Population Health as a Service

Driving Results in the Accountable Care Era

The 16th Population Health Colloquium

March 8th 2016 (1pm-2:45pm)

Mini Summit

athenahealth

Panel Introduction

Bridget Buckley
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Chief Medical Officer, CareCentrix. Hartford, CT

Stephen Kahane, MD, MS
President, Client Organization, athenahealth, Inc., Watertown, MA

Bill Winkenwerder Jr. MD, MBA
Chairman, Winkenwerder Strategies LLC
Former President and CEO, Highmark Inc., Locust Valley, NY

Format for Today

Purpose: Share the experiences and results from a national network built to deliver network-enabled services that support the operations of healthcare providers including the support for provider and patient engagement and population health. Encourage the audience to share their own experiences and results related to these critical areas of care delivery.

Process: Brief overview of athenahealth, more on population health services and a deeper dive on an early and very successful physician network that was a very early adopter of risk contracting. Live polling will promote dialog; feel free to ask questions of us and of one another.

Payoff: A highly engaging session and the opportunity to learn from colleagues and take away new insights.

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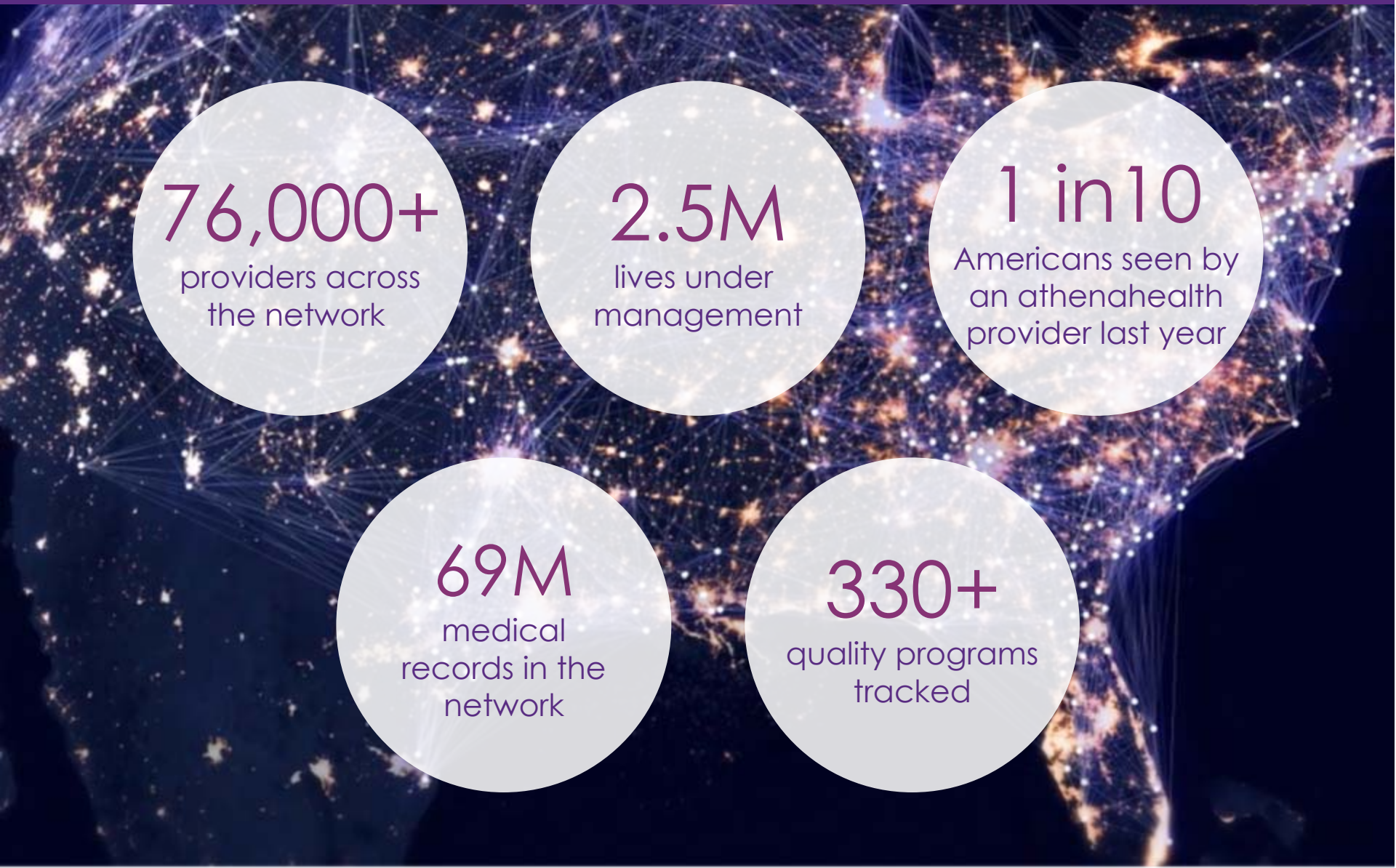
OUR VISION:

To build the health information backbone that makes health care work as it should.



Revenue Cycle Management

Increase in collections, increase in patient payments, lower total cost to collect

Clinical Performance and EMR

Improved provider productivity, quality management success, MU & PQRS performance, broad provider adoption

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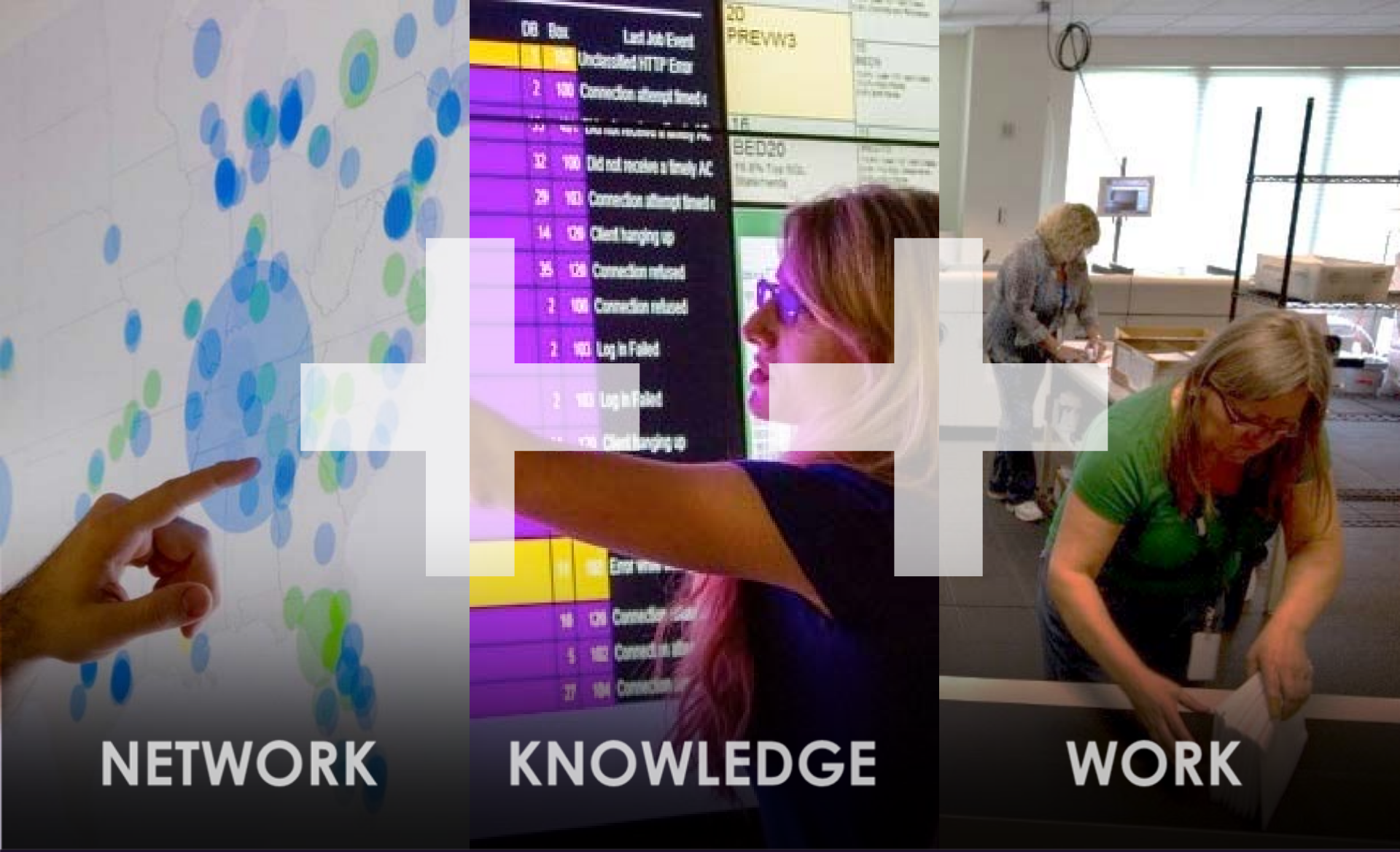
Patient Access & Care Transitions

