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Value Based Care—Turning Population Health into Reality

Population Health Colloquium

March 2019

Today’s Program:

- **Population Health**—a practical definition for today’s health care landscape
- **Value-Based Payment Models**—where pop health meets reimbursement
- **Critical Capabilities**—what we are seeing all over the country
  - Advanced Integrated Care Models
  - Patient Engagement and Experience
  - IT Infrastructure and Interoperability
  - Outcomes Reporting and Analytics
- **Provider-payor collaboration**—advancing population health under value based payment models
- **Real world example**—the Carle/Health Alliance journey integrating pop health and care management
- **Q & A**

Population Health—our practical definition:

"Population health refers to health care efforts that aim to use health care resources effectively and efficiently to improve the lifetime health and wellbeing of a specific population."

The “Population Health Way of Thinking”

Population health is more than health care analytics or a new care model. It is a true and lasting shift in the mindset that determines how all the stakeholders in health care approach their work everyday.

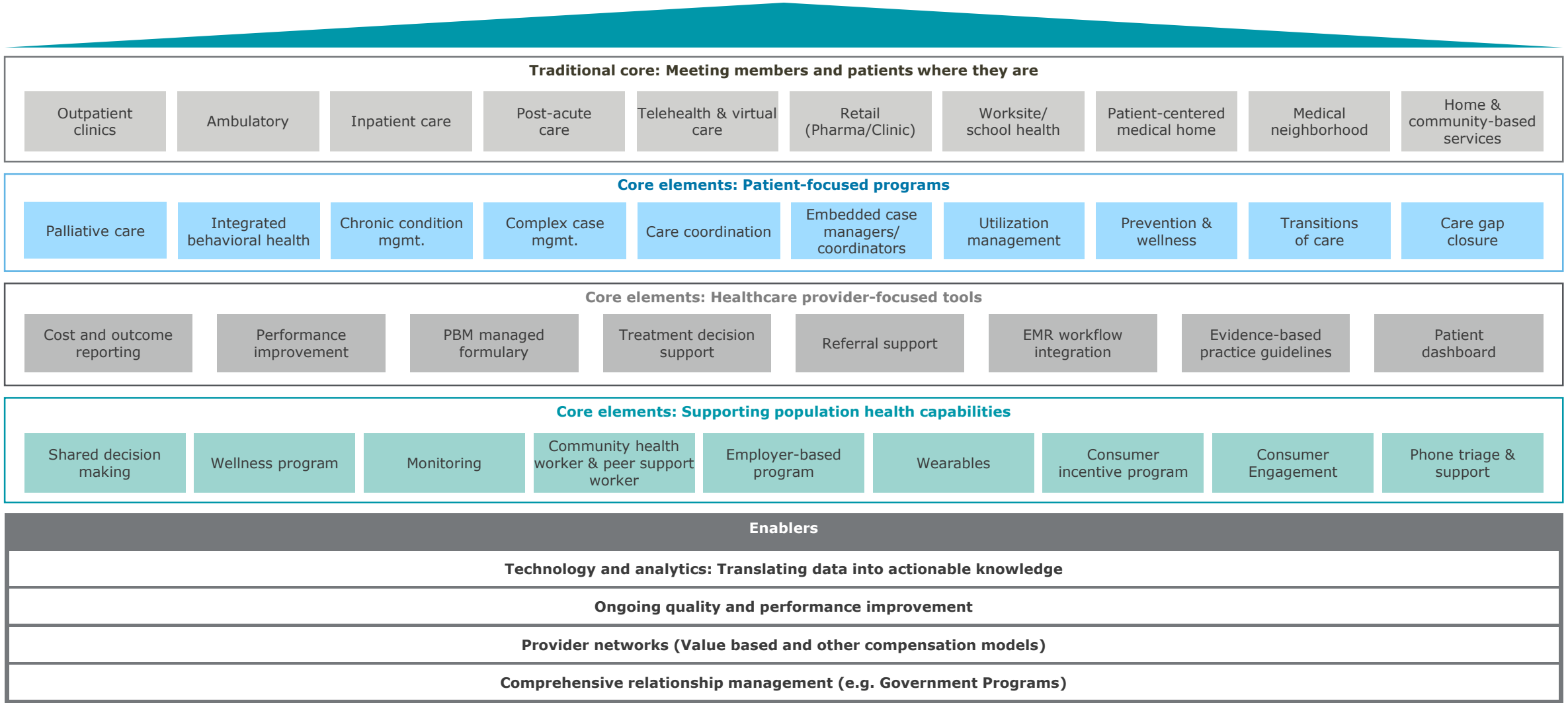
It calls for changes in behaviors and ways of thinking in health care:

- Planning and collaboration across all specialties and services to maximize overall outcomes—both clinical and financial
- Leveraging technology to improve monitoring, access to care, and communications between patients and the care team members
- Focus on the sum total of the populations’ health experience, as well as the risks and utilization across continuum of care

With the new state of mind, job of actors in the health care system is to plan for and take actions to help ensure better health for a population, both now and in the future

Access and share My Take “Defining and Delivering Population Health” at:
http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/health-care-current-october13-2015.html
Access and share Es’ Blog post ‘The new population health state of mind’ at
http://blogs.deloitte.com/centerforhealthsolutions/the-new-population-health-state-of-mind/

A comprehensive suite of capabilities is needed to support population health in a value-based care model…..but we have yet to see a health care organization with all



VBC: Where pop health meets reimbursement

What is Value Based Care?

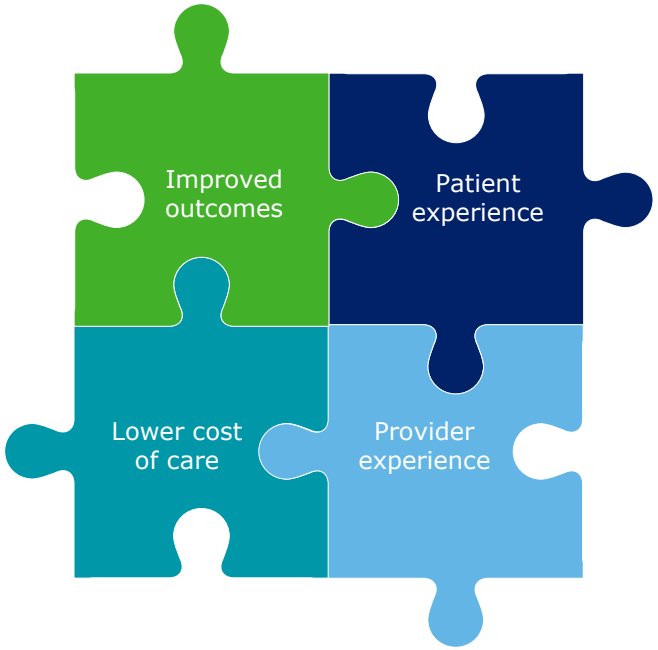
Value Based Care (VBC) is fundamentally different from fee-for-service because it focuses on outcomes, clinical integration, and aligned financial incentives to create value. VBC payment models require population health delivery models to succeed.

Outcomes focus + **Integration** = **Value**

"Pay for Volume"
to
"Pay for Outcomes"

"Fragmented"
to
"Integrated & Coordinated"

There are many VBC payment models with varying degrees of incentive alignment and integration, but ***all rely on a population health care delivery model*** to drive the desired cost and quality results



VBC payment model structures

There are many VBC payment models, each with varying incentive structures aimed to scale up the clinical integration and population health delivery approaches along with level of risk required for sustained value.

	Performance Targets	Bundled Payments	Shared Risk	Global Risk
Model Overview	• **Incentives** for meeting pre-defined **cost and/or quality** metrics • **No downside risk**	• Arrangement with predetermined reimbursements for **defined episodes** • Can include **downside risk**	• Arrangement with **upside and downside risk** within a pre-determined corridor • Members attributed to provider (typically by PCP usage)	• **Full-risk arrangement** with provider bearing the full impact of any upside or downside risk • Providers receive a PMPM for attributed lives
Success Factors	• Robust reporting and quality improvement programs	• Care coordination • Physician engagement	• Integrated data and analytics • Network and incentive alignment	• Population health management • Leading patient engagement tools • Financial performance mgmt.
Market Examples	• P4P • PCMH	• CMS BPCI	• Pathways to Success (formerly Pioneer ACO/MSSP) • Partial capitation	• CMS PACE programs • Global capitation

Increasing Level Of Risk & Population Health Capabilities Required

Critical Capabilities for Pop Health

Core components to delivering population health in a value based payment model

Leadership, Governance, and Talent

Good relationship, governance and ways of working between the Ministry of Health, Department of Health, LHDs and PHNs, providing a collaborative platform. Strong leadership and direction from MoH

Outcomes reporting and analytics

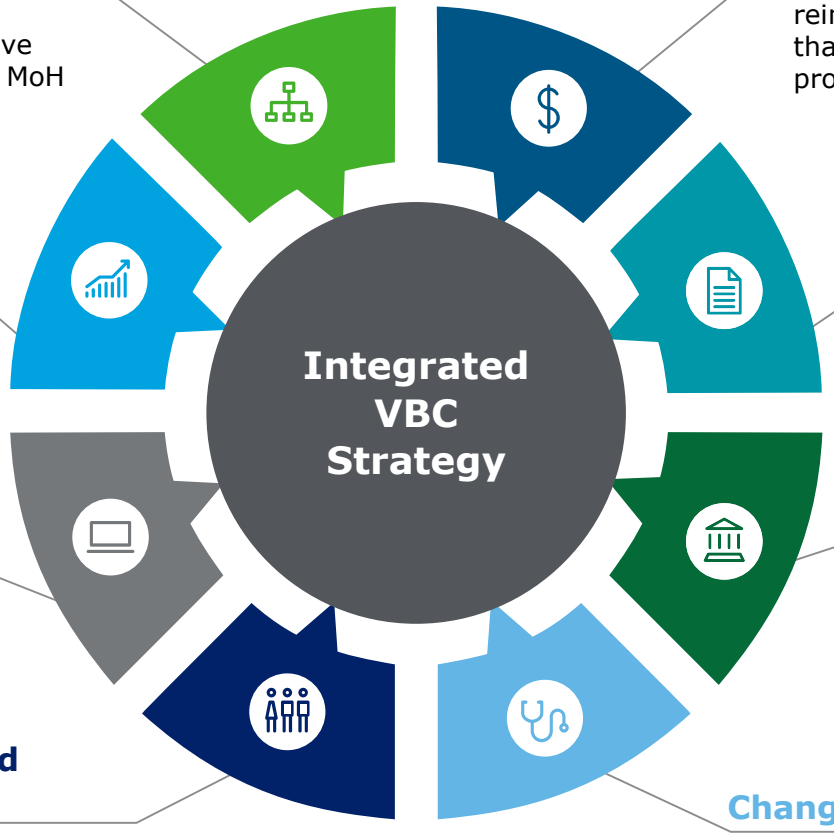
Develop the information connectivity, infrastructure, analytics, information governance, and workflow tools to enable coordination of care and report on outcomes

IT infrastructure and interoperability

Engage clinicians in designing, developing, and using care improvement initiatives, inform leading practices across clinicians, and monitor quality and cost performance

Patient experience and engagement

Patients have the tools and capabilities to self-manage, combined with active patient cohort care management.



Funding models and financial incentives

Design & implement payment models that reimburse for the full cycle of care and policies that enhance transparency, reduce costs and promote clinician buy-in

Advanced Integrated care models

Organise case around patient medical conditions and/or distinct patient segments underpinned by coordinated care

High Performing Provider Network and business models

Provider collaboration is formalized through defined provider-payor collaboration or integration

Change management

Engage clinicians in designing, developing, and using care improvement initiatives to inform leading practices across clinicians, and monitor quality and cost performance

Critical Capability #1: Advanced Integrated Care Model

Renewed focus on care model design and delivery

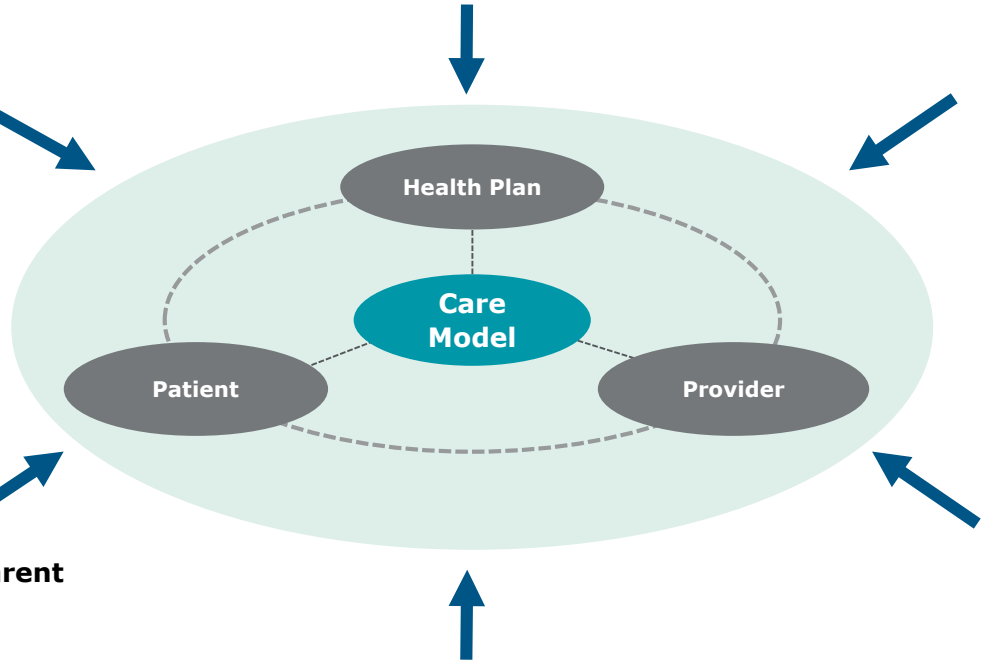
Health Plans are **seeking additional effective** and efficient population health solutions due to market forces

Unsustainable Costs

Payers are continuing to **push for reduction in medical costs** through **effective health management** of whole populations; especially for **senior chronic populations** that represent a significantly higher proportion of costs

Digital & Analytics Advancement

Rapid advancement of analytics, digital and advanced interoperable technologies creates a **significant opportunity** for **enhancing identification** of care needs and the related care planning/coordination



Existing Gaps in Foundational Capabilities

Most providers and health plans still have **gaps in foundational care management capabilities** that need to be addressed; can provide opportunities to **leverage strengths of providers and health plans**

Consumerism

Patients demand **care that is transparent** with "no surprises", cost-effective and creates a **trusted patient-provider relationship**

Increasing Regulatory Pressures

Expanding membership in the individual insurance market creates **significant pressures** on **demand for Care Management**; in addition, new government regulations (e.g., MACRA) increase the **focus on quality and outcomes**

VBC Transition

Increasing percentage of risk business is forcing provides and health plan partners to **design care models** that focus on **quality and cost effectiveness**

Care management process

The optimum lifecycle of care

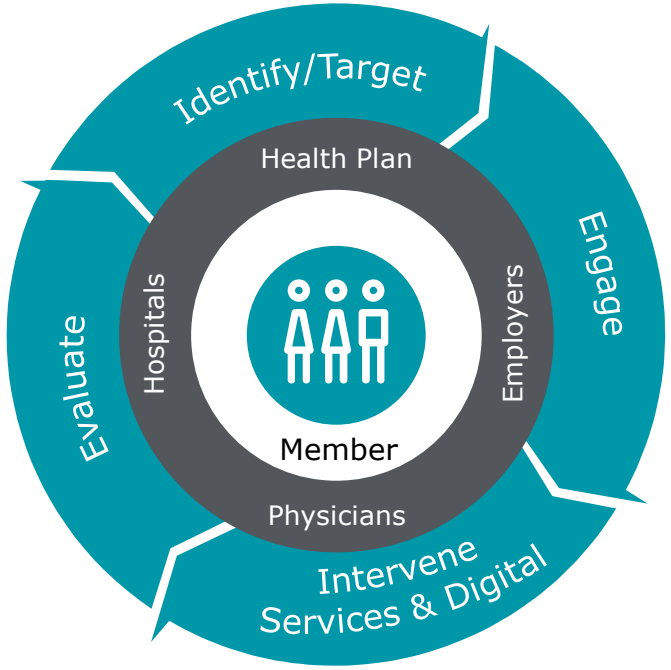
The Care Management Process has four key steps that need to be supported for any program

Utilize data to identify high cost and high risk members and stratify the population

- Triggers
- HRA
- Comprehensive assessments
- Predictive modeling
- Claim Pattern Recognition.

