Welcome to today's webinar titled, "New approaches involving measurement, accountability and financing to transform practices"

- L. Gordon Moore

DOES NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

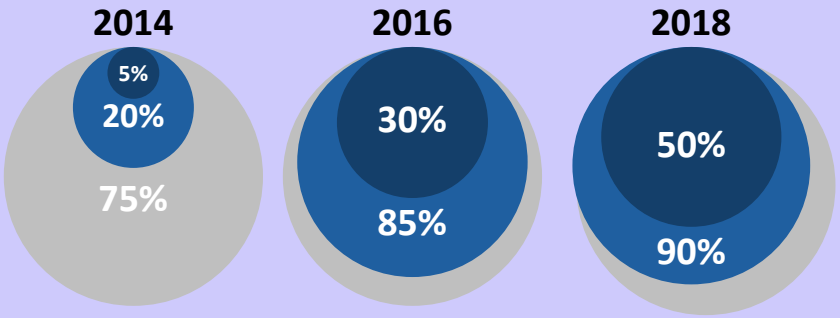
New approaches involving measurement, accountability and financing to transform practices:

An exploration of issues for groups or systems in value-based payment arrangements

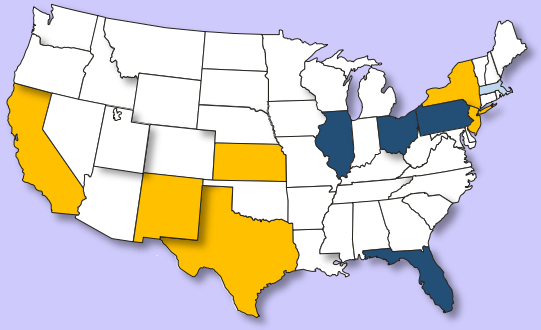
MI-CCSI Webinar
June 6, 2016
L Gordon Moore MD

Move to value has accelerated dramatically

1 Medicare shift to value-based payment



2 Key Medicaid state programs shift to value-based payment



DSRIP States represent **47%** of the total US population

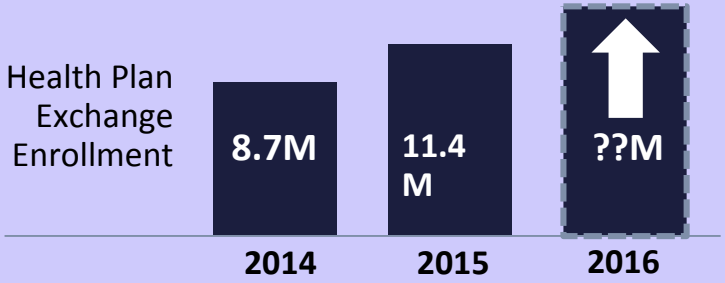
In Place – Delivery System Reform Incentive Payment (DSRIP)

In Process – Delivery System Reform Incentive Payment

3 Employer mandate for insurance coverage (ACA) drives more volume to the health care exchange programs

	Insurance Coverage	
FTEs	2015	2016
100+	70%	95%
50-99	Delayed	95%
1-49	NA	NA

Health Plan Exchange Enrollment



National Healthcare Expenditure (NHE) representation by Medicare (26%), Medicaid (17%) and Private Employers (21%) combine for 64% total

Interesting issues facing practices

- Increasing burden of measurement
- Gap between measures and outcomes
- Living in transition
- Funding inadequate to the essential work of high performing primary care

Some solutions

- Maintaining focus on the work that matters
- Opportunities for collaborative work
- Extracting understanding from information

Evidence on improving population health outcomes

"[A] greater emphasis on primary care can be expected to lower the costs of care, improve health through access to more appropriate services, and reduce the inequities in the population's health."

Starfield, Barbara, Leiyu Shi, and James Macinko. "Contribution of Primary Care to Health Systems and Health." The Milbank Quarterly 83, no. 3 (September 2005): 457–502. doi:10.1111/j.1468-0009.2005.00409.x.

