Building the Universal Roadmap to Population Health Management

Executive Webinar
January 21, 2016

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IBM Watson Health
House Keeping

1. **Using the control panel** - Use the control panel on the right side of your screen to minimize and expand this panel by clicking on the arrow in the upper right corner.

2. **Ask Questions** - You can submit questions using the Question section located near the bottom of the control panel. We will take time to answer as many questions as we can during Q&A at the end of the presentation. If your question was not answered, we will respond to you individually after the event.

3. **After the webinar** - We want your feedback! Please take the short survey at the completion of the webinar. Also, all registrants will receive a copy of the presentation, and the recording for on-demand replay.
“Flipping Healthcare”: A Sign of the Times
Where is Your Organization On the Journey to Value?

FULL CLINICAL RISK
New risk contracts fail to return significant margins without clinical transformation

OPTIMAL VALUE CREATION AND VALUE CAPTURE
Optimal clinical delivery allows value creation to accrue predominantly to the payer

Balanced Pathway to Value Transformation

Max risk

Max transformation

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Where You Are in Your Transition to Value

- High readiness for risk, high clinical transformation: 32%
- High readiness for risk, low clinical transformation: 13%
- Low readiness for risk, high clinical transformation: 30%
- Low readiness for risk, low clinical transformation: 25%
PHM: Moving To A 24/7 Person-Centered Community

- **Care Management**
  - Clinical Analytics
  - Clinical Decision Support
  - Advanced Care Planning

- **Patient Population of the Primary Care Office**

- **Primary Care Office**

- **Care of a patient**

- **Patient Engagement**
  - Mobile
  - Automated Outreach
  - Patient Portals

- **Claims and Cost**
  - Risk Stratification

- **Others who supply/require information and coordination**
  - Specialty Care
  - Hospitals
  - Device
  - Radiology, Lab, Rx
  - Referral Tracking/HIEs

- **Distance Monitoring**
  - Telehealth/Telemedicine
  - Remote Patient Monitoring
It’s Coming: Value-Based Payment Will Dominate

<table>
<thead>
<tr>
<th></th>
<th>Historical performance</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>Alternative payment models (Categories 3–4)</td>
<td>~70%</td>
<td>~20%</td>
</tr>
<tr>
<td>FFS linked to quality (Categories 2–4)</td>
<td>~80%</td>
<td>&gt;80%</td>
</tr>
<tr>
<td>All Medicare FFS (Categories 1–4)</td>
<td></td>
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But, Preparing for Value is a “Work In Progress”

PHM Strategy Confirmed
- Buy/Affiliate to Complete Care Continuum
- Secure ACO, CIN and Direct Employer Contracts
- Reduce Total Cost of Care
- Scale PCMH

Mixed Financial Incentives
- FFS Dominant but Shifting
- FFS Contracts Include Quality Bonuses
- Medicare and Commercial Shared Savings
- Funding for Care Teams Unstable

PHM Infrastructure Evolving
- Multiple Systems and Data Sources to Integrate
- Analytics Initially Focused on Cost and Care Gaps
- Interoperability Not There Yet
- Medical Neighborhood Loosely Coordinated

Front Line Not Yet “Top of License”
- Workflows Largely Manual and Vary Across Practices
- Actionable Data Minimal
- Focused on “Tip of the Iceberg”
- Patient Engagement Episodic and Visit-Centered
Moving to Value Can be A Rollercoaster Ride

Providers/Payors must embrace this transition.

FFS Peak
- Reduced ER Visits
- Reduced Re-admissions
- Reduced Admissions
- Reduced Specialty Visits
- Reduced Procedures/1000

“Loss Valley”

Population Management Peak
- Capitated Risk
- Gainshare Contracting
- Care Coordination/ Pt. Engagement
- PCMH/PCP Engagement
- EMR/Central Data Repository

Revenue Control
Managing the Transition to Value is Key

<table>
<thead>
<tr>
<th>Increase Revenue</th>
<th>Decrease Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS visits to close care gaps</td>
<td>Avoid admissions and readmissions</td>
</tr>
<tr>
<td>Medicare CCM fee</td>
<td>Bundled payments</td>
</tr>
<tr>
<td>PCMH and PHM incentives</td>
<td>Medicare Shared Savings Programs</td>
</tr>
<tr>
<td>Medicare value payments to MDs</td>
<td>Manage self-insured risk</td>
</tr>
<tr>
<td>Worksite clinics</td>
<td>Lean out waste</td>
</tr>
</tbody>
</table>
A New Model of Care

Traditional View
Patients Who Arrive

Fee for Service

New View
Entire Patient Population

Value-Based Care
Value-Based Care Creates New Questions

What is risk profile of my population?
How do I compare to others on quality & costs?
Who are my high-cost, high-risk patients?
Which patients are likely to develop chronic conditions?
How do I most effectively engage my population?
How do I effectively manage them?
How do I get paid for performance?
“Bottom Up” Model Drives Scale and Improvement

