Building a High Performance Integrated Population Health Infrastructure

Fulfilling Our New Medical Management Responsibilities
Presenters

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No conflict of interest

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Potential conflict of interest:
Paid employee of Verisk Health
Reliant Medical Group

Overview

- Reliant Medical Group is an independent, fully integrated, multi-specialty group of physicians conveniently located throughout Central Massachusetts. With over 250 doctors and 2000 employees across more than 20 locations, Reliant Medical Group offers a unique collaborative approach to care that helps patients through sickness and health with compassion and a dedication to service.

- Reliant Medical Group accepts all major forms of health insurance.
Reliant Medical Group

158 Advanced Practitioners

365 Physicians

25000 Employees

325K Patients

18 Primary Care

25 Freestanding Clinical Locations

Pediatrics

Adult Medicine

Geriatrics
Fully Integrated Healthcare Delivery System
Primary Care / Urgent Care

Specialty Care

Endoscopy – New England SCOPE

Optical Centers – InSTYLE Optical

Eye Surgery – SEE New England

Durable Medical Equipment – Lakeview Medical

Occupational Health

Rehabilitation & Physical Therapy

24-Hour Nurse Triage
Revenue Mix

- 73% Risk (Capitation)
- 25% Fee for Service
- 2% Other Income
Your Questions Lead To Our Answers.

As healthcare evolves, our clients face increasingly complex clinical and financial risk.

Verisk Health is transforming the business of healthcare by providing data services, analytics, and advanced technologies that address the healthcare industry’s most complex challenges.

- How do I know I’m paying claims accurately?
- What tools can help us shift from volume to value?
- How can I better understand my population’s risk?
- What can we do to improve quality and compliance?
Addressing Business Challenges

By collecting and leveraging disparate healthcare data sources, and then applying our analytics expertise, we’ve created new ways to inform your toughest decisions.

**Providers**
- Population Health Analytics
- Visibility into Total Patient Risk
- Quality and Efficiency of Care
- Medical Cost Management
- Provider Performance Variation

**Health Plans**
- Provider Network Management
- Appropriate Risk-Adjusted Revenue
- Payment Accuracy & Fraud Prevention
- Quality Measurement & Reporting
- Population Health Risk Management

**Employers**
- Employee Risk Profiling & Budgeting
- Vendor Selection & Management
- Data-driven Benefit Design
- Reporting & Benchmarking
Agenda

• Market Overview
• Critical Success Factors
• Transforming Care Delivery
• Analytics Drive Results
• The Road Forward
Risk Shifting to Providers in Various Forms

- Shift from FFS to capitation will not happen overnight—financial / actuarial / clinical infrastructure critical
- Providers will likely need to navigate multiple types of payments over the next 5 years
- Local market dynamics, degree of clinical integration, benefit plan design and patient population (i.e. commercial, Medicare) are all key factors
The number of covered lives associated with new risk contracts is growing rapidly

Covered Lives Under Risk-Bearing Contracts

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimated</th>
<th>Projected</th>
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<tbody>
<tr>
<td>2011</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>14</td>
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<td>2013</td>
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<td>2016</td>
<td>57</td>
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<tr>
<td>2017</td>
<td>80</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>96</td>
<td></td>
</tr>
</tbody>
</table>

Growth Drivers

Growth will tend to be faster in areas with:

- Higher density of medium and large hospitals
- Higher concentration of physician practices
- Higher per capita spend

1. Estimates based on data from Leavitt Partners
2. Projections from Stax Consulting

Source: CMS, Leavitt Partners, Stax Consulting
Health Reform is changing the playing field for Payers and Providers

Health Reform

- Reimbursement Shifting from FFS to Value-Based
  - Providers Bear Increasing Risk
  - Aligning Quality & Payments
- Regulatory / Reporting Requirements
  - Analytics/Reporting Capabilities
  - Connectivity / IT Infrastructure
  - Bending the Cost Curve / Fixed Pie

- Medical Cost Management / Care Coordination
  - Structural considerations – type of risk?
- Providers Bear Increasing Risk
  - Timing likely to be gradual
  - Geography & market share matter
  - Broad range of capabilities required (IT, analytics, actuarial, consulting, research)
  - IT / Connectivity critical – nascent phases of development; clinical data challenges
  - Providers galvanized around the Triple Aim
Critical Success Factors

The bridge from FFS to accountable care arrangements

What are the underpinning building blocks?

