need for both consumers and healthcare providers by offering an efficient, alternative payment system.

These are just several examples of how the healthcare industry is changing, with more efforts to come to simplify the healthcare system and engage consumers. By making it easier for consumers to understand and navigate the healthcare system, and enabling people to more easily handle their healthcare financial obligations, health plans and other industry stakeholders are helping to improve and modernize the nation’s healthcare system.

1 “January 2013 Census Shows 15.5 Million People Covered by Health Savings Account/High Deductible Health Plans (HSA/HDHPs).” America’s Health Insurance Plans. June 2013.
5 UnitedHealthcare internal review of myHealthcare Cost Estimator data.
6 Ibid.

Yasmine Winkler serves as chief product and innovation officer for UnitedHealthcare. She can be reached at yasmine_winkler@uhc.com.

Payer/Provider Partnerships Enable Value-Based Reimbursement… continued from page 1

Payers cannot simply contract for VBR; they must enable it through changes in how information and knowledge are shared, which requires breaking administrative, IT and legal barriers within a payer organization.

Getting There

Collaborative innovation among partners is essential to ensuring new care models successfully result from changes to payment methodology. Establishing trust and transparency, while it may seem rudimentary, is probably the greatest challenge in a partnership. A major area of trust and transparency is data sharing prior to a contract. This is critical because each party needs to have information from the other to help make the decision to enter into an agreement and potentially share risk. In particular, providers must understand the complete and actual costs of the patients they are agreeing to manage and are often unaware of the flaws that exist in their own data.

Only a payer knows two vital elements:

- The full longitudinal care the patient receives, including care outside of the provider organization’s data footprint. Identifying the provider who is rendering care needs to be included as much as possible, especially if that provider is not part of the partner’s organization. Having knowledge of visits to urgent care, the emergency room and uncoordinated self-referrals to specialists offer some of the greatest opportunities for improvement.
- The actual cost of the historical care, measured in “allowed amount.” Billed amounts are not useful and never the unit used in the execution of a VBR agreement. Even if providers have all the relevant claim data, it is almost impossible for them to match their incoming payments to their outgoing claims in a way that allows them to measure actual payer cost.

Most payers are aware of the specific legal considerations and IT challenges associated with sharing data in this way. In addition to legal and IT barriers, it requires a great deal of trust by the provider to offer this type of transparency. Outside of the partnership, in the fee-for-service world, a payer will be at a great disadvantage when negotiating with a provider that has received these data. So if payers think they can be successful forever operating in a fee-for-service world, they might not be willing to share such data. But the willingness to offer this level of transparency is a significant way a payer can establish trust with a provider. In addition, providers no longer want reports only from payers, but the raw data that they can manipulate themselves.

A second major area of trust and transparency is the role of the payer in monitoring and sharing the progress (financial and quality) of the provider during the execution of the VBR contract.

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Payer/Provider Partnerships Enable Value-Based Reimbursement… continued from page 7

During the term of the agreement, and with the right level of transparency, a payer will continuously monitor providers’ performance and share this information with them in ways they can comprehend and apply.

Dashboards showing cost and utilization, current attribution, the use of key performance indicators and interim quality results are all extremely valuable to a provider and necessary for success.

This type of ongoing transparency is vital to assist the financial management of the provider under risk; however, alone, it is not sufficient. A provider also needs clinical data and derived knowledge to enable its clinical interventions, care management and other proactive changes.

While provider systems, such as electronic medical records (EMRs) and decision support systems, are useful here, a provider is still hampered by a lack of longitudinal data. Providers do not know what they do not know.

This is one reason why it makes financial sense for payers to provide health information exchange and population health management capabilities to providers. These will not only enable claims data to be shared, but also make it possible for payers to accept clinical transactions from provider systems. With this technology, providers can have a complete view of all care being delivered to the attributed patients, along with knowledge (analytics) to help them identify risk, stratify the population and identify opportunities to intervene, especially in care transitions. In addition, clinical transparency offered by a provider can assist payers in medical policy and plan-based care management.

Change workflows and administrative processes to be successful under new VBR models.

Partnerships do not exist in a vacuum. Most providers partner with other payers, as well as with the government, and leaving the core IT capabilities unaffected, can help achieve this goal. Core claim systems and EMR systems are difficult to change rapidly and are poorly suited to support innovation.

