# Practices for Improving Population Health


County Ideas that Work

NACo | Virtual Learning Community

*February 13, 2014*

# Healthy Counties Initiative Sponsors











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- After the webinar, you will receive a notice asking you to complete a webinar evaluation survey. Thank you in advance for completing the webinar evaluation survey. Your feedback is important to us.

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- This box can collapse so that you can better view the presentation. To unhide the box, click the arrows on the top left corner of the panel.
- If you are having technical difficulties, please send us a message via the questions box on your right. Our organizer will reply to you privately and help resolve the issue.

# Today's Speakers

**Ross Owen**

Deputy Director, Hennepin Health

Hennepin County, Minn.

**Clarence Williams**

Vice President, Accountable Care Solutions

Aetna – Accountable Care Solutions

# How many people are attending this webinar from your computer?

a. 1

b. 2

c. 3

d. 4

e. 5 or more

Are you familiar with the term "Accountable Care"?

a. Yes

b. No

c. Not sure

# Has your county partnered with your local hospital or health care provider?

a. Yes

b. No

c. Not Sure

# What is an Accountable Care Organization (ACO)?

- An ACO is a group of health care providers, such as doctors, hospitals, and/or insurers who have joined forces to provide coordinated and comprehensive quality care to patients by:
  - Providing better care
  - Improving Health
  - Lowering health care costs

# What does an ACO do?

- An ACO takes a population from fragmented care that is paid for based on services provided to coordinated care that is paid for based on value.
- It promotes and fosters wellness by ensuring care is provided at the right time in the appropriate setting to eliminate redundancies.
- ACOs connect the data to allow for population health to be better managed.

# Who is involved in an ACO?

Hennepin Health

PEOPLE. CARE. RESPECT.

# National Association of Counties

February, 2014

Ross Owen, Deputy Director

working for you

# What is Hennepin Health?

## Minnesota Department of Human Services (DHS)

## &

## Hennepin County

Collaborative Demonstration for Healthcare Innovation

**Hennepin County Accountable Care Partners:**

Hennepin County Medical Center (HCMC)
NorthPoint Health & Wellness
Human Services and Public Health Dept. (HSI )
Metropolitan Health Plan (MHP)

*Jointly contract with DHS to provide the full Medicaid benefit to a population of ~6,400 complex residents on a full risk prospective total-cost-of care basis*

working for you

# Population Served

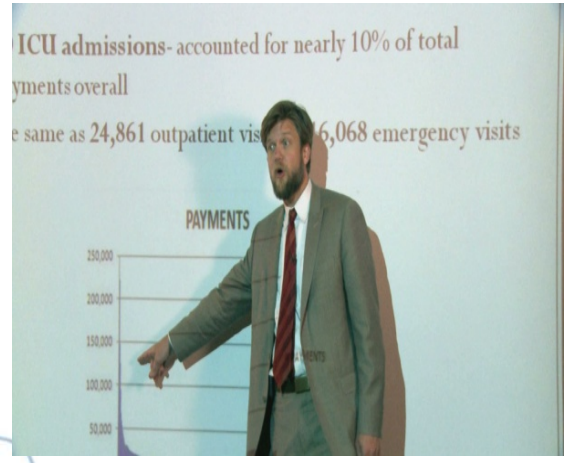
- Medicaid Early Expansion in Hennepin County
- 21 - 64 year-old Adults, without Dependent Children
- At or Below 75% Federal Poverty Level (moving to 133% in 2014)
- Current Enrollment ~6,300 members
- Program Start Date: January 2012

# Population Characteristics

- ~75% Male
- ~69% Racial/Ethnic Minority
- ~45% Chemical Use
- ~42% Mental Health Needs
- ~30% Chronic Pain Management
- ~32% Unstable Housing
- ~30% 1+ Chronic Medical Conditions
- Members' Self-Assessment of Needs:
  - High: Food, Social/Family Support, Work, Medications
  - Low: Legal Issues, Drug Dependency, Phone Communication

# Premise


- Need to Meet Individuals' Basic Needs Before We Can Meaningfully Impact Health
- Social Challenges Often Result in Poor Health Management and Costly Revolving Door Care
- By Financially Aligning and Coordinating Systems, we can Improve Health Outcomes and Reduce costs



# Care Model

- Based on a Primary Care Medical Home with a Strong Community Health Worker Role
- Evolving Roles and Functions:
  - Social Service Navigators
  - Housing Navigators
  - Building Population Health Capacity
  - Outreach to Keep Members Eligible

# Finance Model

- Replacing Volume Incentives with Value Incentives
- Avoided Hospitalizations No Longer Lost Revenue to the Safety Net – All “Rowing in the Same Direction”
- Individual Partner Incentives to Share Savings + Common Re-Investments in System Improvements

# Keys to Success

- Measure the impact of social services on health care spending
- Reinvestment of short term savings in long term solutions
- Strong leadership support
- Win/Wins = Business Case

# Challenges

- Moving a clinic-based model into the community, and vice versa
- Data privacy laws
- Pilot → System-wide change
- Managed care regulatory requirements absent a national “ACO roadmap” for Medicaid

