Population Health:
Opportunities and Challenges for Smaller Hospitals

October 20, 2016

Carol Davis, Principal

hfma™
kentucky chapter
healthcare financial management association

VERALON™
Agenda

1. What is population health?
2. Does your organization need a population health strategy?
3. Getting started with population health
4. Approaches to population health by smaller health systems
5. Key takeaways
6. Discussion and questions
Part I: What Is Population Health?

Depends on who you ask . . . .
For some, it includes the entire population

Public Health

Pop health = everyone

- Health outcomes
- Health determinants (wide range)
- Policies and interventions to improve health outcomes

Health Policy Experts

Pop health = everyone

- It means bending the overall cost curve and achieving better value for dollars spent; i.e., the Triple Aim:
  - Improving the experience of care
  - Improving the health of populations
  - Reducing per capita costs of health care
For others, it’s a subset of the population

Payers

Pop health = covered lives

It means aligning incentives with providers to better manage total cost of care

- Narrow networks
- Pay for performance
- Bundled payments
- Shared savings
- Shared risk
- Capitation

Physicians

Pop health = patient panel (still a stretch)

- Short answer:
  - More work and less money
- Longer answer:
  - A major reorientation from 1 on 1 patient care to managing the care and clinical outcomes of entire groups of patients
  - Includes those that may not be actively seeking care
What does population health mean to the general public?

"People use patient and consumer interchangeably... they're not the same."

- Jeff Margolis, chairman and CEO of Welltok, a consumer-facing health optimization platform

- Patients receive care, while consumers make choices
  - Only 15% of population are patients at any given time; all others are consumers
  - Engaged patients follow treatment recommendations
  - Engaged consumers make choices that impact their health status; not particularly interested in being engaged with providers

- Neither patients nor consumers:
  - Feel responsible for bending the healthcare cost curve
  - View themselves as part of a population that needs to have their health managed

Source: Consumers vs. patients: healthcare’s biggest misunderstanding, Becker’s Health IT and CIO Review, February 18, 2015.
And for hospitals and health systems?

**FOR PURPOSES OF TODAY’S DISCUSSION**

- Population health means having **proactive strategies** to measure and positively impact the health of individuals through targeted interventions that are **outside the usual scope of fee-for-service medical care**

- The catalyst for population health is generally **financial** – can be a **carrot or a stick** – that links provider reimbursement to activities that take place outside of their walls
Part II:
Does Your Organization Need a Population Health Strategy?
Yes . . . depth and breadth aligned with your specific market dynamics

- Payers
- Employers
- Competitors
- Community Health Needs
Payer environment is #1 driver for instituting a population health strategy

- Medicare
- Medicaid
- Private plans
Fee-for-service Medicare has been leading the charge

Value-based Payments (VBP) and Alternative Payment Models (APMs)

- HHS achieved its 2016 goal of 30% of Medicare payments linked to APMs – slightly ahead of schedule -

- By 2018, HHS aims to have 50% of payments linked to APMs and another 40% tied to quality and value through VBP mechanisms (total of 90% payment linked to quality and value)
2 new Medicare developments will further advance population health in small hospitals

**MACRA**

- MACRA will accelerate the shift to population health
- Potential for positive and negative financial adjustments
- Payments increasingly tied to performance on external variables
  - Value-based P4P, such as readmissions within 30 days and % of diabetes patients with well controlled A1C’s
  - Speculation that physician participation in advanced APMs will grow (bundled payments, shared risk contracts)
- Commercial payers may start linking reimbursement to MIPS scores

**Mandatory reporting by small hospitals (proposed)**

- “Non-participation . . . deprives rural residents of information about provider performance . . . and potentially signals that rural providers cannot provide high quality care”
- Overarching recommendation to “make participation in CMS quality measurement and quality improvement programs mandatory for all rural providers”
- Phased in over 4 years, with focus on incentives rather than penalties

Meanwhile, enrollment in Medicare Advantage plans continues to grow.

