Dear Colleagues,

On behalf of the Care Continuum Alliance (CCA), I am delighted to share with you new market research on the perspective of primary care practices toward integration of population health management strategies.

This important assessment examines physician attitudes and provides a status-check on the ongoing transformation of primary care practices toward patient-centered, collaborative models focused on quality and outcomes rather than volume of services rendered. CCA believes that integration of population health management strategies is critical to the success of this transformation to new care delivery models. The survey findings outlined here are in strong support of population health management as a catalyst to transform the delivery of care to improve quality, patient satisfaction, and outcomes and to keep healthcare costs down. The opportunity for our industry is also clearly outlined here in responses that show strong support in and interest for adapting population health management strategies but also a lack of clarity on how to accomplish the task.

CCA could not have accomplished this assessment without the significant support and input of Health Dialog, an industry leader in population health management services and strategies and a Presidential sponsor of Forum 12.

The Care Continuum Alliance aligns all stakeholders in the continuum of care toward the goal of improving the health of populations. The Care Continuum Alliance promotes the role of population-based strategies in raising care quality, improving health outcomes, and reducing preventable healthcare costs for the well and those with or at risk for chronic conditions. The Care Continuum Alliance accomplishes this through advocacy, research, and the promotion of best practices. This year’s Forum 12 recognizes industry leadership, innovation, and best practices and focuses on support and engagement with provider-led care models. I welcome you to this year’s Forum and, along with Health Dialog and the Physician Engagement Committee, we hope these findings prove valuable to you and your organization.

Tracey Moorhead
President & CEO
The Care Continuum Alliance

© Care Continuum Alliance, October 2012, Page 1
About the Care Continuum Alliance

The Care Continuum Alliance represents more than 200 organizations and individuals and aligns all stakeholders along the continuum of care toward improving the health of populations. Through advocacy, research and education, The Care Continuum Alliance advances population-based strategies to improve care quality and value and to reduce preventable costs and improve quality of life for individuals with and at risk of chronic conditions. Learn more at www.carecontinuumalliance.org.

Acknowledgements

The Care Continuum Alliance (CCA) would like to thank Health Dialog Services Corporation (Health Dialog) for sponsorship and development of this research and report. Health Dialog is the Presidential Sponsor of this year’s annual Forum and we are grateful to have their support. CCA would also like to recognize its Physician Engagement Committee for their knowledgeable counsel and review of the research plan and document. Finally, CCA would like to recognize Psyma Marketing Research for its market research expertise and services in conducting this assessment.

About Health Dialog

Health Dialog Services Corporation is a leading provider of total population health, including healthcare analytics and decision support. The firm is a private, wholly-owned subsidiary of Bupa, a global provider of healthcare services. Health Dialog helps healthcare payors, providers, and employers improve healthcare quality while reducing overall costs. Company offerings include health coaching for medical decisions, chronic conditions, and wellness; population analytic solutions; and consulting services. Health Dialog helps individuals participate in their own healthcare decisions, develop more effective relationships with their physicians, and live healthier, happier lives. For more information please visit www.healthdialog.com.
Established in 2008, CCA’s Physician Engagement Committee supports and educates primary care providers on implementing population health management (PHM) at the practice and point of care levels. Members include Chief Medical Officers and Medical Directors from leading PHM organizations. Committee work has included an overview of aligning Patient Centered Medical Home and disease management strategies; a report on the value of PHM to Accountable Care Organizations; and a 2011 webinar series and Symposium on the role of PHM in Accountable Care. The Committee has also contributed to CCA’s recently published *Population Health Management: A Roadmap for Primary Care*, and has supported CCA’s collaboration with Deloitte Consulting to identify best practices in patient engagement.

**About Psyma**

Founded in 1957, Psyma is one of the largest European marketing research companies at an international level. PSYMA GROUP AG is the holding company of 16 highly specialized agencies. Each of these agencies is an analytical expert in their respective field which allows us to combine a product-specific focus with an extensive range of methodology. The practical analysis of the perception of and the reaction to facts is the foundation of Psyma’s core competence. We deal with people and their feelings, symbols, motivations and obstacles as they relate to market-relevant behaviors. Through this we are able to provide marketing solutions perceptively, skillfully, and with precision in a globally proficient manner. The world’s largest brand names put their trust in our specialists. These include global players in healthcare, pharmaceuticals, automotive, consumer and industrial goods, financial services and communications as well as national suppliers in media and transportation. For more information please visit www.psyma.com.

