HIMSS

Intermountain Healthcare

AMAM Stage 7

Case Study

Intermountain Healthcare

Profile

Intermountain Healthcare is a not-for-profit system of 24 hospitals, 215 clinics, a Medical Group with 2,500 employed physicians and advanced practice clinicians, a health insurance company called SelectHealth with over 900,000 members, and other health services in Idaho, Utah, and Nevada. We have over 40,000 caregivers serving the needs of our patients and members. Intermountain is widely recognized as a leader in transforming healthcare by using evidence-based best practices to consistently deliver high-quality outcomes and sustainable costs. For over 50 years Intermountain has made the use of data and analytics integral to the support of our care delivery.

The Challenge

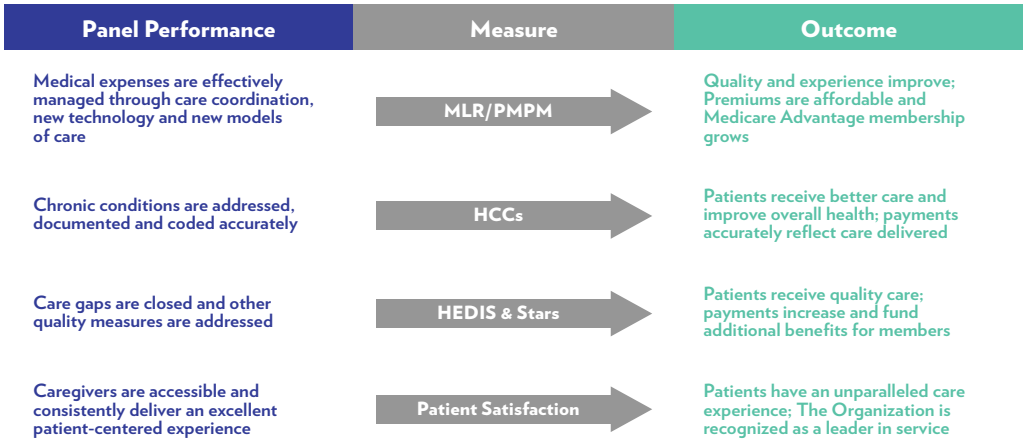
Reimagined Primary Care (RPC) is a novel practice model designed and implemented at Intermountain Healthcare that delivers high value care for patients with financially aligned, "at risk" payers (payers with whom the system has a financial risk-bearing or risk-sharing relationship). RPC is designed around multi-payer risk, incorporating all of Intermountain's insurance/payer group products (including commercial, Medicaid, and Medicare Advantage), Intermountain's Accountable Care Organization (MSSP 1+ ACO), and multiple other aligned commercial and Medicare Advantage plans. Reimagined Primary Care represents the leading edge of the Intermountain's rapid shift from volume to value-based care.

RPC started in mid-2018 with 8 providers and 5,000 patients in four of the system's clinics. By the conclusion of 2019, RPC will include 45 physicians and advance practice providers in 25 clinics across the region, including both urban and rural settings, caring for approximately 50,000 patients in a totally value-aligned practice model. RPC providers include internal medicine, family medicine, and geriatric specialist providers practicing in Intermountain's Medical Group.

Implementation Overview

RPC was conceived and designed in late-2017 and early-2018 by a team comprised of executive leadership, the Enterprise Initiative Office, and Internal Medicine leaders. Important design features include creating meaningful alignment around value, building teams for value-based care, and implementing supportive workflows and technological innovations.

Goals were set around 4 main categories:



RPC aligns the incentives of patients, providers, the health system, and payers.

The deployment process including processes, staff roles, training, and engagement

Panel Alignment

In order to allow providers and caregiver teams to focus on value-oriented care, provider patient panels are narrowed to only those patients associated with at-risk payers. (Accommodations are made for patients displaced by RPC to see other system providers in standard clinical environments.) By narrowing provider panels to strictly aligned payer plans, teams can focus efforts on value-based care without concerns for sacrificing fee-for-service productivity or having to restrict value-oriented activities to subgroups of patients within a panel. Aligned panels also allow provider teams to educate patients on important elements of value-based care, helping patients implement value-based activities (such as health promotion and involving primary care in healthcare decision making).