Key attributes of high performing primary care

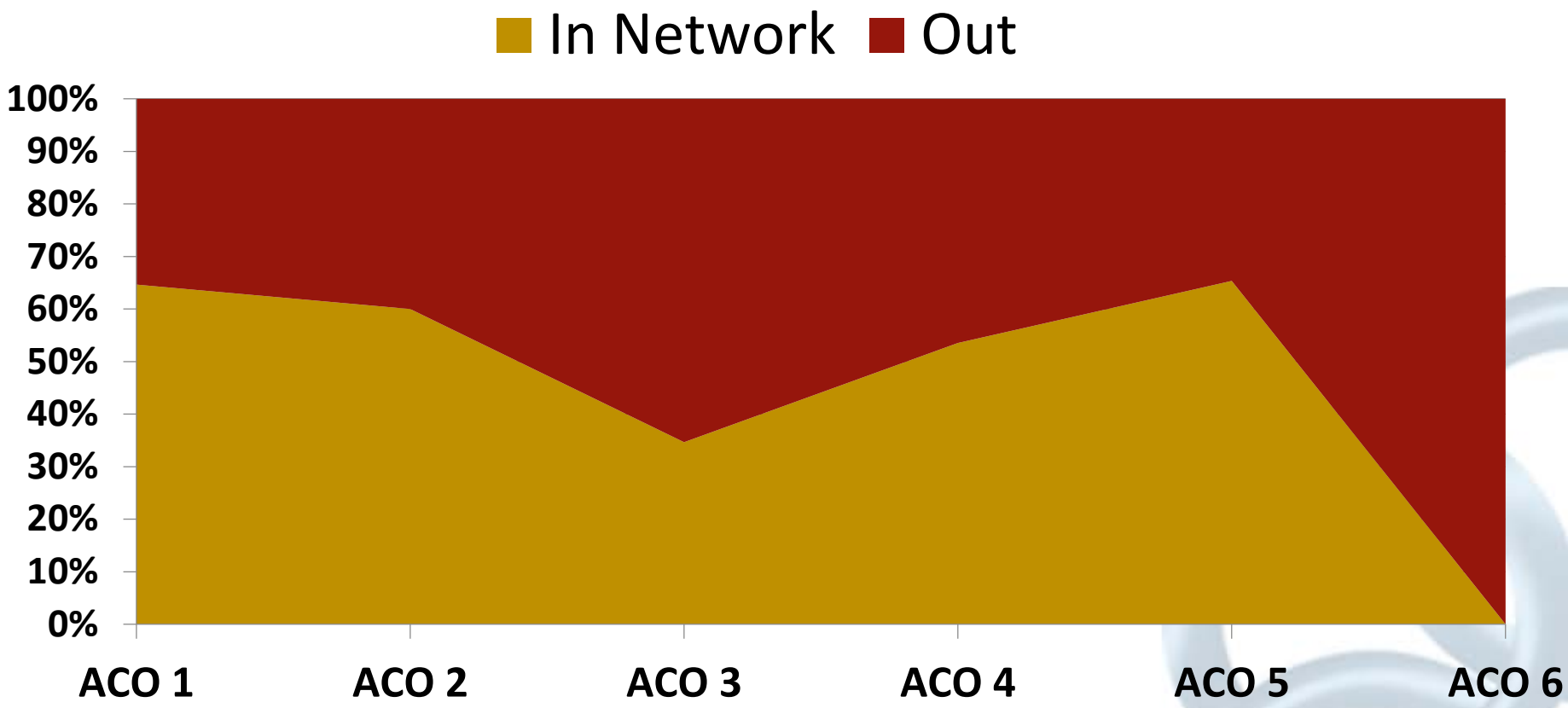
- Access
- Person (not disease) -focused relationship over time
- Comprehensive care
- Coordination

Collaborative opportunities

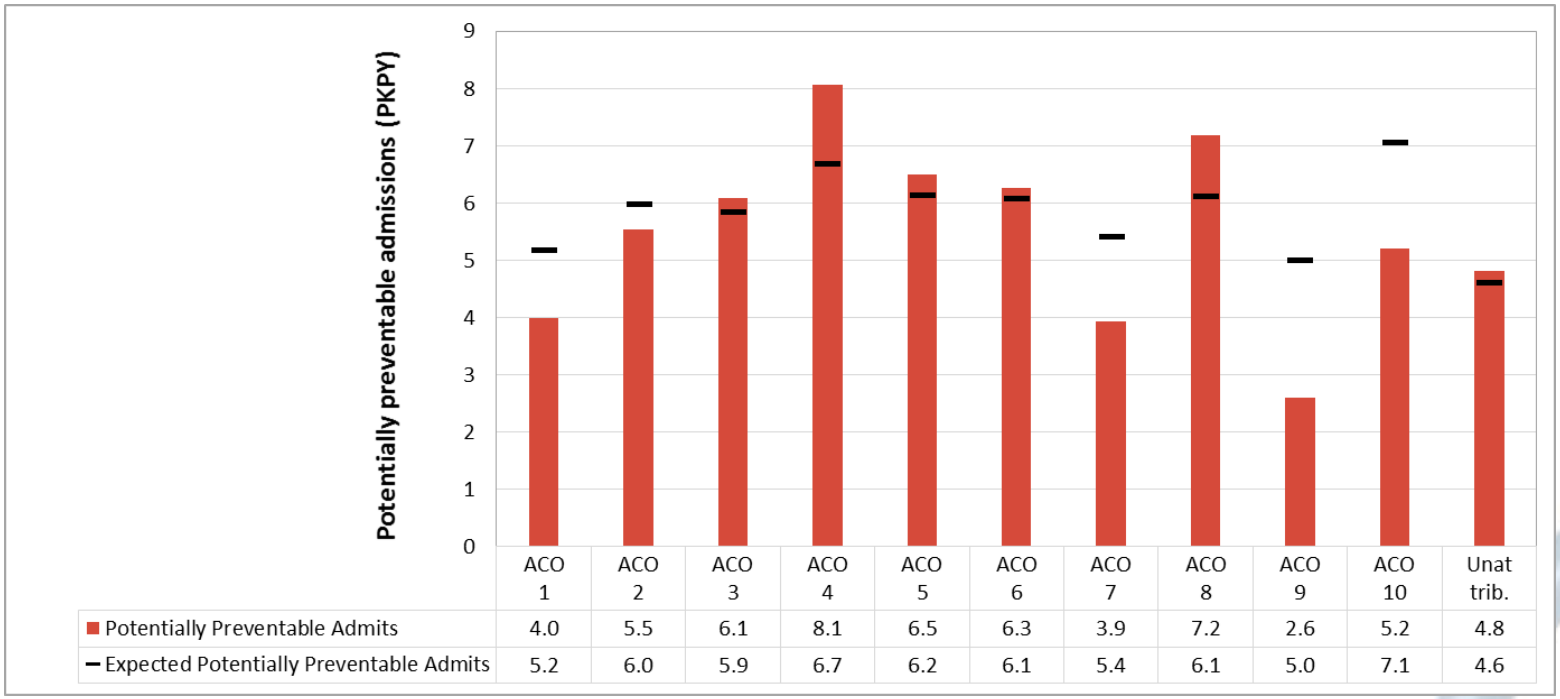
- State/regional entities
- MSO
- ACO
- Health plan as resource

Some ways to gain understanding from data

"The EMR will tell us everything I need to know"
Health plan data says otherwise in value-based payment models



The importance of risk-adjusting key performance indicators



	ACO 1	ACO 2	ACO 3	ACO 4	ACO 5	ACO 6	ACO 7	ACO 8	ACO 9	ACO 10	Unat trib.
Potentially Preventable Admits	4.0	5.5	6.1	8.1	6.5	6.3	3.9	7.2	2.6	5.2	4.8
Expected Potentially Preventable Admits	5.2	6.0	5.9	6.7	6.2	6.1	5.4	6.1	5.0	7.1	4.6

- PPA (red bars) rates are displayed in units of per thousand persons per year (PKPY).
- Expected values (black lines) are risk adjusted by 3M Clinical Risk Groups (CRG), age group, and gender.

