Early Lessons in Population Health Management and Risk-based Payment Models

Presentation to National Accountable Care Congress
November 1, 2012
While Some Uncertainty Still Exists…

Components of the Affordable Care Act Still in Doubt

Competing Visions on Future of Health Care Reform

“I am not the first President to take up this cause, but I am determined to be the last.”

“If I were President, on day one I would issue an executive order paving the way for Obamacare waivers to all 50 states.”

External Forces the Driver of Continued Action

Financial, Clinical Pressures Outstrip Political Uncertainty

Decelerating Price Growth
- Federal, state budget pressures constraining public payer price growth
- Payments subject to quality, cost-based risks
- Commercial cost shifting stretched to the limit

Continuing Cost Pressure
- No sign of slower cost growth ahead
- Drivers of new cost growth largely non-accractive

Shifting Payer Mix
- Baby Boomers entering Medicare rolls
- Coverage expansion boosting Medicaid eligibility
- Most demand growth over the next decade comes from publicly insured patients

Deteriorating Case Mix
- Medical demand from aging population threatens to crowd out profitable procedures
- Incidence of chronic disease, multiple comorbidities rising

Source: Health Care Advisory Board interviews and analysis.
No More Blank Checks

Only Two Paths to Affordability

Twin Demands from Purchasers

1. Reduce Pricing
   - Narrow networks
   - Steerage
   - Rate cuts

2. Lower Utilization
   - Cost shifting
   - Care management
   - Benefit design

Source: Health Care Advisory Board interviews and analysis.
### Not Just Within the Medicare Program

**Private Payers Accelerating Payment Innovation**

<table>
<thead>
<tr>
<th>Model</th>
<th>ACA-Based Program</th>
<th>Private Payer Equivalents</th>
</tr>
</thead>
</table>
| Pay-for-Performance    | • Percentage of hospital inpatient payments withheld, earned back based on quality performance  
                          • Payment changes commence in FY 2013                                         | WellPoint launched pay-for-performance program centered on 52 quality metrics             |
| Hospital Readmissions Penalties | • Hospitals with greater than expected readmission rate subject to financial penalty  
                                   • Penalties start in FY 2013                                                 | Private insurers, including a number of state BlueCross/BlueShield plans, have begun considering readmissions in setting reimbursement rates |
| Bundled Payments       | • Center for Medicare and Medicaid Innovation (CMMI) bundling initiative starts June 30, 2012  
                          • National pilot on episodic bundling starts in 2013                           | Hospitals in 15 states have partnered with private payers in bundled payment contracts     |
| Shared Savings Models  | • Shared savings and Pioneer pilots commenced in early 2012                         | Private payers Humana, WellPoint, United, Cigna, Aetna and at least four state BlueCross plans have announced shared savings pilots |
Multiple Accountable Payment Scenarios

Physician Alignment Foundation for All Accountable Payment Scenarios

Value Based Purchasing
- Engage physicians
- Standardize care processes
- Engage patients
- Track and analyze performance
- Leverage physician incentives

Hospital-Physician Bundling
- Standardize devices
- Implement care maps
- Reduce orders and consults
- Implement evidence base guidelines
- Disease Registries
- Care Managers

Pay-for-Performance

Shared-Savings Model
- Partner with PCPs
- Deliver preventive & chronic disease management
- Reduce utilization

Provider Cost Accountability

Actions needed under all payment reforms

Degree of Management Challenge
Transition Planning Critical to Success

Shifting Paradigm Requires Navigating Two Disparate Models

**Success Under FFS**
- Maximize high margin procedural volumes
- Control DRG/case rate related expenses
- Minimize hospital acquired infections, never events

**Success Under Value Based Payment**
- Minimize utilization of high cost acute care, procedural, ED services
- Control expenses across the continuum
- Manage to comprehensive outcomes/standards as basis for payment

**Revenue Generated Through Incentive Model**
- 100%
- 0%

**Total Cost Accountability**

**Fee for Service**

**Time**
Keeping Up with the Joneses

Knee-Jerk Reaction May Lead to Unsound Strategy

ACO Development and Market Reaction in Lernerville

Zimmerman Hospital
- **Main Risk:** Physician-led demand destruction quickly undermines hospital volumes
- **Strategic Imperative:** Collaborate with ACO to remain preferred provider

Strasburg Medical Group
- **Main Risk:** Contract success erodes long-term market share
- **Strategic Imperative:** Prepare to enter value-based contract as soon as necessary

Frequent referrals

Limited referrals

Case in Brief: Lernerville
- 500,000-person city located in East
- Major group of independent physicians forms Medicare ACO
- Competitor reactions differ based on existing relationship with Strasburg Medical Group

Source: Health Care Advisory Board interviews and analysis.