**Authors**

**The Care Continuum Alliance**
  Tracey Moorhead, President & CEO
  Jeanette May, PhD, MPH, Vice President, Research & Quality

**Health Dialog**
  Kiran Ganda, MBA, Director, Communications
  Lee Jarm, MBA, Senior Manager, Market Intelligence
Executive Summary

Healthcare delivery reform is dramatically shifting physician practice models toward more collaborative, longitudinal care structures that reward outcomes over volume of services rendered. As an industry, we must understand attitudes and needs of primary care physicians and practice models as they evolve in this rapidly changing environment. To that end, the Care Continuum Alliance (CCA) and the Physician Engagement Committee have commissioned research to provide in-depth feedback from primary care practices throughout the country on progress toward the adoption and implementation of population health management strategies to support these new care models.

The majority of practices surveyed recognized the importance of population health management but lacked the knowledge of and familiarity with how to deploy these strategies in practice. Major challenges included increased administrative burden, cost, and time. However, the practices surveyed showed openness to short-term disruption of patient care for the longer-term benefit of achieving the Triple Aim – improved patient experience, improved health of populations, and reduced healthcare costs. Further, the practices surveyed see population health management strategies as a way to get there.

In order for practices to continue to succeed in a value-based payment system, they will need to more fully adopt the population health management framework. An enormous opportunity exists for our industry to help practices implement the structures and support services to keep up with healthcare delivery and payment evolution.
Healthcare delivery reform is dramatically shifting physician practice models toward more collaborative, longitudinal care structures that reward outcomes over volume of services rendered. As such, physician attention has turned to population health management as a relevant and necessary undertaking for success in a post-reform future. Population health management, as defined by CCA, is a collection of physician-supervised interventions, implemented for populations defined by a healthcare need or condition, that help patients and caregivers optimize care, prevent future complications, and maximize opportunities for wellness\(^1\). CCA has developed the following framework to outline the process flow and strategies associated with delivering population health management in a targeted and individualized way.

Key components of population health management include:

- Population Identification
- Health risk assessment
- Tailored and targeted interventions combined with patient engagement, such as Shared Decision Making, health coaching, and online education
- Evaluation of program impact

Accordingly, population health management seeks to accomplish greater coordination of care, increased patient self-management, improved functional health status, and reduced healthcare costs. With roughly 30%, or approximately $700 billion, of the $2.5 trillion in annual healthcare spending in the United States estimated to be unnecessary\(^2\), intervention is long overdue. Patients deserve higher quality and coordinated care and our nation must strive to get costs under control.

The September 2012 Institute of Medicine Report, “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,” issues ten recommendations on how to achieve a healthcare system that is consistently reliable and that constantly, systematically, and seamlessly improves.\(^3\) Importantly, the recommendations all but mirror the diagram above in their call for reliable data capture and use, clinical decision support, patient-centered care, community-level health support, care continuity and optimized operations, incentives for value-driven care, performance transparency, and broad leadership.

As an industry, we must understand what physicians in primary care are facing today and where they are headed in the way they care for patients. As we head into a critical election year, one thing is for certain no matter which outcome results: We must support physicians in caring for their entire populations – and it is only through knowing where we are right now that we can determine how far we have to go.

As such, CCA commissioned research to provide in-depth feedback from more than 100 primary care practices throughout the country. The research surveyed practice leaders on where they stand on adoption of a patient-centered model of care and implementation of population health management. Further explored in the survey were tools deemed necessary for practice assessment and implementation, challenges in adoption, anticipated benefits of adoption, and recommendations for aspiring practices.
Respondents were self-reporting practice leaders from 105 physician practices representing 1,916 physicians. They were sourced from Psyma’s Primary Care Physician panel. Practice size ranged from 5-95 physicians. Selection criteria dictated that the practice had already adopted a patient-centered model of care (such as patient-centered medical home (PCMH), was in the process of adopting a patient-centered model of care, or planned to do so in the next year. Practices that did not self-report into one of these three categories were instructed to terminate from completing the survey. Also required was that the practice be primary care-focused – defined as primary care, family practice, or internal medicine. From here on the term adopters is taken to mean all respondents that had either already adopted patient-centered care or were in process at the time of the survey.

