

# Strategic approaches to population health in independent practice

MI-CCSI Meeting

June 16, 2016

# Assumptions

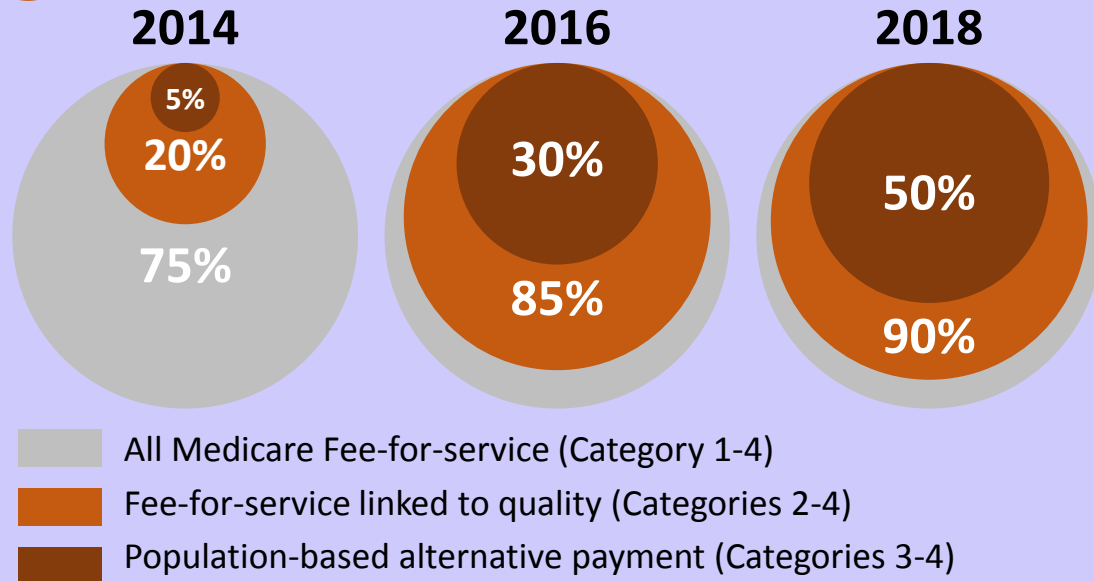
- Primary care is the foundation of high performing health systems
- High-performing primary care results in better outcomes
- Primary care in the US is under-funded relative to the work of high performing primary care
- Technologies are often inadequate to required tasks
- There has been an explosion of required tasks

# Evidence on improving population health outcomes

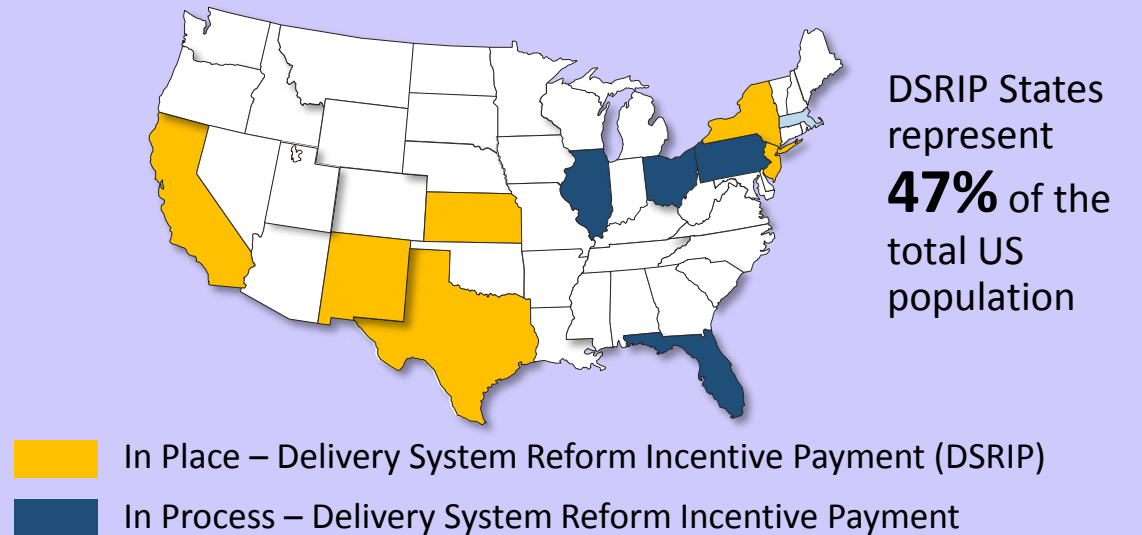
“[A] greater emphasis on primary care can be expected to **lower the costs of care, improve health** through access to more appropriate services, and **reduce the inequities** in the population’s health.”

# Move to value has accelerated dramatically

## 1 Medicare shift to value-based payment

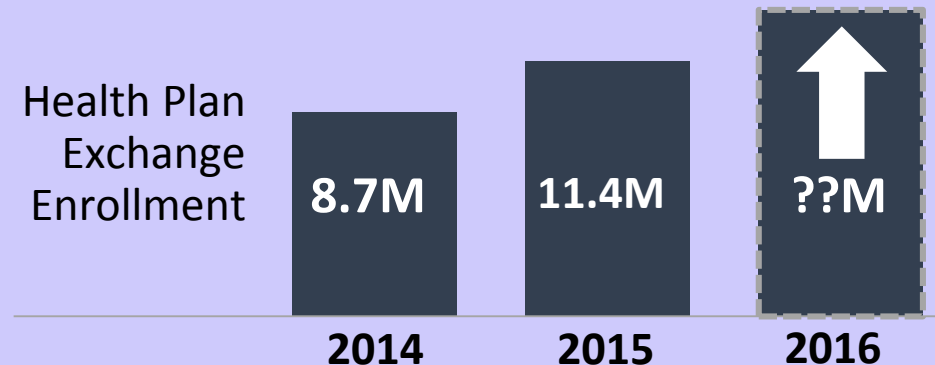


## 2 Key Medicaid state programs shift to value-based payment



## 3 Employer mandate for insurance coverage (ACA) drives more volume to the health care exchange programs

FTEs	Insurance Coverage	
	2015	2016
100+	70%	95%
50-99	Delayed	95%
1-49	NA	NA



National Healthcare Expenditure (NHE) representation by Medicare (26%), Medicaid (17%) and Private Employers (21%) combine for 64% total

# Issues particular to independent practices

- Infrastructure
- Economies of scale
- Specialization of staff
- Negotiating leverage – with insurers, HIT vendors, health systems
- Meaningful denominators
- Speed of decision making
- Control over your environment
- Costs relative to hospital based groups
- Easier business case

# Primary Care

- First point of contact
  - Person (not disease) focused relationship over time
  - Comprehensive scope of services
  - Coordination of care
- 
- World Health Organization 1978 Alma Ata Conference

## Key attributes of comprehensive primary care

I receive exactly the care I want and need exactly when and how I want and need it	Strongly agree	Strongly disagree
--	----------------	-------------------

<b>Do you have:</b>	% agree	%agree
Continuity	95%	60%
Access	85%	10%
Efficiency	80%	20%
Information	80%	20%
Confident Self-Care	75%	15%