Finally, consider the age of the data being shared. If it takes months for data to flow in and out of a warehouse and into a provider’s view, it has far less value for a partnership. While true real time is unnecessary, getting data in “near time” (days, maybe a week) from the event occurring is the most useful so that providers have the opportunity to react to a case in progress.

Common themes reported by successful programs include:

- While an agreement might be with a hospital, integrated delivery network or a practice lead, it is the front line physicians who must change their behavior to be successful. Most physicians are still rewarded for volume, even if their parent organization has contracted for value. Frequent and accurate communication with physicians and having physician champions are essential.
- Understand and plan for the administrative changes within a payer organization that result from VBR. Outside the new requirements discussed above, there is often significant impact to the payer’s existing workflows and capabilities. For example, if a shared savings arrangement is successful and a large bonus check is written, how can they be allocated back to self-funded employers whose patients benefited? How can bonus payments be reflected in medical spend, underwriting and finance operations if that check is not created out of the claim system? How should benefit design, clinical edits and pre-authorization be changed given the goals of the VBR program?
- Partnerships do not exist in a vacuum. Most providers partner with other payers, as well as with the government, and they want similar, yet different things in VBR. Consider how to foster a community approach to VBR by creating or supporting multi-stakeholder programs and agreeing upon common use of quality data.

Assessing Readiness

These changes and partnerships require collaboration and time. Administrative challenges will also arise. Before embarking on this initiative, payer and provider organizations should decide if they are prepared to:

- Understand and measure the risk a provider organization is accepting in quantitative terms.
- Start quickly and small, with a low cost of experimentation, yet able to scale quickly around success.
- Enable provider-based care management to identify and proactively intervene on high-risk patients to reduce the cost and acuity of their condition.
- Share data between payers and providers and among providers.
- Support care transitions and longitudinal views of all care.
- Provide knowledge that providers can use to intervene.
- Measure progress quantitatively while the program is in operation.
- Support a rapid cycle of intervention and measurement.
- Change workflows and administrative processes to be successful under new VBR models.

Jay Sultan serves as strategy consultant at Edifecs, Inc. based in Bellevue, Wash. He can be reached at jay.sultan@edifecs.com.
Thought Leaders’ Corner

Each month, Population Health News asks a panel of industry experts to discuss a topic suggested by a subscriber. To suggest a topic, write to MLEdlin@comcast.net. Here’s this month’s question:

Q. What Do You Foresee as the Most Important Trend in Population Health Management for 2015?

One of the most important trends this coming year will be an increased focus on outcomes and pay-for-success approaches to funding. The goal is not “to address suicide prevention,” as one community described its goal, but to prevent suicides.

We at HICCup are looking to find investors for pay-for-success projects in our five Way to Wellville communities but more importantly, we’re working with communities to make their programs investable. So much of population health is focused on doing things rather than the impact of those activities. Communities need to define crisply who is doing the intervention, how they do it, what the outcomes are—and also the financial implications. What will it cost? What will it save down the road? How can you structure a contract that will direct some of those later savings into the preceding intervention? (Big data helps us predict the costs so that we can calculate the savings.)

Thinking like a financier rather than a community servant is a challenge for people who have devoted their lives to public service, but it’s an increasingly necessary skill—both to deliver those services more effectively and to find funding for them. With luck, that will lead to yet another trend in 2016: more effective programs!

Esther Dyson
Founder
HICCup/WaytoWellville
N.Y., N.Y.

Population management delivery models will continue to advance. They will better integrate improved analytics with the human components that drive specific patient success for the top 3% to 10% of patients and will have the ability to leverage the power of automation to deliver broader outreach in a time- and cost-efficient fashion for the entire population.

New reimbursement models place increasing financial gain and risk directly on those for whom the patient is attributed. Meaningful and accurate prospective outreach is absolutely necessary if we are to impact the long-term medical cost increase, slow disease progression and reduce chronic condition prevalence rates, which have and will improve overall outcomes. In addition, better use of financial and human resources is required to ensure that the processes and technologies are in place to enable clinical teams to proactively manage populations.

Real world success or failure for accountable care organizations (ACOs) and physician-driven care management lies in the ability to:

- Better understand and stratify the entire patient population.
- Deliver personalized care plans in a consistent and efficient fashion across payers.
- Engage patients, understand their behaviors between visits and develop their sense of patient commitment.
- Collaborate with the entire care team.
- Meet payer quality metrics and achieve meaningful reductions in trend.
- Careful and deliberately manage patients though their transitions in care.

