Managing Risk: Cleveland Clinic’s Population Management of Employees and Their Families

James Gutierrez MD FACP
Chair, Community Internal Medicine
Cleveland Clinic

Bruce Rogen MD MPH FACP
Chief Medical Officer, Employee Health Plan
Cleveland Clinic
Cleveland Clinic Overview

Ohio
1,450 bed Tertiary Care Medical Center
16 Family Health Centers
10 Community Hospitals

Abu Dhabi
Operational in 2015
Multi-specialty Hospital & Clinic

Canada: Toronto Health & Wellness Centre

Florida: Weston Clinic & Hospital

Nevada: Lou Ruvo Center for Brain Health

2
Cleveland Clinic Key Facts

- Not-for-profit multi-specialty group practice
- 3,034 employed physicians
- 1,000 affiliated physicians (Quality Alliance)
- 43,890 employees
- Physician leadership
- Statistics
  - Clinical visits: 5.1 million
  - Surgical cases: 200,808
  - Admissions: 157,474
  - Beds: 4,450 (1,450 main campus)
  - Revenue: $6.2 billion
  - Self-Insured: Group/WC/Disability
Northeast Ohio Background

Cleveland Combined Statistical Area- 3,500,000 inhabitants, 15th largest CSA in the USA (2010 census). Cleveland Metropolitan Statistical Area (main population base for the Cleveland Clinic) is 2,000,000 inhabitants, includes city of Cleveland and suburbs.

Gross regional product- $170 billion. Household median income $49,000.

25 of the Fortune 1000 companies are headquartered in the Northeast Ohio area, including Goodyear, Progressive Insurance, Sherwin-Williams, Key Bank, Diebold, and others.

Three large health care systems, all non-profit: Cleveland Clinic, University Hospitals, and MetroHealth.
## Attributed PCP Membership to Cleveland Clinic
(Not all inclusive, only top 6 contracted insurers)

<table>
<thead>
<tr>
<th>Payer</th>
<th>Type</th>
<th>Approximate Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHP</td>
<td>Commercial</td>
<td>80,000</td>
</tr>
<tr>
<td>Major Insurer #1</td>
<td>Medicare Advantage</td>
<td>20,000</td>
</tr>
<tr>
<td>Major Insurer #1</td>
<td>Commercial</td>
<td>50,000</td>
</tr>
<tr>
<td>Major Insurer #2</td>
<td>Medicare Advantage</td>
<td>10,000</td>
</tr>
<tr>
<td>Major Insurer #2</td>
<td>Commercial</td>
<td>20,000</td>
</tr>
<tr>
<td>Major Insurer #3</td>
<td>Commercial</td>
<td>111,000</td>
</tr>
<tr>
<td>Major Insurer #4</td>
<td>Commercial</td>
<td>8,000</td>
</tr>
<tr>
<td>Major Insurer #5</td>
<td>Medicare Advantage</td>
<td>12,000</td>
</tr>
<tr>
<td>Major Insurer #6</td>
<td>Commercial</td>
<td>26,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>337,000</strong></td>
</tr>
</tbody>
</table>
“To ensure that our employees receive high quality evidence-driven health care that includes both prevention and treatment at a sustainable cost to the employee and the organization.”
The average annual cost of healthcare for hospital employees and their dependents in 2010 was $4,662 — 13 percent greater than the average cost for U.S. workers. Costs for employees only were 10 percent higher than average.
Employee Health Plan Total Care

- Medical, Pharmacy, Behavioral Health, and Wellness Programs

- Programs include chronic disease management, rare disease management, case management, and utilization management
Employee Health Plan Total Care

- Chronic disease management currently includes hypertension, diabetes, hyperlipidemia, asthma, tobacco cessation, weight management, CHF, CKD, depression, low back pain and migraine

- Weight management coordinated with wellness programs and using wearable tech collecting objective data has become the keystone
Enterprise Wellness Initiatives

2005-2007... Building the foundation
- Banning smoking on Campus, smokers need not apply
- Banning transfats
- Integrate Wellness/Health Plan

2008-2009... Building the foundation
- Free fitness, weight loss, and smoking cessation programs
- $100 rewards
- Banning candy and soft drinks (except diet)
Integrating the Components

2010 - 2011... Expanding the scope
• Healthy Choice Rebate
• Focus on chronic disease management of 6 key diseases
• Expand access to programs for EHP dependents
• Physical Capability Evaluation for new hires

2012 – 2013... Premium Differential
• Levels: Gold, Silver, Bronze
• Premium based on
  – Historical Participation
  – Goal Attainment
Enterprise-wide Wellness Initiatives

2014 – the future...

