PREMIER

Population Health – Competencies and Measurements for Success

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6th Annual Eastern Regional Patient Safety and Quality Symposium
Eastern AHEC Department of Nursing Education

September 10, 2014

Objectives

1. Identify transformation drivers
2. Define population health
3. Describe necessary health system partnerships
4. Discuss competencies and measurements for successful population health
5. Identify elements of a self- assessment approach

Followed by Q &A / Discussion

1. Transformation Drivers

A. Reimbursement changes

B. Practice response and course shifts

“Americans always do the right thing, after they have tried everything else”

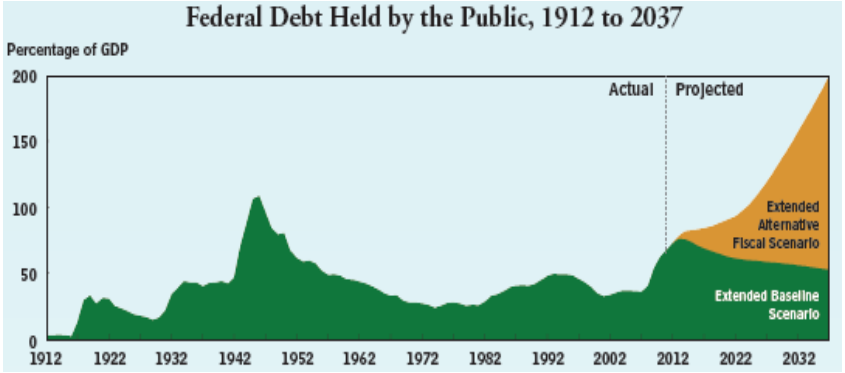
– Winston Churchill

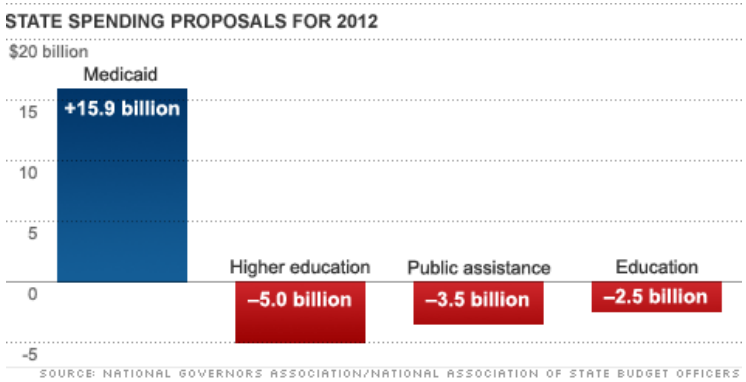
Increasing market pressure nationally

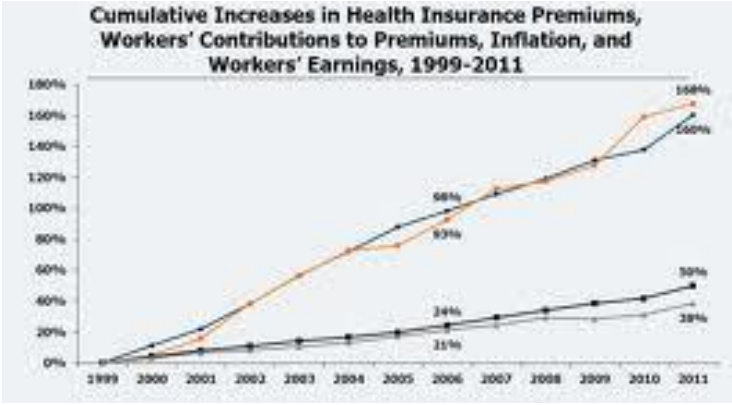
Federal

State

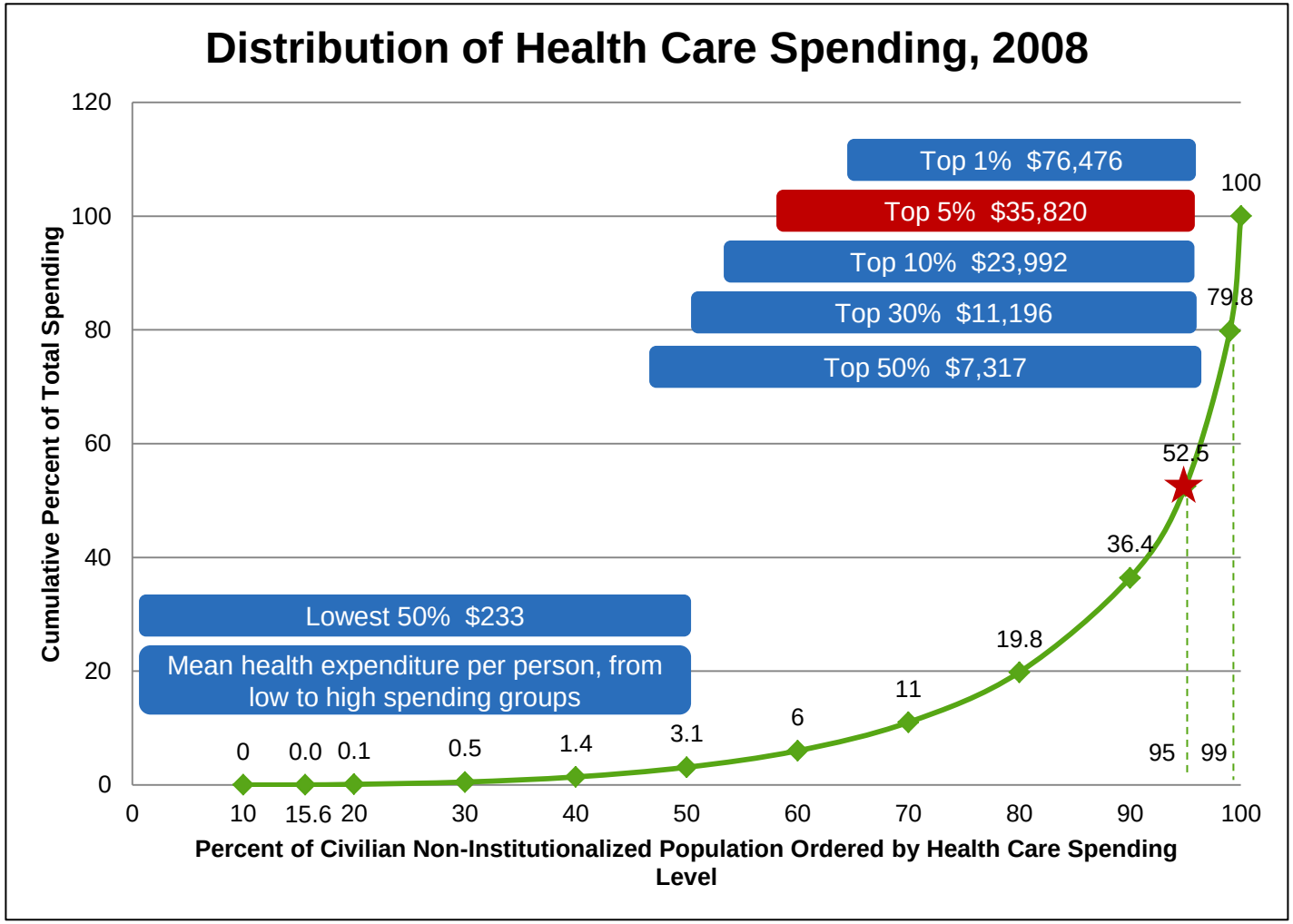
Private:
Employee / Commercial







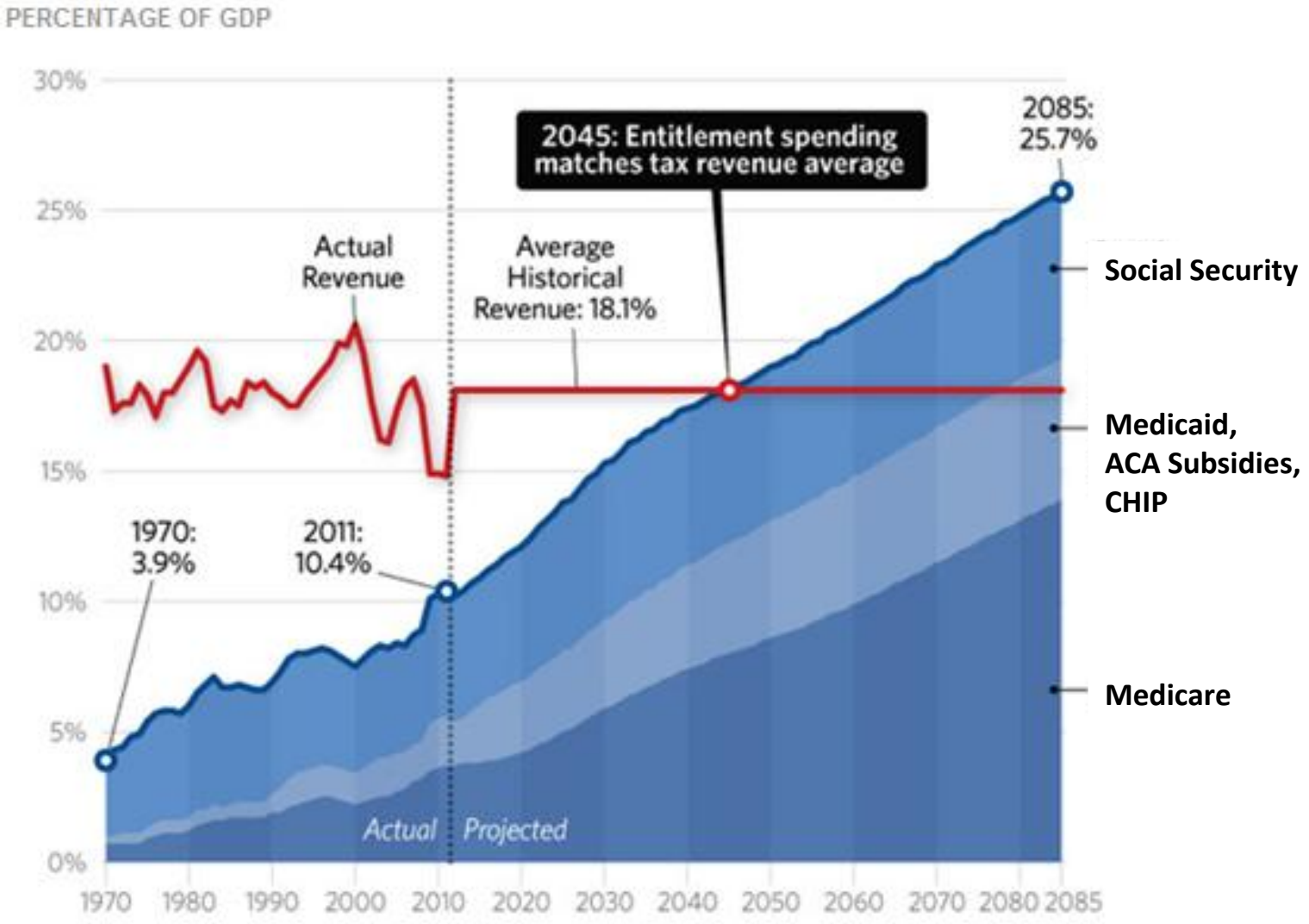
Approximately 5% of the U.S. population accounted for 47.5% of its health care spending, from 2005 to 2009



Driven by an increase in high medical spending by the general population, "spending by the Top 5% of spenders declined from 56 percent in 1987 to 47.5 percent in 2008. This flattening of the spending distribution is consistent with the well-documented increase in population risk factors – most notably, obesity – and a concomitant increase in treated disease prevalence for chronic conditions that are clinically linked to these risk factors, such as hypertension, diabetes and hyperlipidemia."

