Institute for Healthcare Improvement

Innovation Project Final Report:
Optimizing the Physician Role in Population Medicine
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Intent & Aim: Any health care provider system that is taking on the responsibility for population medicine recognizes that partnership with physicians is an essential component to achieve Triple Aim outcomes for a population. Recent interviews with ACO providers reinforced the idea that for population medicine to be successful you need to engage physicians. Now "engaging physicians" is actually an interesting statement because physicians are doing quality, safety and population management. work. It would be erroneous to assume that MDs are 'disengaged' as we have seen in the past. A major push should be to identify MD pain points and help them with barriers they face such that we can partner with physicians to accomplish Triple Aim goals for populations. Therefore this work will focus on optimizing the physician role in population medicine.

Background:
Healthcare is in a state of transition. It is moving from health care that is provided on a piecemeal basis to coordinated, well planned out care to support population medicine. The new models of care are asking for answers to a different set of question. The old question was something around the services that you provide. The new question deals with big economic issues: How can we reduce the cost of care and at the same time improve the health of populations? How do we maximize the use of our resources for better outcomes?
At IHI we have spent significant time in the past working on ways to engage physicians on a shared quality agenda. In 2005 an IHI Health Foundation Fellow, Noeleen Devany, MD and I worked on a change package for engaging physicians. That document focused on culture, leadership, process and structure to engage physicians. In 2007 IHI produced a white paper on Engaging Physicians in a Shared Quality Agenda. That paper focused on a model that involved six major themes: discover common purpose, reframe values and beliefs, segment the engagement plan, use engaging improvement methods, show courage and adopt an engaging style. In addition, further applicable work was led by Neal Baker, Roger Resar and myself around the IHI white paper on Reducing Cost Through Appropriate Use of Specialty Services.

Recent discussion with ACOs continues to highlight the need to work with physicians to change the system in order to provide better population medicine.

Description of the Work:
The initial work was conducted by reviewing past work that had been done at IHI, a literature review that focused on physician involvement with population management and a number of interviews with various physicians.

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We held a Webex session with past and present Triple Aim sites to discuss this work and get input. And some of these ideas were tested with present Triple Aim sites.

Results:
Based on the work done to date, we identified a set of barriers preventing physician involvement in population medicine:

1) *Misaligned financial incentives.*
Many health care systems operate in a fee-for-service (FFS) environment, which is primarily contact-based. This payment system incentivizes providers to see patients quickly for whatever presenting complaint brings them to the office. This increases the number of services they provide and thus increases payment. The product of this is the production of "widgets of health care" when the product we need is "widgets of health". Population medicine, which often requires more time than treating discrete, acute care episodes, is not conducive to FFS. Few systems incentivize providers to focus their attention on chronic disease management, care management, or preventative care or to concentrate on a specific population with complex needs.

2) *Physician culture and expectations around population medicine*

The IHI white paper on Engaging Physicians in a Shared Quality Agenda describes physician culture. "A belief in personal responsibility for quality is powerfully engrained in the physician professional culture—and is largely responsible for physicians' fierce attachment to individual autonomy." Population medicine is a team sport and changes are needed that connect physicians with many other types of providers to produce better health outcomes. In addition to a lack of financial incentives to practice population medicine, getting physicians to view their patients and population differently and thus changing the way they provide care is an immense challenge. Physicians have traditionally thought of population health and considering how social factors affect their patients' health outcomes as pertaining to public health professionals and not necessarily to medical practice. Public health officials and primary care providers usually work in isolation from one another, but they have much to learn and much to gain from increased collaboration. Indeed, many providers view population medicine as another method of disease management rather than having a more holistic view of patients that requires a fundamentally different way of caring for their patients. Finally, a related barrier is a lack of physician support and comfort with team-based care and integrated technology, both integral components of successful population management.

3) Societal Expectations

Society has certain expectations for physicians. Even the concept of population management is not one that the community may readily embrace. Many individuals expect their physician to concern themselves with medical problems and not to go beyond health care into life circumstances and other factors that contribute to health. While some patients may embrace the change, others may feel that physicians are intruding into their lives and may not see a direct connection between their health and other factors.