1) Pseudonym.
The Business Case for Change
Substantial Opportunity in Becoming Population Health Managers

Strategic Benefits of Transformation

**Financial Advantage**
- Move away from faltering fee-for-service economics
- Capture greater share of premium dollar

**Market Advantage**
- Attract preferred physician partners
- Secure attractive purchaser contracts

**Clinical Advantage**
- Align financial incentives with mission
- Support investments in better health

Source: Health Care Advisory Board interviews and analysis.
So, What’s Stopping Us?
Structural Barriers, Uncertainty Paralyzing Proactive Strategy

So, What’s Stopping Us?
Structural Barriers, Uncertainty Paralyzing Proactive Strategy

Slowed by Structural Barriers...

- **Challenge of Incumbency**
  Inertia, daily challenges of managing organization slow pace of change

- **Institutional Memory**
  Past experiences with value-based contracts may cause hesitation

- **Responsibility to Community**
  Mission, role in community requires conservative decision making

...Unclear about Path Forward

"In Over Our Head"

"Too Far, Too Fast"

**Charting the Path Ahead**

“We have a pretty good idea what the end state looks like. But we don’t know how to time it—how fast to move—and we don’t know the sequence of change or where to start.”

*CEO, Two-Hospital System in Midwest*

Source: Health Care Advisory Board interviews and analysis.
Advisory Board Member Analyses Confirm Need for Decisive Action

Service in Brief: The Margin Improvement Intensive
- Customized, multi-phase process available to all Health Care Advisory Board members
- Includes:
  - Margin Scenario Planning Diagnostic
  - Executive Management Workshop
  - Improvement Opportunity Identification
  - Customized Action Plan

Margin Improvement Analysis Results

5-Year Margin Projections

<table>
<thead>
<tr>
<th>Improvement</th>
<th>0%-5% Decline</th>
<th>5-10% Decline</th>
<th>Greater than 10% Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15%</td>
<td>35%</td>
<td>35%</td>
</tr>
</tbody>
</table>

10-Year Margin Projections

<table>
<thead>
<tr>
<th>Improvement</th>
<th>0%-5% Decline</th>
<th>5-10% Decline</th>
<th>Greater than 10% Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0%</td>
<td>3%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Two Plausible Transition Paths

One Foot Must Move First

Two Transitions to the Value-Based Business Model

- **Leading with Care Transformation**
  - Invest quickly
  - Prove concept
  - Obtain value-based payment

- **Leading with Value-Based Contracts**
  - Meet payer demands for risk
  - Secure share
  - Adapt care model

Source: Health Care Advisory Board interviews and analysis.
Investment Far from a Guarantee of Success

Physician Group Practice Demonstration
- Medicare Shared Savings project with 10 large, advanced multispecialty practices, affiliated hospitals in most cases
- Average $1.7M investment in infrastructure in Year 1
- Providers earned bonuses based on total cost and quality outcomes over a 5 year project duration

Number of Sites Earning Bonus

<table>
<thead>
<tr>
<th>Earned Bonus in &lt;2 of 5 yrs</th>
<th>Earned Bonus in 3 of 5 years</th>
<th>Earned Bonus in all 5 of 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 of 10</td>
<td>3 of 10</td>
<td>2 of 10</td>
</tr>
</tbody>
</table>
Building Towards a New Model

St. John’s First Earned PGP Bonus in Year Three

Total Expenditures Relative to Target

$4.5 M

Year 1

Year 2

($700 K)

Year 3

($9.1 M)

Year 2 savings not sufficient to earn bonus

Shared Savings Bonus Earned

Accountable care infrastructure under construction; institutional willpower drives efforts despite bonus absence