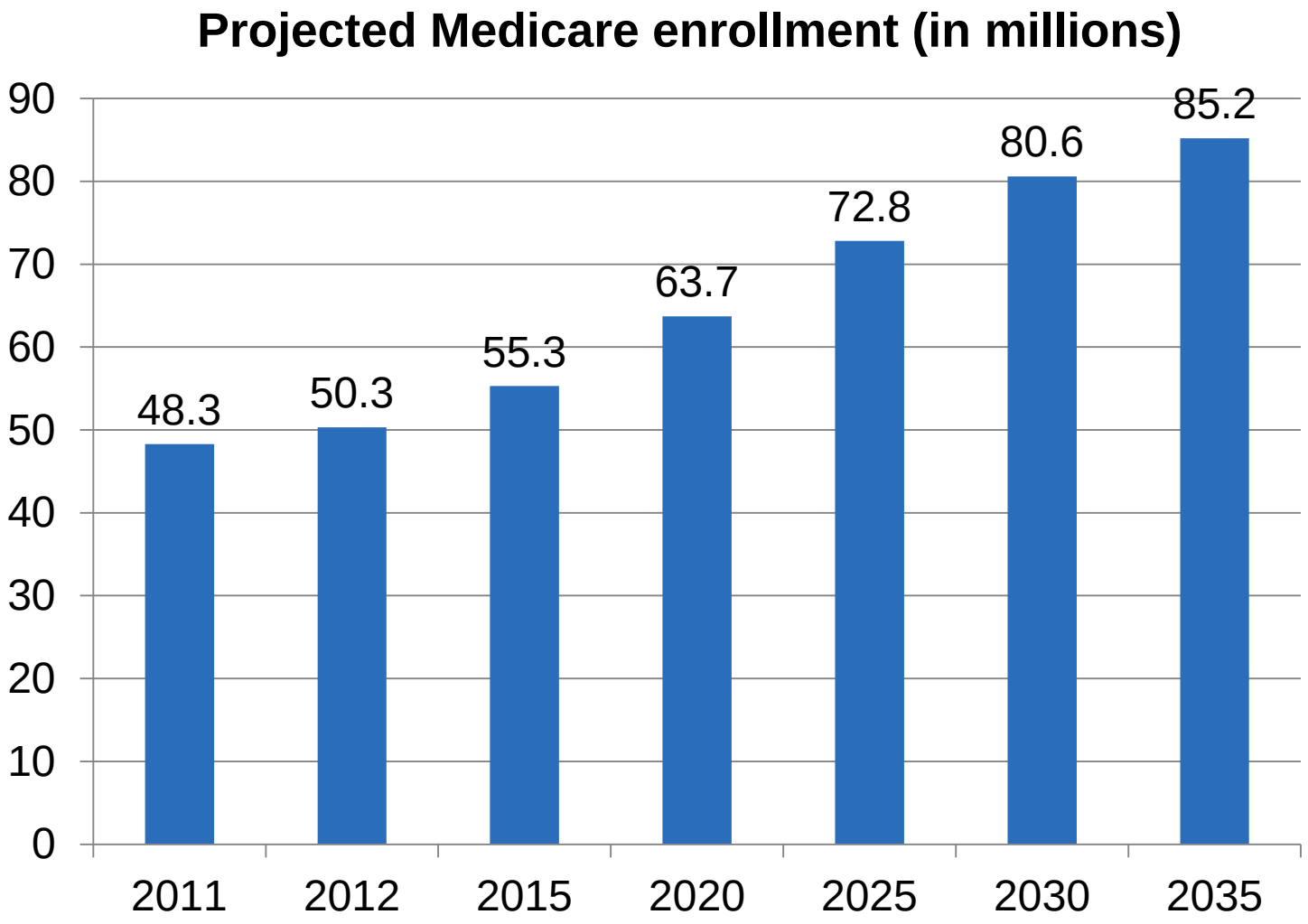
Source: Understanding U.S. Health Care Spending: National Institute for Health Care Management Foundation, July 2011.

What drives our debt: Entitlement spending as share of economy



Source: Congressional Budget Office (Alternative Fiscal Scenario).

Projected Medicare enrollment



Source: 2012 Annual Report of the Boards of Trustees for the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds

Government/Medicare is driving change now

Payment Models

	Physician	Outpatient Hospital and ASCs	Inpatient Acute Care	Long Term Acute Care	Inpatient Rehab	SNFs	Home Health Care
	RBRVS	APC	MS-DRG	MS-DRG	RICs	RUGs	HHRGs
Track 1	VBP modifier plan published on 11/1/11 Implement in FY2013 PFS	P4R in FY2013; VBP implementation plan submitted to Congress on 4/18/11	VBP commenced 10/1/12	P4R in FY14: VBP test pilot by 1/1/16	VBP test pilot by 1/1/2016	VBP impl. plan sent to Congress 6/15/13	VBP impl. plan to Congress overdue (10/1/11 deadline)

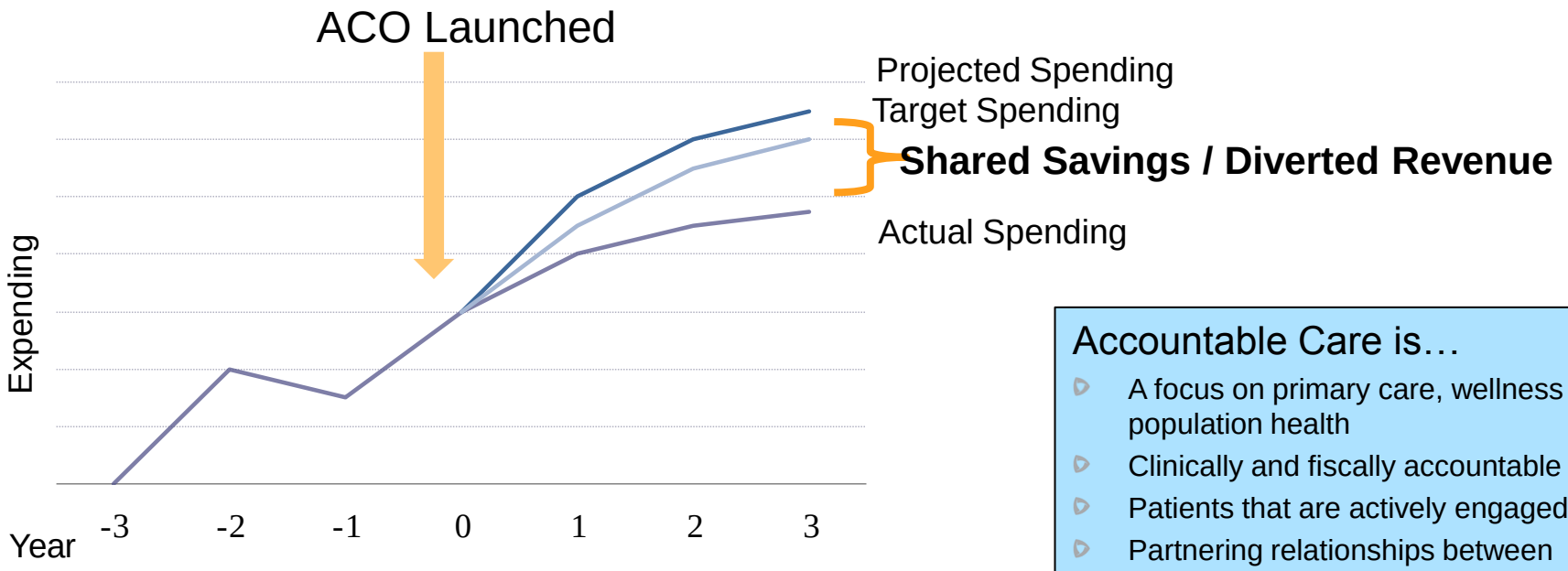
Track 2

Accountable Care Organizations

- Care Management
- Bundled Payment Models
- Shared Savings
- Medical Home

Accountable care and the shared savings model

Accountable Care Organizations (ACOs) or Accountable Care Delivery Systems, while still evolving, are expected to connect groups of providers who are willing and able to take responsibility for improving the health status, efficiency and experience of care for a defined population.



Accountable Care is…

- A focus on primary care, wellness and population health
- Clinically and fiscally accountable
- Patients that are actively engaged
- Partnering relationships between hospitals and physicians
- Anticipating health needs and proactively managing chronic care

Source: Lewis, Julie. *"What Could be Next for Health Reform? The Debate In Washington" Presentation*. The Dartmouth Institute for Health Policy & Clinical Practice. 2009-07-02.

Other major payor developments across the U.S.

- **Acceleration of consumer driven health plans and new payment arrangements**
- **Components of new payment models**
  - Transformational funding
  - Care management
  - Shared Savings
- **Early adopters include the following**
  - Regional Blue Cross plans (MN, MA, IL, HA, etc.)
  - Commercial Health Plans (Aetna, Cigna, Humana, etc.)
- **Partnering with MSSP ACOs**
  - Universal American (31 MSSPs)
  - Walgreen's (3)
- **Building delivery systems**
  - Highmark purchases seven hospitals/physician practices
  - Cigna – Primary Care Network (PCMH)-Phoenix
  - United HealthCare-Monarch physicians group (2300 physicians) and Optum
  - Aetna purchases Active Health
  - Da Vita acquires Healthcare Partners
- **Growth in Provider Sponsored Health Plans**
- **Medicaid Managed Care/ACOs**
- **New Maryland Waiver Program (Global Revenue Program)**

1. Transformation Drivers

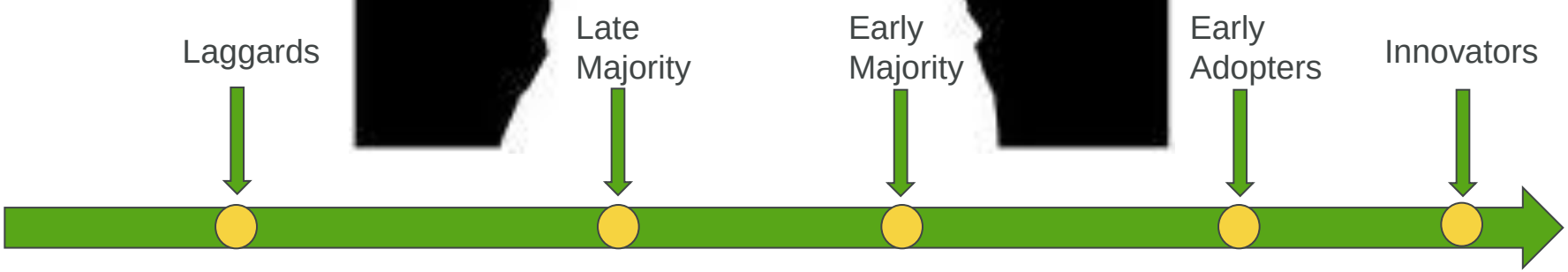
A. Reimbursement changes

B. Practice response and course shifts

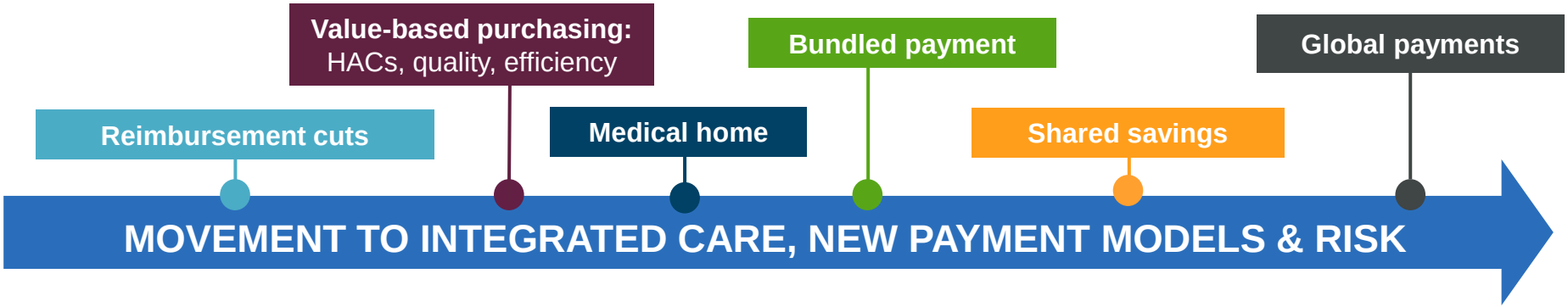
Transitioning to population health management:
Requires a foot in more than one camp

- Pay for volume
- Fragmented care
- FFS
- Treating sickness
- Adversarial payors
- Little HIT
- Duplication & waste

- Pay for value
- Coordinated care
- Global payment
- Fostering wellness
- Payer partners
- Fully wired systems
- Right care, right setting, right time



The journey to population health management



High Performing Hospitals
- Cost management
- Waste elimination
- Best outcomes in quality, safety
- Satisfied patients
- Physician alignment
- Growth strategies

High Value Episodes
- DRG and episode targeting
- Care models
- Gainsharing
- Data analytics
- Cost management
- Physician integration

Population Management
- Population analytics
- Care management
- Financial modeling and management
- Legal
- Physician integration and leadership
- Covered lives

Overall major market response to drivers of change

Increasing focus on value and quality:

- Ongoing transition toward value-based payment models
- Increased regulatory complexity will lead to greater transparency
- Growth in evidence based medicine (Choosing Wisely)

Collaboration and consolidation on the rise:

- Blending of delivery systems, health insurance plans, and technology firms
- Consolidation of hospitals, health systems, physicians and the continuum of care

Significant investments in IT to continue:

- Investment in EHRs to meet federal incentive programs
- Information technology will drive data integration and care redesign
- New informatics needed to understand patients, populations and providers

2. Concepts of Population Health

“Things do not get better by being left alone”

– Winston Churchill

Alphabet soup - Part 1

- **Population health -** the health outcomes of a group of individuals, including the distribution of such outcomes within the group. A group can be defined by geography or include other types such as employees, ethnic groups, disabled persons, etc.*