- Spouses included

- Integrate programs into Patient Centered Medical Homes and Move Care Coordination into Provider Offices

- Levels: Diamond, Platinum, Gold, Silver, Bronze (or “base rate”)

- For healthy and for weight management, wearable tech device (Fitlinxxx Pebble) for tracking activity and integration into goals.
Incentives Focusing on 6 Chronic Diseases, and the “healthy”

Asthma
Diabetes
Hypertension
Hyperlipidemia
Smoking
Obesity

Those with none of the above—“The Healthy”
Healthy Choice Program – “The Guts”

- Program effective 1-1 to 9-30 each year
- Health Visit Form (Not HRA) – Determines requirements one must follow for the discount
- HVF must be updated every 2 years
  - If HVF completed in 2011---required to have updated physician visit in 2013
  - If HVF completed in 2012---required to have updated physician visit in 2014
- Annual personal letter with instructions
- Must participate each year to maintain gold status
Annual Individualized Letters

Here is what to do if the letter you received says:

- **You need to submit more health info**
  
  Schedule a health visit to have the health visit report form completed and submitted to the health plan

  AND

  After your visit if you are healthy or receive one of the 6 diagnoses follow these steps

- **You’ve been diagnosed with:**
  
  high blood pressure, high cholesterol, asthma, diabetes, weight management or tobacco use

  THEN

  Join the appropriate Coordinated Care program(s) and meet its requirements

- **You are healthy**
  
  Join an EHP Physical Activity Program and go 10x a month for 6 months

  OR

  Participate in the first 2 Shape Up & Go! challenges in 2012
Healthy Choice Programs

Coordinated Care:
- Weight Management
- Diabetes
- Hypertension
- High Cholesterol
- Tobacco
- Asthma

Physical Activity:
- Cleveland Clinic owned fitness centers
- Curves fitness centers
- Shape up and Go linked to the Pebble
Healthy Choice Premium

- **Bronze** – standard premium – employee and spouse both not participating in Healthy Choice
- **Silver** – one (either employee or spouse) participating, but not meeting Healthy Choice goals
- **Gold** – both employee and spouse participating, but neither meeting Healthy Choice goals, or one participating and meeting Healthy Choice goals
- **Platinum** – both employee and spouse participating, but only one meeting Healthy Choice goals
- **Diamond** – both employee and spouse participating, and both meeting Healthy Choice goals
• Participation during current year will determine next year premium
• Voluntary Program
• Bronze Members who meet the goal in the year they join also qualify for premium rebate to Silver status in first paycheck of the following year (taxable income) - important for new hires
Other Participation $ Incentives

Coordinated Care Meeting Goals - Reimbursement of:

- Office Co-payments
- DME Co-Insurance
- Pharmacy Co-Insurance
Why Target Obesity???
• $190 billion in annual medical costs due to obesity, double some earlier estimates.

• $1,850 more per year in medical costs for an overweight person than for someone of healthy weight.

• $5,530 more per year in medical costs for a worker with a BMI above 40. (By comparison, smokers' medical costs were only $1,274 a year higher than nonsmokers’, who generally die earlier).

• $1,026: annual cost of absenteeism per very obese male worker (BMI > 40). $1,262: Annual cost of absenteeism per very obese female worker.

Source:
Overweight / obese adults are more likely to develop serious conditions...

Increased likelihood for:

- 20.0 x Diabetes
- 2.0 x Heart disease/stroke
- 2.5 x Hypertension
Wearables at Cleveland Clinic

- For healthy members, and the overweight and obese population, we struggled for years with getting objective data on activity for our goals.

- An online program, Shape Up and Go, was a required part of the program - to meet goal you had to participate in 2 out of three annual Shape Up and Go challenges.

- But... all data on activity was entered by the member- totally subjective!