# Ideal Medical Practices Project

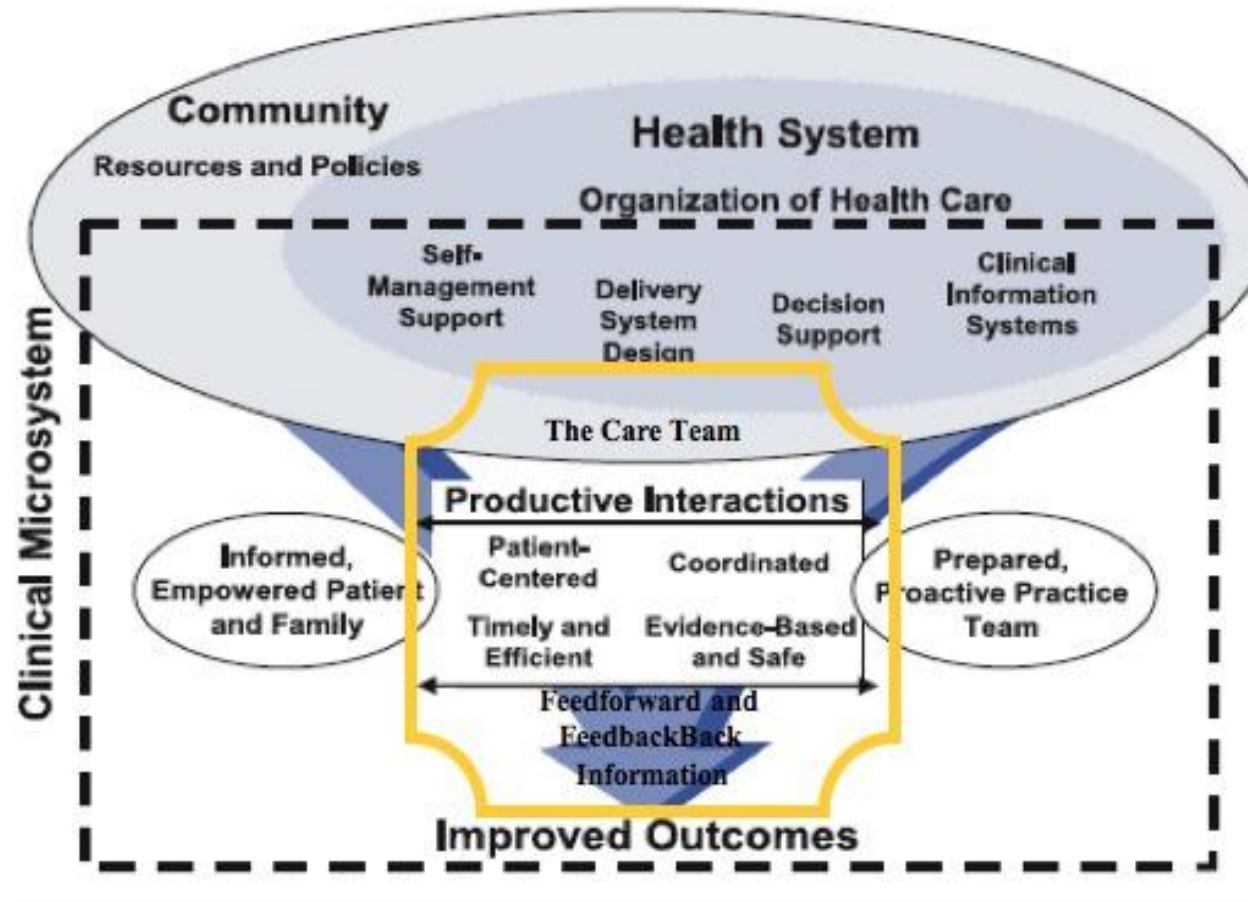
- 2006-2009
- Volunteer practices
- Mostly solo/small and independent
- Low cost IT/EMR



Funded by the Physician's Foundation



# Schematic of the Planned (Chronic) Care Model



Adapted from Wasson et al, Jt. Comm J Qual Safe 29:5, 227 – 237, May 2003

CM = Clinical Microsystems



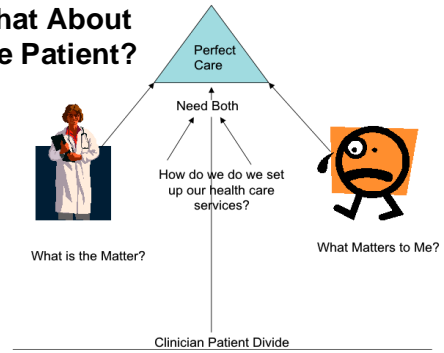
Welcome wasson. [Logout](#)

[home](#) [practice](#) [toolchest](#)

### Toolchest

Curriculum	TOOL TITLE	BRIEF DESCRIPTION	LINK
<b>Patient at the Center</b>	The "Pyramid" and ways to improve care	How the IMP approach fits and works	<a href="#">Pyramid</a>
	CARE Vital Signs and Visit Planning	Paper method to identify what matters and plan visit	<a href="#">CareVital/Visit Planning</a>
	HowsYourHealth	Foundational for improving and measuring IMP	<a href="#">Using_HowsYourHealth</a>
	Resource Planning	A behaviorally sophisticated, effective and efficient alternative to N of 1" medical care"	<a href="#">Resource Planning</a>
	Problem-Solving Module	Phone Support; and "Campaign for Confidence", Needed to support patient confidence for self-management	<a href="#">Confidence Toolkit</a>
	Group Visits	Another way to support patient self management	<a href="#">Group Visits</a>
	Podcast: Patient at the Center	A discussion of how some practices use HowsYourHealth to place patients at the center	<a href="#">PatientPod Sharing Audio -- Sharing Slides</a>
<b>Access and Efficiency</b>	Know Your Processes	Handy tool from clinicalmicrosystem work; reduce the waste that is undermining your care	<a href="#">Processes</a>
	10 Points of Advanced Access; Advanced Access FAQs	These documents provide a very helpful checklist for what you need to do to start and establish advanced access.	<a href="#">Advanced Access</a>
	Podcast: Access and Efficiency	A discussion of basic principle and approaches that make access and efficiency sustainable	<a href="#">AccessEfficPod Access Audio; Access Slides -- Efficiency Low Flow Audio; Low Flow Slides -- High Flow Audio; High Flow Slides</a>
<b>Defragmentation</b>	Specialty Referral/Consult Form and Follow-up	Under advanced testing by advanced IMPs	<a href="#">Specialty -- Editable Specialty</a>
<b>Other Approaches</b>	Medication Care	Helpful for patients and useful for practice to describe basic office procedures/expectations.	<a href="#">Med Card</a>
	Newsletters	Describe progress of IMPs and useful to tell patients about your practice's participation	<a href="#">News Sample</a>
	Podcast: Technology	Before you invest, see how others spend pennies to save thousands.	<a href="#">Tech Demo</a>
	Getting Paid	How IMPs might get paid for performance.	<a href="#">PaidPod Audio One -- Audio Two</a>

