The Shifting Sands of U.S. Healthcare: Volume to Value Based Care

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Goals

- Review the current state of US Healthcare expenditures and the factors that are driving policy and regulatory reform towards Population Health-based approaches.
- Explore some of the basic tenants of and tools employed in population health management.
- Describe the team based care model and its evolution in the context of population-based health care delivery.
- Briefly describe and contextualize the Milwaukee/Eastern Wisconsin Health Care Market and the challenges we face in addressing local populations.
- Outline a portfolio of clinical and business strategies that we are employing to meet the Triple Aim and to thrive in the changing environment.

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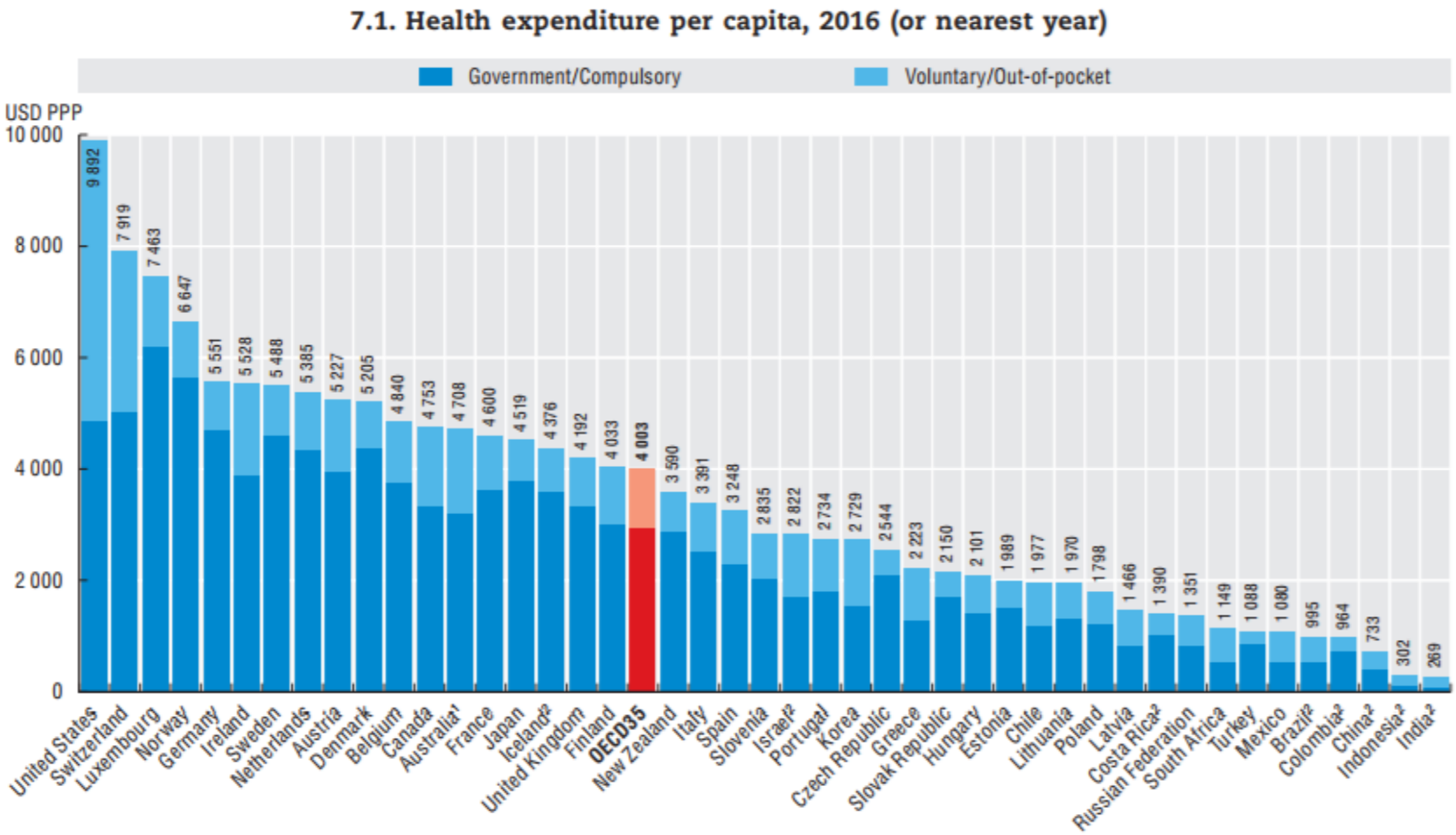
Current State of Affairs

- A significant proportion of the $3.3 trillion the US spent on healthcare in 2016 was allocated to direct medical services.
- These services only account for 10-15% of health outcomes.
- An estimated 40% of deaths are caused by behaviors that could be modified by preventative population-based interventions.

Healthcare Expenditure Per Capita (2016)



Note: Expenditure excludes investments, unless otherwise stated.

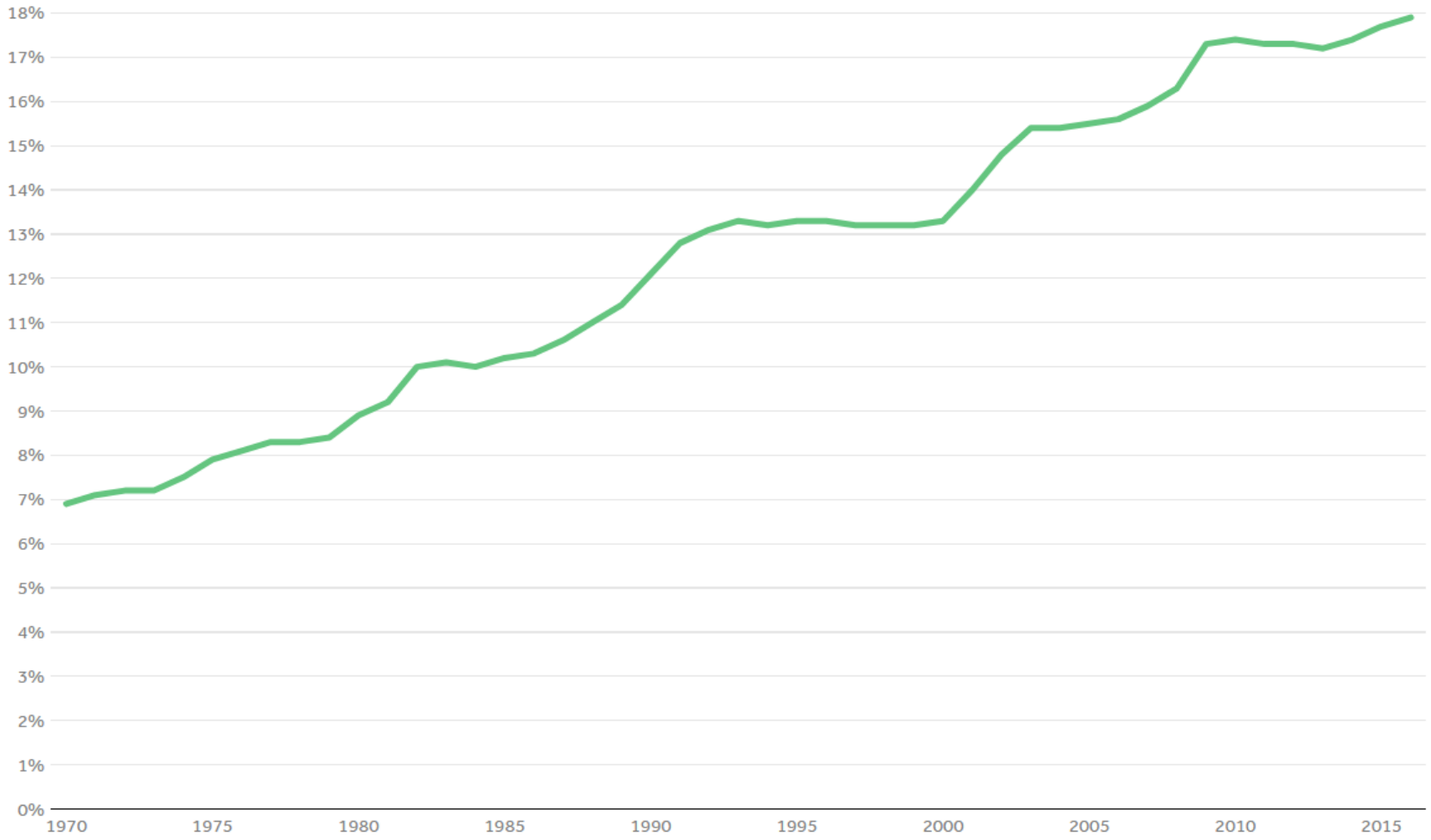
1. Australian expenditure estimates exclude all expenditure for residential aged care facilities in welfare (social) services.
2. Includes investments.