Ensure interventions/programs are continuously measured and evaluated to meet needs and realize benefits

- Operational metrics
- Clinical outcomes
- Program effectiveness & Efficiency
- Quality metrics
- Overall financial reporting.



Engage and enroll members and providers; promote accountability for care

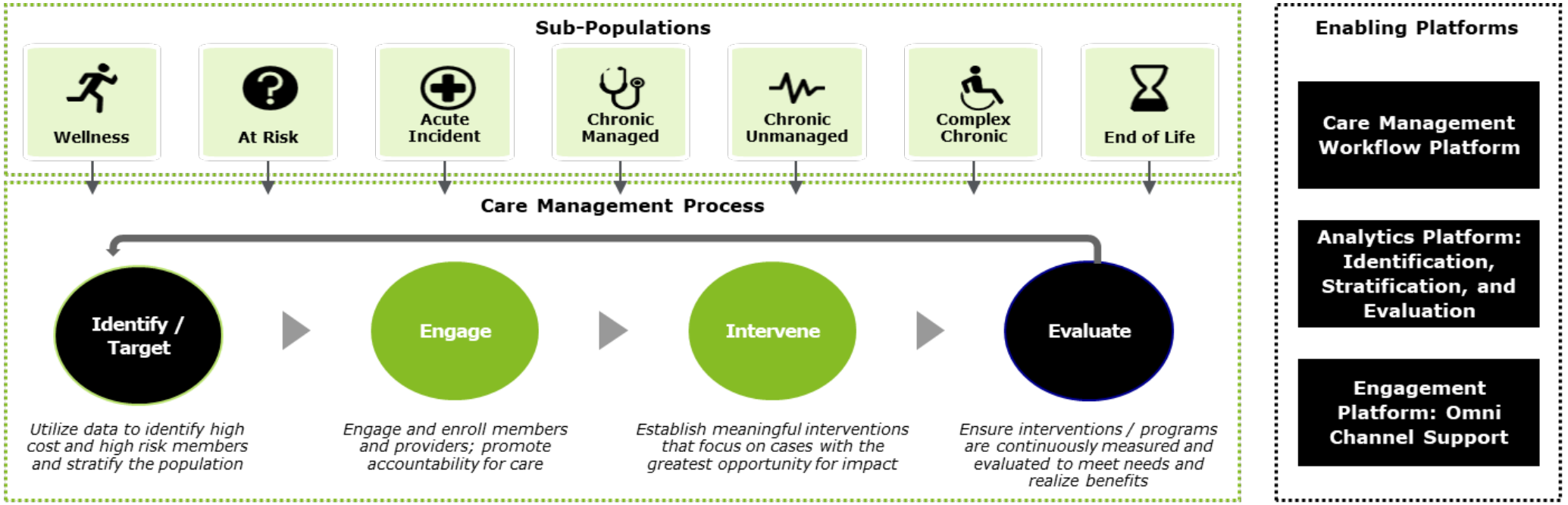
- Outreach tools and approaches
- Web based and educational tools
- Digital engagement
- Aligned with provider incentives
- Use of outreach programs
- Consistent approach to using plan design and aligned to incentives.

Establish meaningful interventions that focus on cases with the greatest opportunity for impact (high volume, high variance, high cost, high modifiability)

- Case Management
- Disease/Chronic Condition Management
- Integrated mental and medical health
- Education
- Steerage-informed decision making
- Wellness/Well-being.
- Digital Interactions
- Member portals
- Virtual sessions
- Wearables & Remote Monitoring
- Targeted UM/Auto authorization.

Population Health Interventions Depend on Integrated Data and Platform

In a modular-based model an organization **leverages a single workflow platform and analytics methodology** (for ID, stratification, and evaluation) but can **customize engagement and intervention approaches** for each population



ID & Strat algorithms may be unique to specific sub-populations, but should be run off a single integrated platform

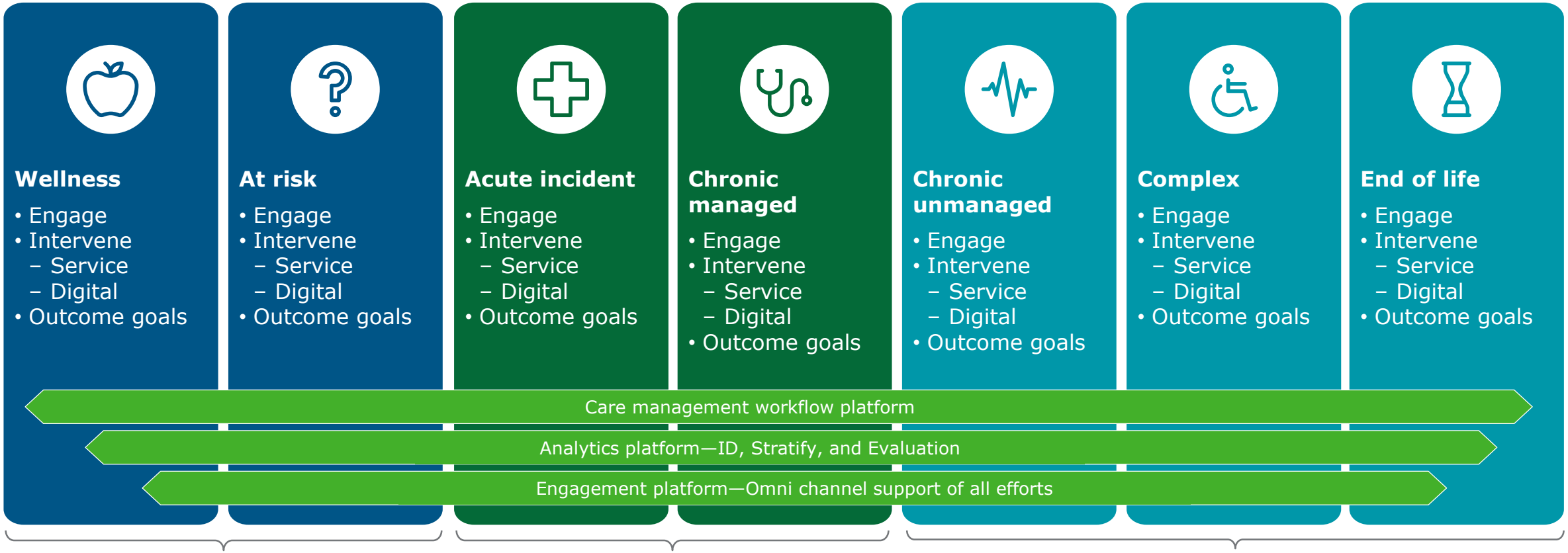
The socio, economic, and community dynamics of a sub-population will impact the details of a program's approach. The individual member's personality, behavior preferences, and life experiences will change how the member should be engaged and what format of an intervention will be most impactful

Every program should have similar outcome goals and standardized approaches for outcome measurement, including common vocabulary and explicit measures

A single workflow and analytics platform allows an organization to gain enterprise knowledge of how to best leverage the tools in which it has invested

Customization Layer Standardization Layer

The basic clinical program components are still important



81.3% Rest of the Population (81%)

Focus on prevention and at-risk support.

Increased behavior modification and screening.

16% of Members Driving 40% of the Costs

Decrease episodic care support

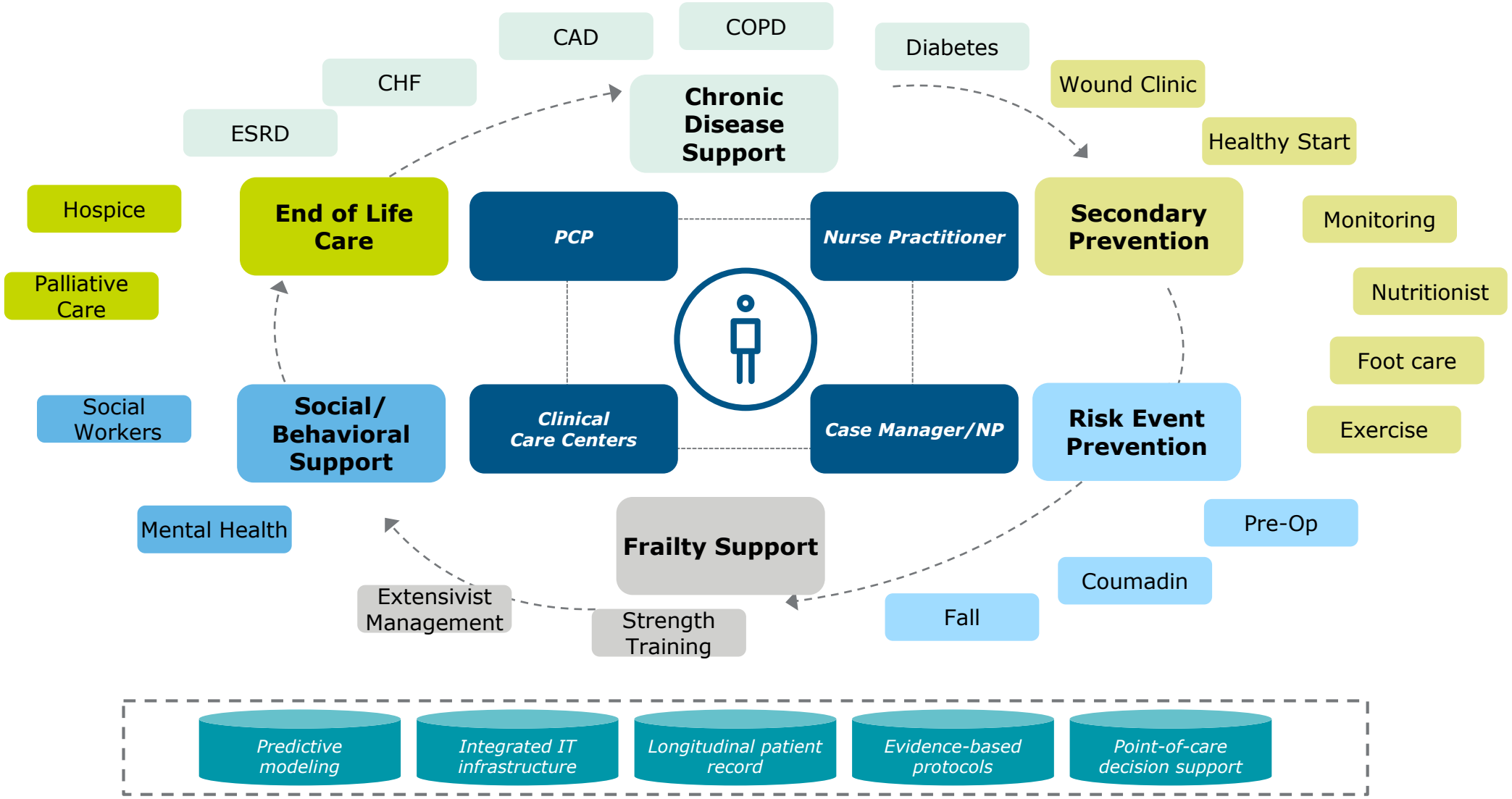
Increase continuum of care support; targeted chronic/disease interventions and engagement of members and providers.

2.7% Members Driving 41% of the Costs

High risk care management

Increase channeling of members to appropriate transition of care, providers and levels of care.

A Comprehensive Model of Care for A Medicare Population



Sample Medicare Client —Member Needs

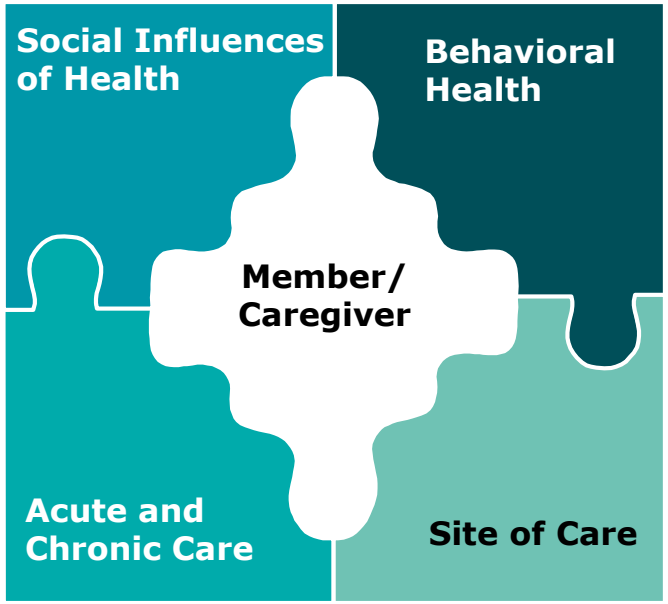
Our sample client operations cover a wide range of member complexities which require a comprehensive approach to member and patient management. Fundamental to the client model is wrapping a set of services around the member that are coordinated and managed. The client's interventionist and care delivery model enable a unique care management experience for the member.