### What About the Patient?

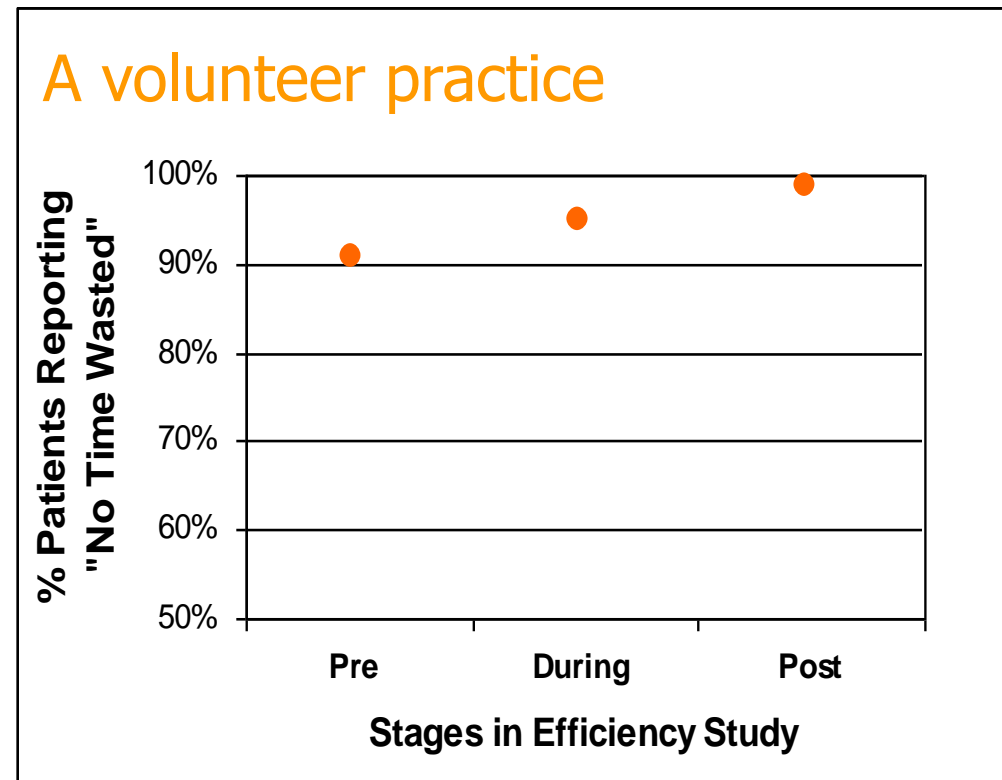
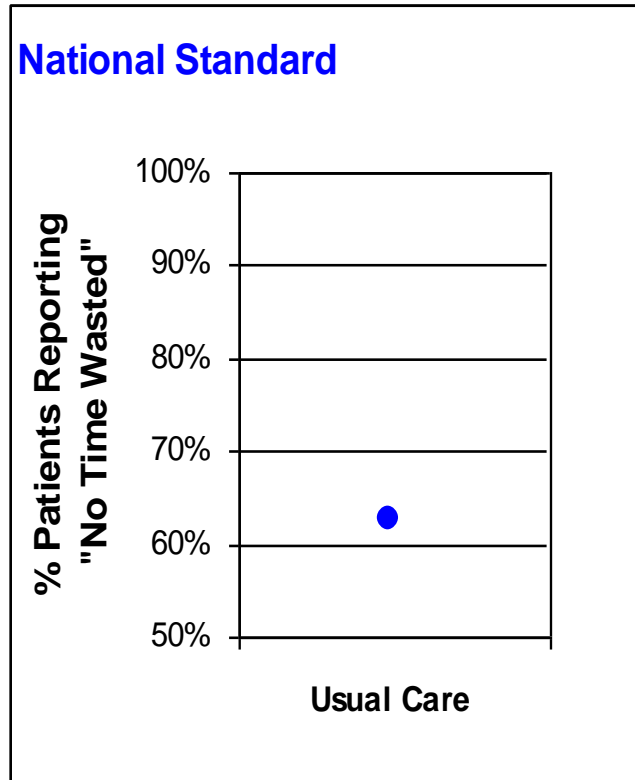


# Testing of a Standard IMP Curriculum for Two Years with Ongoing Evaluation

Experience By Respondents	Rank order of Curriculum Tools	Rank order of Curriculum Information
<b>High (70+ percent have used/recalled)</b>	Problem Solving (8.5)	Advanced Access (8.4)
	HowsYourHealth (8.0)	The Pyramid (7.5)
	Staff survey (7.0)	
	Overhead Survey (7.0)	
	C.A.R.E. Vital Signs (6.5)	
<b>Not High (Fewer than 70% used/recalled)</b>	Know Your Processes (7.6)	Defragmentation (8.6)
	Specialty Referral Process (7.4)	Resource Planning (7.0)
	Phone Coach for Confidence (5.4)	Managing Standard Problems (6.7)

When you visit your doctor's office, how often is it well organized, efficient, and does not waste your time?