Care coordination across the continuum, improved patient experience, increased in-network utilization

Population Health & Engagement

Close gaps in care, demonstrable improvement in quality, lower TME, increased in-network/market share



RESULTS

Our network helps achieve success in Population Health

Quality results have improved …

1. **Improve Results in Quality Measures**
2. Decrease Total Cost of Care
3. Increase Patient Loyalty

30%

higher influenza vaccination rates*

46%

of hypertensive patients moved from "uncontrolled" to "controlled"

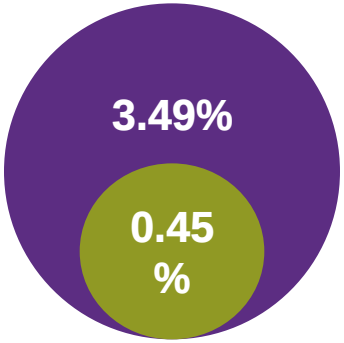
29 of 33

ACO33 measures above national average

* Compared to clients who did not run an adult or pediatric influenza campaign

… while clients are thriving under risk…

1. Improve Results in Quality Measures
2. Decrease Total Cost of Care
3. Increase Patient Loyalty



Saved more than **7 times** as much as the **average MSSP ACO**

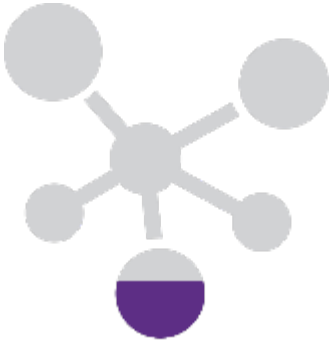
Received **shared savings payments** of **$152 per beneficiary**; $61 for all other ACOs that beat benchmark

… and patients are showing a higher degree of engagement

1. Improve Results in Quality Measures
2. Decrease Total Cost of Care
3. Increase Patient Loyalty

95%

of pop health campaigns successfully reach patients



17%

increase in in-network utilization

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Our clients include some of the most forward-thinking provider organizations

University Hospitals

Dignity Health

MPS Medical Professional Services

Steward
Steward Health Care System

SUMMIT GROUP MEDICAL
SUMMIT MEDICAL GROUP

PRIVIA HEALTH

SSPHO
SOUTH SHORE PHYSICIAN HOSPITAL ORGANIZATION
781-624-4200

GraniteHealth
Leading innovation.

Hallmark Health

MILLENNIUM
PHYSICIAN GROUP

Heywood Hospital
Member of the Heywood Healthcare Family

Beth Israel Deaconess
CARE ORGANIZATION LLC
Affiliated with
Beth Israel Deaconess Medical Center
A teaching hospital of Harvard Medical School

Children's Hospital Boston

Lowell General Hospital

Harbor Medical Associates

HUDSON HEADWATERS Health Network

NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Lahey Health

CMIPA

BOSTON MEDICAL CENTER
EXCEPTIONAL CARE. WITHOUT EXCEPTION.

The Landscape

We spend more
on health care than
Canada does…
on everything.

And we have quality results comparable to

Libya

Projected number of Medicare beneficiaries

2014	2015	2016	2017	2018	2019	2020
54M	56M	57M	59M	61M	63M	64M

Projected Medicare Fee-for-service Payment Cuts per the ACA

2014	2015	2016	2017	2018	2019	2020
-14B	-21B	-25B	-32B	-42B	-53B	-64B

Source: CMS, "2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," May 31, 2013, available at: http://downloads.cms.gov/files/TR2013.pdf

2018: **90%** **of Medicare** payments tied to quality.

2020: **75% of commercial** plans will be value-based.