In 2015, successful organizations will continue to improve analytics and how information is consumed, which will enable more efficient delivery models for proactively managing populations.

Joseph M. Taylor CEBS, RHU, HIA
Vice President/ACO Practice Leader
FluidEdge Consulting
Malverne, Pa.
Over the next few years, population health systems and electronic medical record/electronic health record (EMR/EHR) systems will become less disjointed. Many of the population health functions are migrating into the EMR as core functions. Population health systems will differentiate by pulling data from more and more data sources to provide a level of meaningful use that isolated electronic medical record (EMR) data cannot. EMR systems integrate data because they are told to, but rarely use that data because day-to-day EMR functions don’t really need it.

On the other hand, because they are not EMRs, population health systems can make greater use of this data integration. The data are analytically based, and analytics improve with more and more source data, as well as with more and more reference data.

Population health systems will become more specific and targeted. This will follow the same trend that pharmaceuticals are taking in terms of becoming less generic and more individualized to a patient’s combination of conditions. Comorbidities are one of the hardest things to deal with, and many of the recommendations from these systems ignore them; however, adding in sophisticated rule engines is one way to allow these systems to effectively manage comorbidities. Allowing an EMR’s care plan of computerized physician order entry to interface to leverage a sophisticated rule engine will bring the value of a population health system to the forefront. Rule engines will drive population health systems as patient-centered care becomes mainstream, and the technology to achieve coordinated care becomes mainstream.

It is also time that the evidence-based standards, such as those from the National Quality Forum, expand exponentially and get released in a standardized, vendor-neutral form that would operate within any certified EMR. Of course the certification for the EMRs would need to change to require an interface for such a set of rules. That has not happened yet, but would transform care if it did.

Andrew Braunstein
CEO
ClinLogica
Weston, Mass.

In 2015, we will see the development of ACOs and other new care models driven by direct contracting by large employers, as well as by commercial health plans. There is also an opportunity to improve the existing Medicare ACO program, but the cutting edge initiatives in 2015 are likely to come primarily from the private sector. Successful new care models will embrace the principle of accountability for costs, as well as for quality of care. And the best will go beyond that to develop true partnerships with their patients.

Among the key elements are the “three I’s”:

- **Inclusion** of patient-generated data in electronic health records, including patient-reported outcomes, health status and patients’ experience of care.
- **Interoperability** and sharing of electronic health data among hospitals, physicians, other health providers and patients.
- **Involvement** of patients in the design of care, as well as partnership in individual care, e.g., mutual goal-setting and care planning, shared decision making, ongoing solicitation of patient and family feedback, use of patient/family advisors and engagement with community resources.

All of this will require culture change on the part of all stakeholders, as well as redesign of care processes. To achieve the kind of patient- and family-centered care that results in better population outcomes, health professionals and payers will need to embrace the unique expertise and experience of patients and families as critical to improving health and healthcare. This “culture shift” should foster genuine partnership in which all parties are engaged, active and accountable.

Bill Kramer
Executive Director, National Health Policy
Pacific Business Group on Health
Co-Chair, Consumer-Purchaser Alliance
San Francisco, Calif.
Program Results
Population Health Alliance, Jefferson School of Population Health Announce Affiliation Agreement

PRWeb—The Population Health Alliance (PHA), a leading non-profit organization dedicated to advancing the principles of population health, and the Jefferson School of Population Health (JSPH), the first designated school of population health in the country, have announced that they have entered into a formal affiliation agreement, allowing the two organizations to work together to build capacity for education and advocacy.

The agreement makes it possible for the organizations to work together on shared priorities around population health advocacy and education, including developing, marketing and presenting professional programs, conferences and webinars on population health, policy, benefit design, governance and related healthcare topics, along with preparing and submitting joint grant applications, according to Fred Goldstein, executive director of PHA.

"PHA has long been an advocate for incorporating academic rigor and research into the evolving population health industry," Goldstein says.

The affiliation announcement took place during the annual 2014 PHA Forum in Scottsdale, Ariz., organized by PHA and attended by hundreds of employers, health plan executives, population health management companies, disease management experts and medical directors.

Population Health Alliance...continued

"JSPH has supported the important work of PHA for many years. This type of collaboration, between academia and industry, is a key component to improving population health outcomes across the United States," says David Nash, M.D., dean of JSPH and a keynote PHA Forum speaker. "The job is too big to take on alone, and we are pleased to have a capable and willing partner in PHA."