## PATIENT EFFICIENCY DATA

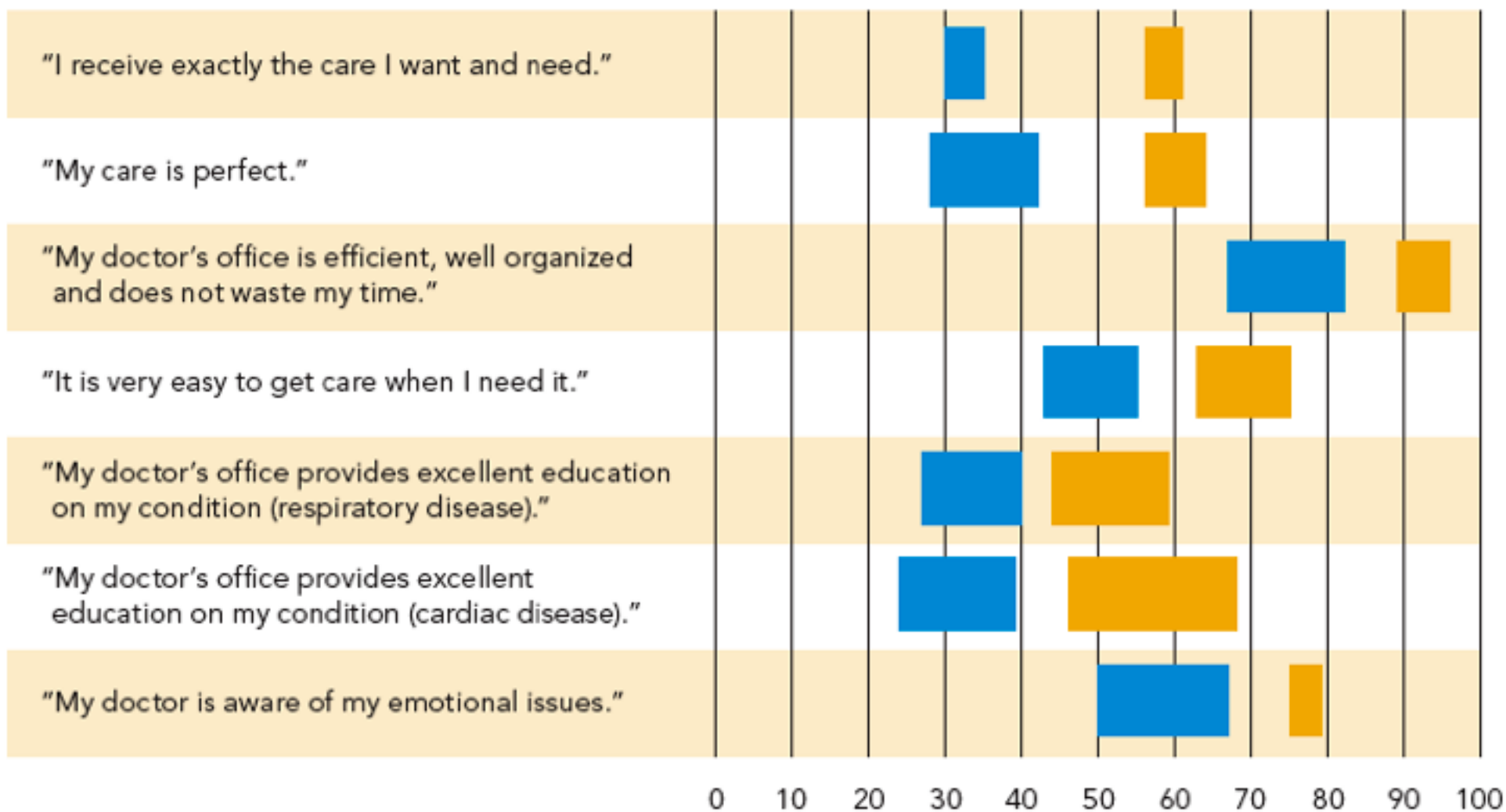


DATA FROM HOWSYOURHEALTH SURVEY

## Percentage of patients who say ...

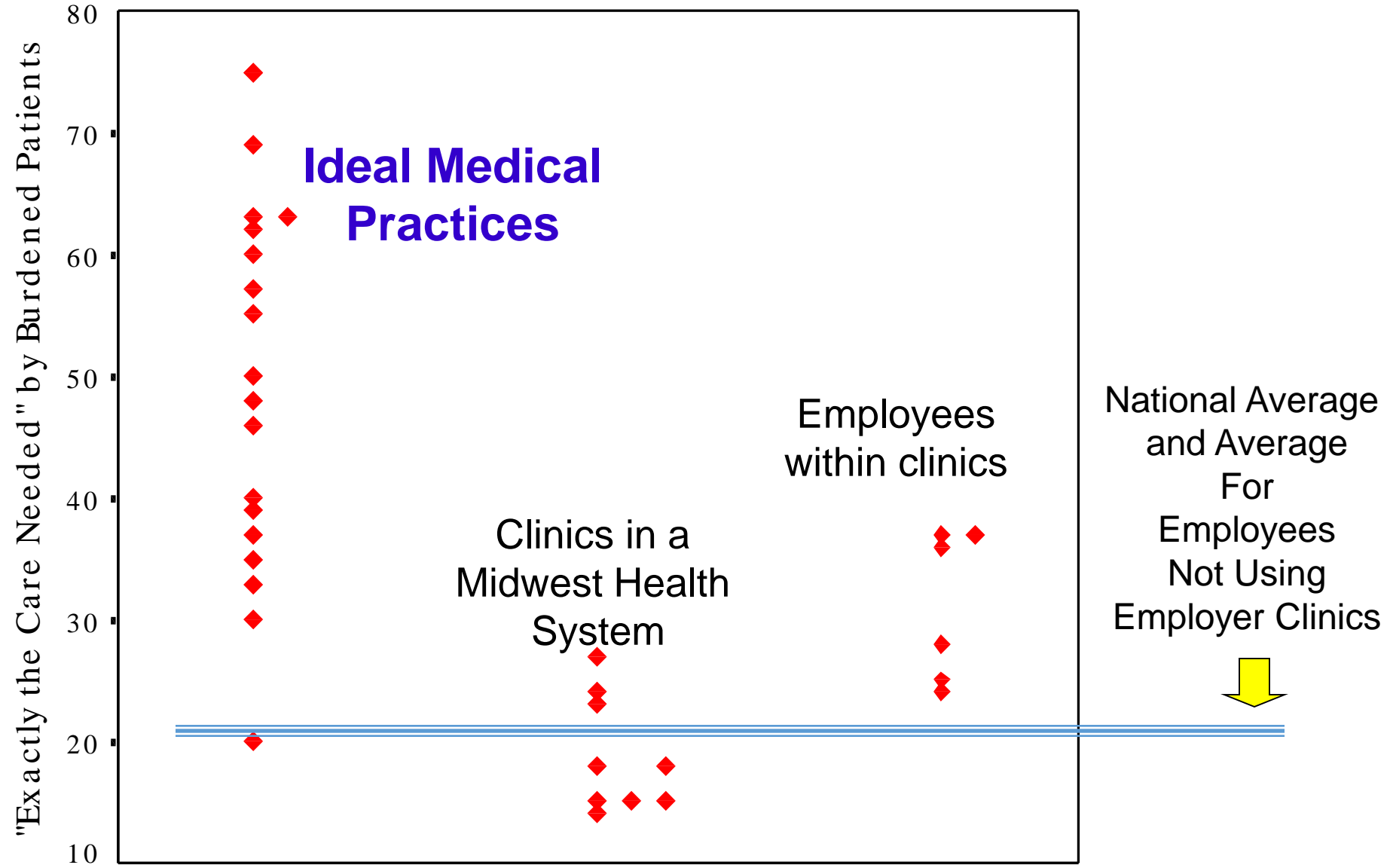
■ Usual practices

■ Ideal medical practices



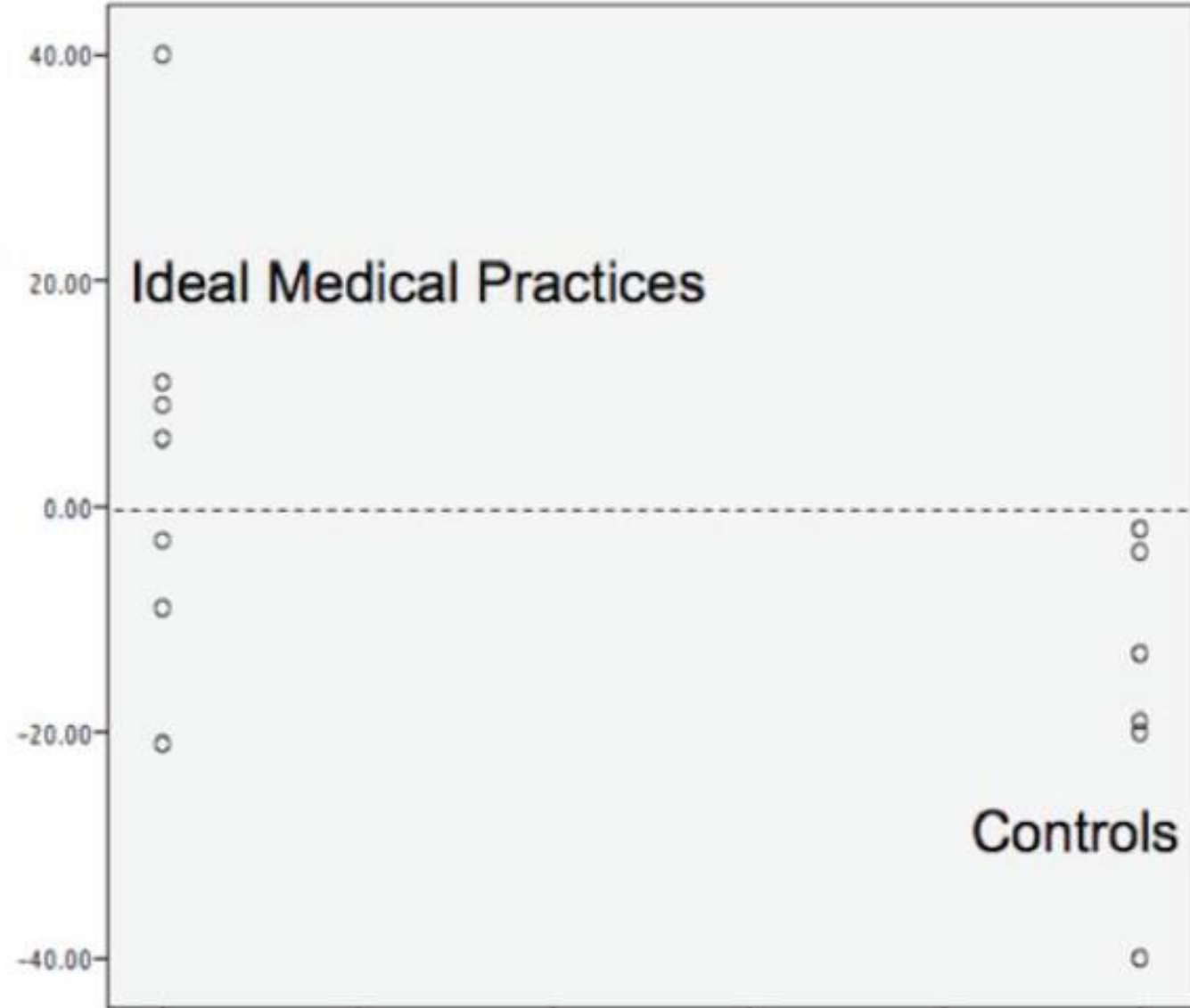
Moore LG, Wasson JH. **The Ideal Medical Practice Model: Maximizing Efficiency, Quality, and the Doctor-Patient Relationship.** *Family Practice Management* September 2007 pp. 20-24

# Performance On a Measure of "Exactly the Care Wanted and Needed"



# 18 Month Change In Care Quality for Volunteer Practices Who Used (IMP) Or Did Not Use (Controls) HowsYourHealth

Baseline to Final Change in Overall Quality  
(Patient Report of "Exactly the Care...")





**Clinical Microsystems Series**

## Clinical Microsystems, Part 2. Learning from Micro Practices About Providing Patients the Care They Want and Need

*John H. Wasson, M.D.; Scott G. Anders, M.D.; L. Gordon Moore, M.D.; Lynn Ho, M.D.; Eugene C. Nelson, D.Sc., M.P.H.; Marjorie M. Godfrey, M.S., R.N.; Paul B. Batalden, M.D.*

Usual medical care in the United States is frequently not a satisfying experience for either patients or primary care physicians. For example, only a minority of patients agree that they receive “exactly the care they want and need exactly when and how the patients want and need it,” whereas many primary care physicians are leaving primary care or not entering primary care at all.<sup>1,2</sup> Whether primary care can be saved and its quality improved is a subject of national concern. In this context, an increasing number of physicians are using microsystem principles to radically redesign their practices.<sup>1,3</sup> The transformation is motivated both by physicians’ self-interest and altruistic interest for the sake of their patients.