Jan 2015. http://www.hhs.gov/news/press/2015pres/01/20150126a.html

athenahealth's approach

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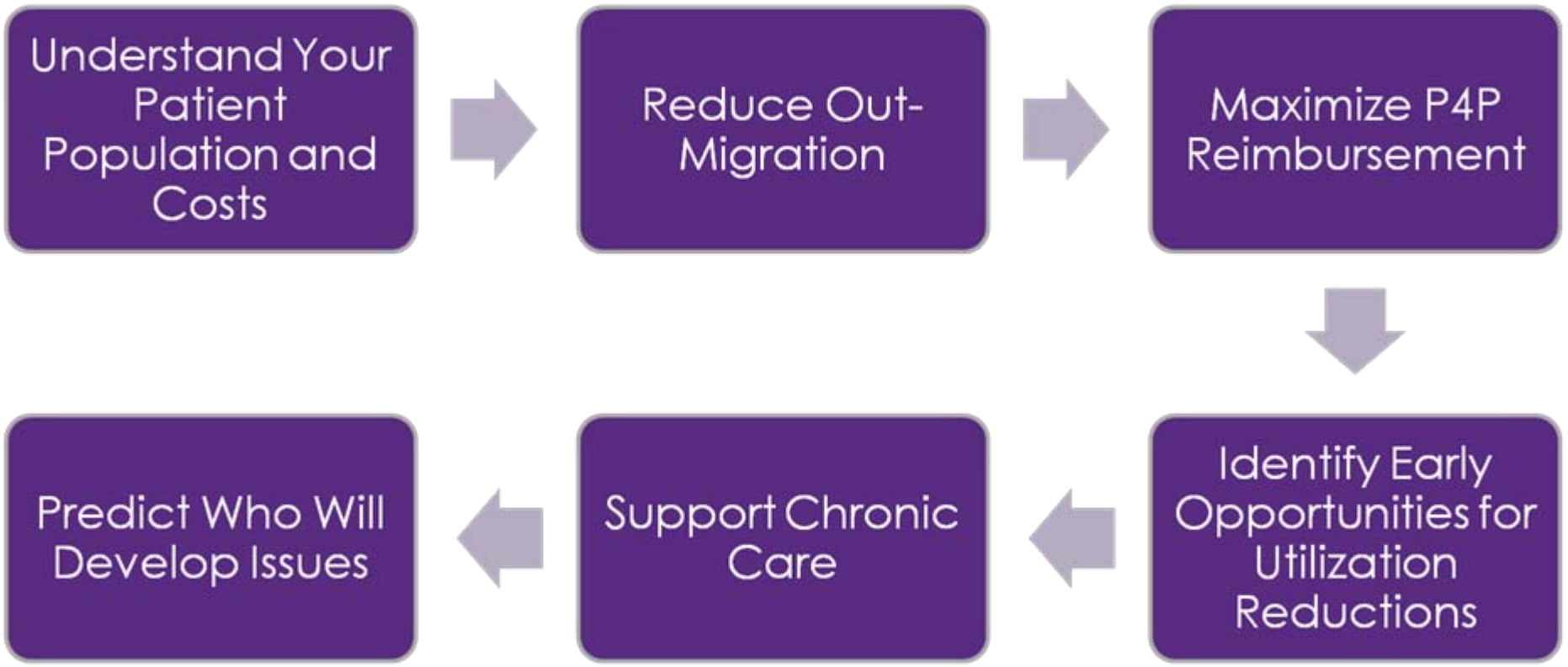
Six Tactics for Population Health Success



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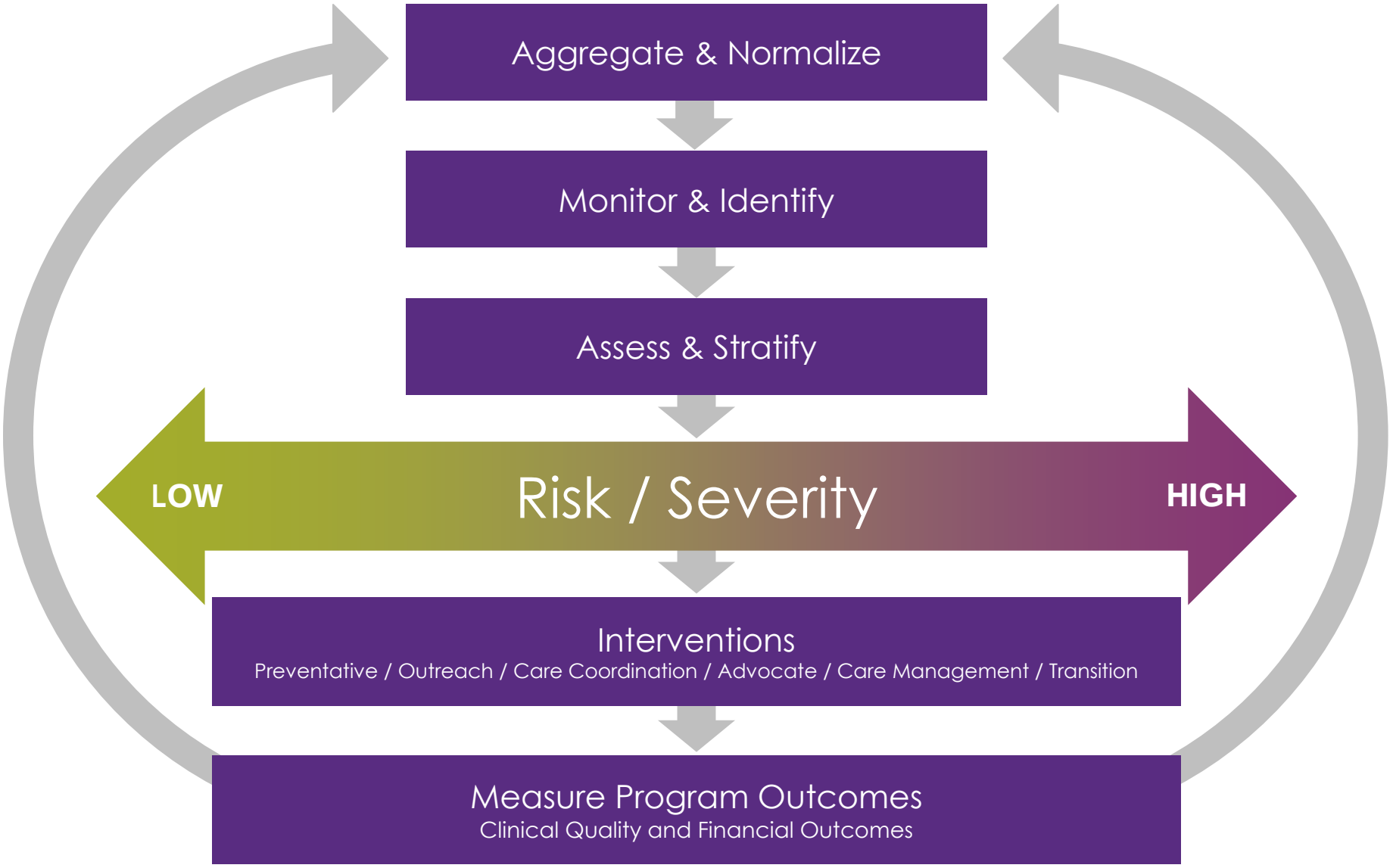
Population Health Management Framework



We aggregate data to create a complete view of your patient population

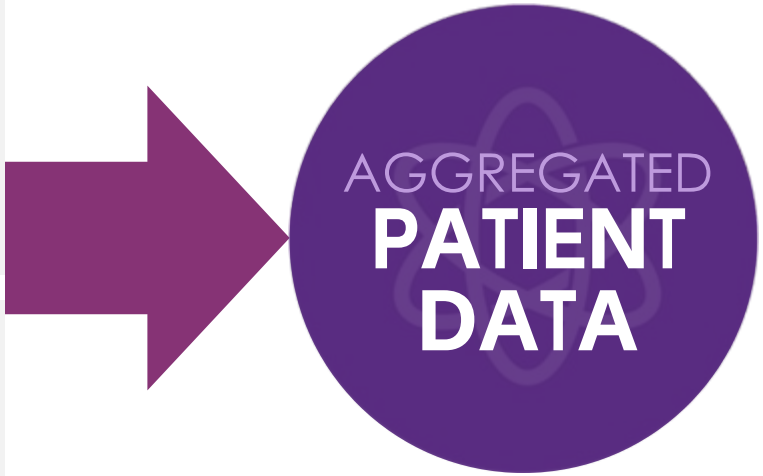
Data Sources

PAYERS
CIGNA
AETNA
Anthem
United
CMS
BCBSMA
Harvard Pilgrim

CLINICAL SYSTEMS
athenahealth
Allscripts
Meditech
EPIC
eClinicalWorks
GE Centricity
Cerner
NextGen

