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POPULATION HEALTH PLAYBOOK

Mark Wendling, MD | Executive Director LVPHO/Valley Preferred

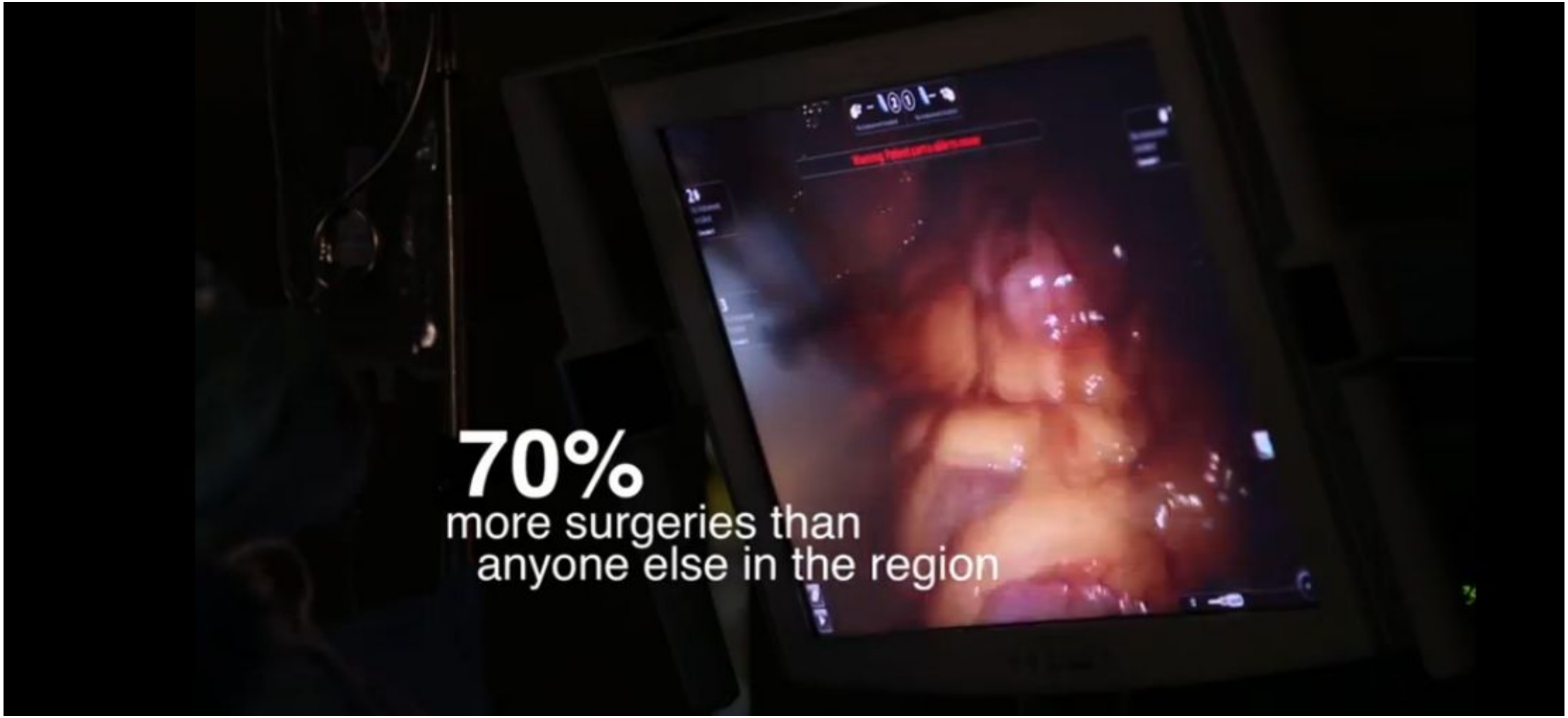
Today's Agenda

- Outline
- LVHN, LVPHO and Populytics Overview
- Population Health Approach
- Population Health Analytics
- Population Health Playbook
- LVHN Case Study Results
- Discussion

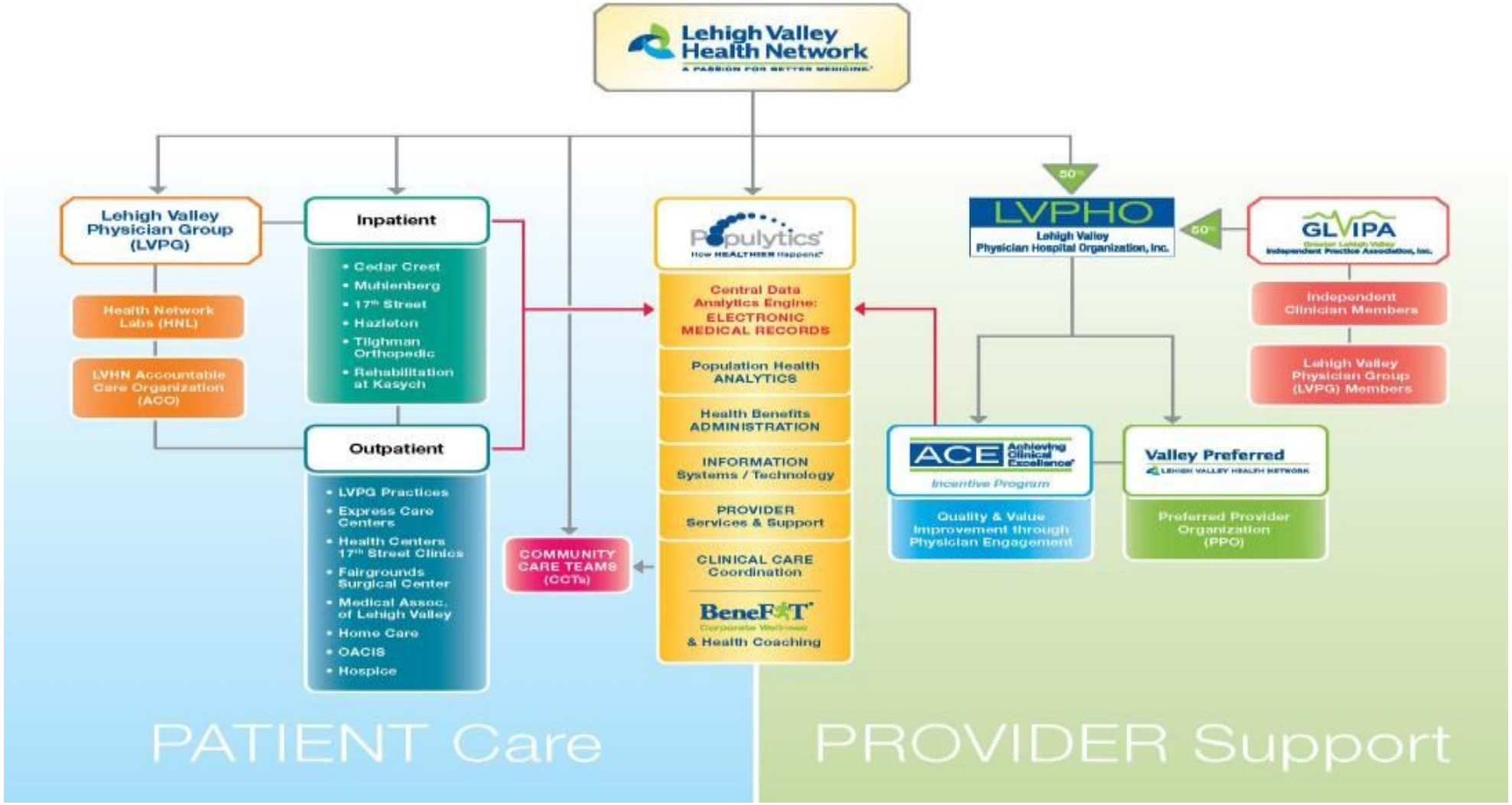
Lehigh Valley Health Network (LVHN)