Two problems confront health systems when they try to improve the quality of office practice. First, there is the problem of the weak link in the chain. From the patient’s perspective, the value of care in a health system can be no better than the services generated by the small clinical units—or microsystems—of which it is composed.<sup>4</sup> When some of its microsystems are weak links, essential services of the health system will back up, break down, or result in inefficient and costly workarounds.

The second problem is the need to get many processes and handoffs right. For example, there seem to be at least nine attributes of successful microsystems within an exemplary health system.<sup>4,5</sup> Imagine that your health system can reliably

### Article-at-a-Glance

**Background:** Usual medical care in the United States is frequently not a satisfying experience for either patients or primary care physicians. Whether primary care can be saved and its quality improved is a subject of national concern. An increasing number of physicians are using microsystem principles to radically redesign their practices. Small, independent practices—micro practices—are often able to incorporate into a few people the frontline attributes of successful microsystems such as clear leadership, patient focus, process improvement, performance patterns, and information technology.

**Patient Focus, Process Improvement, and Performance Patterns:** An exemplary microsystem will (1) have as its primary purpose a focus on the patient—a commitment to meet all patient needs; (2) make fundamental to its work the study, measurement, and improvement of care—a commitment to process improvement; and (3) routinely measure its patterns of performance, “feed back” the data, and make changes based on the data.

**Lessons from Micro Practices:** The literature and experience with micro practices suggest that they (1) constitute an important group in which to demonstrate the value of microsystem thinking; (2) can become very effective clinical microsystems; (3) can reduce their overhead costs to half

# Necessary ingredients

- Room to breath
- A method for improvement
- Ideas that work
- Ongoing feedback on performance
- Supportive technology



# Some opportunities for independent practices

- Virtual group: MIPS, CareFirst
- Joining a group: local hospital, venture-backed entities, CIN
- Use a technology solution that automates the work
- Opt out

# Some strategic thoughts

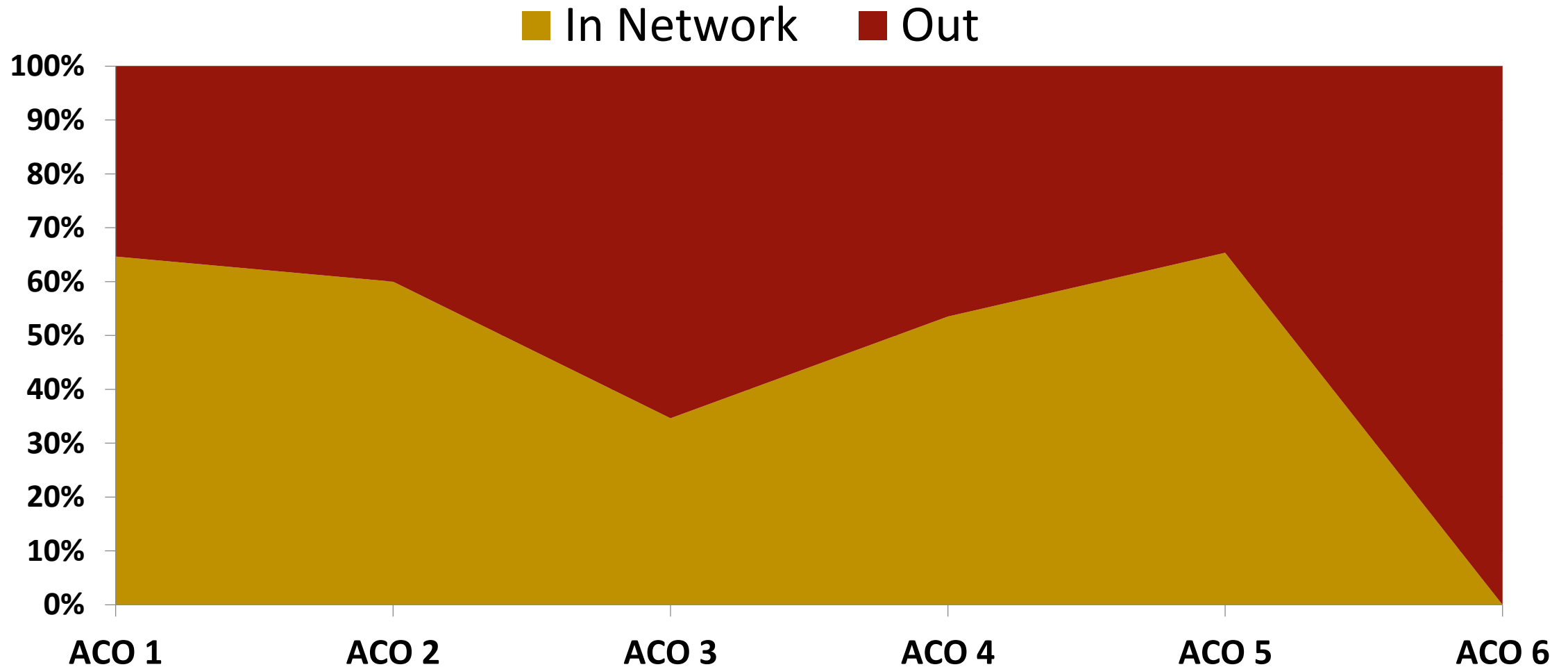
- Leverage the data and analytics of others
- Use technologies that automate work
- Focus on the work that helps your patients get the best outcomes
- Point out gaps between well-intended programs and the support your patients need
- Embrace trial-and-error
- Use your independence and size to your advantage

# Some things that have helped

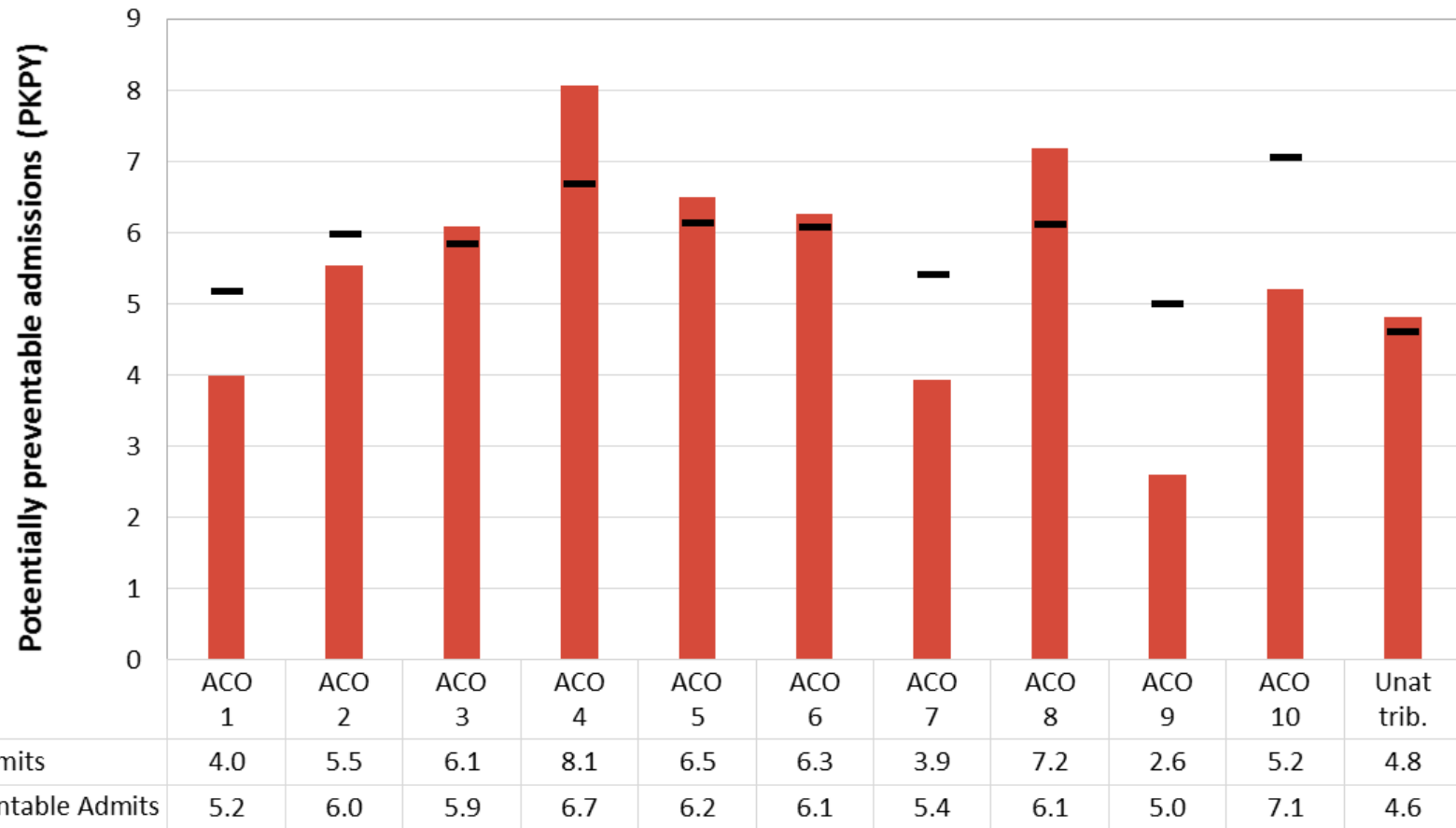
- Patient volunteers
- Group visits
- Collaborating with community resources
- Using innovative technologies