The online survey, fielded in the United States between August 1, 2012 and August 13, 2012, consisted of 15 open- and closed-ended questions. The survey was designed to gather insights from practices that had already adopted a patient-centered model of care or were currently in the process of doing so, so the research could shed light on what the process entails, likely challenges to adopting such a model (including population health management, which was defined in the survey), and the benefits that can be achieved. Simultaneously, the instrument gathered expectations from practices planning to adopt the model within the next year, to see if those expectations were in line with actualities experienced by the earlier adopters. The survey design also allowed for comparison of differing needs as related to practice size as well as along the adoption continuum.

Of the 105 respondents:

- 33% (35) reported having already adopted a patient-centered model of care
- 39% (41) reported being in the process of adopting the model
- 28% (29) said they planned to adopt within the next calendar year

**Size and Geography**

Average practice size overall was 18 physicians, with more than half of responding practices (55%, 58 practices) classified as small (5-10 physicians), 24 practices classified as medium (23% of respondents, 11-20 physicians), and 23 practices (22% of respondents) classified as large (more than 20 physicians). The small practices were much more likely to be in the planning stages of adopting patient-centered care. Adopters tended to be larger (23 and 16 physicians, on average, respectively) than those still in planning stage (14 physicians, on average). Geographically, the large practices that have adopted patient-centered care and population health management were most prevalent in the northeast. Figures 2-6 below include multiple charts on the respondent demographics, including by size, geography, and adoption status.
Figure 2: Respondents by Adoption Stage

- Adopter: 33%
- In process: 28%
- Planners: 39%

N = 105

Figure 3: Respondents by Geography

- Northeast: 31% (33)
- Southeast: 31% (32)
- North Central: 23% (24)
- West: 15% (16)

N = 105
Figure 6: Adopters by Size and Geography

X axis = Intersects Y axis at Mean
Adopter practice size

N = 105
Awareness of Population Health Management and Movement to Patient-Centered Models of Care

With 72% of respondents reporting that they had either already adopted or were in the process of adoption a patient-centered model of care, it was interesting that only 19% of practices self-reported as Patient-Centered Medical Home (PCMH) and only 10% as an Accountable Care Organization (ACO). Considering the critical role that population health management will play in both types of practice models, the data suggest that while they are undertaking population health management initiatives, many practices may not yet be at a level of transformation to warrant presenting as PCMH or ACO at this point in time. Also interesting is that of the 11 practices that did self-report as ACO, only 5 of the 11 also reported as PCMH – showing again perhaps another disconnect or struggle with implementation and understanding. PCMH, after all, has been described as “foundational” to Accountable Care Organizations.

What is certain is that furthering the deep implementation of population health management will be essential for success in bringing down costs, improving quality, and revamping the primary care delivery system. Both PCMH and ACO standards and definitions from prestigious organizations, including the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ) tout population health management as a catalyst for achieving patient-centered care. And our respondents agreed – 85% said population health management was important in the transformation to a PCMH or patient-centered practice, with over half (55%) selecting 4 and 5 on a 5-point importance scale, indicating they view population health management as “very important.” However, despite this recognition of importance, only about half of our respondents claimed to have knowledge and familiarity with using population health management in practice and 38% ranked their knowledge and familiarity even lower, saying they were not at all or not very familiar or knowledgeable about population health management. These data represent a disconnect but they also represent an opportunity – physicians recognize the need for population health management solutions in practice, they aspire to transform to patient-centered models of care, but they need guidance and assistance in putting the necessary tools into practice.