- 26% of Medicare beneficiaries who live in Kentucky are enrolled in Medicare Advantage plans – somewhat less than the national average of 31%.

- Medicare Advantage participation in Kentucky is highly concentrated among just three companies that collectively enroll 93% of all MA covered lives.

Understanding the competitive landscape is another important consideration

- Medicare
- Medicaid
- Commercial plans

Payers

Employers

Competitors

Community Health Needs

- Bundled payments
- ACOs
- Capitation
- Provider-sponsored health plans
The prevalence and influence of ACOs continues to increase

Commonwealth of Kentucky

State Innovation Model (SIM) Model Design Grant

State Health System Innovation Plan (SHSIP)
December 2015

Kentucky’s SHSIP establishes goals related to future growth of ACOs:

1. Increase enrollment in ACOs
   • Payer incentives to expand
   • Individual incentives to choose
2. Reduce administrative and financial barriers that limit expansion of ACOs
3. Expand to address social determinants of health and coordination with community resources
4. Expand to include more at-risk populations

Source: State Health System Innovation Plan (SHSIP), Commonwealth of Kentucky, December, 2015.
Are local self-funded employers interested in direct contracting?

- Medicare
- Medicaid
- Commercial plans

Payers

Employers

- Direct contracting with incentives
  - P4P
  - COE/bundled payment
  - Shared savings

Competitors

- Bundled payments
- ACOs
- Capitation
- Provider-sponsored health plans

Community Health Needs
Are there significant community needs that could be addressed through pop health?

Payers
- Medicare
- Medicaid
- Commercial plans

Employers
- Direct contracting with incentives
  - P4P
  - COE/bundled payment
  - Shared savings

Competitors
- Bundled payments
- ACOs
- Capitation
- Provider-sponsored health plans

Community Health Needs
- Uninsured population
- Access/utilization issues
- Health status
- Risk factors
Consider a phased approach to pop health that aligns capabilities and risk with market opportunities.

Financial Risk

Cost of care exceeds payments received

Cost of care coordination exceeds value created

Population Health Expertise

Provider Sponsored Health Plan

Payer Partnerships

Downside Risk

Shared Savings

Bundled Payments

Workforce

Current P4P Measures
Part III:
Getting Started with Population Health
A 6 Step Process for Population Health

1. Define Population
2. Identify Care Gaps
3. Stratify Risks
4. Measure Outcomes
5. Manage Care
6. Engage Patients

Data Integration Analysis Reporting Communication

Source: Adapted from Population Health Management: A Roadmap, Institute for Health Technology Transformation.
8 Building Blocks for Pop Health

- Advanced IT functionality
- Redesigned primary care models
- Acute care link to population health
- Shared vision and committed leadership
- Sufficient scale
- Access to robust continuum of care services
- Effective health IT capabilities
- Aligned physicians with a strong primary care base
Population Health Building Blocks

Foundational Requirements

- Sufficient scale
- Access to robust continuum of care services
- Effective health IT capabilities
- Aligned physicians with a strong primary care base
Foundational Requirements

Physician and Hospital/System Alignment

Challenge

HIGH

Equity Joint Venture
Information System Linkages

Professional Services Agreement
Recruitment Assistance
Acquisition w/o Employment
Real Estate Partnerships

LOW

Clinical Leadership Councils

Degree of Alignment and Clinical Integration

HIGH

Physician Employment
ACO/CIN
Medical Foundation
Co-management Agreement
MSO
Medical Directorship
Selling/Contracting Outpatient Services
Joint Operating Agreement

Target Group Key:

- Any
- Independent Physicians
- Employed Physicians
- New Physicians
- Retiring Physicians
- Office-Based and Hospital-Based Physicians

Prevalence Key:

- Low
- Moderate
- High

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Foundational Requirements

Health IT Capabilities

● Does your IT system record **accurate and complete data from all care delivery sites** and store it so that it is accessible, understandable and useful?
  
  o Is it designed to capture the important data elements?
  
  o Are users inputting the data consistently and correctly?
  
  o Can you do anything with the data?

