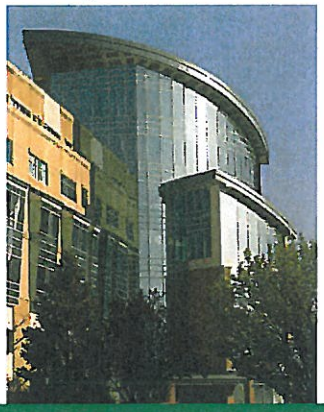
Accountable Care and Population Health Management

Mercy Medical Center – Des Moines and Mercy Health Network

February 2013



Mercy

Outline

- Mercy Overview
- Who is Mercy ACO?
- How does an ACO work?
- Data
- Care Management
- Q&A

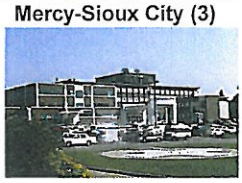
Mercy ACO

Mercy Health Network Overview

Mercy-Des Moines (3)

Mercy-Sioux City (3)

Mercy-North Iowa (2)



Mercy-Clinton

Mercy-Dubuque (2)

- JOA between Catholic Health Initiatives ($10.7B; 86,000 employees) and Trinity Health ($9B; 56,000 employees)[1]
- 11 owned hospitals: 6 urban; 5 rural community[2]
- 1 joint venture surgical hospital[2]
- 28 affiliated community hospitals[2]
- 625 employed physicians[2]
- 27.2% share of inpatient & observation discharges in Iowa[3]
- 2,856 licensed beds (excludes nursing home)[4]
- 86,630 admissions[3]
- 330,000 outpatient visits[3]
- 16,300 employees[4]
- $2.11 billion in total annual operating revenues[3]

Sources: 1) CHI and Trinity Websites 2) MHN records 3) IHA Dimensions- FY12.
Excludes behavioral health, chemical dependency, and skilled nursing 4) IHA Profiles- FY11

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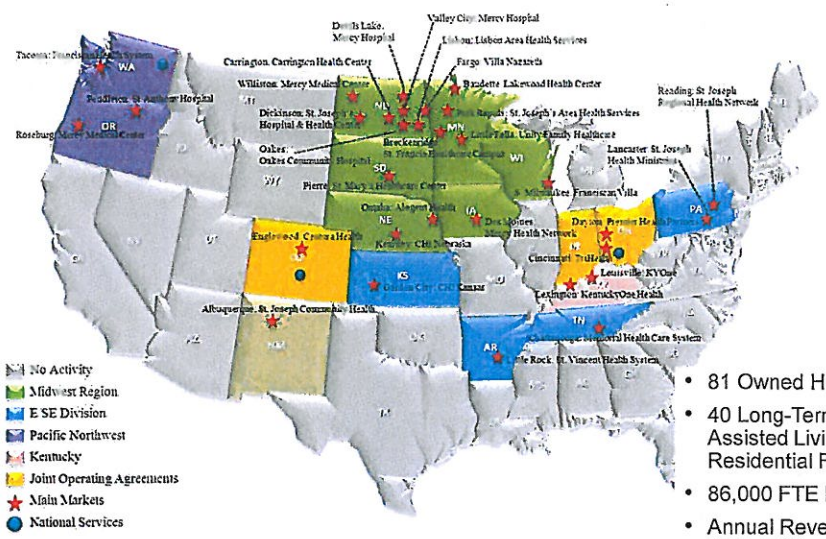
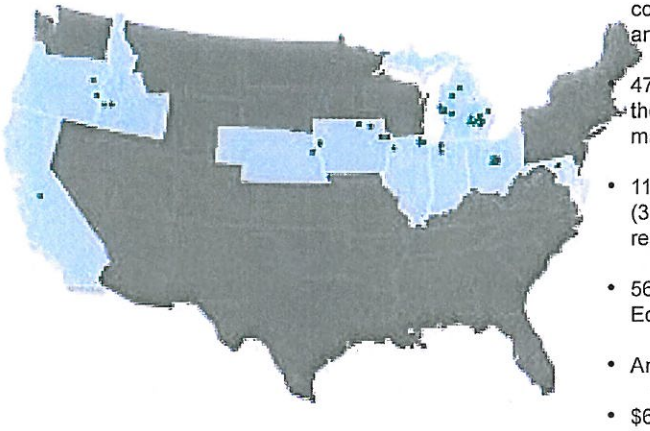
Catholic Health Initiatives