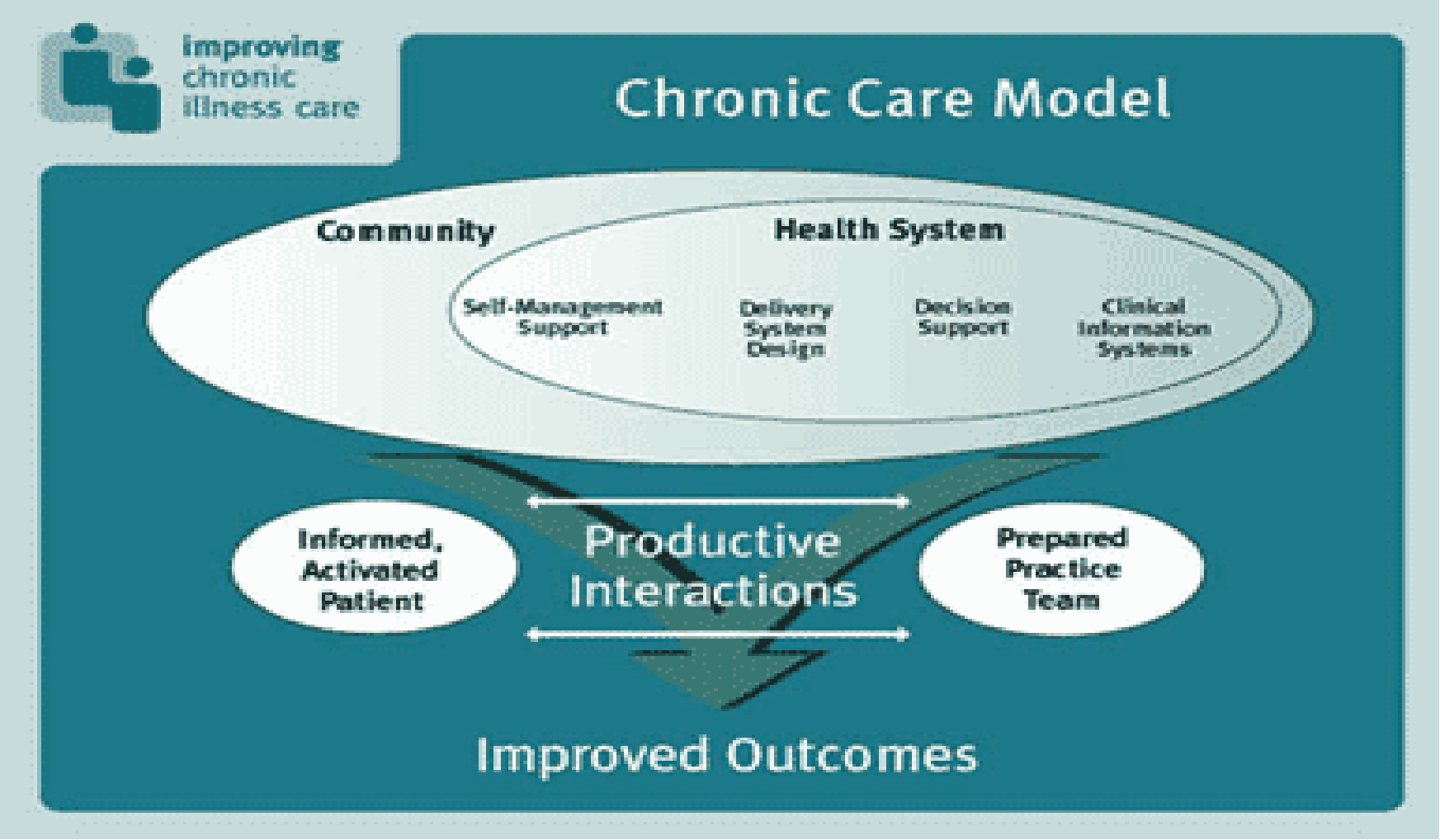
- **Population Health Management** – managing the care for a defined set of individuals with the goal of improving the quality, efficiency and patient satisfaction for the overall group

* Source: Kindig and Stoddart. “What is Population Health?” *Am J Public Health*. 2003 March; 93(3): 380–383.

Population health market segments

- Employee Health Plan
- Self-funded Employers
- Private Health Plans
- Medicaid Program
- Medicare Program
- Uninsured
- Retail Health Insurance

Wagner's Chronic Care Model

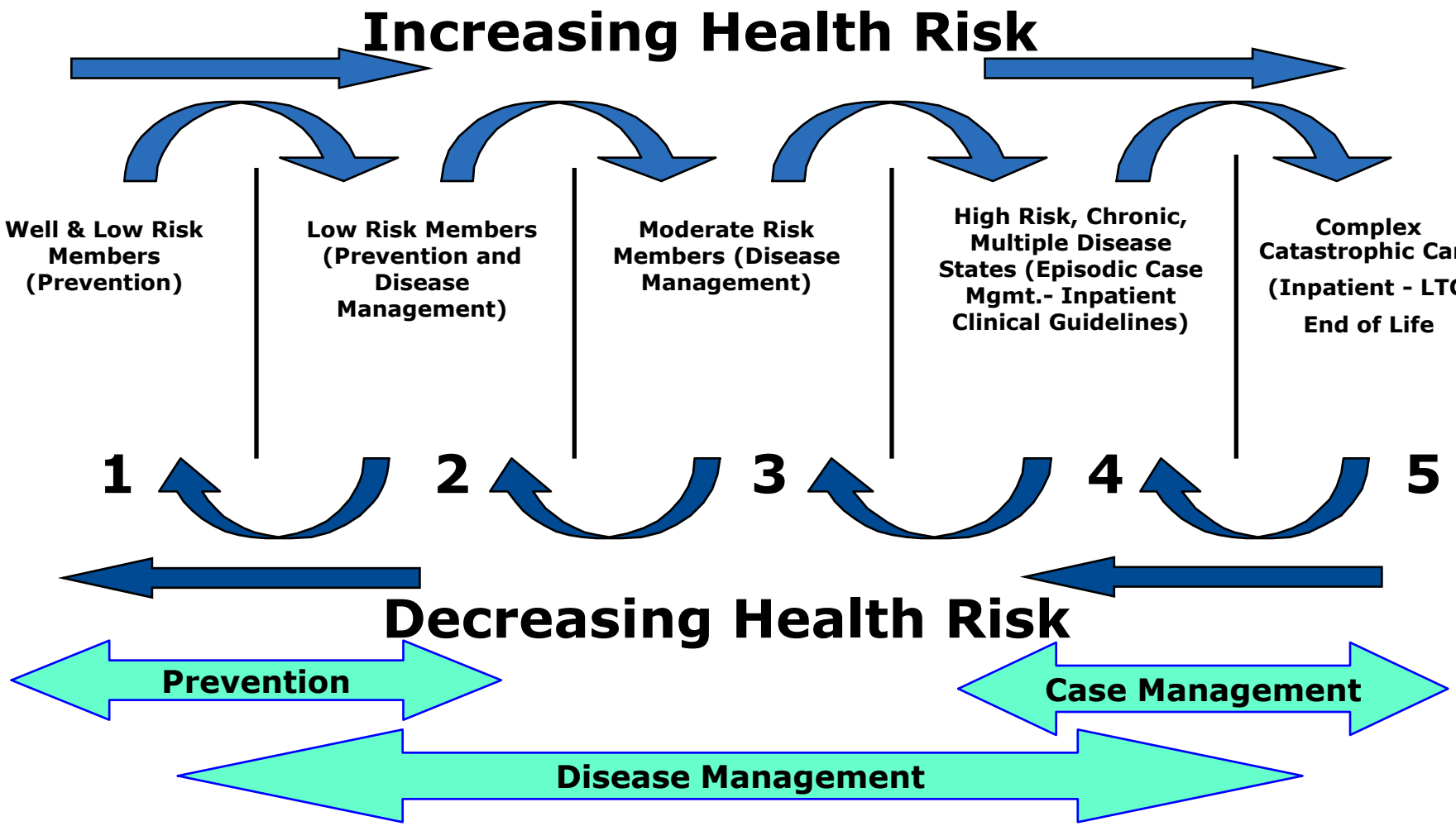


Source: Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effective Clinical Practice*. 1998;1(1):2-4.

Chronic Care Model Essential Elements

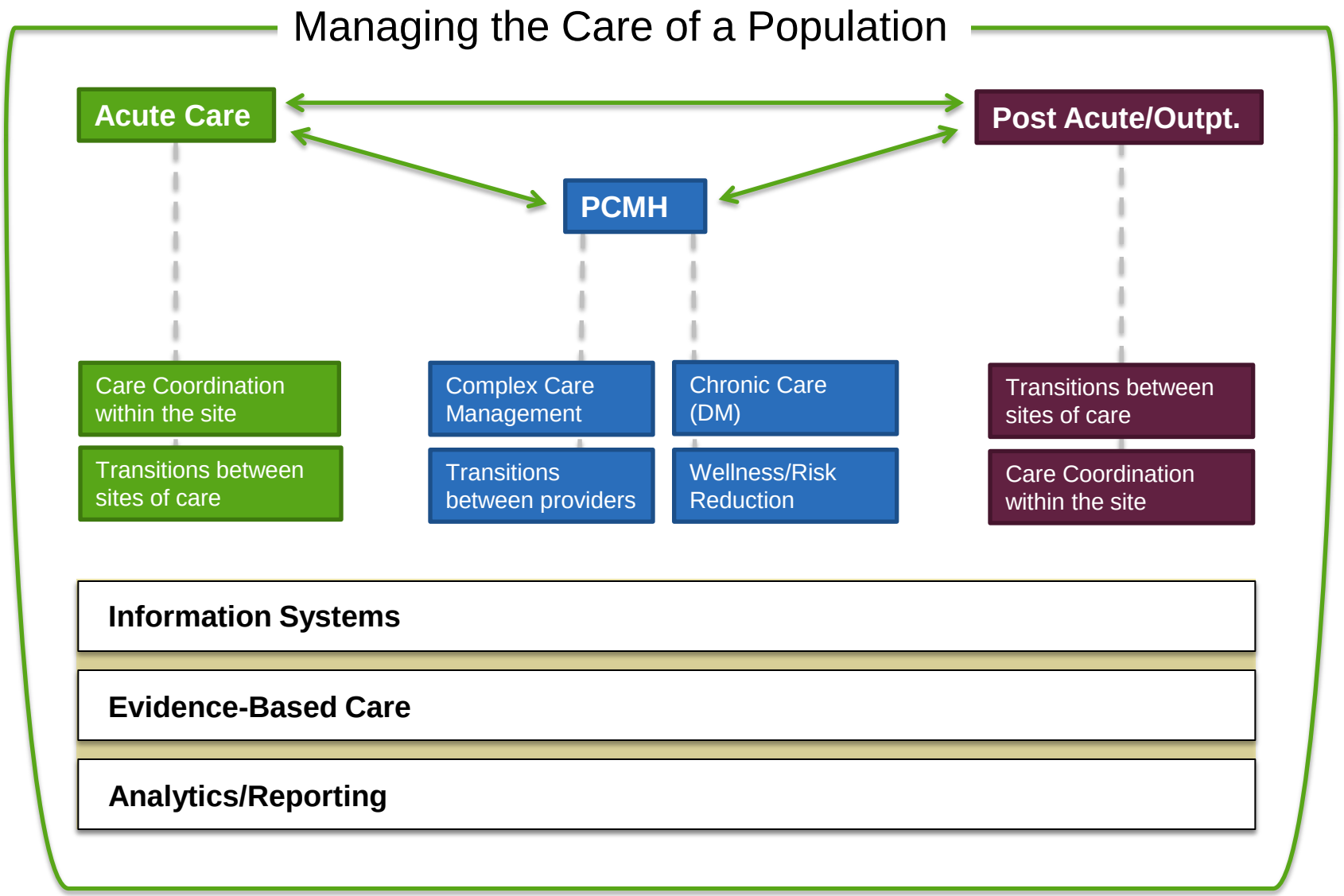
1. Health System – Create a culture, organization, and mechanisms that promote safe, high-quality health care
2. Delivery System Design – Assure the delivery of effective, efficient clinical care and self-management support
3. Decision Support – Promote clinical care that is consistent with scientific evidence and patient preferences
4. Clinical Information Systems – Organize patient and population data to facilitate efficient and effective care
5. Self-Management Support – Empower and prepare patients to manage their health and health care
6. The Community – Mobilize community resources to meet the needs of patients

Population-Based Care Management Framework



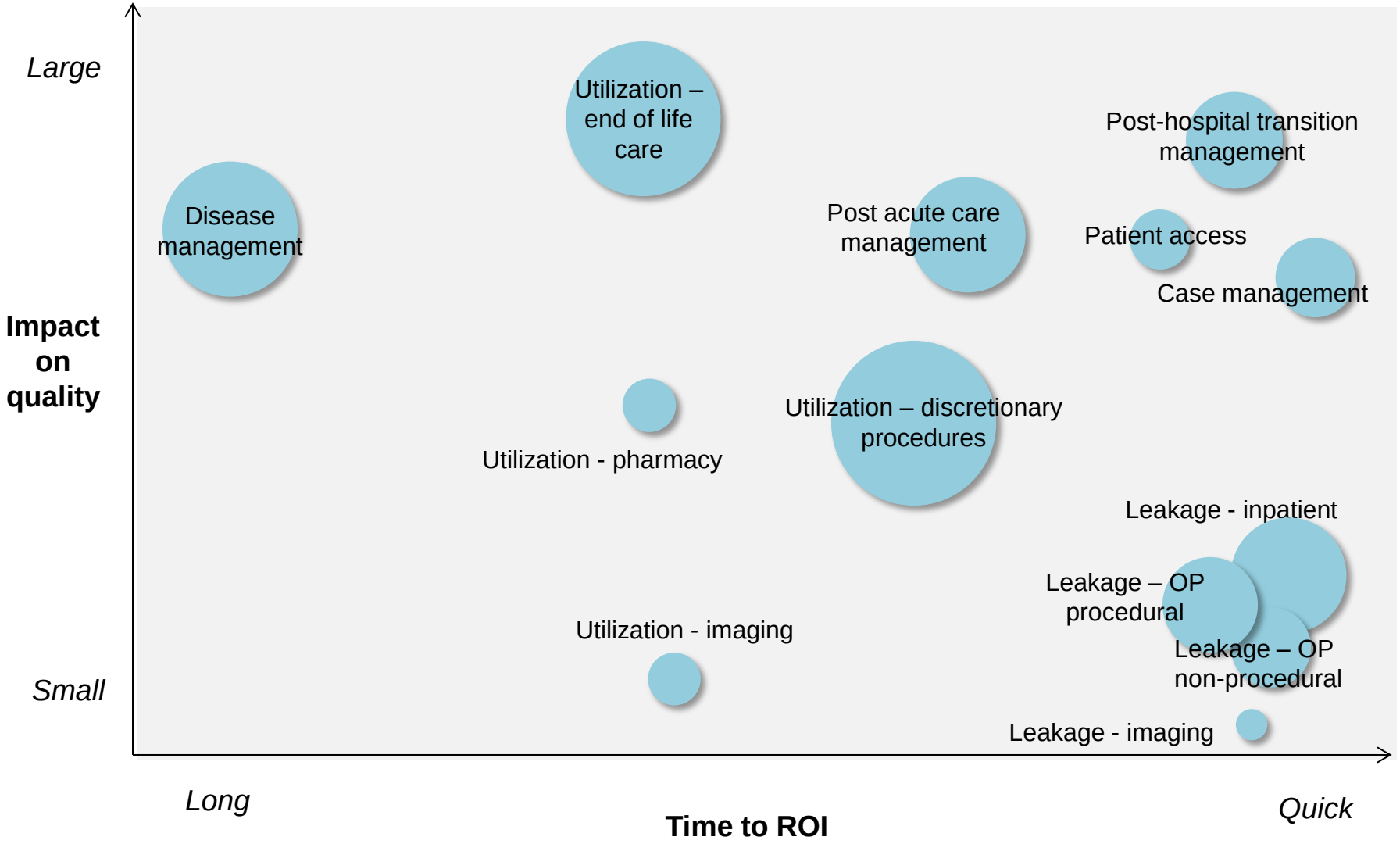
Source: Paul H. Keckley, formerly, Executive Director, Deloitte Center for Health Solutions, Washington DC PhD, 2007 National Predictive Modeling Summit: The Landscape for Predictive Models

Care Management Takes Place Across the Continuum



Prioritizing interventions is key to maximizing ROI

Population health interventions by time to ROI and impact on quality



ROI – Return on Investment, OP - outpatient

3. Health System Partnerships

Care integration and partnerships

Alphabet soup - Part 2

- **Clinical integration** - integration of clinical information and healthcare delivery services across the continuum of care to improve the value of the care provided. This may include preventive, acute care, post-acute, rehabilitation, home health services, and palliative care.

