Creating a Population Health Strategy that Scales

Session #72, March 6, 2018
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UMass Memorial Health Care
Conflict of Interest

Renee Broadbent, MBA

Has no real or apparent conflicts of interest to report.
Agenda

Essential elements for creating a system-wide PHM program

• Investment categories
• Strategy and development
• Management
• Logistical barriers
• Education and communication
Learning Objectives

• Define the investment categories needed to scale a system-wide population health management program

• List the elements of developing and managing a system-wide PHM program, including financial planning and ROI reporting to drive greater executive and physician buy-in

• Describe logistical barriers to a system-wide PHM program, including disparate data sources, physician push back and educational / training needs

• Discuss the role of education and communication in meeting system-level PHM goals
UMass Memorial Health Care Overview

• Largest health care system in central Massachusetts
• Clinical partner with UMass Medical School, with access to latest technology, research and clinical trials
• Locations:
  – UMass Memorial Medical Center (Worcester)
  – HealthAlliance-Clinton Hospital (Clinton, Burbank and Leominster)
  – Marlborough Hospital (Marlborough)
• 1,600 physicians on active medical staff
• 3,000 registered nurses
• 12,000 total employees
• 1,125 hospital beds
UMMHG Geographic Footprint 2018
Population Health Management Organization

• Internal organization within the health system
• Sits at the system level, meaning we have responsibility for the entire organization as the drivers of population health
• Manage multiple programs (MSSP, Bundles, Commercial, Medicaid Pilot)
• Staff of 67 consisting of Administration, Care Management, Physician Leadership, Data Analytics & Reporting, Account Management for Network support and development
• 1,700+ participating providers in Central MA and to the east and west
• Total beneficiary member count across programs: 150,000
• Internal relationships and partnerships with medical school and community organizations to facilitate population health management
• Total of 3 additional hospitals outside the system that participate
Investing in a System-Wide PHM

• Objective: Create a clear picture of population health needs and value-based care performance.

• Data Consolidation (data aggregation)
  – 32 different EMRs from independent ACO providers
  – Claims
  – Multiple internal systems - Single EMR 10/1/2017

• Analytics Platform
  – Collects, integrates and analyzes data from all sources
  – Develops quality and medical expense reports
  – Predictive analytics finds opportunities for population health improvement
  – Enterprise analytics population health as a strategic system effort

• Robust Operations
  – Invest in people, processes and technology to support success
Strategy & Development

- Create a complete PHM strategy:
  - Care management
  - Staffing models
  - Governing models
  - Budgeting
- Create a comprehensive financial plan
- Develop a dedicated team to lead PHM strategies:
  - Responsible for education
  - Monitors compliance
  - Recommends modifications
## Utilization Management Strategic Initiatives

<table>
<thead>
<tr>
<th>CARE MANAGEMENT</th>
<th>PRACTICE ENGAGEMENT</th>
<th>CARE PATHWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care managers focusing on four domains for intervention</td>
<td>Engaging our primary care practices as partners for practice-based care management</td>
<td>Employing clinical interventions that begin in the inpatient setting to reduce overall post acute utilization and improve patient outcomes</td>
</tr>
<tr>
<td>• Readmissions</td>
<td>• Standardized patient management tactics</td>
<td>• Bundle care best practices</td>
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<tr>
<td>• ED utilization</td>
<td>• Rising risk identification and action steps</td>
<td>• Specialist engagement</td>
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<tr>
<td>• Chronic disease management</td>
<td>• Care management team utilization</td>
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<td>• Post-acute care</td>
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</table>
## Care Management Pillar Initiatives

### I. Readmissions
**Pillar Lead**

- **WP2:** Telemonitoring pilot for COPD and CHF
  - PIC
- **WP3:** Readmissions Advisory Committee
  - COPD/CHF CM workgroups with medical center
  - PIC
  - Transitional Care Management coding (educational)
  - PIC
  - SNF/LTAC/Post-Acute Transitions
  - PIC
- **WP4:** D/C Follow-up phone calls for medical center
  - PIC
- **WP5:** Standard CM work & internal summit
  - PIC

**Metrics:**
- Disease-specific readmission rates
- Short-term stay total discharges

### II. ED Utilization
**Pillar Lead**

- **WP6:** Provider triage algorithms, flyers for offices, resource maps, standardized patient education & ID inappropriate ED usage
  - PIC
- **WP7:** Care plans for high ED utilizers/super user lists from XXXX
  - PIC
- **WP8:** Community Paramedicine
  - PIC
- **WP9:** Hotspotting program
  - PIC