Social Influences of Health

- Incorporate social services and address social issues in the care management approach
- Augment health system support with social workers, community-based service providers, health homes, adult day care, homeless shelters
- See caregivers as an extension of the care team

Acute and Chronic Care Management

- Take an interventional approach to prevent future member health needs
- Prepare to manage a higher prevalence of chronic, co-morbid patients with poly-pharmacy
- Develop evidence-based care plans with goals and proactive interventions, socialize regularly across team particularly after events
- Integrate traditional primary care, utilization, case, and disease management and provide direct primary care while coordinating with external PCPs
- Broaden management risk stratification models and reassess continuously and focus on members difficult to find due to behavioral and social complexity



Behavioral Health

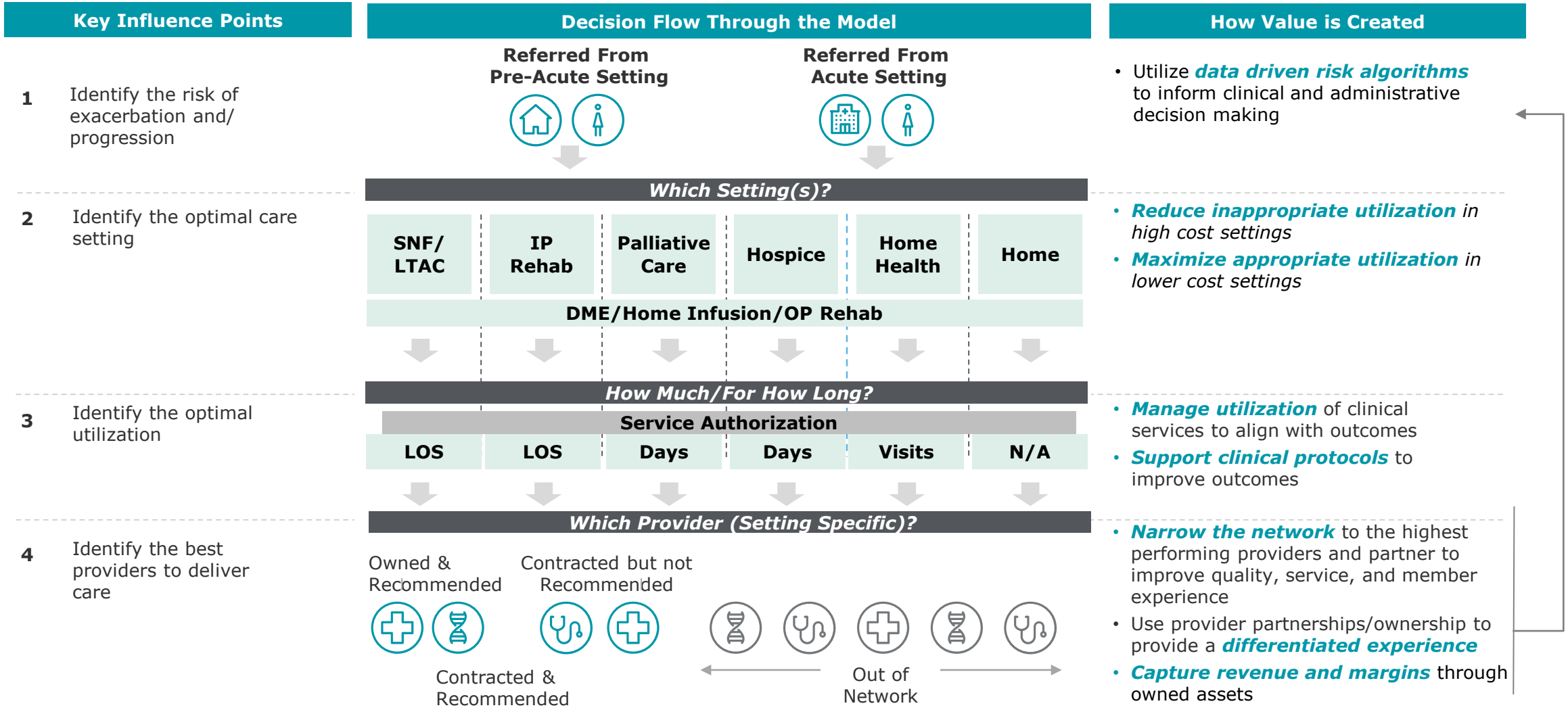
- Integrate access to mental health and substance use services with traditional primary care and other specialty care (interdisciplinary care teams)
- Behavioral health is core to the program
- Maintain partnerships with community-based and county-level agencies (i.e., county clinics)
- Integrate and provide direct access to behavioral health and substance abuse care and coordinate with external PCPs

Site of Care

- Coordinate home care, group home care, skilled nursing facilities, and community-based services when needed
- Better enable home care and allow member to stay safe at home
- Aggressively manage facilities-based patients with pre/concurrent/post-discharge planning
- Wrap in transition of care across settings to manage care to the right site (institution vs. home)

Post Acute Care

Organizations are increasing focus on Post Acute Care to manage cost and utilization and improve clinical outcomes



“Social Determinants of Health” (SDoH) are seen as an area of opportunity

Where & When SDoH are addressed

Wellness ***Preventive care*** ***Sick Care***

SDoH as part of broader engrained social issues

SDoH as part of prevention/addressing rising risk

SDoH as part of treatment

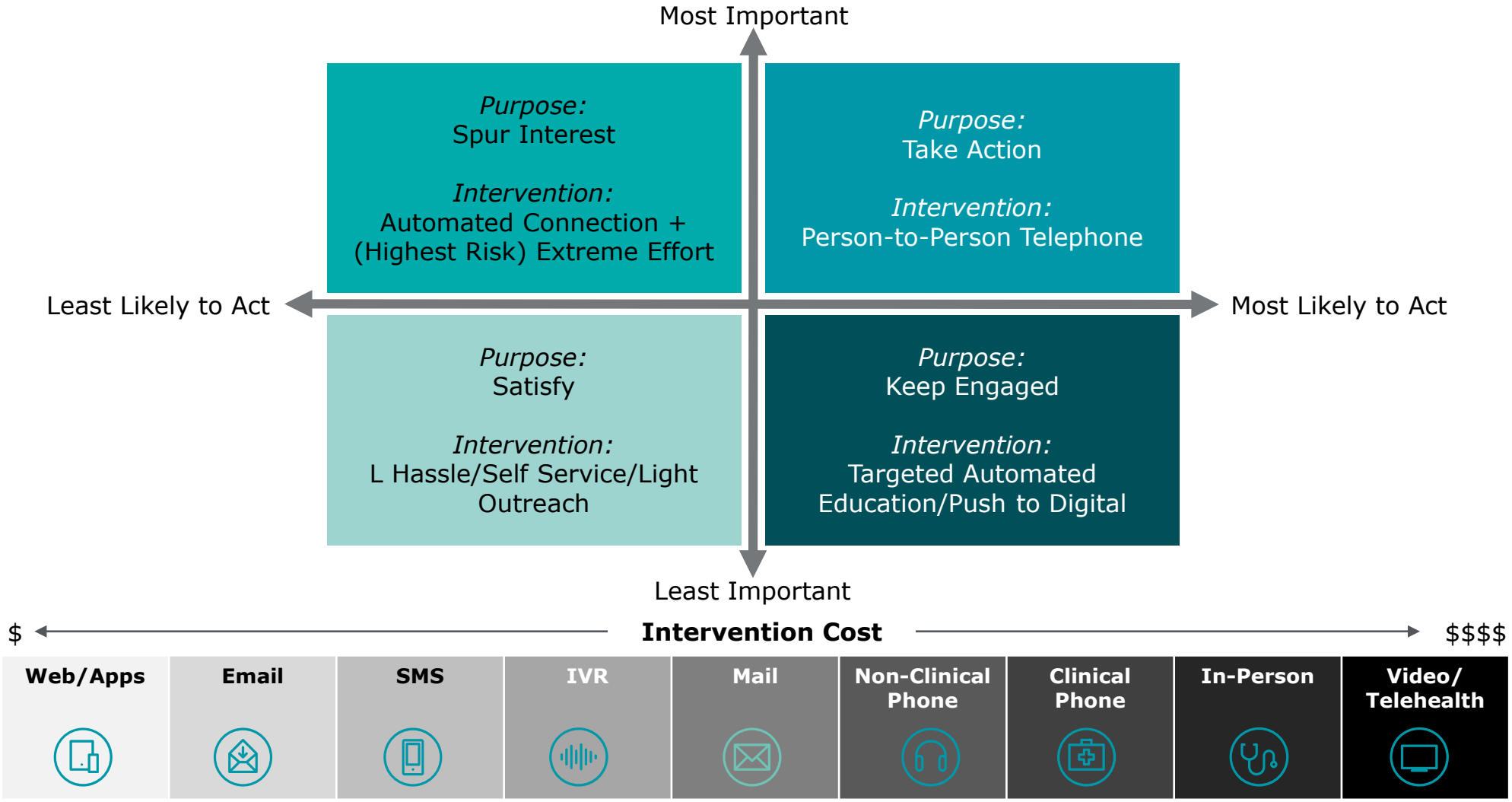
What role Deloitte can play

Analytics	Technology	Strategy	Operations	Partnerships
• Population level data/“hot spots” • Predictive analytics • Measuring impact & outcomes • Actuarial analysis	• Creating tools and engines • Integrating efforts with existing systems • Implementing novel solutions	• Identifying where SDoH play in an organization or state agency • Creating path to address identified issues • Financing of efforts	• Designing efforts to address SDoH • Implementing programs • Identifying and managing vendors/partnerships	• Develop comprehensive solutions • Identify and develop innovative partners for clients • Assist in stakeholder engagement

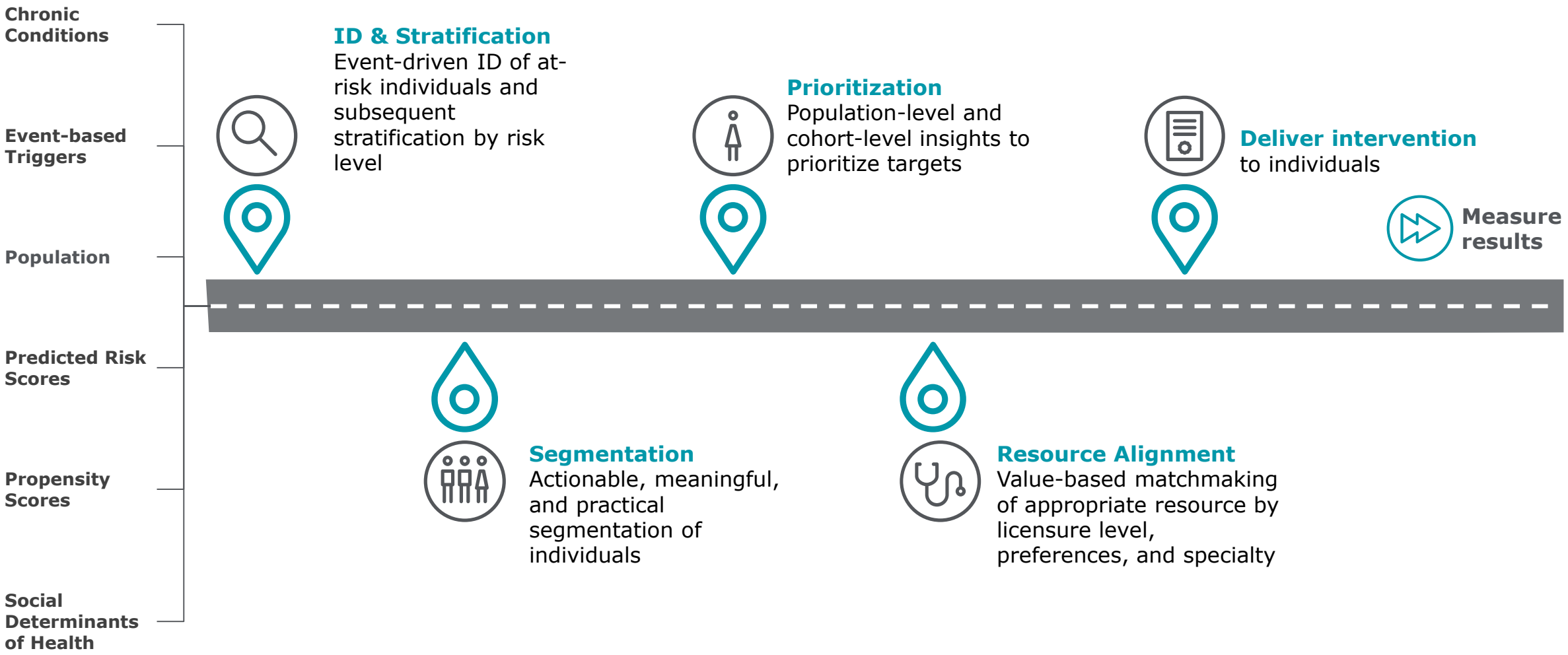
Critical Capability #2
Patient Experience and Engagement

Patient/Member Engagement—How fancy/how effective?

Engagement strategies should seek to balance the goal of "engaging" the individual, the "predicted risk/cost" of the individual, and the likelihood to impact with the expense to implement.

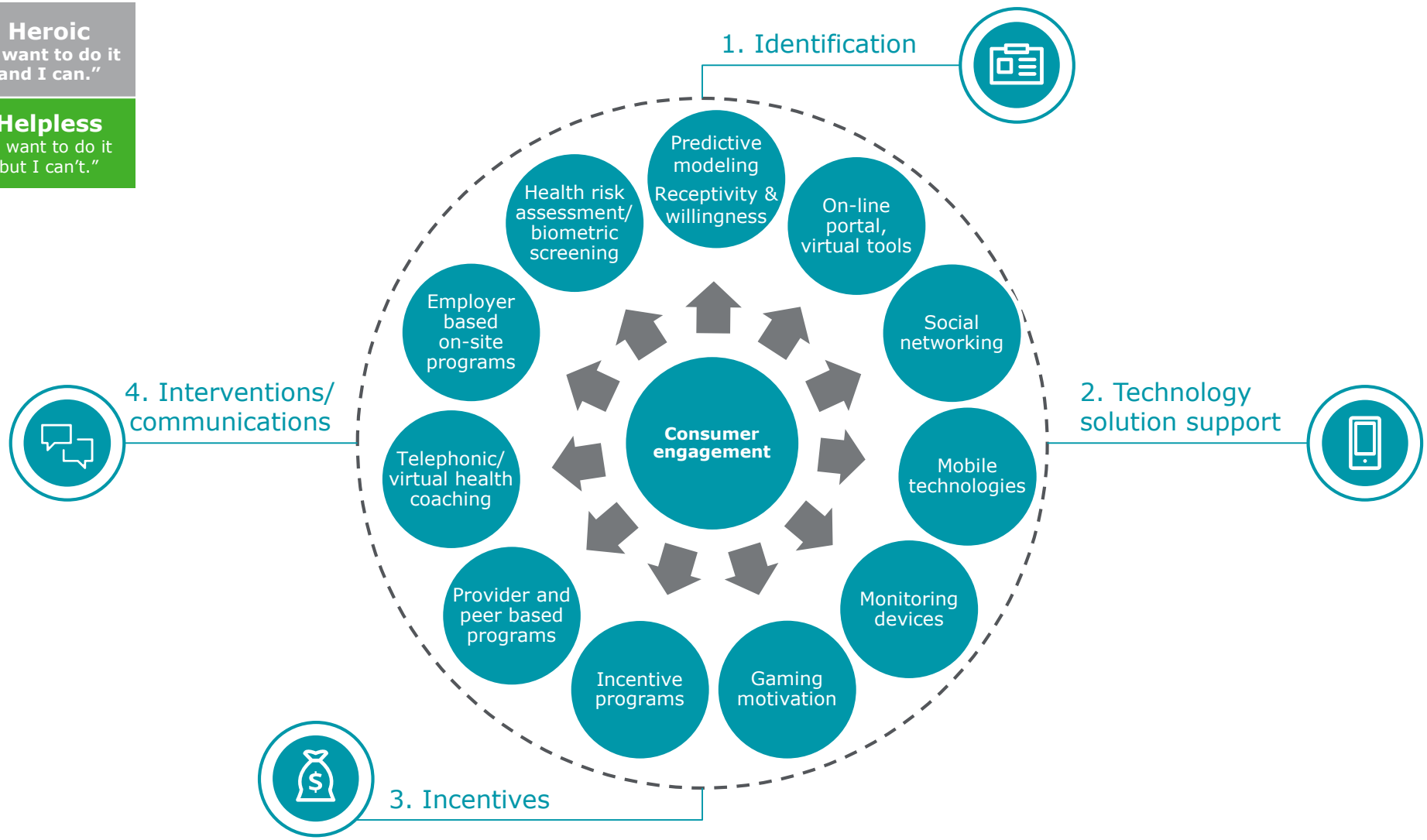


Identification, Segmentation, and Prioritization is not an "end in itself"; it must support resource allocation and result in measurable outcomes



Patient Engagement includes an increasing array of data inputs and delivery channels, leveraging payer, provider and employer partnerships