● Do you have an effective **cost accounting** system?
To succeed in population health, hospitals and health systems must have access to a well-developed continuum of care, either by direct ownership or through partner relationships.
Foundational Requirements

Sufficient Scale: How Big?

- Larger Scale Requirements
- Smaller Scale Requirements

- Pay for Performance
- Bundled Payments
- Shared Savings
- Downside Risk
- Capitation
- Insurance Products

- Less Degree of Financial Risk
- More Degree of Financial Risk

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Collaborative models can provide sufficient scale for smaller hospitals and health systems to pursue shared savings and other initiatives that involve population health.
Achieving Sufficient Scale
Regional Consortium Example

Kentucky Health Collaborative

- Charter signed 01.28.2016
- Primary objectives:
  - Raise statewide standards of care
  - Address Commonwealth’s poor health statistics
  - Reduce the cost of care

Population Health Building Blocks

Intermediate Capabilities

- Advanced IT functionality
- Redesigned primary care models
- Acute care link to population health
- Shared vision and committed leadership
Intermediate Capabilities
Shared Vision and Committed Leadership

From Fee for Service to Value-based Reimbursement

- What does it mean to provide patients with the “right care at the right time in the right place?”
- What will be the impact on your organization if you are successful in achieving the Triple Aim?
  - Improve the experience of care
  - Improve the health of populations
  - Reduce the per capita cost of health care
- Are you committed to driving down avoidable hospital stays and other utilization if it results in lost fee-for-service revenue?
- Are you willing to do what it takes to reduce acute care capacity accordingly?
Intermediate Capabilities

Culture and Change Management: Critical Skills

“I need a little stronger leadership effort on the change management initiative, Henry.”
Intermediate Capabilities

Acute Care Link to Population Health

- **Downside risk**
  - Shared savings
  - Bundled payments
  - Value based payments

- **Total cost of care for covered lives less than expected**:
  - Utilization/performance all services
  - Robust population health

- **Total cost of care for limited set of procedures**:
  - Internal performance
  - Non-acute performance
  - Episode-specific transitions of care

- **Total cost of care for covered lives less than payments received**:
  - Primarily internal performance + condition-specific transitions of care for 30 days:
    - Inpatient readmits
    - Surgical complications
    - Mortality
    - Appropriate follow-up

More pop health

Less pop health
“Practice-based population health” (PBPH) means addressing the health needs of a total patient population, not just those who actively seek care.

Financial incentives based on aggregated results for all patients.

### Intermediate Capabilities

#### Redesigned Primary Care Models

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>1 Physician 2,500 Patients</th>
<th>10 Physicians 25,000 Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperlipidemia</td>
<td>511</td>
<td>5,110</td>
</tr>
<tr>
<td>Hypertension</td>
<td>472</td>
<td>4,720</td>
</tr>
<tr>
<td>Depression</td>
<td>118</td>
<td>1,180</td>
</tr>
<tr>
<td>Asthma</td>
<td>183</td>
<td>1,830</td>
</tr>
<tr>
<td>Diabetes</td>
<td>145</td>
<td>1,450</td>
</tr>
<tr>
<td>Arthritis</td>
<td>381</td>
<td>3,810</td>
</tr>
<tr>
<td>Anxiety</td>
<td>279</td>
<td>2,790</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>140</td>
<td>1,400</td>
</tr>
<tr>
<td>COPD</td>
<td>131</td>
<td>1,310</td>
</tr>
<tr>
<td>CAD</td>
<td>120</td>
<td>1,200</td>
</tr>
</tbody>
</table>