Interesting uses for health plan data

Risk Adjusting Survival Outcomes in Hospitals That Treat Patients With Cancer Without Information on Cancer Stage

David G. Pfister, MD; David M. Rubin, BS; Elena B. Elkin, PhD, MPA; Ushma S. Neill, PhD; Elaine Duck, RN, MA, MS; Mark Radzyner, JD, MBA; Peter B. Bach, MD, MAPP

Identifying opportunity

System

- Primary care environment
- Tools
- Other resources
- Network
- Interface with rules environment

Provider

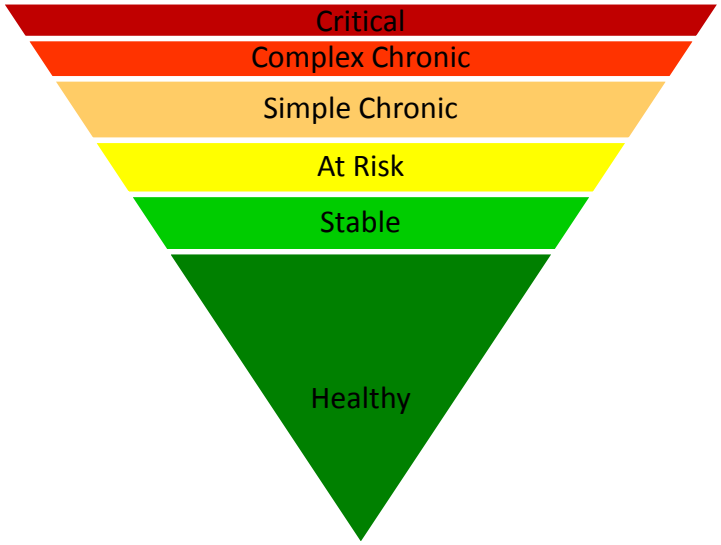
- Specialty
- Availability
- Communication effectiveness
- Capacity for collaborative work
- Professional network
- Referral habits

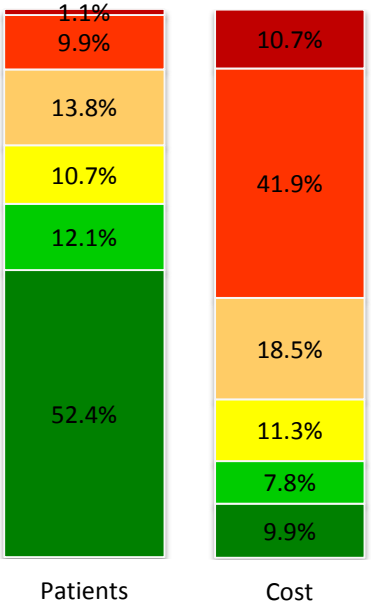
Patient

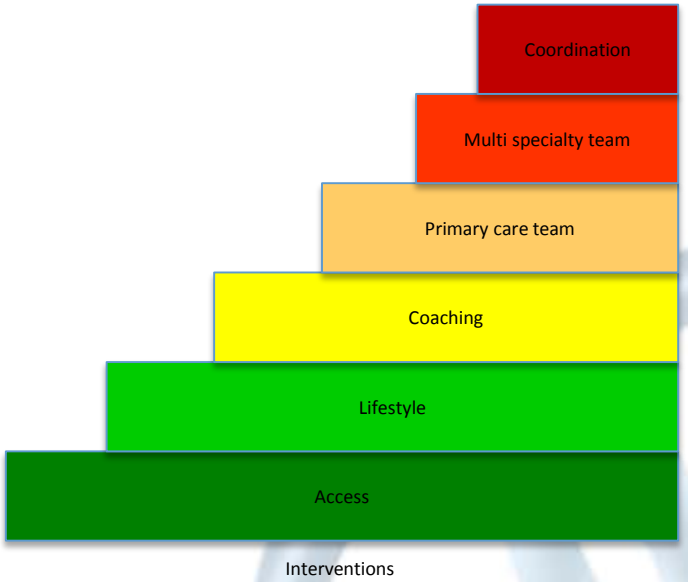
- Access to care
- Diagnosis
- Illness burden
- Capacity
- Social Determinants of Health

Curing the System, Edward Wagner M.D., M.P.H., F.A.C.P., Connie Davis M.N., A.R.N.P., The Robert Wood Johnson Foundation

Segments & interventions







People with diabetes segmented by total illness burden

		Severity Level					
Status (Case Mix Type)		1	2	3	4	5	6
1	Healthy						
2	One or More Significant Acute Diseases						
3	One Minor Chronic Disease						
4	Multiple Minor Chronic Diseases						
5	One Significant Chronic Disease	0.98	1.38	2.21		2.42	
6	Two Significant Chronic Diseases	1.84	3.14	4.07	4.41	7.06	20.41
7	Three or More Significant Chronic Diseases	2.77	4.38	11.48	14.89	18.19	37.43
8	Complicated Malignancies	1.16*	11.64	17.74	34.09	37.20	
9	Catastrophic Conditions	3.21*	9.00	17.95	25.89	22.82	46.81

Bernstein, Richard H. "New Arrows in the Quiver for Targeting Care Management: High-Risk versus High-Opportunity Case Identification." The Journal of Ambulatory Care Management 30, no. 1 (March 2007): 39–51

