NCHICA Presents the 5th Thought Leader Forum

Using Analytics for Population Health Management

Sponsored by

Duke Master of Management in Clinical Informatics
Presenters

- **Mardy Peal**, Director of Business Development, Wellcare

- **Sheldon Hamburger**, Principal, The Aristone Group

- **Dr. Michael Ogden**, Chief Transformation Officer, Cornerstone Health Care

Moderator

- **Melanie Phelps**, Associate Executive Director, NCMS Foundation and Deputy General Counsel, NC Medical Society
Accountable Care
NCHICA Thought Leader Forum
WellCare Health Plans
March 2015
Why discuss accountable care?

With the stated goal of healthcare delivery being the triple aim, accountable care has moved to the forefront of discussion.

Delivering value is the provider’s goal.

Purchasing value is now the key consideration for payers.

The term ACO was coined by Elliott Fisher at a Medpac meeting in 2006.
90% of payers and 81% of providers are already using mixed payment models.

45% of providers surveyed are part of an ACO. 59% expect to be within 5 years. Source: McKesson Health Solutions. The State of Value-Based Reimbursement and the Transition from Volume to Value in 2014.
Health Care Transformation Task Force

• Transformation is personal to us. We commit to having 75 percent of our respective businesses operating under value-based payment arrangements by 2020 and call on the rest of the health care system to do the same.

• Members include
  • Providers
  • Purchasers
  • Payers
  • Others

Further Consolidation

• Collaborative Regions more aligned with VBP
• MidWest Health Collaborative (OH)
• Stratus Health (GA)
• Occurring in NC
  • Partnerships
  • Shared Services Arrangements
“Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today’s announcement is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely,” Secretary Burwell said. “We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement.”

“Advancing a patient-centered health system requires a fundamental transformation in how we pay for and deliver care. Today’s announcement by Secretary Burwell is a major step forward in achieving that goal,” AHIP President and CEO Karen Ignagni said. “Health plans have been on the forefront of implementing payment reforms in Medicare Advantage, Medicaid Managed Care, and in the commercial marketplace. We are excited to bring these experiences and innovations to this new collaboration.”

“Employers are increasingly taking steps to support the transition from payment based on volume to models of delivery and payment that promote value,” said Janet Marchibroda, Health Innovation Director and Executive Director of the CEO Council on Health and Innovation at the Bipartisan Policy Center. “There is considerable bipartisan support for moving away from fee for service toward alternative payment models that reward value, improve outcomes, and reduce costs. This transition requires action not only by the private sector, but also the public sector, which is why today’s announcement is significant.”
Federal Level

This is the first time in the history of the Medicare programs that HHS has set explicit goals for alternative payment models and value-based payments

- Goal of tying 30% of traditional, or fee-for-service Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements by the end of 2016

- Four Payment Categories
  - FFS-no link to quality
  - FFS with link to quality and efficiency; physician value-based modifier; hospital penalties
  - Alternative payment models based on FFS architecture, some payment linked to population health management or episodes of care (ACOs)
  - Population Based Payment where in payment not directly triggered by service delivery; pioneer ACOs after 3-5 years
Federal Level

• Medicare Shared Savings Program

  98% of ACOs gain sharing only
  • Mixed results
    • 58/220 MSSP ACOs earned performance payments of $315 million
    • 60 Additional ACOs reduced health costs compared to benchmark but didn’t qualify for savings
    • 89 ACOs were added to MSSP effective Jan 2015 for a total of 405 serving 7.2 million beneficiaries
    • CMS draft revised rule in Jan 2014 allowing ACOs to extend gain sharing for an additional three years
  • ACO Performance in NC
State Payers

- Medicaid Managed Care
  - Encouraging VBP
  - **Iowa RFP (released Feb 2015)**
    - It is encouraged, but not required, that the Contractor enter into value-based purchasing agreements with its provider network. The Contractor shall propose the percentage of provider contracts that will be consistent with value-based purchasing by calendar year 2018 and specify the percentage annually each year thereafter. If the Contractor intends to move into value-based purchasing contracts prior to 2018, the Contractor shall incorporate that into the proposal.
  - **Oregon RFP (2014)**
    - Payment systems much support and drive delivery system changes. By 2019, HCA and King County expect that payers will hold providers accountable for cost, quality, and patient experience of care and provide incentives for controlling the total cost of care for their patients….what financial incentives/alternative payment models and strategies your organization currently has in place or is planning to implement in the next five years.
NC Medicaid Reform Journey

January 2013

- McCrory Administration announces Medicaid reform as a top priority and launches “A Partnership for a Healthy North Carolina”
- Enabling legislation mandates DHHS to recommend a reform plan by March 17, 2014

February 2013 - Ongoing

- Governor McCrory, Secretary Wos and other DHHS staff gather comments, recommendations from stakeholders
- General Assembly establishes a Medicaid Reform Advisory Group of legislators and public stakeholders to gather input