- So- we decided to use the Pebble- a wearable fitness tracker
“The Pebble” at Cleveland Clinic

• To participate all Healthy Choice members without chronic disease must have and use the Pebble, which downloads into our online tracking program.
• To reach goal, they have to hit target of 100,000 steps a month, or 600 exercise minutes a month, for the six month program period.
• Exceptions are granted on appeal for those who have a limiting disability.
Preliminary Results

24,321 Pebbles distributed  
(as of 8/5/14)

17,171,535,205 steps walked  
(since 1/1/14)

3,365,019 exercise hours  
(since 1/1/14)

$36 \times$ to the moon and back
Population Health: Care Coordination Program - Stratification is key

Stratification Counts by Disease
Data Source: Impact Pro (Filtered by EHP Primary Members)
TimeFrame: As of February 2012

### Employee Health Plan Member Counts

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>ASTHMA</th>
<th>CAD</th>
<th>CHF</th>
<th>CKD</th>
<th>COPD</th>
<th>DEPRESSION</th>
<th>DIABETES</th>
<th>HPL</th>
<th>HTN</th>
<th>MIGRAINE</th>
<th>LBP</th>
<th>WEIGHT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>150</td>
<td>204</td>
<td>67</td>
<td>59</td>
<td>102</td>
<td>34</td>
<td>502</td>
<td>206</td>
<td>128</td>
<td>152</td>
<td>143</td>
<td>395</td>
<td>2,142</td>
</tr>
<tr>
<td>Moderate</td>
<td>232</td>
<td>220</td>
<td>51</td>
<td>56</td>
<td>51</td>
<td>259</td>
<td>886</td>
<td>2,401</td>
<td>852</td>
<td>174</td>
<td>324</td>
<td>4,252</td>
<td>9,758</td>
</tr>
<tr>
<td>Low</td>
<td>560</td>
<td>169</td>
<td>23</td>
<td>26</td>
<td>38</td>
<td>1,924</td>
<td>1,178</td>
<td>4,466</td>
<td>2,077</td>
<td>1,054</td>
<td>1,502</td>
<td>10,800</td>
<td>23,817</td>
</tr>
<tr>
<td>TOTAL COUNT</td>
<td>942</td>
<td>593</td>
<td>141</td>
<td>141</td>
<td>191</td>
<td>2,217</td>
<td>2,566</td>
<td>7,073</td>
<td>3,057</td>
<td>1,380</td>
<td>1,969</td>
<td>15,447</td>
<td>35,717</td>
</tr>
</tbody>
</table>

| Variance    | -      | -   | -   | -   | -    | -          | -        | -    | -   | -        | -    | -         |

<table>
<thead>
<tr>
<th>DENOMINATOR</th>
<th>ASTHMA</th>
<th>CAD</th>
<th>CHF</th>
<th>CKD</th>
<th>COPD</th>
<th>DEPRESSION</th>
<th>DIABETES</th>
<th>HPL</th>
<th>HTN</th>
<th>MIGRAINE</th>
<th>LBP</th>
<th>WEIGHT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>16%</td>
<td>34%</td>
<td>48%</td>
<td>42%</td>
<td>53%</td>
<td>2%</td>
<td>20%</td>
<td>3%</td>
<td>4%</td>
<td>11%</td>
<td>7%</td>
<td>3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Moderate</td>
<td>25%</td>
<td>37%</td>
<td>36%</td>
<td>40%</td>
<td>27%</td>
<td>12%</td>
<td>35%</td>
<td>34%</td>
<td>28%</td>
<td>13%</td>
<td>16%</td>
<td>28%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Low</td>
<td>59%</td>
<td>28%</td>
<td>16%</td>
<td>18%</td>
<td>20%</td>
<td>87%</td>
<td>46%</td>
<td>63%</td>
<td>68%</td>
<td>76%</td>
<td>76%</td>
<td>70%</td>
<td>66.7%</td>
</tr>
<tr>
<td>TOTAL COUNT</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
# Stratification Count by Condition and Care Management Program Participation