Accountable Care Core Components

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

Foundational Philosophy: Triple Aim™

Measurement

Slide Content Courtesy of Premier, Inc.
Managing your accountable care contracts

1. Provide leadership, governance and the infrastructure needed to support our delivery system goals
2. Develop information technology that spans measurement analytics, risk prediction and automated care management
3. Monitor and manage service delivery and finance in new ways
4. Reform primary care payment to reflect expanded responsibilities
5. Develop high performing “care teams”
6. Match investments in healthcare technology with innovations in the patient care process

Source: Verisk Health
Information Technology Foundation

• Invest in and learn to use appropriate information technology to manage population health.

• Acquire the technological infrastructure and establish a culture that uses this technology to promote population health.

Source: Verisk Health
Considerations for Success

Building Population Health Capabilities: Key Choices

- **Resources** to Staff the Program
  - Care Management Staff
  - Data “Mining” and Analytics Staff
  - Training and Support Staff
- **Funding** for Technology Investments
- **Governance** (Policies, Processes, and Investments)
- **Privacy** and Data-Sharing Agreements
- **Processes** for Ongoing Communication

Source: Verisk Health
Population Health Management

Data driven analytics, risk models, metrics, provider performance measurement

Figure 5: A Stepped approach: Move beyond data to insights, decisions, and actions to realize value.

- Data does not guarantee insights
- Insights do not guarantee decisions
- Decisions do not ensure actions
- Learning

Industry and analytics skills sets are required to create hypotheses and valuable insights

The “last mile” of action requires alignment of workflow, personalized decisions, and incentives

Source: PWC Partnerships
TRANSFORMING THE DELIVERY OF CARE
Primary Care Competencies in a Successful ACO

- Deliver people-centered primary care
- Establish medical home value systems with a focus on “health”
- Optimize chronic, acute and preventative care
- Manage population segments to optimize health status
- Coordinate care across continuum
- Drive continuous improvement in outcomes of the ACO’s population
- Develop new delivery models to improve coordination of care for complex medical
Reliant Medical Group
Office of Population Health

Supporting the organization in fulfilling our new medical management responsibilities in a global risk environment
Goals: Patient Centered - Quality driven - Cost Stewardship

1) Content
   Clinical best practices, quality/cost stewardship, patient experience, guidelines, safety, evidence based

2) Analytics
   Measurement system (for quality/financials/performance, population risk profiles)

3) Organizational operations
   Defining regional patient populations, team based care, practice support, care continuum management, communication

Source: Reliant Medical Group
Tactics for Team Based Care

Physician led team based care where each member of the health care team takes collective responsibility for the ongoing care of the patient.

- Each team member will be encouraged and supported to provide this team based care to the full extent of their license and/or training.

Patient-centered care that provides for all the patient’s health care needs, or coordinates that care, for:

- Acute Care
- Chronic Care
- Behavioral Health
- Preventive Services
- End of Life

Source: Reliant Medical Group
Tactics for Care Coordination
Care that is coordinated and/or integrated across all elements of the complex health care system and the patient’s community, to include care that is facilitated by:

- Registries
- Information Technology
- Health Information Exchange
- Complex Care Management
- Pharmacy and Social Support

Assure patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Source: Reliant Medical Group
Tactics for Supporting Infrastructure

Quality and Safety to include:

- Evidence-based medicine and decision support tools to guide decision making;
- Continuous quality improvement through engagement in performance measurement and improvement;
- Patient and family participation in quality improvement activities at the practice level;
- Continuous effort to facilitate and improve the patient’s experience of care.

Enhanced Access that includes same day and open scheduling

- Expanded hours
- Alternate options (i.e., My Chart) for communication between patients and the medical practice team

Integration

- Working in coordination with other committees to ensure integration throughout the organization.