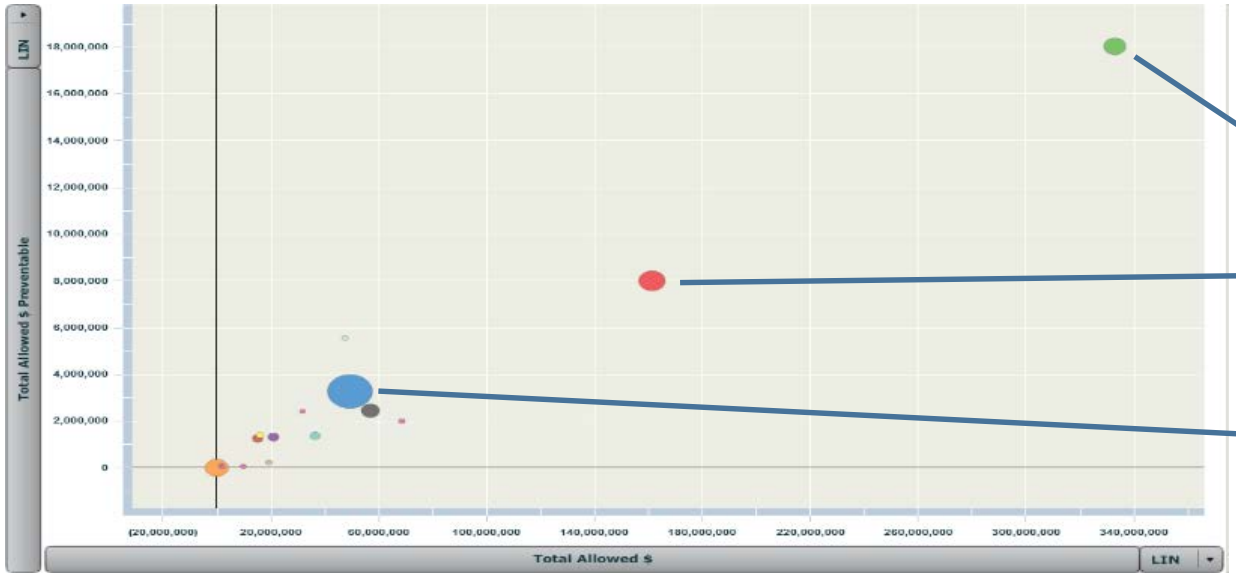
Rates of hospital admission per 1,000 people with diabetes

		Severity Level					
Status (Case Mix Type)		1	2	3	4	5	6
1	Healthy						
2	One or More Significant Acute Diseases						
3	One Minor Chronic Disease						
4	Multiple Minor Chronic Diseases						
5	One Significant Chronic Disease	26	88	100		247	
6	Two Significant Chronic Diseases	43	119	195	320	644	1023
7	Three or More Significant Chronic Diseases	132	269	497	845	1343	1606
8	Complicated Malignancies	416*	209	493	1294	2242	
9	Catastrophic Conditions	290*	626	806	990	1685	2486

Bernstein, Richard H. "New Arrows in the Quiver for Targeting Care Management: High-Risk versus High-Opportunity Case Identification." The Journal of Ambulatory Care Management 30, no. 1 (March 2007): 39–51

What are the opportunities at the intersection of cost and quality?

Sample commercial population



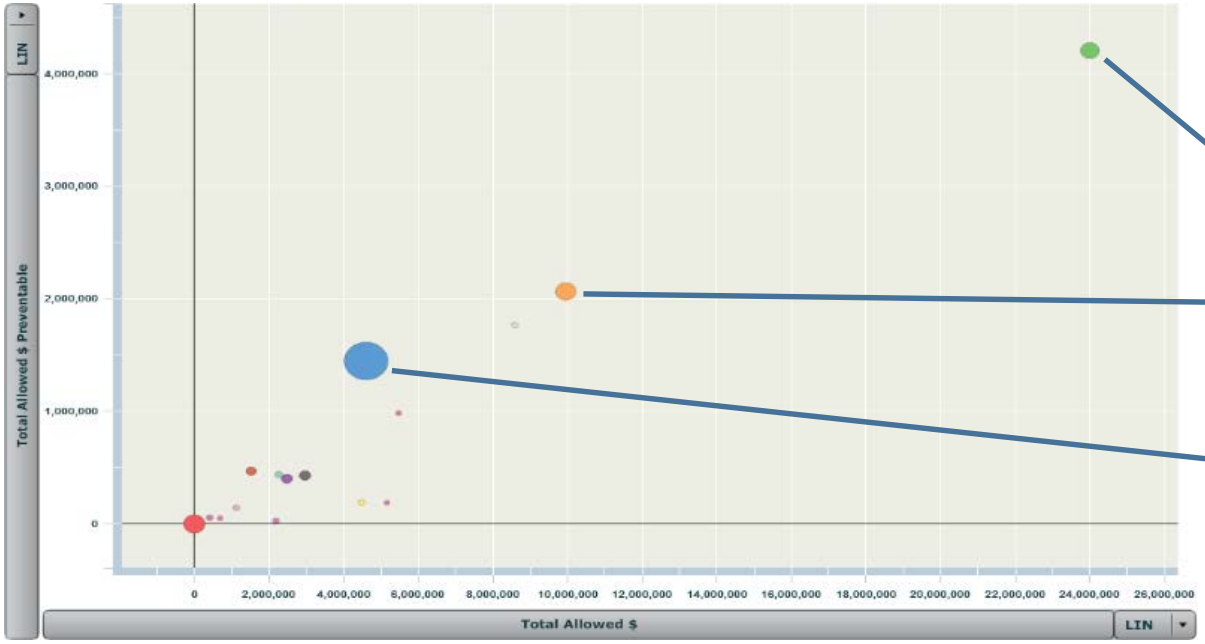
Two significant conditions
Total Cost: $712 PMPM
Preventable Cost: $39 PMPM