- 81 Owned Hospitals
- 40 Long-Term Care, Assisted Living & Residential Facilities
- 86,000 FTE Employees
- Annual Revenues of $10.7 Billion
- $715 Million in Annual Community Benefits

Source: www.catholichealthinit.org. Retrieved 12/13/12

Trinity Health



- 10th largest health system in the U.S. and 4th largest Catholic health care system in the country, by total # of hospitals and bed count, respectively.
- 47 Hospitals across the Nation (35 owned, 12 managed)
- 11,000 active staff physicians (3,400 employed physicians and residents)
- 56,000 Full-Time Equivalent Employees
- Annual Revenues of $9 Billion
- $616 Million in Community Benefit Ministry
- Recently announced merger with Catholic Healthcare East

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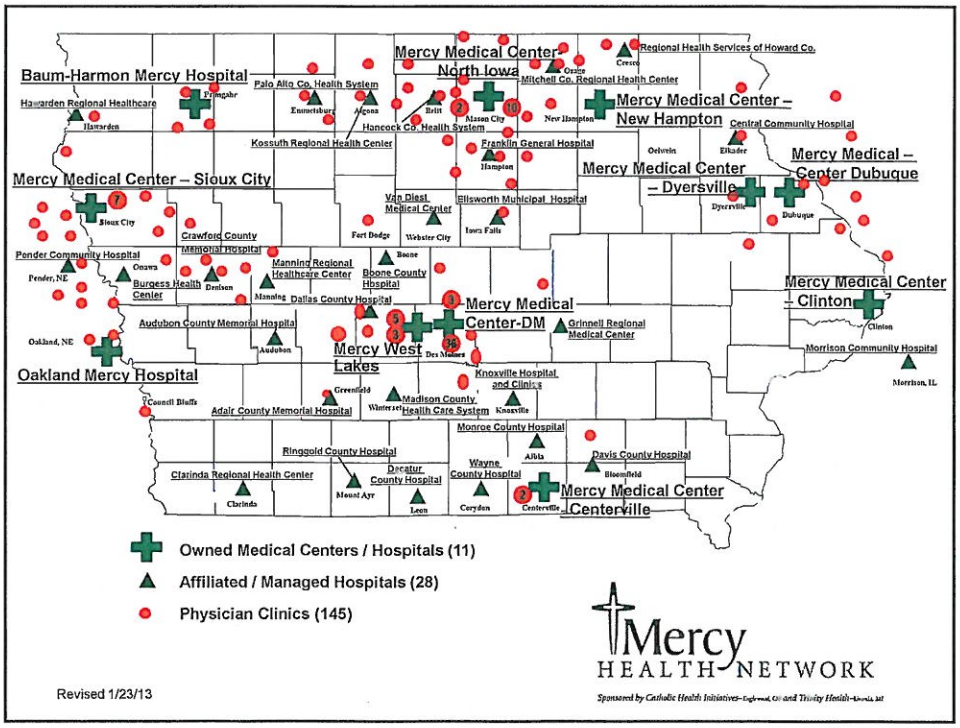
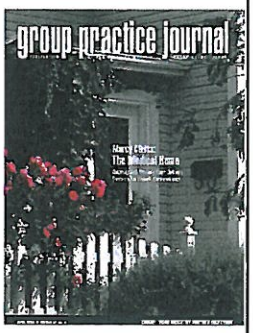
Source: www.trinity-health.org. 12/13/12