PHARMACY BENEFIT MANAGEMENT
Caremark
Envision
ESI

REGIONAL LABS
Quest Diagnostics
LabCorp
Converge
Diagnostics



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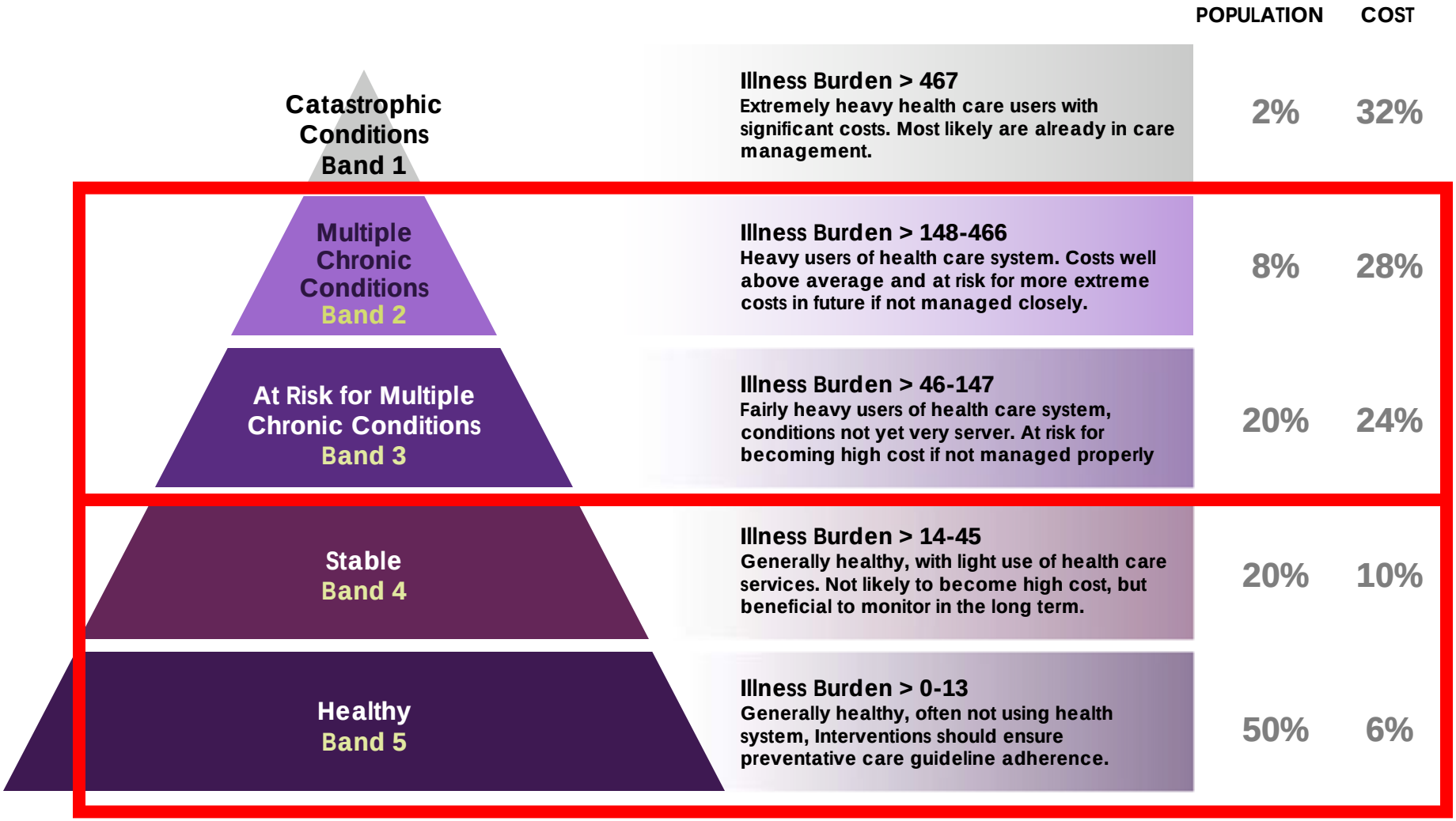
Identify and stratify populations



SOURCE: CareFirst PCMH Program Description and Guidelines, pg 17

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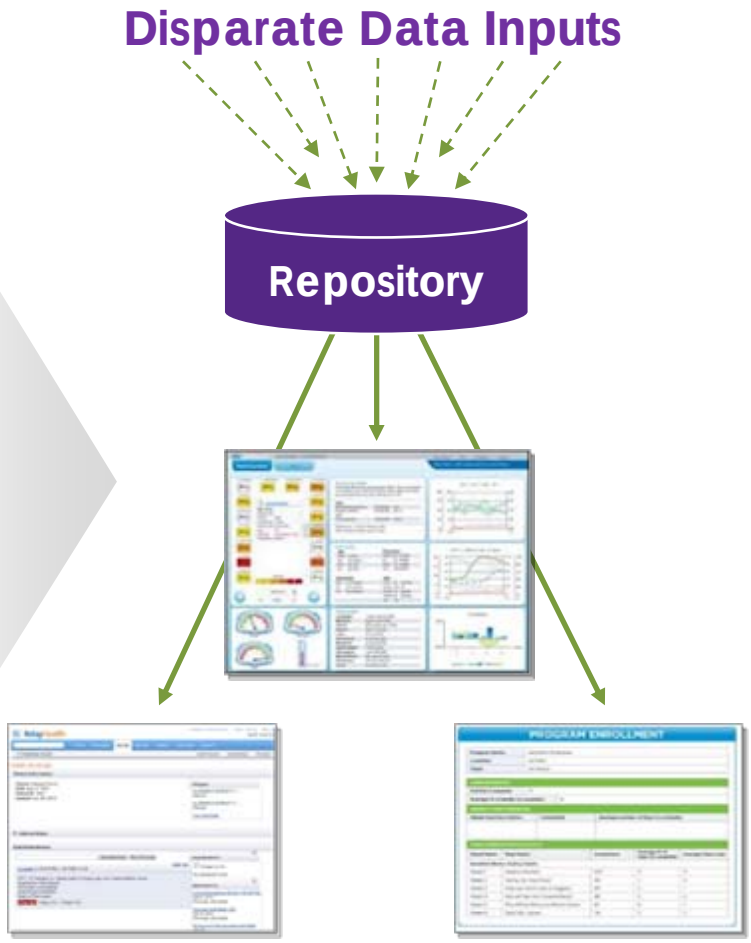
Software alone doesn't create a partnership for success

Cerner
CONIFER HEALTH SOLUTIONS
wellcentive
PASSPORT A part of Experian
dbMotion Allscripts
Alere
McKESSON
RelayHealth
MedVentive
Midas+
Healthagen
The Advisory Board Company | Crimson