# Thank you!

Videos and more information:
www.hennepin.us/healthcare

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# Population health

## A practical overview to a complex topic

**Clarence Williams**
Accountable Care Solutions
VP, Regional Head of Client Strategy

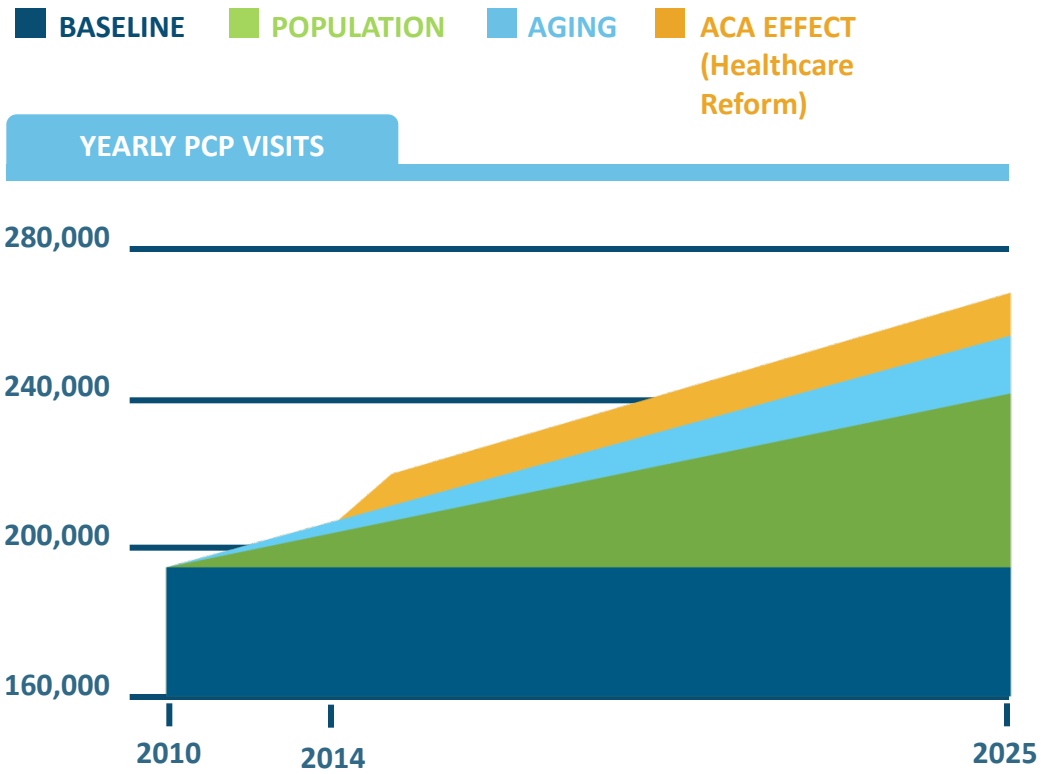
February 14, 2014

# Ask yourself …

- What does “engagement” mean to us?
- What can we do to begin moving toward population health management?
- Who are my most likely partners in this?  Least likely?
- Can I find one “common sense” solution to consider?

# The primary care doctor supply-demand gap

The demand in the number of yearly PCP visits due to population increase and expanded coverage will drive the need for more PCPs





"Projecting US Primary Care Physician Workforce Needs: 2010-2025"; Stephen M. Petterson, PhD, Winston R. Liaw, MD, MPH, Robert L. Phillips Jr, MD, MSPH, David L. Rabin, MD, MPH, David S. Meyers and Andrew W. Bazemore, MD, MPH; November/December 2012

# People misuse the emergency room

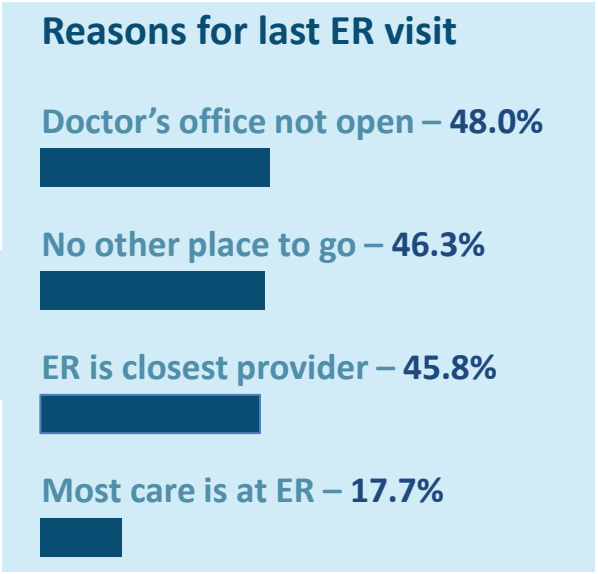
## Recent CDC and ACEP data:

**85%** of ER visits were the result of not being able to wait to see person's regular medical provider.[1]

**20%** of adults from age 18-64 visited an ER in the past 12 months.[2]

**80%** of adult ER visits were due to lack of access to other providers.[2]

**46%** of ER visits were not classifiable as immediate, emergent or urgent at triage.[3]




1 American College of Emergency Physicians Emergency Care Poll 2012

2 "Emergency Room Use Among Adults Aged 18-64: Early Release of Estimates From the National Health Interview Survey", Renee M. Gindi, Ph.D.; Robin A. Cohen, Ph.D.; and Whitney K. Kirzinger, M.P.H., Division of Health Interview Statistics, National Center for Health Statistics, January-June 2011