- **Clinically Integrated Network (CIN)** – providers in a joint venture that meet the Federal Trade Commission (FTC) definition of an active and ongoing program that evaluates and modifies practice patterns by the venture's participants and creates a high degree of interdependence and cooperation among the venture participants to control costs and ensure quality.

- **Accountable Care Organization (ACO)** - groups of providers who are willing and able to take responsibility for improving the health status, efficiency and experience of care for a defined population.

- **Medicare Shared Savings Program (MSSP)** – program that started in 2012 that allows ACOs to contract with CMS with the goal of improving quality and efficiency. ACOs that contract with CMS are deemed as CINs

A CIN overview

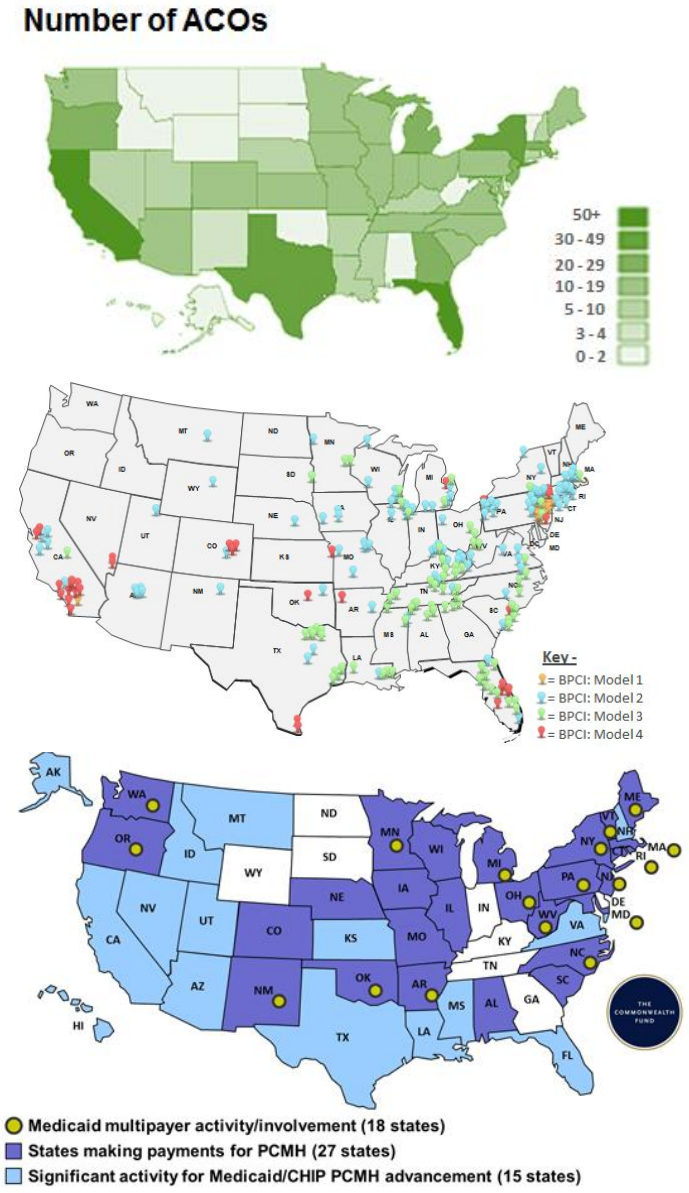
- Despite the movement to employ physicians, there will remain many mixed medical staffs (employed and independent physicians)
- A CIN is a vehicle to align the incentives of hospitals and physicians on the medical staff in order to work together on quality and efficiency improvement and to approach the market as a united enterprise
- A CIN is a building block for the development of strategies that allow physicians and hospitals to prosper in the new reformed payment environment
  - Value based purchasing
  - Bundled payments
  - Medical homes
  - Shared savings distribution
  - Accountable Care Organizations

New reimbursement accelerating nationwide

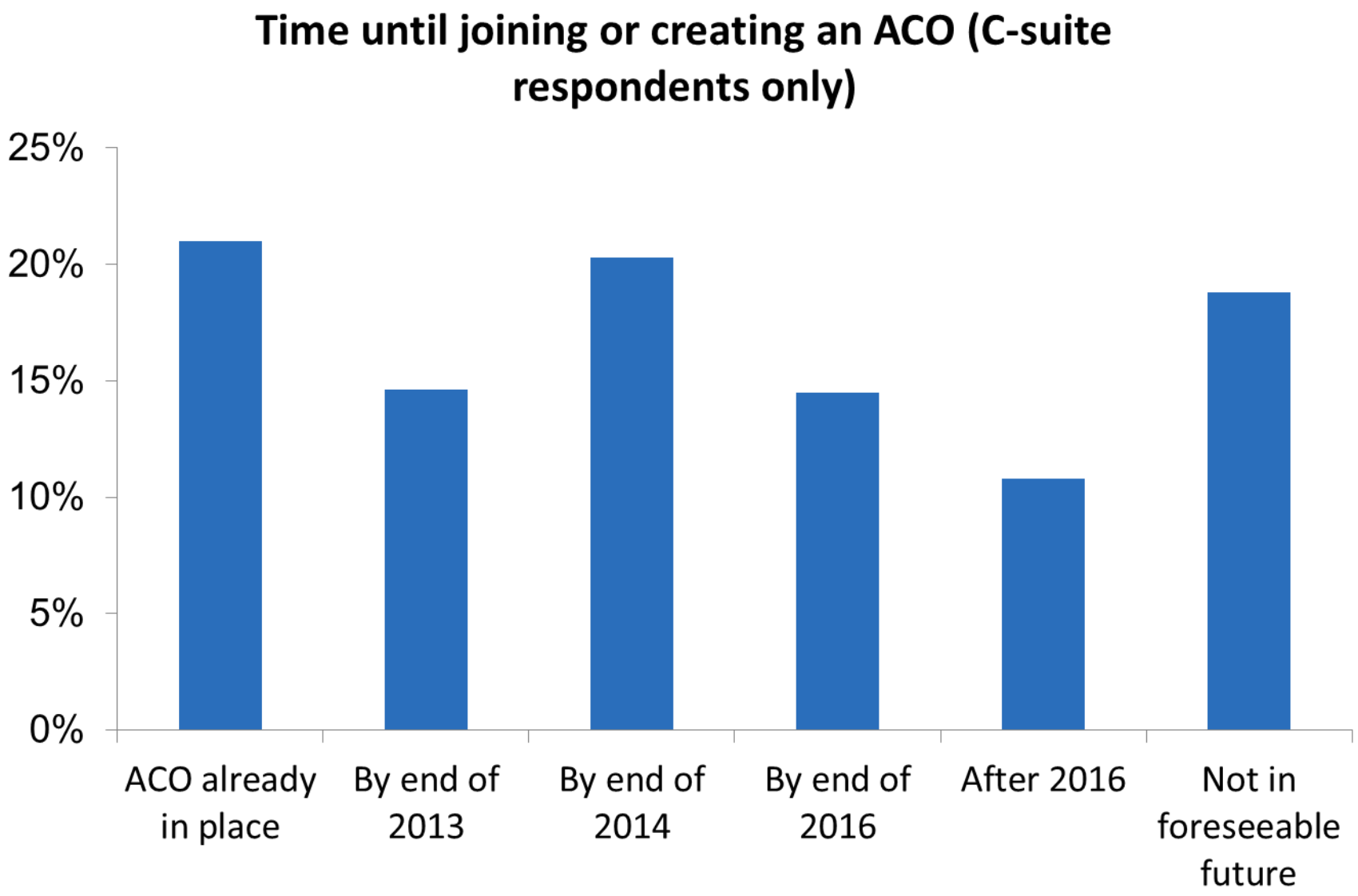
- Over 600 Commercial and Medicare ACOs now operating nationwide
- 5.3 M Medicare lives are covered
- For first time in decades the Medicare per capita growth was below GDP growth

- CMS Bundled Payment initiative has 500 participants and growing
- Arkansas has a Medicaid Bundle
- Commercial payors and employers increasingly adopting bundle payment arrangements

- 42 state Medicaid/Chip programs planning/implementing PCMH
- 27 states making medical home payments
- 18 involved in multi-payer pilots