Source: OECD Health Statistics 2017, WHO Global Health Expenditure Database.

StatLink http://dx.doi.org/10.1787/888933604191

Health spending growth has outpaced growth of the U.S. economy

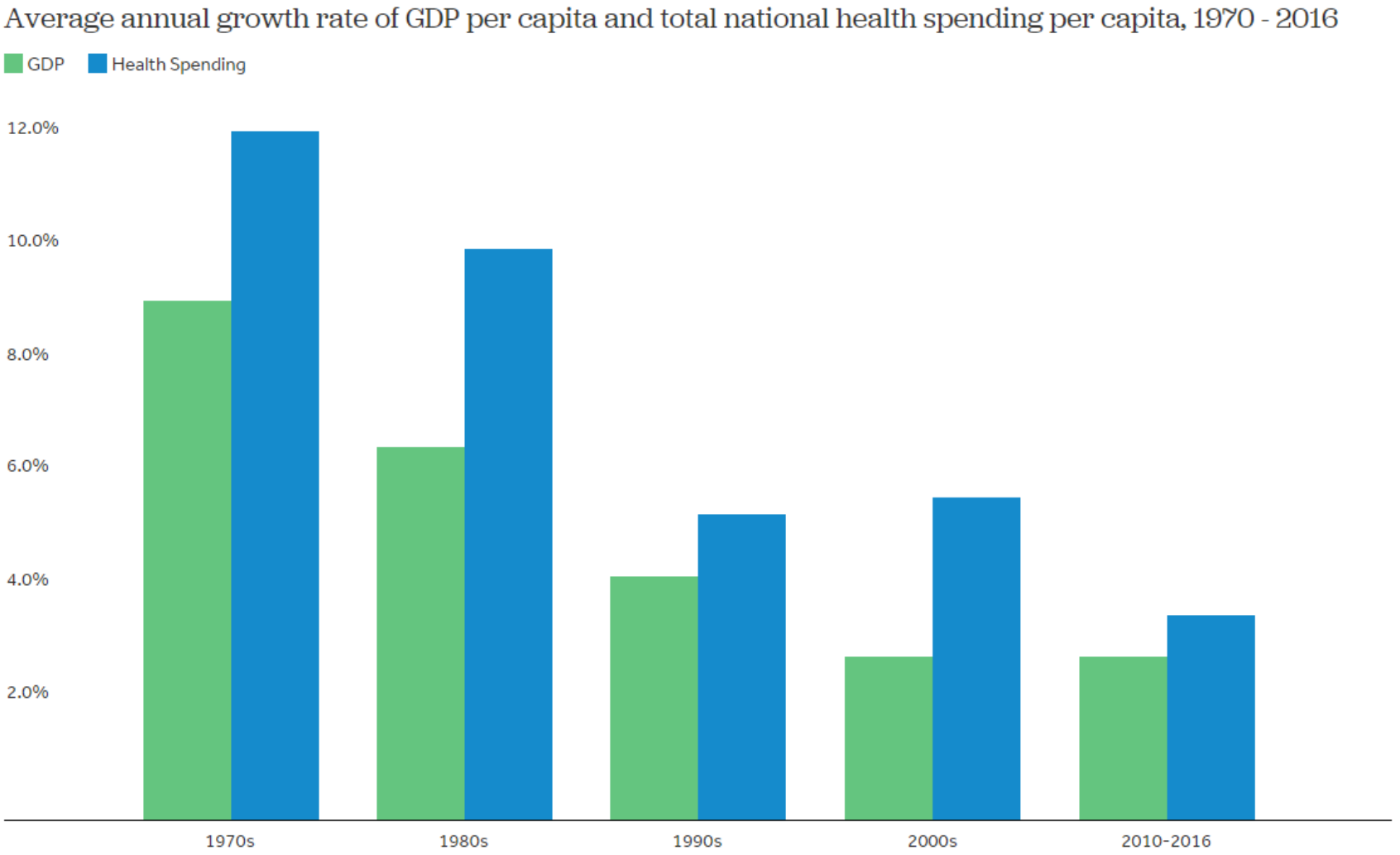
Total national health expenditures as a percent of Gross Domestic Product, 1970-2016