A brief foray into health plan data

*“The EMR will tell us everything I need to know”*  
Health plan data says otherwise in value-based payment models



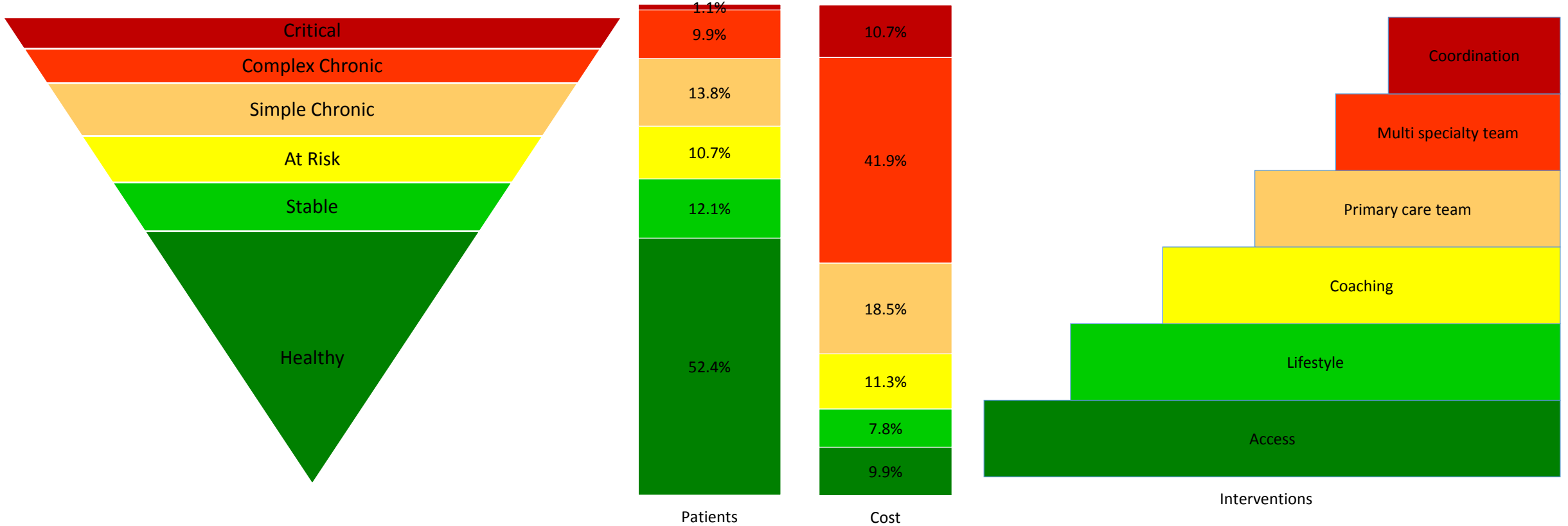
# The importance of risk-adjusting key performance indicators



PPA (red bars) rates are displayed in units of per thousand persons per year (PKPY).

Expected values (black lines) are risk adjusted by 3M Clinical Risk Groups (CRG), age group, and gender.

# Segments & interventions



# Rates of hospital admission per 1,000 people with diabetes

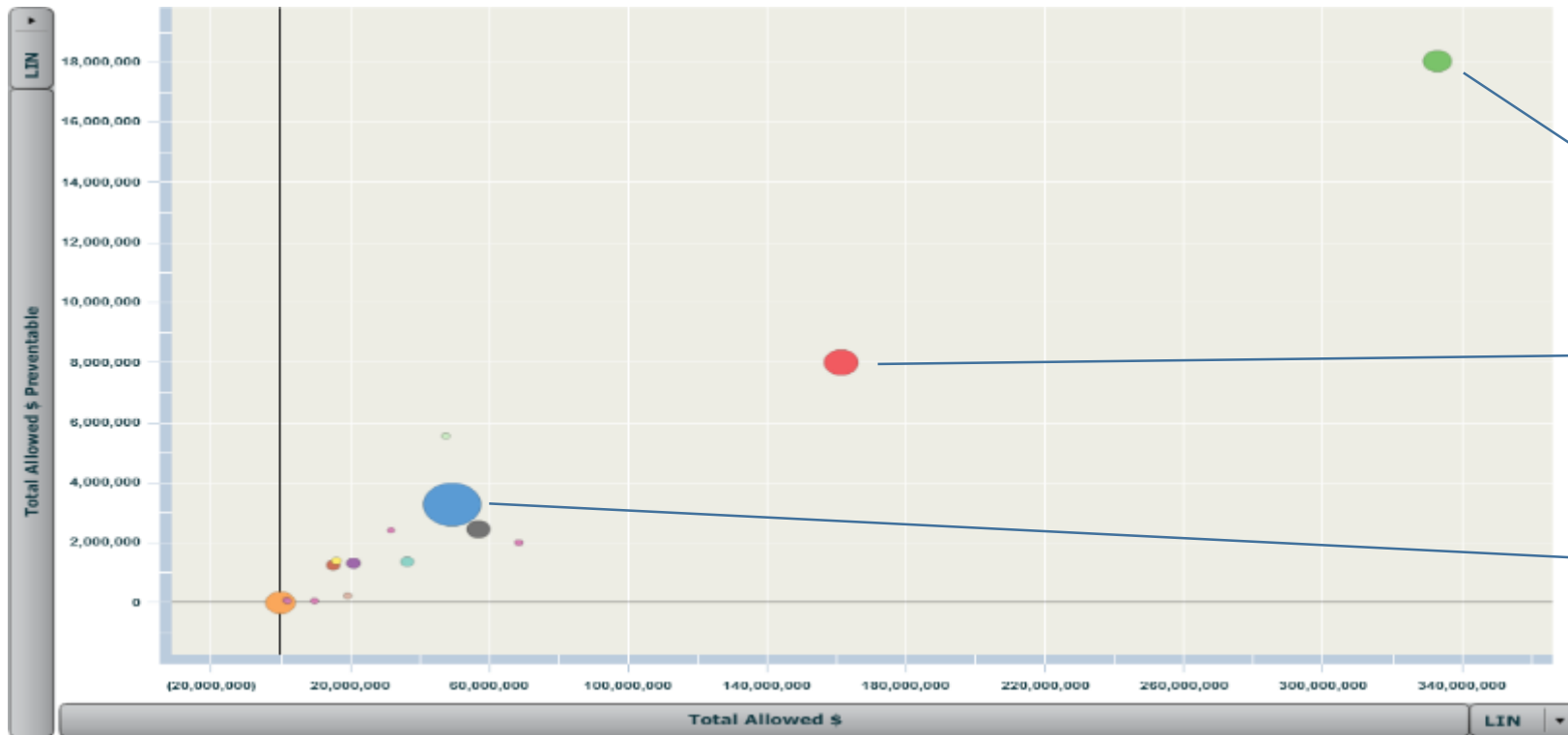
Status (Case Mix Type)		Severity Level					
		1	2	3	4	5	6
1	Healthy						
2	One or More Significant Acute Diseases						
3	One Minor Chronic Disease						
4	Multiple Minor Chronic Diseases						
5	One Significant Chronic Disease	26	88	100		247	
6	Two Significant Chronic Diseases	43	119	195	320	644	1023
7	Three or More Significant Chronic Diseases	132	269	497	845	1343	1606
8	Complicated Malignancies	416*	209	493	1294	2242	
9	Catastrophic Conditions	290*	626	806	990	1685	2486