One significant condition
Total Cost: $289 PMPM
Preventable Cost: $14 PMPM

Healthy
Total Cost: $49 PMPM
Preventable Cost: $3 PMPM

Concentration of potentially preventable events

Sample Medicaid population



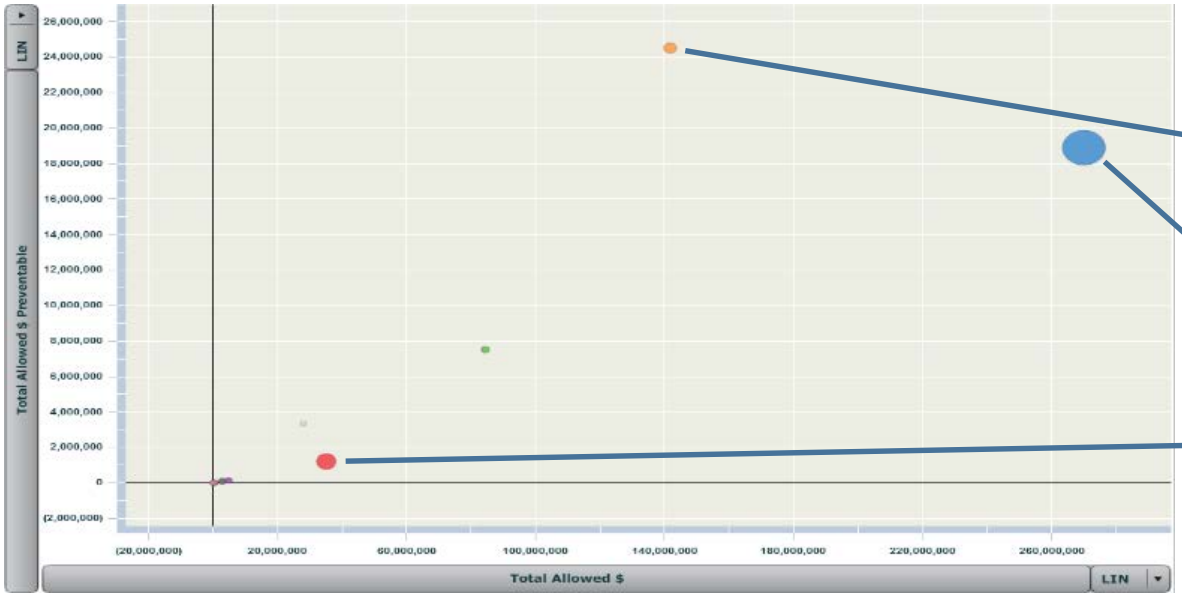
Two significant conditions
Total Cost: $451 PMPM
Preventable Cost: $79 PMPM

One significant condition
Total Cost: $184 PMPM
Preventable Cost: $38 PMPM

Healthy
Total Cost: $34 PMPM
Preventable Cost: $11 PMPM

Total illness burden population segments drive opportunities

Sample Medicare population



Three significant conditions
Total Cost: $2,066 PMPM
Preventable Cost: $357 PMPM

Two significant conditions
Total Cost: $743 PMPM
Preventable Cost: $52 PMPM

One significant condition
Total Cost: $267 PMPM
Preventable Cost: $9 PMPM

HSR Health Services Research

DOI: 10.1111/1475-6773.12222
RESEARCH ARTICLE

SRH measures provide a promising way to prospectively profile Medicaid-eligible adults by likely health care needs.

Using Self-Reported Health Measures to Predict High-Need Cases among Medicaid-Eligible Adults

Laura R. Wherry, Marguerite E. Burns, and Lindsey Jeanne Leininger

Patient-reported confidence (aka "activation")—a strong indicator of risk

Low confidence individuals also report the following:	Adjusted Odds Ratio*
Hospitalization or ED for a chronic condition†	1.552
More than one hospitalization or ED visit**	1.865
Hospitalization or ED use perhaps unnecessary**	1.609
Time lost from work due to emotional or physical problem	4.049
Medication for chronic illness maybe causing some illness†	2.882
Do not have enough money to buy things for everyday life	2.787
Fair to poor info received from MD on chronic disease†	2.566

All ORs were statistically significant

* Adjusted for Age, Sex, and 3M Clinical Risk Group (CRG) weight

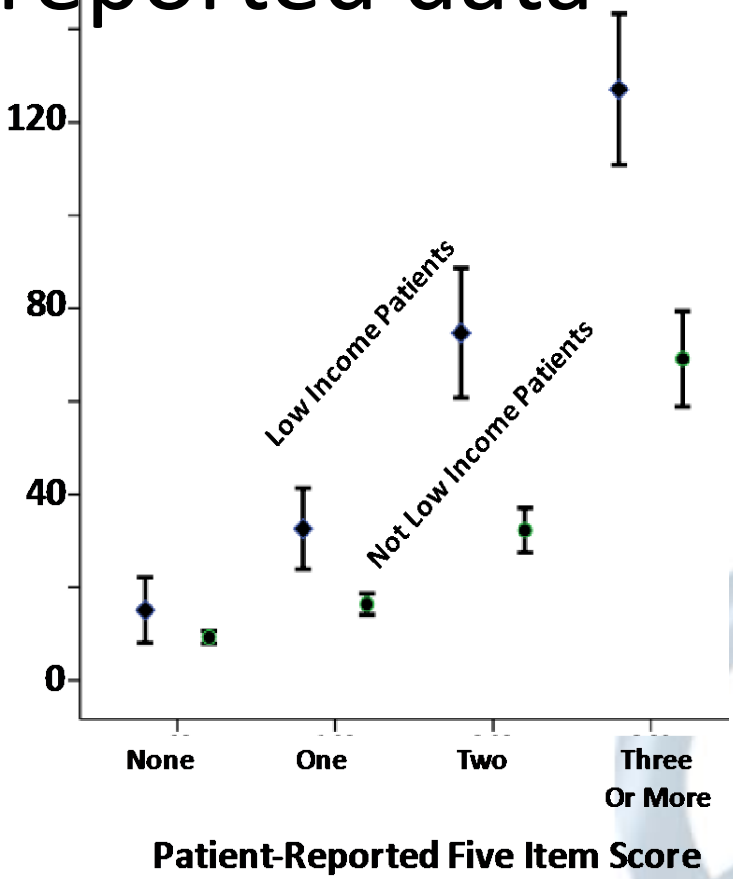
† Based on a question asking about chronic conditions