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group • Get the data • PNG

Peterson-Kaiser
Health System Tracker

Health spending growth has slowed, and is now more on pace with economic growth



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group • Get the data • PNG

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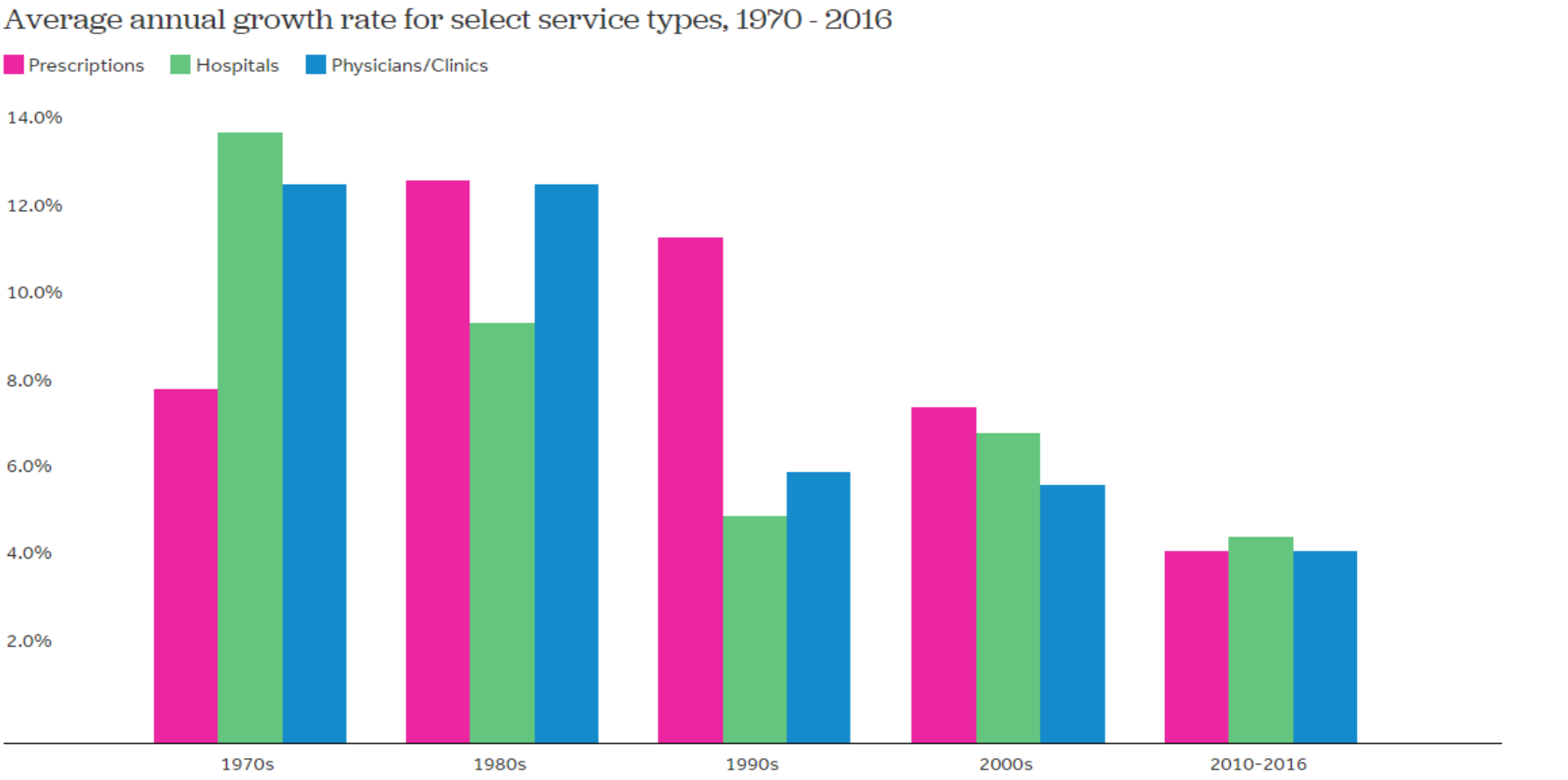
Health System Tracker

Moderation in Spending has been across all services



Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group • Get the data • PNG

Peterson-Kaiser Health System Tracker

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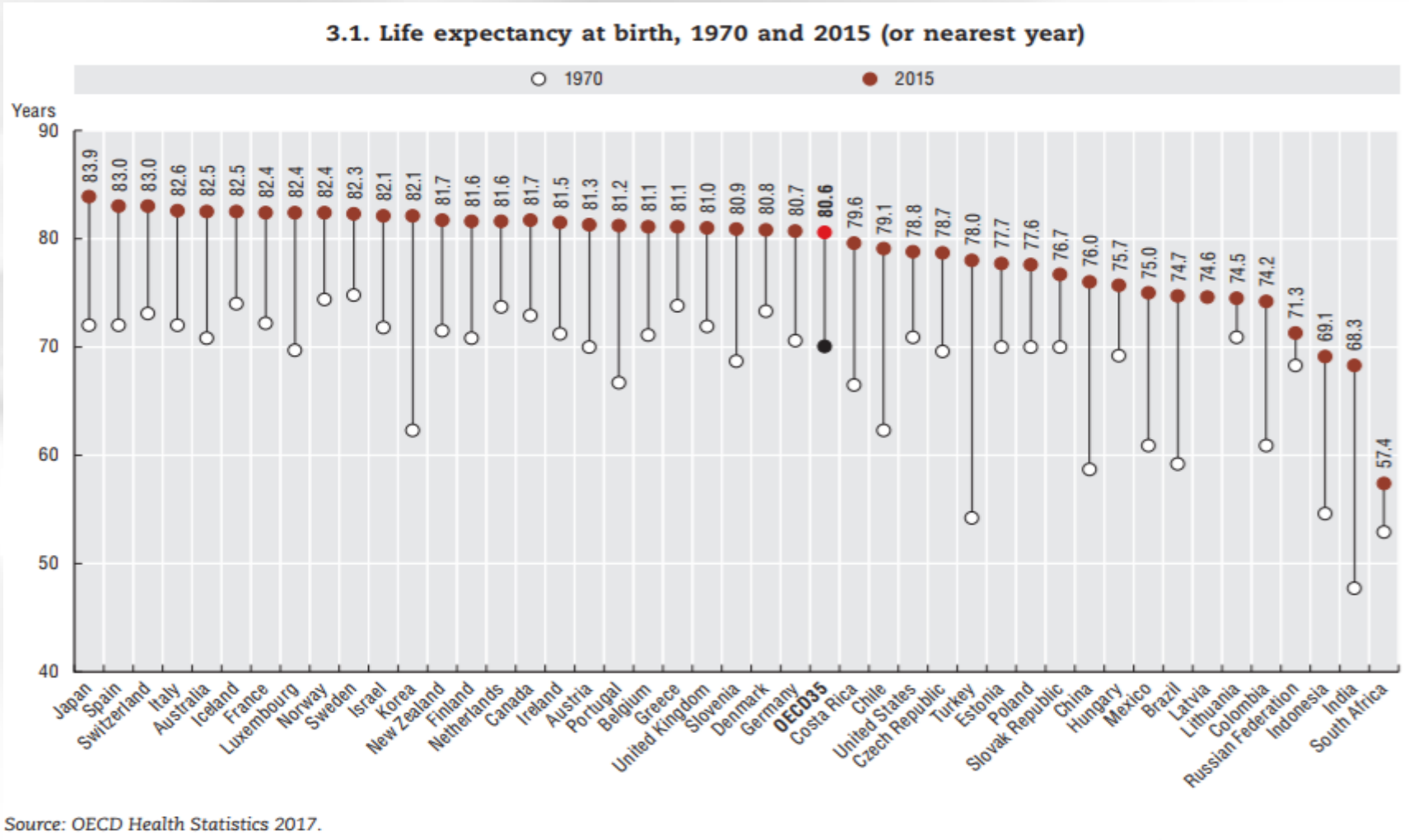
Life Expectancy Data



Source: OECD Health Statistics 2017.