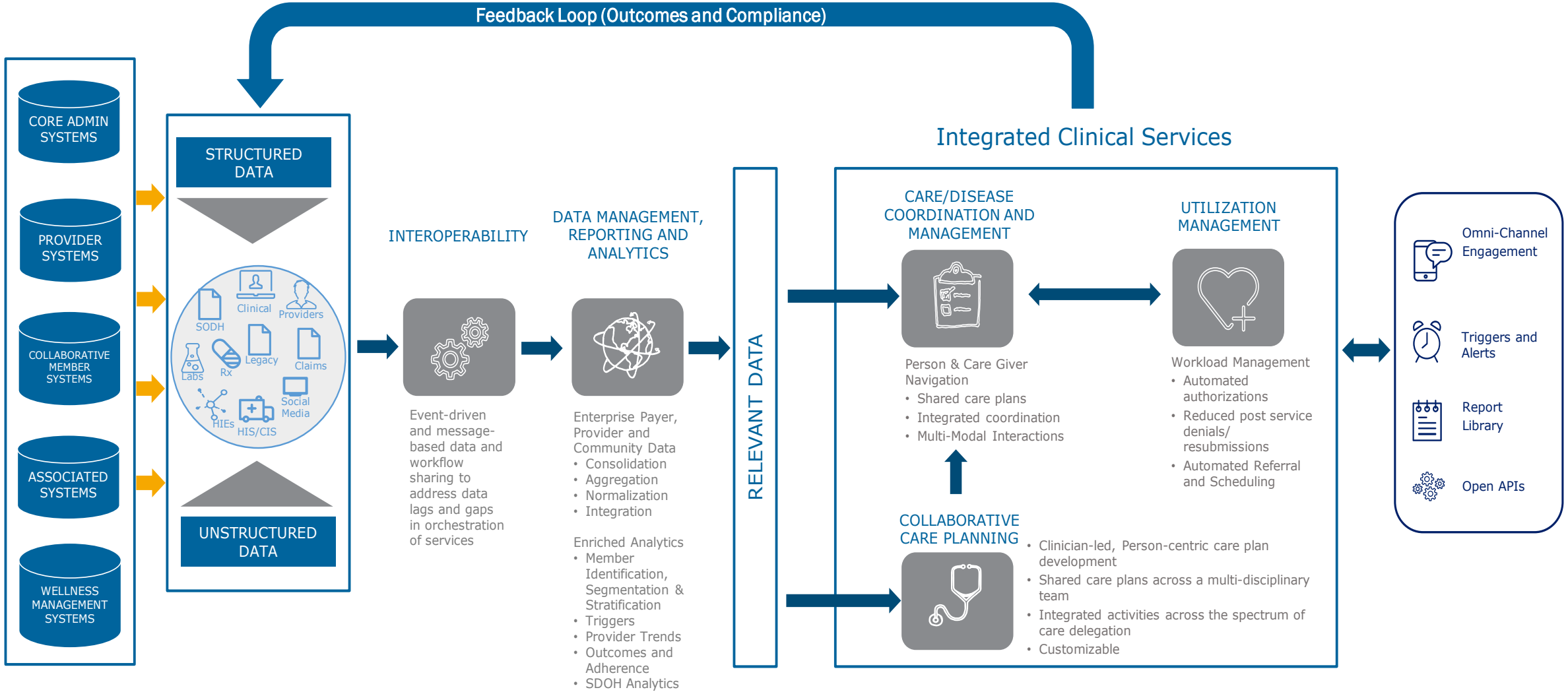
Haughty "I can do it but I don't want to."	**Heroic** "I want to do it and I can."
Hopeless "I can't do it and I don't want to."	**Helpless** "I want to do it but I can't."



Critical Capability #3
IT Infrastructure & Interoperability

Capabilities of High-Performing, Clinically-Integrated Care

Clinically-Integrated Care requires an interoperable Health IT and Data Analytics architecture…



“Person 360”

A Comprehensive Person View is orchestrated by the aggregation of disparate attributes, ranging from static master attributes to dynamic transient attributes

Master Person Attributes

The most static, identifiable person-related information:

- D.O.B.
- Address
- Demographics
- Socioeconomics
- Coverage status
- Contact information & permissions
- Relationships & family
- Xref IDs (ECI, eUID, eMPI)
- Social network IDs

Transient Attributes

Encounter-specific information:

- Communication channel
  - In person
  - Self-service portal
  - Telephone, text
  - Social Media
- Communication location
  - Site of visit
  - Digital footprint
  - Telephonic footprint
- Time of communication
- Personalization Attributes from cookies and other forms

Associated Attributes

Supplemental person information from external sources:

- Clinical summary
  - Procedure history
  - Medications/Labs
  - Chronic conditions/Allergies
  - Mental health attributes
- Financials
  - Referrals/Authorizations
  - Utilization
- Care Team
  - Primary care provider (NPI)
  - Community support services
  - Personal care partner(s)
- Engagement
  - Communication frequency
  - Outreach history
  - Touch history

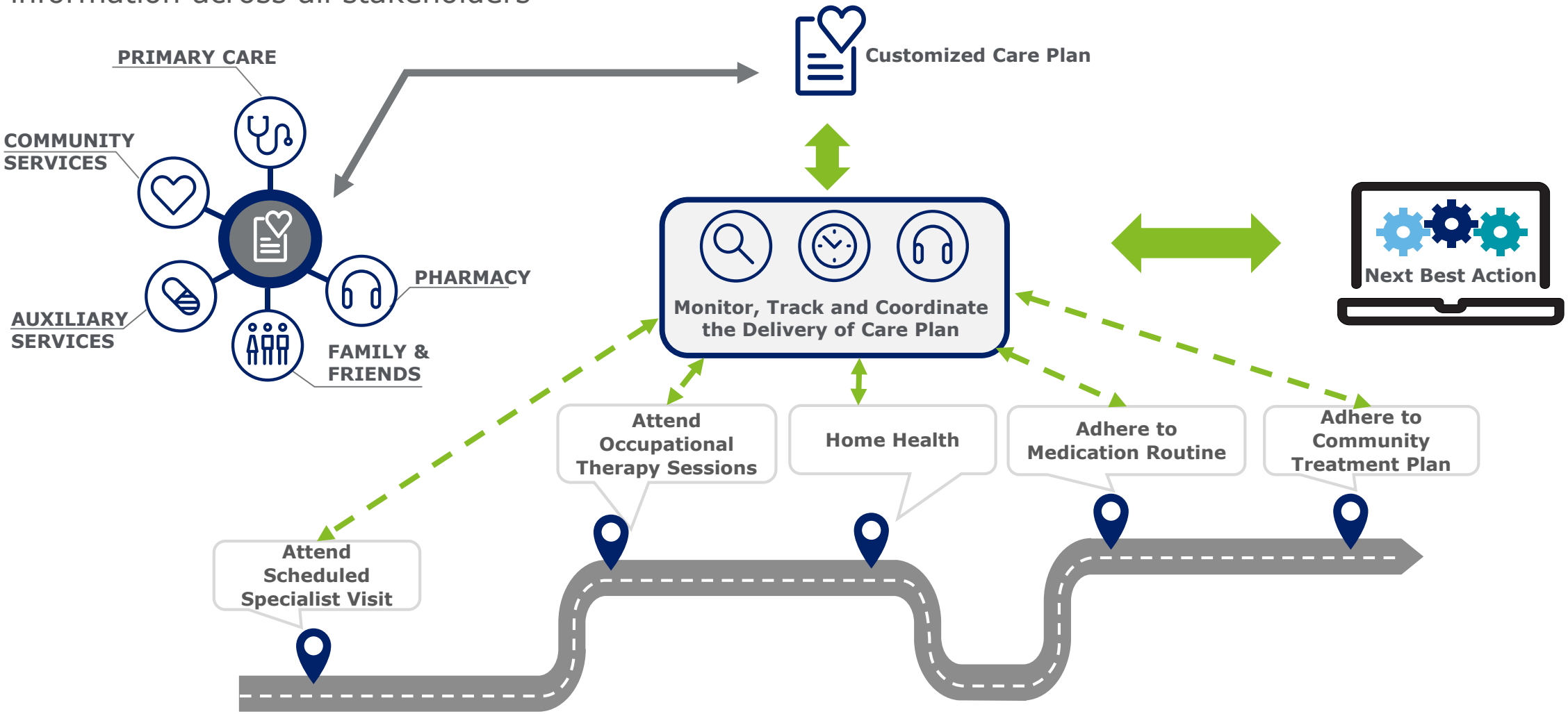
Derived Attributes

Analytics-derived, actionable, person-centric information:

- Risk scores
  - Clinical
  - Cost
  - Social needs
  - Socioeconomic
- Gaps in care
- Change propensities
- Communication channel propensities

Integrated & Customized Care Plan

Integrated, customized care plans/pathways, shared with all health partners, matching need with level of support to determine the 'next best action'. This capability enhances the product/services by disseminating information across all stakeholders



Connected Care Options leading to "Virtual Care"

Real time electronic connections between the person and caregivers necessary to enable seamless delivery of care across the continuum and to enable pre-emptive care management and "self management"

Remote Tracking & Care Management

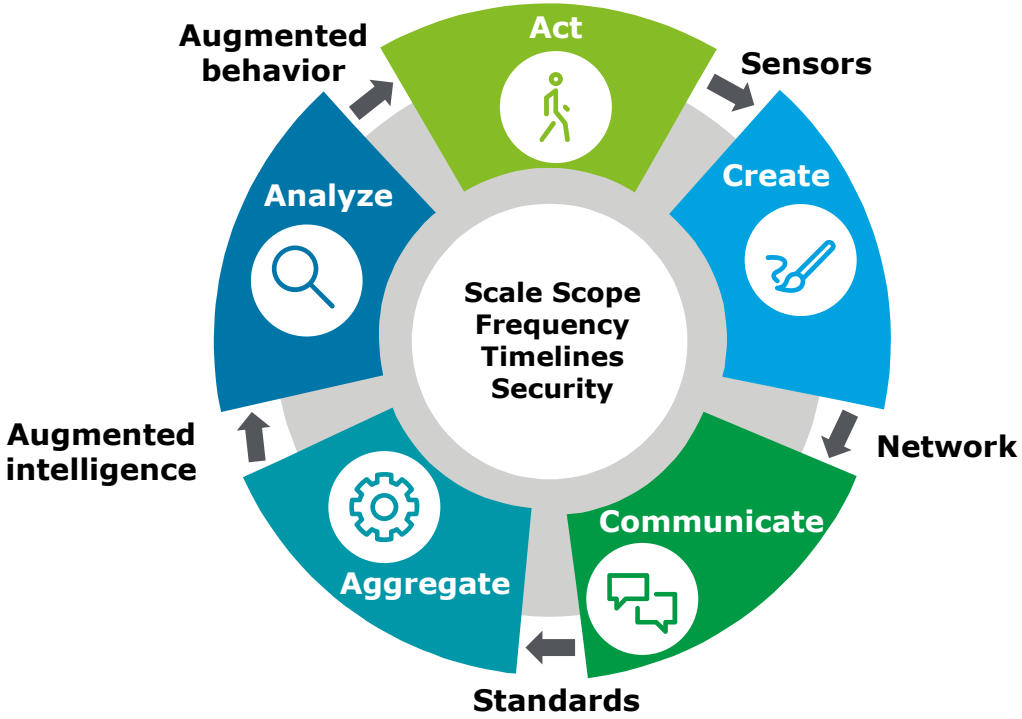
Use IoT tools to incorporate data into decision making and remotely manage and provide care

Connected Monitoring

Using wearable devices, track conditions of consumers and compare personal baselines to real-time monitoring of vitals, treatment compliance, and notify the care team members to defined threshold breach

Real Time/Predictive Analytics

Conduct real time dashboarding and analytics to monitor members enrolled in specific programs provide data-driven insights



Medical Device Tracking

Track and locate shared assets in real-time, including defibrillators, ECGs, beds, etc. Provide security by limiting, tracking and auditing the access to the medical devices

Medical Devices of the Future

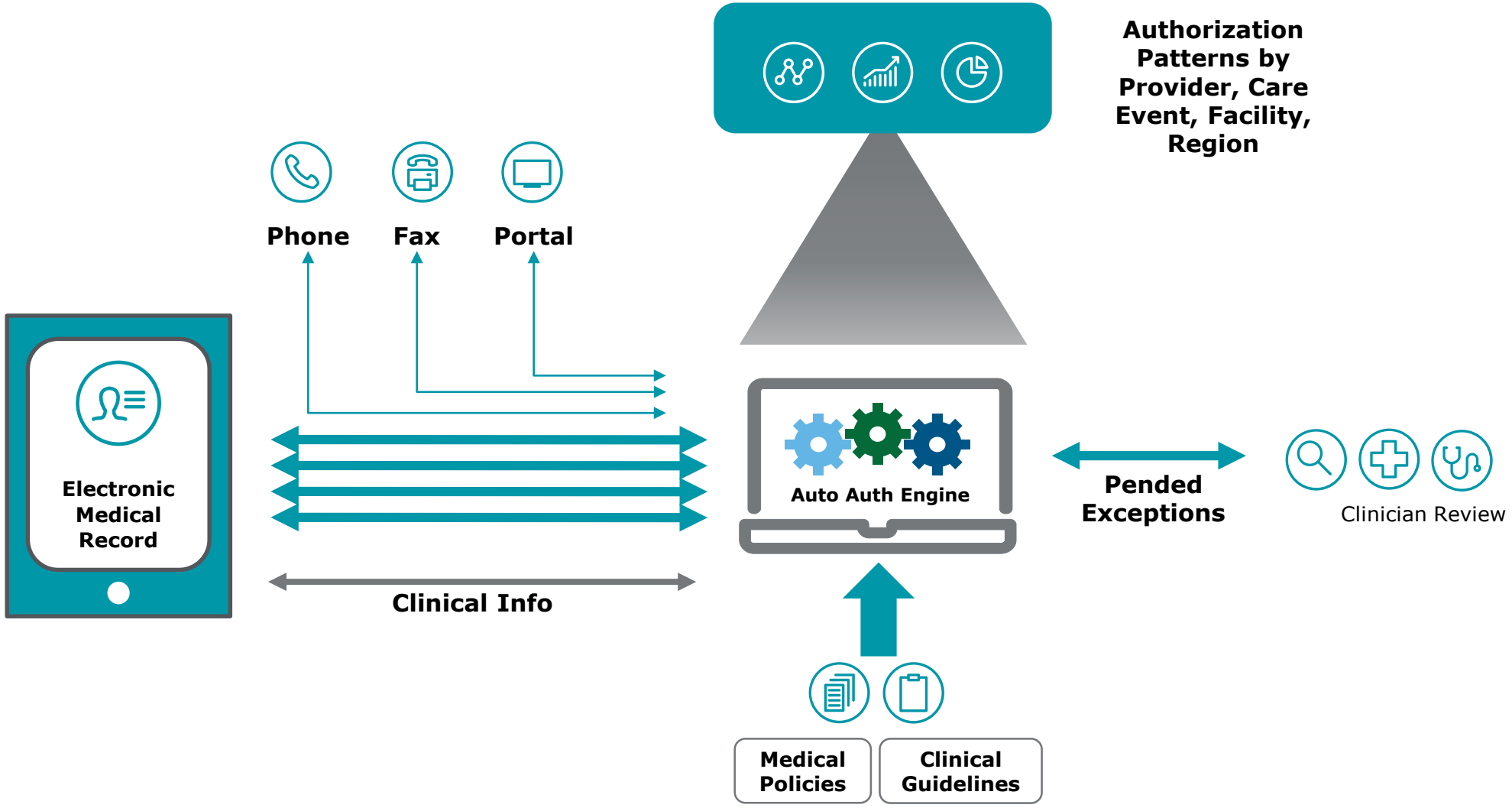
Track condition, part, and system failures and optimize operating performance for better availability, care, and outcomes

Virtual Care

Establish real-time, video connections between members and caregivers for primary consultation, follow ups and/or secondary or specialized consultation

“Exception-based UM” to reduce administrative burden

Evidence-based automated authorizations. This UM model utilizes advanced analytical and interoperability capabilities to drive real-time, event-based automated decision making



