

ACCELERATING ADOPTION OF EVIDENCE-BASED CARE: PAYER-PROVIDER PARTNERSHIPS



PARTICIPATING ORGANIZATIONS

AvMed

Miami, Florida

Capital District Physicians' Health Plan

Albany, New York

CareOregon

Portland, Oregon

Dean Health Plan

Madison, Wisconsin

Geisinger Health Plan

Danville, Pennsylvania

Group Health Cooperative of South Central Wisconsin

Madison, Wisconsin

Harvard Pilgrim Health Care

Wellesley, Massachusetts

Health Alliance

Champaign, Illinois

Health Alliance Plan

Detroit, Michigan

HealthPartners

Minneapolis, Minnesota

Independent Health

Buffalo, New York

Kaiser Permanente

Oakland, California

Martin's Point Health Care

Portland, Maine

PacificSource

Springfield, Oregon

Presbyterian Health Plan

Albuquerque, New Mexico

Priority Health

Grand Rapids, Michigan

Scott & White Health Plan

Temple, Texas

Security Health Plan

Marshfield, Wisconsin

SelectHealth

Salt Lake City, Utah

UCare

Minneapolis, Minnesota

UPMC Health Plan

Pittsburgh, Pennsylvania

TABLE OF CONTENTS

Executive Summary.....	2
Introduction.....	6
How Community Health Plans Accelerate Evidence to the Point of Care: Five Best Practices.....	7
1. BUILD CONSENSUS AND COMMITMENT TO CHANGE.....	8
2. CREATE A TEAM THAT INCLUDES THE NECESSARY SKILL SETS, PERSPECTIVES AND STAFF ROLES.....	10
3. CUSTOMIZE EDUCATION, TOOLS AND ACCESS TO SPECIALIZED KNOWLEDGE FOR PHYSICIANS AND FOR PATIENTS.....	12
4. SHARE TIMELY AND ACCURATE DATA AND FEEDBACK IN A CULTURE OF TRANSPARENCY, ACCOUNTABILITY AND HEALTHY COMPETITION.....	14
5. ALIGN FINANCIAL INVESTMENTS WITH CLINICAL AND PATIENT EXPERIENCE GOALS.....	16
Combining Best Practices for Meaningful Impact.....	18
Closing.....	19
APPENDIX.....	20

Additional case studies and resources at www.transforming-care.org.

Executive Summary

With the universe of medical knowledge doubling about every three months, physicians are challenged to keep up with changes in evidence-based care.¹ Delays — sometimes decades long — in bringing new best practices to the exam room or bedside can result in health disparities, variations in care quality, adverse events, waste and unnecessary costs for consumers and the health system.

New research by the Alliance of Community Health Plans (ACHP) shows that when high-performing health plans collaborate closely with health systems and communities, evidence-based decision making increases. The unique ability of these health plans to influence provider behavior through consensus building, enhanced transparency, aligned incentives, real-time data and trusting environments accelerates dissemination and adoption of evidence-based interventions.

As a result, care improves, costs go down and patients experience better outcomes.

The organizations studied — nonprofit, community-based, provider-aligned health plans that comprise ACHP — have joined forces with their physician partners to significantly reduce opioid prescribing and use; eliminate risky elective inductions of labor prior to 39 weeks; cure Hepatitis C in nearly all patients; improve diabetes and hypertension control across multiple populations; increase depression screening and treatment; and dramatically reduce costs associated with some surgeries, among other results.

The role of health plans in influencing physician behavior and aiding evidence-based adoption is an important one to consider. Community-based health plans have deep roots in the regions they serve and invest heavily in local provider organizations. Focused on innovation, care coordination and the patient experience, provider-aligned community plans consistently deliver better value for our scarce health care dollars.

ACHP's research revealed five best practices for health plans seeking to influence and support the adoption of evidence-based practices. Case studies, summarized in the report and included in full at www.transforming-care.org, illustrate these best practices at work. The case studies showcase replicable, scalable strategies that other health plans and clinical leaders may explore and adapt to foster improved health outcomes at a lower cost.

FIVE BEST PRACTICES

The organizations in our study vary in size and business model. Some are fully integrated systems while others work entirely with contracted providers. But across these different models, commonalities emerged about how community health plans effectively partner with physicians to promote more evidence-based clinical practice. The research revealed five best practices for health plans collaborating to accelerate the delivery of evidence-based care.

1. BUILD CONSENSUS AND COMMITMENT TO CHANGE

Health plans and providers share a desire to achieve the Triple Aim — better health and patient experience at lower cost. The most successful health plans foster strong partnerships through co-creation, in which open dialogue generates a shared sense of ownership leading to more rapid change. Plans also capitalize on the influence of clinical and community leaders to engage the provider community.

Geisinger Health Plan in central Pennsylvania assembled a team of pharmacy leaders, health plan medical directors, service line physician leaders, nurses, case managers, data experts and benefits managers to develop clinical and operational best practices for treatment of Hepatitis C virus (HCV). They designed an evidence-based CarePath to treat more than 2,000 HCV patients, with a cure rate of 97.5 percent and significant savings.

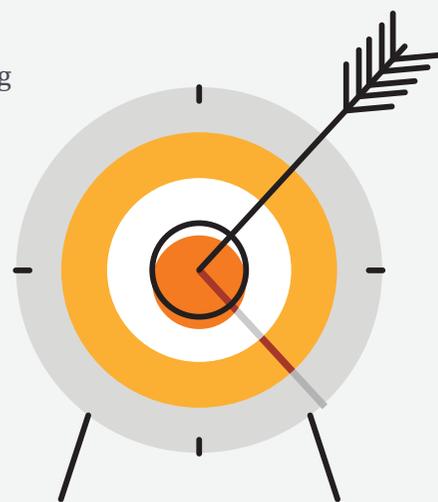
2. CREATE A TEAM THAT INCLUDES THE NECESSARY SKILL SETS, PERSPECTIVES AND STAFF ROLES

Presbyterian Health Plan in New Mexico formed a multidisciplinary workgroup to tackle the deadly opioid epidemic. Medical directors, behavioral health specialists and addiction experts from the delivery system, as well as leaders from the health plan, designed a comprehensive, integrated initiative involving collaboration with community groups. As a result, system-wide opioid prescriptions are down by 16 percent.