** Based on a question asking about overnight hospital stays

Patient reported data

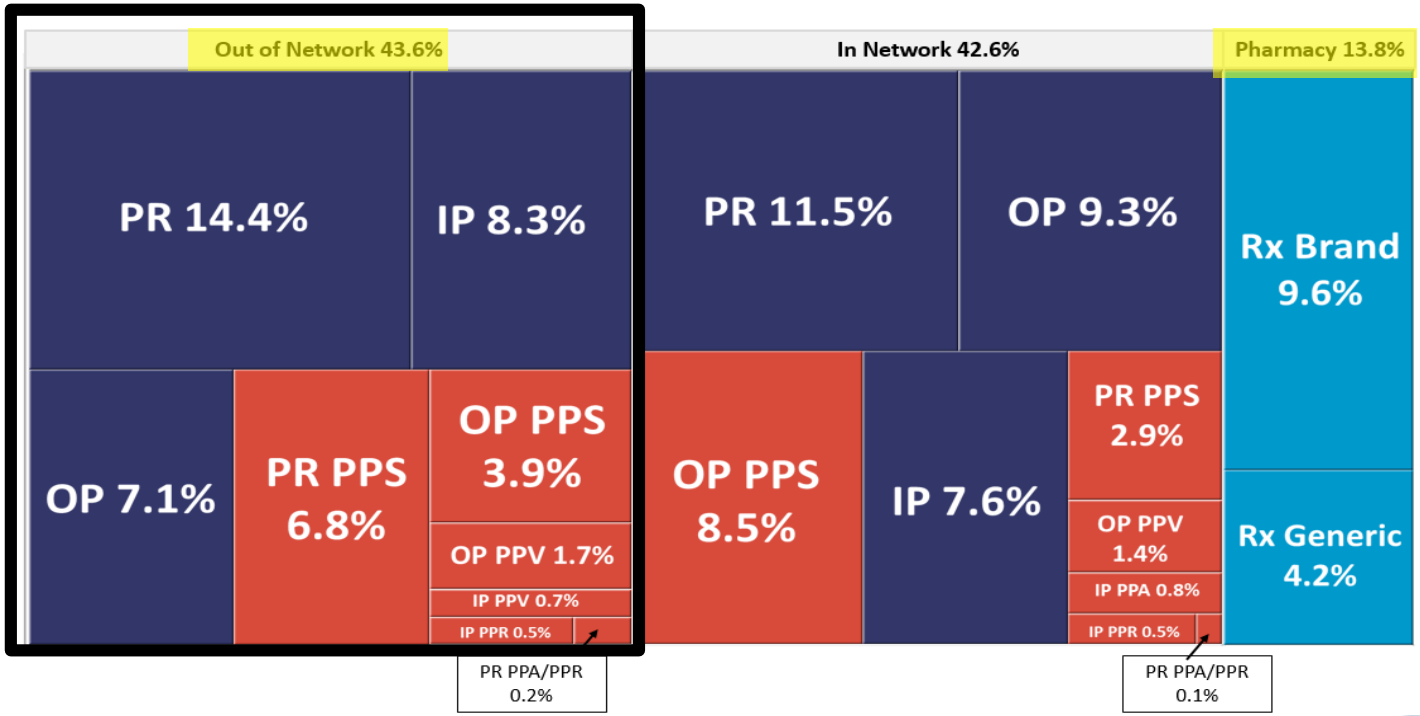
Use of Emergency Or Hospital During Past Year

(Uses Per Hundred for 9000 Adults (aged 35+) with at least One Chronic Disease)



Understanding budgets and buckets

- Looking at total cost of care for an attributed population



Box Color	Category
	Non-Preventable (IP, OP, PR)
	Potentially Preventable
	Pharmacy

Data Source: 3M HIS Informed Analytics Platform

43% of **population cost** incurred out of network (leakage)—typical in VBC, even for a large IDN

Considerable preventable events in and out of network (RED)

13% pharma – some originated outside system

Creates opportunity

- ✓ Market share
- ✓ Patient engagement
- ✓ Care coordination

Dashboards

Members With Missing HCCs

Key Performance Measure	Current YTD 01/2014-09/2014	
Members with missing HCCs	23,658	Member List

Total Cost of Care

Key Performance Measure	Rolling 12 months 07/2013-06/2014	Program YTD 01/2014-06/2014
Variance from Budget (PMPM $)	N/A	$19.47
Allowed (PMPM $)	$413.98	$413.28

Facility or group variation

Variance PPA Admits PKPY (07/2013-06/2014)

Results: 1 to 10 of 10 Page: 1 Display: 15 per page

	Name	Variance PPA Admits PKPY -4 -3 -2 -1 0 1	Variance PPA Admits PKPY	PPA Admits PKPY	Budget PPA Admits PKPY	PPA Allowed	Risk Weight	Members
	Treo Demo		(1.6)	5.3	6.9	$11,456,423	1.096	208,670
1	Livingston Park Hospitals and C...		1.3	7.4	6.1	$300,836	0.985	4,668
2	Seton Memorial IPA		1.1	7.2	6.1	$1,389,622	1.087	20,776
3	MidState Doctor and Hospital P...		(0.6)	6.6	7.2	$1,802,705	1.112	32,372
4	West Fairview Health Services		(1.5)	5.4	6.9	$422,044	1.063	9,844
5	Mountain Valley Health Network		(1.5)	3.5	5.0	$74,937	1.020	2,519
6	North City Health Services Netw...		(1.7)	4.9	6.6	$3,152,019	1.096	59,844
7	Park County ACO		(2.1)	5.5	7.6	$2,616,182	1.129	31,167
8	Forest Park Regional Health Clinic		(2.3)	0.4	2.7	$11,603	0.571	3,222
9	South Village Healthcare Partners		(3.0)	4.0	7.0	$860,940	1.080	23,495
10	Midwest Health Alliance		(3.6)	4.2	7.8	$825,535	1.175	20,763

Dashboard: Quality Measures

Treo Demo 11/2013-10/2014 (Claims paid through 01/31/2015)

Enter text to search...