3 National Hospital Ambulatory Care Survey published by the CDC 2009 Link: http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2009_ed_web_tables.pdf

# Learnings from successful programs?

***Health Affairs: Driving Quality Gains and Cost Savings Through Adoption of Medical Homes*** found four common features for a PCMH that create value and can be replicated:


ANALYSIS & COMMENTARY
Driving Quality Gains And Cost Savings Through Adoption Of Medical Homes

1 **Care managers**

- Some embedded – some included in community health teams
- Care coordination function is essential to driving medical home success which requires dedicated resources

2 **Expanded access**

- Round-the-clock access to a health provider to reduce ED use
- Direct communication between care coordinator and patient
- Technology – member portals

3 **Data-driven analytics**

- Accessible data to manage performance and track patients
- Population based decision making with predictive modeling
- Ensure achievement of clinical goals for patients

4 **Incentive payments**

- Motivate behavior change among providers
- Reward physicians and providers who demonstrate consistent and successful application of the medical home features

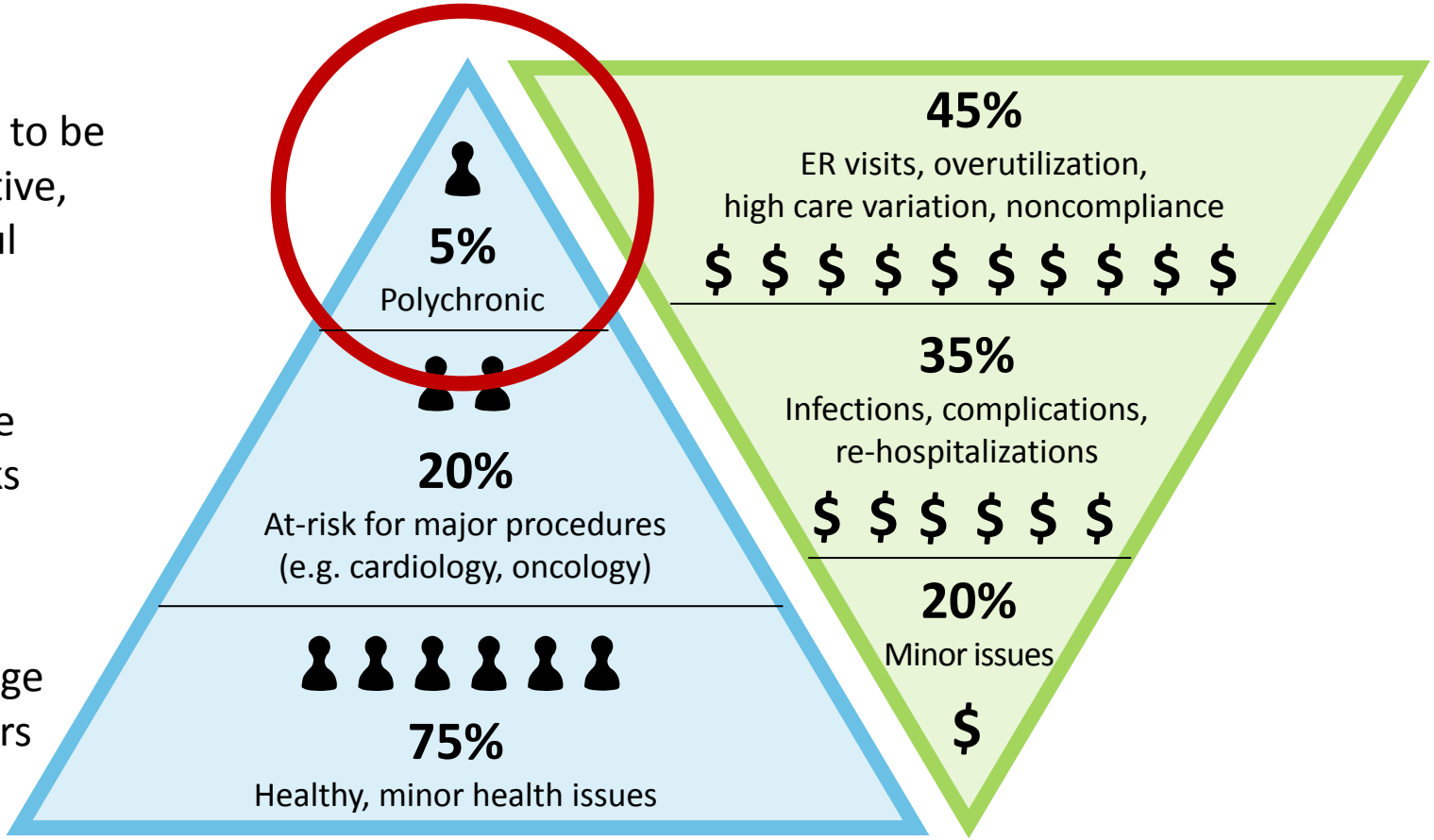
1.Fields, D. (2010, May). Driving Quality Gains and Cost Savings Through Adoption of Medical Homes. *Health Affairs*, p. 29:5.