Source: Reliant Medical Group
Regional Support

– Case Management
  • Episodic, Complex, Transitions
– Social Work
  • Behavioral Health
– Geriatrics
  • SNF, Home Run, Palliative Care, Hospital at Home
– Clinical Pharmacist
  • Med Rec, disease management, p4p
– Behavioral Health providers
– Population Health Coordinators
  • Hypertension, Diabetes and Hyperlipidemia outreach

Source: Reliant Medical Group
Central Support

– Risk and Quality Management
  • Clinical Quality (p4p), Risk and Patient Safety, Peer Review
– Patient Experience
– Referral Management
  • External and Preferred provider
– Population analytics
  • Risk Revenue, Verisk, Quality and External Triple Aim performances
– Special Projects
  • PCMH recertification

Source: Reliant Medical Group
## Reliant Medical Group
### Historical Separation of Cost and Quality

<table>
<thead>
<tr>
<th>COST</th>
<th>QUALITY</th>
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</thead>
<tbody>
<tr>
<td>UM Efforts</td>
<td>Patient Registries</td>
</tr>
<tr>
<td>Referral Management</td>
<td>Disease Management</td>
</tr>
<tr>
<td>High Cost Patients</td>
<td>Quality Measures</td>
</tr>
<tr>
<td>Budget Accountability</td>
<td>Access</td>
</tr>
<tr>
<td>Case Management</td>
<td>“Risk” = Potential</td>
</tr>
<tr>
<td>“Risk” = Contractual</td>
<td>Litigation</td>
</tr>
<tr>
<td>Arrangement</td>
<td></td>
</tr>
</tbody>
</table>

Source: Reliant Medical Group
Future State – Population Health

QUALITY

COST

SWEET SPOT

Source: Reliant Medical Group
“Sweet Spot” Opportunities

• Improving both Quality and Cost
  – Home Run Program – 5:1 ROI and marked improvement in service and quality of care
  – COPD Disease management – YOY improvement in ER, hospital days, and quality of care
  – HIV care – 10% lower TME vs national average due to improved disease management
  – DM – Our Medicare diabetic population is at 10th percentile in TME vs national
  – Referral management - 20% leakage

Source: Reliant Medical Group
ANALYTICS TO DRIVE RESULTS
Top Opportunity Identification

Framework for review – selected components

**Area of focus**
- Pop Health
- Manage Medical Cost
- Practice Management

**System/ Network Management**
- Preventive Care, Care Gaps
- PMPM cost, Top cost –DX, PX, Imaging, Lab
- Clinic efficiency index, Out of network

**Clinic/ provider Management**
- ‘Very high’ groups’ risk
- Conversion analyzer, prescribing patterns
- Efficiency index - Imaging & ER/1000

**Improve patient outcomes**
- Disease prevalence & PMPM
- No office visit after hosp, ER with non-urgent DX
- Amb care sensitive admits

Source: Verisk Health
Predictive Risk Perspective
Relative Risk Scores Derived from Hierarchical Condition Category (HCC) Predictive Models

<table>
<thead>
<tr>
<th>Prospective Risk Score</th>
<th>4.90</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age/Gender</strong></td>
<td></td>
</tr>
<tr>
<td>✓ 45 - 54 Male</td>
<td>0.50</td>
</tr>
<tr>
<td><strong>Condition Categories</strong></td>
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<tr>
<td>✓ Type I Diabetes</td>
<td>0.75</td>
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<tr>
<td>✓ Hypertension</td>
<td>-----</td>
</tr>
<tr>
<td>✓ Congestive Heart Failure</td>
<td>2.13</td>
</tr>
<tr>
<td>✓ Depression</td>
<td>0.92</td>
</tr>
<tr>
<td>Interaction</td>
<td></td>
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<tr>
<td>✓ Type I Diabetes &amp; CHF</td>
<td>0.60</td>
</tr>
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</table>

John contributes additional risk to the group’s illness burden and is predicted to spend 4.9 times the plan average.

Individual average spending for medical services factors into aggregate medical costs for a defined fiscal period.

Provider contracts are based on the relative risk of their affiliated members.

Source: Verisk Health
Population Health Management Framework

<table>
<thead>
<tr>
<th>ACO Population</th>
<th>Goal</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Costs ($)</td>
<td>Manage high costs &amp; help members navigate system</td>
<td>Case Management</td>
</tr>
<tr>
<td>High Care Gaps (CGI)</td>
<td>Close gaps in care</td>
<td>Disease Management</td>
</tr>
<tr>
<td>Low Care Gaps (CGI)</td>
<td>Monitor compliance rates</td>
<td>Disease Management</td>
</tr>
<tr>
<td>Low Disease Burden (RRS)</td>
<td>Manage risk factors</td>
<td>Wellness Management</td>
</tr>
</tbody>
</table>

Source: Verisk Health

RRS = Relative Risk Score
Verisk DxCG Acuity Scores

• Data can be used to:
  – Sort and target high risk groups within a population for CM
  – Help manage medical expense variation
  – Build sound financial budgets and utilization targets
  – Partner with payers to optimize resource allocation and outreach
  – Contracting for appropriate capitation rates
  – **Support efforts at growing our patient base**