$3.1 M

Year 1

Year 2

Year 3

$0

$0

Case in Brief: St. John’s Health System

• Six-hospital integrated delivery system located in Missouri; part of Sisters of Mercy Health System
• Employs over 450 physicians
• Participant in Medicare Physician Group Practice Demonstration
• $3.1 million bonus earned after completing IT investments, care redesign
Payers Following the Savings

Local Employers Want to Share in Savings Too

PGP Success Leading to Direct Contracts with Employers

- Local employers interested in contracting with St. John’s Health System following PGP success
- Employers negotiating three-year contracts with health system

Expenditures below calculated threshold shared between employers and health system

PGP Year 3 Success

PGP Year 3

PGP Year 5
Case Study: Deciding Whether or Not to Pursue

Multi hospital system considering Shared Savings Contracts as physician alignment/defensive strategy

Sagebrush Healthcare

- Sagebrush Healthcare system is developing a Clinically Integrated organization to increase alignment with independent providers
- The CI organization is applying for Medicare Shared Savings Program and actively pursuing value-based contracts with other payers and local employers
- Pursuing Shared Savings in reaction to strong local competitors (and competing Medicare ACOs) as well as to prepare for future changes in reimbursement
- Due to importance of physician alignment strategy, the system agreed to distribute 70% of shared savings to physician participants
- Combined cost of infrastructure and shared savings requires “investment” of ~$2,500 per physician/year…a small price to pay for enhanced physician alignment and loyalty without employment
- Sagebrush has also submitted their MSSP application for 2013 start date

Case in Brief: Sagebrush Healthcare

- Multi hospital system that is part of larger non-profit healthcare system
- Very competitive market with three ACOs already established
- ACO projected at around 20,000 attributed lives
Building Differential Market Assets Profitably

Focus on CI Network Capabilities for Expansion of Market Share

Medical Management Investments

Areas of Opportunity

- **Optimize Hospitalizations**
  - Reduce preventable readmissions
  - Reduce preventable complications

- **Decrease Length of Stay**
  - Streamline episode of care
  - Reduce per case costs

- **Provide Wellness & Chronic Care**
  - Disease registry to identify gaps in care
  - Care managers to fulfill patient needs
  - Reduce preventable admissions

- **Address ED Utilization**
  - Improve PCP access & continuity of care
  - Reduce cost of care

*Institute for Healthcare Improvement’s “Triple Aim” of providing “Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs”*
Economic Roadmap: Estimated Net Financial Impact

Net financial impact based on 20% reduction in preventable utilization

Projected Net Financial Impact from Gain Sharing Program

1) Commercial demand destruction is modeled at 5%, 10% and 20% in Year 1, 2, and 3 respectively
2) Non-Commercial demand destruction is modeled at 0%, 5% and 10% in Years 1, 2, and 3 respectively
Additional Managed Care Opportunities to Leverage

Qualitative Analysis of Additional Opportunities to Leverage the Population Health Management Infrastructure and Grow Profitable Market Share across the CI Network

Source: Data provided on 7/30/12 for CY2011 net revenue
Key Areas for Critical Analysis

Evidence Based Medicine/Chronic Disease Management/Preventive Care

Deploying proactive treatment using standard and scientifically-proven approaches; managing patients with chronic diseases and eliminating gaps in care drives down utilization at all levels of care.

Examples: Chronic Disease Management programs for diabetes, CHF, COPD, asthma, obesity, depression/anxiety/bipolar. Proactive targeting for patients needing mammograms, colon screening, etc.

Ambulatory Care Sensitive Admissions

Admissions can be identified as Ambulatory Care Sensitive Admissions using Prevention Quality Indicators.

Examples: Poorly managed diabetes, asthma, COPD.

Potentially Preventable ED Visits

Four key categories of ED utilization:
- Non-Emergent
- Emergent, but Primary Care Treatable
- Emergent, but Preventable/Avoidable
- Emergent, not Preventable/Avoidable

Examples: Toothaches, coughs, moderate fever.

Potentially Preventable Complications

Potentially Preventable Complications are harmful events or negative outcomes resulting from the process of care and treatment and not from the natural progression of illness.

Examples: Hospital-acquired pneumonia, C. difficile colitis, pulmonary embolisms.