- In Allentown/Bethlehem/Hazleton/Schuylkill/Pocono
- Recognized by U.S. News & World Report, Fortune, Modern Healthcare, Leapfrog, others
- 8 hospital campuses,
  16 Health Centers
- 11 ExpressCARE locations
- 163 physician practices
- 17,000+ employees
- Physician Hospital Organization (1100+ member physicians)

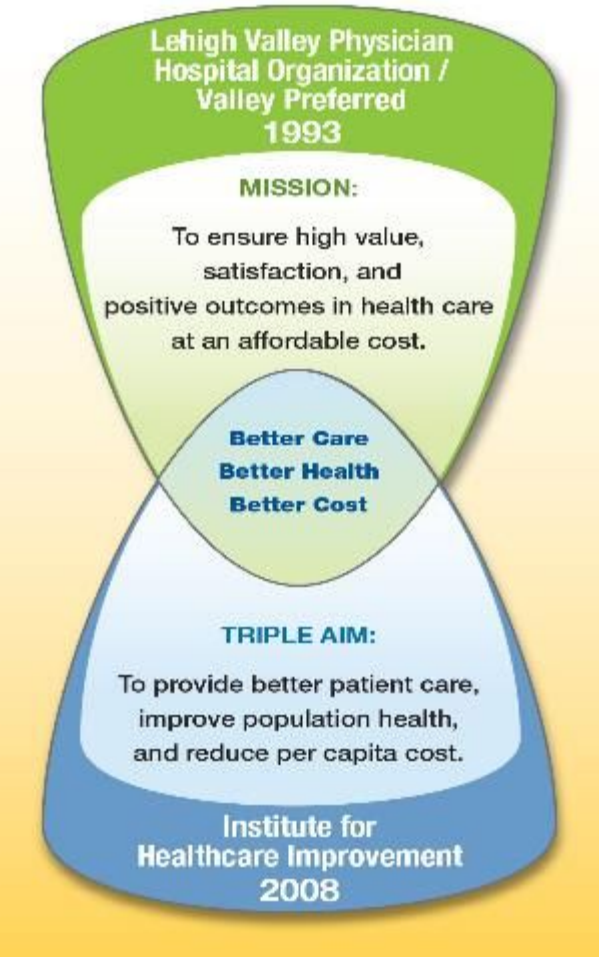
Lehigh Valley Health Network



Lehigh Valley Health Network Organization



Lehigh Valley Physician Hospital Organization (LVPHO) Mission



To ensure **high value, satisfaction, and positive outcomes** in health care at an affordable cost.

Populytics Overview

Established December 2013

Population health management and analytics firm

Integrated services

- Population health analytics
- Clinical care coordination
- Health benefits administration & consulting
- Corporate wellness programs

Expert professionals

- Payer & provider informatics
- Medical management services
- Advanced analytics
- Business development
- Insurance and risk management

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LVHN Vision

We will build on our foundation as a premier academic community health system and become an **innovative population health leader** that creates superior quality and value for the patients and communities we serve.

U.S. Healthcare Delivery System Evolution

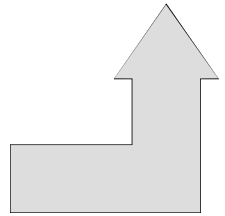
- Healthy population–centered, population health–focused strategies
- Integrated networks linked to community resources capable of addressing psycho-social/economic needs
- Population-based reimbursement
- Learning organization: capable of rapid deployment of best practices
- Community health integrated
- E-health and telehealth capable

Community Integrated Healthcare System 3.0

Community Integrated Healthcare

- Patient/person centered
- Transparent cost and quality performance
- Accountable provider networks designed around the patient
- Shared financial risk
- Health information technology–integrated
- Focus on care management and preventative care

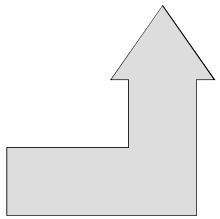
Coordinated Seamless Healthcare System 2.0



Outcome Accountable Care

- Episodic healthcare
- Lack of integrated care networks
- Lack of quality & cost performance transparency
- Poorly coordinated chronic care management

Acute Care System 1.0



Episodic Non-Integrated Care

*Halfon N, Long P, Chang DI, Hester J, Inkelas M, Rodgers A. Applying a 3.0 transformation framework to guide large-scale health system reform. Health Affairs 2014;31(11). doi: 10.1377/hlthaff.2014.0485.

LVPHO Lehigh Valley Physician Hospital Organization, Inc.

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LVPHO and LVHN Population Health Playbook

- Mutual accountability
  - Compact
- Aligned incentive plan
- Population Health support
  - Care management strategy
- Prioritized quality improvement
  - Care gap and utilization prioritization
- Populytics data and analytics