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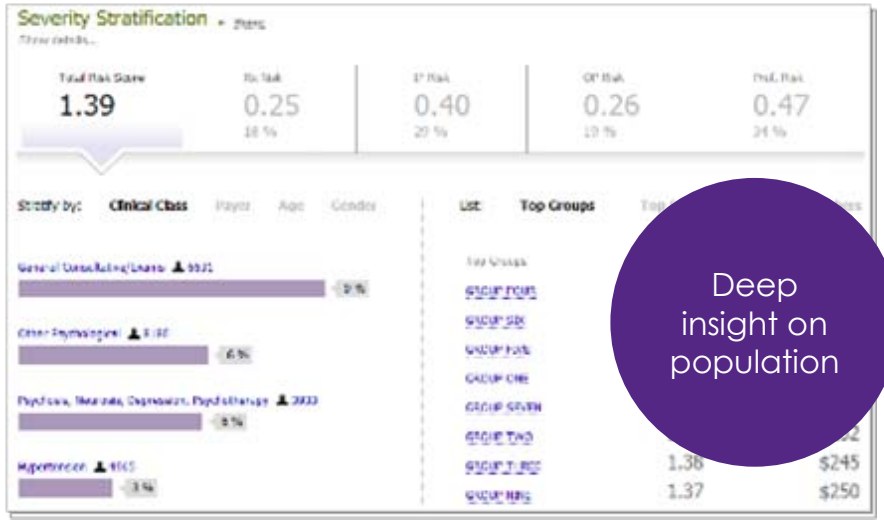
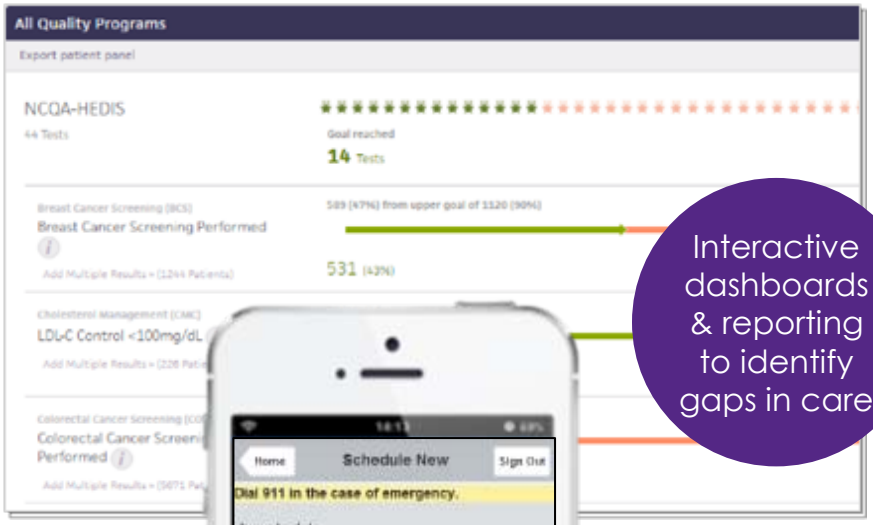
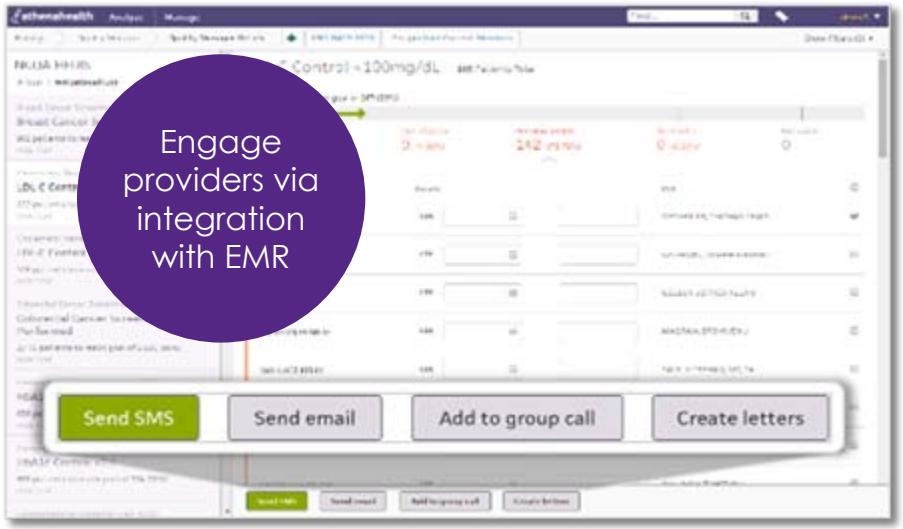
Network-enabled services optimize engagement, transparency and insight



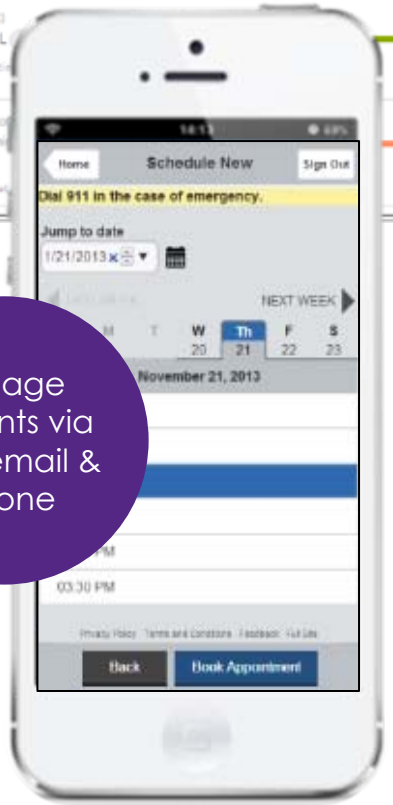
Deep insight on population



Interactive dashboards & reporting to identify gaps in care



Engage providers via integration with EMR



Engage patients via text, email & phone

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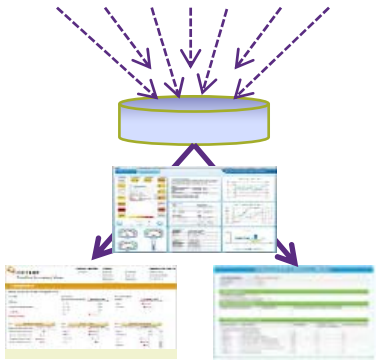
Must add knowledge and work to achieve closed-loop care coordination.

Network/Software

- Repository
- Connections / data feeds
- Reports
- Network facesheet
- Secure messaging
- Patient communication tools
- Direct scheduling



Knowledge

- Risk adjustment scoring options
- Quality management rules
- Patient outreach best practices
- Scheduling logic
- Curated risk stratification
- Care coordination best practices

Work

- Population health campaigns/gap in care outreach
- Patient scheduling for campaigns (live operators)
- Interoperability service
- Pre-certification, pre-registration
- Referral management with care coordination