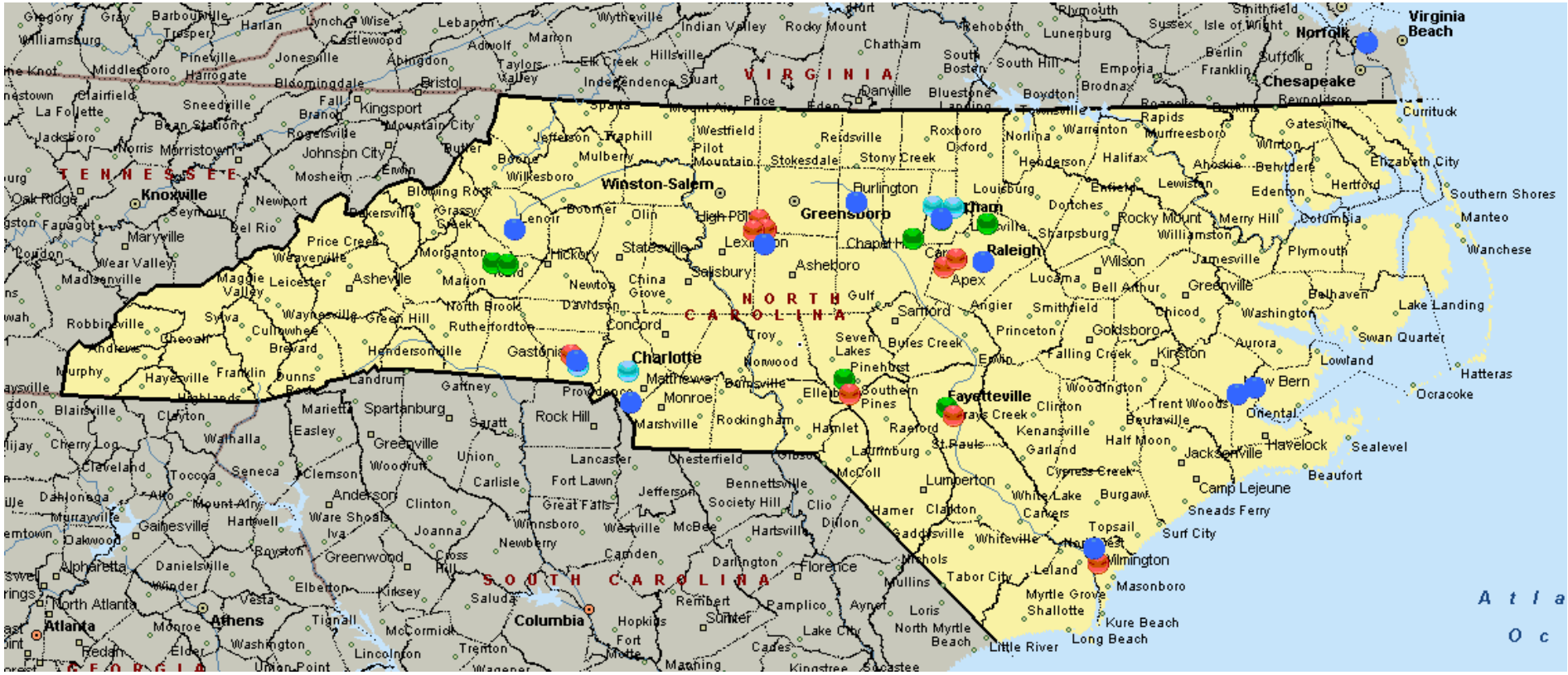


Majority of hospitals will have an ACO by 2016



Source: Premier Economic Outlook, Spring 2013

Accountable care programs in North Carolina growing

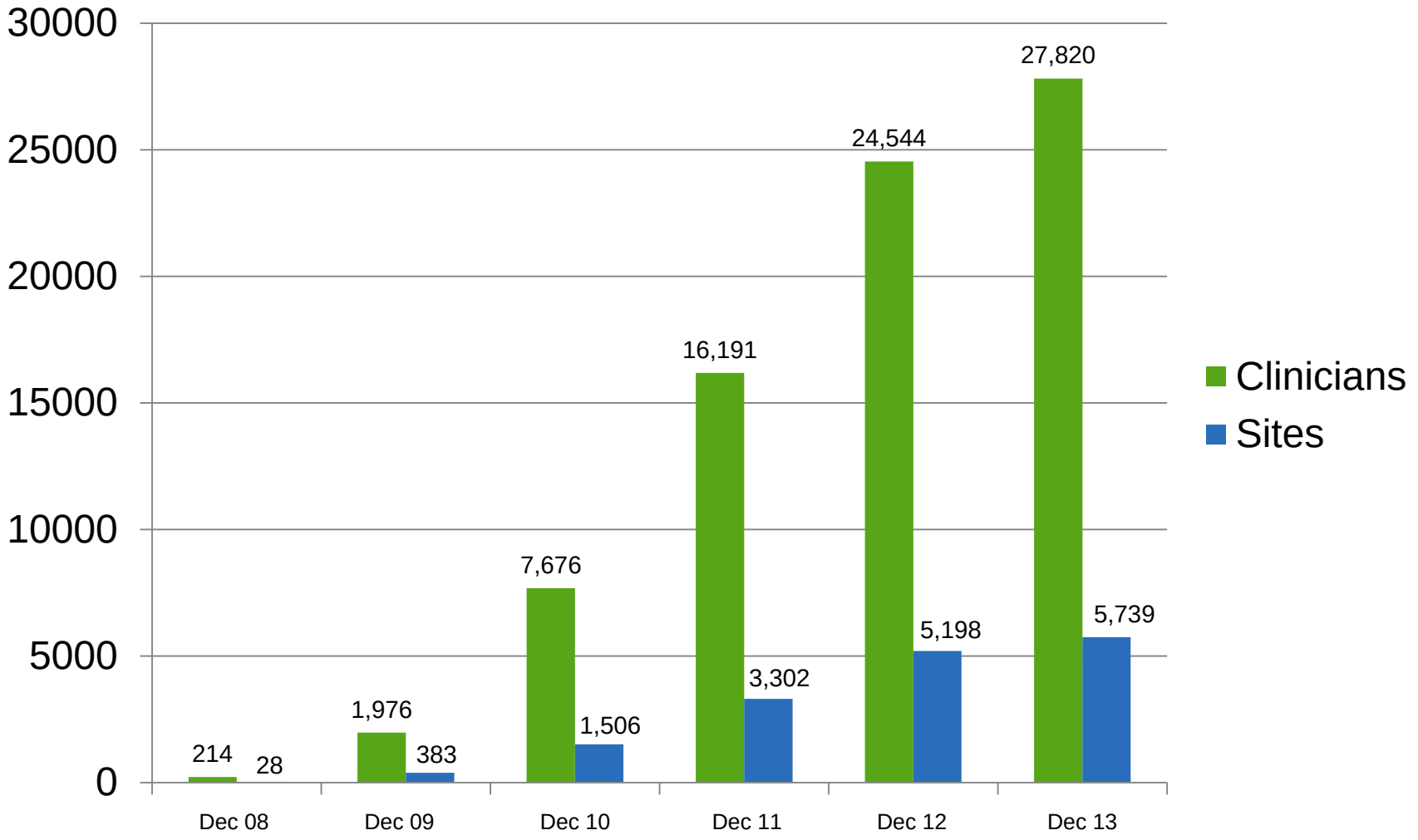


- **Medicare ACOs (14)**
- **Commercial ACO Arrangements (9)**
- **Medicare Bundle Payment for Care Improvement (7)**
- **Commercial Bundle Payment Programs (4)**

In the VH area (3 Medicare ACOs):

1. Accountable Care Coalition of Eastern North Carolina
2. Coastal Carolina QualityCare
3. Bayview Physician Group

NCQA Patient Centered Medical Home growth 2008-2013



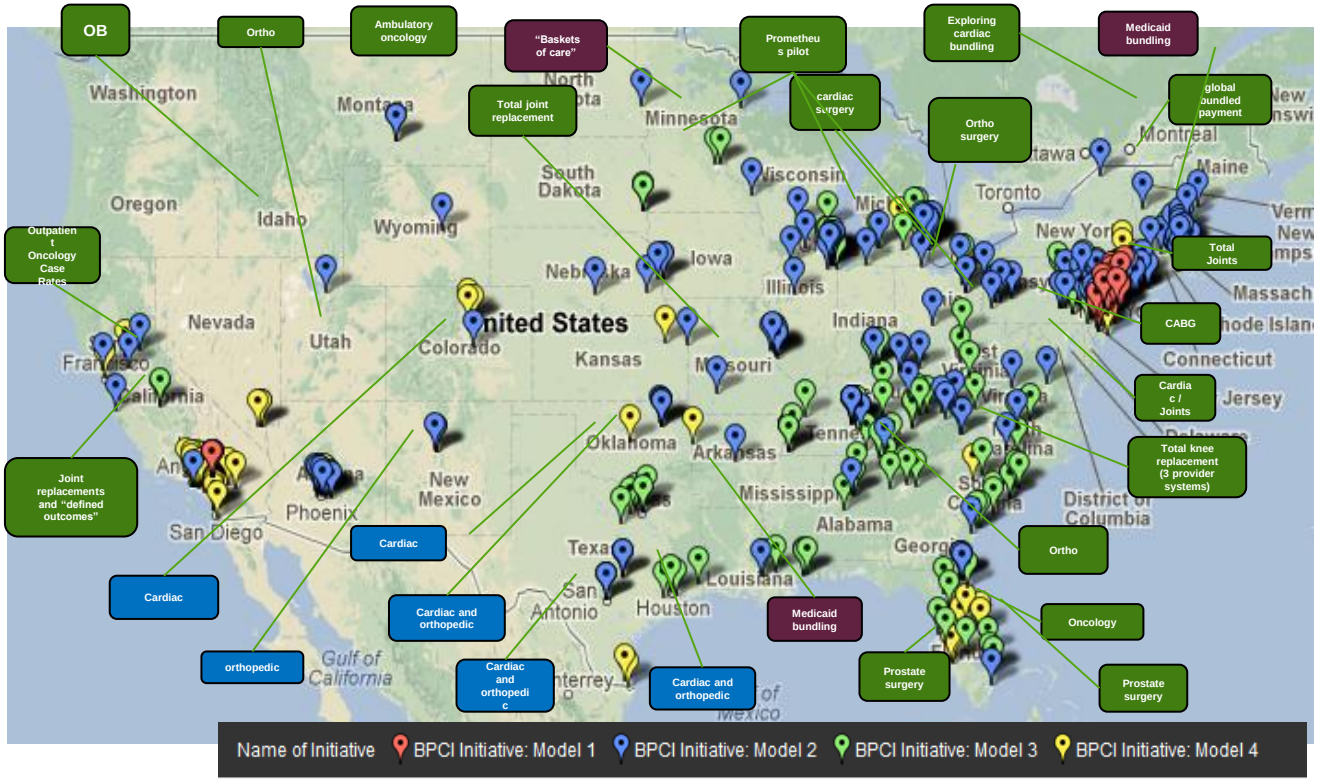
Source: National Committee for Quality Assurance, 2013

Bundled payment arrangements expanding rapidly

CMS Innovation Grant OP Bundles

States requesting Medicaid waivers

Post-Acute Bundling



Commercial

Medicaid/low income

CMS ACE demo

Goals:

- Better care coordination
- Support accountability at the patient's care level
- Payment model is synergistic with ACO and medical home models
- Reduce health care spending over current FFS payment
- Align hospital and physician incentives, enhancing collaboration across the episode

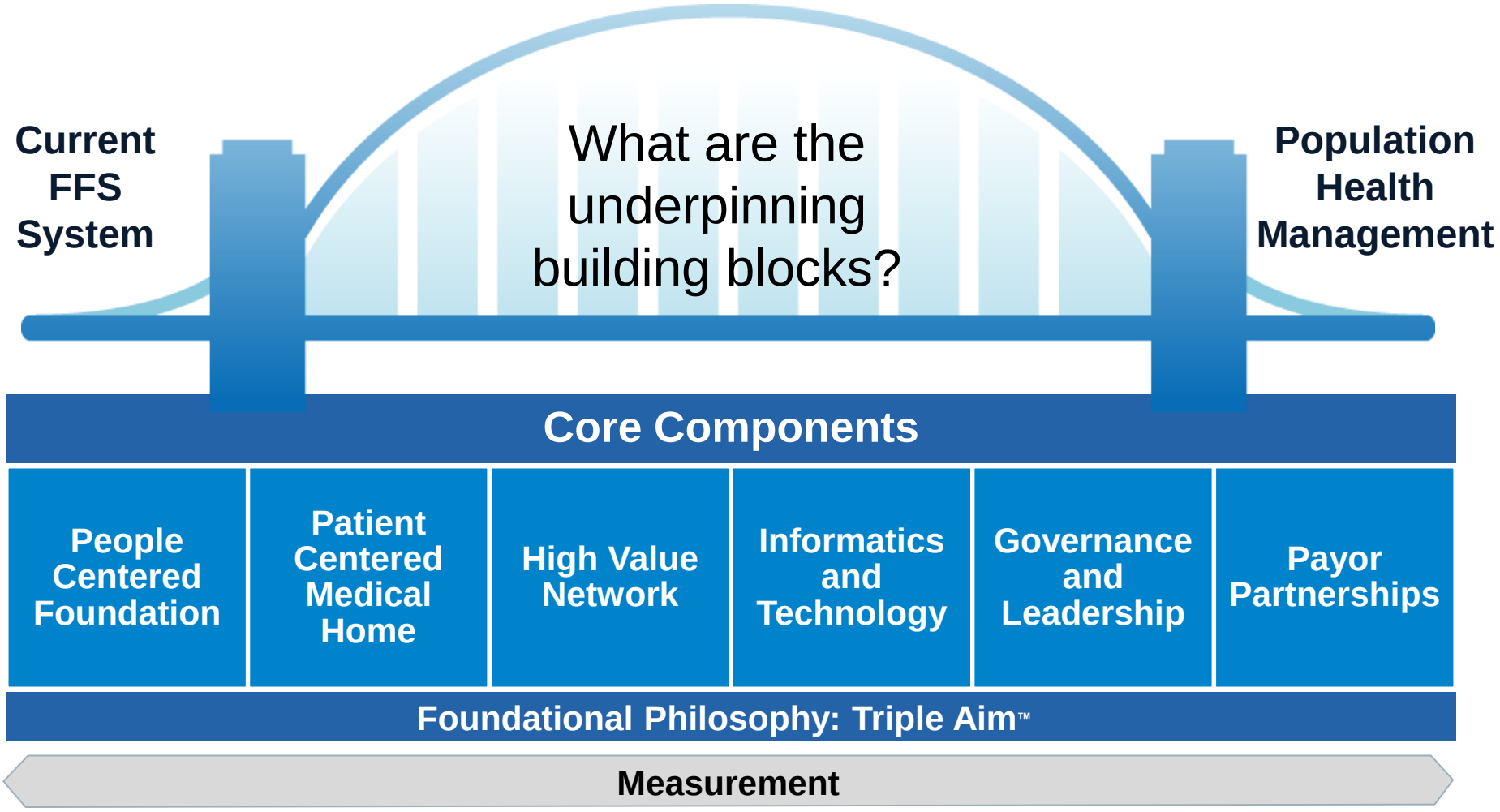
4. Measuring Successful Population Health

A. Components and competencies

B. Measures

C. Case study of best practice and success

The bridge from FFS to population health management



The Premier HIT Maturity Model

	Transaction	Interaction	Integration	Collaboration	Transformation
	IT supports individual providers in delivering care and measuring outcomes	Basic care coordination capabilities emerge with initial population based metrics	Care coordination capabilities improve and health status measurement is possible	Seamless care coordination with demonstrable improvement in population health status	Triple Aim goals realized across the population
Accountable care Sustainability					• Advanced population analytics • Continuous process improvement • Risk and financial management
Population Management				• Evidence-based standards • Team based care collaboration • Individual accountability	
Clinical Integration			• Outcomes measurement and reporting • Virtual care team coordination • Individual engagement		
Care Coordination		• Clinical decision support • Care management and registries • Population analytics			
Meaningful Use	• Process measurement and reporting • Health information exchange • Clinical systems (ancillary, EHRs, EMRs)				

Need to aggregate data from a number of sources – many are new!

- Adjudicated Claims from a TPA (employer), PBM or Payer
  - Includes both medical and pharmacy claims
  - Provides insight into patients' experience in/outside of the CIN / ACO / health system
  - Provides financial data to estimate total cost of care and cost trends
- Pre-Adjudicated Claims from Billing Systems
  - Provides utilization and cost information from within the CIN / ACO / health system
- Clinically Relevant Data
  - EHR data from CIN / ACO / Health System's employed and affiliated providers
  - Data from laboratories, pharmacies, etc.
  - Data collected outside of care delivery through wellness programs
- Health Risk and Depression Assessments
  - Surveys collected through a wide range of instruments and modes
  - How are repeated assessments captured and managed?
- Disability / Attendance Data from Employers
  - Can presenteeism or absenteeism estimates be calculated?
  - Can disability program data identify employees for disease mgmt.?