Leveraging Existing Infrastructure

The role of nurse practitioners (NPs) and physician assistants (PAs) in extending the reach of primary care for increased efficiency and improved patient care is widely documented and supported. With a primary care physician shortage and increasing patient needs, the role of additional clinical health professionals is critical to population health management. Care Continuum Alliance members delivering population health management solutions largely leverage nurses, dietitians, respiratory therapists, and other physician-extenders where appropriate, so care remains continuous and coordinated. A 2011 Health Affairs article presents nurse practitioners as a solution to many primary care service pressures and highlights the critical role they can play in “reinventing” primary care. The Kaiser Family Foundation also examines the role of nurse practitioners and physician assistants in expanding access to primary care as part of a 2011 issue brief that calls for the “harnessing” of NP and PA talent as fully as possible in the primary care workforce. The same issue brief rightly notes that a substantial body of research finds that these clinicians perform as well as physicians on important clinical outcome measures, such as mortality, improvement in pathological condition, reduction of symptoms, health status, and functional status and patients report high levels of satisfaction with care provided by NPs and PAs.
This is critical here because our research has shown that the majority of practices surveyed in all three categories (small, medium, and large) reported employing nurse practitioners, physician assistants, and care coordinators. Although the aforementioned disconnect between the importance of population health management and the knowledge/familiarity of it in practice does exist, it is promising to see that the professionals so critical to implementing population health management and enhanced access to primary care are firmly in place. Further, large practices were strongest overall on this trend with 96% employing NPs, 70% employing PAs, and 91% employing care coordinators. While it is unclear as to exactly how respondents were defining care coordinators (i.e. were respondents referring to clinician care coordinators or administrative care coordinators?) it is certainly clear that regardless, having dedicated staff in place to help patients navigate care is a priority and is being addressed.

As the large practices were more likely to have made progress in implementing patient-centered care, the data supports the idea that alternative clinicians are a key component of implementing population health management.
**Consideration of Compensation and Pay-for-Performance**

The 72% of respondents who had already adopted (33%) or were in the process of adopting (39%) a patient-centered model of care warrant a closer look with regard to physician compensation. As stated in the methodology section, the survey instrument was designed with the intention of comparing these adopters to the practices that were still in planning stages for adoption and planned to do so within the next calendar year (28%). Not only were the adopters more likely to be larger in size and employ physician-extenders, but also they were more likely to pay physicians through salary or a combination of salary and incentive (65% of adopters) as opposed to revenue/volume-based payment (33%). Nearly half of respondents (48%) who were still in the planning stages of implementation reporting being paid based on practice revenue/volume of services rendered. This is important in the context of healthcare reform as the system moves towards value-based care and away from fee-for-service reimbursement structures. Fee-for-service, as we know, has created a misalignment of incentives, rewarding providers for volume-based rather than outcomes-based care. The data suggest that the fee-for-service world is also an impediment to the realization of population-based care and that as more and more practices are faced with payment restructuring, the adoption of population health management and patient-centered care may have more potential to become a reality as incentives become more aligned with quality rather than volume of services. In fact, respondents from across our 105 practice sample unanimously agreed that they expect their number of patients under risk-based contracts to increase, signaling that there will be an upcoming need for greater controls on unnecessary spending and higher-quality outcomes – which can be accomplished through population health management.

**Strong Support for Population Health Management**

The evidence base for population health management as a method for reducing costs and improving quality has grown strong in recent years and consensus on its role in transforming healthcare delivery is high. This is perhaps most clearly demonstrated through its inclusion in the Patient Protection and Affordable Care Act of 2010, which includes a number of reforms designed to realign incentives towards prevention and reinforce the role of primary care, using in part principles of population health management and enhanced infrastructure such as disease registries and systems for tracking tests and referrals. The question is no longer, “Does population health management work?” The question has become, “How do we implement population health management at the practice level?”