1. **Risk-based programs** are the way of the future…
2. …but **getting paid** can be harder than expected
3. **Align incentives** and get **full engagement** from providers, patients and partners

carecentrix

It pays to care at home

Using Data to Achieve The Quadruple Aim

Mike Cantor, MD, JD
Chief Medical Officer
michael.cantor@CareCentrix.com

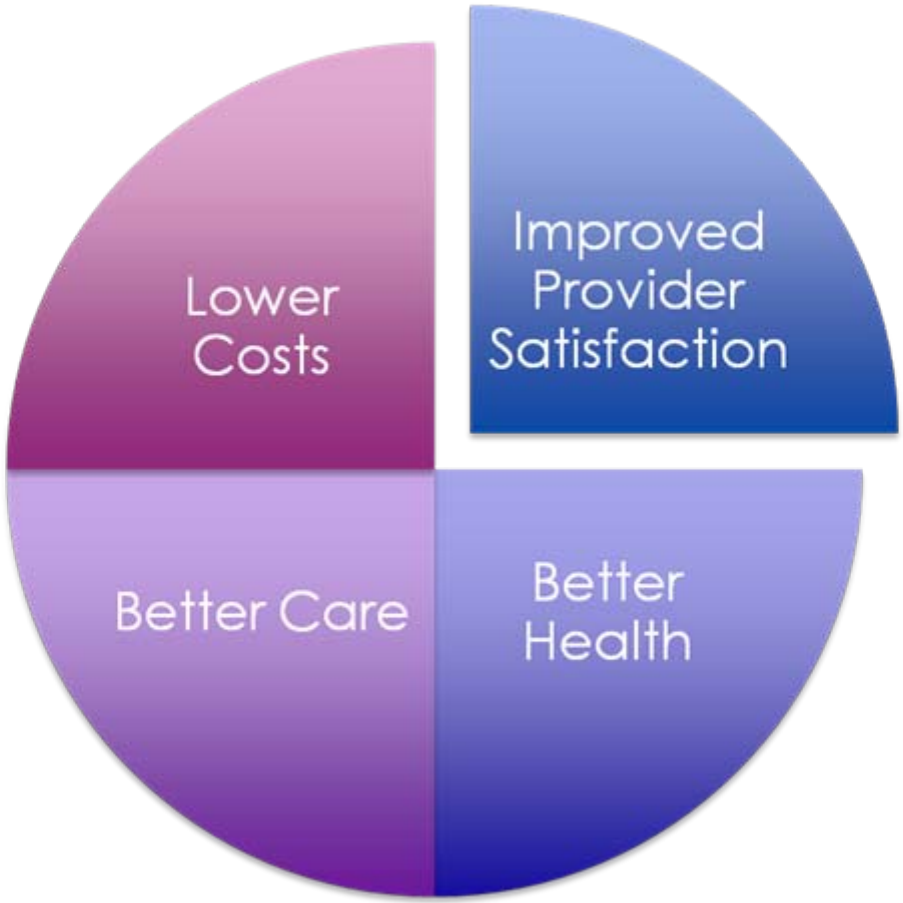
Context: Pay for Value

Quadruple Aim

- Quality measurement and improvement
- Cost-related analyses and interventions
- Patient experience measurement

Paying for Quality

The Quadruple Aim



Bodenheimer T, Sinsky C: From Triple to Quadruple Aim: Care of the Patient Requires
Care of the Provider, *Ann Fam Med* 2014;12:573-576.

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AQC Contract: Making the Triple Aim Concrete

Improve Population Health

- Process Measures
- Patient Experience
- Outcomes measures

Patient Experience Improvement

- Part of Quality Score Calculation

Reduce Rate of Growth of Cost

- Budget: average annual cost per member
- Providers paid fee for service, then settlement 4th quarter following year

Health care is a team sport

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How To Achieve The Triple Aim?

1. Data
2. Education - Meetings
3. Incentives

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Improving Quality of Care: Registry Use

Cannot improve quality without knowing who needs what by when

- Registries: can be free-standing or Electronic Health Record based
- Must know where opportunities are
- Helpful to know how much further you need to go

Best registries combine claims data and EHR data

- Claims data show more comprehensive view of patient
- EHR data are more current

May need to invest in additional people to use registry

Incentive payments may also be useful – but be careful

Managing Costs: Data Mining

Use of data warehouses and analytics to identify key opportunities for interventions

- Identify basic drivers of costs: unit cost (price per service) and utilization
- Are there opportunities to influence either of these?
- Care management: an example of data-driven clinical intervention

Improving Patient Experience: Surveys

Measurement key to evaluating patient experience

Surveys are mandated in many payer contracts: AQC and Medicare Accountable Care Organizations (ACOs)

- Most use Consumer Assessment of Healthcare Providers and Systems (CAHPS) tools
  - Apply to healthcare providers: physicians, hospitals, etc
  - Also applies to health plans

Need to use survey data for two purposes: accountability and quality improvement

- Accountability: results determine payments, usually annually
- Quality improvement: use data to shape practices, usually more frequently

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Five Stages of the AQC (Apologies to Kubler-Ross)

Denial	• You're kidding, right?
Anger	• You want me to do WHAT?
Bargaining	• How many meetings do I have to go to?
Depression	• Why are my patients more [sick, non-compliant, unable to pay co-pays, resistant]? There is nothing I can do…
Acceptance	• How do I get on to the registry?

Take Home Messages

- Payment based on quality is no longer optional
- MUST have data systems to measure quality, costs, patient experience
- Using data systems can lead to significant and consistent improvement in performance

THIS CAN BE DONE!

Live Polling

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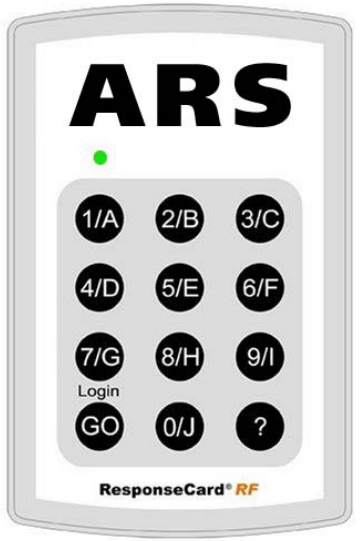
Using your Keypad

- Press and release the button that best represents your answer
- A light indicates your answer was received
- Your last answer will be recorded
- There is no need to press “GO” or “?”
- Please leave the Keypad on the table at the end of this session



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10

Strategically, what does "population health" mean to your organization?

- 0% A. Moving to risk or value-based reimbursements
- 0% B. Becoming patient-centric
- 0% C. Defining new care delivery models
- 0% D. Achieving the triple (or quadruple) aim
- 0% E. Fixing social determinants of health

Answer Now

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What capability does your organization have to best allow you to succeed in an era of population health (pick two):

- 15% A. Strong leadership vision
- 7% B. Brand awareness & loyalty with patients
- 11% C. Market scale
- 16% D. Care Management & Coordination capabilities
- 7% E. Ability to partner with other entities (payers, retail, community providers, etc.)
- 11% F. Financial/capital resources
- 9% G. Fully integrated system – from community providers to an insurance plan
- 15% H. Comprehensive access to data
- 9% I. Other

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My organization's most significant roadblocks to implementing a pop health strategy are (pick two):

- 9% A. Lack of leadership vision
- 13% B. Low brand awareness & loyalty with patients
- 11% C. Market scale
- 13% D. Care Management & Coordination capabilities
- 13% E. Ability to partner with other entities (payers, retail, community providers, etc.)
- 15% F. Financial/capital resources
- 11% G. Not a fully integrated system – from community providers to an insurance plan
- 9% H. Comprehensive access to data
- 7% I. Other

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What has your organization learned developing population health programs?