StatLink http://dx.doi.org/10.1787/888933602234

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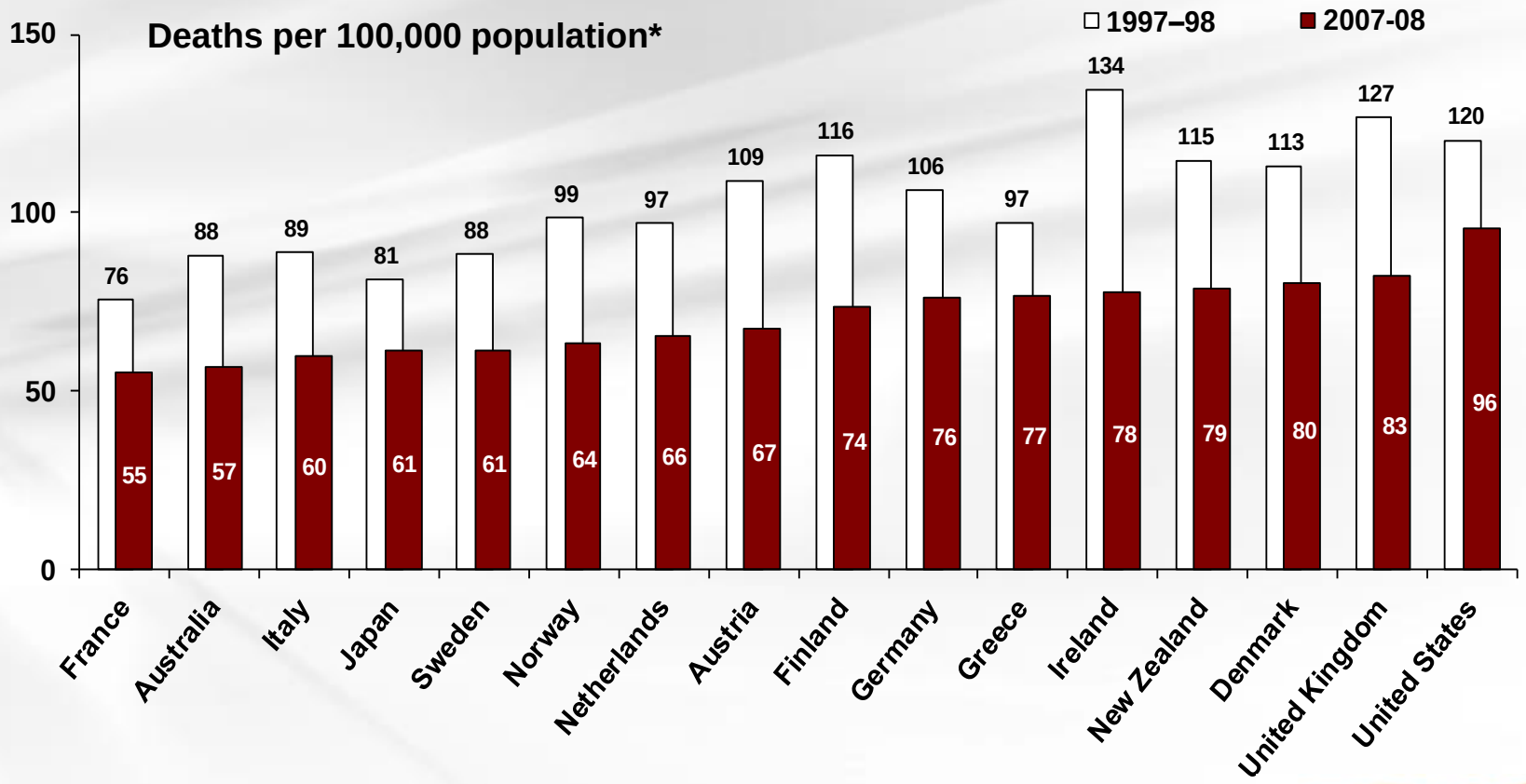
U.S. Lags Other Countries: Mortality Amenable to Health Care



* Countries' age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections. Analysis of World Health Organization mortality files and CDC mortality data for U.S.

Source: Adapted from E. Nolte and M. McKee, "Variations in Amenable Mortality—Trends in 16 High-Income Nations," *Health Policy*, published online Sept. 12, 2011.

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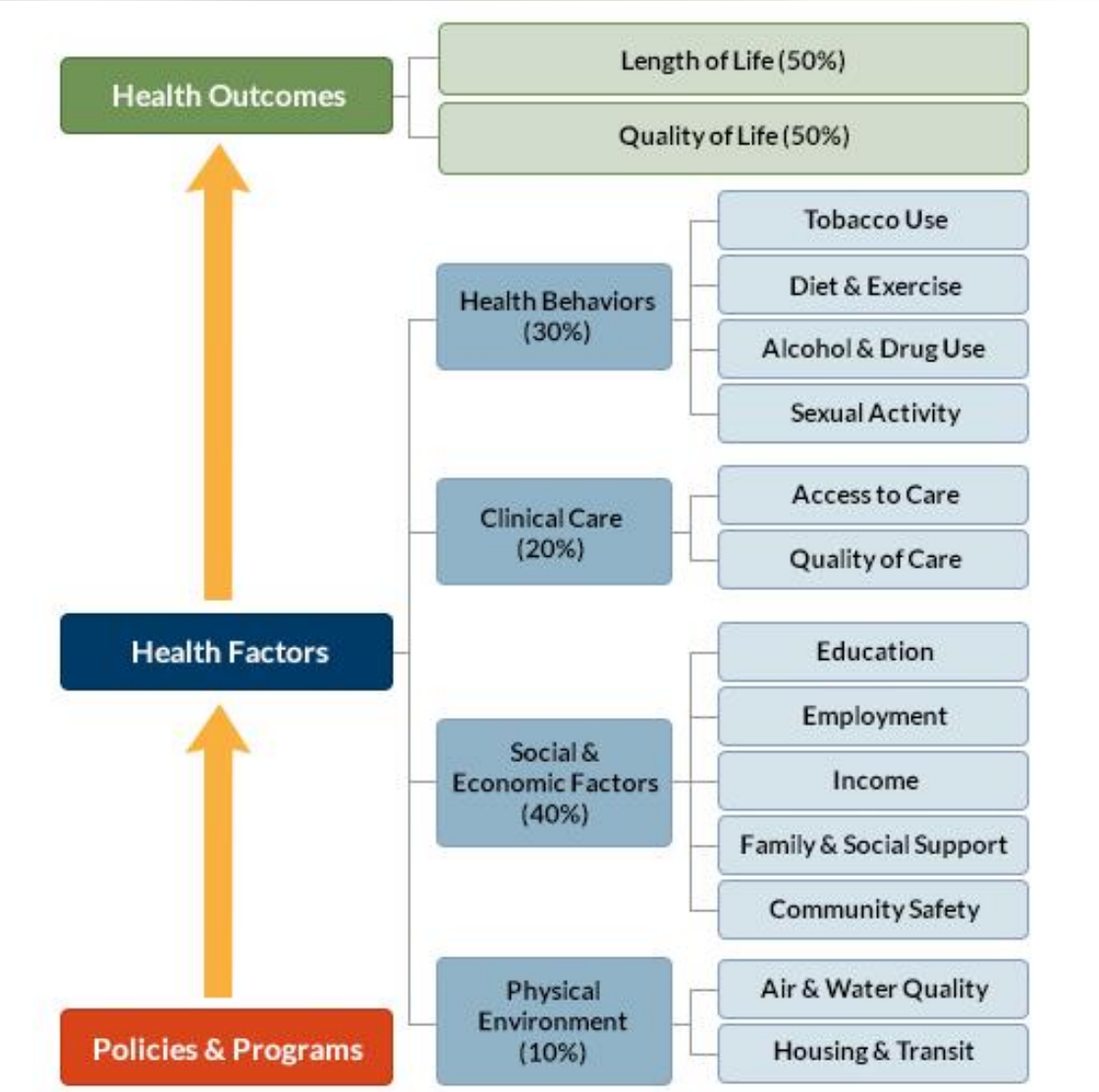
A Broader Focus on Health