Critical Capability #4
Outcomes, Reporting, and Analytics

Performance and Outcomes Measurement

Clinical, operational, market, and financial analytics delivering actionable information, embedded in all areas of care, and accessible by all stakeholders through their lens

Cost & Quality

Improve target identification accuracy to ensure coordination of timely, H quality care management

Program Management

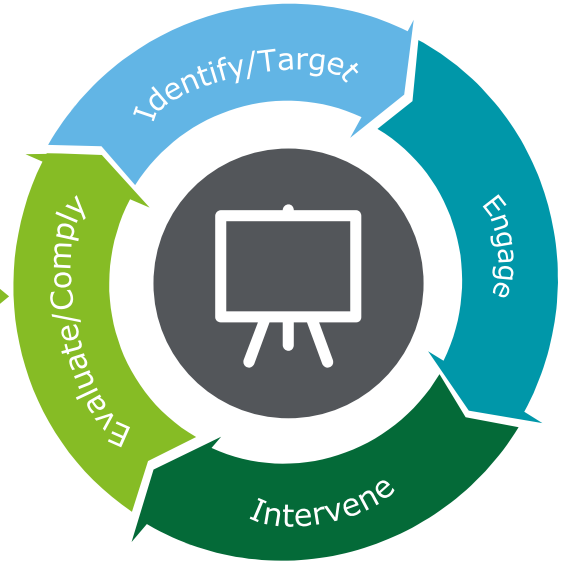
Using process and outcomes data to improve overall program performance through learning iterations

Business Operations

Visibility into operational metrics (productivity, case load, external factors) from multiple levels and roles to enable not only productivity monitoring but also 'escalation based workflow' for aged items

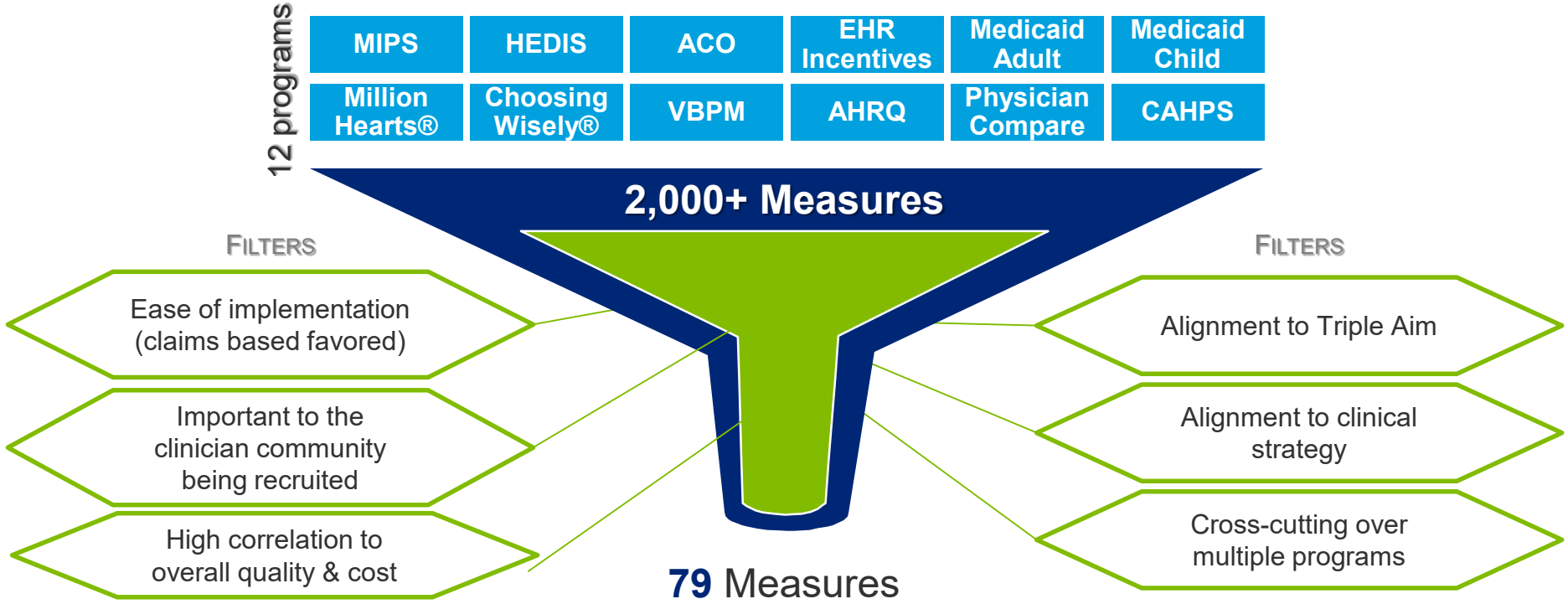
Consumer/ Caregiver Satisfaction

Measuring the key constituents including satisfaction of the consumer and the provider and using the data to drive future decisions



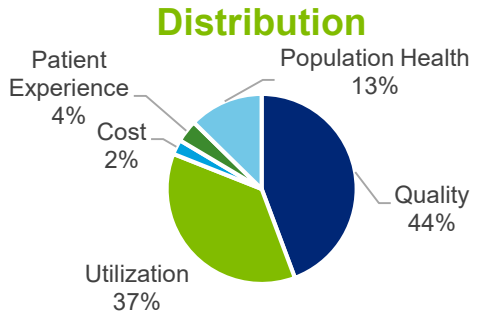
Client Case Study: Measurement is critical, but must also be reasonably operationalized

After opting in to 12 VBC/Pop Health programs, a provider had more than 2,000 unique measures. These were analyzed against a filtering process by plan and provider physicians with the goal of reducing to a manageable volume of impactful measures applied to programs.



Summary of Selected Measures

- Includes all 8 Million Hearts® measures
- Includes all ACO measures
- Includes 22 MIPS measures
- Contains 2 “wish list” measures (highly impactful but not currently reporting)



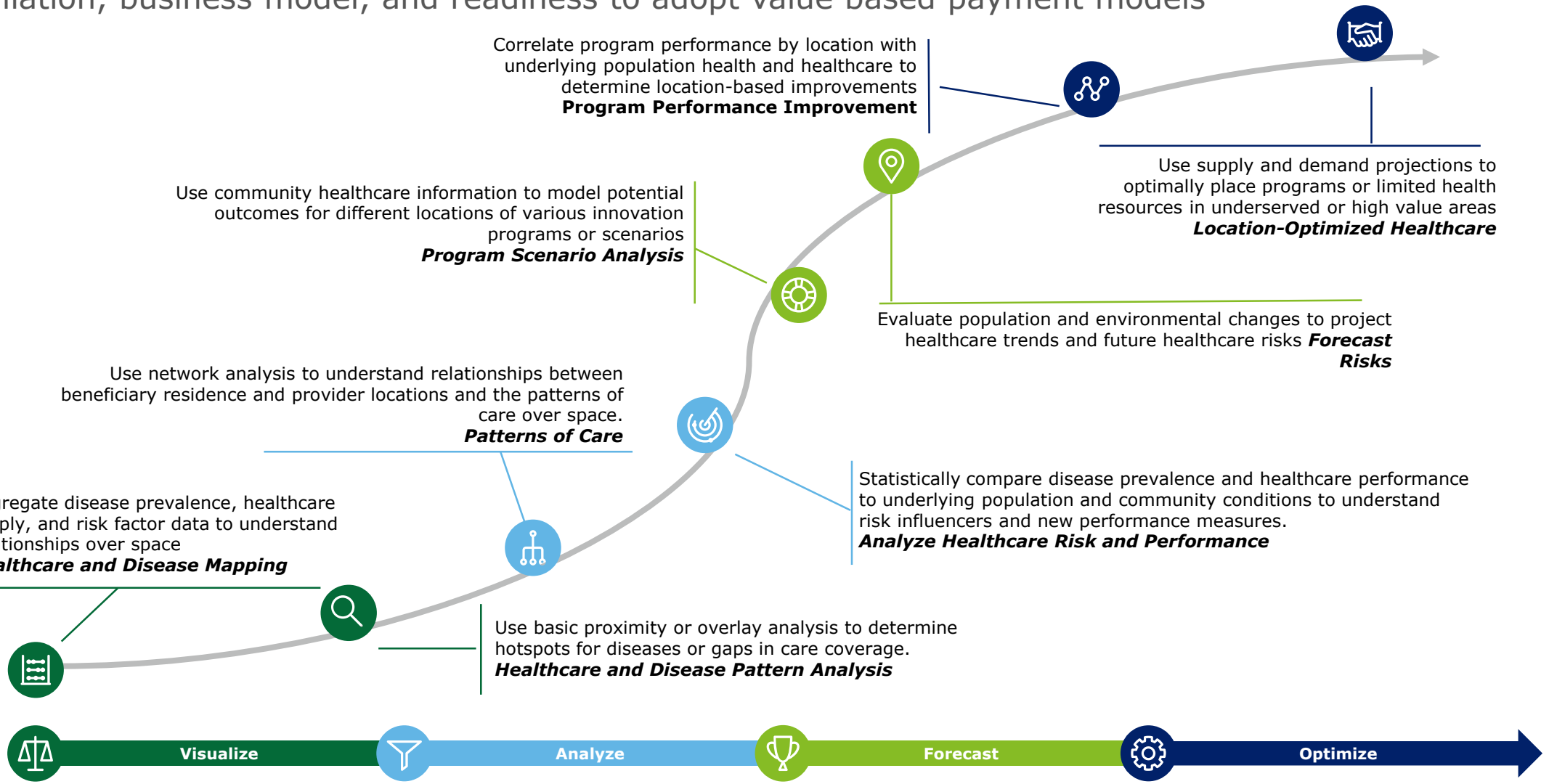
Subsequent Steps

- Reviewed with specialists to ensure applicability beyond primary care
- Met with Decision Support to confirm claims-based reporting capabilities
- Circulated final set of ~50 measures for clinical buy-in
- Established committee for monitoring, performance improvement, and refresh as needed

Provider/Plan Collaboration

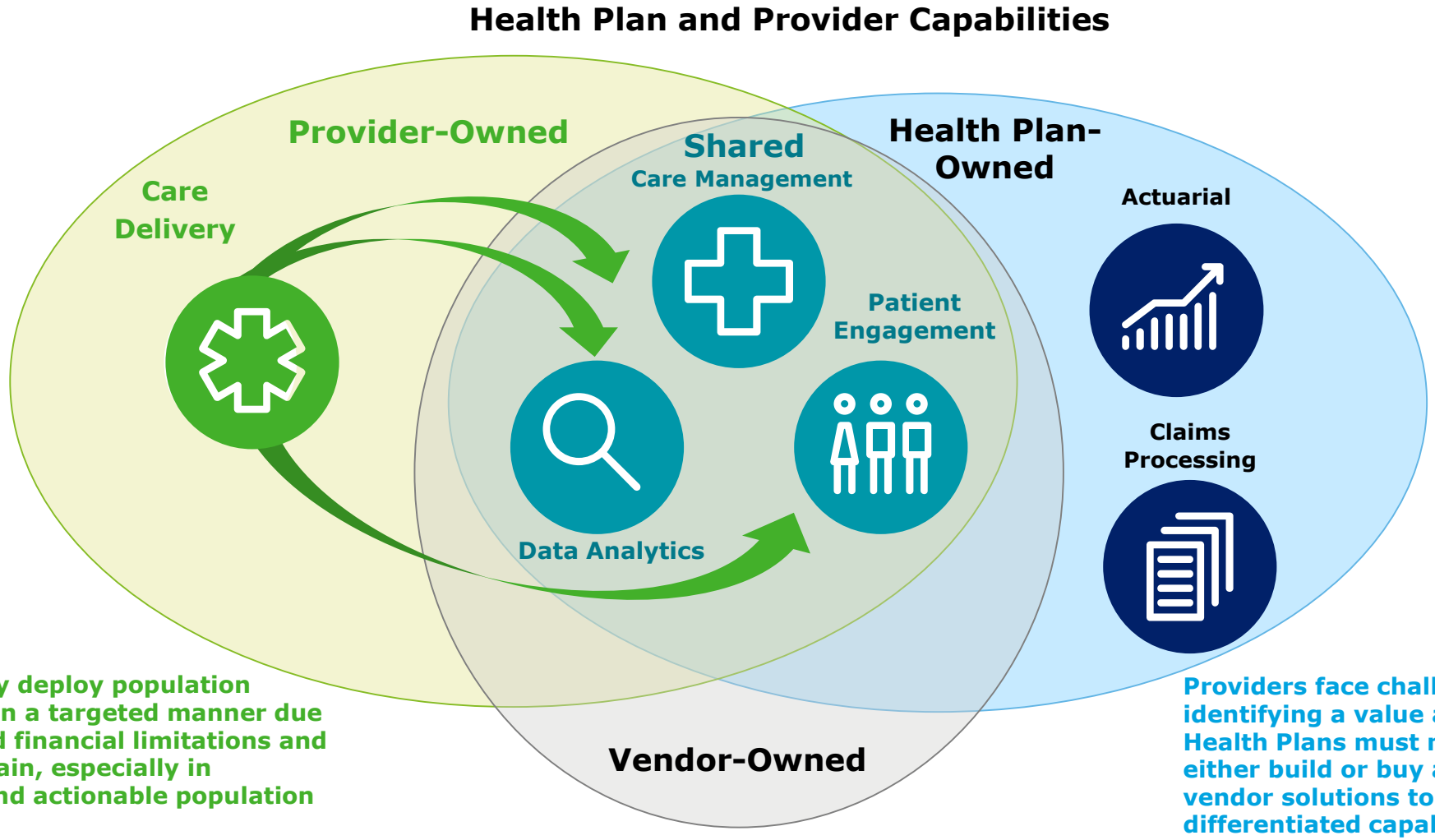
Provider Journey: A staged progression to population health maturity

Providers are scattered across the population health maturity spectrum based on market dynamics, affiliation, business model, and readiness to adopt value based payment models



Population Health Management Capabilities

In order to advance on the journey to population health maturity, providers look for the right partners to close capability gaps



Providers typically deploy population health resources in a targeted manner due to operational and financial limitations and unmet needs remain, especially in interoperability and actionable population health analytics

Providers face challenges in identifying a value add partner, and Health Plans must make a choice to either build or buy and integrate vendor solutions to bring truly differentiated capabilities to market

Source: 1) ModernHealthcare

Health plan solutions can help improve patient care, but will providers adopt them?

Collaborative care shows promising results, but providers may not be willing to engage with health plans

Collaborating with health care practitioners can create superior member and patient experiences, improve outcomes, and lower costs… but are health care practitioners willing to adopt the solutions health plans offer to improve patient care?

To answer this critical question we set out to understand health care practitioners' interest in and their perceived value of potential solutions offered by health plans. We asked about barriers to adoption or utilization of health plan solutions, and how plans may overcome those barriers.

The Methodology

- Surveyed an online panel of health care practitioners (i.e. physicians, nurse practitioners, physician assistants, nurses, and practice administrators
- Practitioners across 300 US ambulatory primary care and specialty care practices (i.e. adult and pediatric endocrinology and adult cardiology)

Key Survey Focus Areas

These focus areas were chosen because health plans already have existing capabilities or useful data within these categories

Cost Transparency

Knowing the costs associated with an individual patient's care

Chronic Care Management

Caring for patients with complex or chronic conditions

Practice Performance

Meeting individual practices' financial and quality goals

Care Coordination

Aligning care across multiple providers or sites

Wellness and Prevention

Enabling and ensuring that patients stay healthy

How willing are providers to use programs from organizations in the industry?