Across the survey sample, we asked respondents to rank a list of expected benefits and the top three that emerged sample-wide were as follows:

- Improved patient outcomes
- Improved relationship with patients, including increased patient satisfaction
- Ability for the practice to benchmark itself versus national and location performance metrics

Importantly, these three also emerged as the top-ranked benefits when we looked at only the adopters. The logical assumption here is that for those who have already gone down the road of adopting patient-centered care, the outcomes are meeting the expectations. It is important to note the expected benefits are centrally patient-focused. Physicians largely want to implement population health management because it is quite simply the right thing to do. Additional expected benefits receiving attention on the survey included improved care coordination, identification of care gaps, and improved admission and readmission rates. So how can the practices get there?
The research questioned adopters about what they would recommend aspiring practices do even before beginning the implementation process for population health management. The survey also questioned this group about necessary tools they would classify as “must haves” for achieving population health management implementation.

The top three recommendations for practices even before beginning population health management implementation were as follows:

- Purchase an Electronic Medical Record (EMR) system
- Conduct and end-to-end practice assessment of practice layout and workflow
- Leverage resources provided by third-party organizations such as NCQA, PCPCC, CCA, AHRQ, etc. as part of conducting the practice assessment

**Figure 8: Needs and Expected Benefits**

- **Investment in technology, a practice assessment, and 3rd party expertise** will help practices achieve the vision of patient-centered care

- **Adopters recommended the following as “musts.”**
  - Acquire technology – the 1st step is an EMR system
  - Conduct a comprehensive assessment of the layout and workflow of the practice
  - Take advantage of resources available from organizations like the CCA, NCQA, or the PCPCC

- **Which will help achieve the following benefits:**
  - Improved patient outcomes
  - Improved relationship with your patients
  - Ability to benchmark the practice and monitor its performance relative to others

© Care Continuum Alliance, October 2012, Page 14
**Practice Assessment**

For CCA, the focus on third-party organizations as part of conducting practice assessments is a very welcome outcome. CCA has worked tirelessly to develop tools for providers and payors that will help them progress in healthcare delivery, striving to achieve the Triple Aim – improved patient experience, improved health of populations, and reduced healthcare costs. These efforts include the CCA Accountable Care Organization Toolkit of 2011 and the Population Health Management Road Map for Primary Care of 2012. And our research found that not only was turning to an organization such as CCA recommended, but it is what the adopters actually did: When asked what tools they actually used to conduct their practice readiness assessment, the number one response was “guidance from an organization like the NCQA, PCPCC, and/or the CCA”. The second response was use of “a related professional organization, such as the AMA or AAFP”. Collectively, 91% of adopter respondents said their practice assessment was conducted with guidance from one of these two types of organizations. The responses here show that we must work together as an industry to share ideas and best practice examples – we truly are all in this together. Despite competitive pressures, learning from experience and best practices on what has worked is the way the industry collectively will get ahead and transformed US healthcare will be achieved.

**EMR Adoption**

There is also promise in the recommendation that an EMR be leveraged – 93% of our respondents reported already having an EMR in place. But, only 33% of respondents had a disease registry in place, which may represent an opportunity for continued movement along the path to self-reporting as a PCMH or ACO. With EMRs in place, which are geared to individual patient tracking, perhaps the next phase in transformation to becoming recognized as a PCMH or ACO is to turn to population-level trackers of care.

**Implementing Population Health Management – Must Haves**

Once a readiness assessment has been conducted and an EMR is firmly in place, implementation of population health management can begin, according to the survey trends. We asked adopters what are the necessary tools or must haves for population health management implementation? More specifically, what specific needs did your assessment identify? Respondents could select all that applied from a list of 15 different needs or could self-report on any other need not reflected on our list.

While there was variation in responses by practice size and adoption status, what was clear overall across all the adopter respondents was a need for change in roles and responsibilities of practice staff, including in many cases a need for additional personnel. As with any transformative process, a cultural shift is needed. What this signals is the need for internalization from the top-down and across a practice, so that population health management becomes embedded in the day-to-day. As we remarked earlier in this analysis, a majority of practices have adequate staff in place, including NPs, PAs, and care coordinators. The next step that is needed is making sure roles are appropriately defined to create efficiencies in care.

While the need for role clarity in staffing was consistent across all responding adopters, some differences did emerge when looking across practice size and when looking between the two groups of practices who had adopted versus those who were in the process of adoption.