Population Health Management Executive Committee

Clinically driven and inclusive of key network leadership

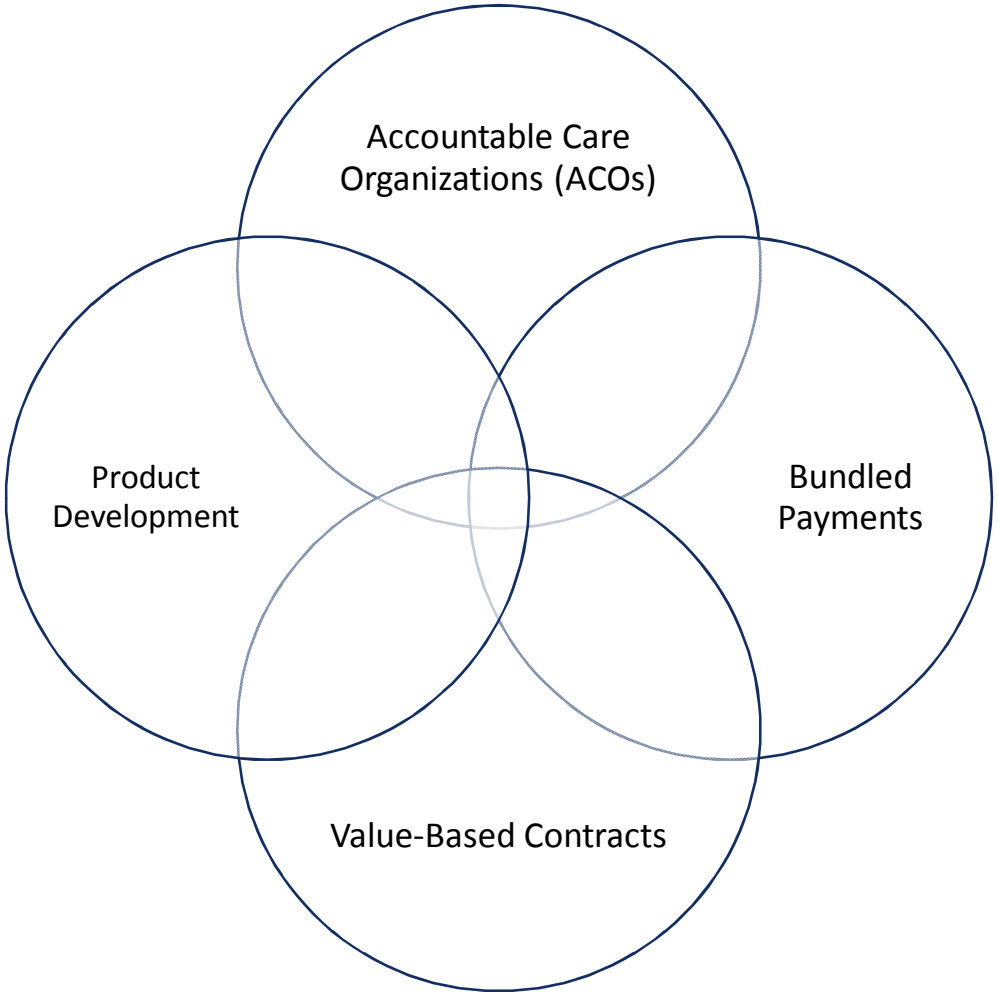
- **Programmatic focus leverages clinical integration and care alignment**
  - Leakage
  - Cardiovascular disease
  - Diabetes
  - Orthopedics (includes Back Care, TJR Pathway)
  - Chronic Kidney Disease
  - Chronic Obstructive Pulmonary Disease

- **Shared KPIs**
  - Clinical pathway (variations)
  - Costs/Spend
  - Inpatient Utilization (includes readmissions)
  - ED Utilization for ASC
  - ED Utilization/1000
  - Pharmacy Costs
  - Select ACE, LVPG, ACO metrics

- **Informs and facilitates concurrent work**
  - Virtual Care
  - Choosing Wisely
  - Patient Activation and Engagement
  - Advanced Care Planning
  - Post Acute Care

Payment Innovation

- Manage commercial, Medicare and Medicaid populations
- Implement and manage shared savings and shared risk contracts
- Identify priority quality and utilization measures
- Align performance measurement on value based contracts
- Implement bundled payments
- Implement joint venture products



Approach to Value Based Contracts

Align Quality & Utilization Measures

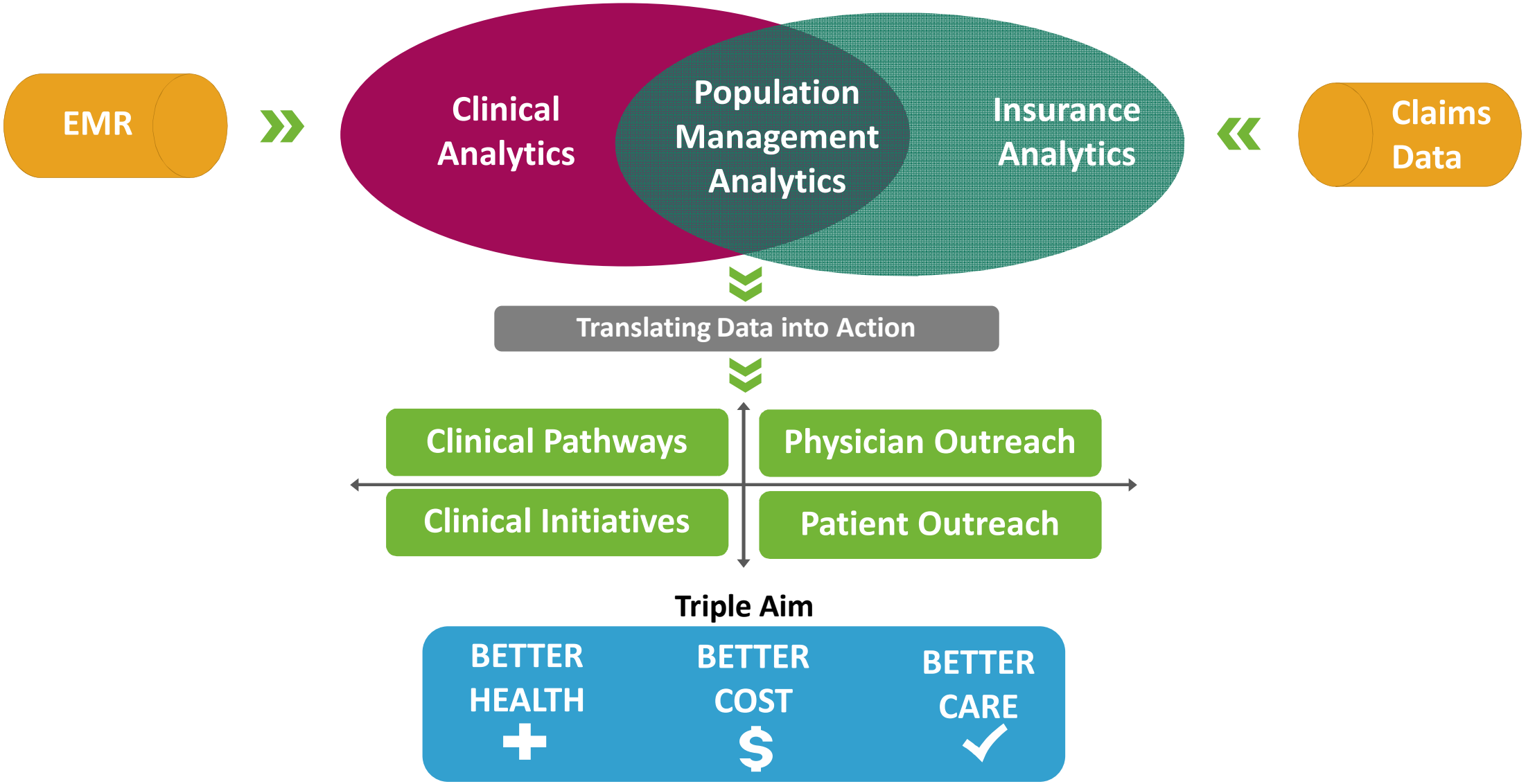
LVHN champions 30 priority measures using 3 primary tactics:

- Physician Incentive Program – *Achieving Clinical Excellence ®*
- Analytics based on claims and clinical analytic information
- Consistent care management strategy

Powered by Populytics

Lehigh Valley Health Network

A More Complete Picture



Foundations for Success: Managing Population Risk

CLINICAL & PHYSICIAN ANALYTICS

Data-driven review of populations to identify and stratify risk to reveal opportunities and inform providers

FINANCIAL MANAGEMENT

Strategy to monitor performance under accountable care arrangements

DATA MANAGEMENT

Acquisition, integration & maintenance of data critical to the management of populations