### Health Risk Category

<table>
<thead>
<tr>
<th>Health Risk Category</th>
<th>1 Physician 2,500 Patients</th>
<th>10 Physicians 25,000 Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>550</td>
<td>5,500</td>
</tr>
<tr>
<td>Injury Prevention</td>
<td>400</td>
<td>4,000</td>
</tr>
<tr>
<td>Nutrition</td>
<td>2,400</td>
<td>24,000</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>1,200</td>
<td>12,000</td>
</tr>
<tr>
<td>Sexual Behavior</td>
<td>25</td>
<td>250</td>
</tr>
<tr>
<td>Skin Protection</td>
<td>850</td>
<td>8,500</td>
</tr>
<tr>
<td>Smoking</td>
<td>857</td>
<td>8,750</td>
</tr>
<tr>
<td>Depression Symptoms</td>
<td>300</td>
<td>3,000</td>
</tr>
<tr>
<td>Weight Management</td>
<td>1,600</td>
<td>16,000</td>
</tr>
</tbody>
</table>

Source for tables: ACOs and Population Health Management, AMGA.
### Intermediate Capabilities

#### Evolution of Population Health in Primary Care Practices

<table>
<thead>
<tr>
<th>Patient Population Identification</th>
<th>Health Assessment</th>
<th>Risk Stratification</th>
<th>Engagement</th>
<th>Patient-Centered Interventions</th>
<th>Impact Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician receives real time, patient &amp; population specific data at point of care</td>
<td>Clinician auto-notified of new or conflicting info requiring resolution</td>
<td>Valid tools auto-stratify patients &amp; population across all clinicians; gaps flagged for action</td>
<td>“Medical home;” clinician monitors, optimizes care plan &amp; care team across all settings</td>
<td>Clinician/patient collaborative care plan; primary, secondary &amp; tertiary prevention focus; coordinated team</td>
<td>Real time feedback; outcomes meet or exceed patient/population goals</td>
</tr>
<tr>
<td>Clinician registry – key diagnoses, tests, history, and condition control</td>
<td>Clinician evaluates health risks based on year-over-year comparison</td>
<td>New health risks identified through health assessments and registry lists</td>
<td>Clinician engages with patient focusing on both past and newly identified risks</td>
<td>Clinician focuses on primary, secondary &amp; tertiary prevention; strategies for risks identified</td>
<td>Clinician unaware of patient outcome unless directly involved in care</td>
</tr>
<tr>
<td>Clinician identifies patient through direct interaction and clinical records</td>
<td>Clinician assesses patient at the visit</td>
<td>Clinician aware of high-risk patients based on “frequent flier” status</td>
<td>Clinician engages with patient episodically at patient presentation</td>
<td>Intervention based on current patient need and known health risk(s)</td>
<td>Clinician unaware of patient outcome unless directly involved in care</td>
</tr>
</tbody>
</table>

Source: Adapted from A Population Health Guide for Primary Care Models, CareContinuum Alliance, May, 2012.
Intermediate Capabilities

Critical Success Factors for Primary Care

- Care teams: new roles, all practicing at the “top of their license”
- Patient-centered: extended hours, open-access scheduling, electronic communications, including virtual visits
- Care coordination: across settings, between episodes of care
- Patient outreach: not just those with complex needs
- Extensive use of data analytics and automated tools

Incremental Changes to Traditional Practices? vs. New Models from the Ground Up?

New West Physicians
iorahealth
Chen
Concerto Health

We put your health first
Intermediate Capabilities
Advanced IT Functionality

An electronic medical record (EMR) is just the first step!

- IT must compile clinical, financial and operational data from across the care spectrum → health information exchange
- Systems must be able to monitor and identify patients at risk → predictive analytics
- Effective health IT must produce data that is meaningful and actionable
- Algorithms prompt targeted patient outreach strategies → automated and human interactions

Many hospitals are purchasing population health systems (or contracted services) that work in tandem with their EHRs

Source: Adapted from Population Health Management: A Roadmap, Institute for Health Technology Transformation.
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Part IV:
Approaches to Population Health by Smaller Health Systems
Three Hospitals – Three Approaches

√ Current reimbursement arrangements that are causing you to pursue population health management