Primary Care Doctors Report Prescribing Fewer Opioids for Pain

Nine in 10 primary care physicians say that prescription drug abuse is a moderate or big problem in their communities, and nearly half say they are less likely to prescribe opioids to treat pain compared to a year ago, suggests new research from Johns Hopkins Bloomberg School of Public Health reported in the Dec. 8, 2014 issue of JAMA Internal Medicine.

The survey was sent in February 2014 to a nationally representative sample of 1,000 U.S. internists, family physicians and general practitioners, with 58% responding. Among the findings are: A large majority of the respondents (85%) say they believe that opioids are overused in clinical practice. Many report they are “very” or “moderately” concerned about serious risks, such as addiction (55% reporting “very concerned”), death (48%) and motor vehicle crashes (44%) that may be associated with opioid overuse. Many also reported they believe that adverse events, such as tolerance (62%) and physical dependence (56%) occur “often,” even when the medications are used as directed for chronic pain.

Leslie Kelly Hall
Senior Vice President of Policy
Healthwise
Boise, Id.
Catching Up With ….

David B. Nash, M.D., MBA serves as dean of the Jefferson School of Population Health in Philadelphia, which provides innovative educational programming designed to develop healthcare leaders for the future. He also is the Dr. Raymond C. and Doris N. Grandon Professor of Health Policy.

- Member, Board of Directors, The Care Continuum Alliance
- Member, Advisory Board, VHA Center for Applied Healthcare Studies
- Member, Board of Directors, Humana
- Named to Modern Healthcare’s list of Most Powerful Persons in Healthcare
- Principal Faculty Member, American College of Physician Executives
- B.A. degree in economics, Vassar College
- Medical degree, University of Rochester School of Medicine and Dentistry
- MBA degree, Wharton School, University of Pennsylvania

Population Health News: Why did you decide to launch the Jefferson School of Population Health? Is it living up to your expectations?

David Nash: Thomas Jefferson University, as the result of a strategic planning process in 2007, wanted to become a bona fide health sciences university with separate schools in each of the key disciplines. This was the impetus for the creation of the Jefferson School of Population Health. Essentially, the medical school-based Department of Health Policy, which was created in 2003, was then transformed into the School of Population Health by a unanimous vote of the Board of Trustees in 2008. It is clearly living up to our expectations as a source of major educational and research-based innovation on our campus and for thought leadership nationally. We remain the only school of population health in the country.

Population Health News: What do you feel have been the school’s major achievements since its inception in 2008?

David Nash: Our major achievement is, of course, the creation of the school itself. This is an explicit recognition of the importance of practicing population-based medicine, given the inexorable changes wrought by health reform. The School of Population Health has developed a unique online curriculum, focusing on public health, health policy, quality, safety, health economics and outcomes research.

Population Health News: What part does wellness play in population health?

David Nash: Prevention and wellness are clearly important components of population health. We believe more broadly that patient engagement in one’s own care is one of the key tenets of practicing population-based health. Persons cannot improve their level of thriving without appropriate engagement. From the employer perspective, we see prevention and wellness practices as the very beginning of a population health agenda.

Population Health News: Discuss your mantra, “No outcome, no income,” and how do you achieve it?

David Nash: The mantra, “no outcome, no income,” refers to the trajectory of reimbursement in the healthcare system. We strongly believe that organizations will only be reimbursed if they practice population-based care that is evidence-based and care that reduces waste. Simply put, reimbursement will follow the achievement of good outcomes. This will help us bridge the gap from a system based on volume to a system based on value.

Population Health News: Do you believe that the bundled payment model will take hold? Why or why not?

David Nash: We strongly believe that the bundled payment model, which is essentially a broad-based capitation model that engages all stakeholders, including clinical subspecialists, is a very important part of reimbursement in the future. Current research evidence indicates that bundled payments are reducing costs and improving outcomes. We believe bundled payment will not only take hold, but will continue to expand, especially in the next three years.

Population Health News: Do you still practice medicine as an internist? How does that add to your experience as dean of the Jefferson School of Population Health?

David Nash: I still practice general internal medicine as part of the department of medicine at Jefferson Medical College, now called Sidney Kimmel Medical College. I only do outpatient care in a preventive medicine ambulatory program. Each time I put on my white coat, I deeply appreciate how hard primary care for adults really is! Physicians spend so much time coordinating care, and this gives me a better understanding of population health on the front lines. I hope one day that our technology will enable me to improve my own performance.