For the 35 practices who said they’d already adopted a patient-centered model of care, the number one need,
even before staff roles and responsibilities (a close second) was the ability to offer same-day appointments. For the 41 practices in the process of adopting the model, formal care plans, particularly for patients with chronic conditions, emerged as a major need. Logically, these results make sense as putting necessary infrastructure in place would take priority over diversification of services. However, the availability of same-day appointments is essential to recognition as a PCMH, as defined by recognition programs from organizations such as NCQA, URAC, and the Joint Commission. Practices further along in adoption that already have necessary infrastructure in place, such as chronic condition care plans, are likely now looking at service differentiation, which will be required for official recognition as PCMH by quality recognition organizations.

When we looked at adopters by size, larger practices signaled specific needs: healthy lifestyle support or wellness programs and patient decision aids. While these needs certainly did not surpass staffing and same-day appointment needs, what was remarkable was that for large practice adopters these needs were almost double those for small practice adopters. Again, this suggests that since larger practices tend to be further along the adoption continuum, their service-oriented needs increase as necessary infrastructure is already in place and they are looking for ways to differentiate to the consumer.
Despite the struggle associated with moving along the path to achieving patient-centered care, and despite that fact that many of our respondents did not yet self-report as PCMH or ACO, it is reassuring to see that the tools so critical to the population health management framework are on the radar of larger practices who are further along in transformation.

So with reference to the struggle, what are practices seeing as the major challenges?
The top three challenges cited across all adopters in implementing population health management were:

- Increased administrative burden (55 practices or 76% of adopters)
- Costs (46 practices or 64% of adopters)
- Time (43 practices or 60% of adopters)

Time was followed closely by effective training for staff, which mirrors the need the survey identified for changes in roles and responsibilities. Again, the research reiterates the need for continued cultural shift – away from yesterday’s method of practice towards a future of accountable, patient-centered care. Transforming a medical practice will not be achieved by checking off boxes alone – a commitment to broad scale redirection must permeate every aspect of practice activity.

Very interesting in the challenges data was the fact that disruption of patient care ranked quite low on the list of challenges. Physicians, we conclude, are not worried about interim interference with care as the efforts to adopt population health management are for the greater and longer-term good. This is not to say that disruption of care is not an issue at all, however when asked to rank order a list, there were more immediate concerns. We know from the strong support portion of this paper that patient outcomes and satisfaction are important to the surveyed physicians. The data here suggest that despite significant challenges to implementation, including valuable time and money, physicians are willing to undergo the growing pains associated with transforming to patient-centered care – putting the goal of improved patient care ahead of the disturbance of near term practice disruption.

Figure 11: Top Challenges for Adopters and In-Process Practices
Conclusion

Changing the way US healthcare is delivered is no small feat. Since the landmark Institute of Medicine report in 1999\textsuperscript{14} that called attention to the prevalence of medical errors and the subsequent 2001 report\textsuperscript{15} that outlined the human toll and financial cost of these medical errors, we as a nation have been striving hard to improve quality of care while curbing costs and expanding access.

Population health management addresses all three components of the Triple Aim. Population health management as a means to achieving reformed US healthcare is a given. Physicians are on board but we must support them on the journey. Through working together across the industry – population health management providers, physicians, and patients can achieve the Triple Aim. We call attention to this large opportunity for improvement and champion education, tools, and support on population health management to help clear the path towards population-based, patient-centered care.

\begin{enumerate}
\item “Population Health Management: A Road Map for Primary Care,” Care Continuum Alliance, May 8, 2012
\item “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America”, Institute of Medicine of the National Academies, September 2012
\item “Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012”, Patient-Centered Primary Care Collaborative, September 2012.
\item Naylor, MD, Kurtzman, ET, “The Role Of Nurse Practitioners In Reinventing Primary Care,” Health Affairs, May 2010, Vol. 29, No. 5, p. 893-899.
\item National Committee for Quality Assurance, Patient-Centered Primary Care Collaborative, Care Continuum Alliance, Agency for Healthcare Research & Quality
\item American Medical Association, American Association of Family Physicians
\end{enumerate}