√ Rationale and objectives for choosing this path

√ Current capabilities – governance, management and care delivery/coordination

√ Additional opportunities and future direction

√ Challenges

√ Lessons learned – advice for others
Example 1

McDonough District Hospital

- 48 bed acute care hospital
- Public facility with no tax revenues
- Medical staff ≈80% employed; 20% independent
- 31,000 population in PSA
- Favorable payer mix
- 47% inpatient market share in PSA
- 60-90 min drive in any direction to a large system
STRATEGY (the "What")
- Investment model MSSP with 5 other IL hospitals in partnership with Caravan Health (formerly NRACO)
- Became operational Jan 2016 – ≈1,650 lives attributed to MDH
- Independent PCPs invited to participate; so far employed only

RATIONALE (the "Why")
- Prepare for emerging payment models with modest financial investment and limited risk ("no brainer")
- Gain access to claims data not available otherwise
- Do the right thing → improve care, reduce costs

CAPABILITIES (the "How")
- Overall governance and robust infrastructure for IT (Lightbeam Health Solutions) and care management expertise through Caravan Health
- Local Steering Committee and resources for leadership, direction, coordination and specific care management initiatives
- Based on 2 quarters of data, will be focusing on ED utilization
Opportunities, Challenges and Lessons Learned

**Opportunities ("What’s Next")**
- Transition to full PCMH & integrate with OP behavioral health
- Grow outpatient to offset decrease in ED/inpatient (e.g. wellness visits)
- Formalize linkages with post-acute and other community organizations
- Extrapolate learnings to broader patient population
- Use documented quality and value as competitive advantage

**Challenges**
- Enormous amount of data → where to focus?

**Lessons Learned**
- Bring board into process earlier → education, buy-in
- Provide independent and specialty physicians with a clear message about what’s in it for them
- Make sure you have strong primary care leadership and buy-in → critical success factor
Example 2

Summit Healthcare Regional Medical Center

- 89 bed acute care hospital
- Private 501(c)(3) independent facility
- Medical staff ≈50% employed; 50% independent
- 58,000 population in PSA
- Moderately challenging payer mix
- 57% inpatient market share in PSA
- Most outmigration to Phoenix metro – 3.5 hour drive
Summit Healthcare
Pop Health Strategy, Rationale & Capabilities

**Strategy (the “What”)**
- Develop provider network for direct contracting with local self-insured employers
- Create CIN (complete with >99% local provider participation)
- Apply for MSSP (kicks off 01.01.17 with ≈5,600 lives)

**Rationale (the “Why”)**
- Decrease patient outmigration
- Strengthen relationships with independent physicians
  - Out of town ACOs were signing up local independent docs
- Create vehicle for future risk-contracting arrangements

**Capabilities (the “How”)**
- CIN leadership and infrastructure in place
  - Governing board physician-led; heavily primary care
  - Robust committee structure for credentialing, clinical integration initiatives, finance
  - Staff support – executive director, 2 RN case manager, data analytics
- Caradigm as population health IT platform
  - Joint venture of GE and Microsoft
Opportunities, Challenges and Lessons Learned

**Opportunities ("What’s Next")**
- Additional contracting opportunities locally (bundled payments/other risk-based arrangements, private health plans, employee health plan, direct contracting)
- Statewide network of multiple CINs (commercial payers, Medicare Advantage)

**Challenges**
- Multiple disparate EMR systems → working on HIE
- Operationalizing the strategy successfully
- Engaging small, independent practices in new way of doing business

**Lessons Learned**
- Use third party resources for education, advice and facilitation
- Allow sufficient time – 18 months from “go” decision to MSSP kick off
- Be prepared to make a substantial financial investment
- Make site visits to learn from others
Example 3

Yavapai Regional Medical Center

- 2 acute care hospitals with 134 total beds
- Private 501(c)(3) independent health system
- Medical staff ≈50% employed; 50% independent
- 132,000 population in PSA
- Favorable payer mix (despite very high Medicare)
- 74% inpatient market share in PSA
- Most outmigration to Phoenix metro – 2.5 hour drive
Yavapai Regional Medical Center
Pop Health Strategy, Rationale & Capabilities