3. CUSTOMIZE EDUCATION, TOOLS AND ACCESS TO SPECIALIZED KNOWLEDGE THAT THE AUDIENCE NEEDS

Health plans that generate the greatest impact customize information to clinicians' expressed preferences and share it via multiple channels.

At Kaiser Permanente, clinicians can attend a workshop, watch a series of videos or take an online course to learn new protocols for opioid prescribing. In-person presentations are customized, leveraging local clinical pharmacist leaders who meet directly with clinicians. Extensive training, along with changes in prescribing policies, has resulted in a more than 40 percent





reduction in total opioid prescriptions in one Kaiser Permanente region, and a 30 percent reduction in high-dose prescriptions in another.² The initiative has since become a national priority for the organization, with the engagement of clinical leaders across all eight Kaiser Permanente regions.

4. **SHARE TIMELY AND ACCURATE DATA AND FEEDBACK IN A CULTURE OF TRANSPARENCY, ACCOUNTABILITY AND HEALTHY COMPETITION**

Successful initiatives bring community health plans in regular, direct contact with care teams to offer feedback and leverage the inherent curiosity and competitiveness of physicians. While annual retrospective performance data is useful, plans also have invested in more timely reporting to activate physician practices around immediate improvement opportunities. Data is reviewed and refreshed by the plan and shared with clinicians. Ideally, plans also make results available to the public to hold clinicians accountable.

Capital District Physicians' Health Plan (CDPHP) in Albany, New York, regularly shares regional and national comparative performance data with physicians in its Enhanced Primary Care (EPC) program and works closely with the practices to improve quality and efficiency. Data shows that the EPC practices provide higher quality care than non-EPC practices and improve the care they provide at a faster rate. Between 2012 and 2014, CDPHP realized savings of \$20.7 million directly related to the program.

5. **ALIGN FINANCIAL INVESTMENTS WITH CLINICAL AND PATIENT EXPERIENCE GOALS**

Financial incentives alone have only a modest impact on clinician behavior, and to be effective they must be coupled with other best practices such as establishing shared goals, and providing appropriate support. Health plans in the study found that financial incentives, such as bonus payments for Healthcare Effectiveness Data and Information Set (HEDIS) measure performance, can be effective at jumpstarting change efforts.

Non-payment for services or procedures that do not adhere to best practices guidelines can be a very effective strategy to influence clinical behavior. By stepping up communication with physicians about evidence-based guidelines and reaching out to educate patients, SelectHealth in Utah reduced often dangerous early elective inductions of labor to just three percent. It took a policy of non-payment for unapproved early elective inductions to get that number to zero — resulting in shorter labors, fewer C-sections and savings of \$2.5 million per year.

UNIQUE ROLE OF COMMUNITY HEALTH PLANS

Community health plans are uniquely positioned to accelerate the dissemination and delivery of evidence-based care. Their shared community roots and deep investments in relationships with local health care providers build common ground, stability and longevity — important foundations for establishing trust and effective partnerships.

By nurturing teams, aligning resources, enhancing accountability, measuring performance, sharing data and shaping incentives, community health plans play a vital role in increasing adoption of evidence-based practices to improve health outcomes and reduce costs.

This report illustrates best practices health plans and clinical leaders should consider when pursuing strategies for dissemination and implementation of evidence-based interventions. The case studies add to the emerging body of evidence that payer-provider partnerships have sizable and lasting impacts on the health of communities. Often, successful plans combined multiple strategies to achieve faster, more widespread adoption.

Health plans have both a role and a responsibility critical to the nation's pursuit of a high-quality health care system that consistently delivers better care, better experience and lower costs to all Americans.



“From this simple research emerge case studies and best practices from the nation’s leading health organizations that others will want to study and emulate. If all of health care were based on these kinds of approaches, fragmentation of care, high cost and poor results would be much less of a problem in the U.S.”

George Isham, MD, MS
Senior Advisor, ACHP & Senior Fellow, HealthPartners Institute

Introduction

In 1950, medical knowledge doubled every 50 years. Today that estimate has shrunk to less than three months.³ As the rate of new discovery explodes, how can clinicians possibly keep up?



Often, they can't. The Institute of Medicine's landmark 2001 report, *Crossing the Quality Chasm*, cited that it takes an average of 17 years for a new medical breakthrough to make its way to the point of care.⁴

More recent research indicates that it may take just as long for the medical community to discontinue practices shown to be ineffective.⁵ Cholesterol guideline changes in 2013, for instance, were a major paradigm shift requiring unlearning of well-established routines. Five years later, many of the old habits remain.⁶ These lags can result in variations in care quality, health disparities, adverse events, waste and unnecessary costs for consumers and the health system.

Today more than ever, clinical leaders benefit from strategies that help them align care delivery practices with the latest evidence. That can mean adopting new, patient-centered practices and retiring old, often deeply engrained activities no longer recognized as best practice. Sometimes the change can involve moving a procedure out of the hospital and into a local ambulatory surgery clinic or converting in-person appointments to virtual follow-up visits in the home.

The role of health plans in influencing physician behavior and aiding evidence-based adoption has been largely underappreciated. Starting in 2017, with funding from the Patient-Centered Outcomes Research Institute (PCORI), the Alliance of Community Health Plans (ACHP) set out to document how community health plans disseminate timely, relevant research to enable physicians to improve care delivery and ultimately, health.

The research was conducted with ACHP's 21 nonprofit, community-based health plans and provider organizations, all proven leaders in implementing innovations in quality of care, patient experience and affordability. The results show that when high-performing health plans collaborate closely with health systems and communities, evidence-based decision-making increases.

Together these health plans and their provider partners have significantly reduced opioid prescribing and use; eliminated elective inductions of labor prior to 39 weeks; cured Hepatitis C in nearly all patients undergoing treatment; improved diabetes and hypertension control; and increased depression screening and treatment, to name some. They have designed new approaches to surgery, creating more patient-centered facilities that dramatically reduce costs while maintaining safety and improving patient satisfaction, and implemented a simple yet powerful pre-surgery screening tool, supporting more informed shared decision-making.