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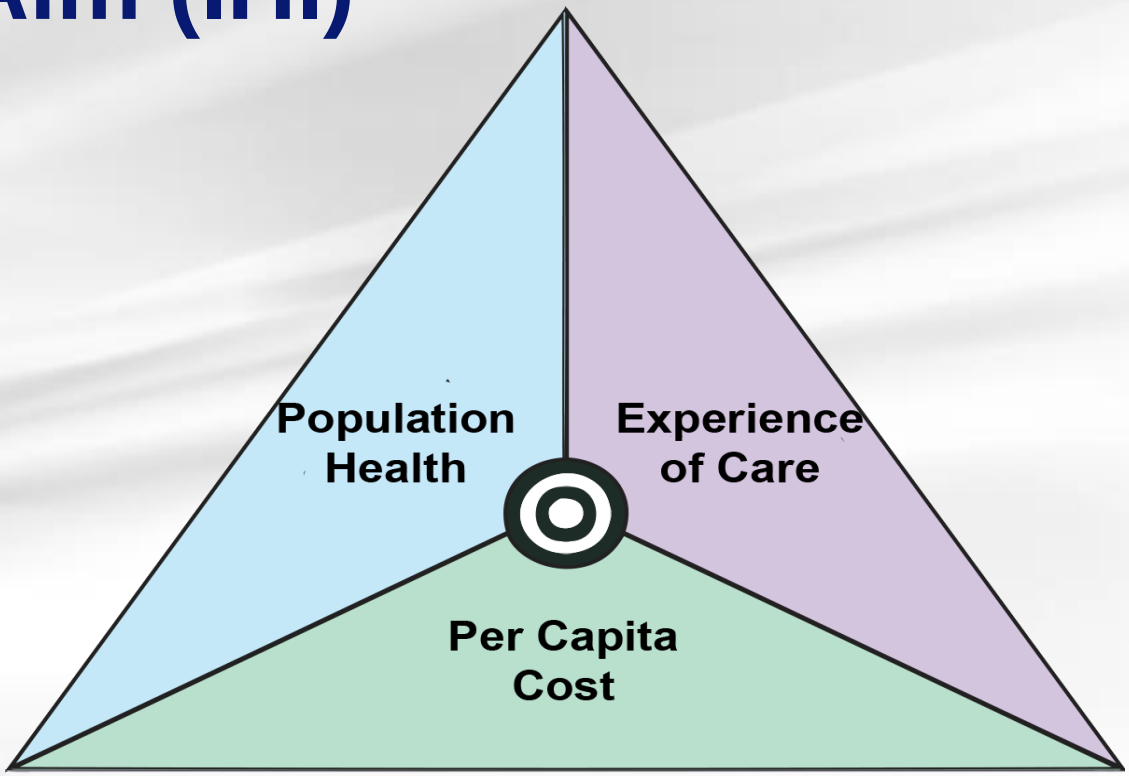
Triple Aim (IHI)



IHI Triple Aim

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations.
- Reducing the per capita of cost of healthcare.

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(Source: IHI, The IHI Triple Aim, http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx)

So what is population health and why are US health systems scrambling to develop competencies in population health management?

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Population Health and Population Health Management Defined

- **Population health** is defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

- A population health approach requires collaboration across a number of groups – patients, providers, health plans, employers, government, the private sector and local communities - to strengthen care delivery and improve the well-being of individuals and families.

- PHM is defined as a set of interventions designed to maintain and improve people's health across the full continuum of care—from low-risk, healthy individuals to high-risk individuals with one or more chronic conditions.

Why is this so important?

- Uncontrolled growth in HC spending has resulted in a industry-wide move to payment reform from volume-based to value-based reimbursements.

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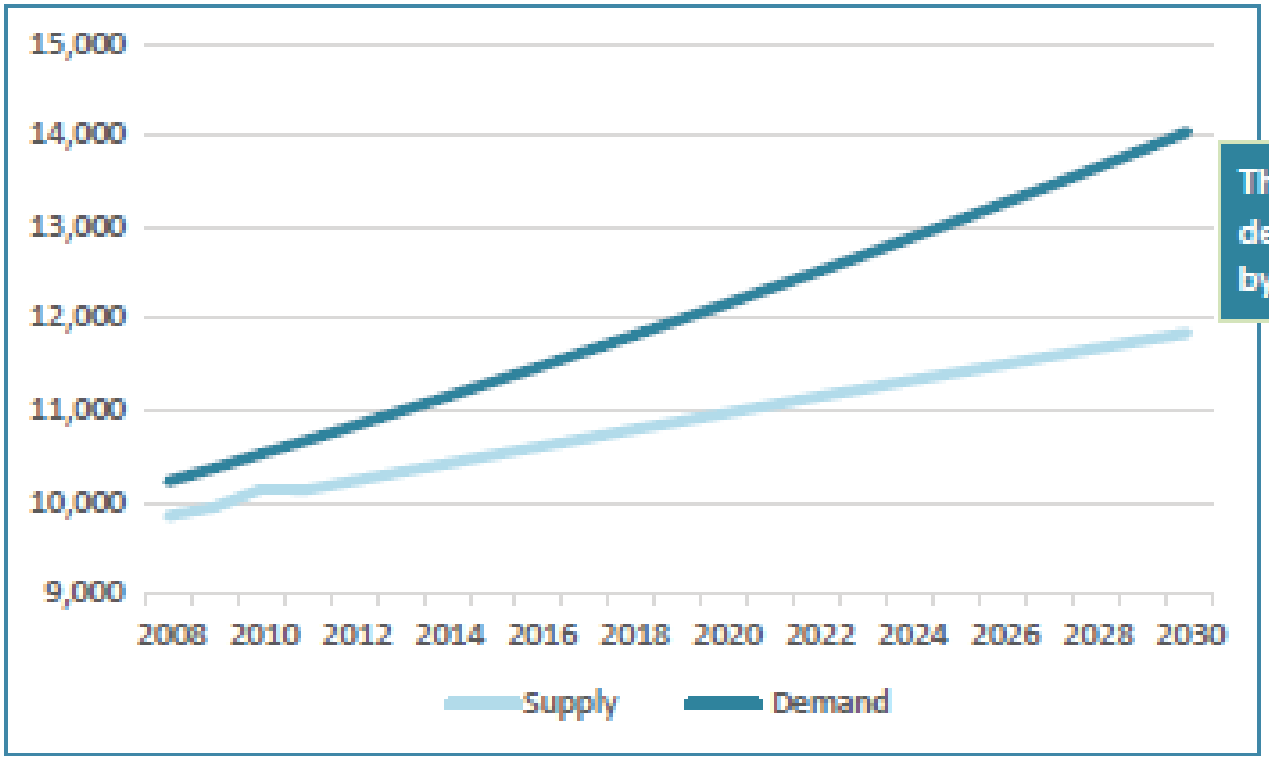
- National shortage of providers – will only get worse in next 2 decades.

Forward Look to 2025

Projected Supply and Demand of WI Physicians



The projections show a deficit of 2,196 physicians by the year 2030.

Source: WI Council on Medical Education & Workforce. (2016). A Work in Progress: Building WI's Future Physician Workforce.

Why is this so important?

- Uncontrolled growth in HC spending has resulted in a industry-wide move to payment reform from volume-based to value-based reimbursements.
- National shortage of providers – will only get worse in next 2 decades.
- Results in control of health expenditure, maximizes access and efficiency.