4) Inadequate Learning System

By learning system we mean feedback loops and other components that help physicians manage the care for their population of patients. Progress has been made in this area over the course of years, but still more is needed. Do physicians reliably know how much the total health care spend was for their patients in the last year? Do they know which patients utilized the greatest amount of resources? How well did they control hypertension or diabetes for their population? What percentage of the population has all of their preventative indicators up to date?

5) Poorly organized practice for care coordination and population management

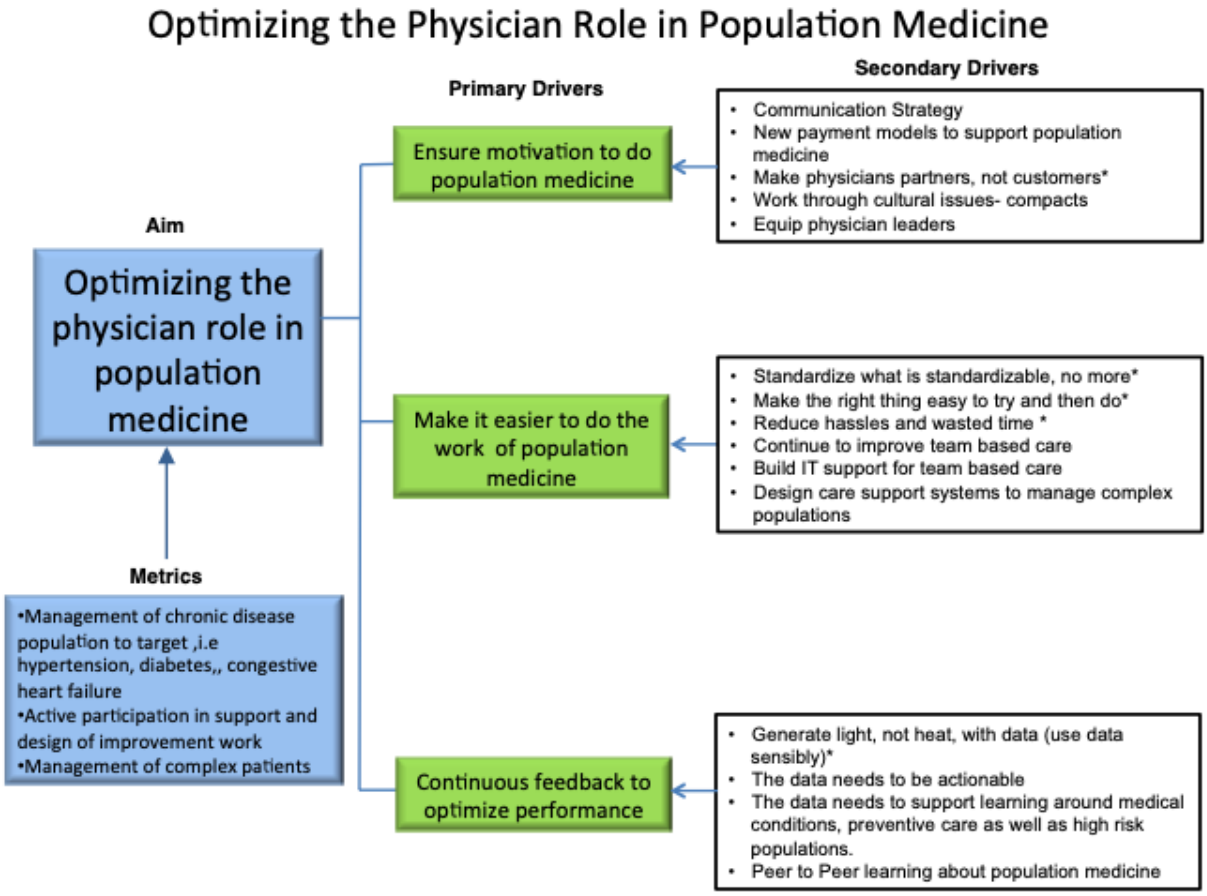
Many providers operate in a poorly organized practice that doesn't support population medicine. These practices lack the team that can help manage and support patient care both in the office and at home. Addressing this barrier may involve hiring new staff, but could also

be accomplished through re-training existing staff to perform a new function. The team-based care model is an attempt to help practices manage patients better.