Incentive Alignment

RPC providers are shifted from a clinical productivity (wRVU-based) compensation plan to a salaried compensation plan with financial incentives for value-oriented behaviors and outcomes. This change eliminates volume as the basis of clinical success, allowing teams to dedicate time and effort to value-oriented activities. Frontline caregivers (medical assistances, care guides, practice administrators, etc.) are similarly incentivized for achievement of value-oriented metrics. Provider and caregiver financial alignment with patient-centered and institutional priorities creates an entire ecosystem of value-oriented care.

Teaming for Value-Based Care

Delivering value-based care is a team endeavor, with each team member contributing vital skills and knowledge to promoting health and treating illness. Each RPC team consists of a provider, care guide, medical assistant, care manager, clinical documentation nurse, a psychologist and psychiatrist (through Intermountain's Mental Health Integration team), and pharmacist support.

Select RPC roles are designed as follows:

- Physician and APP: Provide excellent care to patients across the spectrum of illness while leading the team in implementing health promoting, value-oriented care models.
- Medical Assistant: Assist the provider with delivering patient-centered care during clinical visits.
- Care Guide: Support the provider and patient by identifying patients in need of care, addressing care gaps (such as needed preventive services), and following through on important health and social needs to minimize unnecessary medical expense.
- Clinical Documentation Nurse: Support the provider in identifying and capturing important risk-adjusting coding opportunities.
- Care Manager: Engage with high risk patients (such as post-hospitalization) to improve clinical care and minimize unnecessary medical expense.

Supporting Value-Based Care

Value-based care requires important changes in how healthcare is delivered.

Workflows

RPC teams implement a variety of value-oriented workflows. RPC teams conduct daily huddles focusing on identifying, preparing, and following up patient-centered value-based activities. Examples include addressing gaps in care, monitoring and intervening during high risk clinical moments (such as transitions of care), attending to social needs of patients, and ensuring same-day access in order to avoid unnecessary utilization of high cost, low value medical services. RPC teams also conduct weekly huddles on topics such as improving patient experience, assessing and improving medical expense trends, and addressing clinical needs of patients.

Technology

RPC teams use novel technologies to drive value-based care. An electronic daily huddle board surfaces information on patients who require medical attention, have unaddressed clinical quality indicators, are hospitalized or recently discharged, or who have other unaddressed needs. Reporting technology also identifies important elements of population health (such as unnecessary utilization) that is actionable by RPC teams.

Partnerships

RPC leadership has built (and continues to build) functional high-value care pathways with multiple clinical specialties focused on high-value care. For example, RPC providers have access to a special musculoskeletal triage and treatment pathway involving caregivers and providers from Intermountain's Musculoskeletal Clinical Program.

Implementing Value-Based Care

With support from the Executive Leadership Team and Enterprise Initiative Office, the Internal Medicine/Geriatric and Family Medicine Service Lines implemented RPC in 2018 and 2019. Over that time, three cohorts transitioned to RPC. Cohort 1 transitioned in Q3/2018. Cohort 2 transitioned in Q1-2/2019. Cohort 3 transitioned in Q3-4/2019.

Provider/Team Selection

Prospective RPC providers were chosen based on high pre-existing risk panels, natural inclination to provide value-based care, and growth mindset. Individual providers were approached by RPC leaders to explain RPC design and implementation, review current panel constitution, and discuss panel transition processes. Providers were given financial information on panel performance and personal impact from shifting to salaried, value-based care. Other caregivers were involved in the discussion of transition expectations and value-based care.

Clinic Transition

Providers and clinics who elect to change from standard practice to RPC go through many transitions. In order to align patient panels, clinics and leadership develop access plans for displaced patients, often involving hiring additional non-RPC clinical staff. RPC teams adopt a process of daily patient-centered huddles centered on the RPC huddle board and weekly data-driven value-based huddles on important population health topics. Teams change daily visit templates (schedules) to accommodate more same-day access. Caregivers develop and implement patient "onboarding" education to help them understand how to make the best use of new clinic value-based processes and access.