March 17, 2014

- McCrory Administration submits its Medicaid Reform proposal to the General Assembly

Summer 2014

- House and Senate each approve their own Medicaid Reform bill
- Legislative Oversight Committees hear from a variety of Medicaid stakeholders including other states
Enabling Legislation mandated three goals for reform
Whole person care
Ease of use by providers
Budget predictability

Process of Reform
• Medicaid Reform Advisory Group
  • Legislators and Stakeholders
  • Public Meetings including presentations by stakeholders
Physical health
ACOs with up and downside risk
Coverage and risk will rise progressively
Gains and losses capped/shared with the state

Mental health, IDD/SAS
Strengthen contracting with LME-MCOs
Consolidation of LME-MCOs

Long-term services and supports (LTSS)
Strengthen case management for LTSS
Long term strategic planning

http://www.ncdhhs.gov/medicaidreform/docs/meetings/140226/140226_Medicaid_Reform_High-Level_Recommendations.pdf
<table>
<thead>
<tr>
<th>ISSUE</th>
<th>HOUSE</th>
<th>SENATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Delivery Model</td>
<td>Accountable Care Organizations (ACO)</td>
<td>Managed Care Organizations (MCO) and provider led entities</td>
</tr>
<tr>
<td>Operations</td>
<td>Provider-led (physicians, hospitals, etc.)</td>
<td>Qualified health care entities and provider-led entities</td>
</tr>
<tr>
<td>Gains and Risk Sharing</td>
<td>• Full capitation in 5 years</td>
<td>• Full capitation in 2 years</td>
</tr>
<tr>
<td></td>
<td>• Share savings with the State</td>
<td>• No shared savings</td>
</tr>
<tr>
<td>Metrics</td>
<td>Cost savings and quality</td>
<td>Cost savings and quality</td>
</tr>
<tr>
<td>Home Medical Model (CCNC)</td>
<td>CCNC helps State and ACOs manage utilization and quality</td>
<td>CCNC role to be determined</td>
</tr>
</tbody>
</table>
| Medicaid Division: Oversight & Organization | • Division of Medical Assistance  
• Within DHHS  
• Reports to Secretary of DHHS | • Department of Medical Benefits  
• Separate from DHHS  
• Reports to new 7-member board |
“Effective collaboration with our key providers is vital to our short and long-term success,” said Ken Burdick, President, National Health Plans. “When we actively engage our providers and respond quickly to their issues and concerns, we build a partnership that ultimately helps our members lead healthier lives,” he added.

Mr. Burdick was named CEO of WellCare Group in December 2014.
WellCare has strong provider partnerships that run the full gamut of structures

- Approach largely dependent on an entity’s ability and willingness to take risk and oversee care coordination and administrative activities

<table>
<thead>
<tr>
<th>Financial Risk</th>
<th>FFS</th>
<th>FFS + Capitation</th>
<th>Shared Savings</th>
<th>Full Medical Risk</th>
<th>Full Financial Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operational Services</td>
<td>Medical Services + Care Coordination + Admin Services</td>
<td>All Operations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Model</td>
<td>Traditional Provider</td>
<td>PCMH</td>
<td>ACOs</td>
<td>Fully Delegated</td>
<td>PSNs</td>
</tr>
</tbody>
</table>
WellCare Is Partnering for Value

Beyond financial risk, there are many critical operational components and capabilities that must be considered

**Key Operational Components and Capabilities**

<table>
<thead>
<tr>
<th>Coordinated Functions between Plan &amp; Provider</th>
<th>Provider Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration</strong></td>
<td><strong>Care Coordination</strong></td>
</tr>
<tr>
<td>• Enrollment</td>
<td>• Utilization mgmt</td>
</tr>
<tr>
<td>• Claims/Appeals</td>
<td>• Care mgmt</td>
</tr>
<tr>
<td>• Authorizations</td>
<td>• Disease mgmt</td>
</tr>
<tr>
<td>• Referrals</td>
<td>• Network expansion</td>
</tr>
<tr>
<td></td>
<td>• Quality</td>
</tr>
<tr>
<td></td>
<td>• LTC coordination</td>
</tr>
<tr>
<td></td>
<td>• Inpatient mgmt</td>
</tr>
<tr>
<td><strong>Care Delivery</strong></td>
<td><strong>Care Coordination</strong></td>
</tr>
<tr>
<td>• Primary care</td>
<td>• Utilization mgmt</td>
</tr>
<tr>
<td>• Specialty care</td>
<td>• Care mgmt</td>
</tr>
<tr>
<td>• Surgical</td>
<td>• Disease mgmt</td>
</tr>
<tr>
<td>• Hospital</td>
<td>• Network expansion</td>
</tr>
<tr>
<td></td>
<td>• Quality</td>
</tr>
<tr>
<td></td>
<td>• LTC coordination</td>
</tr>
<tr>
<td></td>
<td>• Inpatient mgmt</td>
</tr>
<tr>
<td></td>
<td>• Home health</td>
</tr>
<tr>
<td></td>
<td>• Mental health</td>
</tr>
</tbody>
</table>
WellCare has partnered with providers in a variety of arrangements including ACOs. As an example, the following is a profile of a partnership we have in another state.

