Population Health Management Innovation – Payer and Provider Collaboration
Agenda

- Strategic Context
- Population Health Journey – Key Elements
- Enabling Capabilities
- Payer & Provider Collaboration
A Profound and Lasting Impact

Lowering the cost trend

-$100 billion
Unnecessary costs due to improper payments and administrative inefficiencies

22 hours per day
Time physician needs to see patients and meet recommended guidelines

>50%
Portion of unnecessary clinical costs that consumers can influence

>$80 billion
Unnecessary annual spend due to low health information technology adoption
The Opportunity in Population Health Management

Population medical costs are largely from treatment of chronic conditions in the ambulatory setting.

2012 medical claims cost distribution among 5.5 million commercial members using Optum for Population Health Management services
### Key Success Factors for Population Health Management

| Leadership & Cultural Change | • Provider-driven governance, physician leadership and engagement  
|                             | • Compassionate, accountable culture  
|                             | • Transparency  
|                             | • Spirit of innovation  
| Coordinated Care           | • Team care and PCMHs  
|                             | • Robust medical management programs  
|                             | • Evidence-based standards  
|                             | • Patient engagement and shared decision making  
| Aligned Incentives         | • Partnerships with physicians & post-acute providers  
|                             | • Shared savings  
|                             | • Contracting strategy to achieve alignment (shared responsibilities and investments)  
| Infrastructure             | • Clinical information systems to share data at the point of care  
|                             | • Robust analytics & informatics  
|                             | • Care coordination platform  

---

*hfma* maryland chapter
healthcare financial management association
Navigating the Journey from Providing Care to Managing Health

- Patient Access
- Medical Necessity
- Reimbursement
- Clinical Care
- Coding and Documentation
- Optimize Performance
- Aligned Incentives
- Invest New Capital
- Financial and Clinical Analytics
- Population Health Management
- Care Delivery Model
- Prepare for Change
- Quality
- Patient Satisfaction
- Cost
- Managing Health

hfma
maryland chapter
healthcare financial management association
Optimize Performance

• Optimize performance to invest in a new strategy for care delivery

1. PATIENT ACCESS
   Enhancing patient flow

2. CLINICAL CARE
   Simplifying clinical workflow

3. MEDICAL NECESSITY
   Proactively addressing payer compliance

4. CODING AND DOCUMENTATION
   Automating & optimizing coding

5. REIMBURSEMENT
   Augmenting cash flow
Invest New Capital

- With expert financial and clinical predictive analytics as your enabler, patient risk now becomes an opportunity to manage health and drive down costs.

Financial & Clinical Analytics

Combining the right data with comparative and predictive analytic tools reveals a wealth of untapped knowledge about your population and patients.

Population Health Management

With actionable information gleaned from analytics, more effectively engage patients and providers in prevention, wellness, care coordination and disease management.
Four Steps of Population Health Management

- Provider groups who have been successful in value-based contracts consistently cite the same four areas of critical focus for success in population health management.

1. Optimize network
   - Share cost/quality reporting with referring providers

2. Manage care transitions
   - Track patients across the continuum of care

3. Invest in high acuity interventions
   - Intensively manage the progress and outcomes of interventions for the highest risk cohorts

4. Expand disease management
   - Manage all populations, not just high-risk cohorts
Step 1: Optimize Network Management

- Refer to clinically effective and financially efficient sub-specialists. Ensure patient experience with referral and specialty care is optimal.

**IMPACT TO INDIVIDUAL**

- 10% reduction in surgical intervention rate for spine, hip and knee surgeries
- $10,000–15,000 average medical cost savings per redirection

**IMPACT TO POPULATION**

- 49% fewer redos and 60% lower complication rate for implantable cardiac device surgeries when performed by quality-designated cardiothoracic surgeons
- 14% total cost savings when population is consistently referred to the highest quality and most cost-efficient providers for all specialty care
Step 2: Manage Care Transitions

- Utilize on site and post-discharge resources to reduce readmission rates.
  
  - Onsite RNs
  - Home visits
  - Telephonic case managers
  - Telemedicine

\[ \text{Insight: In 2013 about 18 hospitals are projected to forego greater than one million dollars in Medicare reimbursement this year due to readmission penalties.} \]

\[ \text{37\% Reduction in 30-day readmit rates*} \]

* For adults with medical (non-surgical, non-maternal) admitting diagnosis
Step 3: Invest in High-Acuity Interventions

- Focus intense resources on patients with highest acuity needs following acute illness

**Post-acute care**
- Complete thorough in-home assessment using mobile device
- Share results with treating physician
- Trigger alerts for potentially urgent health issues
- Identify key topics for patients to discuss with primary physician
- Recommend and ensure appropriate follow-up appointments

**High-risk patients**
- 51% fewer prescriptions per high-risk member*
- 64% drop in acute admit rate

*9 or more initial prescriptions
Step 4: Expand Chronic Disease Management

- Moving chronic care from the exam room to the community.