Potentially Preventable Readmissions

Potentially Preventable Readmissions are readmissions within 30 days that are clinically related to the care received during a prior admission.

Examples: Surgery patient readmitted for surgical site infection.

Potentially Preventable Services

Potentially Preventable Utilization can be measured by accurate and relatable benchmarking across providers and sites.

Examples: Generic drug utilization rates, imaging rates, specialty utilization.
Leverage contribution margin analysis to identify care management programs.

**Total CM for Top Five Ambulatory Care Sensitive Admissions**

- **Bacterial Pneumonia**: $2,270,053
- **CHF**: $2,672,769
- **COPD**: $2,083,703
- **Diabetes (Combined)**: $1,744,394
- **UTI**: $1,291,468

Contribution margin was calculated by subtracting direct costs from net payment.
Build the Program in “Profitable” Subpopulations

Clinical Integration Organization

- Medicare Shared Savings
- Self-Insured Employers
- Medicare Advantage
- Managed Medicaid
- Commercial Health Plans
- Hospital Self-Insured Employees

Vehicle for alignment between Hospital/Health System and their Medical Staff
Economically Guided Strategic Roadmap

Must develop market ready population health core competencies

Important Next Steps

• Develop economically feasible, clinically targeted Population Health Management capabilities in network, among physicians and management

• Select and Build Population Health Management Tools and Processes within the network and at physician office settings (i.e. EHR; Disease Registry; Risk Stratification; Claims Business Intelligence; Care Managers; Referral Management; Health Information Exchange; Quality; Data Collection and Reporting)

• Operationalize evidence based standards with protocols to address quality and cost opportunities (LOS reductions, improvement on focused quality initiatives, care management protocols.)

• Implement referral management tools to reduce network leakage and capture market share.

• Need network administrative resources to build out network and provide service bureau functions (i.e. IT support, deployment of care plans)

• Build collaboration with recently constructed physician network.
Overcoming an Antagonistic Relationship

ACE Demo Provides Opportunity to Mend Fences in San Antonio

Historical Tensions Between Hospital and Physicians

- Limited formal hospital-physician relationship structure or performance transparency
- Some physicians have historical tension from actions of prior hospital administrators before Vanguard acquisition
- Fiercely independent physicians unaccustomed to collaborating outside of their practices

Case in Brief: Vanguard Baptist Health System

- Five-hospital health system based in San Antonio, Texas
- Launched cardiac, orthopedic bundling program in 2009 as part of Medicare ACE Demo
- Prior to ACE Demo, hospital had worked to improve on history of limited formal integration with local physicians; ACE Demo provided new vehicle to further strengthen relationships
Opening the Books for Partner Physicians

“Trust evolves over time; you have to prove it along the way. The more openness, cohesiveness and open communication that we have as this project evolves, the more it creates relationships [with orthopedic surgeons] that are tight, because we are both winning.”

Chief Development Officer and SVP
Vanguard Baptist Health System
Realizing Significant Improvement

Implant Savings
Vanguard Baptist Health System
June 2009-May 2010

Improving Order Set Compliance
Vanguard Baptist Health System

<table>
<thead>
<tr>
<th>Orthopedics</th>
<th>Cardiology</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1.4 M</td>
<td>$800 K</td>
<td>$2.2 M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Before ACE</th>
<th>After ACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Establishing Readiness for Accountable Care

Case in Brief: Yale New Haven Health System

- 3-hospital health system in Connecticut
- Self-insured employee benefits plan with 10,000 employees and 22,000 total subscribers; $97 M in total paid claims annually
- Established goal of designing self-insured employee management pilot to prepare for potential future risk-based payment/accountable care contracts

Addressing the Challenge of Accountable Care on Multiple Fronts:

- Physician group expanding network of providers in specialties and primary care
- Epic will serve IT infrastructure across the continuum of care
- Opportunities to develop expertise in care coordination and application of evidence-based protocols and metrics
Revitalizing Condition Management at YNHHS

**livingwell CARES:**
Name for new employee health management initiatives launched January 2012; includes in-house diabetes pilot program and partnership with TPA vended program to provide management of all other conditions

**Partnership with ActiveHealth Management**
to provide new health and disease management carve-out programs as part of YNHHS medical plans