# Cost is driven by the sickest of the sick

Treatment needs to be efficient, effective, non-wasteful

Need to mitigate and manage risks

Need to encourage healthy behaviors



# Finding outliers and intervening is the key

Behind on a year's worth of prescription refills

At risk for a second heart attack

Visited the emergency room five times but missed primary care appointments

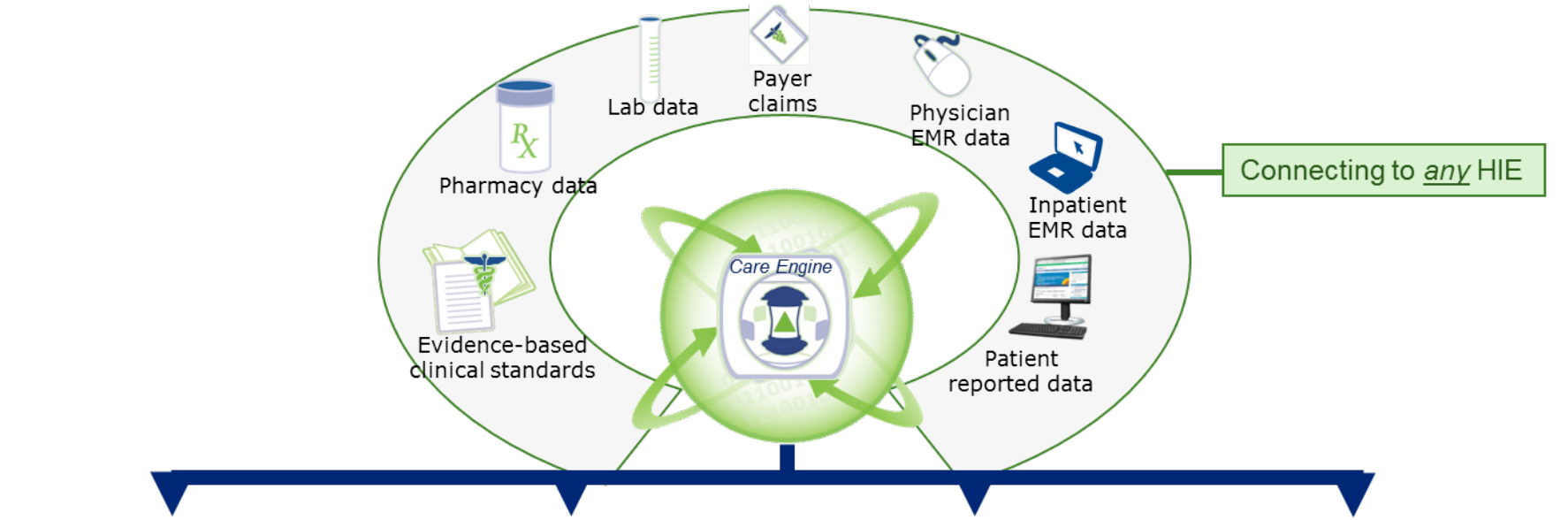
Only 17% compliant with prescribed diabetes medications

Overdue for a mammogram

Visiting three specialists for one chronic condition

# The engine that enables results ...

## The Aetna CareEngine® = data Integration




### Alerts

Identifying and Alerting for Patient Specific Gaps in Care

*Ensure critical clinical issues are not overlooked*

### Analytics

Registries, Population & Patient Specific Risk Analysis

Quality Metrics & Reports

*Identify and track highest risk members of your population to get them to clinical quality goals*

### Care Coordination

Primary MD Specialty MD

RN DM CM

Care Coordination, Communication & Workflow

*Enables active and coordinated care management across providers and settings*

### Patient Engagement

Patient

PHR, Patient Portal, eVisits, Access, Wellness Mgmt.

*Engages the patient in their care and helps them navigate the system*

# … allowing providers to understand and manage populations

Who is overusing the emergency room?

Who isn't following up on prescriptions and appointments?


Who is overdue for important preventive testing?

Who isn't compliant with their diabetes medication?

Who is driving up costs and weighing down your quality improvement?

Who is seeing three specialists outside of your system?

# Exceeding the Medicare Shared Savings Program (MSSP) "hurdle rate"

## What do we need to do to achieve success with this program?

- ED Visits
- Avoidable hospitalizations
- Avoidable readmissions
- Appropriate generic drug use
- OP/ free standing radiology
- Unnecessary subspecialist visits
- Unnecessary imaging, lab, etc.
- Quality measures
- Patient experience/ satisfaction


## How do we achieve these objectives?

- Initiate "open access" scheduling
- Refine care coordination, transitions of care, and referral processes
- Identify high and moderate risk patient cohorts by disease state (risk stratification/ predictive modeling) to facilitate targeted engagement
- Mine healthcare data for specific gaps in care/ EBM guideline compliance
- Utilize automation/ technology to engage with low and moderate risk patients
- Deploy dedicated care managers (RNs) to engage with targeted high and moderate risk patients
- Perform sophisticated healthcare analytics to benchmark quality & efficiency metrics (group, site, and physician level)
- Insight into the cost and quality of ancillary and other healthcare service providers to inform referral decisions

# The goal is a solution that is comprehensive and end-to-end…

## Healthcare Technology

### Data Ingest


Lab Data


Pharmacy Data


Patient Reported Data


Payer Claims Data


Physician EMR Data


Inpatient EMR Data

### Data analytics

ACTIVEHEALTH MANAGEMENT.