**Key Operational Components and Capabilities**

**WellCare**
- Appeals
- Benefits & claims adm
- Community outreach
- Member outreach
- Compliance
- Customer service
- Enrollment
- HEDIS date collection
- Marketing & Sales
- Ancillary
- PBM
- Pharmacy Network

**ACO**
- Care management
- Data analytics
- Disease management
- HEDIS collection support
- Inpatient Transportation
- Medical home support
- Payer contract/relations
- Prior authorization
- UM
- 24 Hr Nurse advise line
- Payment model determination

**Shared Services**
- Government relations
- Credentialing
- Financial reporting
- HIT platform
- Website design
- Patient outreach & prevention

**Coordinated Functions between Plan & Provider**

Shared Services
Analytics in Bundled Payments

NCHICA Presents the Fifth Thought Leader Forum on Informatics & Analytics

Using Analytics for Population Health Management

March 9, 2015

March 9, 2015 • 1:00-3:00 pm
Research Triangle Foundation of NC
What are bundled payments?

Episode - all services provided to a patient related to a specific medical problem in a limited timeframe.

Bundle – all services provided during an episode for which “you” are financially responsible.
Who is using them?
Who is using them?

- Cleveland Clinic
- Virginia Mason
- Mayo Clinic
- Duke Medicine
- Johns Hopkins Medicine
- Kaiser Permanente
- NYU Langone Medical Center
- CJRI
Who is using them?

- Pepsi
- Colorado Business Group on Health
- Walmart
- Lowe's
- Kroger
Today

- PAC: 30%
- DRG: 70%

CMS

Centers for Medicare & Medicaid Services

The Arisone Group
BPCI

70%

30%

DRG+Savings

PAC
The Future

100%

New DRG

PAC

The Future

CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES

The Aristone Group
Limited number of bundles

<table>
<thead>
<tr>
<th>MDC</th>
<th>BUNDLE</th>
<th>DRG</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORTHOPEDICS</td>
<td>Amputation for MSK/CT or endocrine/nutrition or circ disorder</td>
<td>239, 240, 241, 255, 256, 474, 475, 617</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Back &amp; neck except spinal fusion</td>
<td>490, 491</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Cervical spinal fusion</td>
<td>471, 472, 473</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Combined anterior posterior spinal fusion</td>
<td>454, 455</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Complex non-cervical spinal fusion w/ spinal curv/malig/infxn/9+fusion</td>
<td>456, 457, 458</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Double joint replacement of the lower extremity</td>
<td>461, 462</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Fractures femur and hip/pelvis</td>
<td>534, 536</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Hip &amp; femur procedures except major joint</td>
<td>480, 481, 482</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Knee procedures w/ and w/o infection</td>
<td>485, 486, 487, 488, 489</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Lower extremity &amp; humerus procedure except hip, foot, femur</td>
<td>492, 493, 494</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Major joint replacement of the lower extremity</td>
<td>469, 470</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Major joint upper extremity</td>
<td>483, 484</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Medical non-infectious orthopedic problems (sprains, strains, back pain)</td>
<td>537, 551, 552, 533, 554, 555, 556, 557, 558, 59, 560, 561, 562, 563</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Removal of devices (both hip/femur and other)</td>
<td>495, 496, 497</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Revision of the hip or knee</td>
<td>466, 467, 468</td>
</tr>
<tr>
<td>ORTHOPEDICS</td>
<td>Spinal fusion (non-cervical)</td>
<td>459, 460</td>
</tr>
</tbody>
</table>
The challenge of analytics

- Large data sets
  - Size: millions of records
  - Data exchange
  - Data storage
  - Backup

- New types of data
  - Bundles
  - Unadjudicated claims
  - Post-acute data sets

- Lack of tools/skills
  - Simple ETL
  - Advanced tools
Examples

- Singletrack
  - SQL-Server enterprise DB
  - PowerPivot analytic tool
- Verras
  - Proprietary model
  - Service oriented delivery
  - AHA endorsed
The role of analytics

- Extract actionable information
  - Bundle selection
  - Strategy
  - Episode duration
  - Post-acute opportunity
  - Internal (DRG) savings
The role of analytics