<table>
<thead>
<tr>
<th>Disease</th>
<th>High Count</th>
<th>High Enrolled</th>
<th>High Pct</th>
<th>Moderate Count</th>
<th>Moderate Enrolled</th>
<th>Moderate Pct</th>
<th>Low Count</th>
<th>Low Enrolled</th>
<th>Low Pct</th>
<th>Not IPRO Count</th>
<th>Not IPRO Enrolled</th>
<th>Not IPRO Pct</th>
<th>Total Count</th>
<th>Total Enrolled</th>
<th>Total Pct</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASTHMA</td>
<td>99</td>
<td>52</td>
<td>53%</td>
<td>144</td>
<td>74</td>
<td>51%</td>
<td>253</td>
<td>149</td>
<td>59%</td>
<td>696</td>
<td>696</td>
<td>100%</td>
<td>1,192</td>
<td>971</td>
<td>81%</td>
</tr>
<tr>
<td>DIABETES</td>
<td>330</td>
<td>151</td>
<td>46%</td>
<td>614</td>
<td>311</td>
<td>51%</td>
<td>800</td>
<td>435</td>
<td>54%</td>
<td>165</td>
<td>165</td>
<td>100%</td>
<td>1,909</td>
<td>1062</td>
<td>56%</td>
</tr>
<tr>
<td>HYPERTENSION</td>
<td>90</td>
<td>15</td>
<td>18%</td>
<td>570</td>
<td>203</td>
<td>36%</td>
<td>1,508</td>
<td>498</td>
<td>33%</td>
<td>1,008</td>
<td>1,008</td>
<td>100%</td>
<td>3,175</td>
<td>1725</td>
<td>54%</td>
</tr>
<tr>
<td>WEIGHT MGMT</td>
<td>308</td>
<td>161</td>
<td>52%</td>
<td>2,968</td>
<td>1,419</td>
<td>48%</td>
<td>7,382</td>
<td>2,937</td>
<td>39%</td>
<td>3,119</td>
<td>1,875</td>
<td>60%</td>
<td>13,977</td>
<td>6392</td>
<td>46%</td>
</tr>
<tr>
<td>HYPERLIPIDEMIA</td>
<td>123</td>
<td>47</td>
<td>38%</td>
<td>1,593</td>
<td>502</td>
<td>32%</td>
<td>2,974</td>
<td>1,072</td>
<td>36%</td>
<td>870</td>
<td>870</td>
<td>100%</td>
<td>5,560</td>
<td>2491</td>
<td>45%</td>
</tr>
<tr>
<td>CHF-HTN</td>
<td>33</td>
<td>7</td>
<td>21%</td>
<td>37</td>
<td>4</td>
<td>11%</td>
<td>16</td>
<td>4</td>
<td>25%</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>97</td>
<td>26</td>
<td>27%</td>
</tr>
<tr>
<td>MIGRAINE</td>
<td>113</td>
<td>11</td>
<td>10%</td>
<td>128</td>
<td>9</td>
<td>7%</td>
<td>704</td>
<td>41</td>
<td>5%</td>
<td>83</td>
<td>83</td>
<td>100%</td>
<td>1,028</td>
<td>144</td>
<td>14%</td>
</tr>
<tr>
<td>CHRONIC KIDNEY DISEASE</td>
<td>38</td>
<td>5</td>
<td>13%</td>
<td>33</td>
<td>1</td>
<td>3%</td>
<td>15</td>
<td>1</td>
<td>7%</td>
<td>2</td>
<td>2</td>
<td>100%</td>
<td>88</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td>DEPRESSION</td>
<td>19</td>
<td>7</td>
<td>37%</td>
<td>186</td>
<td>7</td>
<td>4%</td>
<td>1,223</td>
<td>28</td>
<td>2%</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>1,432</td>
<td>46</td>
<td>3%</td>
</tr>
<tr>
<td>CAD</td>
<td>109</td>
<td>0</td>
<td>0%</td>
<td>115</td>
<td>0</td>
<td>0%</td>
<td>96</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>320</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>LOW BACK PAIN</td>
<td>95</td>
<td>0</td>
<td>0%</td>
<td>210</td>
<td>0</td>
<td>0%</td>
<td>938</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>1,293</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>COPD</td>
<td>55</td>
<td>0</td>
<td>0%</td>
<td>29</td>
<td>0</td>
<td>0%</td>
<td>23</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0</td>
<td>0%</td>
<td>107</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,412</strong></td>
<td><strong>457</strong></td>
<td><strong>32%</strong></td>
<td><strong>6,627</strong></td>
<td><strong>2,530</strong></td>
<td><strong>38%</strong></td>
<td><strong>16,182</strong></td>
<td><strong>5,165</strong></td>
<td><strong>32%</strong></td>
<td><strong>5,958</strong></td>
<td><strong>4,714</strong></td>
<td><strong>79%</strong></td>
<td><strong>30,179</strong></td>
<td><strong>12,866</strong></td>
<td><strong>43%</strong></td>
</tr>
</tbody>
</table>