- **13%** A. Physician engagement and alignment is challenging
- **18%** B. We underestimated financial/capital resource requirements
- **16%** C. We have limited ability to analyze performance and make decisions
- **5%** D. Patient engagement is something we need to focus on
- **16%** E. We've had limited success partnering/contracting with other entities (payers, retail, community providers, etc.)
- **18%** F. We need to focus on access to data
- **13%** G. Other

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What one population health capability has highest ceiling for improvement?

- **13%** A. Telemedicine
- **11%** B. Care Management services (enrollment and transitional services)
- **18%** C. Advanced risk stratification/predictive analytics
- **11%** D. HCC/RAF calculation and assessment needs
- **22%** E. Multi-channel patient outreach service to fill gaps in care - email, text, and automated phone, and targeted live operator support
- **9%** F. Consultative and advisory services to enable contract optimization and success
- **16%** G. Other

Thank You

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Extra polling questions

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Assuming data aggregation is a top priority for future pop health success, what capabilities and investments are your next priority (pick one):

A. Patient stratification & care gap identification

B. Clinical decision support at the point of care

C. Patient outreach and engagement

D. Care coordination

E. Analytics and reporting

F. Care management

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0 of 55

10

Assuming data aggregation is a top priority for future pop health success, what capabilities and investments are your next priority

0% A. Patient stratification & care gap identification

0% B. Clinical decision support at the point of care

0% C. Patient outreach and engagement

0% D. Care coordination

0% E. Analytics and reporting

0% F. Care management

Answer Now

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My organization has well-defined metrics and benchmarks for determining pop health success:

A. Strongly agree

B. Moderately agree

C. Neither agree or disagree

D. Moderately disagree

E. Strongly disagree

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0 of 55

10

My organization has well-defined metrics and benchmarks for determining pop health success:

0% A. Strongly agree

0% B. Moderately agree

0% C. Neither agree or disagree

0% D. Moderately disagree

0% E. Strongly disagree

Answer Now

What percentage of your revenue do you expect will be at risk for total cost of care 5 years from now?

A.0-20%

B.21-40%

C.41-60%

D.61-80%

E.81% or more

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10

What percentage of your revenue do you expect will be at risk for total cost of care 5 years from now?

0%	A. 0-20%
0%	B. 21-40%
0%	C. 41-60%
0%	D. 61-80%
0%	E. 81% or more

Answer Now

Extra slides

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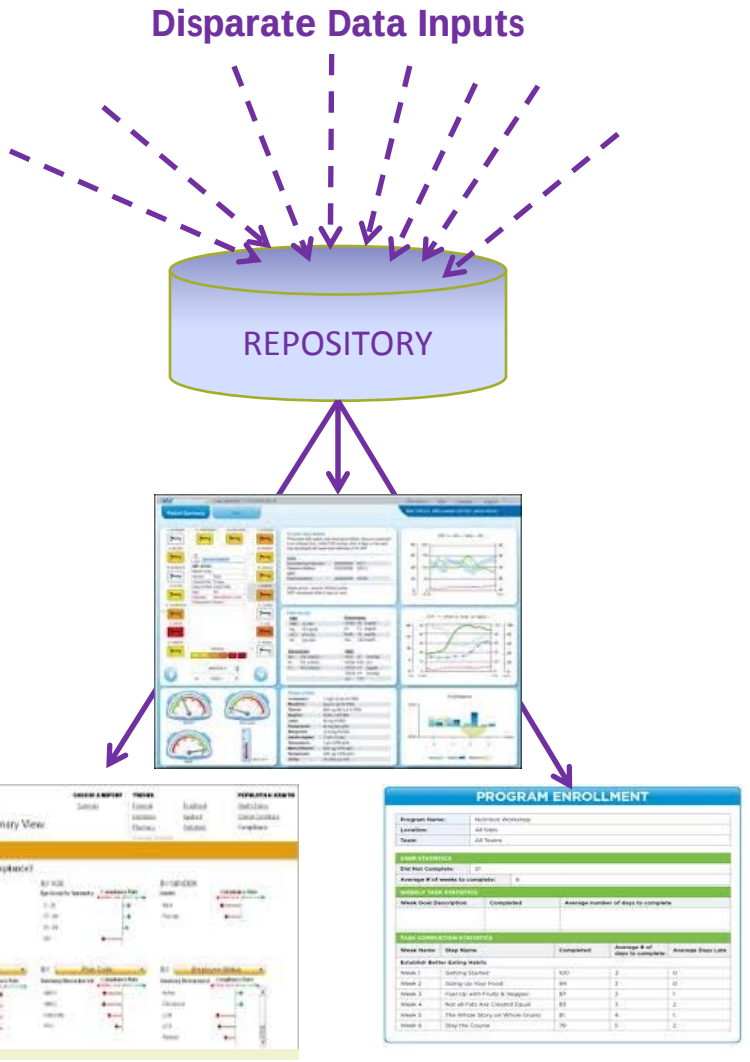
Over 100+ population health companies exist, however software alone is not the answer.

Cerner
CONIFER HEALTH SOLUTIONS
PHYTEL
evolent HEALTH
wellcentive
PASSPORT A part of Experian
dbMotion Allscripts
OPTUM
McKESSON
RelayHealth
Alere
MEDVENTIVE
Midas+
Healthagen
The Advisory Board Company
Crimson



We add knowledge and work to achieve closed-loop care coordination.

Software

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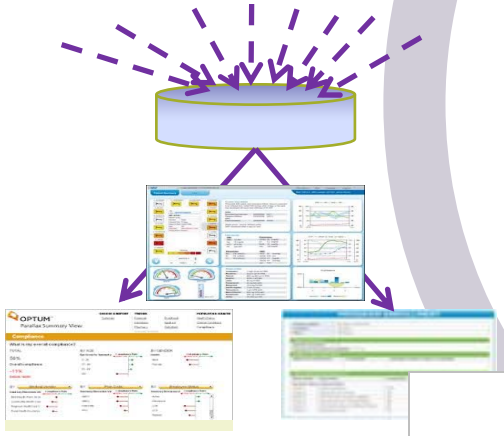