- Extract actionable information
  - Bundle selection
  - Strategy
  - Episode duration
  - Post-acute opportunity
  - Internal (DRG) savings
<table>
<thead>
<tr>
<th>Episode Owner/Episode Family</th>
<th>Episode Count</th>
<th>Average Net Episode Payment per Episode</th>
<th>Total Net Episode Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint replacement of the lower extremity</td>
<td>229</td>
<td>$27,838</td>
<td>$6,374,997</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>218</td>
<td>$22,364</td>
<td>$4,875,416</td>
</tr>
<tr>
<td>Simple pneumonia and respiratory infections</td>
<td>215</td>
<td>$21,926</td>
<td>$4,714,059</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>163</td>
<td>$15,136</td>
<td>$2,467,138</td>
</tr>
<tr>
<td>Stroke</td>
<td>139</td>
<td>$28,088</td>
<td>$3,904,178</td>
</tr>
<tr>
<td>Sepsis</td>
<td>134</td>
<td>$30,362</td>
<td>$4,068,483</td>
</tr>
<tr>
<td>Renal failure</td>
<td>132</td>
<td>$24,805</td>
<td>$3,274,285</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease, bronchitis, asthma</td>
<td>121</td>
<td>$19,019</td>
<td>$2,301,264</td>
</tr>
<tr>
<td>Esophagitis, gastroenteritis and other digestive disorders</td>
<td>110</td>
<td>$16,932</td>
<td>$1,862,508</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>108</td>
<td>$17,724</td>
<td>$1,914,159</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>102</td>
<td>$19,022</td>
<td>$1,940,246</td>
</tr>
<tr>
<td>Gastrointestinal hemorrhage</td>
<td>95</td>
<td>$17,596</td>
<td>$1,671,612</td>
</tr>
<tr>
<td>Other respiratory</td>
<td>92</td>
<td>$32,687</td>
<td>$3,007,214</td>
</tr>
<tr>
<td>Medical non-infectious orthopedic</td>
<td>85</td>
<td>$23,099</td>
<td>$1,963,389</td>
</tr>
<tr>
<td>Hip &amp; femur procedures except major joint</td>
<td>80</td>
<td>$46,230</td>
<td>$3,698,431</td>
</tr>
<tr>
<td>Percutaneous coronary intervention</td>
<td>66</td>
<td>$23,458</td>
<td>$1,548,245</td>
</tr>
<tr>
<td>Major bowel procedure</td>
<td>65</td>
<td>$32,587</td>
<td>$2,118,170</td>
</tr>
<tr>
<td>Nutritional and metabolic disorders</td>
<td>62</td>
<td>$19,958</td>
<td>$1,237,422</td>
</tr>
<tr>
<td>Gastrointestinal obstruction</td>
<td>54</td>
<td>$14,519</td>
<td>$784,027</td>
</tr>
<tr>
<td>Red blood cell disorders</td>
<td>54</td>
<td>$20,914</td>
<td>$1,129,344</td>
</tr>
<tr>
<td>Medical peripheral vascular disorders</td>
<td>53</td>
<td>$23,293</td>
<td>$1,234,512</td>
</tr>
<tr>
<td>Transient ischemia</td>
<td>49</td>
<td>$14,212</td>
<td>$696,404</td>
</tr>
<tr>
<td>Acute myocardial infarction</td>
<td>42</td>
<td>$17,732</td>
<td>$744,726</td>
</tr>
<tr>
<td>Syncope &amp; collapse</td>
<td>34</td>
<td>$14,026</td>
<td>$476,884</td>
</tr>
</tbody>
</table>
Bundle selection

Average Episode Payments by Setting
Bundle selection

MLJ
Bundle selection

Average Episode Payments by Setting

CHF
The role of analytics

- Extract actionable information
  - Bundle selection
  - **Strategy**
  - Episode duration
  - Post-acute opportunity
  - Internal (DRG) savings
Bundle selection

MLJ

The Aristone Group
Bundle selection

PCI

- Readmission
- Readmission_Professional
- Professional
- SNF
- HHA
- IP Rehab
- IP Psych
- Outpatient
- Hospice
- DME
The role of analytics

- Extract actionable information
  - Bundle selection
  - Strategy
  - Episode duration
  - Post-acute opportunity
  - Internal (DRG) savings
Bundle selection

- **1-30 Days**
  - Readmission
  - Readmission_Professional
  - Professional
  - SNF
  - HHA
  - IP Rehab
  - IP Psych
  - Outpatient
  - Hospice
  - DME

- **31-60 Days**
  - Readmission
  - Readmission_Professional
  - Professional
  - SNF
  - HHA
  - IP Rehab
  - IP Psych
  - Outpatient
  - Hospice
  - DME

- **61-90 Days**
  - Readmission
  - Readmission_Professional
  - Professional
  - SNF
  - HHA
  - IP Rehab
  - IP Psych
  - Outpatient
  - Hospice
  - DME
Bundle selection
The role of analytics