QI
Patient Engagement
Enabled Care Teams
Line of Sight
Data Integrity

Intelligent, Accessible, Scalable Technology
Requirements to Optimize PHM

- Technology
  PHM and Engagement
  EMR Analytics

- Processes
  Efficient Ways of Working, Scale

- People
  Knowledge, Skills, Teams, Leadership, Culture

- Automation

- LEAN & Process Design
## HIT is Fundamental: Creating Smart Care Teams

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care team</strong></td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Broad PCP-led team, with coordination across specialty and ancillary</td>
<td>Patient-centered team fully integrated with specialty and ancillary that is integrated with hospital and specialty data using analytics based on clinical data and implied financial impact</td>
</tr>
<tr>
<td><strong>Data &amp; analytics</strong></td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Integrated with hospital and specialty data using analytics based on clinical data and implied financial impact</td>
<td>Integrated clinical, claims, financial, lifestyle, and biometric data providing real-time cognitive analytics</td>
</tr>
<tr>
<td><strong>Team activity</strong></td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Patient engagement pre/during/post visit using an approach based on patient segmentation</td>
<td>Longitudinal engagement across care settings that is personalized and adaptive in real-time</td>
</tr>
<tr>
<td><strong>Workflow tools</strong></td>
<td><strong>Future State</strong></td>
</tr>
<tr>
<td>Clinical decision support tools within EMR and care management workflow solutions that leverage broad set of information</td>
<td>Automated and actionable using full range of clinical, financial &amp; lifestyle data, with a single integrated workflow across care team</td>
</tr>
</tbody>
</table>
Let’s Harness The Exogenous Data to Drive Behavior Change

Exogenous data
(Behavioral, Socioeconomic Environmental)

60% of determinants of health

1100 TB generated per lifetime

Genomics data

30% of determinants of health

6 TB generated per lifetime

Clinical data

10% of determinants of health

0.4 TB generated per lifetime

Source: “The Relative Contribution of Multiple Determinants to Health Outcomes”, Laura McGovern et al., Health Affairs, Health Policy Brief, 2014
Population Health: One Person at a Time

Data and knowledge driven

Every person has a plan

Automation to manage a population down to the individual

Team based
Roadmap Elements: Moving to Value

- **Patient Experience**
  - Improved Quality
  - Decreased Cost

**RISK MANAGEMENT**
- Clinical, cost, & claims data integration
- Measure and track quality performance
- Historical and projected utilization
- Provider performance and variance
- Financial, future cost and risk management
- Predictive and cognitive analytics

**CARE MANAGEMENT**
- Population profiling; risk stratification
- Identify and close care gaps
- Coordinate care and engage population continuously
- Transform care delivery model
- Advanced clinical decision support
- Lean out and scale care management
6 Pillars of PHM

1. Leadership and Culture and More Leadership….
2. Governance, Operational and Financial Model
3. Care Coordination Across the Continuum
4. Analytics and Performance Management
5. Evidence-Based Practices
6. Team-Based Care and Patient Engagement
A Tale of Two Organizations
1. Culture: Everything we do starts with you!

Every story along the way makes us who we are...

...John is the story of Orlando Health.
“Don’t have to quit doing what you’re doing just because you have cancer; you don’t have to give up your dreams.”

...Judith is the story of Orlando Health.
“They really made me want to change … to be a better person. They gave me the strength I needed to get better.”

...Marcia is the story of Orlando Health.
“It’s your life, your body. You have to take care of your own needs first; you need someone you can trust.”

...You are the story of Orlando Health.

Join us on our journey. Hear the stories of these and other inspiring patients. Share in our milestones and highlights of the past year. Discover how Orlando Health’s Patient-First journey is redesigning care delivery. Learn about our innovative collaborative initiatives. Take a look at our role in the community, in the outstanding services we provide and in the amazing work of our philanthropic foundation.

The Orlando Health 2011 Annual Careholders’ Report, available online now at orlandohealth.com/careholders
PHM Pillar 1: Culture

- Culture is critical but takes time to develop
- Identify & begin developing physician leaders early in the process
- While culture is developing, take the opportunity to layer in elements that support your PHM journey
- “Get started, and keep the ball moving!”
2. Governance, Operational & Financial Model

Commercial payors are monitoring CMS programs and will be fast followers with the common goal of lowering costs, improving outcomes and increasing access.

**Continuum of Medicare Risk Models**

<table>
<thead>
<tr>
<th>Pay-for-Performance</th>
<th>Bundled Payments</th>
<th>Shared Savings</th>
<th>Shared Risk</th>
<th>Full Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Generation Accountable Care Organizations (ACOs)</td>
<td>Bundled Payments for Care Improvement Initiative (BPCI)</td>
<td>Medicare Shared Savings Program (MSSP) Track 1 (50% sharing)</td>
<td>MSSP Track 2 (60% sharing)</td>
<td>Next-Generation ACO (optional full performance risk)</td>
</tr>
<tr>
<td>Hospital VBP Program</td>
<td>Hospital Readmissions Reduction Program</td>
<td></td>
<td>MSSP Track 3 (up to 75% sharing)</td>
<td>Medicare Advantage (provider-sponsored)</td>
</tr>
<tr>
<td>HAC Reduction Program</td>
<td>Merit-Based Incentive Payment System (MIPS) for Providers</td>
<td></td>
<td>Next-Generation ACO (80-85% sharing)</td>
<td></td>
</tr>
</tbody>
</table>