By developing and refining collaborative techniques that speed up adoption of evidence-based practices, these community health plans defy the common perception that insurers and physicians are reluctant — even adversarial — players in today's

health ecosystem. In fostering strong partnerships, health plans advance both the art and the science of evidence dissemination to the exam room.

The research revealed five best practices for health plans seeking to influence and support physicians in adopting patient-centered, evidence-based interventions. Case studies, summarized in the report and included in full in the Appendix at www.transforming-care.org, illustrate these best practices at work. Many organizations employed multiple best practices, further accelerating adoption. While integrated delivery systems benefited from assets such as joint clinical and technology resources and often shared financial structures, our research found that success can be achieved in plans working with non-employed provider networks. Health plans and clinical leaders should closely examine these best practices and consider them when pursuing strategies for dissemination and implementation of evidence-based practices.

The case studies also add to a nascent body of evidence that payer-provider partnerships have sizable and lasting impacts on the health of communities. They highlight replicable, scalable strategies that health plans can deploy, and demonstrate how deeper collaboration, actionable data and targeted use of financial incentives lead to better, more efficient care and improved health outcomes.

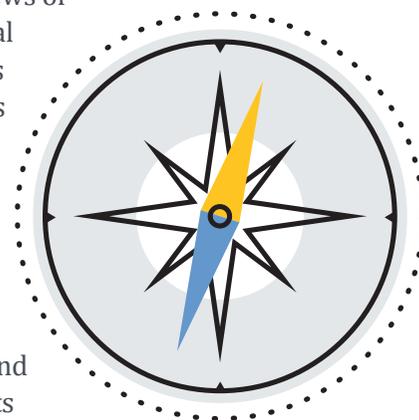
HOW COMMUNITY HEALTH PLANS ACCELERATE THE DELIVERY OF EVIDENCE TO THE POINT OF CARE: FIVE BEST PRACTICES

The community health plans in our study vary in size and business model. Some are fully integrated systems while others work entirely with contracted providers. But across these different models, several commonalities emerged about how community health plans effectively partner with physicians to adopt evidence-based interventions.

Often the impetus to improve delivery of evidence-based care arose from reviews of performance against standardized measures, particularly those tied to financial incentives or regulatory review (e.g., Centers for Medicare & Medicaid Services (CMS) Star Rating programs). In most instances, plans had the greatest success adopting evidence-based interventions when they combined multiple best practices and enlisted patients in the endeavor.

And not every innovation was a new test, procedure or therapy. In Marshfield, Wisconsin, Security Health Plan collaborated with the Marshfield Clinic Health System to relocate where surgical procedures such as hip and knee replacements are performed. By shifting to new ambulatory surgical centers and its family-friendly Comfort and Recovery Suites, the plan not only reduced costs but also created a rehabilitation center designed around patient preferences.

Our findings revealed five best practices amongst community health plans collaborating with provider partners to accelerate evidence-based care delivery. They are:



1. BUILD CONSENSUS AND COMMITMENT TO CHANGE

Health plans and providers share a desire to achieve the Triple Aim — better health and patient experience at lower cost. But setting specific priorities to support that aim can be challenging. Plans and providers that build consensus around clinical goals and priorities are more likely to succeed at improving care and outcomes.

To begin the dialogue with providers about improving care, health plans in our study capitalize on the influence of clinical leaders, community leaders and well-regarded executives. Supporting a physician leader with passion for change and helping to amplify his or her message — the way UPMC Health Plan⁷, leaders supported the UPMC surgeon⁸, who championed the use of a frailty-screening tool for surgical patients⁹ — is an effective way for plans to engage with the busy provider community.

Existing payer-provider committees can serve as valuable structures for building consensus for change. These cross-organizational groups may already be charged with reviewing clinical strategy, best practices and guidelines. If such a group does not exist, its creation should be a priority. Health plan leaders also support consensus-building by engaging in discussions built upon shared understanding of external clinical guidelines, regulations, performance metrics and industry expertise. Scott & White Health Plan in Texas formally collaborates with providers to make data-driven decisions about goals and clinical objectives. After targeting hypertension control, the health plan convened a Hypertension Work Group to, among other tasks, perform a root cause analysis of non-compliance among patients with uncontrolled hypertension. Close collaboration across the plan and delivery system helped Medicare Advantage and commercial enrollees with hypertension improve their blood pressure control by 18 and 17 percentage points, respectively.

Additional alignment strategies depend on the degree of integration between plans and provider organizations. In more integrated settings, plans have more levers of influence, including hiring practices, training and orientation to common goals; the design of incentive payment and performance review practices, and the availability of a single standard information technology data set and a single electronic health record.

“When creating a medical or drug policy, we regularly ask a network specialist or leader, ‘We’re looking at a new policy in this area to reduce unnecessary variation; what are you seeing in latest standards of care?’ This creates opportunities for physicians to identify how they want to practice; it’s not about the health plan telling them what to do, it’s about helping all of us align with evidence informed care.”

Dean Health Plan; Madison, Wis.

CASE STUDY

Creating Buy-In: Geisinger's Hepatitis C Virus Treatment Protocols

The recent evolution of pharmacotherapy to treat the Hepatitis C virus (HCV) is dramatic in terms of both efficacy and cost. While the cure rate is upwards of 90 percent, the initial launch price was nearly \$100,000 for a 12-week course of treatment. For both of these reasons, clinical and health plan leaders at Geisinger Health Plan created a robust protocol for diagnosis and treatment of HCV.

A team of pharmacy leaders, health plan medical directors, service line physician leaders, nurses, case managers, IT and data experts, and benefits managers together developed clinical and operational best practices. Products of this collaboration included standard treatment algorithms and clinical informatics tools to alleviate administrative burden and increase data transparency. Updates to the care pathway were rapidly communicated to the health plan, allowing for efficient prior authorization of treatments. The subsequent HCV CarePath was built into the delivery system's electronic health record, recommending steps from initial diagnosis to downstream specialist referrals.