• Extract actionable information
  – Bundle selection
  – Strategy
  – Episode duration
  – Post-acute opportunity
  – Internal (DRG) savings
## Bundle selection

<table>
<thead>
<tr>
<th>First Post Discharge Setting</th>
<th>Episode Count</th>
<th>Total Net Episode Payments</th>
<th>Average Net Payment Per Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>170</td>
<td>$3,330,864</td>
<td>$19,593</td>
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<tr>
<td>Hospice</td>
<td>1</td>
<td>$15,511</td>
<td>$15,511</td>
</tr>
<tr>
<td>IP Rehab</td>
<td>14</td>
<td>$703,390</td>
<td>$50,242</td>
</tr>
<tr>
<td>Readmission</td>
<td>2</td>
<td>$69,583</td>
<td>$34,791</td>
</tr>
<tr>
<td>Self-Care</td>
<td>2</td>
<td>$42,098</td>
<td>$21,049</td>
</tr>
<tr>
<td>SNF</td>
<td>143</td>
<td>$4,701,915</td>
<td>$32,881</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>332</strong></td>
<td><strong>$8,863,362</strong></td>
<td><strong>$26,697</strong></td>
</tr>
</tbody>
</table>
## Bundle selection

<table>
<thead>
<tr>
<th>Post-Acute Provider</th>
<th>Count of Post-Acute Care Episodes</th>
<th>Payments to Post-Acute Care Providers</th>
<th>Average Payments to Post-Acute Care Providers</th>
<th>Count of Readmissions from Post-Acute Provider</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our own HHA</td>
<td>128</td>
<td>$425,163</td>
<td>$3,322</td>
<td>13</td>
<td>10%</td>
</tr>
<tr>
<td>Competitor</td>
<td>23</td>
<td>$92,298</td>
<td>$4,013</td>
<td>3</td>
<td>13%</td>
</tr>
<tr>
<td>Competitor</td>
<td>14</td>
<td>$84,364</td>
<td>$6,026</td>
<td>3</td>
<td>21%</td>
</tr>
<tr>
<td>Competitor</td>
<td>11</td>
<td>$47,692</td>
<td>$4,336</td>
<td>3</td>
<td>27%</td>
</tr>
<tr>
<td>Competitor</td>
<td>9</td>
<td>$34,511</td>
<td>$3,835</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Competitor</td>
<td>5</td>
<td>$11,554</td>
<td>$2,311</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td>Competitor</td>
<td>5</td>
<td>$22,385</td>
<td>$4,477</td>
<td>3</td>
<td>60%</td>
</tr>
<tr>
<td>Competitor</td>
<td>5</td>
<td>$22,043</td>
<td>$4,409</td>
<td>4</td>
<td>80%</td>
</tr>
<tr>
<td>Competitor</td>
<td>4</td>
<td>$17,188</td>
<td>$4,297</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Competitor</td>
<td>4</td>
<td>$9,808</td>
<td>$2,452</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Competitor</td>
<td>4</td>
<td>$17,918</td>
<td>$4,480</td>
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<td>Count of Readmissions from Post-Acute Provider</td>
<td>Readmission Rate</td>
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Bundle selection

Episode Readmission Rate By First Post Discharge Setting

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<td>IP Rehab</td>
<td>43%</td>
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<td>SNF</td>
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Bundle selection

[Image of a software interface with various fields and checkboxes, including:
- EpisodeOwner
- IndexHospitalName
- IsMultiOwner
- EpisodeA...
- EpisodeFamily
- IndexDRG
- Year
- Complete...
- IsUnrelated
- ClaimRole
- Timeframe]

[Image of a PowerPivot Field List dialog box with checkboxes for:
- AttendingName
- BeneKey
- Claim DRG
- ClaimCompleted
- ClaimID
- ClaimRole
- DataType
- DaysFromAnchorEndDa]

[Image of a report filter with Slicers Vertical and Slicers Horizontal options]
The role of analytics

- Extract actionable information
  - Bundle selection
  - Strategy
  - Episode duration
  - Post-acute opportunity
  - Internal (DRG) savings
Internal (DRG) savings

Clinical Variation
Internal (DRG) savings

- Age
- Gender
- Principle Diagnoses
- Secondary Diagnoses
- Procedures
Internal (DRG) savings
Internal (DRG) savings
Internal (DRG) savings
Lessons learned

Fee-based

Value-based
Questions?

Sheldon Hamburger
shamburger@thearistongroup.com
(248) 613-7166
Are YOU Ready?

Prepare yourself to
Change the World
Agenda

• Healthcare Transformation - Why?

• The Physician’s Role

• Next Steps
We’ve all seen the scary data...

The U.S. Health Care System is too expensive, wildly variable, with lower than desired quality and outcomes.
An Unsustainable Future

The funding gap is widening, creating a need for rapid transformation in the market.