Care Engine

Evidence Based Medicine (EBM) Rules Engine

MEDICITY

### Applications

Patient Specific Alerts, Gaps in Care, and Care Plans

Care Management Workflow Application, Advanced Registry, and Population Health Tools

Patient Engagement Platform

Quality Measure Reporting and Benchmarking, Contract Performance Reporting

## Care Management

Scalable & Skilled Clinical Resources

- Scaled to patient population risk and volume
- Staff is local and represents a combined approach:
  - Embedded
  - Telephonic
- Population health experts:
  - Disease Management
  - Case management
  - Wellness
  - Senior Programs

## Business Services

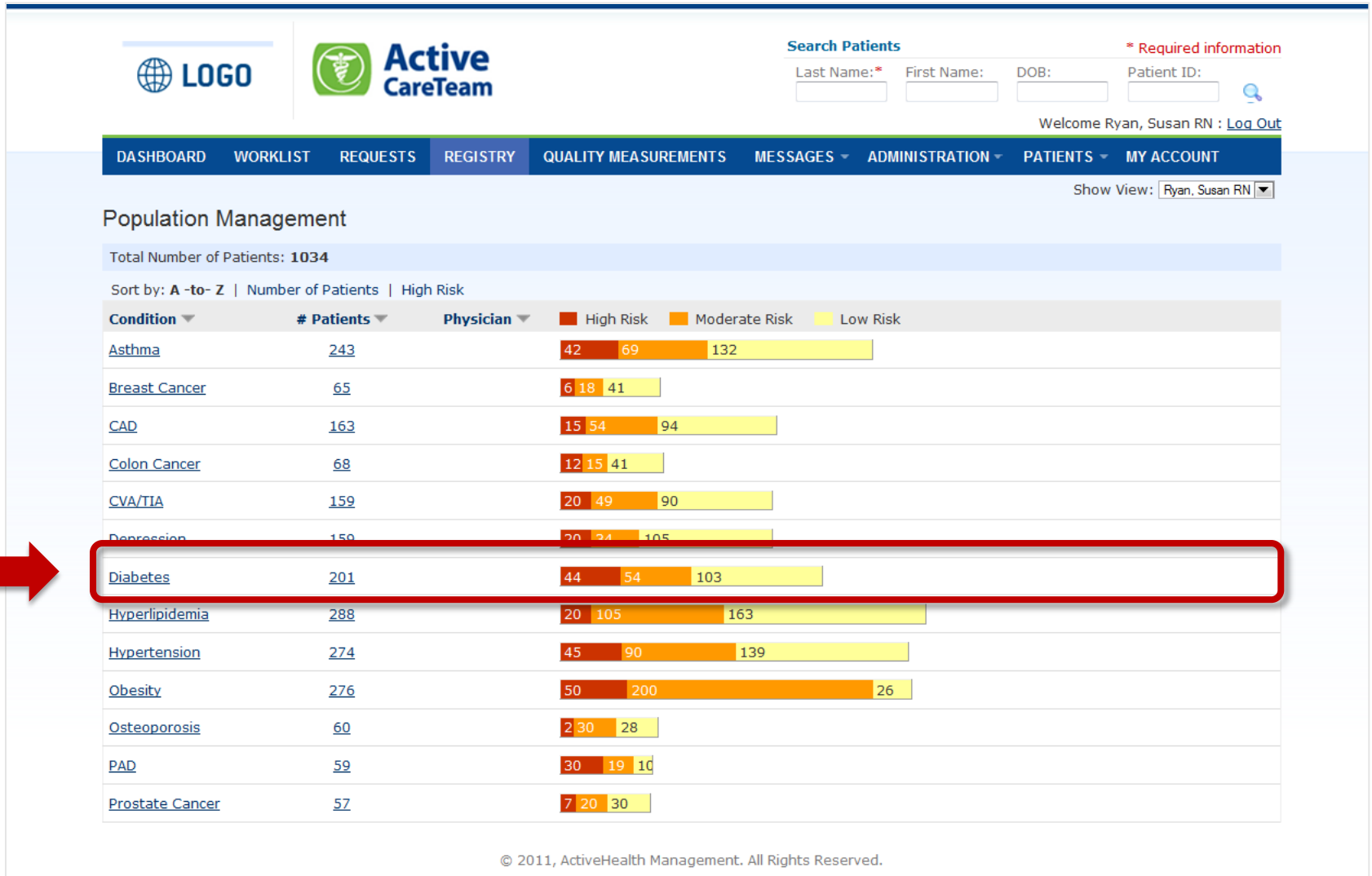
Dedicated Operational Support

- Program Director
- Implementation Manager(s)
- Program Operations Manager(s)
- Practice Marketing Manager
- Informatics Manager
- Performance-Based Contracting Manager