Demo QEP

Quality Performance Measures

Target Quality Measure	Current	Prior
Annual Dental Visit (ADV)	64.39 %	64.13 %
Breast Cancer Screening (BCS)	67.27 %	70.90 %
Cervical Cancer Screening (CCS)	65.95 %	68.94 %
Adolescent Well-Care Visits (AWC)	58.86 %	55.88 %
Cholesterol Management for Patients with Cardiovascular Conditions (CMC) LDL-C Screening	34.13 %	20.70 %
Comprehensive Diabetes Care (CDC) HbA1c Testing	83.95 %	81.57 %
Comprehensive Diabetes Care (CDC) HbA1c Control <=9	39.42 %	30.63 %
Comprehensive Diabetes Care (CDC) LDL-C < 100	24.51 %	24.72 %
Frequency of Ongoing Prenatal Care (FPC>=81%)	42.17 %	35.29 %
Lead Screening in Children (LSC)	78.45 %	80.33 %
Medication Management for People With Asthma (MMA)	35.74 %	34.96 %
Postpartum Care	40.59 %	35.12 %
Prenatal Care	67.87 %	72.15 %
Controlling High Blood Pressure (CBP)	2.83 %	1.77 %
Aggregate Score	60.91 %	61.26 %

Dashboard – Member List: Missing HCCs

Member List (limited to 1,000 members)

This list includes all patients who are attributed to the provider who were identified with one or more chronic HCCs in the prior calendar year, but have not been identified with the same HCC(s) in the current calendar year.

Export All **23,658** Members

Search:

Show 10 entries

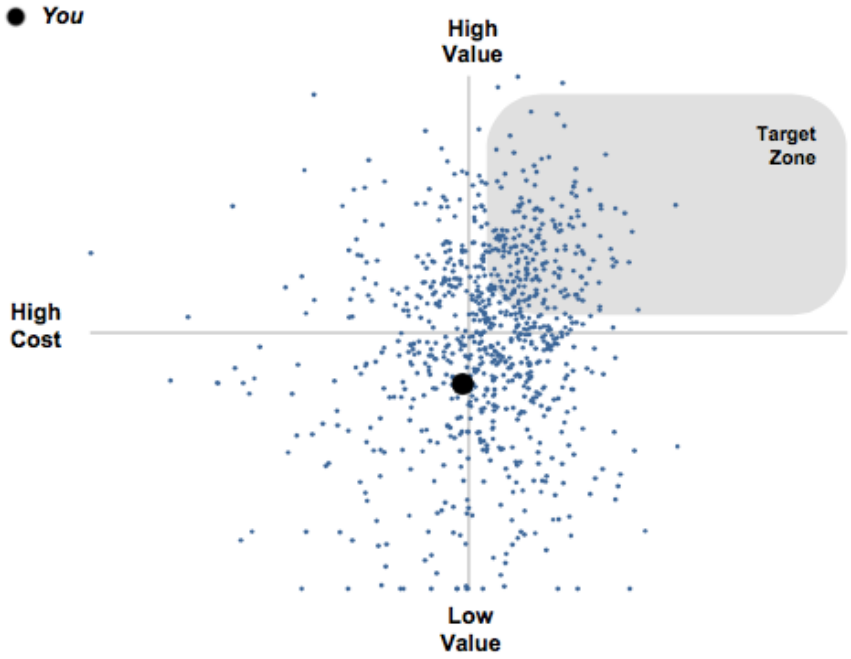
Member ID	Last Name	First Name	Gender	Person DOB	Demographic Model	Physician Group	Physician Name	Decile	Missing HCCs	Prior Factor	Missing Factor
648155	YOUNG (DE-ID)	MELVIN O.	M	01/26/2002	C	Bluth Community Medicine	TERRY D. EDWARDS (DE-ID) MD	10	7	170.91	170.91
538882	CAMPBELL (DE-ID)	RACHEL X.	F	11/27/1962	A	Stinson Professional Care	EDWARD E. JACKSON (DE-ID) MD	10	11	89.987	87.762
403713	WALKER (DE-ID)	SHAWN N.	M	05/25/1931	A	Atlantic Medical Group - North	WALTER V. ALLEN (DE-ID) MD	10	8	79.969	75.737
51659	WRIGHT (DE-ID)	ANNIE P.	F	05/18/1950	A	Centerville Clinic Center	GLENN A. TURNER (DE-ID) MD	10	5	75.193	75.193
787916	LOPEZ (DE-ID)	JOSEPHINE S.	F	03/29/1944	A	Washingtonville Community Practice	TIMOTHY Z. JONES (DE-ID) MD	10	6	74.983	74.983
341570	COLLINS (DE-ID)	SHARON T.	F	04/22/1932	A	Centerville Clinic Center	FLORENCE L. MARTINEZ (DE-ID) MD	10	5	76.082	71.462
828996	PEREZ (DE-ID)	SAMUEL T.	M	06/19/1953	A	Mount Thompson Maternity Center	ANNIE F. HARRIS (DE-ID) MD	10	5	69.75	69.75
851995	THOMAS (DE-ID)	VINCENT J.	M	07/02/1949	A	St. Mary's Physician Services	KEITH Q. BROWN (DE-ID) MD	10	4	78.212	68.013
358058	LEWIS (DE-ID)	JANE Y.	F	11/25/1932	A	Kingston Medical Group - South	CINDY E. MOORE (DE-ID) MD	10	7	76.671	67.932
127473	JOHNSON (DE-ID)	ASHLEY S.	F	07/31/1995	C	Lakeside Park Primary Physicians	CONNIE G. GREEN (DE-ID) MD	10	5	71.358	66.024