- **Expected future trend (6.5% growth)**
- **Sustainable trend (affordability followed by 4.5% growth)**

Sources: National Health Expenditure data, Bureau of Economic Analysis, Oliver Wyman analysis
We need to increase quality, lower costs, increase patient satisfaction.

Healthcare costs are bankrupting America.

We must address decreasing physician income and satisfaction.
The transformation requires comprehensive change of our business models.

**Volume Based**
- FFS/DRGs
- No payment for readmits, never events, etc.
- Departmental
- Volume
- Efficiency (procedure level)
- Visits
- Surgery / Procedures
- Outpatient ancillary
- Capacity
- Revenue-producing assets
- Patient referrals

**Value Based**
- Outcomes & Quality based
- Global payments
- Populations
- Conditions
- Focused factories
- Quality and low variability
- Efficiency (population level)
- Wellness and prevention
- Population management
- Chronic condition management
- Health IT
- Clinical integration
- Commercialization
Value Requirements

• **Highly Reliable Quality:** Waste and variation in practice (unexplained and unnecessary clinical variation) lead to 30% of costs that can be taken out of the system.

• **Lowering Costs:**
  • But, lowering payments is *not* a good answer.

• **Incentivizing patients, providers, and payers around value** and appropriate utilization should be a key strategy for improvement.
Take the message to the community. “Population health management is moving quickly and we need to do more to educate our communities about what’s happening and help them understand that the way we’re trying to lower the cost of care is by providing better care, not keeping them from the care they need.

--Brent Asplin, MD, MPH
Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- **All Medicare FFS (Categories 1-4)**
- **FFS linked to quality (Categories 2-4)**
- **Alternative payment models (Categories 3-4)**

**2016**

- 85%
- 30%

**2018**

- 90%
- 50%
Physician Compensation Models must change...

- Fee for Service
- Value-based Reimbursement
- Revenue Transition Period
- Revenue Mix

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5 Strategic Options

- Status Quo
- Sell
- Collaborate
- Innovate
- Transform
Innovation changes how services are delivered...
A Strategy without Effective Leadership will Fail
“Selling” population health management to clinicians. “You have to deliver two messages. Physicians must understand that it’s the evolution of the system, and that it’s inexorable. Remind them of the good news: Population health management will deliver higher value and preserve the patient at the center, which is really what physicians are all about.”

--David Nash, MD, MBA
What is holding us back?
Historical Attitudes...

The time had come for radical change...The management of medical care has become too important to leave to doctors, who, after all, are not managers to begin with.

*Fortune* Magazine, January 1970
Physicians Have Traditionally Been Risk Adverse Due To:

- Minimal business education
- Prolonged years of education necessitating a quicker return on investment that mitigates access to capital
- High levels of personal indebtedness and low level of savings
- Competition from hospitals subsidized through the not-for-profit bond market
Too much to do...

- Quality
- EHR
- Documentation
- Meaningful Use
- FFS vs PFV
- Medication Management
- ICD 9 and ICD 10 Coding
- CME
- Board Certification

CHESS
But, we must Transform Healthcare...
The Change Process
Population health management requires three changes...

1. Patient care model redesign
2. Infrastructure redesign
3. Payment system redesign
...patient care model redesign...
Beyond the Triple Aim

There will be continued pressure on health care providers to control costs while improving the quality of care provided.
Changing The Way We Deliver Care
Patient Centered Care Model

- Clinical Psychology
- Dietician
- Medical Oncology
- Surgery
- Research
- Support Groups
- Radiation Oncology
- Pathology
- Chaplain
- ENT
- Navigators
- Radiology
- Pharmacist
- Urology
- Pulmonology
- Social Work
Making the Move to Value & Enabling the Triple Aim Goals

- Education of physicians and staff
- Creation of a top notch patient experience
- Patient Centered Medical Home (PCMH) Recognition
- Establishing appropriate risk stratification: Hierarchical Condition Category (HCC) Coding
- Creation of “Smart Care Teams” that drive care model transformation
Patient Centered Smart Care Teams

Hub Model (available remotely)

Embedded in Clinic OR Centrally Located

Exam Room

MD/PA/NP
CMA
Encounter Specialist

Health Navigation Staff
Patient Care Advocates

Clinical Pharmacist
Registered Dietician
Clinical Social Work
and other Resources
...infrastructure redesign...

- Facilities
- Information Technology
- People
Data is Critical...

1. Identify Opportunity
2. Develop Care Model
3. Quantify Impact

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Stratifying patients is crucial. “Take the time to stratify your [system’s] patients and to develop care models for each segment—the high risk, the rising risk and the healthy. In the past, we have put them all through the same care model. That just doesn’t work.”