**Key program components:**
- **MyActiveHealth** web portal
- **ActiveHealth Coaching**, targeting 42 conditions with telephone coaching and support
- **ActiveHealth Maternity**
- “Care considerations,” preventive care and gaps in care reminders/alerts to patients and physicians

Accountable Care “Care Coordination” Pilot program with focus on employees and spouses enrolled in medical plan who have diabetes

**Launching a program:**
- Care coordinators employed January 30
  - One FTE, RN for New Haven
  - One FTE, RN for Bridgeport and Greenwich
- Establish on-site care coordination access for face-to-face condition management
- Launch employee communications
- Begin outreach/enrollment
Developing a Pilot Program: Establishing Goals

Comprehensive Care Coordination
for YNHHS Employees, Spouses and Dependents

- Build competencies for managing the health of a population – an essential element of accountable care
- Focus on "at risk" employees / spouses / dependents (adults) and manage a targeted sub-population across the continuum of care
- Measurably improve clinical quality of care, reduce ED visits and readmissions, optimize utilization, and manage costs associated with care

Key Tenets of Care Coordination
- Comprehensive
- Across the continuum
- Differentiated
- Engages patient and family

Pilot Program Designed to:
» Increase access to care
» Build knowledge and understanding
» Leverage existing resources
» Provide support
Pilot Design: Target Population

**Criteria for identifying target population**

1. Ability to identify patients, including high-risk sub-populations
2. Sufficient volume of covered lives
3. Opportunity for improvement
4. Amenable to care coordination

<table>
<thead>
<tr>
<th>CONDITION HIERARCHY</th>
<th>CHRONIC CONDITION</th>
<th>TOTAL SPEND</th>
<th>ACTUAL PMPM</th>
<th>NORM PMPM</th>
<th>DIFFERENCE</th>
<th>MEMBERS PER 1K</th>
<th>MEMBERS PER 1K BENCHMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Active cancer</td>
<td>$21.8M</td>
<td>$3.1K</td>
<td>$1.4K</td>
<td>$1.8K</td>
<td>23.49</td>
<td>17.85</td>
</tr>
<tr>
<td>12</td>
<td>Diabetes without CAD</td>
<td>$10.2M</td>
<td>$763.45</td>
<td>$418.50</td>
<td>$345.95</td>
<td>40.86</td>
<td>31.87</td>
</tr>
<tr>
<td>13</td>
<td>Hypertension (includes renal vascular disease)</td>
<td>$8.7M</td>
<td>$511.12</td>
<td>$509.86</td>
<td>$1.26</td>
<td>50.22</td>
<td>61.04</td>
</tr>
<tr>
<td>15</td>
<td>Asthma</td>
<td>$7.4M</td>
<td>$525.50</td>
<td>$540.90</td>
<td>$15.40</td>
<td>40.57</td>
<td>23.49</td>
</tr>
<tr>
<td>18</td>
<td>Chronic musculoskeletal/arthritic/osteoporosis</td>
<td>$6.6M</td>
<td>$920.53</td>
<td>$783.45</td>
<td>$137.08</td>
<td>23.83</td>
<td>27.13</td>
</tr>
</tbody>
</table>
Pilot Design: Intervention

**Services include:**

<table>
<thead>
<tr>
<th>Review of Current Care</th>
<th>Individual Care Coordinator Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Review overall health and develop plan</td>
<td>• Mitigate barriers to care and medication access</td>
</tr>
<tr>
<td>• Review medications for compliance</td>
<td>• Coaching for response to acute events or changes in health status</td>
</tr>
</tbody>
</table>

**Programs for Support and Education**

| • Engage with Diabetes Self-Management Programs           | • Coordinate and navigate specialist care                  |
| • Engage with Occupational Health for wellness visits (checking blood pressure, meeting with a nutritionist) | • Facilitate transportation to visits                      |
| • Refer to EAP if indicated                               | • Align other care or support services                    |
Promising Early Results
While Too Soon to Measure ROI, Early Indicators are Positive

Strong Early Enrollment
Number of Participants by Month

February 40
March 75

Already Improving Health of One Participant
Care coordinators identified a need for an annual foot exam for one program participant; exam reveals existing foot ulcers. Treatment of ulcers now will avoid more serious future complications. This type of early intervention will drive savings among participants in years 2-3.
About Covenant Health