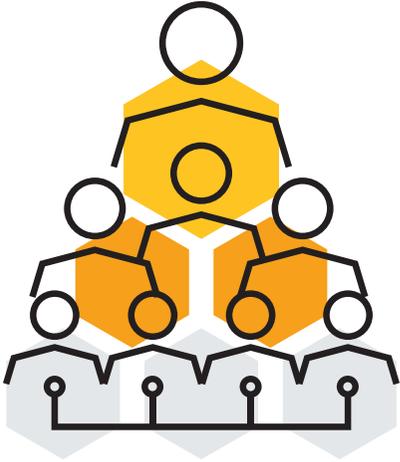
“When we focused on efficacy and total cost of care, we found a shorter treatment plan provided the same patient outcomes. Allowing us to use fewer doses of a preferred drug reduces costs by 30 percent. That means for every two patients we treat, the third is free.”

Geisinger Health Plan, Danville, Pa.

Previously, HCV patients would see a hepatologist three to five times during the 12- to 24-week course of antiviral treatment¹⁰, heavily burdening this specialty schedule. The biggest change brought about by the HCV CarePath is the use of hepatologists not as the primary physician who manages all aspects of HCV treatment but instead as a clinical expert who sees the patient once and, based on lab results, determines the customized treatment plan. Ongoing care and care management is then provided by a multidisciplinary HCV team via telephone and through Geisinger's online patient portal. This move enhances patient-provider connections and reduces the need for additional in-person visits.

A system dashboard available to all care team members gives detailed information on HCV treatments and outcomes. This data informs continuing refinements to the CarePath to maximize patient access and adherence to treatment. For example, Geisinger researchers determined that the original 12-week course of therapy was not necessary and subsequently scaled back the treatment to eight weeks. This change resulted in savings of \$30,000 per patient. By sharing with providers the economic benefit of the updated treatment plan, Geisinger was able to obtain strong clinician buy-in and consensus. To date, Geisinger has treated more than 2,000 HCV patients using the HCV CarePath, with a cure rate of 97.5 percent. The CarePath model has been replicated across other treatments, and is now being used to treat patients with psoriasis, macular degeneration and multiple sclerosis.

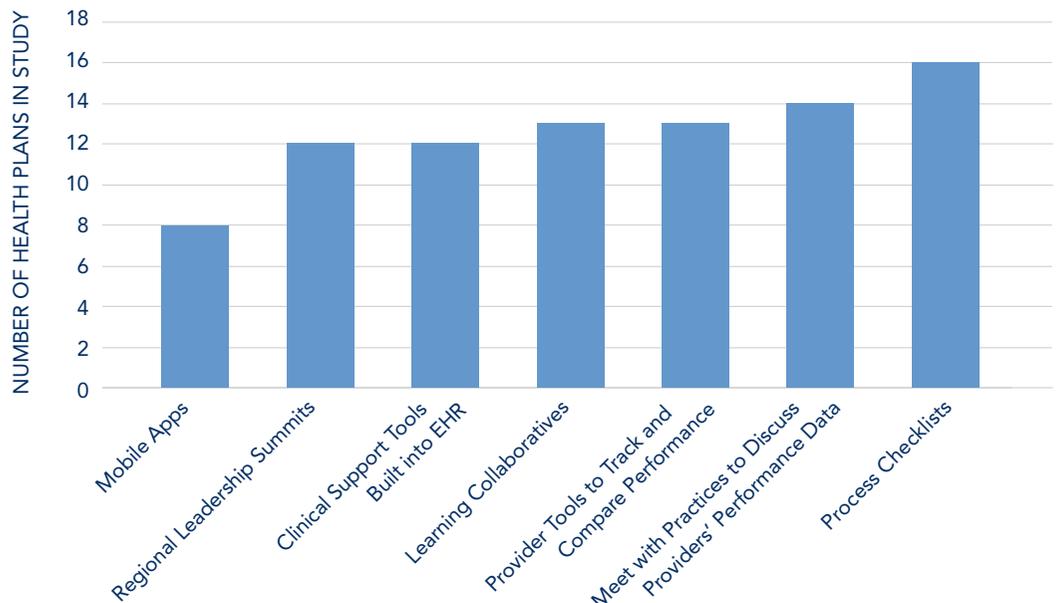
2. CREATE A TEAM THAT INCLUDES THE NECESSARY SKILL SETS, PERSPECTIVES AND STAFF ROLES



Effective improvement teams bring together front-line staff with first-hand knowledge of how the system of care works, as well as leaders capable of inspiring and implementing change. These teams may already exist in established multi-disciplinary groups, but more often they must be created to address a specific improvement project. Health Alliance Plan in Detroit, Michigan uses a holistic team of community health workers, case management nurses, care coordinators and behavioral health specialists to conduct home and nursing facility visits and to engage with patients at a frequency pegged to their risk. Patients with the highest risk also have the highest level of engagement, and environmental modifications enable them to stay at home as opposed to being transferred to a facility.

Health plans that are successful at building effective teams take a broad and inclusive approach. Not only do they recognize clinicians as equal partners in driving and supporting change, but they also engage community stakeholders in meeting population health goals and include patients in efforts to design new care delivery initiatives. In Minnesota, UCare developed a clinical-community initiative to address social determinants of health. In one of 10 projects with area health systems, UCare partnered with the local children’s hospital on a multi-disciplinary care model to better address socio-economic challenges. Integrating utilization data with clinical operations and community support has helped connect over 600 families to supportive resources in the first six months of the project.

PLANS AND SPECIFIC DISSEMINATION TOOLS AND STRATEGIES



The health plans in this study use a wide range of tools and strategies to collaborate with providers.