Whatever data that is integrated, keep an eye on the long term population health strategy ball - What do you need to manage risk across populations?

TPA – third party administrator, PBM – pharmacy benefit manager, CIN – clinically integrated network, ACO – accountable care organization

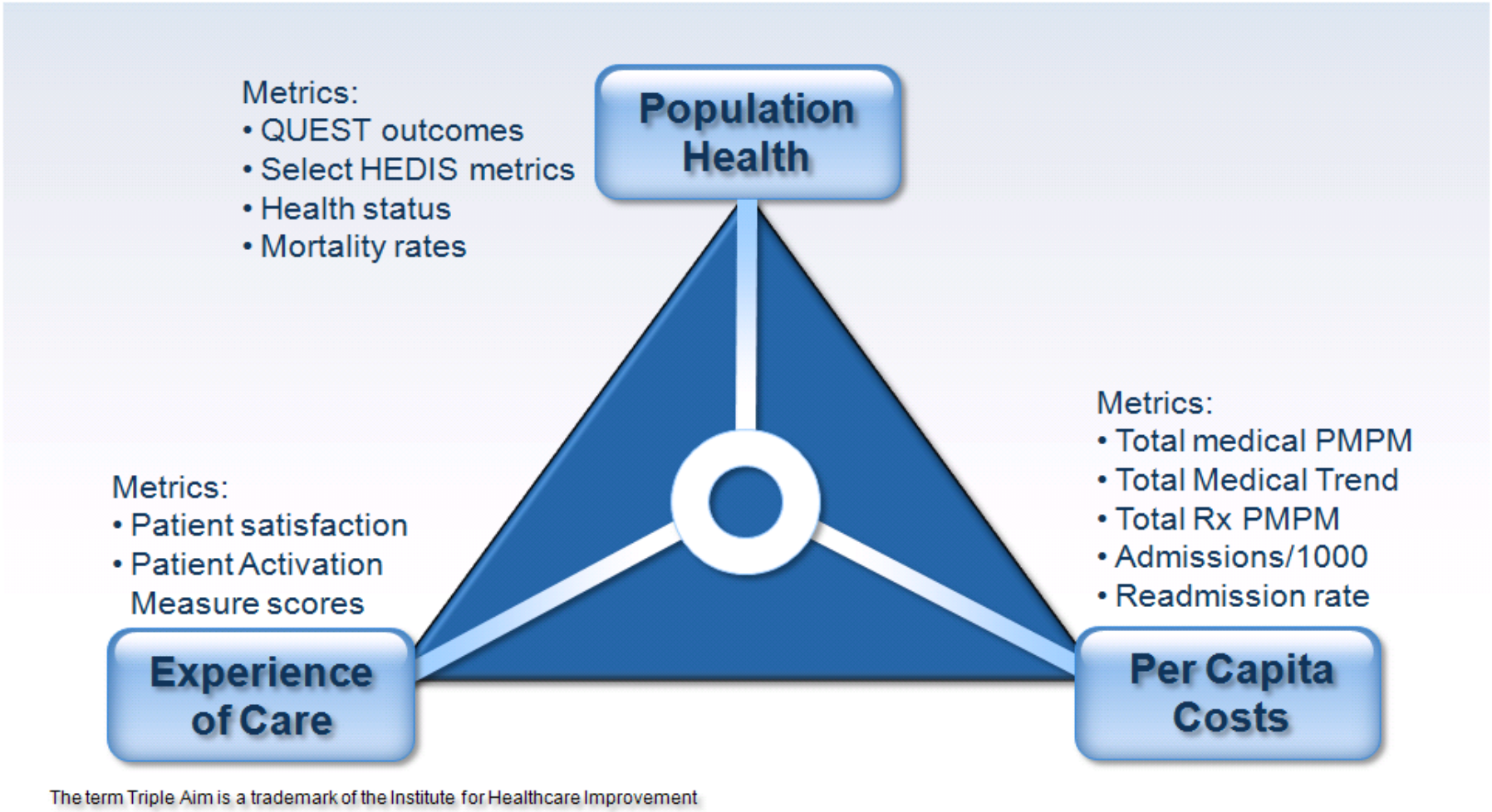
4. Measuring Successful Population Health

A. Competencies

B. Measures

C. Case study of best practice and success

Definition of success: Improving Triple Aim™ outcomes

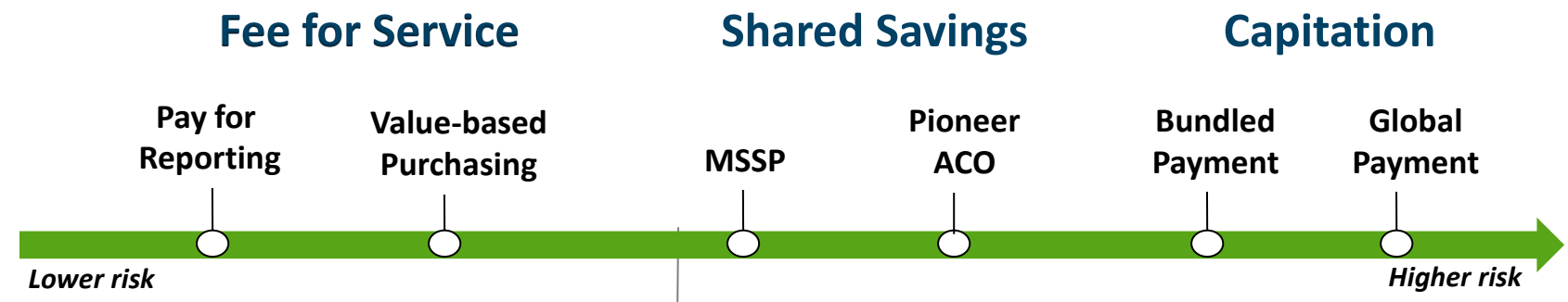


The term Triple Aim is a trademark of the Institute for Healthcare Improvement

CMS 33 MSSP (ACO) quality measures

Measure	Number	Owner	Data Submission Source
Preventive Health 8 Measures	5 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	CMS	GPRO Data Collection Tool
	2 Measures	AMA-PCPI	GPRO Data Collection Tool
At Risk Population 12 Measures	5 Measures	MN – Comm Measurement	GPRO Data Collection Tool
	2 Measures	CMS / AMA-PCPI	GPRO Data Collection Tool
	4 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI	GPRO Data Collection Tool
Patient/Care Giver Exp 7 Measures	6 Measures	AHRQ	Clinician Group CAHPS Survey
	1 Measure	AHRQ	Medicare Advantage CAHPs Survey
Care Coordination / Patient Safety 6 Measures	1 Measure	CMS	Claims
	1 Measure	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI/ NCQA	Survey or GPRO Data Collection Tool
	2 Measures	AHRQ ACSC	Claims
	1 Measure	CMS	GPRO Data Collection Tool / eRx Incentive Prog Reporting
Shared Savings			

As risk increases, so does a shift in the business model



Financial Management	***Manage volume***	***Manage Total Payer Cost of Care (PMPM)***
Clinical Management	***Manage care process***	***Coordinate care***
Data Management	***Manage silos of data***	***Integrate silos of data (acute, ambulatory, pharmacy)***

MSSP – Medicare Shared Savings Program; ACO – Accountable Care Organization, PMPM – per member per month

In a population health world, there are new indicators of success

Traditional FFS

More is good

- Number of admissions
- Number of procedures
- IP Case Mix Index (CMI)
- Net revenue per adjusted patient day
- Patient Census Report (PCR)

Population Health

More is bad

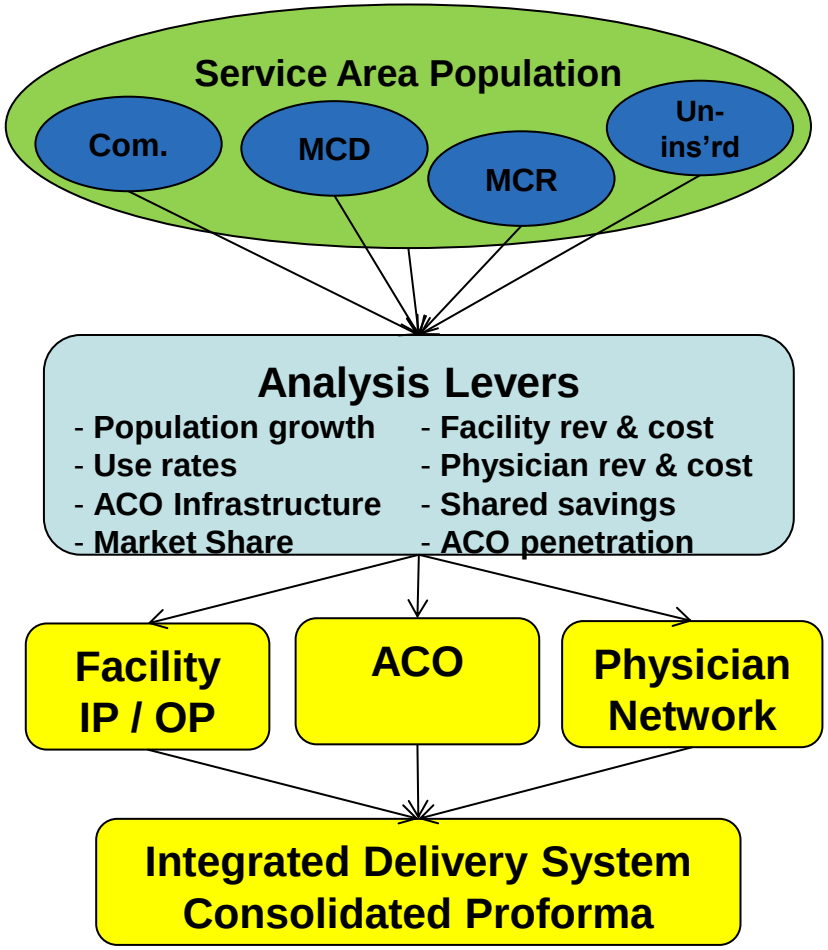
- IP admissions / 1,000
- OP visits / 1,000
- Potentially avoidable admits
- Total medical cost / svc
- Per member per month
- Ambulatory / preference sensitive conditions
- Re-admits / 1,000

FFS – fee for service, IP – inpatient, OP – outpatient, svc - service

The MSSP (ACO) impact on utilization rates

- Primary Care/Urgent Care/Minute Clinic visits **increase**
- Emergency Department visits **decrease**
- Admissions **decline**
  - Readmissions related to chronic disease
  - Avoidable Admissions
  - End of life/Palliative Care
- Skilled Nursing Facility volume **decline**
- Home care visits **increase**
- Market share can **increase** (less leakage)

Assessing the financial impact of health system transformation



Early results continue to show promise

- **Medicare costs per capita grew 0.8% in 2012** (while **Pioneers grew at 0.3%**). For first time in decades the Medicare per capita growth was below GDP growth
- Physician Group Practice (PGP) Demonstration Project **reduces cost of Dual Eligible Beneficiaries by $532 per year**
- **All 32 Pioneers achieved quality improvements** and 2/3 achieved cost savings in 2012
- **Group Health and Geisinger** report findings that team based **medical homes reduced per capita spending 7-8%**
- **Montefiore achieved $14 million** in shared savings in 2012, due in large part to **a 10% decline** in hospital admissions
- **Oregon's new Medicaid program** reports early success (**1% decline in per capita costs** in first year)

4. Measuring Successful Population Health

A. Competencies

B. Measures

C. Case studies of best practice and success

Case Study #1 –

Eastern Maine Health System
Brewer, Maine

A large integrated health system primarily serving very rural, poor patient populations in a vast geography with a flagship medical center and several community hospitals, now expanding its presence in competitors' markets

EMHS' ACO organization is Beacon Health (a subsidiary)

One of 32 CMMI Pioneers with a 1/1/2012 Start

Beacon Health by the Numbers

"Beacon Health is building a statewide network of providers and nurse care coordinators that provide high quality care tailored to the needs of community and patient. This ensures that Maine people continue to have the care they need close to home. Our network has a proven record of improved quality outcomes, cost reductions, and highly engaged patients. As a member of EMHS, Beacon Health is committed to being innovative and inclusive so the care we deliver to our family, friends, and neighbors allows them to lead full and healthy lives."