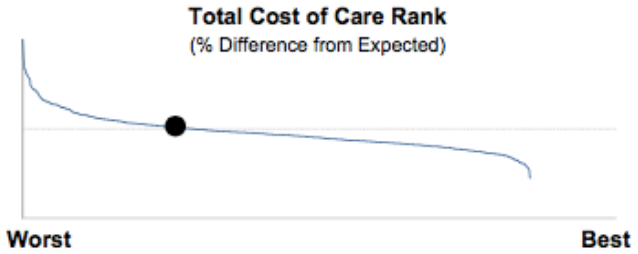
Showing 1 to 10 of first 1,000 entries

First Previous 1 2 3 4 5 Next Last

Provider Variation

Performance Summary





Value Index Score

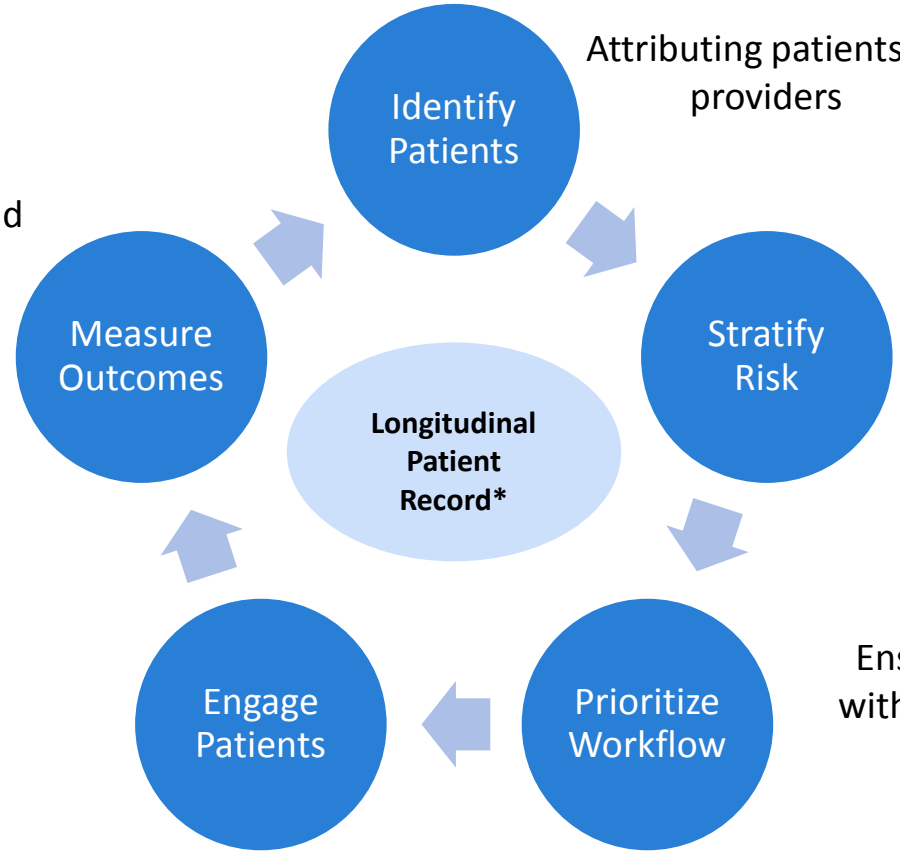
	%ile
Overall	**27**
Primary & Secondary Prevention	38
Tertiary Prevention	76
Health Status Change	4
Continuity	27
Chronic & Followup Care	62
Efficiency	21

Total Cost of Care (% Difference from Expected)

	%ile
Overall	**37**
Inpatient	28
Outpatient	29
Professional	36
Prescription	65

Worst → percentile → Best

Population health management (PHM) cycle



* Even for IDNs, less than half of services provided to patients are provided in-system. Physicians need insight into all services, thus the importance of the longitudinal record

HCC Impact: Capturing more complete and accurate patient picture

83 y/o male, living at home with nursing assistance

Documented Conditions	CMS Risk Score	Demographic Score	Total RAF Score	Negotiated PMPM Payment	Annual Payment
Diabetes, Type II, Uncomplicated	0.162	0.44	0.846	$800	$8,162
UTI	0				
Old Myocardial Infarction	0.244				

- Patient identified as having missed HCCs from prior year and schedule for office visit
- During visit provider is prompted to document more complete patient diagnosis information
- Additional chronic conditions are documented

Diabetes, Type II, Uncomplicated	Trumped by CKD Stg 3	0.44	2.586	$800	$24,826
UTI	0				
Old Myocardial Infarction	0.244				
CKD Stage 3	0.368				
Diabetic Nephropathy	Trumped by CKD Stg 3				
Malnutrition, Mild	0.856				
BKA Status	0.678				

+$16,704

Bottom line

- Population outcomes improvement relies on changing systems of care
  - Improvement of discrete metrics may not add up to significant population improvement
- Given limited time and resources, focus on interventions with the greatest potential positive impact
  - While drilling down is essential, resist the urge to stay in the weeds
- Improving systems of care may start with a discrete focus (e.g. diabetes)
- Population outcomes are more likely if the discrete focus is a pilot phase to establish new systems of care
  - Focus on improving the core attributes of effective primary care

Thank you

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