Successful population health management to thrive in value-based care models

CONSULTATIVE SUPPORT

Leverage the experience of our experts for the benefit of your strategic goals

Overview of Clinical & Physician Analytics

- Clinical Analytics that use EMR data to identify Gaps in Care, High Risk Patients, etc.
- Risk Analytics that use Claims Data to track prospective costs and stratify risk
- Registries with patient level profiles
- Predictive Analytics
- Easy to use Dashboards

Stakeholders

Care Coordinator

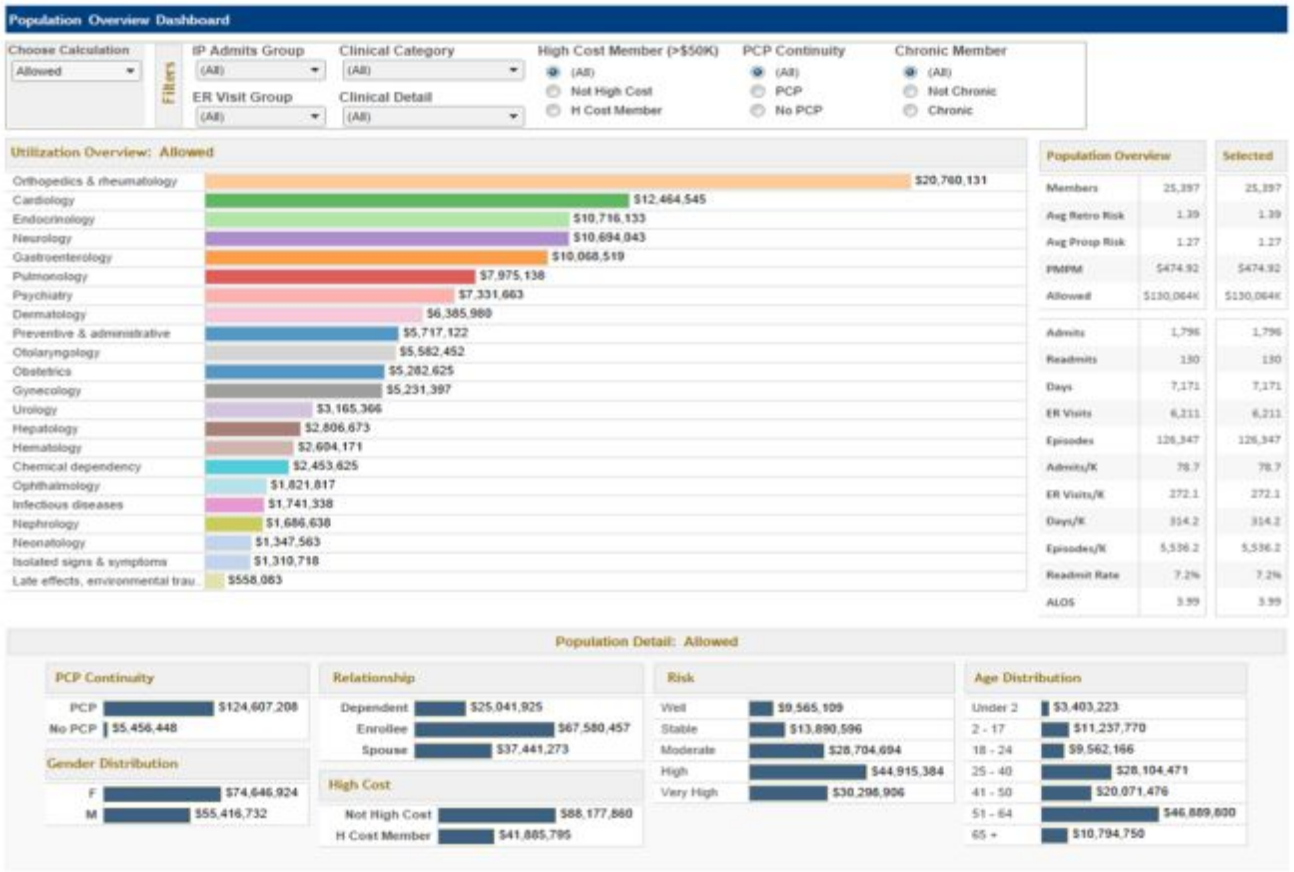
Clinicians

Quality Leadership

Executive Leadership

Clinical & Physician Analytics

- 11 drillable analytic dashboards to identify achievable opportunities to improve overall population health
- Create customized data segments around demographic, financial and health information to support targeted initiatives including:
  - Clinical pathways dashboards for COPD, oncology, CHF & AFIB