Predictive modeling analytics

+ Systematic, population-based care manager outreach

20% improvement in optimal care compliance among chronically ill

The chronic disease patient with the greatest need …

is also the one least likely to show up in your office
Information Technology
Technical Blueprint for Population Health Enablement

1. **Data Aggregation**
   - Collect the data generated by providers, then aggregate the provider community’s data around individual health consumers and defined populations.

2. **Risk Stratification**
   - Use aggregated data to:
     - Identify and stratify
       - Patients at risk for unfavorable future medical experience
       - Provider performance relative to peers and best practice

3. **Care Coordination**
   - Convert data analysis into actionable information at the time of care
   - Catalyze action to mitigate identified risk at the point-of-care

4. **Patient Engagement**
   - Convert data analysis into actionable information at the population level
   - Catalyze action to:
     - Identify
     - Engage
     - Impact every individual with a health need within a defined population

hfma™
maryland chapter
healthcare financial management association
• Analytics to predict future medical costs of individuals and populations are limited by the characteristics of the types of available data:

**Claims data**
- insensitive
- non-specific
- untimely
+ always available

**Clinical data**
+ sensitive
+ specific
+ timely
- variably available (may be incomplete or unstructured in EMR, or unavailable from non-EMR users)

**Socio-demographic and Care Management data**
+ sensitive
- non-specific
+ timely
+ generally available
GOOD DATA : Building the Foundation

<table>
<thead>
<tr>
<th>Cleansing</th>
<th>Normalizing</th>
<th>Mapping</th>
</tr>
</thead>
</table>
| • 200 Ft tall people  
• Men having babies  
• Numerous misspellings of medications or other manually entered data  
• Obviously incorrect dosages, weight, etc… | • Identify unit variations for lab results and normalize them (ex: mg/10hr, ug/min, mg/24h)  
• Normalize lab results embedded in unstructured text strings (ex: “<30”, “4406.3 HI” (<300=Clinical albuminuria)”)  
• Detect and normalize clinically important facts embedded in dictations (ex: Smoking history, Exercise level, Fear of needles, Rationale for medication changes) | • Multiple field locations for data (Arrival time, blood pressure, procedure date, etc…)  
• Map labs and medications to a common set so that rates of testing/medication are comparable  
• Map fields to a common set of codes (ex: gender, race, smoking status) |
Population Health Management Technology
Care Delivery Model Transformation

1. Enhanced Access Enablement
   - Access and communication via preferred delivery channel
   - Increased availability of services
   - Utilization of technology to create greater continuity of care

2. Practice Performance Improvement
   - Office redesign
   - Practice management systems
   - Revised policies and/or procedures

3. Quality Improvement
   - Adoption of evidence based guidelines, NCQA/HEDIS quality measures, and other healthcare quality programs
   - Integration of training programs and resources focused on quality

4. Transition to Team Based Care
   - Change management support
   - Leadership/management training
   - Enhanced interactions with the broader medical neighborhood

5. Practice-Based Services Advisory
   - Care for acute and chronic conditions
   - Preventative screening and services
   - Basic surgical procedures
   - Ancillary therapeutic/diagnostic services

6. Track Performance Measures
   - Identifying clinical patterns
   - Reporting on how well providers and care teams meet quality measures and other key metrics

Patient

hfma™ maryland chapter healthcare financial management association
Aligned Incentives are Critical to Success

- A 2011 RAND study identified 90 payer/provider payment models in practice today, classified into 11 types, but wide variation and blending of program types

- **Optimize for volume**
- **Optimize for outcome**

- **Size of circle = ability to bend the medical cost trend curve**

- **Risk Managed by Provider**

- **ACO Shared savings, Global payment**
- **Fee For Service**
- **Physician & hospital P4P**
- **Payment for coordination**
- **Bundled payment**
- **Medical home**
- **Hospital-physician Gain-sharing**
- **Payment adjustment for hospital-acquired conditions, readmissions**
- **Pay for reporting**

**Optimize for volume**

**Optimize for outcome**
**Provider and Payer Maturity to Deliver Population Health**

Population health management capabilities naturally align to providers, but payers typically have more experience and maturity with population health management.