MIKE DONAHUE, MBA, EMHS BEACON HEALTH
VICE PRESIDENT NETWORK DEVELOPMENT

2012

- 25 Primary Care Practices
- 111 Providers
- 14 Maine Towns and Cities
- 12 Nurse Care Coordinators
- 9,400 Pioneer patients

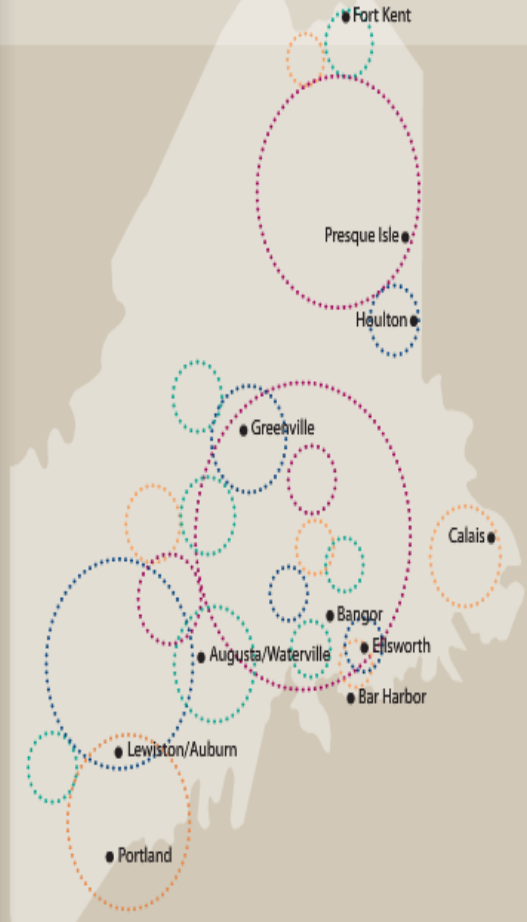
2013

- 54 Primary Care Practices
- 350 Providers
- 31 Maine Towns and Cities
- 1 Director of Nurse Care Coordination
- 3 Regional Managers of Nurse Care Coordination
- 46 Nurse Care Coordinators
- 26,000 Patients we care for

2014

- 72 Primary Care Practices
- 600 Providers
- 42 Maine Towns and Cities
- 1 Director of Nurse Care Coordination
- 3 Regional Managers of Nurse Care Coordination
- 55 Nurse Care Coordinators
- 60,000 Patients we care for

The EMHS/Beacon Health Statewide Network



EMHS MEMBERS

Acadia
Blue Hill Memorial Hospital
CA Dean Memorial Hospital
EMMC
Inland Hospital
Mercy
Sebasticook Valley Health
The Aroostook Medical Center

BEACON HEALTH PARTNERS

Mount Desert Island Hospital
Bridgton Hospital
Rumford Hospital
St. Joseph Healthcare
Central Maine Medical Center
Downeast Community Hospital
Maine Coast Memorial Hospital
Northern Maine Medical Center
Three Rivers Primary Care
Sebasticook Family Doctors
Fish River Primary Care
Health Access Network
Katahdin Valley Health Center

Members and Partners as of 9/13

Hospital readmissions down **13.2%**

Nurse care coordinators follow-up with **91%** of patients

Patient Satisfaction **93%**

Cost to care for Medicare patients down **4.9%**

http://emhs.org/cmstemplates/lws-emhsaspx/differenceincare2013/index.html#1

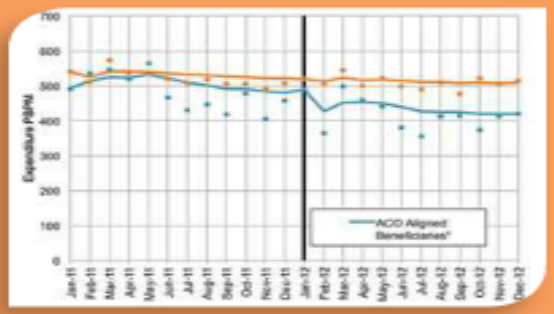
EMHS Employee health plan (~8k) and Pioneer ACO (~9.4K) results

JILL SMITH: BACK TO WORK

Care is a phone call away

When EMHS began working with Geisinger Health of Pennsylvania, a great new benefit was added to the system's health plan that is making a real difference for EMHS employees and their family. Jill Smith, an administrative secretary at EMMC, was pleasantly surprised when her phone rang at home the day after she had neck surgery. Jill chose an in-system provider and received the added benefit of nurse care coordination. More than 40 care coordinators across EMHS are making a difference in how patients access the care they need. The care coordinators quickly become reliable resources who are only a phone call away.

"Kathleen made sure I had what I needed so I could be successful and could function and get back to work. She even helped with my prior authorizations."



Pioneer ACO

The cost of care for our Medicare patients while in the hospital is going down. EMHS is the teal, national average is the orange.

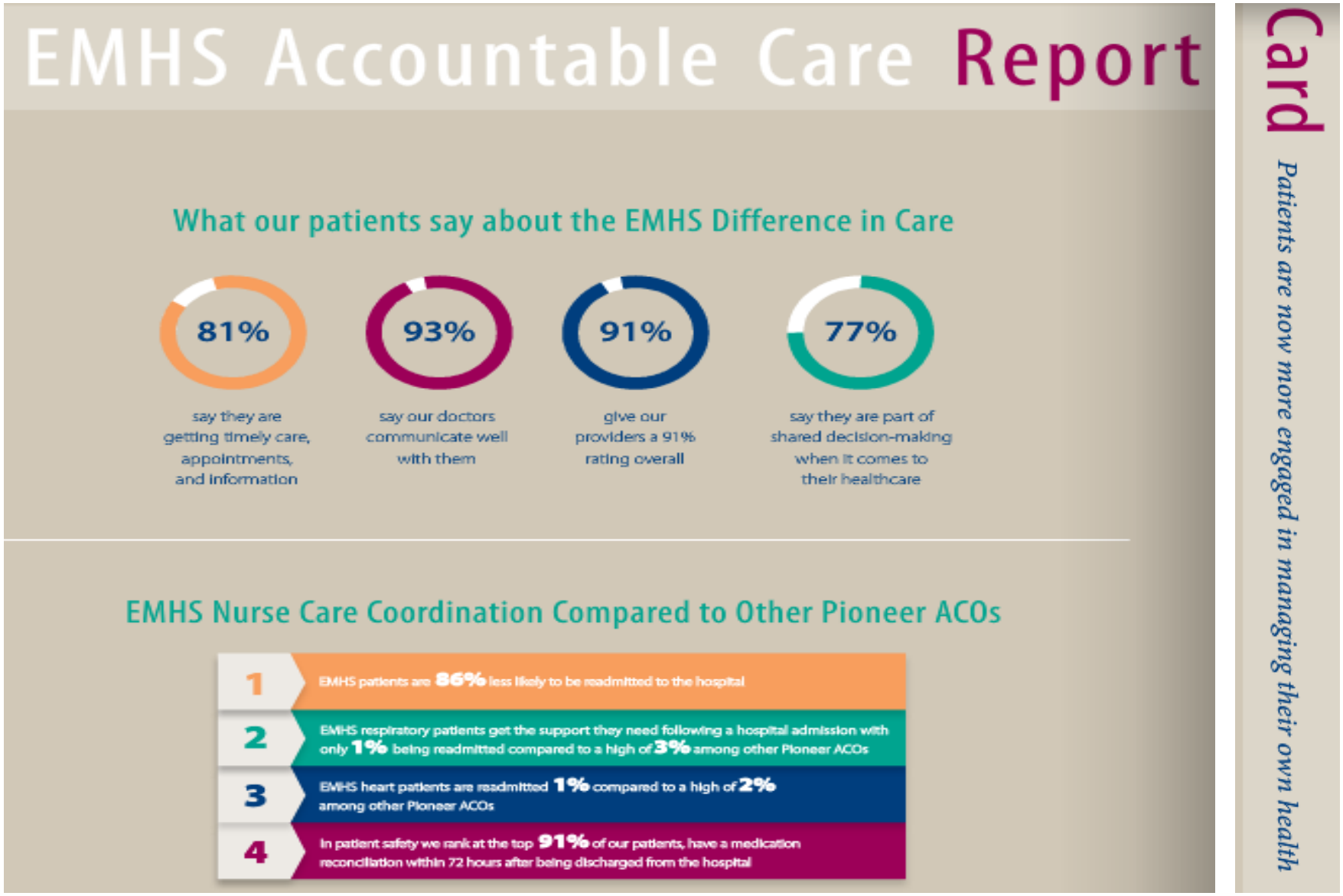
Year 1: 5% savings

Even though Jill isn't pain free, she is back at work and enjoying a better quality of life. The relationship she's developed with her nurse care coordinator has proven to be a huge benefit and will continue to help her receive the right care, at the right time, and in the right place.

Read more about Jill at www.emhsdifferenceincare.org

http://emhs.org/cmstemplates/lws-emhsaspx/differenceincare2013/index.html#1

EMHS is succeeding as a CMMI Pioneer ACO



http://emhs.org/cmstemplates/lws-emhsaspx/differenceincare2013/index.html#1

Case Study Review #2 –

Commonwealth Fund White Paper on Premier's Partnership for Care Transformation

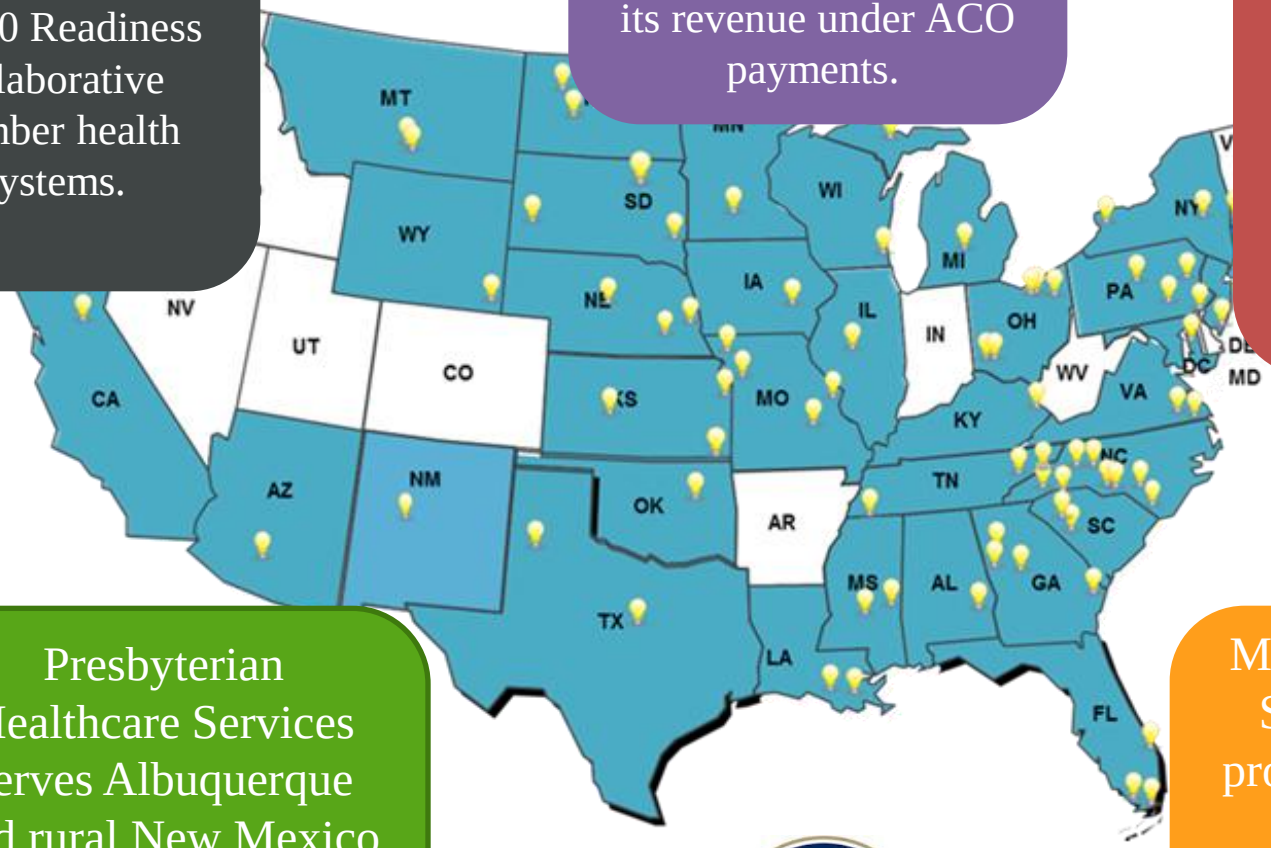
ACO case studies

PACT

More than 20 Implementation and 80 Readiness collaborative member health systems.

Fairview Health Services is a nonprofit health care system based in Minneapolis with more than 50% of its revenue under ACO payments.

AtlantiCare, in Southeastern New Jersey is the region's largest healthcare organization and largest non-casino employer



THE COMMONWEALTH FUND

Presbyterian Healthcare Services serves Albuquerque and rural New Mexico with physician services at more than 30 different locations.

Memorial Healthcare System is a public provider of healthcare services to South Florida. It is the 5th largest public system in the nation.

ACO case studies: lessons learned

Managing populations requires fundamental change in health delivery.

The focus of primary transformation should be aligning clinical with payment.

Physician leadership and engagement is pivotal in the shift to accountable care.

Care models and coordination are critical building blocks to success under value-based reimbursement models.

Executive leadership with Governance support is vital to success.

Comprehensive, coordinated primary care services and integrated IT systems are key ingredients for success.

Market pressures can create opportunities for novel partnerships that serve both parties well.

The pace of execution will be limited by payer readiness to participate in innovative, value-based reimbursement models.