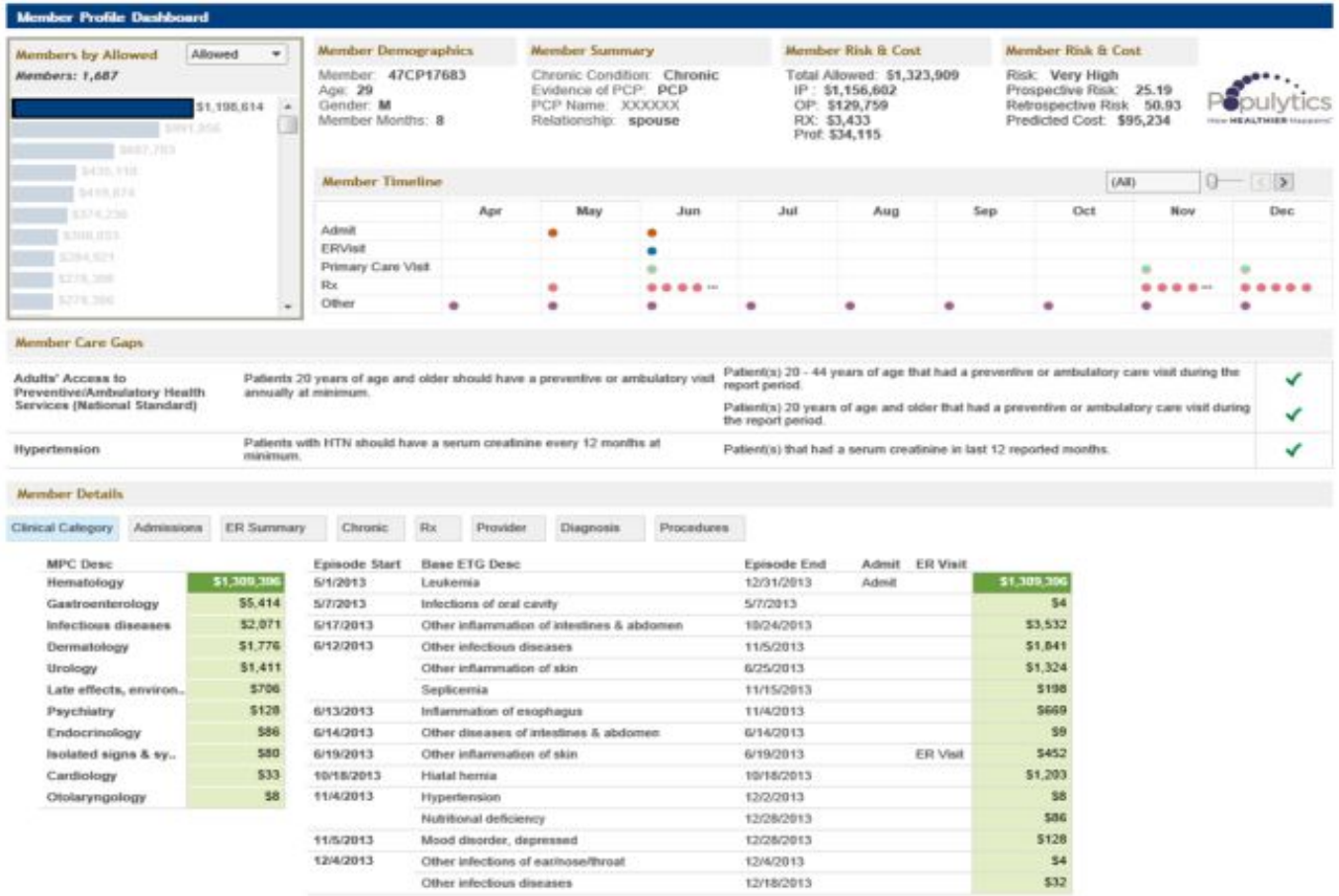


Population Health Dashboards – Drillable to Patient Level

- **Overview of the At-Risk Population**
- **Inpatient Activity:** High utilizers, risk stratification, ACSC, chronic, high cost
- **Emergency Room:** High utilizers, risk stratification, ACSC, chronic, high cost
- **Chronic Care Members**
- **RX:** Review Rx utilization by drug class, brand, generic, high utilization members
- **Care Gaps:** Identification of key care gaps for attributed population
- **Provider/Outmigration:** Outmigration by clinical condition, specialty, PCP
- **Choosing Wisely®**
- **Cancer (collaboration with MSK)**
- **Diabetes, COPD**
- **Dropped HCCs**

Closure of Gaps in Care

- Highlight gaps in care and opportunities for intervention at the individual level
- Align patient intervention strategies with health system programs
- Interface with EPIC for point-of-care management



Targeted Population Health Patient Registries

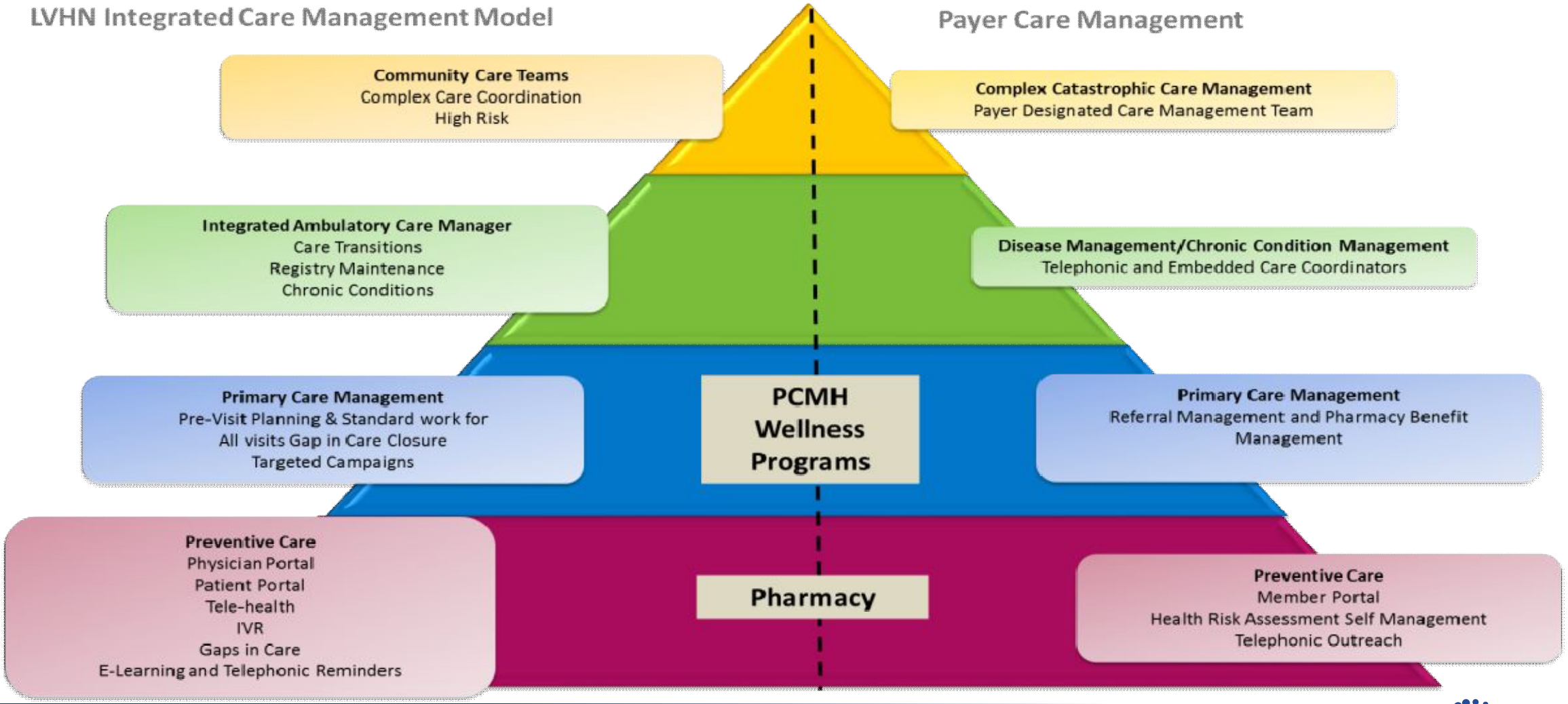
- **High Risk:** HCC Score > 3 & Likelihood of Hospitalization > 80%
- **High Utilization:** 2 Inpatient Admits or 3 ER visits in a 6 month time period
- **High Cost:** > $100K in a 12 month period
- **High Risk/Low Cost:** HCC Score > 2 & < $15K in a 12 month period
- **Newly Identified Chronic Patients:** Education opportunity
- **Newly Identified High Risk Patients:** Using claims & clinical data
- **Members with No PCP Visits:** Dropped attribution
- **Members with Visits to Multiple Specialists – Same Specialty:** "Doc Shopping"

Aligned Incentive Plan

Achieving Clinical Excellence® (ACE)

- **Semi-Annual Practice-Based Group Incentive Plan:** Designed to provide physicians with incentives to meet the Triple Aim
- **Measurement Categories**
  - Better Care: CG CAHPs participation, Meaningful Use standards
  - Better Cost: Risk Adjusted ALOS, Risk Adjusted Episode Cost, Admissions and Readmissions, ED visits, and generic Rx Utilization
  - Better Health: Evidence-based Quality Measures, QI Projects
- **Funding Sources:** Include employer, payers & shared savings distribution
- **CME Opportunities/Online Modules**