2017 – A Year of Change

Possible merger would put Columbia St. Mary's and Wheaton Franciscan in largest hospital company, Wall Street Journal reports

Advocate Health Care and Aurora Health Care combined would be one of the biggest regional health systems

By Alex Kacik | December 9, 2017

UnitedHealth Group to Buy DaVita Medical Group of El Segundo for $5 billion

By Dana Bartholomew

Monday, December 11, 2017

CVS, Aetna Could Close $70B Merger Deal as Soon as December

By Greg Roumeliotis and Carl O'Donnell | November 6, 2017

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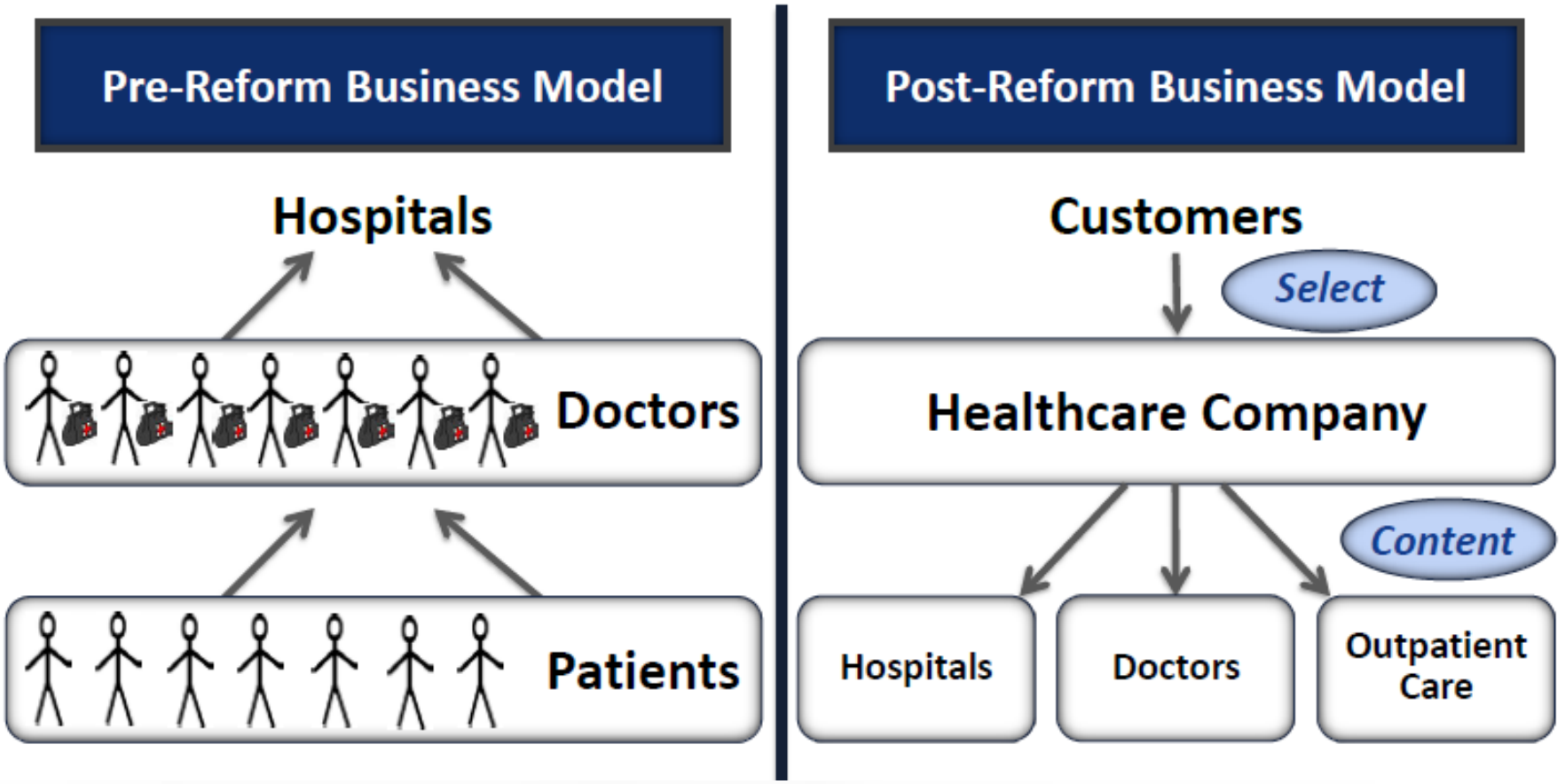
Factors driving Consolidation

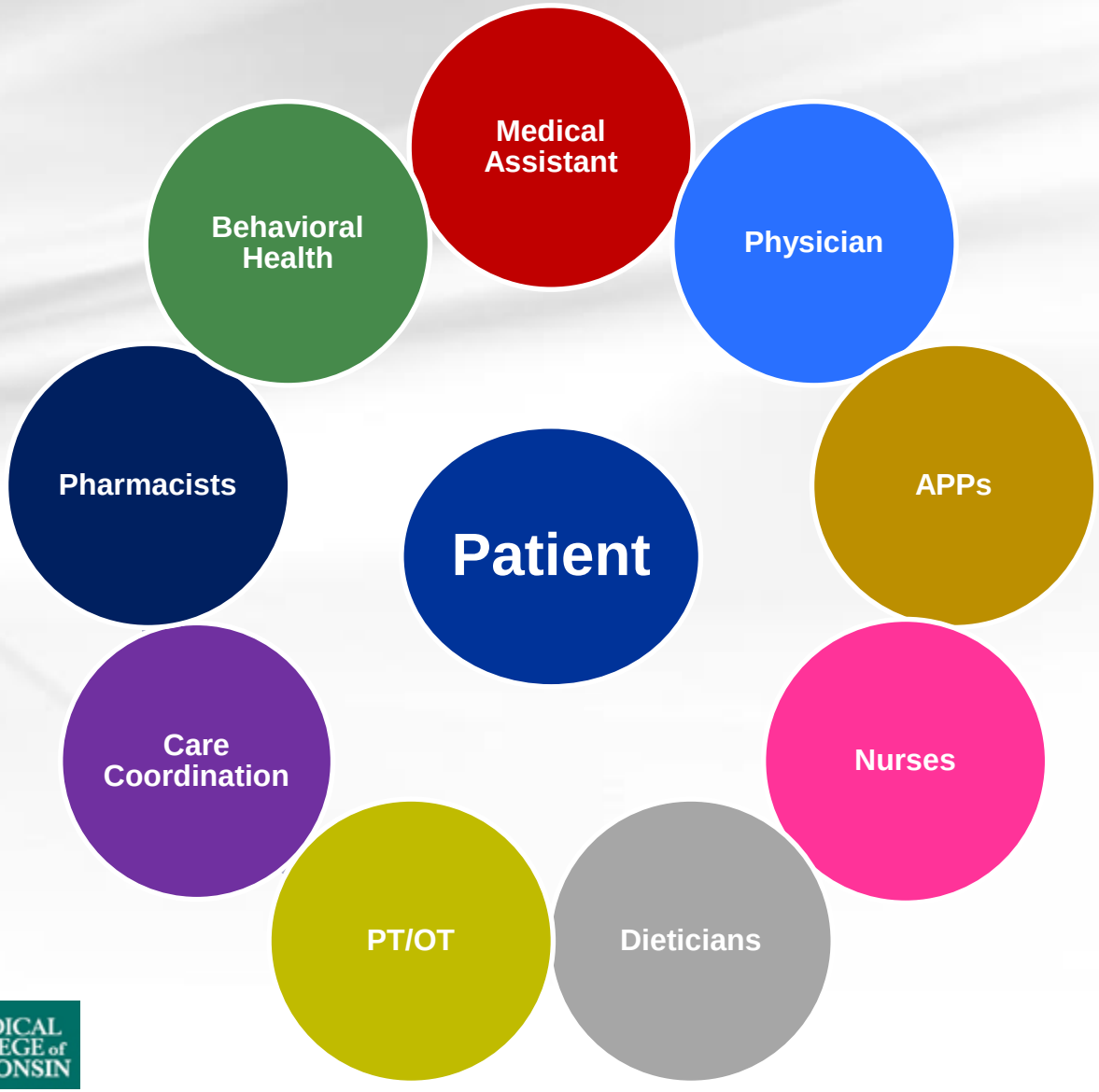
- Reduces expenses – through both purchasing power and reduction in administrative overhead.
- Attains scale to begin managing healthcare cost through aligning the delivery side with the insurance vehicle (plan design).
- Provides working capital to smaller systems which may accelerate transformational change.
- Improves market competitiveness for in-network rates and access to insured lives through integration into a larger health system.
- Reduces risk as number of lives under management attains a significant scale.