Case in Brief

*Integrated Healthcare Delivery System*
- 5 acute care facilities and 1,181 beds
- Partial ownership of FirstCare HMO
- 14 affiliated facilities throughout Texas and eastern New Mexico
- ~30K admits and ~104K ED visits a year

*Member of St. Josephs Health*
- Largest healthcare institution in West Texas and Eastern New Mexico Region
- Serves 1.2 Million people across 62 counties
Uniting the Medical Staff Around Performance

Clinical Integration as vehicle for quality improvement & joint contracting

Covenant Health Partners (CHP) Clinical Integration Program

Case in Brief: Covenant Health Partners

- Clinical integration program for the Covenant Health
- Combination of 150 employed and 150 independent physician participants
- $48.7 M in contracts secured to date
- Physician-governed, physician-led, physician-driven organization

1) P4P: Pay For Performance
**Initial Experience in Population Management**

2010 total population contract had to be managed with limited data

- Population Management Contract Details
  - 30,000 covered lives
  - Bonus payments based on PPPM savings compared to prior fiscal year
  - Based on medical and pharmaceutical costs
  - 50% of resulting savings given to CHP physicians
  - **$563K in incentives paid out to CHP physicians across 2010**

---

Maximizing Savings on Population Contracts are Challenging Without Detailed Data
Gaining Additional Experience with Employees

Gave physicians “skin in the game” through gainsharing contract

Initial Shared Savings Period
Jan – Jun 2012

Additional Shared Savings Period
Jul 2012 – Jun 2013

Shared Savings Arrangement

- Approximately 8,700 Employees

2011 Shared Savings Contract

- Two shared savings time period to help calibrate targets
- Initial time period target set as 2012 budgeted PMPM
  - Based on Target Gross Health Expense (Employer + Employee Health Premiums)
  - If actual claims cost exceed budgeted PMPM, no savings are shared with any providers
- Must meet quality targets set through CI contract to receive bonus
- CHP to receive all claims detail for population

1) Total savings paid to professional providers in the time period will be limited to $2 Million
Leverage Existing Organizational Structure

Developed committees dedicated to population management

**Governance Structure Over Population Management**

- **Covenant Health Partners Board of Directors**
  - Decides on overall strategic direction
  - Approves overall focus and success metrics
  - Champion within CHP and Covenant Health

- **Population Management Committee**
  - Determines focus areas that target quality and cost reductions
  - Evaluates progress and success of subcommittees
  - Consist of Physicians, Administration, Human Resources, Wellness Programs

- **Population Management Subcommittees**
  - Identifies opportunities for quality/cost improvements within focus areas
  - Communicate/implement new process or programmatic changes
Operational Support for Population Management

Non-physician support staff provide analysis, coordination, & programs
Software Used to Support CI & CHP Physicians

Leveraging multiple data sources to provide information to physicians

**Continuum of Care**
- Utilization Management
- Quality Improvement
- Inpatient Data

**Population Risk Management**
- PMPM Cost Management
- Risk Stratification
- HEIDIS Reporting

**Market Advantage**
- Custom Quality Performance Metrics
- Inpatient/Outpatient Data Aggregation
- Transparency among peer profiles
- PQRS Dashboard

**Crimson Care Registry**
- Chronic Disease Registry
- Care Coordination
- Notification to Patients
- Lab Results
- PQRS Reporting
- Office Practice Care Guidelines

**Clinical Integration**
- Custom Quality Performance Metrics
- Inpatient/Outpatient Data Aggregation
- Transparency among peer profiles
- PQRS Dashboard

**Allscripts EHR**
- CHP 75% Subsidy
- E Rx HIE Capabilities
- Work towards meaningful use

**Data Sources**
- Hospital
- Physician
- Lab
- Payer
Opportunity Analysis Informs Initial Value Streams

Transparency allows for focused efforts to maximize population savings

Initial & Ongoing Focus Areas for Population Management

**Pharmacy**

- Focus on therapeutic classes with low generic use rates

**Emergency Department**

- Focus on frequent flyers and PCP/Member education for select non-emergent conditions