## Risk Stratification Shapes Care Coordination

<table>
<thead>
<tr>
<th>High Risk Members</th>
<th>Medium Risk Members</th>
<th>Low Risk Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call once a week until compliant or when presents lower acuity</td>
<td>Call every month until compliant</td>
<td>In compliance or monitoring phase of program for one year</td>
</tr>
<tr>
<td>Call every month once compliant or when presents lower acuity</td>
<td>Quarterly call once compliant</td>
<td>Two calls per year</td>
</tr>
<tr>
<td>Consultation with medical director</td>
<td>Referrals as needed</td>
<td>Quarterly mailings</td>
</tr>
<tr>
<td>Referral to dietitian or class</td>
<td>Appointment with MD three months after joining program</td>
<td>Annual medication review</td>
</tr>
<tr>
<td>Referral to endocrinologist</td>
<td>Quarterly medication review until compliant</td>
<td></td>
</tr>
<tr>
<td>Appointment with MD within one month of starting program</td>
<td>Medication review twice a year once compliant</td>
<td></td>
</tr>
<tr>
<td>Needs assessment with case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly medication review until compliant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarterly medication review once compliant</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EHP Healthy Choice Results

• Improved participation
• Improved utilization
• Improved cost trends
• Improved quality measures
• Improved weight control
EHP Care Management Enrollment by Quarter
Unique Employees Enrolled in Disease Management

EHP employees only
Data is from Care Management Database COACH; includes FL employees
Percent of Unique Employees with Diabetes, Hypertension, Asthma, Hyperlipidemia or BMI >27 enrolled in Care Management

EHP employees only
Percent of Unique Dependents with Diabetes, Hypertension, Asthma, Hyperlipidemia or BMI >27 enrolled in Care Management

Dec 2013: 7%
June 2014: 48%

EHP dependents only
Trended EHP-Paid PMPM by Quarter from 2004 (Medical and Pharmacy Claims)

Average yearly increase PMPM 2004 – 2009: 7.5%
Average yearly increase PMPM 2010 – 2013: 3.6%

EHP primary members only; claims paid through 12/31/13; Data Sources: EHP Warehouse, HCTA, EHP Financial Summary
PMPM normalized for ASC Grouper, PBB, 09/01/2010 rate change and rate exception (April 2012 – March 2013)
Includes pharmacy CMS subsidy, rebates, internal savings and error adjustment
PBB = Provider Based Billing
ASC = Ambulatory Surgery Center
2009 vs. 2013 Four Year Change in Utilization, Cost and PMPM (Medical and Pharmacy Claims)

% Change

-8%  -4%  0%  4%  8%  12%  16%  20%  24%  28%  32%

-3.8%  19.8%  15.3%  15.3%  31.4%  15.3%  -8%  -4%  0%  4%  8%  12%  16%  20%  24%  28%  32%

Encounters/1000 (Utilization)  Paid/Encounter (Unit Cost)  PMPM

EHP  EHP  PMPM Milliman median

-3.8%  19.8%  15.3%  15.3%  31.4%  15.3%

EHP primary members only
Milliman median commercial benchmark
## Pre vs. Post Care Management Enrollment Utilization Trend

<table>
<thead>
<tr>
<th></th>
<th>Inpatient per 1000</th>
<th></th>
<th>ED per 1000</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>% Change</td>
<td>Pre</td>
</tr>
<tr>
<td>Diabetes</td>
<td>225.7</td>
<td>190.0</td>
<td>-15.5%</td>
<td>395.70</td>
</tr>
<tr>
<td>Asthma</td>
<td>193.0</td>
<td>153.8</td>
<td>-20.3%</td>
<td>547.3</td>
</tr>
<tr>
<td>HTN</td>
<td>152.0</td>
<td>115.2</td>
<td>-24.1%</td>
<td>338.2</td>
</tr>
</tbody>
</table>

1. Number of employees: 1,142 (Diabetes), 1,197 (Asthma), 1,545 (HTN); data refreshed through Q4 13
2. Non-normalized PMPM
3. EHP comparison average change year over year during enrollment period
Pre vs. Post Care Management Enrollment
Quality Compliance Diabetes