The Healthcare Business Model is Changing



Source: Kaufmann Hall and Associates, 2014

Inter-Professional Care Model



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Patient-Centered Medical Home NCQA Recognized Practice

Collaboration

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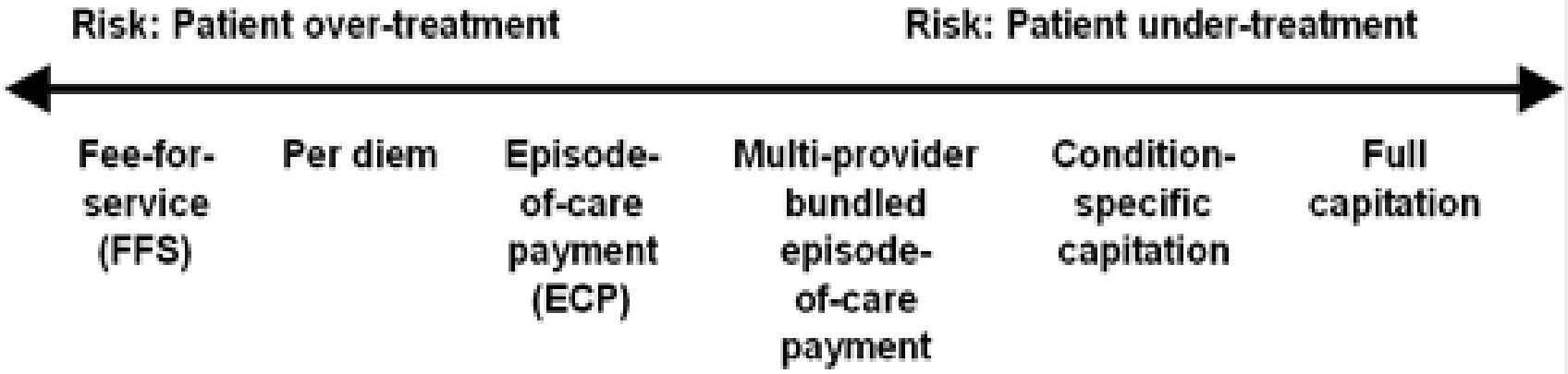
Team Based Care

- Care team members operating at top of their capabilities.
- Symbiotic and collaborative care processes all aimed at highest care outcomes.
- Efficiencies is managing larger populations per provider.
- All members of team equally valuable.
- Panels of patients cared for more efficiently and effectively.

Healthcare Payment Reform



H. D. Miller, *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform* (New York: The Commonwealth Fund, Sept. 2007).

FFS vs Capitation

ELEMENT	CAPITATION	FEE FOR SERVICE
CONCEPT	Payment of a fixed amount per patient usually monthly; services are expenses against revenue	Fee (revenue) for each service provided
FUNDING	Based on the number of enrollees, not the number of services	Based on the number of service units provided, not related to the number of patients
INCENTIVE	Control utilization and provide fewer and/or less costly services; provide early detection and treatment to lower total cost of care	Provide more services or charge more per service; sick patients require more services and generate more revenue

Changing Nature of Care Delivery

Fee for Service Model

- Transactional: visit or episode-based care delivery.
- Primary care valued for its front door access and its downstream revenue contribution to the health system.
- Margins realized in specialty care and facility utilization.

Provider Workforce

Today's Medical Staff Composition

- Primary care MDs and APPs in sufficient number to handle the most basic of patient care needs and to generate patient referrals to specialty care.
- Specialists responsible for most chronic illness care.
- Ratio of specialists to primary care fairly high as a result of predominant specialty-based model of care.

Population Health Model

- Relational: care delivered in real time via in office and phone / electronic communications. Payment no longer linked to visits.
- Primary care valued for its contribution to promoting health and thereby driving down utilization.
- Margins realized as a result of a favorable variance in healthcare spending for a population.

Provider Workforce

Tomorrow's Medical Staff Composition

- Primary care teams comprised of MDs, APPs, behavioral health, pharmacy, RNs, MAs who are responsible for longitudinal patient care.
- Primary care manages the majority of chronic illness in periodic consultation with specialists.
- Ratio of specialists to primary care much lower as a result of consultative model of care.

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Lack of Aligned Payment Models

- Current fee for service model accounts for 90%+ of payments.
- Little historical payment from CMS or commercial payers for population health / value.
- Movement to value-based payments has been slower than anticipated.

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CMS: Merit-base Incentive Payment Program

MIPS Year 2 (2018) – Calculating the Final Score

Remember: *All of the performance category points are added together to give you a MIPS Final Score.*

*The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.*

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Population Health Concepts 101

- Patient registries
- Gaps in care identification
- Care Transitions
- Health Risk Stratification
- Care management process and Team-based Care
- Automated outreach
- Advanced population analytics

Patient Registries

- Lists of patients with common characteristics, many times based on disease process or demographics.
- Registries provide patient identifying information and identify actionable clinical data which can then be acted upon.
- Generally used dyssynchronously with an office-based visit.

Gaps in Care

- Refers to an unmet care need – diagnostic or screening, preventative or therapeutic.
- Historically identified via office visit or professional encounter.
- Increasingly processes becoming automated.

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Transitions in Care

- Refers to a change in care environment and how care handoffs between environments affect outcomes.
- Example – transition from inpatient setting to home health care.

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Health Risk Stratification

- Process of identifying those at greater risk for poor health outcomes.

- Utilizes clinical, demographic, and utilization data to predict risk.

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Care Management Process

- Coordination and care processes established at the level of the care teams.
- A team of ‘average talent’ individuals working in a standardized environment will consistently out perform a team of ‘superior talent’ individuals working in an environment without standardization.

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Automated Outreach

- Resolving some gaps in care or acting on ADT / transitions in care can be automated.

- MyChart messages, social media, standard letters and alerts.

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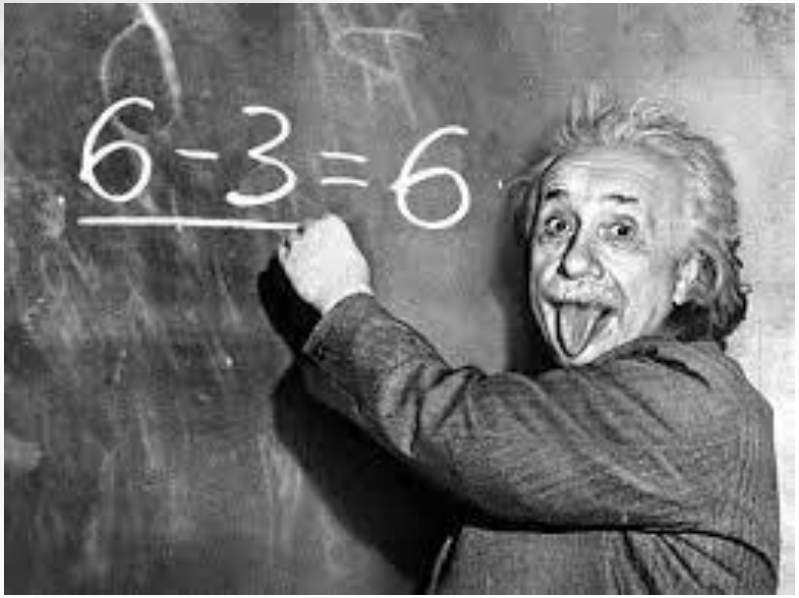
Technology Impact

Advanced Analytics

- A variety of open source and propriety software packages which risk stratify patients and actuarially stratify individuals and groups of patients.