**Strategy (the “What”)**
- Partner with Northern Arizona Healthcare to create NCAAC and participate in MSSP (completing year 2 with 8K of 14K lives attributed to YRMC; barely missed threshold for shared savings in year 1)
- Develop co-management/bundled payment strategy for orthopedics (substantially complete)

**Rationale (the “Why”)**
- Protect and strengthen local market position (competing ACO in town – physician led MSSP)
- Gain access to total claims data
- Prepare for new risk-based payment models

**Capabilities (the “How”)**
- Population health resources developed at local level rather than for ACO overall
- Developing care management expertise (transitional care, complex case management, 24 hour nursing triage, post-acute and home visits, patient engagement)
- Population health IT capabilities improving but underdeveloped
Opportunities, Challenges and Lessons Learned

**OPPORTUNITIES (“WHAT’S NEXT”)**
- Expand scope of bundled payment arrangements → cardiac?
- Facilitate development of legal structure for independent physicians
- Partner with Medicare Advantage plan for branding, PMPM $$$ → likely on regional or statewide basis

**CHALLENGES**
- Shared vision and new mindset for providers → from “they” to “we”
- Integration and evolution of systems → IT, care management, coding
- Thoughtful allocation of resources to population health initiatives

**LESSONS LEARNED**
- It takes a village
- Huge change for providers → educate, communicate, repeat
- Give it time
Part V:
Key Takeaways
Key Takeaways

- If value and shared risk reimbursement models are here to stay (and so it seems), **population health capabilities will be required** for future success.

- It may not be necessary to become a market leader in population health, but **don’t fall behind the curve**, because you won’t be able to catch up.
  - If you don’t take the lead, **others will likely step in**.

- As financial risk increases, so does the need for scale and sophisticated analytics; **smaller hospitals will most likely need partners** when they get to that level.

- Don’t underestimate the importance of shared vision and difficulty of culture change.

- As you get better at population health management, prepare for a **significant decrease in inpatient volume and associated revenue**.
Discussion and Questions
Speaker Information

Carol Davis, MSHA
Principal

Carol Davis is an experienced strategy consultant and project leader with more than 25 years of experience working with hospitals and health systems, both as a strategy advisor and health system executive. She has led over 250 consulting engagements for rural and community hospitals, health systems, and academic medical centers.

Her expertise includes:

- Strategy development and implementation for rural and community hospitals/health systems, including affiliations and partnerships
- Ambulatory services and facilities planning and development
- Service line strategy development in women’s health, neurosciences, and cardiovascular services
- Physician-hospital alignment strategy, including development of clinically integrated networks

Contact Information

- Email: CDavis@Veralon.com
- Phone: 215.399.1888 (office) or 970.219.4737 (mobile)
About Veralon

● Veralon was formed in January 2015 by the merger of two respected national healthcare management consulting firms, DGA Partners and Health Strategies & Solutions. Veralon consultants are trusted advisors to healthcare leaders, partnering with those leaders to achieve success for their organizations and to transform the healthcare industry. We offer the expertise and thought leadership of the nation’s leading healthcare strategy firm, combined with outstanding valuation skills and financial capabilities in fully implementing planning recommendations.

● Our management team averages more than 25 years healthcare consulting and operations experience, so we can attack problems requiring senior level intuition and expertise. Veralon has completed almost 5,000 healthcare consulting engagements for more than 1,100 clients in 47 states and Canada, including health systems, academic medical centers, teaching hospitals, community hospitals, ACOs/PHOs/CINs, physician groups, health plans, and more.

● Our commitment to our clients is a responsibility we take seriously. Seventy percent of our business comes from clients we have worked with previously, and our longevity in the field speaks to our ability to deliver results.

● We have offices in five metropolitan areas: Philadelphia, New York, Chicago, Atlanta and Los Angeles