<table>
<thead>
<tr>
<th>Capability</th>
<th>Natural Alignment</th>
<th>Typical Maturity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Panel Mgmt Prgs (CM/DM)</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Patient / Member Engagement</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Medical Expense Management</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Multi-Disciplinary Care</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Community Engagement</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Health Status and Segmentation</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Actionable, Insightful Analytics</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
<tr>
<td>Quality Management</td>
<td><img src="Alignment" alt="Alignment" /></td>
<td><img src="Maturity" alt="Maturity" /></td>
</tr>
</tbody>
</table>

![Maturity Legend](Maturity Legend)
Population Health/Care Management Programs are Under Transition

**Traditional Programs (Payer Based)**
- Transactional focus
- Fragmented and siloed
- Focused on discrete conditions and events
- Seen as restrictive and reactive

**Integrated (Payer + Based)**
- Integrated programs / platforms
- Member Centric (360 view)
- Population / condition based
- Increased focus on:
  - Wellness
  - Gaps in Care
  - Provider Coordination
- Focus on trend management

**Delegated/Assigned (Provider Based)**
- Physician led
- Accountable Care Models
- Aligned incentives
- Integrated at point of care
- Value-add services
- Robust informatics
- Navigation support

How will our customers migrate to a new business model while still managing the existing models?
## Evolution of Payer Provider Collaborative Models

Based on payer and provider capabilities, there can be three models: Aligned Care Delivery Transformation, Collaborative Care Delivery Transformation, and Integrated Care Delivery Transformation.

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Aligned Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider has basic and manual CM capabilities in place and is not integrated with plan technology</td>
<td></td>
</tr>
<tr>
<td>• Plan will provide intense CM resource, training, education and tools to support care coordination and transformation activities</td>
<td></td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
<td></td>
</tr>
<tr>
<td>• Least up front investment for provider and most ongoing SG&amp;A costs for plan</td>
<td></td>
</tr>
<tr>
<td>• Provider is least likely to understand care management benefits and, therefore, may require more change management</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Model 2</th>
<th>Collaborative Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider has automated CM capabilities in place (i.e., EMR, registry, embedded care manager) but it is still not fully integrated with plan technology</td>
<td></td>
</tr>
<tr>
<td>• Plan will provide focused or moderate CM resource, training, education and tools to support care coordination and transformation activities</td>
<td></td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
<td></td>
</tr>
<tr>
<td>• Moderate investment required for provider</td>
<td></td>
</tr>
<tr>
<td>• Overlap with health plan on responsibilities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Model 3</th>
<th>Integrated Care Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider has automated CM capabilities in place (i.e., EMR, registry, advanced CM capabilities) and is integrated with plan technology (i.e., integrated CDT workflows, bidirectional data)</td>
<td></td>
</tr>
<tr>
<td>• Plan will provide less CM resource support as technology automation will serve most requirements</td>
<td></td>
</tr>
<tr>
<td><strong>Considerations</strong></td>
<td></td>
</tr>
<tr>
<td>• Will likely result in best outcomes</td>
<td></td>
</tr>
<tr>
<td>• Highest initial IT investment required for provider</td>
<td></td>
</tr>
<tr>
<td>• Least amount of overlap between plan and provider</td>
<td></td>
</tr>
<tr>
<td>• Least amount of ongoing plan staffing costs</td>
<td></td>
</tr>
<tr>
<td>• Could evolve into threat to plan business</td>
<td></td>
</tr>
</tbody>
</table>
Example Population Health Models

**Example A**

- **PCP**
- **Care Team**
- **CARE MANAGERS**
- **CLINICAL LIAISON**
- **PCCC**

- **Health Plan**
- **Tools, Technology and Support**
- **Care Management Support Programs**

**Example B**

- **PCP**
- **Care Team**
- **Provider or Third Party Vendor**
- **LOCAL CARE COORDINATOR**
- **REGIONAL CARE COORDINATOR**

- **CARE MANAGERS**
- **Tools, Technology and Support**
- **Care Management Support Programs**

**Provider**
- **Care Planning / Care Coordination / Embedded CM**

**ILLUSTRATIVE**
Navigating the Journey from Providing Care to Managing Health

- Patient Access
- Medical Necessity
- Reimbursement
  - Optimize Performance
  - Clinical Care
  - Coding and Documentation

- Financial and Clinical Analytics
- Aligned Incentives
- Care Delivery Model
- Prepare for Change

- Invest New Capital
- Population Health Management

- Quality
- Patient Satisfaction
- Cost

- Providing Care
- Managing Health
Anu Sharma, MD, MHA, MS
SVP, Network & Population Health Consulting
Optum

M 315-491-1748 (Preferred)
T 952-202-3064
F 877-960-7438

anu.sharma@optum.com
www.optum.com