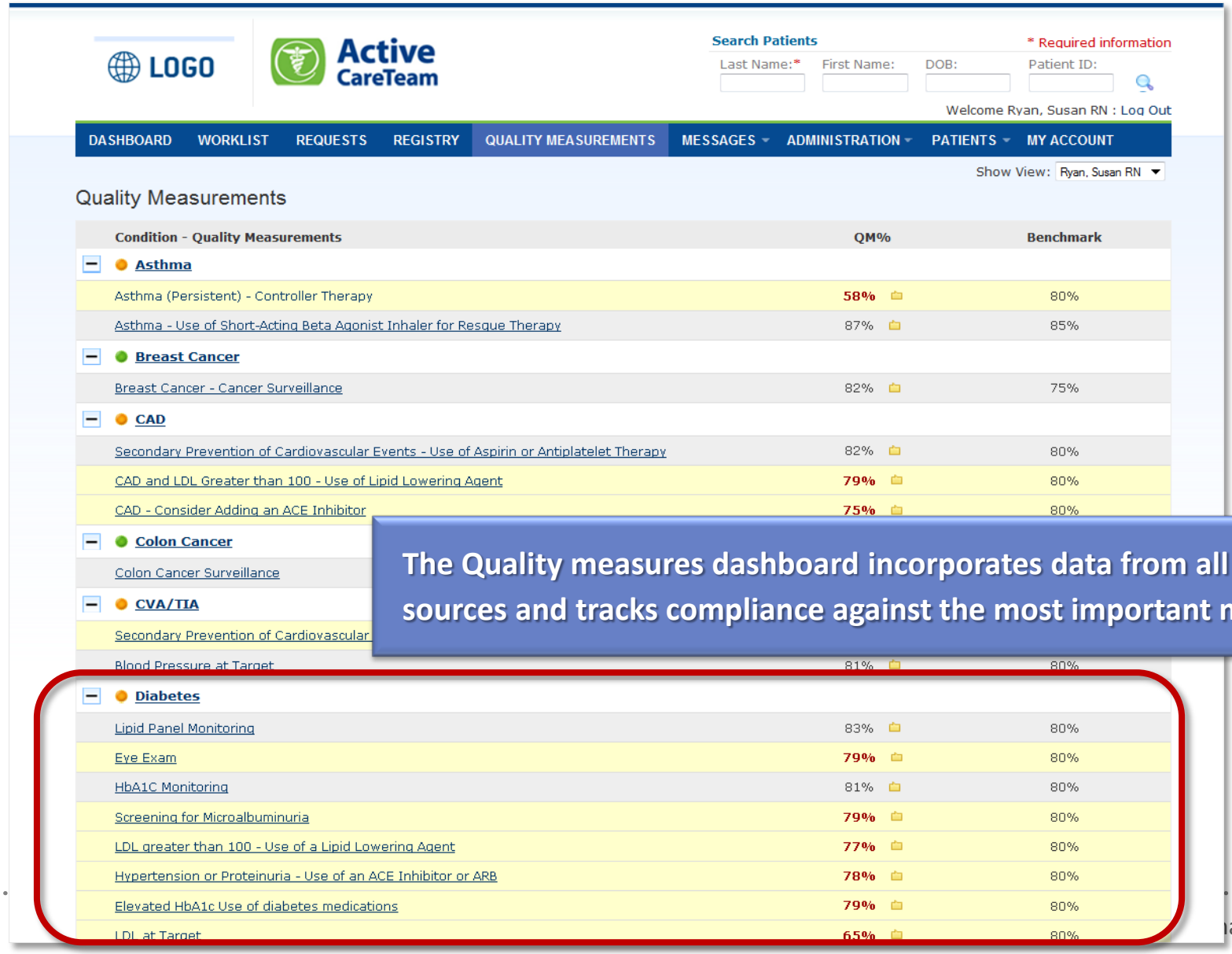
# At-risk populations

| Condition (At-Risk Pop.) | Measure | Submission | Data Source | Options to Meet Reporting Requirement |
|---|---|---|---|---|
| Diabetes Composite *(All or Nothing Score)* | Hemoglobin A1c control (<8%) | GPRO | Discrete lab value | • Access to lab result from: lab, HIE, EHR, manual entry |
| | LDL (<100) | GPRO | Discrete lab value | |
| | Blood Pressure <140/90 | GPRO | Clinical record – patient vitals | • Clinical record with diastolic and systolic values, HIE |
| | Tobacco non use | GPRO | Clinical record – progress note | • EHR, manual entry, HIE |
| | Aspirin Use | GPRO | Clinical record – progress note | |
| | A1c Poor Control (>9%) | GPRO | Discrete lab value | • Access to lab result from: lab, HIE, EHR, manual entry |
| Hypertension | Blood pressure control | GPRO | Clinical record – patient vitals | • Clinical record with diastolic and systolic values, HIE |
| Ischemic Vascular Disease | Lipid profile and LDL control <100 mg/dl | GPRO | Discrete lab value | • Access to lab result from: lab, HIE, EHR, manual entry |
| | Use of aspirin or another antithrombotic | GPRO | Clinical record – medication list/prescription hx | • EHR, manual entry, access to pharmacy data via eRx or HIE |
| Heart Failure | Beta-blocker therapy for left ventricular systolic dysfunction | GPRO | Clinical record – medication list/prescription hx | • EHR clinical record, manual entry, access to pharmacy data via eRx or HIE |
| Coronary Artery Disease Composite *(All or Nothing Score)* | Drug therapy for lowering LDL | GPRO | Clinical record – medication list/prescription hx | |
| | ACE inhibitor or reception blocker | GPRO | Clinical record – medication list/prescription hx | |