1. Number of employees: 1,160; data refreshed through Q4 13
### Diabetes

#### PMPM

<table>
<thead>
<tr>
<th>Category</th>
<th>Not In ($$)</th>
<th>In ($$)</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Total</td>
<td>$1,113</td>
<td>$1,080</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$196</td>
<td>$261</td>
<td>33.4%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$290</td>
<td>$190</td>
<td>-34.4%</td>
</tr>
<tr>
<td>ED</td>
<td>$19</td>
<td>$16</td>
<td>-17.6%</td>
</tr>
<tr>
<td>Office</td>
<td>$65</td>
<td>$60</td>
<td>-7.9%</td>
</tr>
</tbody>
</table>

#### Utilization

<table>
<thead>
<tr>
<th>Category</th>
<th>Not In (per 1000)</th>
<th>In (per 1000)</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Total</td>
<td>65,051</td>
<td>77,841</td>
<td>12.0%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>25,151</td>
<td>28,802</td>
<td>14.5%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>266</td>
<td>178</td>
<td>-33.3%</td>
</tr>
<tr>
<td>ED</td>
<td>496</td>
<td>396</td>
<td>-20.1%</td>
</tr>
<tr>
<td>Office</td>
<td>9,284</td>
<td>9,797</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

### Notes

1. Number of employees: In CM: 1,084 Not In CM: 986; 07/01/12 - 06/31/13
2. Non-normalized PMPM; risk adjusted analysis
3. EHP comparison is 07/01/12 – 06/31/13

---

---

---
BMI Trend Analysis
Weight Management Participants 2011 - 2013

Three Year Averages
Gold Recipients = -7.9%
Silver Recipients = 0.0%

Legend
Darkest Color = 2011
Middle Color = 2012
Lightest Color = 2013
The “Offshore” medical home model of telephonic disease management from EHP:

• Risk stratification with program modification so that program requirements (phone contacts, follow up, referrals to specialists and programs) vary based on risk level.

• Review of lab and test outcomes and results in addition to whether they were done. Modification of medications and diet and lifestyle recommendations to alter outcomes in the future.

• Use of EPIC electronic medical record to communicate with physicians and providers and give updates, order labs and tests (pended), and inform.

• Use of phone and fax to communicate with community providers who are not on EPIC for updates, labs and tests, and inform.

• Access claims, clinical, and wellness databases to get information on patient’s activities, incentives, and appeals.

• Health coaching component to provide support and encouragement.
Patient-Centered Medical Home

“Patient-centered medical home (PCMH) is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the care provided to the patient and arranges for appropriate care with other qualified providers as needed.”

NCQA
The Plan: Transition that model of care to the provider’s patient centered medical home

- Transformation of all 29 primary care practice sites into value-based Patient Centered Medical Homes

- Develop infrastructure and culture to support ACO and risk contract readiness

- Core Clinical Components:
  - Care Coordination of high risk patients
  - PreVisit planning function
  - TeamCare to enhance access
  - Integration of the clinical team: PharmDs, behavioral health, etc.

- Roll out began March 1, 2013
High Level Goals

• Coordinate care for high risk patients
• Reduce all-cause readmissions
• Close gaps in care
• Engage and activate patients
• Enhance patient access
• Reduce cost per unit of service
• Improve provider productivity
• Build competency in risk contracting
Goals of Transition

- Transition medical management of 800 high risk patients to PCP care coordination-the high risk definition includes: Asthma, HTN, DM, CHF, CAD, CKD, and COPD.

- Develop a single operating model for all patients in need of care coordination

- Achieve spend reduction to meet EHP target

- Develop care coordination model for independent providers

- Learn from the transition... Care Coordination Team
  - Identify, validate IT tools
  - Integrate with PCMH / clinical workflows
  - Find, manage patients across continuum

Out of scope:
- Weight management program
- Healthy Choice/benefits management
Key Considerations

• Weight Management program – dual coordination

• Alignment of high risk definition
  – Should include clinical and claims
  – Plan for additional claims data to be loaded in Optum tools needs to be created

• Hand-off communication b/w care coordinator groups

• Education of MI care coordinators

• Ongoing data review and impact analysis
# EHP High Risk Patient Transition

<table>
<thead>
<tr>
<th>Timing</th>
<th>EHP Patient Group</th>
</tr>
</thead>
</table>
| Phase 1 January | • Non-Healthy Choice (686)  
• All High Risk  
• Includes: HTN, DM, Asthma, CKD, CAD, CHF, COPD |
| Phase 2 February | • Prepare goals functionality in Epic to accept Healthy Choice patients  
• Letter to Healthy Choice Patients  
• Schedule 3-way call for handoff of pts not at goal |
| Phase 3 March | • Healthy Choice (499)  
• All High Risk – at goal and not at goal  
• Includes: HTN, DM, Asthma, CKD, CAD, CHF, COPD |
## Shift in Patient Priority