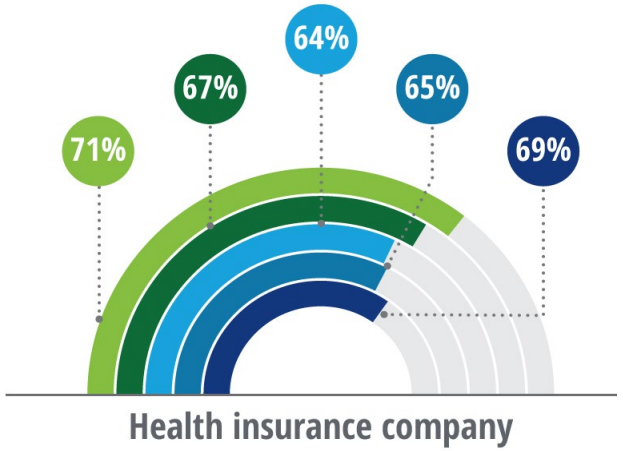
Most health care practitioners are open to solutions from health plans, but provider systems are preferred

Survey Question

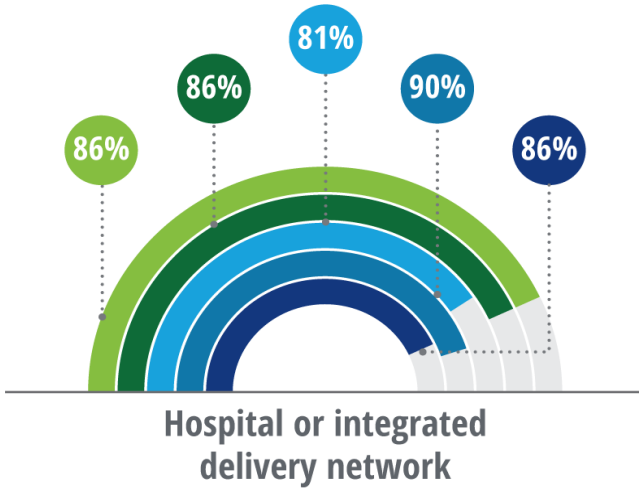
How likely will [practitioner] be to use the following programs from the following types of organizations? (Reported percentages are for "definitely will use" and "probably will use.")

Cost Transparency	n=241
Chronic Care Management	n=245
Practice Performance	n=233
Care Coordination	n=233
Wellness and Prevention	n=234

Key Insights



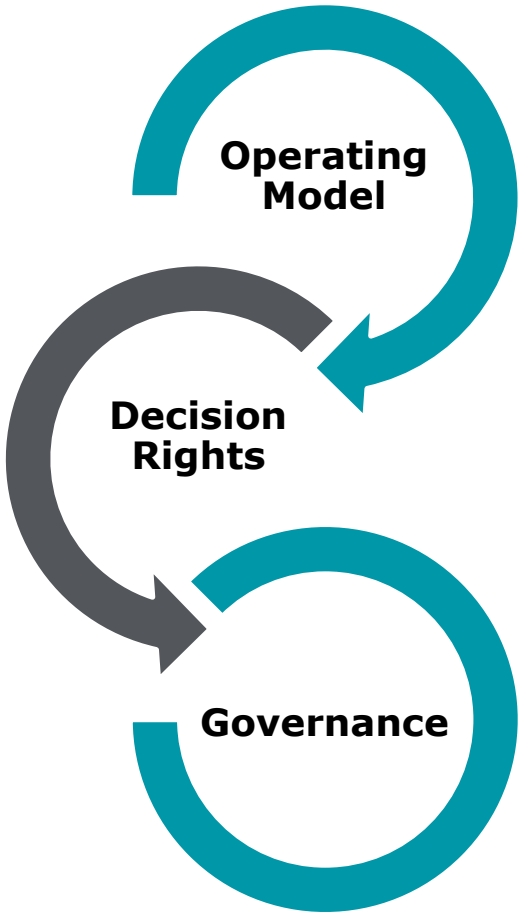
2 out of 3 health care practitioners are open to ***solutions from health plans***



However, ***health systems are the preferred partner*** in all areas

Physician leadership is crucial to the success of population health

Effective governance is important to a lasting and sustainable partnership with health plans, but for managing risk, reducing costs, and enhancing quality, physicians have to be in the driver's seat



Key challenges when adopting Pop Health and moving to VBC payment models

1. **Bandwidth**
   Leadership can be spread too thin between stakeholders—be sure to plan for obtaining support where needed

2. **Autonomy**
   All stakeholders should be placed in the governing body of the VBC organization, however the organization must be able to make its own decisions irrespective of the interests of individual stakeholders.

3. **Physician leadership**
   Many organizations do not think through which physicians need to be involved at the highest levels. Physicians must be engaged, knowledgeable, and reliable and should represent a variety of characteristics such as primary care and specialists

4. **Physician alignment**
   Many physicians are still skeptical of the impact of VBC, which can make their buy-in and participation in new governance models challenging. It is essential to work with local champions to identify individuals and groups who will most impact medical spend

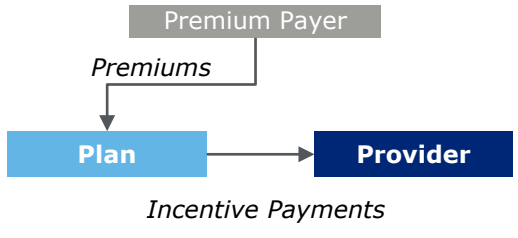
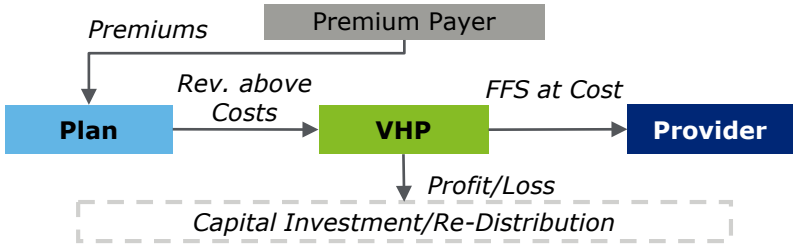
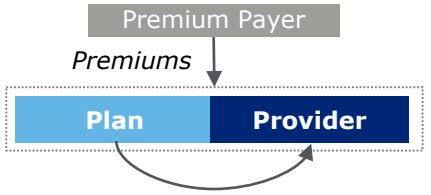
Examples of Provider/Plan Collaborations

Health Plans and Providers are at different stages of support for population health and value based payment models and therefore will be seeking solutions with each other that align relationships and fill capability gaps

	Limited VBC relationships	Have Significant Value-Based Contracts and Support Tools	Business Strategy to Actively Enable Providers in VBC	Health Plan and Provider are synonymous and aligned for value
Description	*May have limited share of provider attention in market; may have participated in regional collaboratives but not a catalyst. Limited resources to support non-owned providers*	*Experienced with value-based contracts for both physician groups and hospital systems. Able to report financial and clinical outcomes to VBC providers.*	*Actively promoting VBC capabilities; forming business lines or subsidiaries to provider VBC enablement to providers*	*Staff-model or Group-model Health Plan with aligned delivery system. Or payor is buying providers. Compensation is tied to value*
Solution Opportunity	• VBC Strategy • Contracting models • Care model design • Report design and production	• Integrated payor/provider care management models • Embedded, Telephonic and virtual options	• MSO Platforms • Data analytics & reporting • Patient Engagement and Convenient Access • Multi-payor care management	• Wellness to end of life care support options • Virtual Health design • Advanced engagement and predictive models

Level of VBC

Which Provider/Plan Collaboration Model is right for you?—depends on willingness and readiness to take risk AND modify the care delivery model

	Accountable Care Organizations[1]	Virtual Health Plans	Provider Sponsored Health Plans[2]
Financial Structure			
Capabilities	**Plan** • Administrative • Enrollment • Analytics • GTM • Branding **Provider** • Care Management • Population Health • Potential Capitated Payment Structure	**Plan** • Administrative • Enrollment • Branding • GTM **VHP** • Care Management • Analytics • Population Health **Provider** • Fully Capitated Payment for Services	**PSP** • Administrative • Enrollment • Branding • GTM • Care Management • Analytics • Population Health • Potential Capitated Payment Structure
Capital Required	**Moderate** On average, an ACO requires start-up capital of $4 million	**Moderate–High** Required capabilities may exist in both Plan/Provider organizations, but launching and integrating JV may be costly	**High** On average, a PSP requires start-up capital of $15+ million
Reimb. Risk	**Low** Most arrangements have upside risk only	**Moderate** Shared financial risk, margins are shared evenly across partner organizations	**High** The plan assumes all risk, which may also result in greater upside or downside
Reg. Risk	**Moderate** CMS and private plans are supporting ACO development	**High** Subject to state regulations but ability to leverage existing plan's regulatory capabilities	**Intense** States regulate insurance, and Medicare and Medicaid programs have detailed regulation and oversight
Data Integration	**Moderate** Integration required to identify and track enrollees across episodes of care	**High** Dual integration required with health plan and provider systems	**High** Additional integration required to support financial and managerial decisions

Less Clinical/Financial Integration → **More Clinical/Financial Integration**

Sources: 1. Example ACOs provided by Becker's Hospital Review & the NC Medical Society 2. Example PSHP provided by Healthcare Finance

Pockets of provider/plan population health innovation

There are many examples of health plans and providers working together to bring care closer to the community and improve the health of the populations served

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Introduction to Carle Health System

Carle Health serves its communities through physician led, high quality integrated care, medical research, and education

Vertically Integrated Health System

- Founded in 1918, Carle Health is a not-for-profit organization that owns Carle Foundation Hospital, Carle Physician Group, and Health Alliance Medical Plans
- Providing insurance alongside primary, secondary, acute, and post-acute care with community and consumer engagement
- Values: **ICARE** = **I**ntegrity, **C**ollaboration, **A**ccountability, **R**espect, and **E**xcellence

Carle Care Delivery

928 Physicians and APP's in Central IL	58 Medical Specialties
Serving 200,000+ patients annually	3 Hospitals, 571 Licensed Beds
State-of-the-Art Tech: *Epic EMR, Healthy Planet, Telemed.*	Regions only Level I Trauma Center

Carle and Health Alliance: Integration of population health and care management - from concept to execution

Our differentiation lies in our commitment to value-based care and our ability to deliver integrated care in local communities

Commitment to Value-based Care

- We believe that value-based care is the future of healthcare
- 30% of Health Alliance members are in some type of FFV / risk-based arrangements with providers
  - Of those, roughly 57% are in FFV arrangements between HA and Carle Health System

Extensive Experience in Delivering Integrated Care in Local Communities

- We are committed to delivering care – when possible – outside of the hospital
- We leverage population health care and wellness approaches to drive care in local communities and improve health status
- We collaborate with community-based and rural providers by building upon their strengths and supporting their needs

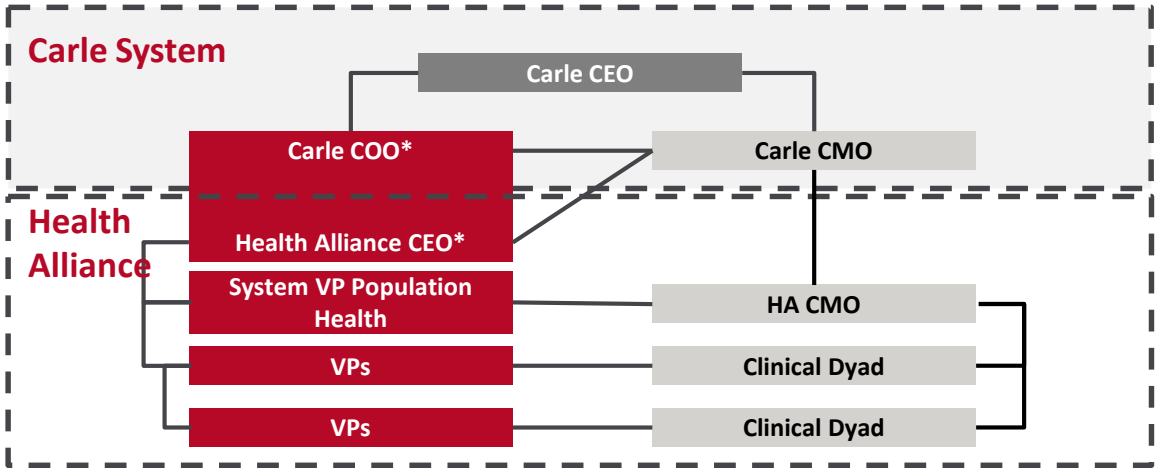
Patient Centric, Physician-led Culture

- Physicians co-own the decisions, not just a seat at the table
- We have integrated our population health and care management teams across Carle and Health Alliance, engaging physicians to establish best practices

High performing networks provide integrated care to patients

High Performing Networks of Care

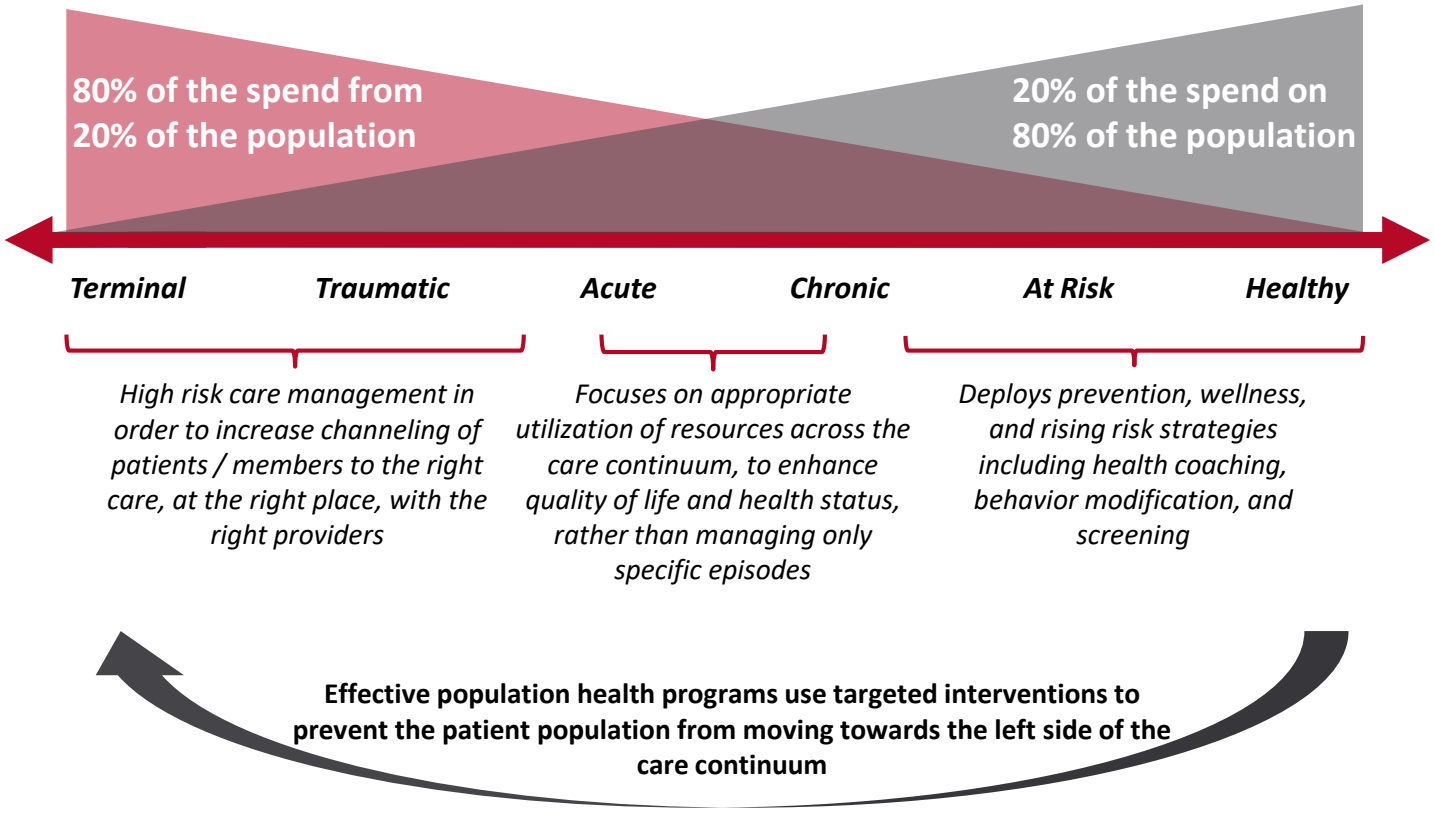
Physician-led Culture



*John Snyder holds position as both Carle COO and HA CEO

Carle Health: Definition of Population Health

Population health is a systematic approach to health and wellness efforts that aims to use health care resources effectively and efficiently to improve the health status of a specific population