Care Management Strategy



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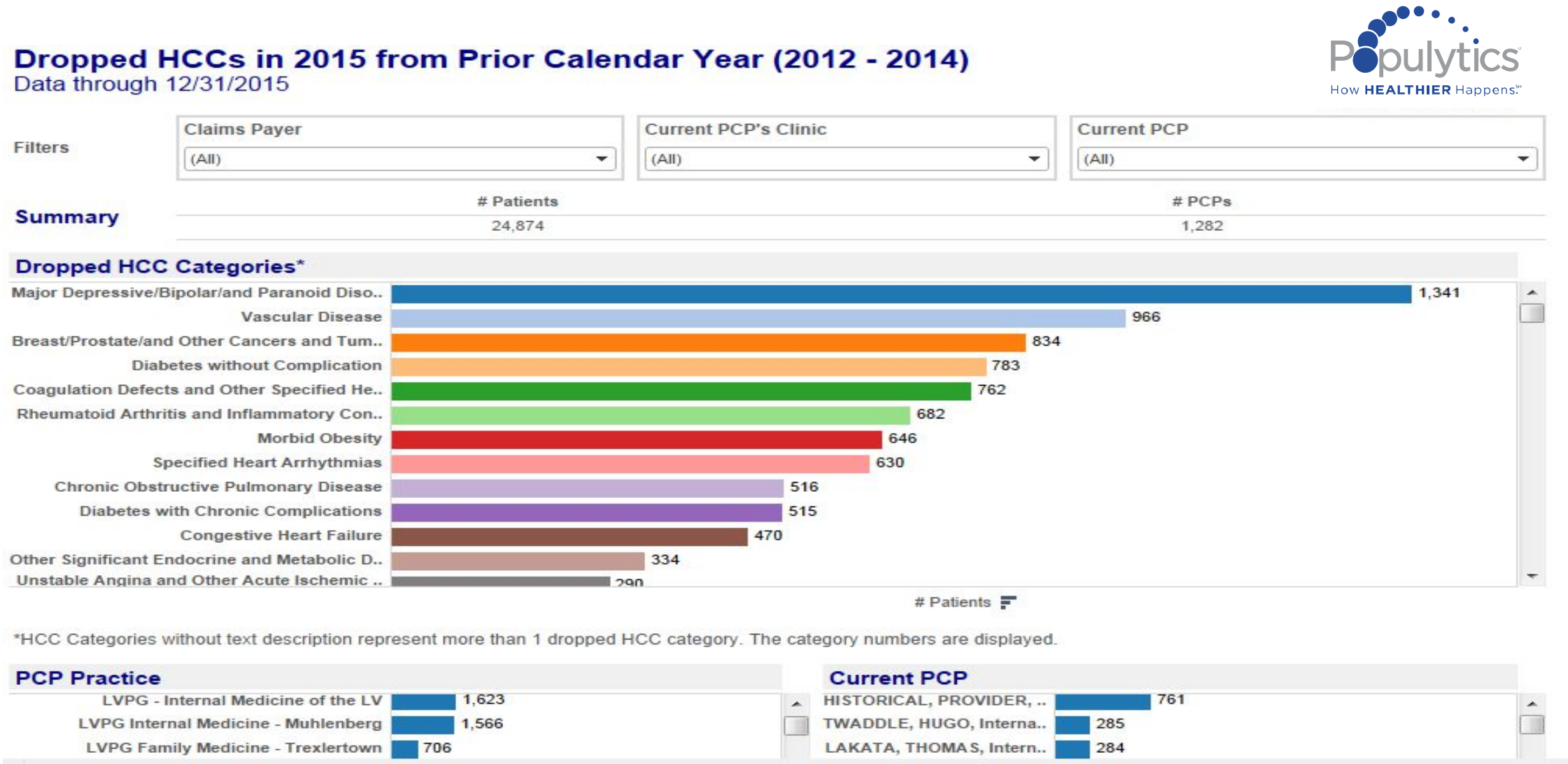
CASE STUDIES AND EXAMPLES

Dropped HCC's Dashboard

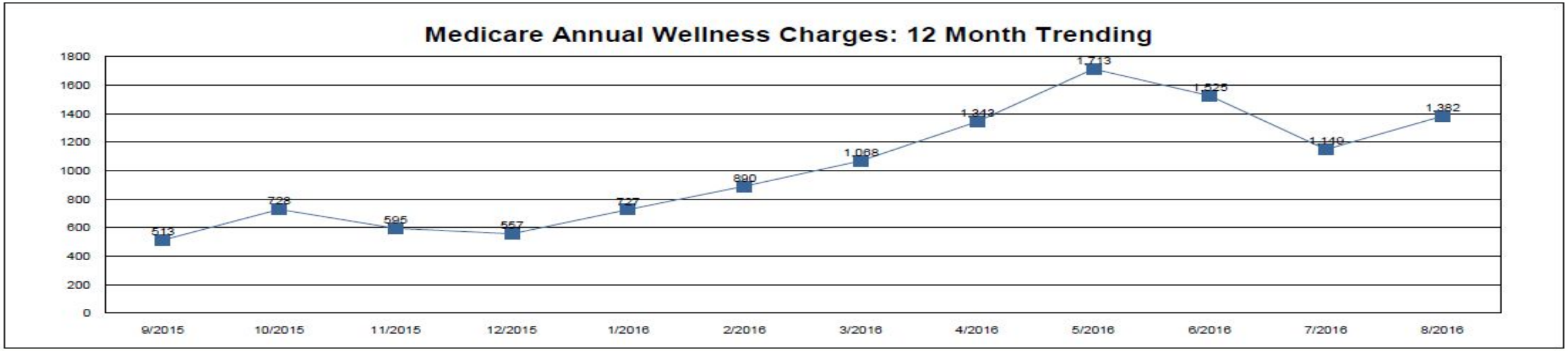


Medicare Annual Wellness

Data by Enterprise Analytics

Medicare Annual Wellness appointments since Epic GoLive (2/18/15)
Grouped by PCP Practice, then Provider
Filtering on Entity
Report only includes Patients with a defined PCP Practice.
Listing of Medicare patients with their most recent Medicare Annual Wellness charge dates.

Medicare Annual Wellness Charge Codes:
G0402 - PR INITIAL PREVENTIVE EXAM (Welcome)
G0438 - PR PPPS, INITIAL VISIT
G0439 - PR PPPS, SUBSEQ VISIT