<table>
<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Discharged</td>
<td>1. EPIC Registry – EHP</td>
<td>EPIC Registry – All Payers</td>
</tr>
<tr>
<td>2. Chronic</td>
<td>2. Discharged</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Chronic</td>
<td></td>
</tr>
</tbody>
</table>

**Reactive** → **Proactive**
Why Shift Priorities?

• Leveraging predictive analytics
• Identify high risk patients before they are admitted (proactive)
• More efficient and effective when managing populations
  ➢ Precise allocation of scarce resources
  ➢ Scalability
Key Challenges

- Culture change
- ITD infrastructure to support activities is complex with multiple interdependencies
  - Availability of key data
- Time to hire and finding the right fit
- Significant impact to population’s health takes time
- Caregiver engagement variable
- Consistency and standardization
- Space – no overhauls
EHP to PCP Transition Measures

1. Tended PMPM Paid Claims for members transitioning

2. Tended inpatient and ED utilization for members transitioning

3. Tended Care Team tab utilization rate over time

4. Tended Goals Section utilization rate over time

5. % patients moved from high to moderate risk categories over time

6. Tended % of the transition population who are not currently care coordinated within EHP that are engaged in MI care coordination
Two measures have been analyzed to date:

✓ Trended PMPM Paid Claims for members transitioning

✓ Trended inpatient and ED utilization for members transitioning

Total of 1,185 high risk members transitioned from the EHP to PCP coordinators, 499 of whom were already in care coordination by the EHP.

676 are currently in coordination on the PCP side (increase of 177 new members in coordination).
## High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

### Asthma Not in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>ED</td>
<td>1,796</td>
<td>1,449</td>
</tr>
<tr>
<td>Inpatient</td>
<td>816</td>
<td>592</td>
</tr>
<tr>
<td>Office</td>
<td>11,898</td>
<td>11,163</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>46,245</td>
<td>46,082</td>
</tr>
</tbody>
</table>

2. **Members transitioned 01/01/2014.** (6 Months overlap – July 1, 2013 – Dec 31, 2013)
3. Unique Members – 49
High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

Asthma in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>ED</td>
<td>1,016</td>
<td>944</td>
</tr>
<tr>
<td>Inpatient</td>
<td>333</td>
<td>302</td>
</tr>
<tr>
<td>Office</td>
<td>10,262</td>
<td>10,024</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>36,746</td>
<td>37,302</td>
</tr>
</tbody>
</table>

3. Unique Members - 126
## High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

### Diabetes Not in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th></th>
<th>PMPM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>% Change</td>
<td>Pre</td>
</tr>
<tr>
<td>ED</td>
<td>1,028</td>
<td>957</td>
<td>-6.9%</td>
<td>$50.78</td>
</tr>
<tr>
<td>Inpatient</td>
<td>504</td>
<td>511</td>
<td>1.4%</td>
<td>$757.65</td>
</tr>
<tr>
<td>Office</td>
<td>10,291</td>
<td>10,631</td>
<td>3.3%</td>
<td>$54.06</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>42,482</td>
<td>42,957</td>
<td>1.1%</td>
<td>$372.83</td>
</tr>
</tbody>
</table>

3. Unique Members - 141
High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

Diabetes in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th></th>
<th>PMPM</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>% Change</td>
<td>Pre</td>
</tr>
<tr>
<td><strong>ED</strong></td>
<td>765</td>
<td>796</td>
<td>4.0%</td>
<td>$ 32.51</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>290</td>
<td>321</td>
<td>10.6%</td>
<td>$ 467.47</td>
</tr>
<tr>
<td><strong>Office</strong></td>
<td>11,500</td>
<td>11,556</td>
<td>0.5%</td>
<td>$ 56.97</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>36,105</td>
<td>35,833</td>
<td>-0.8%</td>
<td>$ 434.54</td>
</tr>
</tbody>
</table>