# Patient registry dashboard

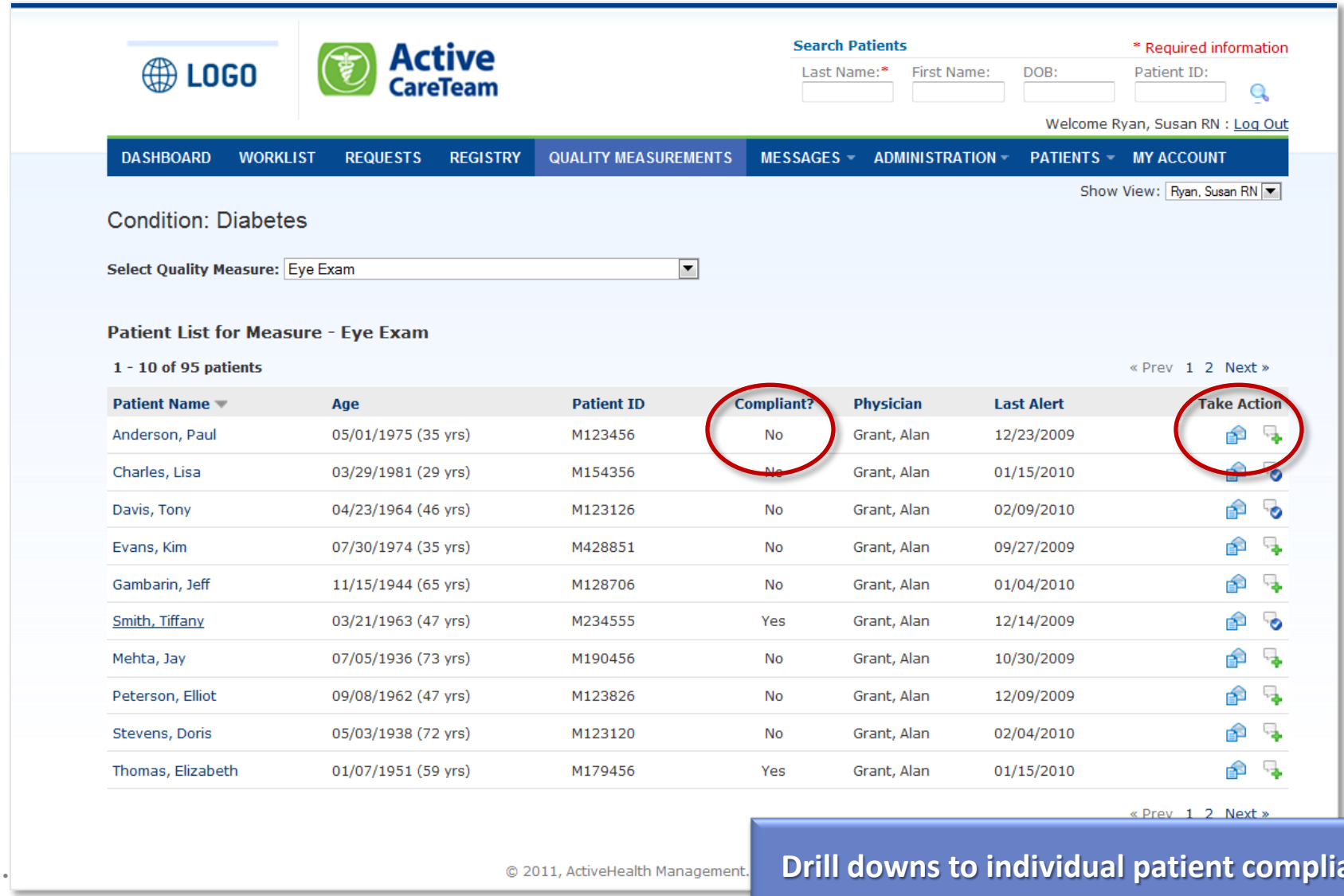


# Quality measures dashboard




**The Quality measures dashboard incorporates data from all available sources and tracks compliance against the most important measures.**

# Individual patient compliance




**Drill downs to individual patient compliance enable clinicians to take action.**

# Patient engagement is critical to health care's "triple aim": cost, quality and satisfaction

**We need to help our population:**

- Become aware and understand their individual risks and individual care plan
- Practice healthy behaviors
- Access and navigate the health care system intelligently
- Adhere to care and treatment plans
- Communicate with care givers and the care team
- Practice appropriate self care

# Case study: NovaHealth

A 2012 HealthAffairs article cited these results for how payer-patient collaboration reduced use and improved quality of care

**Model:** Medicare Advantage Members

- Independent Physician Association (IPA) established by InterMed
- Based in Portland, Maine
- Comprised of primary care, specialty, ancillary service and community resource care team members
- Participating in Medicare Advantage Collaboration Program since 2008