**Metrics:**
- Relationship between no-show patients and ED utilization
- NYU algorithm rates
- % avoidable ED visits

### III. Chronic Disease Management
**Pillar Lead**

- **WP10:** ESRD
  - PIC
  - Palliative Care Consults
  - PIC
  - Davita & Fresenius catheter centers
  - PIC
- **WP11:** National Sleep and Respiratory Pilot
  - PIC
- **WP12:** Complex care clinic (Heywood)
  - PIC
- **WP13:** DM Community classes with HLCOE
  - PIC
  - Omnicare
  - PIC
- **WP14:** Pharm/med adherence programs
  - Shields specialty pharmacy pilot
  - PIC
  - Ormedcare
  - PIC
- **WP15:** CKD Pilot
  - PIC
- **WP16:** DM Clinical Pathway
  - PIC
- **WP17:** Hypertension Control Project
  - PIC

**Metrics:**
- ESRD readmissions
- Catheter days
- Hospitalization rate
- Depression screenings and remission
- HEDUS measures used by commercial contracts
- CKD progression to ESRD and ESRD stage progression
- % of patients who don’t get x-rays within 28 days of first appointment for back pain
- Measures of the month (e.g., hypertension, diabetes retinal exams, asthma medication ratio, etc.)

### IV. Post-Acute Care
**Pillar Lead**

- **WP18:** Non-preferred SNF networks
  - Lifecare
  - PIC
- **WP19:** Preferred SNF networks
  - PICs
- **WP20:** PIC
- **WP21:** SNF Care Management Initiatives
- **WP22:** SNF Palliative Care Pilot
  - PIC
- **WP23:** Post-Acute work groups
  - PIC
- **WP24:** SNF hand off to PCP pilot (LEAN project)
  - PIC
- **WP25:** Advanced care planning/honoring choices
  - PIC

**Metrics:**
- LOS
- Readmissions
Utilization Management Strategic Initiatives

Pillars (Care Management Focus)

- **Project Lead**
  CM Management + Project Plans

I. Readmissions
   **Pillar Lead**
   - Practice Engagement
     1. 4-quadrant list
     2. Practice leadership meetings
     3. Team meeting with CM, PIF, and Med Dir.
     4. Create action steps
        1. Specific patient solutions (who will follow-up)
        2. Practice level interventions/operational changes
        3. Additional tips or hints to address patients on the right/lower quadrant

   Tactics:
   - See next page

   Metrics
   - See next page

II. ED Utilization
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   Tactics:
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   Metrics
   - TBD

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   Tactics:
   - See next page

   Metrics
   - TBD

Care Pathways

**Project Lead**
Inpatient Team + Project Plans

- Employing clinical interventions in the inpatient setting to reduce SNF utilization and improve patient outcome
- Bundle care practices
- Inpatient psych network

Tactics:
- WP1: Inpatient psych network development/telehealth
  - PIC
- WP26: Telehealth
  - PIC
- Bundle best practices
  - PIC

Metrics
- TBD
Where is the expense derived?
How to anticipate and change
Patient Risk Matrix

- **Urgent (Illness/Trauma)**
  - Evaluate potential to benefit from complex care management.

- **Sickest (Chronic Disease)**
  - Assess need for complex care management intervention.
  - Clinical management by Providers.

- **Healthy**

- **Rising Risk (Bubbles Up)**

**TME**

- Complex care assessment.
- Prevention & wellness focus.
Management
Office of Clinical Integration (OCI): The UMass Memorial Health Care model for supporting population health management across the system

- Multi-disciplinary team tasked to manage cultural change
- Oversee areas such as Medicare and Medicaid ACOs and other risk-based contracts
- Functional areas:
  - Quality reporting
  - Quality payment program guidance
  - Practice improvement facilitation
  - State and federal regulatory and policy impact analysis, education and support
  - Data aggregation and analysis
  - Utilization reporting and analysis
  - Care management and coordination
  - SNF utilization management
  - Engagement and decision-making opportunities
Quality Management Report

Quality Management Report
Commercial Payer: Quality Performance

Process Measures

Outcome Measures

Experience Measures

Process Measure: CY2017 claims data updated through 07/31/2017
Outcome Measure: CY2015 final outcome results
Experience Measure: CY2014 MYOP Survey results received in 2017

Measure Year:
- 2017
- 2016
- 2015
- 2014

Select Performance Level:
- Network Level
- Regional
- National

Select Group at:
- Group Level
- UMassMC Network

UMASSMC Network

Diabetes ASC Outcome
Diabetes BP Outcome
HtN BP Outcome

Measure Rate (%)

82.48 82.16 74.19 74.69
73.58 73.58 70.08 70.08

Diabetes ASC Outcome
Diabetes BP Outcome
HtN BP Outcome

Measure Rate (%)

82.35 84.44 94.47 94.48
98.58 98.54 99.23 99.83
86.69 86.69 87.29 87.29
97.70 97.70 97.70 97.70

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What is Practice Improvement Facilitation?