Population health calls for changes in behaviors and ways of thinking:

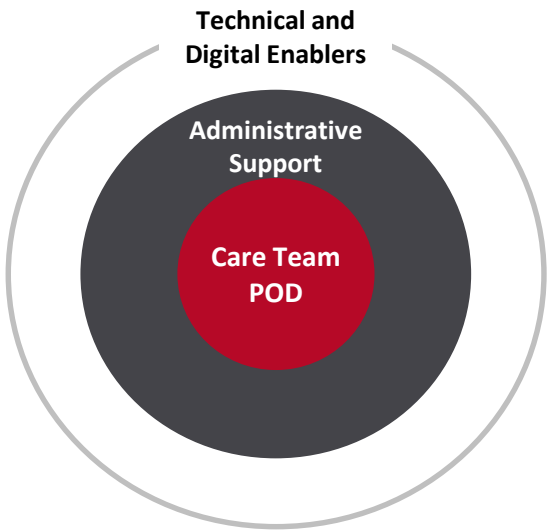
- Planning and collaboration across all specialties and services to maximize overall outcomes – both clinical and financial
- Leveraging technology to improve monitoring, access to care, and communications between patients / members and the care team
- Focus on the sum total of the populations' health experience, as well as the risks and utilization across the continuum of care
- Aggregate and analyze patient data across multiple disparate systems and populate into a single, actionable patient record

From the population health perspective, the role of the care team is to plan for and take collective actions, improve the health and wellness of the entire population, both now and in the future

Defining and Delivering Population Health
The New Population Health State of Mind

Operating Model: PODs and PHCM Resource Center

Care Team POD's, supported by a PHCM Resource Center, will enable effective, coordinated, safe, and efficient care using an integrated approach across Carle and Health Alliance. PODS can be embedded in a practice location where scale warrants or virtual. Physicians who naturally share patients are assigned to the same POD, which enables both their patients and them to have a single, supporting care team rather than multiple points of contact across disparate programs.



A POD model of care delivers a **collaborative** and **data-driven approach** for clinical and social management while **improving quality**, **reducing unnecessary utilization**, and **providing more efficient care** to the shared population

Integrated Care Team PODs

- Enable more effective care management by coordinating convenient and accessible care in the community for the shared population through embedded and virtual resources
- Promote a greater sense of collaboration between clinical care teams by directly linking care coordinators with clinical and non-clinical staff in support of a holistic care plan
- Provide a comprehensive view of all necessary aspects of care across the continuum

PHCM Resource Center Administrative Support

- Allows staff to focus on less-complex care coordination needs, enabling the care team to operate at the top of license while focusing on the highest acuity within the shared population
  - Arranges support to address social determinants (e.g., transportation, food insecurity, other community resource access)
  - Conducts post-discharge follow-up calls, obtains PAC authorization, arranges equipment needs (i.e., DME) facilitates referrals

PHCM Resource Center Technical and Digital Enablers

- Automation of manual tasks (generating care plans, filling out and filing forms, uploading information to patient portals, setting up appointment reminders, etc.)
- Enable virtual visits between patients / members and providers for the shared population
- CRM tool or standardized toolkits to enable efficient and effective workflows, documentation, and hand-offs amongst all care team staff
- Automated patient / member contact to improve resource efficiency
- 24/7 telephonic and / or digital care coordination support for the shared population

Example Patient Journey in PHCM

1. Frank comes in for scheduled **visit with PCP**
2. PCP performs routine tests and new diagnoses are revealed, requiring **follow up appointments and new prescription regimen**. Rx's are sent to Walgreens downstairs
3. PCP deems Frank appropriate for care coordination and sends a referral **for Care Coordination**.
4. Embedded CC meets with Frank to **review diagnoses and perform initial assessment**
5. Taking into account Frank's schedule and provider availability, **CC schedules follow up appointments (both in person and virtual)**
6. Appt with **Diabetes Educator and Nutritionist** (in person) scheduled for next week to help formulate nutrition plan
7. Virtual consult is scheduled with **Cardiologist** to follow up on irregular rhythm on ECG
8. Virtual consult is scheduled with **Clinical Pharmacist** to review medication plan relative to diagnoses
9. CC escorts Frank to meeting with **Social Worker** to address job loss and wife's recent Alzheimer's diagnosis
10. Social Worker schedules **follow up with Therapist (LCSW)** in 2 weeks to address mild depression
11. On his way out, Frank gets **a text message that his prescriptions are ready**
12. Frank picks up new medications from **Walgreens downstairs**
13. CC calls Frank 24-48 hours later **to follow up on yesterday's appointments** and answer any questions

Legend

- Primary Care Physician
- Care Coordinator
- Cardiologist
- Social Worker
- Therapist (LCSW)
- Clinical Pharmacist
- Diabetes Educator
- Nutritionist

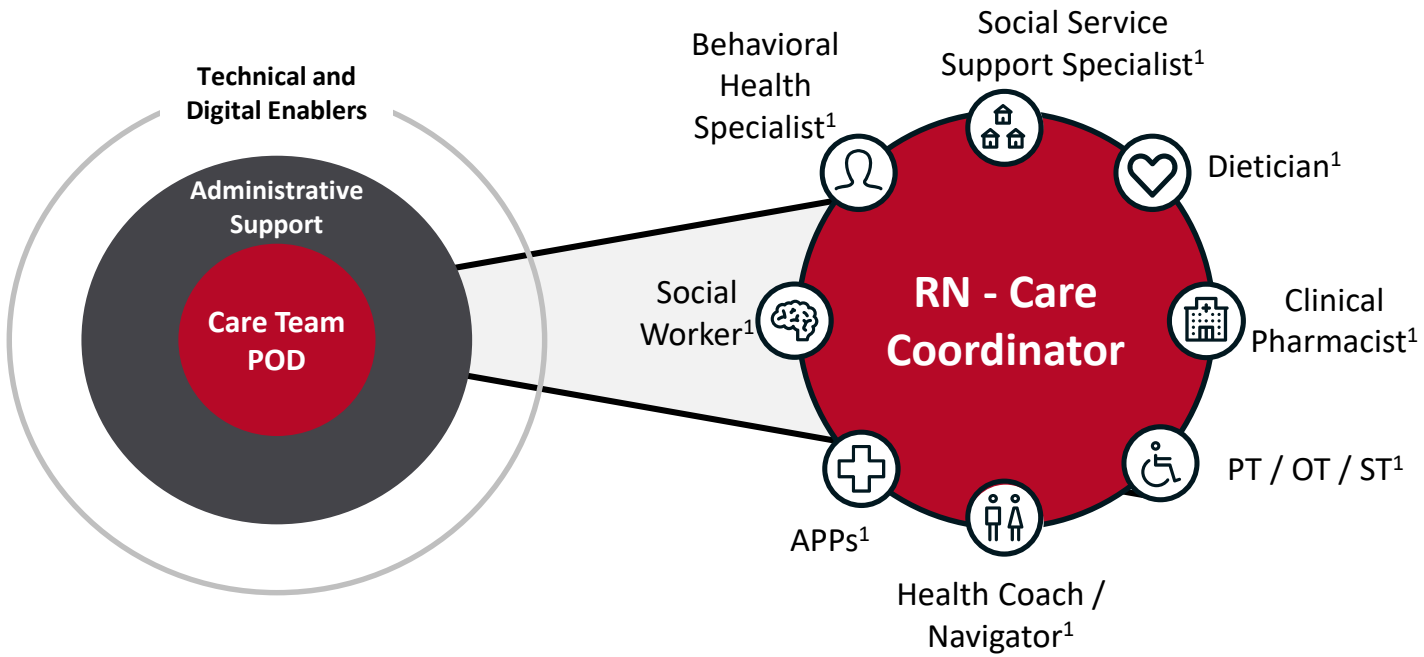
Member Profile: Frank, 57

Risk Score	14
Engagement Score	3.5

- **History:** New patient, has not been to the doctor in 5 years
- **Household Income:** $50,000
- **Location:** Rural
- **Clinical Assessment Reveals**: New onset Atrial fibrillation (irregular heartbeat), high blood pressure, and glucose intolerance
- **Risks / Needs:** BMI is 35 (obese). Frank lost job his job last month and wife was recently diagnosed with Alzheimer's
- **Communication preferences**: Open to text messaging, video conferencing, and/or telehealth
- **Religion**: Not addressed
- **Palliative care preferences**: Not addressed
- **Dental office:** Unknown

Integrated Care Team Place of Delivery (POD) Models

An integrated operating model with Carle and HA resources presents an opportunity for clinical care team integration across the care continuum. The construct of a POD manages the comprehensive needs through direct patient / member contact in the clinical setting and virtually within a centralized resource center.



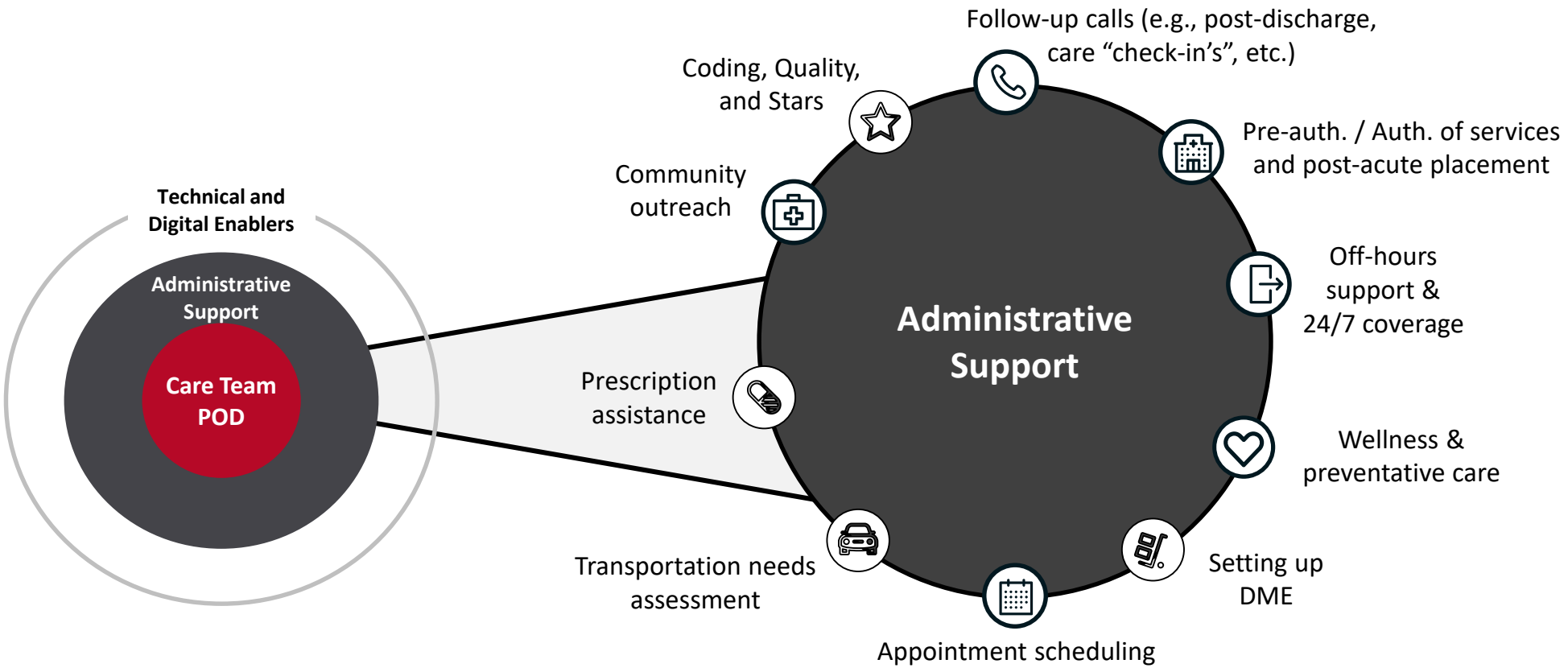
Activities within Care Team PODs

- PODs are integrated units **dedicated to specific clinics / providers** in support of individual panel characteristics and risk levels for the shared population
- PODs are an **evolution of the PCMH model** that provides the **flexibility** of care team staff to **deliver services through a virtual and / or embedded model**
- PODs cover most of the legacy HA and Carle programs (**TOC, complex case management, very high risk patients**)
- PODs may serve **more than one clinic site and provider as resources may be shared as needed** based on patient attribution volumes
- **Wellness and preventive care** will be a function that resides primarily in the PHCM Resource Center

1. 1:1 is not standard resourcing for each POD; flexible based on individual clinic volumes and number of providers

PHCM Resource Center : Administrative Support

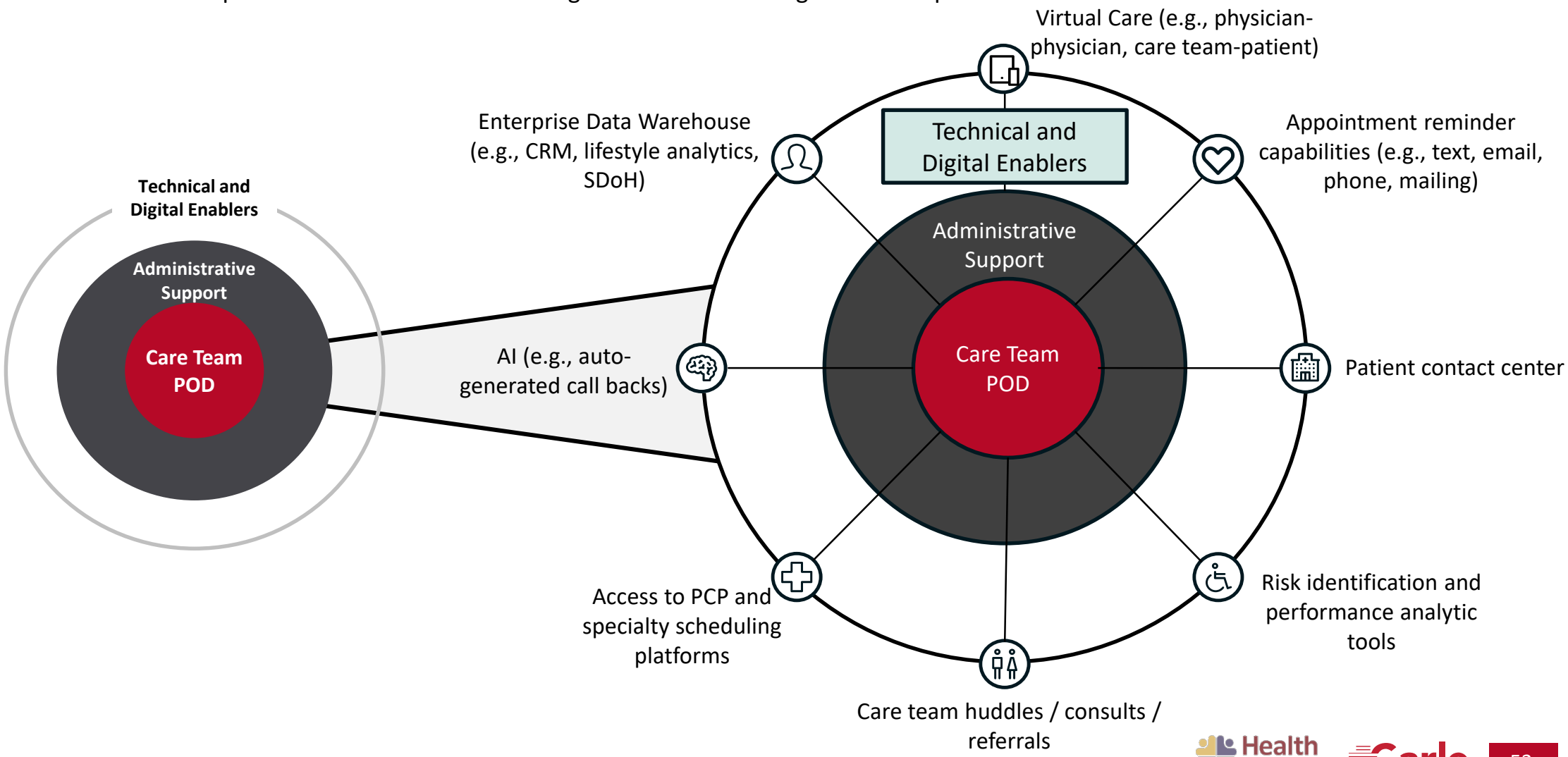
PODs will have the ability to leverage support staff through a PHCM Resource Center for less-complex or administrative activities, allowing care team staff embedded in PODs to focus on the more critical patient / member and provider engagement activities deigned for the shared population