Bernstein, Richard H. "New Arrows in the Quiver for Targeting Care Management: High-Risk versus High-Opportunity Case Identification." *The Journal of Ambulatory Care Management* 30, no. 1 (March 2007): 39–51



# What are the opportunities at the intersection of cost and quality?

## Sample commercial population



### Two significant conditions

Total Cost: \$712 PMPM  
Preventable Cost: \$39 PMPM

### One significant condition

Total Cost: \$289 PMPM  
Preventable Cost: \$14 PMPM

### Healthy

Total Cost: \$49 PMPM  
Preventable Cost: \$3 PMPM

# Patient-reported confidence (aka “activation”)— a strong indicator of risk

	Adjusted Odds Ratio*
Low confidence individuals also report the following:	
Hospitalization or ED for a chronic condition†	1.552
More than one hospitalization or ED visit**	1.865
Hospitalization or ED use perhaps unnecessary**	1.609
Time lost from work due to emotional or physical problem	4.049
Medication for chronic illness maybe causing some illness†	2.882
Do not have enough money to buy things for everyday life	2.787
Fair to poor info received from MD on chronic disease†	2.566

All ORs were statistically significant

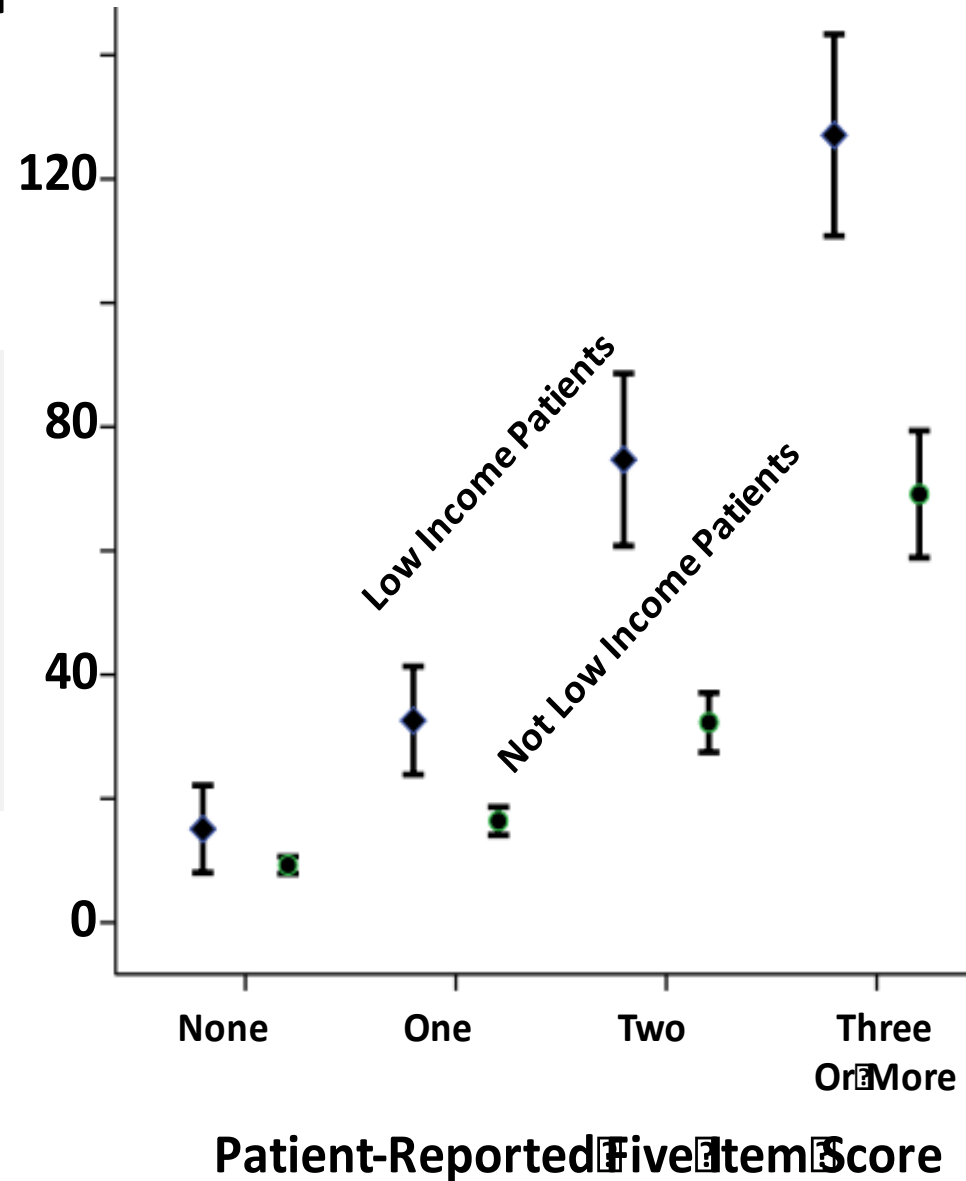
\* Adjusted for Age, Sex, and 3M Clinical Risk Group (CRG) weight