*Practice Facilitation* is a supportive service provided to a primary care practice by a trained individual or team of individuals.

*Practice Improvement Facilitators (PIFs)* use a range of organizational development, project management, quality improvement, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals.

How is support offered?

- On-site
- Virtually (telephonic or webinars)
- Combination of both
When used well, a practice facilitator will build capacity for change

Doing tasks for the team  Facilitating  Consulting  Training  Coaching

Increasing team responsibility for providing content and managing the process

Practice facilitator in role of “doing for to get work done”

Practice facilitator in role of “empowering, eliciting, enabling to get work done”

Created by Neil Baker, Ann Lefebvre, and Cory Sevin for the Institute for Healthcare Improvement
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State and Federal Regulatory Impact

• Rapidly changing regulatory environment requires dedicated resources to monitor state and federal regulatory activities.

• MACRA is a healthcare game-changer with significant financial implications, both positive and negative, and presents unique challenges for ACOs and their provider partners.

• Regulatory liaison with state and federal regulators is key to keeping abreast of the dynamic regulatory and enforcement environment and development of training and tools to ensure compliance with evolving requirements.

• Increased regulatory oversight of value-based program reporting and payment methodologies requires vigilant monitoring and auditing.

• The shift from volume to value by state and federal programs and the resulting waivers of provisions within anti-kickback, Stark and other state and federal laws requires dedicated resources to ensure appropriate applicability to Population Health programs.

• As the environment evolves, organizations need to remain nimble and ensure ongoing assessment of the regulatory parameters around population health management initiatives and how to leverage the existing framework to find optimal performance opportunities within it.
Analytics Platform & Data Consolidation

• Implementing a data aggregation strategy (automated collection and integration of data from all sources); 32 different EMR’s
  ─ Claims data integration
• Development of IT plan for integration/migration plan to hospital EMR; how all the pieces fit together
• Enhanced reporting and predictive analytics; actionable data for the future planning, data governance
• Additional data sources, SNF’s, other facilities, HIE’s, etc.
• Interoperable framework
• What other systems are needed to support the population health management office?
Conceptual Model

- Data is a key part of the VBC strategy
- Conceptual model demonstrates the data sources and process
- It fuels the processes and programs in the VBC model
- It must remain flexible
- Many layers of integration
- Production of robust analytics
Medicare ACO Management Report

Person-Years by Bene Type

<table>
<thead>
<tr>
<th>Bene Type</th>
<th>Members 2017Q2</th>
<th>2017Q2 %</th>
<th>PMPY$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged/Dual</td>
<td>4,233</td>
<td>8.4%</td>
<td>$14,531</td>
</tr>
<tr>
<td>Aged/Non-Dual</td>
<td>33,618</td>
<td>67.0%</td>
<td>$10,046</td>
</tr>
<tr>
<td>Disabled</td>
<td>12,011</td>
<td>24.0%</td>
<td>$10,914</td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td>277</td>
<td>0.6%</td>
<td>$101,842</td>
</tr>
<tr>
<td>Grand Total</td>
<td>50,139</td>
<td>100.0%</td>
<td>$10,662</td>
</tr>
</tbody>
</table>

PMPY Trend by Bene Type

- **Network**: $10,635 - $11,140, 100.0%
- **Aged/Dual**: $12,786 - $14,531, 8.4%
- **Aged/Non-Dual**: $10,005 - $10,546, 67.0%
- **Disabled**: $5,033 - $10,914, 24.0%
- **ESRD**: $3,350 - $1,942, 0.6%

ACO Medicare Patients location Map

Developed by Office of Clinical Integration
Medicare ACO TME (Expense/Utilization) Report

<table>
<thead>
<tr>
<th>TIN and Practice % PMPY by Beneficiary Type by Claim Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Type</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>ESRD</td>
</tr>
<tr>
<td>Disabled</td>
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<tr>
<td>AgeDual</td>
</tr>
<tr>
<td>AgeNoneDual</td>
</tr>
</tbody>
</table>

Note: The CMS Quarterly Report and claims data shown in these reports may differ due to timing and CMS/ACO inclusion differences.
Steps in Building Post Acute Network

- Established and refined post acute SNF evaluation/selection process and criteria

Profile SNFs Against Minimum Requirements

Telephone Screen Subset of SNFs That Meet Minimum Requirements

Site Visits to Narrow Subset

Recommend “High-Value” Providers
SNF Evaluation/Selection Criteria

**Minimum Requirements**
- 4-Star Overall CMS Rating
- 4-Star CMS Quality Rating
- 3-Star Staffing
- 4-Star CMS RN Staff Rating
- 4-Star Health Inspection Rating
- 3-years free of risk/actual harm deficiencies (i.e., none > 2)
- No substantiated DPH complaints rated F or higher
- Risk Adjustment Score > 126