**Outpatient Imaging**

- Focus on PCP and specialist over utilization of low-utility high cost imaging

---

**Prevention - Disease Management**

Establish disease management programs to improve quality while lowering PMPM costs across the care continuum for diseases such as: Diabetes, Asthma, Depression, Post-Partum

**Domestic Steerage**

Create a domestic tier of providers within the health plan to further incentives employees and consider creating an exclusive provider network based on patient habits
Overview of Henry Ford Health System

**Vision:** Make Henry Ford the system that physicians want to practice in—for its quality leadership in creating an integrated clinical framework with a focus on patients first and an imperative for excellence, collaboration, coordination and clinical value.
Overview of Henry Ford Physician Network

The Henry Ford Physician Network – a physician driven, clinically integrated Accountable Care Organization, is in the process of building its core foundation.

- The Network is a physician-led subsidiary of Henry Ford Health System (HFHS), comprised of private practice, HFHS employed and Henry Ford Medical Group physicians, and is focused on delivering even higher quality care and lowering medical costs.

- Quality will be enhanced by measuring performance on physician-defined quality measures, expanding technology into independent practices, and sharing clinical information across the Network with a Health Information Exchange.

- Through the Network, and by using the concept of Clinical Integration, physicians will provide optimal value to patients, payers and employers through collaborative best practices, evidence-based medicine and improved efficiency.
## CMS Bundled Payment Models

<table>
<thead>
<tr>
<th>Payment of Bundle</th>
<th>Acute Care Hospital Stay Only</th>
<th>Acute Care Hospital Stay plus Post-Acute Care</th>
<th>Post-Acute Care Only</th>
<th>Chronic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Retrospective&quot;</td>
<td>Model #1</td>
<td>Model #2</td>
<td>Model #3</td>
<td>Model #7</td>
</tr>
<tr>
<td>(Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Prospective&quot;</td>
<td>Model #4</td>
<td>Model #5</td>
<td>Model #6</td>
<td>Model #8</td>
</tr>
<tr>
<td>(Single prospective payment for an episode in lieu of traditional FFS payment)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:

- Light blue = Current
- Dark blue = Future
## Determining Criteria for Bundle Selection

### Quantitative Criteria
- High volume of cases across system and within individual facilities; initially targeting DRGs with at least 100 cases across system hospitals
- Low to moderate variation in the cost of the bundle so have relative predictability
- Concentration of services and costs within Henry Ford facilities to ensure controllability

### Qualitative Criteria
- Engaged and willing group of specialists and clinicians providing care for the identified DRGs
- Belief among physicians and clinicians that identified DRGs have opportunity for care standardization and improvement
- Areas with existing or planned performance improvement projects
Tapping Existing Data Sources in Advance of Full Claims

Data Need
To identify variation across HFHS in cost and quality of various DRGs

Crimson Continuum of Care Inpatient

Data Need
To understand cross-continuum performance within our market

2009 Medicare 5% Sample
### Representative National Results from Medicare 5% Sample

<table>
<thead>
<tr>
<th>DRG Description</th>
<th>30-day</th>
<th>60-day</th>
<th>90-day</th>
<th>IP Rehab</th>
<th>Long-term Acute Care</th>
<th>SNF</th>
<th>Home Health</th>
<th>OP Rehab</th>
<th>IP Re-admit</th>
</tr>
</thead>
<tbody>
<tr>
<td>291-Heart failure &amp; shock w MCC</td>
<td>$19,332</td>
<td>$23,981</td>
<td>$27,408</td>
<td>$412</td>
<td>$405</td>
<td>$3,195</td>
<td>$374</td>
<td>$33</td>
<td>$3,832</td>
</tr>
<tr>
<td>292-Heart failure &amp; shock w CC</td>
<td>$14,355</td>
<td>$18,603</td>
<td>$22,219</td>
<td>$214</td>
<td>$216</td>
<td>$2,461</td>
<td>$402</td>
<td>$25</td>
<td>$3,579</td>
</tr>
<tr>
<td>293-Heart failure &amp; shock w/o CC/MCC</td>
<td>$10,786</td>
<td>$14,561</td>
<td>$17,682</td>
<td>$132</td>
<td>$57</td>
<td>$1,690</td>
<td>$349</td>
<td>$24</td>
<td>$3,150</td>
</tr>
</tbody>
</table>