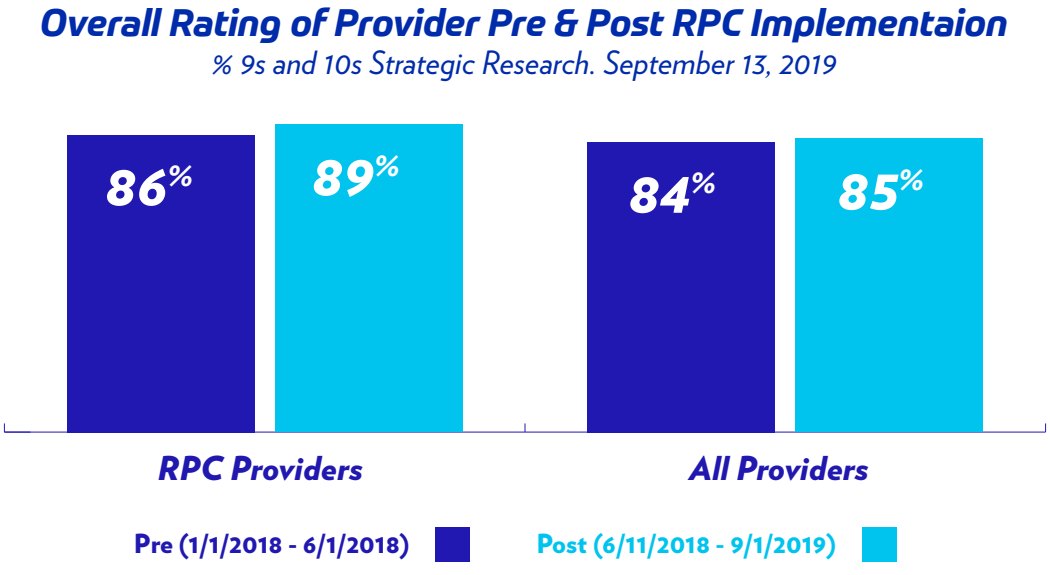
Training Teams

RPC leadership conducted routine in-person and remote training of teams. These trainings included technology orientation, daily huddle orientation and modeling, weekly transition meetings, value-based morbidity and mortality conferences.

Resulting Value / ROI

Reimagined Primary Care has identified and delivered on multiple critical value-based care objectives. The five areas highlighted below demonstrate the results achieved and highlight the analytics used to track these significant improvements.