3. Unique Members - 162
### High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

#### Hypertension Not in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td><strong>ED</strong></td>
<td>1,329</td>
<td>1,316</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>750</td>
<td>579</td>
</tr>
<tr>
<td><strong>Office</strong></td>
<td>10,250</td>
<td>9,395</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>36,868</td>
<td>36,013</td>
</tr>
</tbody>
</table>

2. **Members transitioned 01/01/2014.** (6 Months overlap – July 1, 2013 – Dec 31, 2013)
3. Unique Members - 76
## Hypertension in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td><strong>ED</strong></td>
<td>1,152</td>
<td>1,089</td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>430</td>
<td>354</td>
</tr>
<tr>
<td><strong>Office</strong></td>
<td>9,646</td>
<td>9,582</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>29,101</td>
<td>28,722</td>
</tr>
</tbody>
</table>

2. **Members transitioned 03/01/2014.** (8 Months overlap – July 1, 2013 – Feb 28, 2014)
3. Unique Members - 79
High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

Asthma, Hypertension and Diabetes Not in CM

<table>
<thead>
<tr>
<th>Service</th>
<th>Enc / 1000 Pre</th>
<th>Enc / 1000 Post</th>
<th>% Change</th>
<th>PMPM Pre</th>
<th>PMPM Post</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>1,256</td>
<td>1,150</td>
<td>-8.4%</td>
<td>$ 61.17</td>
<td>$ 56.22</td>
<td>-8.1%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>632</td>
<td>545</td>
<td>-13.7%</td>
<td>$ 1,216.47</td>
<td>$ 1,062.63</td>
<td>-12.6%</td>
</tr>
<tr>
<td>Office</td>
<td>10,575</td>
<td>10,376</td>
<td>-1.9%</td>
<td>$ 55.56</td>
<td>$ 53.41</td>
<td>-3.9%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>41,571</td>
<td>41,549</td>
<td>-0.1%</td>
<td>$ 340.31</td>
<td>$ 376.84</td>
<td>10.7%</td>
</tr>
</tbody>
</table>

3. Unique Members - 266
High Risk Members Pre vs. Post Transition to Medicine Institute Utilization Trend

Asthma, Hypertension and Diabetes in CM

<table>
<thead>
<tr>
<th></th>
<th>Enc / 1000</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>ED</td>
<td>935</td>
<td>910</td>
</tr>
<tr>
<td>Inpatient</td>
<td>335</td>
<td>322</td>
</tr>
<tr>
<td>Office</td>
<td>10,676</td>
<td>10,605</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>34,817</td>
<td>34,807</td>
</tr>
</tbody>
</table>

3. Unique Members - 367
## High Risk Members Pre vs. Post Transition to Medicine Institute

### Time Period Definition

#### Members NOT in Case Management

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1/1/2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jan-14</td>
<td>Feb-14</td>
<td>Mar-14</td>
<td>Apr-14</td>
<td>May-14</td>
<td>Jun-14</td>
</tr>
</tbody>
</table>

**Shared Overlapping Utilization and Cost**

#### Members in Case Management

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3/1/2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Jan-14</td>
<td>Feb-14</td>
<td>Mar-14</td>
<td>Apr-14</td>
<td>May-14</td>
<td>Jun-14</td>
</tr>
</tbody>
</table>

**Shared Overlapping Utilization and Cost**
Lessons Learned

- Ongoing and redundant training imperative
- Embedded ITD partnership critical for workflow and tool alignment
- Physician alignment and input is critical
- Multidisciplinary teamwork from the ground up
- Change management techniques crucial
- Real proactive care coordination takes time... focus on low hanging fruit
- Provider and care team relationship is key
A Takeaway Set of Principles for Population Management Success

- Integrate wellness programs, disease management programs, and provider based care coordination to leverage for maximum gains.
- Treat obesity as a chronic disease and a comorbidity
- Use coaching and behavioral health tools and training.
- Removing financial barriers and ensuring access opens the way to desired behavior.
- Use significant financial incentives to drive both participation and outcomes.
- Accurate downloaded data on exercise activity, clinical data, and payer supplied claims data is a key to success.
- Communication is key - it’s a carrot not a stick.
- Implement in a slow stepwise approach.
Thank You!!

James Gutierrez MD FACP
Chair, Community Internal Medicine
Cleveland Clinic

Bruce Rogen MD MPH FACP
Chief Medical Officer, Employee Health Plan
Cleveland Clinic
Every Life Deserves World Class Care