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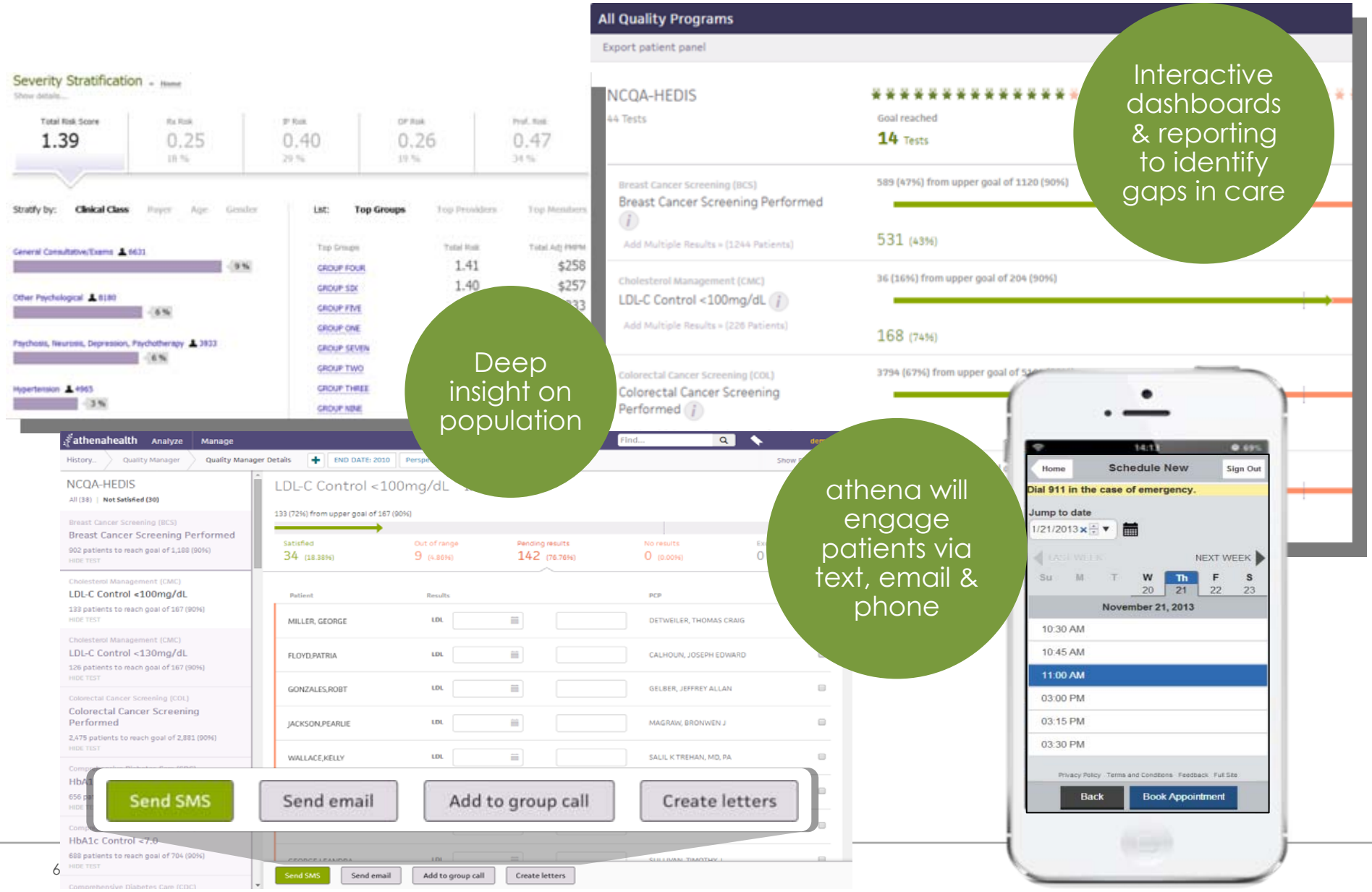
Here's how….



Interactive dashboards & reporting to identify gaps in care

Deep insight on population

athena will engage patients via text, email & phone

Early results are outstanding…

Our tools help manage

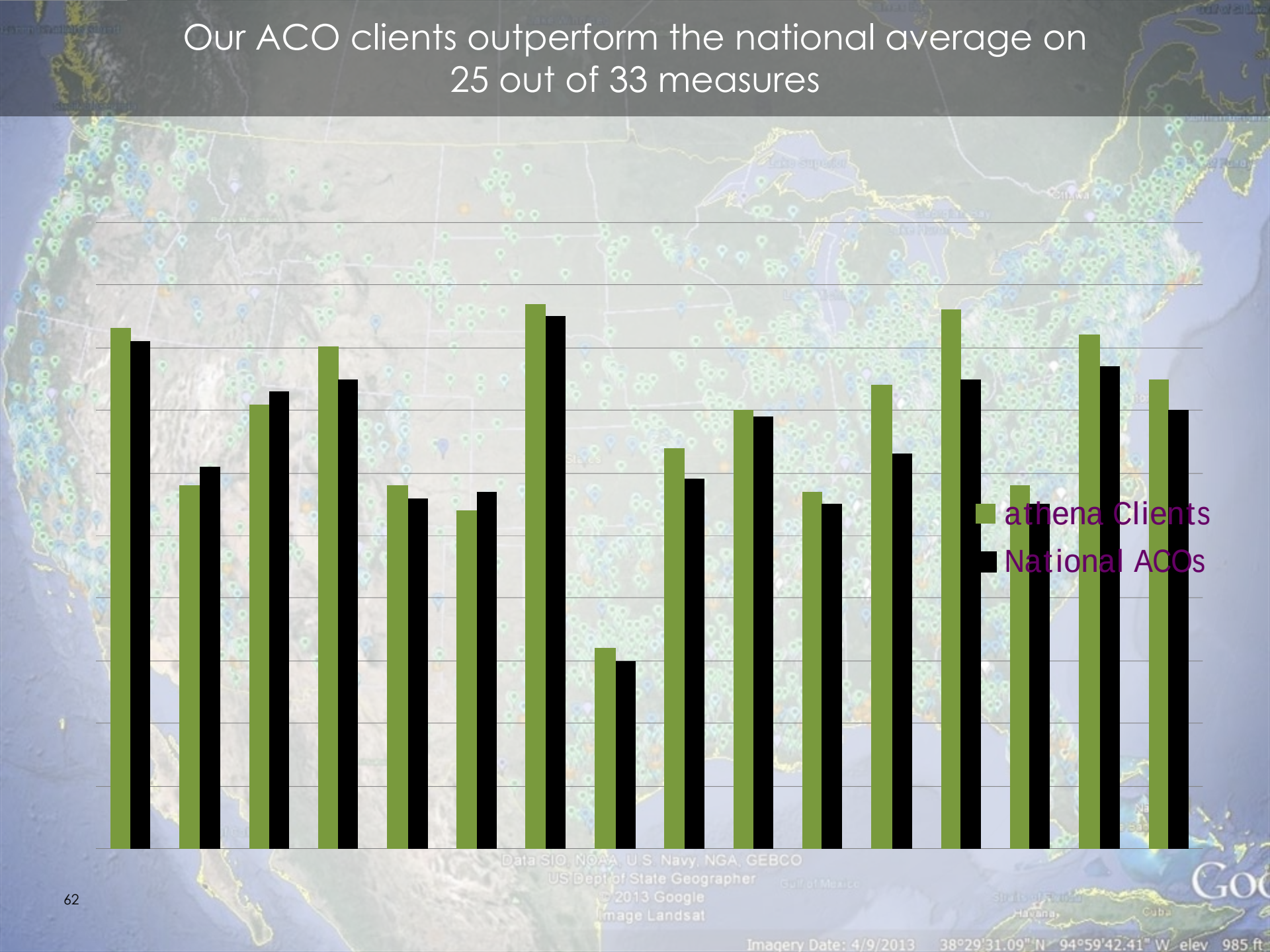
6%

of the at-risk lives in the country

- Appointment wait times reduced to **3.25** days from over **30** days
- **65.2%** reduction in referral-related denials
- **45.6%** improvement in first year ACO33 quality scores
- **18.8%** of appointments directly scheduled by affiliated entities

Source: athenahealth data

Our ACO clients outperform the national average on 25 out of 33 measures



The ACO Guarantee

We guarantee performance against the Medicare's 33 ACO quality measures – you pay only for the quality points you achieve.

Extra slides

Pulled from latest ACHE 3/6/16