Case Study Review #3 –

Hennepin Health (MN) - Integrating public health and health care through transformation

Hennepin Health (MN): Partnering with a county public health department

PARTNERS

- Hennepin County Human Services and Public Health Department
- Hennepin County Medical Center
- Metropolitan Health Plan
- Northpoint Health and Wellness Center

PROGRAM OVERVIEW & OBJECTIVES

- A county-based ACO that integrates medical, behavioral, and social services
- Targets single, nondisabled adults, ages 21-64 with incomes at or below 75% of the FPL ($8,124/year) who qualify for Medicaid
- Offers proactive, comprehensive, and integrated care

Source: Agency for Healthcare Research and Quality. http://www.innovations.ahrq.gov/content.aspx?id=3835

Hennepin Health (*continued*)

EARLY RESULTS

- Increase in primary care utilization – 5%
- Decrease in ED visits – 39%
- Decrease in admissions – 29%
- Decrease in readmissions – 2%
- Lower costs for high utilizers – 40%-95%
- High enrollee satisfaction – 88%
- Increase in housing stability – 10 members/month placed
- Increasing enrollment – 4,884 enrollees to over 6,400

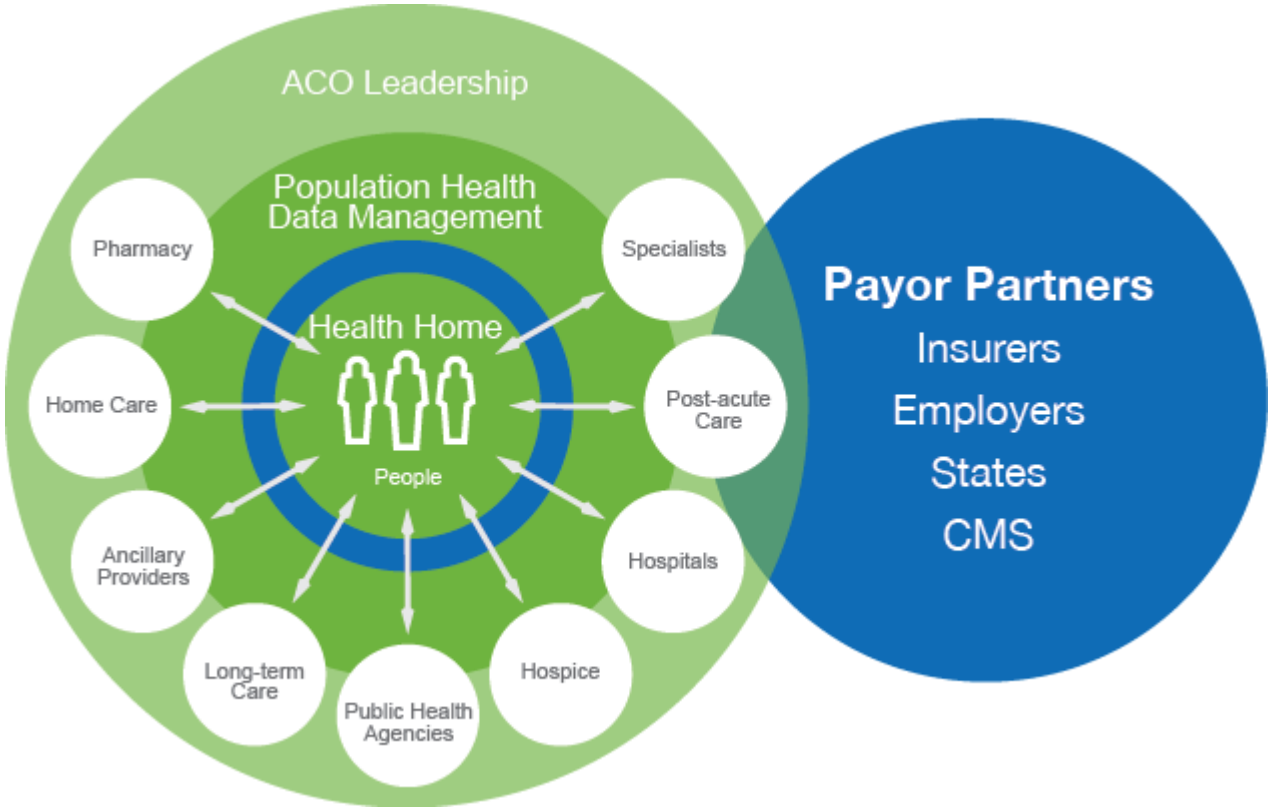
Source: Agency for Healthcare Research and Quality. http://www.innovations.ahrq.gov/content.aspx?id=3835

5. Self Assessment Approach

Sample results for illustration

The Accountable Care Organization Model

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.

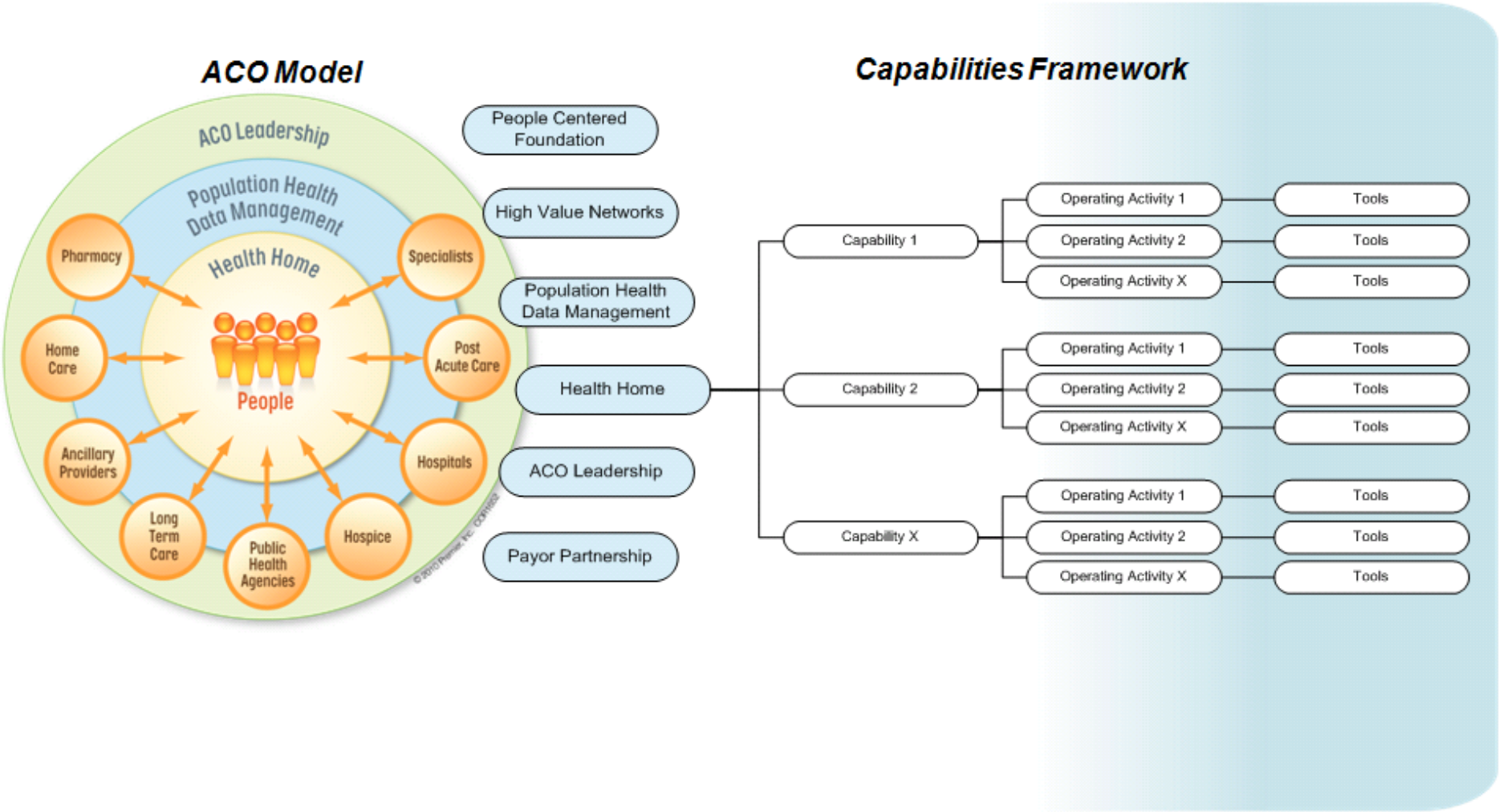


Core Components:

- People Centered Foundation
- Health Home
- High-Value Network
- Population Health Data Management
- ACO Leadership
- Payor Partnerships

Capabilities Framework: Assessing readiness

6 Population Health Components → 50 Capabilities → 176 Operating Activities

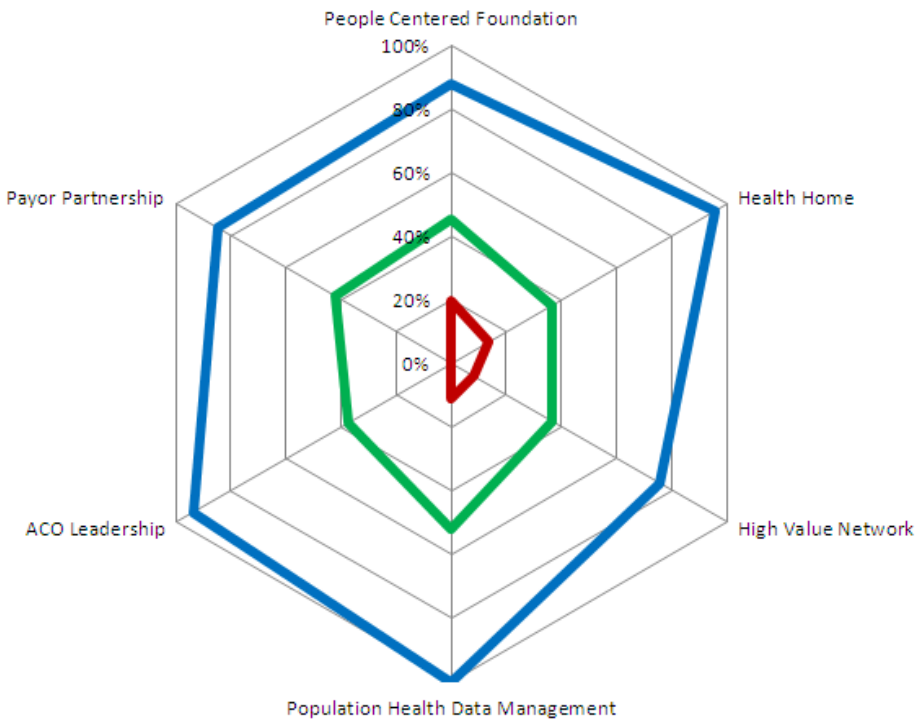


Assessment process should involve many stakeholders

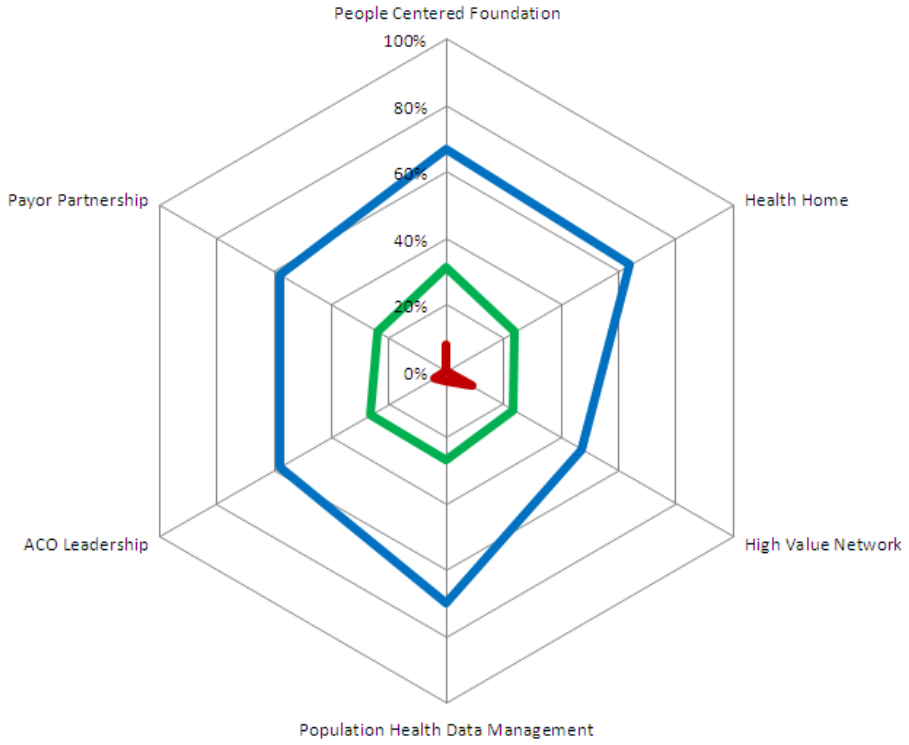
- **Clinical**:
  - Care Management Leaders
  - Physicians and other clinical Leaders
- **Technology**:
  - EHR Leaders
  - IT Leaders
  - Medical and Nurse Informatics Leaders
  - Quality Leaders
- **Administrative**:
  - Clinically Integrated Network/PHO Leaders
  - Physician and other clinical Leaders
  - Financial Leaders
  - Managed Care Leaders
- **Other Constituencies**
  - Public Health Directors
  - Insurance Brokers
  - Employers
  - Elected Officials
  - Etc.

Results inform organizational priorities and action plans

Premier's Advanced Collaborative overall assessment*



Premier's Core Collaborative overall assessment**



Blue = High
Green = Average
Red = Low

*Data from 24 markets
**Data from 51 assessments

Sample Readiness Assessment scores

1. Preparation
2. Transformation
3. Implementation
4. Expansion

Common barriers to transformation success

- Leadership commitment and vision
- Cultural change
- Size / market presence
- Financial resources
- Physician relations
- Lack of primary care network
- Information technology

Critical success factors for the future health care system

- Physician-led/professionally managed
- Primary care network development
- Patient Centered Medical Home (PCMH) development
- Clinically Integrated Network (CIN) development
- Care management programs
- EHR, HIE, and population health analytics
- New payor arrangements
- New revenue sources
- Redeployment of assets (human capital and facilities)

PREMIER

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HEALTHCARE TOGETHER®

THANK YOU

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