**UMMACO Expectations**
- Referral Responsiveness
- Medication Availability
- QI Program Characteristics
- Commitment to Collaboration
- Patient & Family Centeredness
- Performance Reporting
- Take Direct Admissions from Community
- Resident & Family Satisfaction
- Insurance contracts

**UMMACO Preferences**
- Current Referral Volume
- UMMACO Medical Staff Affiliation
Patient Outreach

OCI Weekly Performance Summary

% of Calls/Contacts

0% 10% 20% 30% 40% 50% 60% 70% 80% 90%


% Contacts to Calls 17% 18% 24% 28% 29% 18% 27% 35% 25% 27% 55% 25% 40% 24% 31% 41% 41% 32% 29% 37% 42%

% Appointments to Contacts 47% 45% 39% 37% 54% 27% 46% 37% 61% 64% 56% 37% 58% 77% 66% 50% 58% 79% 78% 60% 59%

% Rejects to Contacts 3% 6% 4% 6% 3% 6% 3% 0% 3% 0% 0% 2% 2% 0% 0% 1% 2% 1% 0% 1%
The 4 Quadrant Patient Risk/TME Matrix
Medicare ACO Patient Management Report
Secure Executive Buy-in

- OCI’s biggest challenge: Change not only mindset, but also behaviors that directly impact program success
- Senior executives needed to drive cultural and behavioral change
- Broad change needed to be preceded by a change in mindset on the part of system leaders
- The key to executive buy-in: data and analytics
  - Analytics showed that streamlining systems helped generate consistently accurate clinical and financial information
Secure Physician Buy-in

- OCI’s next biggest challenge: garnering support from physicians
  - Changed monetary incentives
  - Pod structure where physician groups are organized regionally
  - Generate reports on how individual physicians are performing against peers
  - Allow physicians to express concerns and outline how they can best be supported
  - Ongoing education
POD Structure

Medical Director
- Supervise Pod Leaders
- Pod Leader Meetings
- Doc Engagement/Training
- QI/UM
- Clinical Guidelines

Pod Leaders
- Quarterly Pod Leader Meetings
- POD Outreach/Education

Pods
- QI/UM with Pod Leaders
- MCN Participation Criteria
- Quarterly POD Meeting
- PIF/Outreach Coordinators
Logistical Barriers

• Use actionable data and analytics that highlight actual savings and impacts to patient care
  – Report cards / score cards help provide visuals of ‘actual’ performance and opportunities for:
    • Financial improvements
    • Reductions in TME
    • Patient engagement
    • Provider engagement
    • Rising risk populations – preventable events
    • Care management interventions
Results Attributed to OCI

To help UMass Memorial Health Care accomplish its population health objectives, the Office of Clinical Integration provided the following support:

- Provided practice improvement facilitators, who conducted about 100 practice visits for month and served as practice level resource
- Provided outreach support to help practices contact patients; they made more than 9,000+ calls to patients
- Conducted approximately 230 HCC coding audits to support coder efforts to more accurately demonstrate the burden of illness
- Offered care management team, which has managed more than 7,000 patients
Results Attributed to OCI (cont.)

With the help of data from the Office of Clinical Integration, the system’s Medicare Shared Savings ACO saw a sharp improvement in key metrics for patients receiving care management:

• Average inpatient admissions per patient decreased by 15%; control group increased by 1%

• Average 30-day readmission rate per patient decreased by 15%; control group decreased by 4%

• Average ED visits per patient decreased by 18%; control group decreased by 1%

• Average skilled nursing admissions per patient increased by 19%; control group increased by 41%
Education & Communication

- Senior leadership site visits to network
- Board engagement and education
- POD structure
- Community collaborative efforts (partnering)
- Patient engagement tools for community services
- Weekly blog from president
- Updates weekly (via CRM) about:
  - Regulatory changes
  - GPRO processes
  - Program updates
- PHM WINS – Weekly webinars to educate network and others

Image Credit: http://juntaedelane.com/category/articles/articles-articles/marketing-research/
Recommendations

• Develop clear population health management strategy
• Consider all pieces of the care delivery continuum must be considered
  – Staffing
  – Budgets
  – Care management
  – Education and training
  – Reporting
• Secure executive and physician buy-in
  – Develop a clear financial plan for PHM return on investment
• Create and support dedicated teams to lead PHM strategies and execute PHM programs
• Get the right systems in place
  – Data and analytics
  – Start with a clearly defined PHM strategy and a clearly defined path to value
  – Then need a series of systems to support goals
  – Most health systems will likely need more than one
CHANGE IS GOOD.

You go first!
Questions

• Questions?

• Please complete online session evaluation

• Renee Broadbent contact information: Renee.Broadbent@umassmemorial.org