CASE STUDY

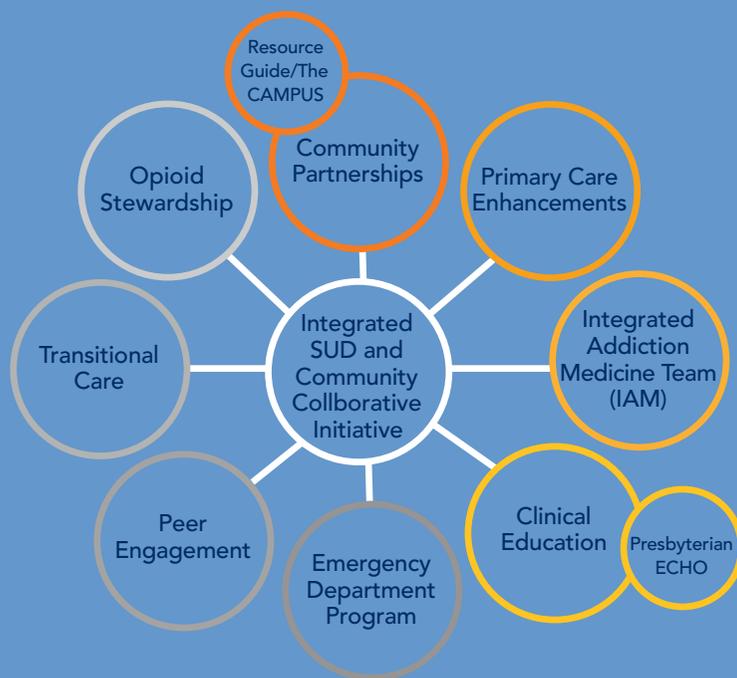
Building a Cross-Organizational, Community-Focused Initiative: Presbyterian's Substance Use Disorder Treatment Initiative

For about 20 years, New Mexico has been at or near the top of the list of states with the highest annual rate of opioid deaths.¹¹ In 2016, the Presbyterian Substance Abuse Task Force was formed to address the serious and growing problem of opiate use disorders. While the work of the Substance Abuse Task Force was underway, Presbyterian Health Plan received \$3.5 million to design and implement an innovative care model targeting individuals with opioid dependence.

With that state allowance, health plan leaders developed a multi-faceted, multi-stakeholder approach to increase screening and treatment for substance use disorders. A multidisciplinary task force made up of medical directors, behavioral health specialists and addiction experts from Presbyterian Healthcare Services, and medical directors and behavioral health and government program leaders from the health plan analyzed cost and utilization data and studied a range of existing clinical models for opioid use disorder treatment.

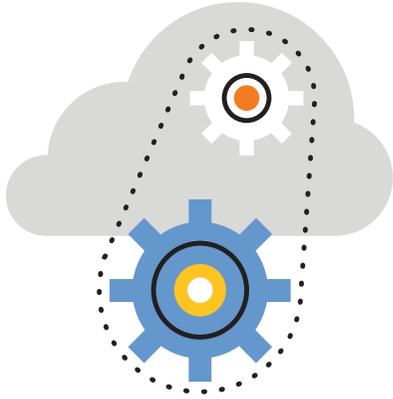
In 2017, the team launched the Integrated Substance Use Disorder and Community Collaborative Initiative, designed to engage patients any time they touch the delivery system. The initiative takes an integrated approach to the opioid epidemic, involving primary care, behavioral health, emergency services and hospital care. Key aspects include the development of a universal screening tool for substance use disorders; widespread training in prescribing drugs that are appropriate for treatment, including buprenorphine; opioid stewardship to support standardized, evidence-based treatments; engagement and care coordination from peer support workers with lived behavioral health experience who have stabilized and are in recovery; and partnerships with community and faith-based organizations focused on recovery, housing and other non-traditional services. Early metrics show that by the first quarter of 2018, more than 550 clinicians had received substance use disorder-specific trainings, nearly 100 physicians were newly certified to prescribe buprenorphine, and more than 1,500 individual lives had been touched. By the second quarter of 2018, system-wide opioid prescriptions decreased by 16 percent, buprenorphine prescriptions increased by 50 percent, and naloxone prescriptions nearly tripled.

PRESBYTERIAN HEALTH PLAN INTEGRATED SUBSTANCE USE DISORDER AND COMMUNITY COLLABORATIVE INITIATIVE



Presbyterian Health Plan is taking an integrated approach to tackling the opioid epidemic.

3. CUSTOMIZE EDUCATION, TOOLS AND ACCESS TO SPECIALIZED KNOWLEDGE FOR PHYSICIANS AND FOR PATIENTS



After developing consensus on evidence-based approaches to care delivery, plans described the importance of providing a variety of relevant, tailored communications and educational resources to their provider partners. Whether health plans share information with physicians through newsletters, periodic emails, updates to guidelines, training sessions, lectures or continuing medical education (CME) — the plans that generate the greatest change solicit provider feedback and customize information to physicians’ expressed preferences. In fact, many offer multiple ways to acquire new information.

Technology can be especially useful in disseminating information and fostering evidence-based patient care.

Plans in the study also facilitate physicians’ easy access to customized education. Through a vendor partnership, Priority Health in Grand Rapids, Michigan provides tailored risk-specific information to help physicians, care teams and patients determine the best plan for transitioning from acute and post-acute care settings. A vast database and severity-risk adjustors help clinicians access information from “like” patients and

their outcomes, providing the individualized predictive care path for each particular patient.

Other plans such as Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin and Independent Health in Buffalo, New York embed clinical support staff such as nurses, social workers and schedulers in busy practices to provide extra support and expertise accessing additional patient services.

Educating health plan members is an important component of supporting evidence-based care. ACHP plans use a wide range of educational strategies and media to inform and educate patients, including videos, in-person or online classes, health education databases, newsletters and targeted phone calls. Helping patients understand their condition and care, and shaping appropriate expectations, boosts compliance.¹²

“We’ve built a tool into the EMR that shows what types of labs are important for what types of medications. It will ping the chart, so the doc doesn’t have to do chart review. Rather than send an email or pamphlet about drug X, we just build it into the tool because they trust us to do that. If there is something they don’t understand or agree with, then they provide us with that feedback.”

Group Health Cooperative of South Central Wisconsin; Madison, Wis.