**Increasing Financial Risk**

Source: Advisory Board, 2015
PHM Pillar 2:
Governance, Operational and Financial Model

Program Development Tier

- 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 population
- Develop new delivery models to improve coordination of care for complex medical
3. Continuum of Care and Clinical Integration

Integration of shared patient information
PHM Pillar 3: Coordinating Care Across the Continuum

Effective practice-based PHM is essential to successful Accountable Care
4. Actionable Data & Performance Scorecards

- **PhytoMed - Population Management System**
  - Dashboard
  - Insight
  - Coordinate
  - Remind
  - Outreach
- **Groups:** All Groups
  - Providers: All Providers
- **Diabetes**
  - HbA1c
  - LDL-C
  - Nephropathy Screening
  - Other Measures
  - DM HbA1c Testing (1/y)
  - DM HbA1c Uncontrolled (>39)
  - DM HbA1c Control (<39)
  - DM HbA1c Control (<80)
  - 44
  - 56
- **Condition Compliance**
  - Hypertension
    - Screening
    - 78
    - 22
  - Preventive
    - Screening
    - 92

**Report Generated on November 20, 2019**

- **Eligible for Savings (70% Rule):**
  - 58.13%
  - 91.82%
  - 95.00%
- **61.05 / 68.00 / 92.72%**
PHM Pillar 4: Data Analytics & Performance Measurement

Stair-Step Approach:
Move beyond data to INSIGHTS, DECISIONS and ACTION to realize value

Data

Data gathering & Analysis leads to the creation of improvement initiatives & program objectives

Insights

Data doesn’t guarantee insights

Decisions

Insights don’t guarantee decisions

Actions

Decisions don’t ensure actions.

The last and often biggest step is the action of aligning data, process workflows, financial incentives, and strategy.
5. Evidence-Based Practices

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>CPT, ICD-9</th>
<th>Laboratory Tests</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Examination (all pts)</td>
<td>V70.0</td>
<td>CBC, CMP, Lipid Panel</td>
<td>11 months</td>
</tr>
<tr>
<td>• Women &gt; 30</td>
<td></td>
<td>TSH</td>
<td>11 months</td>
</tr>
<tr>
<td>• Men ≥ 50</td>
<td></td>
<td>PSA</td>
<td>11 months</td>
</tr>
<tr>
<td>Diabetes</td>
<td>250.00</td>
<td>HbA1c</td>
<td>3 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lipid panel</td>
<td>11 months</td>
</tr>
<tr>
<td></td>
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**PROTOCOL: CHEST PAIN**

The Internal Medicine Providers authorize their clinical staff to perform the following tasks when presented with a patient experiencing chest pain:

1.) Registration will notify the nursing staff for assessment and the patient will be placed in an available room immediately.
2.) Patient will be placed on O₂ sat monitor and vital signs obtained including pain level.
3.) Patient will be placed on O₂ @ 2 L via NC.
4.) Provider will be notified of patient status.
5.) An EKG will be obtained by nursing staff, and copy of report presented to provider for review.
6.) If patient is to be admitted, they will be kept under close observation by the nursing staff, with vital signs to be taken every 15 minutes and documentation appropriately. Further orders per provider/physician.

**Parathyroid hormone (PTH), Phos, CMP, Spot Protein, Spot Creatinine**

| Bariatric Surgery (Gastric Bypass)     | V45.86     | Thiamine, Selenium, Folate, Ferritin, Zinc, B-12 | 11 months |
| UTI                                   | 599.0      | UA by Chemstrip           | As needed, S/S UTI |

**The patient’s chart will be reviewed to determine if the above laboratory tests need to be ordered.**

**Abnormal values will be reported to the primary care physician.**
PHM Pillar 5: Evidence-Based Practices

• Clinical Guidelines
  – NCQA Diabetes Recognition
  – NCQA Heart Stroke Recognition

• Standing Orders
  – Primary Care & Specialty
  – Laboratory
  – Disease Management

• Clinical Protocols & Pathways
  – Process protocols
  – Care Protocols
6. Team-Based Care and Consumer Engagement

Patient-Family Advisory Councils

Shared Medical Appointments

Telehealth
PHM Pillar 6:
Automation Drives High Performing Teams
Take Home Messages

• A “universal roadmap to population health management” is emerging

• Culture and leadership are absolutely critical and cannot be underestimated

• Technology is the big enabler—for every PHM pillar (even Culture!)
Contact

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What’s Next?

*Care Team Transformation for Population Health Management*
Hosted by HIMSS Clinical & Business Community
January 28th from 1:00 – 2:00pm ET
[Register now for the event](#)

*New Medicare Value-Based Physician Payment is Closer Than You May Think!*
Karen Handmaker and Dr. Laura Langmade, Clinical Informatics Analyst, IBM Watson Health
February 11th from 12:00 – 1:00pm CT
[Register now for the event](#)