--Dennis Weaver, MD, MBA
## CHESS Care Models and Results

<table>
<thead>
<tr>
<th>Care Model</th>
<th>Target Population</th>
<th>Patients Enrolled</th>
<th>Clinical Impact</th>
<th>Estimated Savings</th>
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</thead>
<tbody>
<tr>
<td><strong>EXTENSIVIST MODEL</strong></td>
<td>Late Stage &amp; Poly Chronic (top 3-5% of spenders)</td>
<td>104</td>
<td>ED chg: -36%</td>
<td>$1.3 Million</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Hosp Chg: -74%</td>
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</tr>
<tr>
<td><strong>PERSONALIZED PRIMARY CARE</strong></td>
<td>Complex Conditions (and late stage &amp; poly chronic) healthy, at-risk, and Early stage chronic</td>
<td>PPCP A: 303 PPCP B: 401</td>
<td>ED chg A: -42% Hosp chg A: -53% ED chg B: -54% Hosp chg B: -54%</td>
<td>A: $0.8 Million B: $0.8 Million</td>
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<tr>
<td><strong>CARE OUTREACH</strong></td>
<td>Focus on dual eligible patients and Medicaid</td>
<td>IMPACT model: 138 Total: &gt;600</td>
<td>ED chg: -60% Hosp Chg: -64%</td>
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<tr>
<td><strong>CARDIOLOGY MODEL</strong></td>
<td>Sickest 20% of CHF patients</td>
<td>230</td>
<td>ED Chg: -41%</td>
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<tr>
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<td>Hosp chg: -54%</td>
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<tr>
<td><strong>ONCOLOGY MODEL</strong></td>
<td>Oncology patients</td>
<td>Breast: 183 Lung: 116</td>
<td>Pending case study</td>
<td>Pending case study</td>
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</table>

*Cornerstone Health Care data*
We can’t manage what we can’t measure...
Quality heat map permits analytics to show results at both the provider and system level.

### Quality of Care Provider Heat Map Hickory Region

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<th>Meas. Abbr.</th>
<th>BP Control</th>
<th>Diabetes</th>
<th>Immunization</th>
<th>Lipid Mgmt.</th>
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</tbody>
</table>

This chart reflects the % of the goal reached (all goals have been normalized to 100%)
The data time frame is 10/01/12-09/30/13
Data Reflects EMR/PDM Assigned patient providers

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How do you compare with your peers?

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<tr>
<th>Normalized Rate</th>
<th>Bundle</th>
<th>Measure</th>
<th>380</th>
<th>400</th>
<th>410</th>
<th>575</th>
<th>620</th>
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<tbody>
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<td>108.7%</td>
<td>108.7%</td>
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<tr>
<td></td>
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<td>84.9%</td>
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<tr>
<td></td>
<td>DM Lipid Lowering Agent if LDL &gt;100</td>
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<td>89.1%</td>
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<tr>
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<tr>
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<td>DM Tobacco Non-Use</td>
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<td>102.0%</td>
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<tr>
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<td>Influenza Immunization</td>
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<tr>
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<td>84.5%</td>
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<td>73.1%</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>ACE ARB Therapy CAD, DM, LVSD</td>
<td></td>
<td>73.5%</td>
<td>94.0%</td>
<td>75.9%</td>
<td>93.5%</td>
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<tr>
<td></td>
<td>HF BB Therapy for LVSD</td>
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<td>92.0%</td>
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<tr>
<td>Preventative Screening</td>
<td>Adult BMI Screen and Follow-up</td>
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<td>45.2%</td>
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<td>83.3%</td>
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<tr>
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<tr>
<td></td>
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<td>107.4%</td>
<td>106.1%</td>
<td>85.3%</td>
<td>74.3%</td>
<td>74.8%</td>
<td>54.7%</td>
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<tr>
<td></td>
<td>Depression Screen and Follow-Up</td>
<td></td>
<td>47.0%</td>
<td>69.5%</td>
<td>27.4%</td>
<td>11.0%</td>
<td>28.6%</td>
<td>15.8%</td>
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<tr>
<td></td>
<td>Screen for Future Fall Risk</td>
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<td>89.9%</td>
<td>143.7%</td>
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<td>13.1%</td>
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<td>16.9%</td>
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<tr>
<td></td>
<td>Tobacco Use and Cessation Counseling</td>
<td></td>
<td>106.9%</td>
<td>104.7%</td>
<td>102.9%</td>
<td>96.9%</td>
<td>98.6%</td>
<td>101.8%</td>
</tr>
</tbody>
</table>

| Diabetes | DM HbA1c >9.0% or Missing (Reverse Measure) | 98.2% | 105.7% | 95.1% | 97.7% | 90.1% | 85.2% |

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How well are you performing?