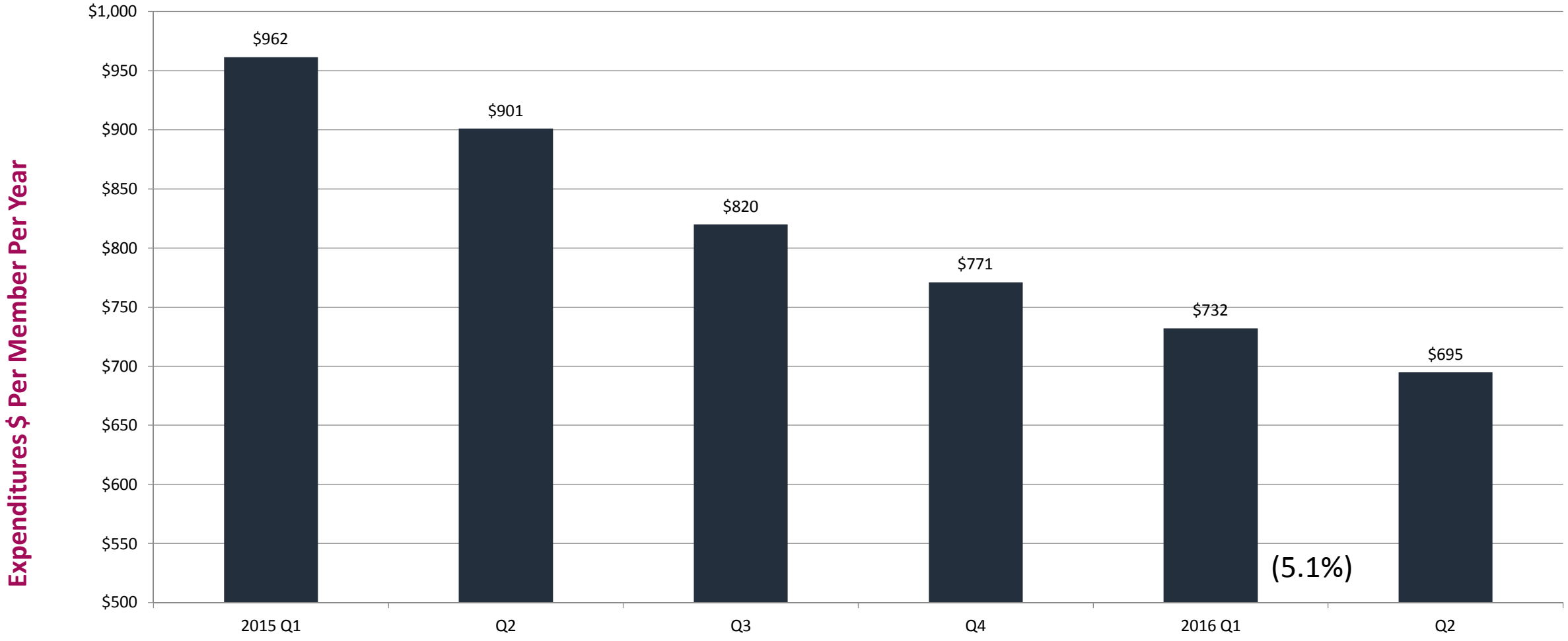


	Total Medicare Patients	"Welcome" Count	"Welcome" %	"Initial" Count	"Initial" %	"Subsequent" Count	"Subsequent" %	Next Scheduled Practice Appt Count	Next Scheduled Practice Appt %
Grand Totals:	47,458	865	1.82%	2,303	4.85%	10,320	21.75%	30,161	63.55%

We have achieved ~ 28.42%!

GOAL – 50% by end of FY 17

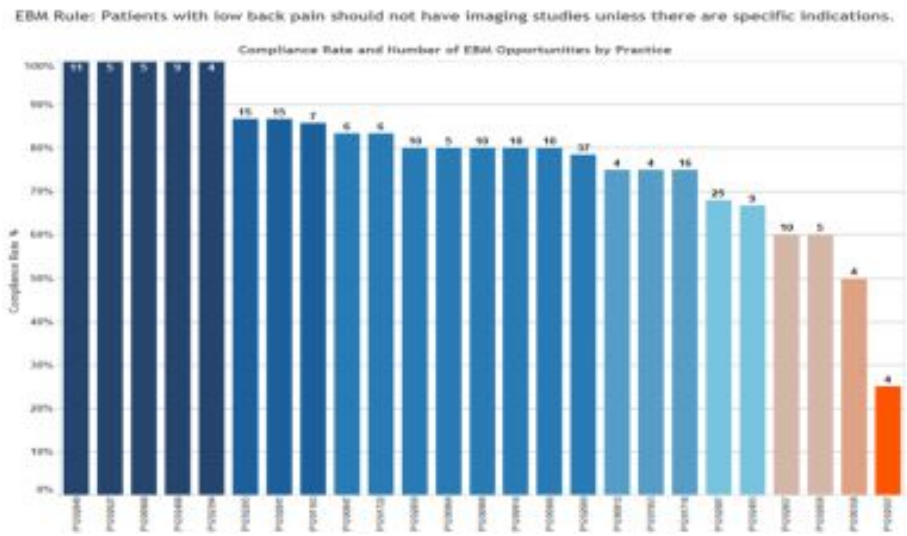
SNF Expenditures



Quarterly Reports are based on Rolling Years

Choosing Wisely®: Launched in 2012 by ABIM Foundation with coalition of medical specialty societies and Consumer Reports

- Encourages conversations between physicians and patients about overuse in health care
- Supports physician efforts to help patients make smart and effective choices
- Educational modules



Care Pattern Analyzer/Physician Network Assessment: Review effectiveness & efficiency physician panels

- Episode cost overview with drill down to drivers of variance
- Provider affiliation (group, practice, practitioner)
- Service type (facility, ancillary, professional, pharmacy)
- Benchmarking against peer groups
- Promotes discussion regarding variances in practice patterns

LVPHO
Lehigh Valley
Physician Hospital Organization, Inc.

Secure Provider Portal

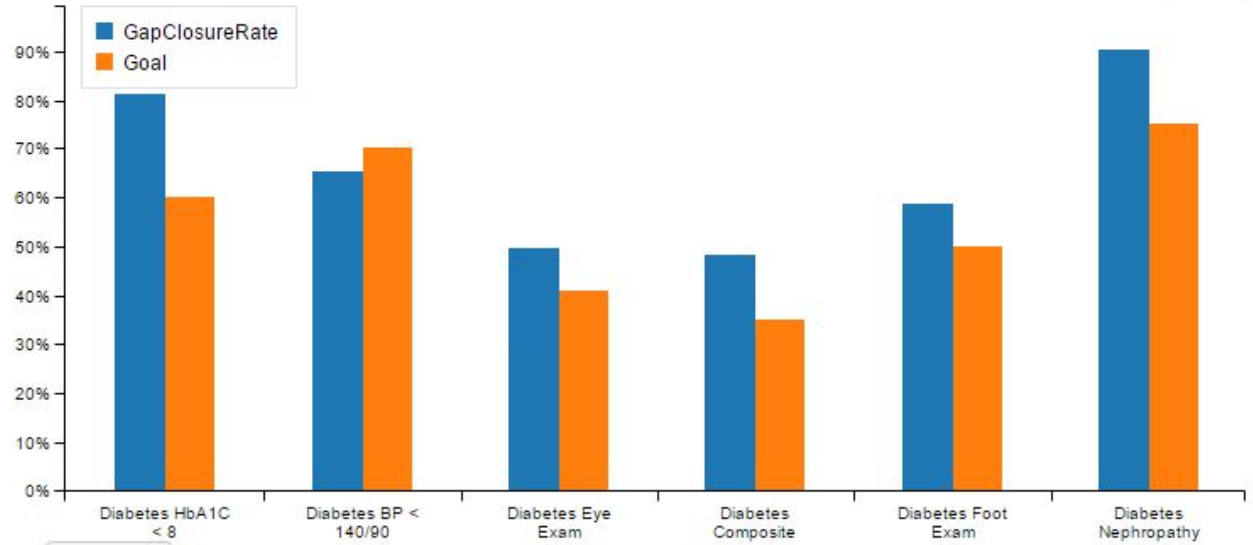
Admin ▾ npileggi ▾

ACE | CG CAHPS | Help

Current View [ ] Go

Quality Outcomes

Dashboard / Quality Outcomes



Filters

Providers:

Show 10 entries

Search:

Provider	Quality Measure Type	Quality Measure	Positive Responses	Total Responses
[redacted]	Diabetes	Diabetes Eye Exam	12	34

Key Initiatives to Improve Financial Performance

- Identification of drivers of trend to target key initiatives that improve financial performance in shared risk arrangement
- Maximize performance in quality incentive programs
- Strategies and programs to ensure proper documentation of coding
  - Case Mix Index
  - HCC
- Operationalizing bundled payment arrangements

Financial Management

Care Cost Review: Monthly process of monitoring care cost

- Review across all arrangements and drillable to the specific agreement
- Identify opportunities to improve quality and reduce cost
- View progress compared to targets and benchmarks
  - PMPM/Utilization/Cost per Unit
  - Quality Metrics
  - Trending at procedure & episode level
  - MarketScan dataset

Medical Expense Budget Dashboard

Population Health Education

Populytics Academy: Programs for physicians & administrators to provide education on topics including:

- Insurance metrics
- Clinical support programs
- Population health analytics
- Pay-for-value reimbursement
- Value of population health

Example AllSpire Dashboard

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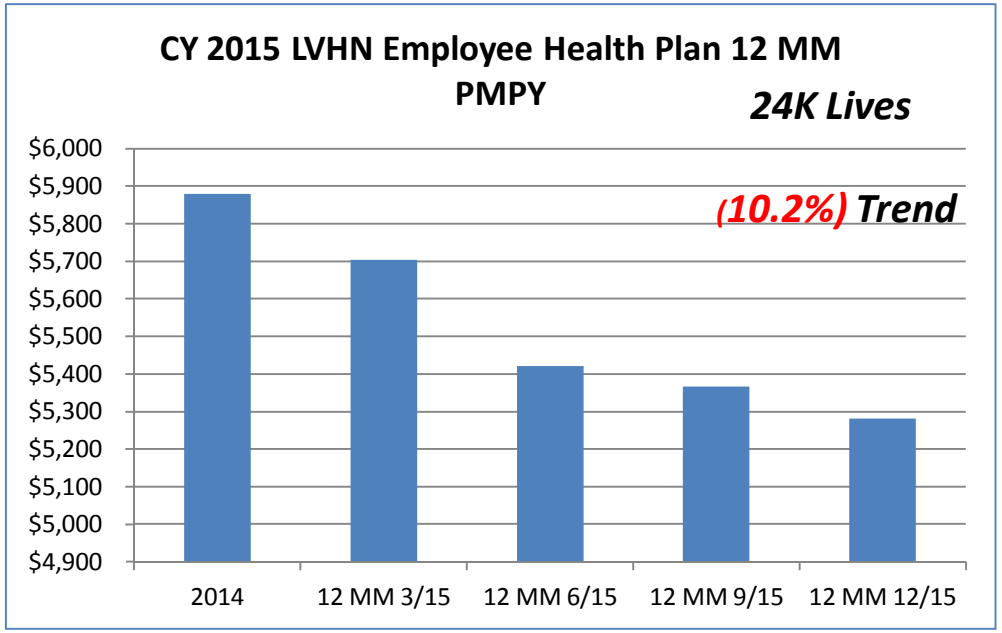
Employee Health Plan

- Set targeted PMPM as a network goal & tied to employee incentives
- Established initiatives with savings of $3.1M
- Achieved savings of over $5M



Category	12 MM Dec 2014	12 MM Dec 2015	Variance	Percent
Inpatient PMPM	$ 1,242	$ 969	($ 273)	(22%)
Outpatient PMPM	$ 1,883	$ 1,712	($ 171)	(9%)
Professional PMPM	$ 1,427	$ 1,264	($ 163)	(11%)
Total PMPM	$ 5,879	$ 5,281	($ 598)	(10%)

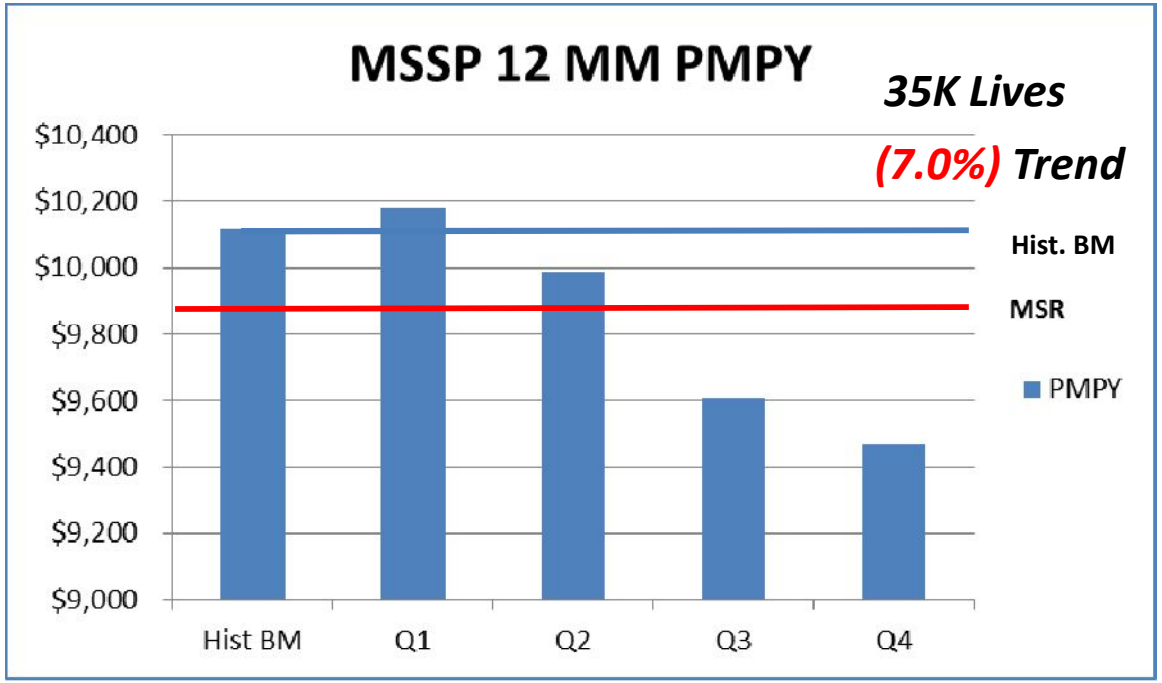
Lehigh Valley Health Network

Results

Year 1 MSSP

12 Months ended Dec 2015

- Based on CMS data received through the fourth quarter 2015
- Waiting for final reconciliation from CMS due in August timeframe



Category	12 MM Dec 2014	12 MM Dec 2015	Variance	Percent
Inpatient PMPM	$ 3,281	$ 3,014	($ 267)	(7%)
Outpatient PMPM	$ 2,064	$ 2,023	($ 41)	(2%)
SNF PMPM	$ 979	$ 771	($ 208)	(21%)
Total PMPM	$ 10,180	$ 9,469	($ 711)	(7%)
Readmissions	178/K	163/K	(15/K)	(8%)

DISCUSSION