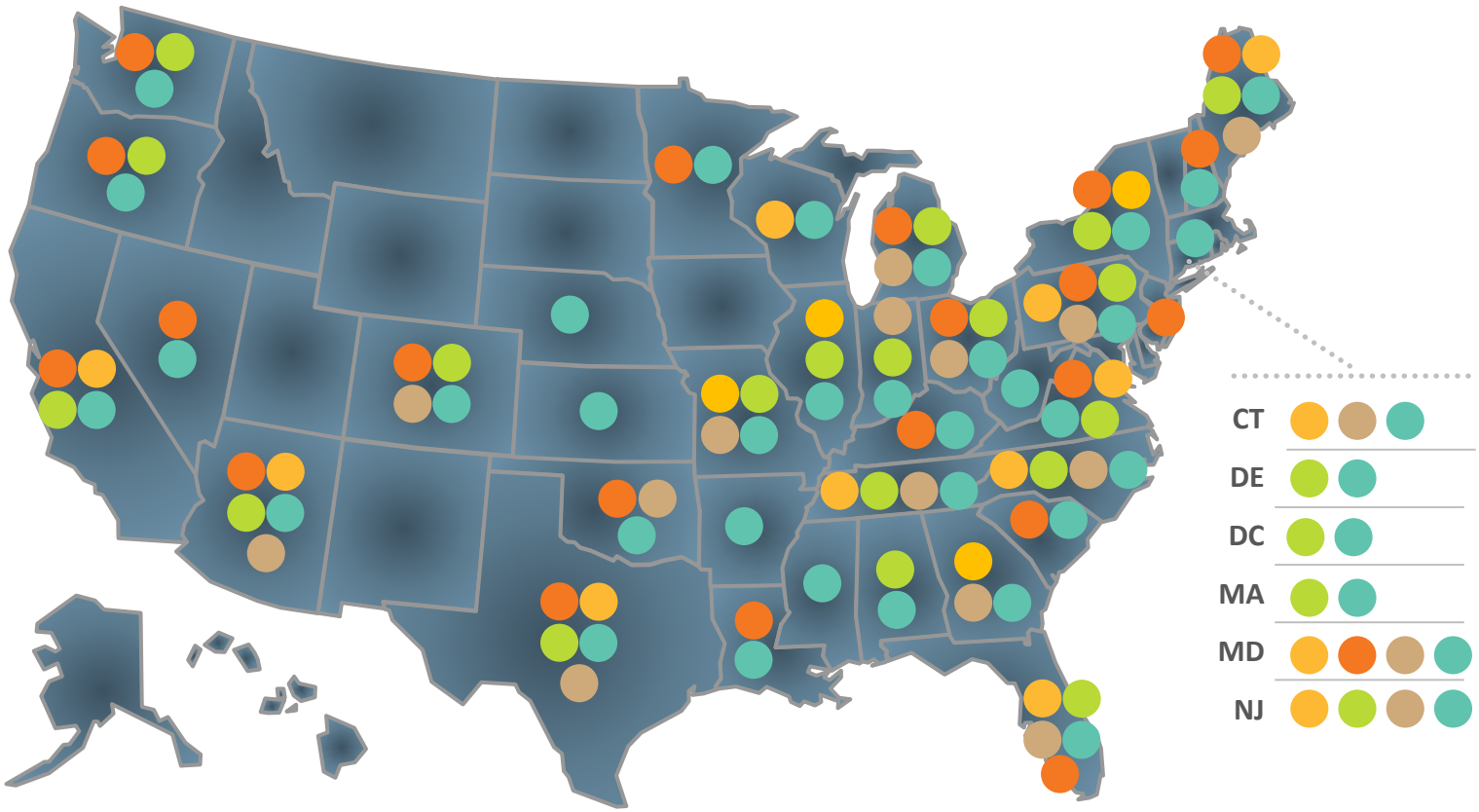
**Results:**

- 50% fewer inpatient hospital days
- 45% percent fewer hospital admissions
- 56% fewer readmissions*
- More than 99% of patients visited their doctors in 2011 to receive preventive and follow-up care
- 16 - 33% lower PMPM costs for Aetna Medicare Advantage members vs. Aetna Medicare Advantage members not cared for by NovaHealth

Source: 2012 HealthAffairs Article , Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan

# ACOs are expanding our value-based network

Over 250 active ACO negotiations covering 60% of U.S. population




Key

- **Contracted ACOs**
- **Primary Care Medical Homes (PCMH)**
- **Medicare Collaborations**
- **ACOs in Negotiation**
- **Other Aetna Value-based contracts** (Institutes of Excellence and Quality, Hospital/Specialty P4P, Bundled Payments, Aetna Performance Network, Aexcel & Savings Plus)

# Healthier populations at a healthier cost?

## Population health management can make it a reality

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Type your question into the questions box and the moderator will read the question on your behalf during the Q&A session.

If we are unable to answer all of the questions during the Q&A session, we will send you the questions and answers in an email.

# Missed the 2014 Healthy Counties Forum?

Additional information regarding:

- Accountable Care Communities,
- Using Information for Better Outcomes,
- Rural Health,
- Behavioral Health,
- Engaging County Employees to Drive Behavioral Change, and
- Criminal Justice System as Your Partner in Improving Health

can be found at www.naco.org/healthycountiesinitiative.

# Legislative Conference

**What:** Health Care Breakfast Roundtable

The ACA has profound implications for counties as employers, health care providers, and public health advocates. What does the future hold for your residents, employees, and retirees? The employer mandate, health insurance enrollment, and prevention will be discussed.

**When:** Saturday, March 1, 2014, 8:00am – 9:30am

**Where**: Washington Hilton, Washington, DC

Please contact Emmanuelle St. Jean, MPH, Program Manager at 202.942.4267 or estjean@naco.org for more information

# Upcoming Webinar

**County Health Rankings and Roadmaps: What's New in 2014?**

Do you know where you county will be ranked? What are the new measures and actions tools for 2014? Participants will get access to the embargoed data prior to its national release.

**When:** Thursday, March 20, 2014, 2:00pm – 3:15pm

**Register**: www.naco.org/webinars

**Contact**: Maeghan Gilmore, MPH, Program Director, at 202.942.4261 or mgilmore@naco.org