- Considerations for the PHCM Resource Center would likely include existing Care Coordinator Reps, Case Management Assistants and Health Coach Reps (whose titles should change to Care Coordinator Rep), and Prescription Assistance Coordinators
- Coders and Quality / PI staff could also be attributed to the resource center focusing on coding, denials management, and meeting stars measures

PHCM Resource Center: Technical and Digital Enablers

The PHCM Resource Center relies on an integrated technology platform and digital enablers to fully support administrative tasks and care team PODs, and must also have the required electronic workflow management tool that integrates with Epic



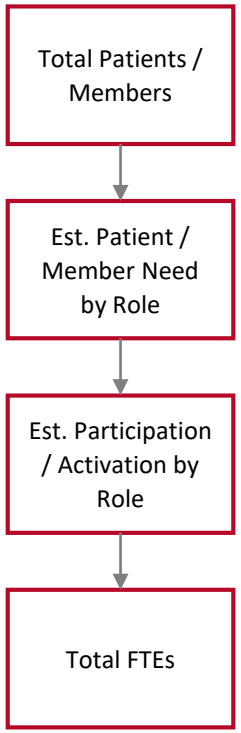
PHCM Staffing Model Approach and Planned Requirements

To better understand the impact of the proposed future state PODs, we identified the current FTE count currently dedicated to in-scope cost centers in relation to projected future state requirements for the entire shared population [1]

PLANNED POD REQUIREMENTS APPROACH

- Serves as an imperfect but **conservative approach to staff appropriately** for the initial Pilot
- **Leverages patient / member risk score ranking and stratification** to differentiate between groups within the shared population
- Uses **benchmarks and industry knowledge** to estimate member need and participation by role
- Applies **blended case load** assumptions to determine total FTEs

LOGIC



	Role	Current State	Pilot Requirements
Care Team PODs	Social Worker	22.5	6.5
	Social Services Support Specialist	3.0	1.5
	Care Coordinator	54.0	9.0
	Wellness, Primary Prevention, Health Coaching	5.0	5.0
	Dietitian*	0.0	3.0
	Diabetic Educator*	1.0	3.0
	Clinical Pharmacist	5.5	2.5
	Pharmacy Tech	7.0	2.5
	Behavioral Health Specialist (LCSW)[2]	N/A	2.0
	PT / OT*	0.0	2.0
	Total Care Team	98.0	37.0
PHCM Resource Center	Care Coordinator Rep., Case Mgmt. Asst., Health Coach Rep.	19.5	2.0
	Prescription Assistance Coordinator	3.0	0.5
	Quality Coordinator	7.0	4.0
	Coder	4.0	2.0
	Administrative Support Advocate[3] (Concierge)	N/A	3.5
	Medical Home Facilitator	4.0	4.0
	Total Admin.	37.5	16.0
	Total	**135.5**	**53.0**

1. FTEs rounded to nearest 0.5 FTEs. Current state FTE counts currently being validated with Directors
2. Current LCSW with clinical background is able to fulfill this role
3. Net new role with potential to be fulfilled through Care Coordinator Rep., Case Mgmt. Asst., Health Coach Rep. available FTEs

* Add'l FTEs identified in Out-of-Scope Departments – 5.87 Dietitian FTEs; 4.2 Diabetic Educators FTEs; 81.66 PT/OT FTE

POD Structure Staffing Model

Clinical and non-clinical staff will be allocated to a specific POD(s) or in the PHCM Resource Center, but will have the flexibility to serve more than one POD based on panel sizes and clinical care needs of empaneled patients / members for the shared population

		Role Description	Proposed Future State Changes
Care Team PODs (embedded and virtual)	**Care Coordinator / Case Manager / Nurse Navigator**	• Leads care coordination efforts for assigned group of patients / members and coordinates activities of panels • Coordinates inpatient care with a focus on discharge planning and transitions of care • Assist patients in navigating throughout internal and external systems in order to facilitate diagnostic and treatment process	**Assignment: POD** • Leads the care team within the POD structure • Decreased responsibility for less complex / admin. tasks as these are transitioned to the PHCM Resource Center • Increased degree of transparency / interaction with providers and encompassing additional disease states (i.e., COPD)
	Social Worker	• Manages psychosocial and behavioral issues, as well as transition planning	**Assignment: POD** • Manage issues and transition planning for shared patients / members within POD
	Social Services Support Specialist	• Facilitate community resource need arrangements	**Assignment: POD** • Duties remain largely unchanged, while operating within the POD in a more coordinated manner
	Behavioral Health Specialist (LCSW)	• Clinical background is leveraged to assist the shared population of patients / members with behavior change	**Assignment: POD** • Work collaboratively within POD structure to facilitate a holistic care plan
	Wellness Primary Prevention Health Coaching	• Engage to help improve self-management and lifestyle behavior modification • Oversees successful integration of vendors providing wellness tools and services to plan members • Primary liaison with internal / external customers about the wellness program • Role currently only exists within HA Quality Management	**Assignment: POD** • Each POD should have a Health Coach that focuses on primary prevention / wellness • Will likely need to staff up for this role, but should also consider transferring some from HA to PODs for the shared population
	Clinical Pharmacist, Pharm. Tech.	• Ensures medication compliance, adherence, education and clinical disease management support as needed	**Assignment: POD** • Increased allocation of duties to Pharm. Tech. so that Clinical Pharmacist can operate at top of license
	Dietitian	• Provide dietetic services to patients in need	**Assignment: POD** • Work collaboratively within POD structure to facilitate a holistic care plan
	Diabetic Educator	• Provide diabetes education services to patients in need	**Assignment: POD** • Work collaboratively within POD structure to facilitate a holistic care plan
	PT / OT	• Provide PT / OT consultation services when appropriate	**Assignment: POD** • Work collaboratively within POD structure to facilitate a holistic care plan

PHCM Resource Center Staffing Model

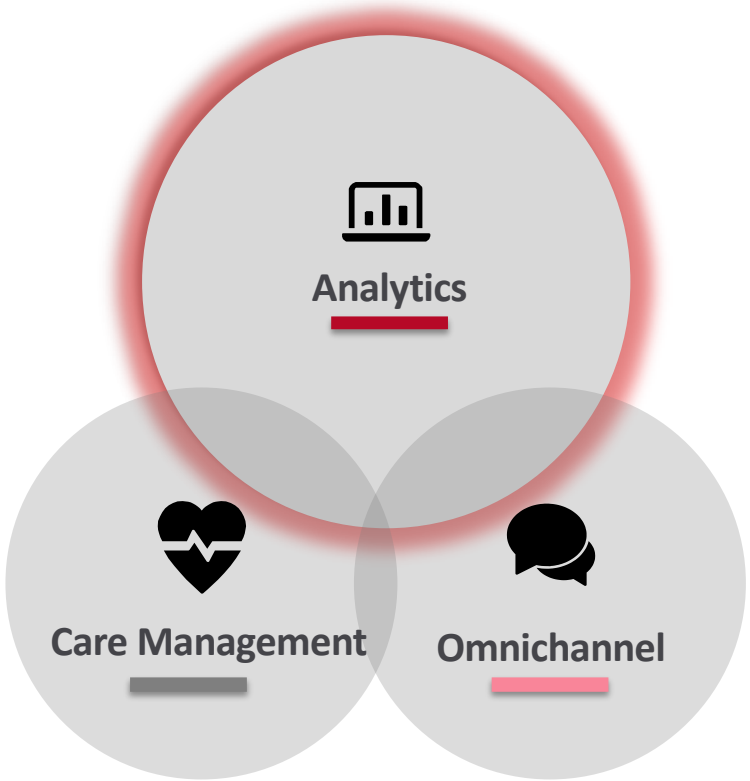
Clinical and non-clinical staff will be allocated to a specific POD(s) or in the PHCM Resource Center, but will have the flexibility to serve more than one POD based on panel sizes and clinical care needs of empaneled patients / members for the shared population

	Role Description	Proposed Future State Changes
PHCM Resource Center		
Care Coordinator Rep. **Case Management Asst.** **Health Coach Rep.**	• Provide non-clinical support to Care Coordinators and Health Coaches • Provide non-clinical support for clinical care coordination staff • Role exists in HA Health Coaching & Consultative Services, HA OP Care Coordination, IP Care Coordination, and OP Care Coordination	**Assignment: PHCM Resource Center** • Gradually transition staff to PHCM Resource Center • Cross-train staff to support care coordination activities across all departments and patient types • Choose one system-wide job title for this role
Prescription Assistance Coordinator	• Provides prescription assistance for the Carle Inpatient Care Coordination department • 2 FTEs aligned to prescription assistance within IP Care Coordination	**Assignment: PHCM Resource Center** • Transition roles to PHCM Resource Center, making prescription assistance available to both IP and OP CC • This role may need to increase staff to more fully integrate pharmacy functions into POD model
Quality Coordinator	• Coordinate quality and stars measures for the shared population	**Assignment: PHCM Resource Center** • Coordinate quality and stars measures for the shared population within PODs
Coder	• Coordinate coding for the shared population	**Assignment: PHCM Resource Center** • Coordinate coding for the shared population within PODs
Medical Home Facilitator	• Support medical home staff and providers through electronic outreach to patients via bulk ordering and present data on quality improvement initiatives to medical home teams	**Assignment: PHCM Resource Center** • Transition roles to PHCM Resource Center
Administrative Support Advocate (Concierge) [1]	• Services in a non-clinical role that triages the shared population to navigate the two systems and assign the correct resource to answer questions relative to care needs	**Assignment: PHCM Resource Center** • Newly formed role to allow administrative navigators to reduce the administrative burden often experienced during the healthcare journey
Population Health Analyst[1]	• Support medical home staff and providers through data analysis on quality improvement initiatives	**Assignment: PHCM Resource Center** • Newly formed resource operating in support of medical home facilitators

1. Net New Role – preliminary role description may evolve throughout Design process

Technology Platforms will Drive Success

Carle and Health Alliance need their innovative approaches to population health and care management to be replicable and scalable, particularly with their large growth aspirations. Several essential technologies need to be modernized to enable this:



Analytics

Carle / Health Alliance must have an advanced and fully integrated analytics platform to support the 360° understanding of each member / patient, to drive key workflows, and to enable meaningful and actionable business insights

Care Management

For Carle / Health Alliance to drive significant population health improvement, they must have a highly advanced care management platform that readily connects plan and provider resources and enables all parties to work on a common care and action plan for each patient / member

Omnichannel

Carle / Health Alliance can efficiently drive increasingly greater levels of patient / member engagement with an advanced omnichannel outreach platform that connects both traditional call center and mail capabilities with updated digital engagement capabilities

Maria Use Case

Member Profile

Maria, 55 *Illustrative*

Risk	2.5
Engagement Score	0.5

- **Stratification:** High Risk
- **Relationship Status:** Married, 2 children
- **Household Income:** $75,000
- **Location:** Suburban
- **Clinical Information**: Diabetes, Heart Disease
- **Risks / Needs:** Poor adherence, high likelihood of hospitalization, high receptivity to telephonic interactions, low participation in health

Sources

- Member Generated Data
- Caregiver Reported
- EMR
- Medical & Pharmacy Claims
- Provider Data
- PHCM

Case Study

Maria is a high risk person with diabetes and heart disease, and has demonstrated low participation in her health and wellbeing, including poor adherence to typically recommended treatment

Goals

Leverage analytics to identify and assign the appropriate resources to coordinate Maria's care in order to reduce costs, improve outcomes, and increase patient engagement in their health

Solution

Utilize predictive analytical capabilities to identify patient risks / needs / triggers, identify and prioritize actions, optimize allocated clinical & community resources, and assign appropriate tasks to care team staff

Results

- Lowered Cost of Care
- Improved Clinical Outcomes
- Increased Patient Satisfaction / Engagement

Maria Use Case – Identification of Actions, Resources, and Process

Member Profile

Maria, 55 *Illustrative*

Risk	2.5
Engagement Score	0.5

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Sources

- Member Generated Data
- Caregiver Reported
- EMR
- Medical & Pharmacy Claims
- Provider Data
- PHCM

Prioritized Actions

1. Automated call to enroll member and assign them to the care management program for combined conditions

2. Assessment of social health and barriers by care manager

3. Addressing social health and barrier needs through direct support by social worker (if assessment bears this out)

4. Motivational interviewing to support proactive health activation. Prioritized focus:

- Addressing emotional health needs
- Adherence to medical care plans
- Provider engagement
- Addressing diet, exercise, sleep, and other health habits

5. Push appointment scheduling with PCP to fill clinical gaps and encourage adherence

Optimization of Resources

Optimize resources based on prioritized actions and relative impact

Process

Build information source and task list for care manager and provider

Launch automated enrollment process

As items get completed tee up next best action

Q&A

So what’s working and where do we go?

“The future is already here—it's just not evenly distributed.”

—William Gibson, The Economist, December 4, 2003

Lessons Learned for Population Health Models Moving Forward

Our work with payers and providers around the country has given us a unique view as to what is working in care models

1—Provider led

Integrating care management into a physician led model **increases patient engagement** substantially even when the program is delivered virtually

2—Data driven prioritization

Prioritization of care management efforts is necessary to **ensure an efficient and effective program**. Deep analysis and benchmarking of historical medical costs help define the priorities for each managed population

3—Care management delegation

There are components of care management that should rarely be delegated. Even when delegated, the **health plan still has a significant role** due to regulatory requirements and risk

4—Continuum of provider model options

Because providers have such a diverse range of internal capabilities and strengths, health plans require a portfolio of care model options to **support providers on their journey**

5—Build vs buy

While care management should be a key skill set for most health plans and point of differentiation, health plans can still leverage purchased services to **improve their impact and ROI**

6—Data & Analytics as a core competency

Regardless of the population, care model, provider collaboration setting, or use of vendors, a health plan with **solid data and analytics capabilities** is **best situated to thrive**

7—Patient generated data

The **future opportunity for patient generated data is significant** but there are many details to be worked out and unknowns to work through

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