6) Lack of physician involvement in organizational change
This barrier can apply to other issues, but a lack of physician input into changing organizational processes can impede engagement. A lack of confidence and trust between physicians and the organization can exacerbate the other barriers, particularly issues related to physician culture and expectations. Physician champions can help persuade colleagues to get on board with changes and increase collective support for making changes to the way they practice.

In addition to these six issues at the IHI International Office Summit Ed Wagner outlined several other issues that were specific for primary care that should be considered: greater care complexity of patients, professional isolation and declining real income.

In response to these barriers we constructed the following driver diagram that considers issues that need to be addressed for any system that is working on population medicine.



Let's work through this driver diagram a piece at a time and discuss some of the testing that we have done around it. The first test was to create a driver diagram and see who would be interested in this tool. I got approximately 20 organizations that were interested in seeing it, but very few who went beyond curiosity. Based on this, I decided to simplify my approach. I next asked organization to interview 2 to 5 physicians, but again the response was limited. However two organizations asked for further involvement in this work so I have been meeting with them on a regular basis and I will share some of those interactions shortly. With them I decided to focus on just the three primary drivers. Now before we talk about the primary drivers let's discuss the important issue of metrics.

What we need to do is ask what we mean by "optimizing the physician role in population medicine". A set of measurements can be used as an operational definition for this. One group of

measures might focus on both chronic disease and preventative measures. Another set of measures might deal with active participation in design and improvement of the work. A third set might deal with specific populations such as complex patients.

Now let's talk about the three primary drivers; ensure motivation, make it easier to do population medicine and provide the feedback that providers need. Behind those primary drivers are sets of potential secondary drivers. However, the work of implementation of those secondary drivers might take a long time. So a test was done to use the three primary drivers and see if we couldn't coach some organizations to make some changes right now that could help them.

During this cycle of R and D we have worked with two organizations. Lets just call them A and B. What I did with them was keep the discussion on the three primary drivers to help them rethink some of their approach with physicians.

Organization A provides services to a group of complex individuals in a major metropolitan area. They are somewhat early in the journey into transforming care from provider led to team-based care. They tried an incentive-based compensation program that failed. It was designed without feedback from providers. As they were in the process of a new compensation system, we suggested to them to think about how they might involve providers so they went ahead and had a focus group with a number of providers to gain some insights. They were also in the process of designing a dashboard. This can be a good feedback loop as long as they make the dashboard actionable, i.e. providers have the time to review and drill down data to the patient level. They are including within their dashboard the ability to identify patients who lack specific items of medical care. They are also still in the process of developing team-based care. Just using the primary drivers helped them test out some new approaches to their work.

The final part of this diagram is the secondary drivers. Those items with a * by them were either taken for or adapted from the IHI white paper, Engaging Physicians in a Shared Quality Agenda. You need a good communication strategy that views the physician as a partner and not a customer. Some key physicians need to be champions for this and you need to support them. One strategy that organizations have used to work through culture issues and help physicians be partners in the work is a compact. Jack Silversin has long been an expert in this, working with many organizations. New financial models are needed, particularly for primary care. See appendix B for some suggestions.

The next section of secondary drivers supports the idea of how to make it easier for physicians to do population management. The first three drivers around standardization, testing and removing waste are relatively straightforward to understand, but will require a great deal of skill to use.

Many modern quality improvement methodologies such as lean are focused on these three items. The build-out of team-based care is a work in progress for primary care at this time. Continuing to develop roles and responsibilities for managing populations is very important. Right now there is a gap in the IT system to support team-based population management. The tools to coordinate care activities across medical providers are inadequate and when you work with others outside of health care it gets worse. Finally we need to have focused strategies for some populations. Just providing usual care is inadequate for certain populations. You need a comprehensive strategy to work with complex patients.