AHRQ Five Domains of Population Health Management

DOMAIN	DESCRIPTION	SAMPLE HIT APPLICATIONS
Identify subpopulations of patients	Identify subgroups of patients that will benefit from additional services or demonstrate gaps in care	• Apply **evidence-based guidelines** to integrated population data sets that continuously identify preventive and chronic care opportunities • Use predictive models for **risk stratification**
Examine detailed characteristics of identified subpopulations	Information management systems identify patients in greatest need of services, using flexible criteria that filters critical patient information	• Provide care teams with tools to **filter populations** of patients by criteria such as disease status, recent hospitalizations, and multiple chronic conditions
Create reminders for patients and providers	Information management systems can be used to create automated communications that remind patients, clinicians and staff about patient care needs	• Provide customized **notifications** for patients via letters, telephone/text messages, emails, electronic reminders) • Generate **automatic alerts** for providers and care teams about patients who meet criteria for preventive care or disease management at the point of care and between encounters
Track performance measures	Provides information that allows clinicians, staff, and systems to track quality and outcomes against national guidelines, peer groups, and to demonstrate longitudinal improvements	• Produce **real-time reports** on how practices, providers, and care teams, are meeting quality, financial and utilization goals • Profile **clinical patterns** within practice by provider (risk level, most frequent diagnoses, number of smokers, etc.) • Allow practices to identify individual patients needing intervention to improve overall performance
Data is available in multiple forms	Information is most helpful and effective to practices when it can be printed, saved, or exported and if it can be displayed graphically	• Facilitate **data-sharing** within organizations and **health information exchange (HIE)** with external providers • Allow providers, care teams and patients to view and understand health care data and trends in real-time

Wisconsin and Milwaukee

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Our Health System Strategy

- Long term strategic plan reflects the Triple Aim
  - Improve quality and satisfaction
  - Improve health of populations
  - Reduce per capital health care costs
- What specific action do we need to take to attain these goals while strengthening our market share and thriving financially?

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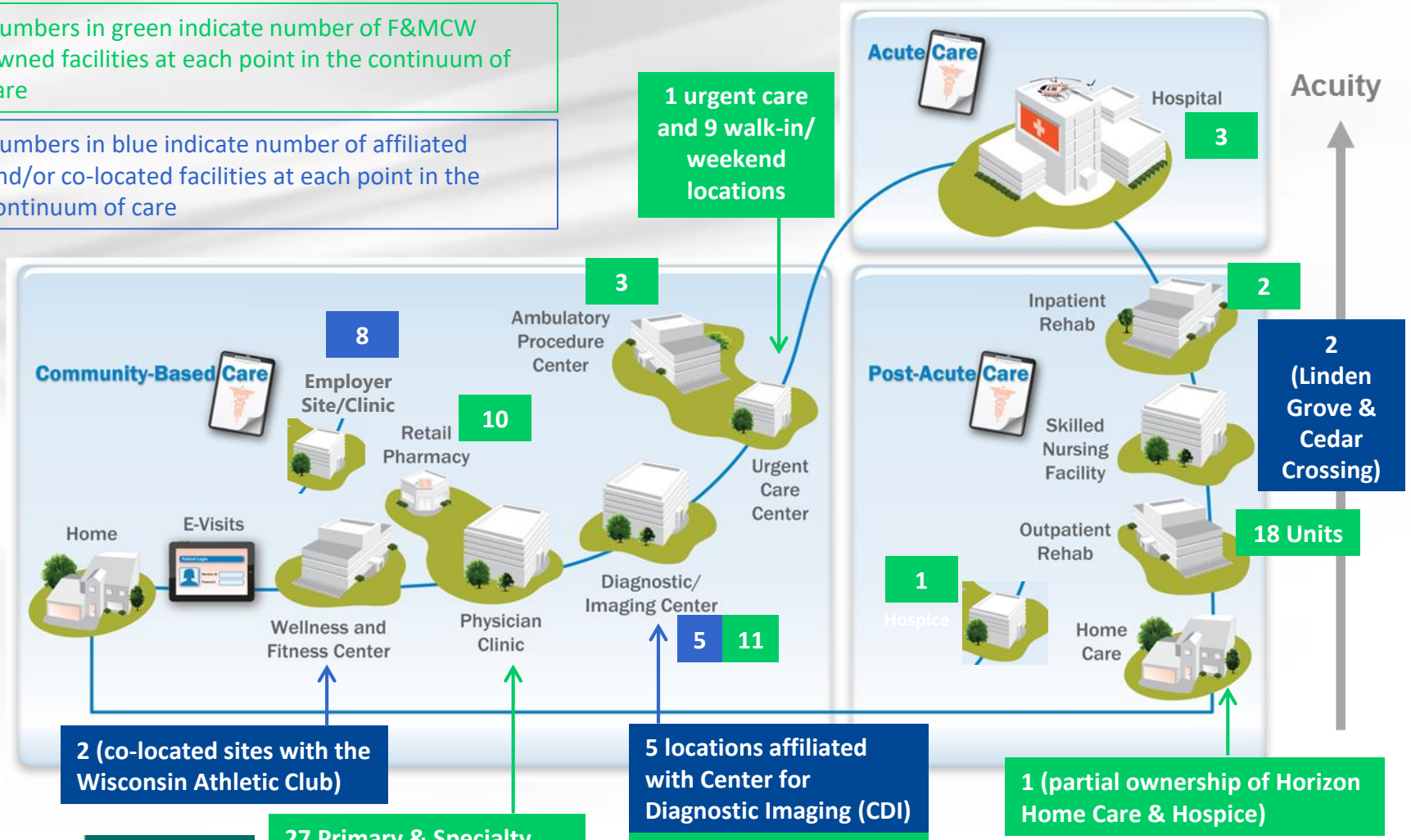
Numbers in green indicate number of F&MCW owned facilities at each point in the continuum of care

Numbers in blue indicate number of affiliated and/or co-located facilities at each point in the continuum of care



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Population Health & Risk Management through a Clinically Integrated Network (CIN)

- Data collection direct from disparate practices and systems
- Query-based analyses to identify populations with specific clinical needs
- Recognize gaps in care proactively
- Stratify engagement efforts based on likely impact and severity
- Engage patients and manage care using population management tools
- Measure outcomes

Final Thoughts

- All of this is challenging work
  - Vision for matrix nature of roles and responsibilities not always aligned.
  - Value proposition of partnership not always equally appreciated.
  - Burning platform not always there
    - If payments are largely intact and volume still driving reimbursement – why change?
  - In an era of great reform, successful organizations will proactively asses their risks and opportunities, align their strategic plan with a focus on future, and have the discipline and nimbleness to effectively execute.

Final Thoughts

- Focused efforts in population-based healthcare are a fundamental catalyst to improved community health.
- Team based care is essential to success and MAs play a very important role.
- Registries, data analytics, creation of standardized systems of care, and operational effectiveness are all critical components of a successful population health initiative.
- Designing an approach which delivers the intended outcome is challenging and requires a capable team of individuals who can diagnose the problem, formulate an intervention, and successfully implement change.