Practices for Improving Population Health

February 13, 2014
Healthy Counties Initiative Sponsors
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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?

- Public Health Department
- Insurers
- Hospitals
- Employers
- Social Services
- Long-term Care
- Home Care
- Pharmacies
- Home Care
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. (HSPHD)
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
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
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.

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

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¹ American College of Emergency Physicians Emergency Care Poll 2012
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:

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

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Cost is driven by the sickest of the sick

- **Healthy, minor health issues**: 75%
- **At-risk for major procedures (e.g. cardiology, oncology)**: 20%
- **Polychronic**: 5%

- **45%**: ER visits, overutilization, high care variation, noncompliance
- **35%**: Infections, complications, re-hospitalizations
- **20%**: Minor issues

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

- Lab data
- Payer claims
- Physician EMR data
- Inpatient EMR data
- Patient reported data
- Evidence-based clinical standards

Connecting to any HIE

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
- 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 isn’t following up on prescriptions and appointments?

Who isn’t compliant with their diabetes medication?

Who is overusing the emergency room?

Who is overdue for important preventive testing?

Who is seeing three specialists outside of your system?

Who is driving up costs and weighing down your quality improvement?
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
- Data analytics
- Applications

### Care Management

- 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

### Business Services

- 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

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

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**ActiveHealth Management**

- Lab Data
- Pharmacy Data
- Patient Reported Data
- Inpatient EMR Data

**Care Engine**

**Evidence Based Medicine (EBM) Rules Engine**

**Medicity**
## At-risk populations

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

**Total Number of Patients:** 1034

**Sort by:** A-to-Z | Number of Patients | High Risk | Moderate Risk | Low Risk

<table>
<thead>
<tr>
<th>Condition</th>
<th># Patients</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>243</td>
<td>42  69  132</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>65</td>
<td>6  18  41</td>
</tr>
<tr>
<td>CAD</td>
<td>163</td>
<td>13  54  94</td>
</tr>
<tr>
<td>Colon Cancer</td>
<td>68</td>
<td>12  15  41</td>
</tr>
<tr>
<td>CVA/TIA</td>
<td>159</td>
<td>20  49  90</td>
</tr>
<tr>
<td>Depression</td>
<td>150</td>
<td>20  64  105</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td><strong>201</strong></td>
<td><strong>44</strong>  <strong>54</strong>  <strong>103</strong></td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>288</td>
<td>20  105  163</td>
</tr>
<tr>
<td>Hypertension</td>
<td>274</td>
<td>43  90  139</td>
</tr>
<tr>
<td>Obesity</td>
<td>276</td>
<td>50  200  26</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>69</td>
<td>220  28</td>
</tr>
<tr>
<td>PAD</td>
<td>59</td>
<td>30  12  10</td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>57</td>
<td>7  20  30</td>
</tr>
</tbody>
</table>
The Quality measures dashboard incorporates data from all available sources and tracks compliance against the most important measures.

<table>
<thead>
<tr>
<th>Condition - Quality Measurements</th>
<th>QM%</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Asthma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma (Persistent) - Controller Therapy</td>
<td>58%</td>
<td>60%</td>
</tr>
<tr>
<td>Asthma - Use of Short-Acting Beta Agonist Inhaler for Rescue Therapy</td>
<td>97%</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Breast Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer - Cancer Surveillance</td>
<td>82%</td>
<td>75%</td>
</tr>
<tr>
<td><strong>CAD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Prevention of Cardiovascular Events - Use of Aspirin or Antiplatelet Therapy</td>
<td>92%</td>
<td>80%</td>
</tr>
<tr>
<td>CAD and LDL Greater than 100 - Use of Lipid Lowering Agent</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>CAD - Consider Adding an ACE Inhibitor</td>
<td>75%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Colon Cancer</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon Cancer Surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CVA/TIA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary Prevention of Cardiovascular Events</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure at Target</td>
<td>81%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipid Panel Monitoring</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>HbA1C Monitoring</td>
<td>81%</td>
<td>80%</td>
</tr>
<tr>
<td>Screening for Microalbuminuria</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>LDL greater than 100 - Use of a Lipid Lowering Agent</td>
<td>77%</td>
<td>80%</td>
</tr>
<tr>
<td>Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB</td>
<td>78%</td>
<td>80%</td>
</tr>
<tr>
<td>Elevated HbA1c - Use of diabetes medications</td>
<td>79%</td>
<td>80%</td>
</tr>
<tr>
<td>LDL at Target</td>
<td>65%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Individual patient compliance

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Age</th>
<th>Patient ID</th>
<th>Compliant</th>
<th>Physician</th>
<th>Last Alert</th>
<th>Take Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson, Paul</td>
<td>05/01/1975 (35 yrs)</td>
<td>M123456</td>
<td>No</td>
<td>Grant, Alan</td>
<td>12/23/2009</td>
<td></td>
</tr>
<tr>
<td>Charles, Lisa</td>
<td>03/29/1981 (29 yrs)</td>
<td>M154356</td>
<td></td>
<td>Grant, Alan</td>
<td>01/15/2010</td>
<td></td>
</tr>
<tr>
<td>Davis, Tony</td>
<td>04/23/1964 (46 yrs)</td>
<td>M123126</td>
<td>No</td>
<td>Grant, Alan</td>
<td>02/09/2010</td>
<td></td>
</tr>
<tr>
<td>Evans, Kim</td>
<td>07/30/1974 (35 yrs)</td>
<td>M428851</td>
<td>No</td>
<td>Grant, Alan</td>
<td>09/27/2009</td>
<td></td>
</tr>
<tr>
<td>Gambarin, Jeff</td>
<td>11/15/1944 (65 yrs)</td>
<td>M128706</td>
<td>No</td>
<td>Grant, Alan</td>
<td>01/04/2010</td>
<td></td>
</tr>
<tr>
<td>Smith, Tiffany</td>
<td>03/21/1963 (47 yrs)</td>
<td>M234555</td>
<td>Yes</td>
<td>Grant, Alan</td>
<td>12/14/2009</td>
<td></td>
</tr>
<tr>
<td>Mehta, Jay</td>
<td>07/05/1936 (73 yrs)</td>
<td>M190456</td>
<td>No</td>
<td>Grant, Alan</td>
<td>10/30/2009</td>
<td></td>
</tr>
<tr>
<td>Peterson, Elliot</td>
<td>09/08/1952 (47 yrs)</td>
<td>M123826</td>
<td>No</td>
<td>Grant, Alan</td>
<td>12/09/2009</td>
<td></td>
</tr>
<tr>
<td>Stevens, Doris</td>
<td>05/03/1938 (72 yrs)</td>
<td>M123120</td>
<td>No</td>
<td>Grant, Alan</td>
<td>02/04/2010</td>
<td></td>
</tr>
<tr>
<td>Thomas, Elizabeth</td>
<td>01/07/1951 (59 yrs)</td>
<td>M179456</td>
<td>Yes</td>
<td>Grant, Alan</td>
<td>01/15/2010</td>
<td></td>
</tr>
</tbody>
</table>

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
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 your 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