The third driver is really about developing a learning system for physicians. They need data that helps show important gaps in performance and provides them the ability to know which patients are not meeting standards so that they can improve their care, decrease their cost or both. One organization had been in the habit of sharing comparative physician data with physicians but they did not reveal the names of the other physicians who they were being compared against. In an open meeting with physicians they decided to share everyone's data in an unblended way. One older physician had kept a small population of poorly controlled elderly diabetics who he felt needed less control for a variety of reasons. The other patients who he wanted to have tighter control had been referred out to other doctors. This doctor's data for his population of diabetics looked bad when compared to others. He was embarrassed by the public display of data and explained to the other doctors why his data looked so bad. The next day his medical partner quit the practice because he thought the health system had gone too far. This is an example of generating heat not light in the use of data. Besides data, physicians need to have the time to either learn from one another directly or indirectly through the sharing of practical intervention to help manage populations.

Conclusions and Recommendations:

In recent interviews with ACO's there is a clear request for help on optimizing the physician role in population management. This work was done as a response to that need. In addition, IHI in the past had a very successful course on engaging physicians in a shared quality agenda. This paper built on some of those ideas along with adding others to develop an overall approach to optimize the physician role in population medicine. Three key drivers emerged around: motivation, making it easier and providing a learning system with good feedback loops. These primary drivers have been tested with two specific organizations and they seemed to work reasonably well as a guide to helping them.

The next step is to test the secondary drivers to see how well these work. We created an assessment tool to help organizations understand where they are right now and this too needs to be tested

Lastly, this work could be used with the new seminar on population management. It could also support our present work with the Triple Aim and possibly be helpful for our work with complex patients.

Open Questions:

Appendices:

Appendix A Assessment tool

Physician Engagement in Population Medicine Assessment

Note: "physicians" refers to both PCPs and specialty care providers

Ensure motivation to do population medicine

1. Do you have a clear communication strategy for population medicine?
2. Are you exploring new payment models for population medicine?
3. Do providers believe they have the capability to undertake and accomplish the changes required to implement population medicine?
4. Are health system administrators ready to share information, power, and resources with physician leaders around population medicine?
5. Has your organization identified any physician champions for population medicine?
    a. If yes, does your organization have a plan to support these physician champions?
    b. Has your organization identified relevant critical physicians (such as early adopters and those who are always receptive to trying new things)? If yes, does your organization have a plan to work with these critical physicians for maximum effect?
6. Are physician leaders involved in creating and refining the organizational strategy around population medicine?
7. Does your organization have a formal physician and administration compact?

8. Does your organization use the improvement of patient outcomes as the primary way to frame and communicate with physicians about population medicine?
9. Are there any legal and "shared business" opportunities to reinforce the common agenda in the population medicine initiative?

Make it easier to do the work of population medicine

1. Has your organization identified what standardization will be necessary to adopt to move towards population medicine?
2. Does your organization provide team-based primary care?
3. Does your organization have an IT system that supports team-based care and population medicine?
4. Is the population medicine initiative set up as a series of multiple, small tests of change?
5. Has your organization made a plan to easily operationalize the new components of the initiative into physicians' daily workflows?
6. Is there a plan for senior executives to be personally engaged in the work alongside physicians you're hoping to keep engaged?
7. Does your organization have a strategy to support care for high risk/complex populations?

Provide continuous feedback to optimize performance

1. Do physicians receive individual-level data showing performance (i.e. gaps, changes and improvement)?
2. Do physicians receive comparative physician data?
3. Does your organization have a plan to use individual physician performance measures to identify opportunities and assess progress?
    a. If yes, is your organization ready to implement this plan?
4. How are you using the data for physicians' learning around chronic care conditions, preventative care, and high risk/complex populations?
5. Does your organization support peer-to-peer learning between physicians to discuss and share ideas about population medicine?

Appendix B **Payment Methodologies for Primary Care**

(This material was It was written by Trissa Torres MD and first used in the R and D report Primary Care 3.0.)