CASE STUDY

Educating Providers and Patients: Kaiser Permanente's Safe Opioid Prescribing Initiative

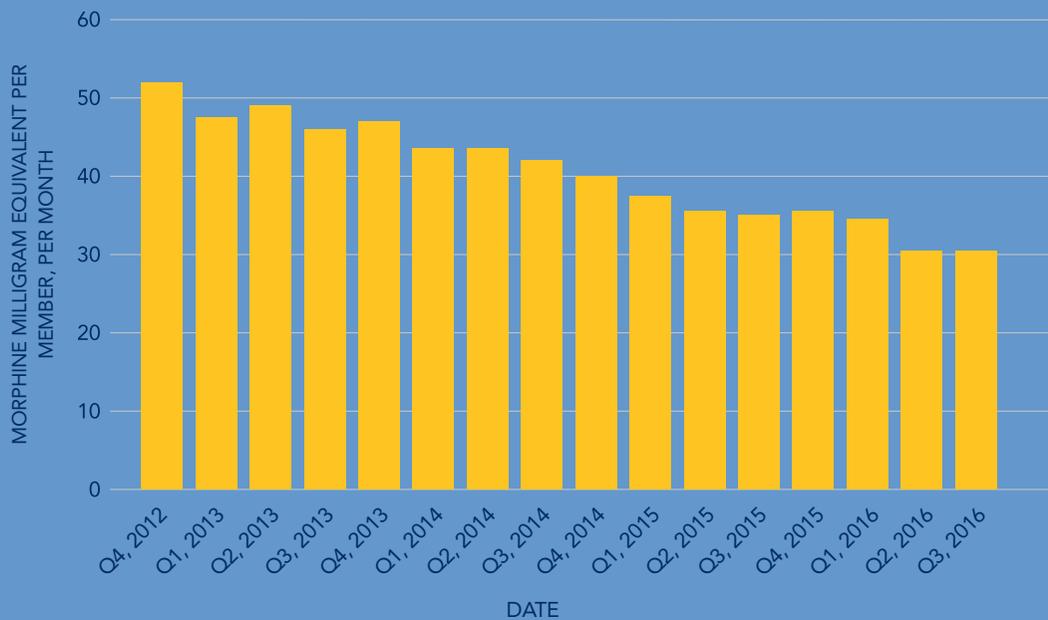
As early as 2012, when it launched its Safe and Appropriate Opioid Prescribing Program, Kaiser Permanente was working to reduce the overall use of prescription opioids among patients and improve the safety of those for whom opioids are appropriate. The California Permanente Medical Groups organized regional education presentations and deployed clinical pharmacists to brief physicians on the program. Training on safe opioid prescribing is available in-person — at live, six-hour didactic workshops led by experienced physician instructors — by video or online through self-guided modules.

Special attention is paid to skills and techniques for effective patient communication, to support physicians in having difficult conversations about pain and treatment options.¹³ Pain patients also receive educational materials and are asked to watch a video or attend an in-person session on pain control. Patients who receive opioid prescriptions are encouraged to read and sign an agreement that outlines the risks and benefits of the medication.

In addition, Kaiser Permanente Southern California established a policy that only pain specialists, oncologists, and palliative care physicians may write a new prescription for OxyContin or Opana.¹⁴ Emergency and Urgent Care Departments follow opioid prescribing guidelines from the American Academy of Emergency Medicine, which limit prescriptions to reduce the risk of opioid misuse and overdose.

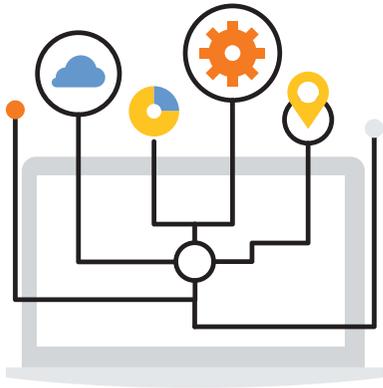
As a result, Kaiser Permanente Southern California saw a 31 percent decrease between May 2013 and December 2015 in the number of opioid users on a high daily dose (>120 MME, or morphine milligram equivalents), and Kaiser Permanente Northern California saw a nearly 50 percent reduction in the average MME per member between 2013 and 2018. Today, the safer opioid prescribing framework created by Kaiser Permanente's California Permanente Medical Groups is being adopted throughout the organization's eight regions across the nation.

KAISER PERMANENTE NORTHERN CALIFORNIA OPIOID OUTPATIENT PRESCRIPTIONS



Kaiser Permanente Northern California significantly reduced opioids dosages when appropriate through its safer opioid prescribing framework.

4. SHARE TIMELY AND ACCURATE DATA AND FEEDBACK IN A CULTURE OF TRANSPARENCY, ACCOUNTABILITY AND HEALTHY COMPETITION



Every organization participating in this study underscored the value of data and feedback in helping to identify improvement opportunities and spark behavior change. ACHP health plans meet with clinical teams to share and review data on specific issues and even specific patients, typically monthly or quarterly. The plans can share specific and aggregated claims data that physicians often cannot access, and when combined with clinical data, this presents a more complete patient picture, including opportunities for improvement.

Physicians' inherent curiosity, competitiveness and desire to do the right thing also drive positive change. Sharing regional or local data, or even comparative data from within a single practice, sets up opportunities for reflection and for peer-to-peer learning. HealthPartners in Minneapolis, Minnesota provides physicians regular data on their performance both clinically and in terms of patient satisfaction. Physicians also have access to performance data through Minnesota Community Measurement and HealthPartners' electronic medical record system. Additionally, health plan medical directors periodically meet with medical groups to review performance data and create action plans for quality improvement. Data transparency is among the key strategies that has helped HealthPartners earn a 4.5 on a 5.0-point NCQA scale for diabetes care.

Some health plans share performance data publicly, helping to hold doctors accountable to their patients and the communities they serve. Others, such as Martin's Point Health Care in Maine, email monthly reports to providers showing performance on productivity, quality, panel size and patient satisfaction. These reports include individual, site and total network performance, allowing physicians to see each other's performance. Health plan leaders hold quarterly performance review meetings with medical groups to discuss performance. These methods are powerful health plan levers in the push to adopt proven care pathways.

“We share data with our groups where they can dig right down to the individual patient. This morning we shared with a medical director a patient who has been using the emergency room a lot, and it helps the physician because sometimes they just don't know.”

Health Alliance; Champaign, Ill.