Patient Experience of Care

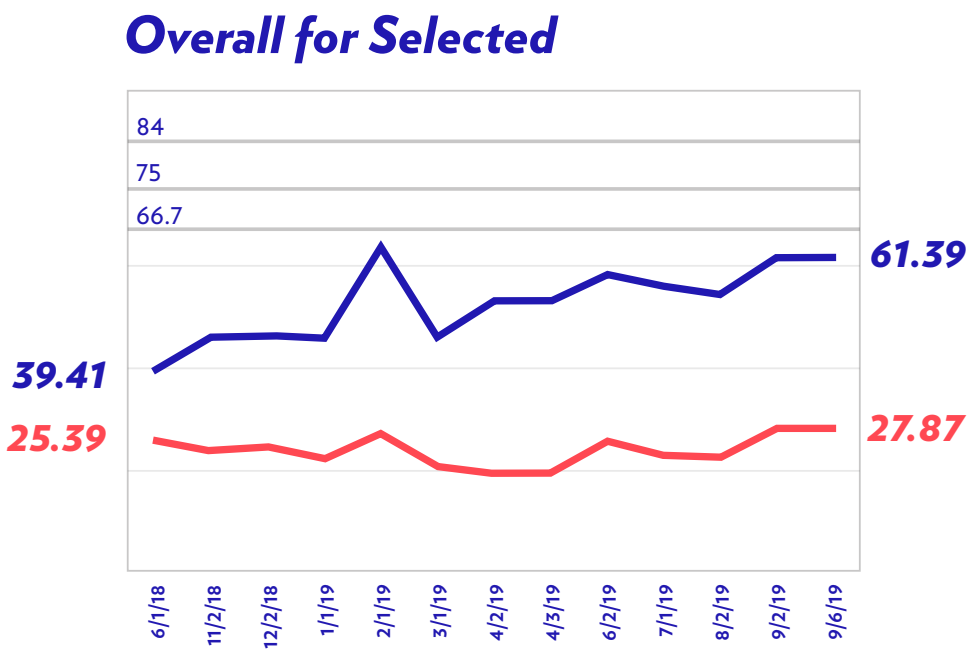


RPC providers achieve 3% improvement compared to 1% improvement of their peers

Provider Experience of Care

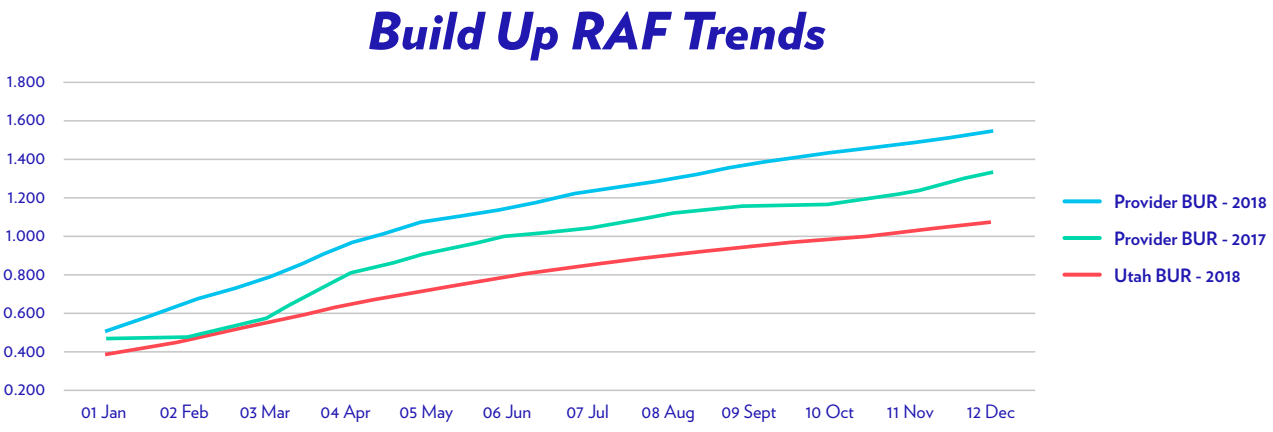
Overall engagement of 4.29 for RPC providers compared to 3.59, other primary care providers.

Improved Clinical Quality



Blue is the rest of the medical group. **Orange** is the RPC cohort.
Represents a quality composite score percentage.

Improved Documentation and Coding Performance



Improved year over year performance in Risk Adjusted Factors (RAF)

Reduced Utilization and Medical Expense

- 10% decline in emergency department (ED) visits
- 30% decline in inpatient admissions
- 39% decrease in specialized nursing facilities (SNF) discharges
- Compared to a matched control group, RPC patients experience ~31% lower costs than the control group.

Lessons Learned

1. Transitioning to a fully value-aligned clinical model in a legacy health system has many opportunities and challenges. A desire to provide high-value, population-health oriented care is palpable among many providers and caregiver teams despite having practiced in a volume-oriented clinical environment for many years. This is true both in the primary care and specialty care environments. That said, there are many adaptive behaviors that promote success in volume-driven care that require retraining and refocus as teams shift to value. At the level of the provider (e.g. daily work), administration (e.g. changing payment models), and payer (e.g. willingness to shift to value-aligned contracting), syncing multiple changes is an ongoing complication. Aligning a historically mixed payer model involves displacing patients from one provider to another, which is a difficult process for patients and providers that requires thoughtful application of clinical and financial resources. Providing insightful data to teams and creating pathways for meaningful data-informed action is an ongoing opportunity for improvement.

2. The principal lessons learned in Intermountain's RPC development and implementation process is that shifting to value-based care thoughtfully and rapidly is possible in a legacy health system if there is dedication within the health system and alignment with payer partners. Results from a shift to value-based care may accrue more rapidly than expected, but significant investment is required.

3. In the future, we will continue to work on aligning more payer contracts, spreading the tools and technologies from this work, and sharing the best practices of RPC across the system.

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