Enhanced Fee-For-Service (FFS)

BCBSM, the largest commercial provider in Michigan with largest existing PCMH demo in the country, including a significant portion of self insured products, currently employs this methodology as part of their payment system for PCMH. They provide a 10% increase in reimbursement on E&M services provided by the PCP designated as PCMH. One advantage of this methodology is that it brings money directly to the practice. It can reward early transformation efforts as well as ongoing support over time. Both an advantage and a disadvantage is that it allows the practice to direct these funds to their chosen areas of need. This can allow flexibility to tailor to individual practice needs, but requires accountability to assure dollars are invested in a manner that best supports improvement. Enhanced FFS is a fit for payers with existing FFS reimbursement payment methodology. In capitated plans, increasing payment for each individual visit alone merely exhausts the primary care pool, and thus an equivalent increase in the primary care pool would be required. Some worry that enhanced FFS rewards volume will drive unnecessary utilization. Others argue that over-utilization of primary care is an oxymoron. There is also the potential that increased reimbursement rates can have the unintended consequence of driving up charges at the practice level. Higher charges may adversely impact self-pay patients, restricting access for this subset of patients due to high out-of-pocket costs.

Incentive or Reward Payments

Most payers are already employing some form of reward or incentive payments based on performance against utilization and/or quality target measures. It would be relatively straight forward to focus these measures on key aspects of PCMH transformation. Early rewards could be for infrastructure development and later rewards could target improved outcomes. Incentive rewards can be directed toward individual providers, practices, and/or practice groups such as POs and PHOs based on individual or group performance. One of the biggest challenges is achieving alignment of these targets across various payers. Mal-alignment creates an undue burden on practices dispersing their focus to many different issues simultaneously. One of the risks of increasing incentive payments to primary care may be decreased availability in the short term, of reward funds for other providers such as specialists and hospitals. This contributes to mal-alignment. Presumably as cost reductions are realized, incentive pool dollars could be increased accordingly. Another disadvantage is that incentive dollars may only be paid once or twice a year limiting availability to support up-front investments such as hiring staff or purchasing equipment.

Per Member Per Month (PMPM)

Increasing a monthly capitated payment to practices (or centrally to POs or PHOs) for practices achieving PCMH designation, or steps toward PCMH, creates a flow of funds to support PCMH activities. This approach is attractive to providers, as they receive their funds up-front in advance of costs. Like PMPM, FFS can fund early transformation efforts and sustain efforts over time. As with FFS uptick, PMPM allows flexibility for practices to invest in chosen focus areas, but without direct accountability for that investment. PMPM methodology is a fit for payers with existing PMPM payment approaches. For payers who historically have utilized a FFS approach, contracts with their purchasers may specifically prohibit a proactive payment methodology such as PMPM. In negotiating between payers, and in calculating and describing budget neutrality projections, it was helpful to discuss different payment options in PMPM equivalents, which became a type of currency for achieving commonality (for example, and x% FFS uptick is equivalent to ~ $z PMPM).

Expanded Service Codes

Some payers have authorized payment for expanded service codes billable for specific services such as care management or telephone follow-up by non-physician providers. One benefit of this approach is that it directly funds a set of care management and care coordination services that have been identified as core to PCMH improvement efforts. One disadvantage from the perspective of the payers is that it can initially be difficult to estimate and budget for the quantity of services that may be billed. Additionally, because these codes are paid FFS, this mode rewards volume, creating a potential risk of overutilization. Some payers have defined the codes as being payable only to certain providers, such as nurses, which limits the ability to fund a broader team of providers. Some models indicate benefits to centralizing the expanded team to a PO, PHO, or community level to support several practices. Traditionally these entities do not bill directly for services and thus may not be able to take advantage of such codes. Lastly, patient co-pays and deductibles may still apply for these services, creating the situation where a patient may owe out-of-pocket expenses for a follow-up phone call to support care coordination. Some feel this creates disincentive to patient engagement and participation.

Delegation Agreements

Delegation agreements are when a payer redirects or “delegates” responsibility and funds for services that were previously provided by the insurer or contractor to a PO or PHO to provide like services more closely aligned with the practices. Historically, delegation agreements have been used for provider credentialing and utilization management. Now, in association with PCMH, they are being tested for services such as case management, care management, care coordination and self-management support. One advantage of this payment method is that it invests directly in the targeted focus areas for PCMH improvement that show promise for improving outcomes and reducing costs. Another advantage is that this type of investment builds

infrastructure at the PO/PHO level crucial to support ongoing practice transformation. The biggest disadvantage is that in redirecting the funds to POs and PHOs, this can be a direct threat to existing programs and staff currently employed by the payer.