Source: Reliant Medical Group
Verisk DxCG Risk Scores

- Reference population of > 30 million lives
- Separate database for Commercial, Medicare, and Medicaid
- Methodology is a predictive model for TME on individual patients and on subpopulations
- Chronic conditions are weighted heaviest, i.e. DM, COPD, CHF, at ICD-9 level
- Co-morbidities may have multiplicative rather than additive weights, i.e. major depression with CHF
- Reference population = 1.0
- Age/sex alone accounts for 2-3 fold variation in cost of care vs. diagnoses which can be 100 fold difference around a reference average

Source: Reliant Medical Group
Case Management at Reliant Medical Group

- Risk stratify our population using “likelihood of hospitalization” score
- Embedded nurse case management in all of our primary care sites
- Sort patients by DxCG score
- Direct referrals by PCP
- High risk roster review includes all of the above plus hospital readmissions and high ER use

Source: Reliant Medical Group
High Risk

Patients with high likelihood of hospitalization (LOH), ED Visits, & Readmissions

- **Data**: Hot Spot report listing patients with high composite score (weighted LOH, ED, and re-admissions) sent to PCP sites and Care Management team monthly
- **Data Source/Tool**: LOH scores generated by Verisk predictive modeling, and claims data for ED Visits and re-admissions.
- **Application**:
  - Used for care management assignment and high risk roster review.
  - Patient’s risk identification in EMR header

Source: Reliant Medical Group
Commercial Risk Summary
Compared to Benchmarks

- Benchmark Population: 11,598,388
- Fallon Commercial Age/Gender: 1.15
- Fallon Commercial DxCG: 1.98

Source: Reliant Medical Group
Conditions/10K Members as a % of Benchmark - Commercial

- Cancer: 176%
- Diabetes: 146%
- Diabetes w/ PVD: 508%
- Hyperlipidemia: 261%
- Liver Disease: 218%
- Substance Abuse: 706%
- Mental Illness: 259%
- Cardiac Conditions/All: 160%
- Hypertension: 169%
- COPD and Asthma: 226%

Source: Reliant Medical Group
Chronic Conditions
Rate's per 10,000 - July 2013 thru June 2014
Commercial Patients

Top Sites by Condition

- Highest RMG Site
- RMG
- National Benchmark
Medicare Risk Summary Compared to Benchmarks

Source: Reliant Medical Group
Conditions/10K Members as a % of Benchmark - Medicare

- Cancer: 130%
- Diabetes: 107%
- Diabetes w/pVD: 267%
- Hyperlipidemia: 138%
- Joint Replacement: 138%
- Substance Abuse: 141%
- Mental Illness: 144%
- Heart Disease: 112%

Source: Reliant Medical Group
Focus on Out-of-Network Utilization

66.7% of office visits with specialists were provided outside of the assigned ACO. Leakage of outpatient specialty care was greater for higher-cost beneficiaries and substantial even among specialty-oriented ACOs (54.6% for lowest quartile of primary care orientation).

How Can I Evaluate Network Affiliation?

Clinically Integrated Networks that are **not** well integrated show opportunity for improvement with > 60% out-of-network (OU).

Results

<40%

Out-of-network utilization by well-managed, Verisk Health Clinically Integrated Network clients

Source: Verisk Health data on file
Reporting for Population Health

• Uncover opportunities based on data
• Focus organization efforts
• Build on existing infrastructure – in new ways
  • QI process
  • Committee structure
  • Support care process redesign
• Understand and manage at-risk population
• Achieve Triple Aim Goals
• Success with at-risk contracts

Source: IHI And Verisk Health
THE ROAD FORWARD
How Will We Evaluate These Initiatives?

Environmental context → Local readiness → Implementation activities → Intermediate outcomes → Impact

**National and state context:**
- Policies, investments, and activities

**ACO structure and capabilities:**
- Governance, leadership, and health IT infrastructure

**Local context:**
- Market structure and health IT capacity

**ACO contract characteristics:**
- Degree of risk, incentives for health IT adoption

**ACO formation and implementation activities:**

**ACO performance**

**Triple Aim**
- Improved access and experience
- Improved health and functioning
- Reduced costs

Fisher E S et al. Health Affairs 2012;31:2368-2378