### CHC PTE Measures

<table>
<thead>
<tr>
<th>Bundle</th>
<th>Measure</th>
<th>N, Den</th>
<th>Rate</th>
<th>Goal</th>
<th>% of Goal Reached</th>
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</thead>
<tbody>
<tr>
<td><strong>BP Control</strong></td>
<td>Adult High BP Screen</td>
<td>37,913, 91,620</td>
<td>46.9%</td>
<td>86.0%</td>
<td>93.2%</td>
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<tr>
<td></td>
<td>BP Screen by 18</td>
<td>1,373, 1,409</td>
<td>97.4%</td>
<td>92.6%</td>
<td>105.9%</td>
</tr>
<tr>
<td></td>
<td>HTN BP &lt;140/90</td>
<td>17,406, 20,512</td>
<td>68.8%</td>
<td>74.0%</td>
<td>92.8%</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>Daily Aspirin for DM and IVD</td>
<td>1,323, 1,685</td>
<td>78.5%</td>
<td>86.0%</td>
<td>96.1%</td>
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<tr>
<td></td>
<td>DM BP &lt;140/90</td>
<td>7,919, 90,379</td>
<td>72.4%</td>
<td>70.0%</td>
<td>103.9%</td>
</tr>
<tr>
<td></td>
<td>DM HbA1c &lt;8.0%</td>
<td>7,942, 90,379</td>
<td>73.8%</td>
<td>88.0%</td>
<td>82.7%</td>
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<tr>
<td></td>
<td>DM HbA1c Test</td>
<td>9,919, 11,311</td>
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<td>97.5%</td>
<td>88.9%</td>
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<tr>
<td></td>
<td>DM LDL &lt;100mg/dL</td>
<td>8,085, 90,379</td>
<td>58.3%</td>
<td>80.0%</td>
<td>72.9%</td>
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<td>8,148, 11,311</td>
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<td>DM Lipid Lowering Agent If L.E.</td>
<td>863, 2,573</td>
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<td>41.4%</td>
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<td>8,357, 11,414</td>
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<td>81.4%</td>
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<td>81.0%</td>
<td>30.9%</td>
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<tr>
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<td>DM Tobacco Non-Use</td>
<td>8,627, 90,379</td>
<td>83.1%</td>
<td>85.0%</td>
<td>97.8%</td>
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<tr>
<td><strong>Immunization</strong></td>
<td>Influenza Immunization</td>
<td>31,489, 90,409</td>
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<td>63.3%</td>
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<td></td>
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<td>15,053, 25,842</td>
<td>57.9%</td>
<td>80.0%</td>
<td>94.6%</td>
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<tr>
<td><strong>Lipid Mgmt.</strong></td>
<td>CAD Drug Therapy for LowerL.</td>
<td>3,044, 4,045</td>
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<td>84.0%</td>
<td>116.0%</td>
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<td>Cholesterol Screening for C.</td>
<td>18,416, 20,975</td>
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<td>77.9%</td>
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<tr>
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<td>99.0%</td>
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<td><strong>Preventative Screening</strong></td>
<td>Adult BMI Screen and Follow.</td>
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<td>86.3%</td>
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<td>Depression Screen and Follow.</td>
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<td>Screen for Future Fall Risk</td>
<td>8,055, 25,861</td>
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<td>Tobacco Use and Cessation</td>
<td>77,156, 93,605</td>
<td>82.4%</td>
<td>86.0%</td>
<td>97.0%</td>
</tr>
</tbody>
</table>

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EMR Changes for streamlined provider documentation
HCC Documentation and Coding Innovations...
...and payment system redesign
Future Compensation will be dependent on contract changes...

- Fee For Service: 100%
- FFS + P4P: 98%, 2%
- Gainshare: 98%, 7%
- Risk: 90%, 25%
CLINICAL INTEGRATION DRIVES HIGH VALUE CARE

Commitments to Delivering High Value Care

Data Sharing
• Sharing information across the CIN helps promote care coordination
• HIE shuttles data between physician, hospital IT systems

Care Coordination
• Health Navigators drive care coordination and can be embedded or centralized
• Mutually-defined standards of care
• CHESS-preferred network honored

Discharge Planning
• PCP notified of patient discharge, collaborates on discharge care plan
• Patient Care Advocates utilized to facilitate transitions of care (and capture enhanced revenue)

Strategic Alignment
• CHESS staff with partner hospital and physicians guide clinical integration projects
• Projects focus on strategically important areas of opportunity

Source: Advisory Board interviews and analysis.
Most are just at the starting line...
What is your next move?

- Move toward Value Based Care
- Obtain partnerships
- Participate in ACOs
- Identify Stakeholders
It’s your move...

We cannot solve our problems with the same thinking we used when we created them.

-Albert Einstein
Questions?

Please fill out the forum evaluations at:

http://tinyurl.com/March9Forum
Join us for our next Forum:

Connected Health & Patient-Generated Data
March 27, 2015
9:30-11:30 am
Research Triangle Foundation of NC