CASE STUDY

Using Data to Improve: CDPHP's Enhanced Primary Care Program

In 2008, Capital District Physicians' Health Plan (CDPHP) in Albany, New York, created its Enhanced Primary Care (EPC) program, a patient-centered medical home model that shifts payment from fee-for-service to risk-adjusted capitation with pay-for-performance bonuses. Along with financial support, CDPHP provides ongoing help and expert consultation to EPC practices. The health plan's Physician Engagement Team includes former pharmaceutical representatives who use industry knowledge to work directly with practices on performance improvement and cost savings, including more affordable prescription drug options. The health plan also embeds case managers and/or behavioral health and pharmacy staff within some practices to increase patient access and care coordination to these often-siloed services.

Through the CDPHP provider portal, physicians in EPC practices have access to data showing how their performance compares with their peers in the region and nationally on quality measures such as diabetes care and cancer screening rates among their patients. Data shows that the EPC practices provide higher quality care than non-EPC practices, and improve the care they provide at a faster rate. Between 2010 and 2014, quality scores for EPC sites rose from 71 to 77 percent, while quality scores for non-EPC sites rose from 65 to 68 percent.

Moreover, between 2012 and 2014 CDPHP realized a cost savings of \$20.7 million directly related to the program. Approximately 60 percent of this savings was experienced in the commercial line of business.

In 2017, in addition to reimbursing practices at rates greater than fee-for-service, CDPHP also distributed \$3.1 million in bonuses to 175 practices that improved quality, efficiency and patient satisfaction scores. The bonuses have allowed Enhanced Primary Care practices to invest in staff and technology that support improvements such as expanded office hours, easier appointment access, more electronic communications and coordinated care.

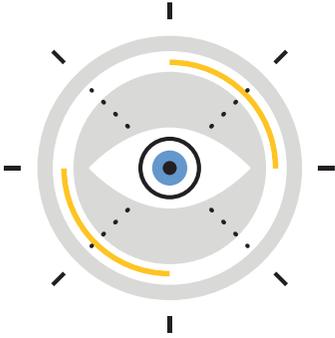
“We share extensive, detailed information with providers about their performance on key utilization and quality metrics. Providers appreciate this opportunity to view their data, and report that they get more extensive information from us than from other payers. Providing robust data helps to support providers' efforts to improve their services and to assess their initiatives.”

UPMC Health Plan; Pittsburgh, Pa.



5. ALIGN FINANCIAL INVESTMENTS WITH CLINICAL AND PATIENT EXPERIENCE GOALS

Financial incentives such as pay-for-performance arrangements have only modest impact on clinician behavior unless coupled with other best practices, such as establishing shared goals and providing appropriate education and support.



Health plans in the study, however, found that financial incentives are most effective at jumpstarting change efforts or underwriting the cost of new staffing and tools, particularly as those incentives focus on outcomes rather than process measures. A health plan's investments in providers and practices can take other forms, such as embedding nurses to provide case management.

When Independent Health of upstate New York enrolled thousands of new Medicare members due to changes in the marketplace, the plan worked with physicians to design pre-visit and visit tools to streamline information gathering. Independent coupled that with a 60 percent higher payment rate for these longer-than-normal intake visits. The number of Medicare members with a documented Enhanced Annual Visit increased from 44,000 to 66,000. Data from these assessments is a critical element in ensuring that the health plan receives appropriate reimbursement from Medicare and seniors receive comprehensive care.

Non-payment for services or procedures that do not adhere to best practices guidelines can also be a very effective strategy to influence physician behavior.

“Financial incentives are very effective at promoting provider engagement and discussion. I have yet to see them change provider behavior or outcomes dramatically. Sometimes it's because they were already performing well. But regardless, incentives do not produce overnight change.”

AvMed; Miami, Fla.

Alternative payment models, including risk contracts that tie payment to overall care and patient outcomes, can foster a stronger sense of partnership between plans and providers, and can create incentives for more robust information sharing in both directions.

For example, in spring 2018, Massachusetts-based Harvard Pilgrim Health Care negotiated an outcomes-based contract with AstraZeneca for SYMBICORT®, a drug to treat asthma and chronic obstructive pulmonary disease (COPD). Through the agreement, Harvard Pilgrim will monitor whether asthma-related symptoms for patients on SYMBICORT® are in line with the clinical trial results provided by the drug maker. If the occurrence of worsening symptoms or exacerbations requiring medical intervention exceed predetermined thresholds, Harvard Pilgrim will pay a lower amount. This is the third outcomes-based contract the plan has signed with the manufacturer in the last two years.

CASE STUDY

Using Financial Policy to Cross the Finish Line: SelectHealth's Initiative to Eliminate Inappropriate Early Inductions of Labor

Located in Utah, the state with the highest birth rate, Intermountain Healthcare and its health plan, SelectHealth, began to focus in 2001 on reducing the incidence of elective inductions of labor prior to 39 weeks. Early inductions that do not meet clinical criteria can increase the risk of infection, can result in premature birth, longer labor and increased need for Cesarean deliveries, and do not improve pregnancy outcomes.¹⁵ Additionally, Intermountain's data shows an increase in Neonatal Intensive Care Unit (NICU) admissions and ventilator usage in relation to gestational weeks.

An improvement team developed clinical guidelines including a new protocol: clinicians wishing to schedule an early-term elective delivery were asked to get advanced permission from their department chair or a perinatologist. Within six months, the percentage of early elective inductions had dropped to less than 10 percent for SelectHealth members who get their care in the Intermountain network. By 2007, that number had dropped to less than three percent.¹⁶

Fast-forward to 2015, when the statewide preterm birth rate of 9.1 percent exceeded the March of Dimes goal of 8.1 percent. Working with the March of Dimes and a statewide quality collaborative, SelectHealth and Intermountain leaders set a new, more ambitious goal: eliminate all elective inductions prior to 39 weeks.

An important new policy was established: Beginning in July 2015, the health plan would no longer pay for non-medically necessary elective inductions prior to 39 weeks' gestation in its network. If such deliveries occurred, financial sanctions (non-payment) would be applied against both the provider and the hospital where the delivery occurred. Today Intermountain's rate of inappropriate elective inductions is zero — resulting in shorter labors, fewer C-sections and demonstrating savings of \$2.5 million per year. Based on the success of this initiative, SelectHealth has replicated the payment model for five other surgical procedures, including hip and knee replacements, spinal surgery, tonsillectomies and adenoidectomies, and hysterectomies.