† Based on a question asking about chronic conditions

\*\* Based on a question asking about overnight hospital stays

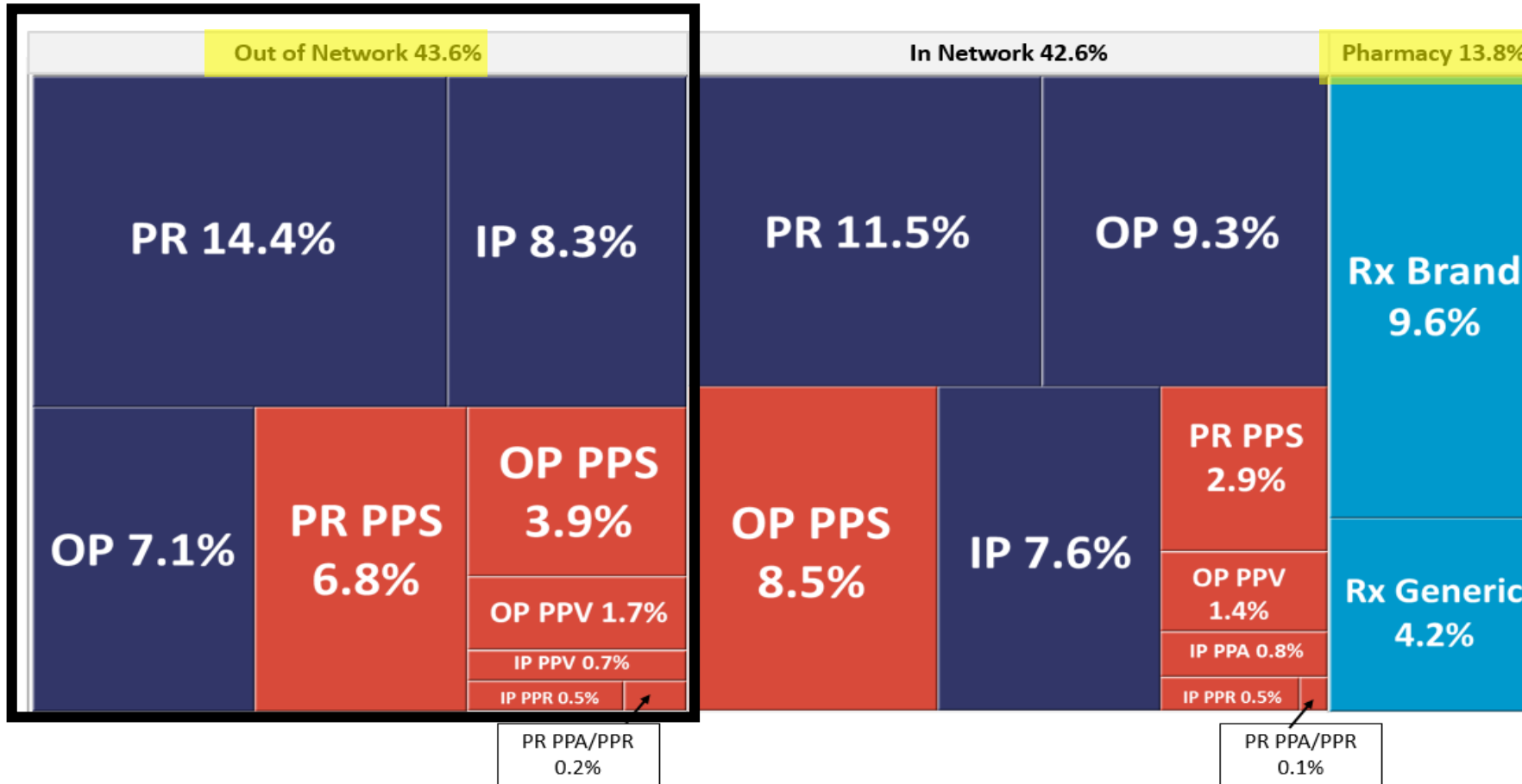
# Patient reported data

**Use of Emergency  
Or Hospital During  
Past Year**  
(Uses Per Hundred  
for 1000 Adults (aged 35+)  
with at least  
One Chronic Disease)



# Understanding budgets and buckets

- Looking at total cost of care for an attributed population



43% of population cost incurred out of network (leakage)—typical in VBC, even for a large IDN

Considerable preventable events in and out of network (RED)

13% pharma – some originated outside system

Creates opportunity

- ✓ Market share
- ✓ Patient engagement
- ✓ Care coordination

Data Source: 3M HIS Informed Analytics Platform

Box Color	Category
Dark Blue	Non-Preventable (IP, OP, PR)
Red	Potentially Preventable
Light Blue	Pharmacy

# Dashboards

Members With Missing HCCs <span>?</span>		
Key Performance Measure	Current YTD <span>i</span> 01/2014-09/2014	
Members with missing HCCs	23,658	<a href="#">Member List</a>

Total Cost of Care <span>?</span>		
Key Performance Measure	Rolling 12 months <span>i</span> 07/2013-06/2014	Program YTD <span>i</span> 01/2014-06/2014
Variance from Budget (PMPM \$)	N/A	\$19.47
Allowed (PMPM \$)	\$413.98	\$413.28

# Facility or group variation

Variance PPA Admits PKPY (07/2013-06/2014) <span style="float: right;">?</span>												
Results: 1 to 10 of 10			Page: <u>1</u>			Display: 15 per page						
Name	Variance PPA Admits PKPY					Variance PPA Admits PKPY	PPA Admits PKPY	Budget PPA Admits PKPY	PPA Allowed	Risk Weight	Members	
	-4	-3	-2	-1	0	1						
Treo Demo							(1.6)	5.3	6.9	\$11,456,423	1.096	208,670
1 Livingston Park Hospitals and C...							1.3	7.4	6.1	\$300,836	0.985	4,668
2 Seton Memorial IPA							1.1	7.2	6.1	\$1,389,622	1.087	20,776
3 MidState Doctor and Hospital P...							(0.6)	6.6	7.2	\$1,802,705	1.112	32,372
4 West Fairview Health Services							(1.5)	5.4	6.9	\$422,044	1.063	9,844
5 Mountain Valley Health Network							(1.5)	3.5	5.0	\$74,937	1.020	2,519
6 North City Health Services Netw...							(1.7)	4.9	6.6	\$3,152,019	1.096	59,844
7 Park County ACO							(2.1)	5.5	7.6	\$2,616,182	1.129	31,167
8 Forest Park Regional Health Clinic							(2.3)	0.4	2.7	\$11,603	0.571	3,222
9 South Village Healthcare Partners							(3.0)	4.0	7.0	\$860,940	1.080	23,495
10 Midwest Health Alliance							(3.6)	4.2	7.8	\$825,535	1.175	20,763

# Dashboard – Member List: Missing HCCs

Member List (limited to 1,000 members) <span style="float: right;">✕</span>												
This list includes all patients who are attributed to the provider who were identified with one or more chronic HCCs in the prior calendar year, but have not been identified with the same HCC(s) in the current calendar year.											Export All <b>23,658</b> Members	
Search: <input type="text"/>											Show <b>10</b> entries	
Member ID	Last Name	First Name	Gender	Person DOB	Demographic Model	Physician Group	Physician Name	Decile	Missing HCCs	Prior Factor	Missing Factor	
648155	YOUNG (DE-ID)	MELVIN O.	M	01/26/2002	C	Bluth Community Medicine	TERRY D. EDWARDS (DE-ID) MD	10	7	170.91	170.91	
538882	CAMPBELL (DE-ID)	RACHEL X.	F	11/27/1962	A	Stinson Professional Care	EDWARD E. JACKSON (DE-ID) MD	10	11	89.987	87.762	
403713	WALKER (DE-ID)	SHAWN N.	M	05/25/1931	A	Atlantic Medical Group - North	WALTER V. ALLEN (DE-ID) MD	10	8	79.969	75.737	
51659	WRIGHT (DE-ID)	ANNIE P.	F	05/18/1950	A	Centerville Clinic Center	GLENN A. TURNER (DE-ID) MD	10	5	75.193	75.193	
787916	LOPEZ (DE-ID)	JOSEPHINE S.	F	03/29/1944	A	Washingtonville Community Practice	TIMOTHY Z. JONES (DE-ID) MD	10	6	74.983	74.983	
341570	COLLINS (DE-ID)	SHARON T.	F	04/22/1932	A	Centerville Clinic Center	FLORENCE L. MARTINEZ (DE-ID) MD	10	5	76.082	71.462	
828996	PEREZ (DE-ID)	SAMUEL T.	M	06/19/1953	A	Mount Thompson Maternity Center	ANNIE F. HARRIS (DE-ID) MD	10	5	69.75	69.75	
851995	THOMAS (DE-ID)	VINCENT J.	M	07/02/1949	A	St. Mary's Physician Services	KEITH Q. BROWN (DE-ID) MD	10	4	78.212	68.013	
358058	LEWIS (DE-ID)	JANE Y.	F	11/25/1932	A	Kingston Medical Group - South	CINDY E. MOORE (DE-ID) MD	10	7	76.671	67.932	
127473	JOHNSON (DE-ID)	ASHLEY S.	F	07/31/1995	C	Lakeside Park Primary Physicians	CONNIE G. GREEN (DE-ID) MD	10	5	71.358	66.024	

Showing 1 to 10 of first 1,000 entries

First Previous 1 2 3 4 5 Next Last

# Bottom line

- Population outcomes improvement relies on changing systems of care
  - Improvement of discrete metrics may not add up to significant population improvement
- Given limited time and resources, focus on interventions with the greatest potential positive impact
  - While drilling down is essential, resist the urge to stay in the weeds
- Improving systems of care may start with a discrete focus (e.g. diabetes)
- Population outcomes are more likely if the discrete focus is a pilot phase to establish new systems of care
  - Focus on improving the core attributes of effective primary care



# Thank you

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