After cost of initial admission, SNF and readmission costs represent greatest costs HF bundles.
Plans for Improving Post-Acute Care

Post-Acute Care Spread Widely

Henry Ford FFS Medicare patients admitted to over 180 skilled nursing facilities with half having greater than $100,000 in charges

Proposed Performance Improvement Strategy

1. Identify skilled nursing facilities, home health agencies, and inpatient rehab facilities with relatively high volumes and/or high rates of readmissions

2. Offer Henry Ford Health System performance improvement teams and resources to high volume or underperforming facilities

3. Encourage physician and case manager referrals to high quality providers
Staging the Transition to Population Management

Building Blocks of Accountable Care

Lay the Foundation
- Establish visibility into cross-continuum utilization
- Engage physicians in detailed performance data
- Create a culture of transparency, alignment, performance improvement

Pinpoint Opportunity
- Evaluate efficiency and quality of network performance
- Identify care gaps, unnecessary utilization opportunities
- Assess and manage populations being considered for risk; stratify patients and prioritize interventions

Transform Care Delivery
- Provide clinicians with care management and point-of-care tools to facilitate proactive delivery of evidence-based care
- Enable comprehensive management of complex, chronically ill patients
One Health System’s Journey to Accountable Care

Lay the Foundation

• Began sharing case-level data with hospitalists. Improved readmissions, cost per case and core measures performance ($3.7M savings).
• Expanded effort to all Medicare patients; achieved profit on 62% of cases in 6 months ($20M savings).
• Rolled out data transparency through Crimson to 2000+ physicians (lowered LOS by 29% and complications by 15%).

Pinpoint Opportunity

• Loaded employee population data into Crimson assess care delivery network performance, hone population management capabilities
• Assumed risk for commercial populations, participating in Medicare Shared Savings Program
• Using Crimson to monitor performance at the population level, identify actionable opportunities, pinpoint high risk patients requiring intervention, measure interventions

Transform Care Delivery

• Supporting clinicians in delivery of comprehensive preventative care to complex, high risk patients
• Using Crimson’s evidence-based care prompts, patient outreach and care planning tools to elevate patient health

About

• 9 hospital system in Houston, TX with 3,600 beds, 138K annual admissions
• Over 2000 physicians, 850 independent practices covering 60% discharges in clinical integration network by 2010
• At risk for multiple populations
• Crimson member since 2004
Understanding the Transition Paths

Two Paths Forward

**Leading with Care Transformation**

**Elements of Success:**
- Top-rate care management capability
- Relatively stable fee-for-service foundation
- Credible prospects for further improvement

**Main Risks:**
- Payers refuse to adopt value-based reimbursement models
- Fee-for-service economics fail quickly
- Payers, physicians seek opportunity with more risk-ready competitors

**Leading with Contracting Strategy**

**Elements of Success:**
- Compelling value propositions to attract payers, physicians, patients
- Quick-hit utilization reduction potential
- Accurate analytics for risk pricing, targeting

**Main Risks:**
- Value-based contracts fail to secure market share gains
- Inadequate care management leads to heavy losses across large populations

Source: Health Care Advisory Board interviews and analysis.
Purpose Beyond Commerce

Regardless of Margin, Mission at the Fore

A Return to Mission

- Putting patients and families first in identifying a care plan to achieve individual goals, high-quality outcomes
- Offering high-value care for patients including quality and service
- Building long-term relationships with providers and patients to offer an ongoing, coordinated care experience
- Pillar of community as employer, community stakeholder and partner in improving the overall health and wellness of the population

Questions Guiding Future Strategy

1. Will we proactively lead or reactively follow the transition to value-based business models?

2. What role(s) will we play in our market: acute care hospital, ambulatory care network, and/or risk manager?

3. How will we reorient our services to answer the market’s dual demands for efficient acute care episodes and ongoing care management?

4. What assets, skills, and competencies will we prioritize to support our new roles and responsibilities?

5. How will expanding beyond our traditional competencies impact our mission and culture?

Source: Health Care Advisory Board interviews and analysis.