INTERMOUNTAIN/SELECTHEALTH PERCENT OF ELECTIVE INDUCTIONS PRIOR TO 39 WEEKS



Intermountain and SelectHealth eliminated non-medically necessary elective inductions of labor before week 39.

COMBINING BEST PRACTICES FOR MEANINGFUL IMPACT



The case study summaries in this report are snapshots highlighting how each health plan used a specific best practice. None of the successes came easily. In fact, every health plan in our study employed many or all of the best practices in order to produce meaningful change.

For example, to improve opioid safety at Kaiser Permanente Southern California and Northern California, physicians must complete an education program that is offered in several different formats and media — thus customized to learners’ preferences. At the same time, Kaiser Permanente created new policies that significantly limit the types of specialists who can prescribe certain narcotics, empowered pharmacists to question high-risk prescriptions that do not comply with guidelines, added opioid prescribing decision support tools to electronic health records *and* stepped up patient education efforts, especially for pain patients.

Minnesota-based HealthPartners improved depression screening for high-risk populations such as adolescents and postpartum women¹⁷ by increasing primary care providers’ access to case-based learning; developing electronic health record

prompts and reminders about screenings; opening the care system so that new mothers are screened whenever and wherever they touch the system, including at their baby’s early checkups; embedding social workers and other specialists in primary care clinics for easy consultation; and creating value-based contracts that reward quality, patient experience and affordability.

Recognizing unique circumstances of each organization, the community health plans in this study demonstrated that a combination of multiple initiatives — with data transparency as a foundational building block — increases the speed and success of changing clinician behavior.

“*We separate our members into four cohorts based on health status, from ‘well and occasionally ill’ to ‘frail with complex needs.’ We have specific communication strategies and vehicles for each group. For patients with greater needs, we coordinate communication and education with their care manager and/or physician.*”

PacificSource Health Plans; Springfield, Ore.

Closing

The central role that community health plans play in influencing physician behavior and accelerating evidence-based adoption has been largely underappreciated.

To be sure, clinicians are themselves responsible for keeping up with and incorporating into the delivery of care the most current practices. This critically important challenge is often made harder by competition for attention; insufficient time, staff, funding, materials or technology; and conflicting approaches to evidence.

In today's competitive health sector, myriad companies leverage technology and data in an attempt to overcome these obstacles. Nonprofit, community health plans are uniquely positioned for success because they invest heavily in their relationships with providers and provider organizations. The deep local roots these plans share with local physicians provide common ground, stability and longevity, important foundations for building trust and effective partnerships — centered on patients.

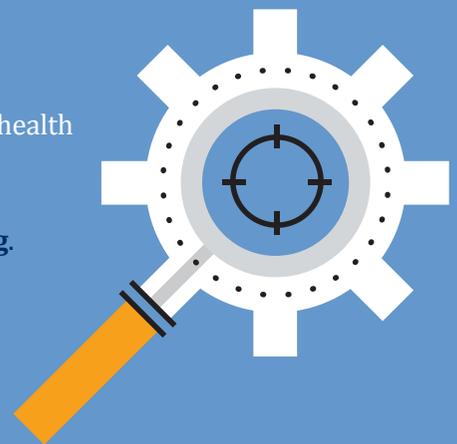
As demonstrated in this report, when high-performing health plans collaborate closely with health systems and communities, evidence-based decision-making increases. These health plans have an uncommon ability to influence provider behavior. Through consensus building, enhanced transparency, aligned incentives, real-time data and trusting environments, they accelerate dissemination and adoption of evidence-based interventions.

It is both a role and a responsibility that is critical to the nation's pursuit of a high-quality health care system that consistently delivers better care, better health outcomes and lower costs to all Americans.

Additional case studies, resources and more at www.transforming-care.org.

“*We don't employ physicians; we are not an integrated system. But we have a deep connection in the community because we reside there. In order for us to provide a high quality of care for our members, it's important for us to have a very clear partnership and collaboration with physicians in this community.*”

Independent Health; Buffalo, N.Y.



APPENDIX

ABOUT THE ALLIANCE OF COMMUNITY HEALTH PLANS

The Alliance of Community Health Plans (ACHP) is a national leadership organization bringing together innovative health plans and provider groups that are among America's best at delivering affordable, high-quality coverage and care. ACHP's member health plans provide coverage and care for more than 21 million Americans across 32 states and the District of Columbia. These organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and quality of care, including primary care redesign, payment reform, accountable health care delivery and use of information technology.

To learn more, go to www.achp.org and follow ACHP on Twitter @ACHP.

ACKNOWLEDGEMENTS

This report was partially funded through a Patient-Centered Outcomes Research Institute® (PCORI®) Eugene Washington PCORI Engagement Award (4109-ACHPF).

The views presented in this report are solely the responsibility of ACHP and do not necessarily represent the views of the Patient-Centered Outcomes Research Institute® (PCORI®), its Board of Governors or Methodology Committee.

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METHODOLOGY

This project was undertaken as a Eugene Washington PCORI Engagement Award Dissemination Initiative. ACHP first conducted a literature review on best-practice dissemination and the role of health plans in physician behavior change. ACHP established an Advisory Panel of external and member plan leaders to guide the project.

ACHP then engaged all member plans beginning in spring 2017. The Advisory Panel helped formulate a set of standardized questions to collect examples of payer-provider partnerships in pursuit of the Triple Aim. Ninety-minute phone interviews with clinical plan leaders identified unique features of each organization's relevant work, common themes, and successes and barriers. Special attention was paid to scalable, replicable approaches.

ACHP also analyzed available performance data from sources such as the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and CMS Medicare Advantage Star Ratings. Follow-up interviews and site visits provided more in-depth exploration. Stakeholder workshops and Advisory Panel consultation took place throughout the project. A group of external reviewers provided valuable feedback on an early draft report, which was refined to reflect their guidance.

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