Mercy Clinics: Advanced Integrated Care

- Pioneers in advanced medical homes and population health management using:
  - Disease registries
  - Health coaches
  - Pre-visit chart reviews
  - Individual comparative reports
- Health coaches in every family practice clinic and every pediatric clinic
- Hospital-based health coaches at Central Campus
- Won the "Acclaim Award" – the highest national award for quality in a physician group practice
- The Advisory Board partnered with Mercy Clinics to develop and market a physician office-based health coach and medical home training program for health systems across the country



Mercy Clinics, Inc.
A member of Mercy Medical Center-Des Moines

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Mercy ACO

- Formed February 2012
- Wholly owned subsidiary of Mercy Medical Center – Des Moines
- Participant Agreements including Mercy Clinics, Independent Primary Care Practices, Independent Specialty Physician Practices, Rural Health Centers, and Federally Qualified Health Center.
- Risk contracts with; Medicare, Wellmark, and Mercy Employees
  - 60,000+ Covered Lives
  - July 2012 recognized Medicare Shared Savings Program ACO

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How Does an ACO Work?

- Patients attributed by primary care doctor.
- Risk adjusted cost target is calculated.
- Fee for service payments made as usual.
- At the end of one year.
  - Costs below the target are shared with the ACO.
- Quality and Patient Satisfaction targets **must** be met to share savings.
- ACO distributes savings to stakeholders (providers).

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How Is This Different From an HMO??

ACO

- Patients are free to self refer.
- Sophisticated risk adjustment.
  - Want the sickest patients
- Data Warehouses and metrics.

HMO

- Primary care must authorize referrals.
- Risk adjustment only by age and sex.
  - Want the healthiest patients
- Rudimentary data.

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How We Get Savings

- Additional low cost Primary Care interventions can improve the health of patients.
  - Many of these are not reimbursed under FFS payments, but can be funded by shared savings.
- Improving the health of patients will reduce.
  - Hospitalizations
  - ED use
  - Drug costs
- Denying needed care will not be effective.

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Emerging Value-Based Reimbursement Model

- Current system rewards volume
- A value-based reimbursement system is emerging which will:
  - Reward keeping people healthy
  - Require health systems to take financial risk and responsibility for populations of patients
  - Require better care at lower cost
- Alignment of mission; volume to value.
- Examples
  - P4P, bundled payments, shared savings, capitation, global risk

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Mercy Accountable Care Contracts

- Wellmark (started 4-1-12) 24,000
  - Includes only fully insured patients (24,000 out of 72,000 Wellmark patients)
- CMS (Started 7-1-12) 24,000
- Mercy Employees (Started 1-1-13) 12,000
- Coventry (Medicare Advantage) 2,000

Total ACO Lives = 62,000

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ACO Measures Required by CMS

Full specifications found at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf

- CMS requires ACOs to report on 33 measures
  - Patient experience - 7 measures
    - CAHPS: Access, Communication, SDM, functional status, Health promotion & education, overall rating
  - Care Coordination – 6 measures
    - Readmission rates, Admit rate for COPD and HF, fall risk assessment, EHR use, Med Rec.
  - Population Health – 20 measures
    - Immunizations – Pneumococcal & flu
    - Screening for weight, tobacco, depression, BP
    - Screening for colon & breast cancer
    - Diabetes – HgA1c, Lipids, BP, ASA use, tobacco non-use
    - CV – BP, Lipids, ASA, Drug Rx (B-blocker, ACEI, Lipid Rx)

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Wellmark 2011 Quality Goals

Significant Quality Incentives Must be Met to get Shared Savings

- Primary and secondary prevention
  - Breast cancer screening
  - Colon Cancer Screening
  - % of members 31 days to 15 months with recommended number of well child visits
  - % of members 3 – 6 year of age with recommended number of well child visits
- Chronic care follow-up
  - Potentially preventable readmissions
  - % of members with a office visit within 30 days of hospital discharge
  - % of members with chronic disease with three or more visits

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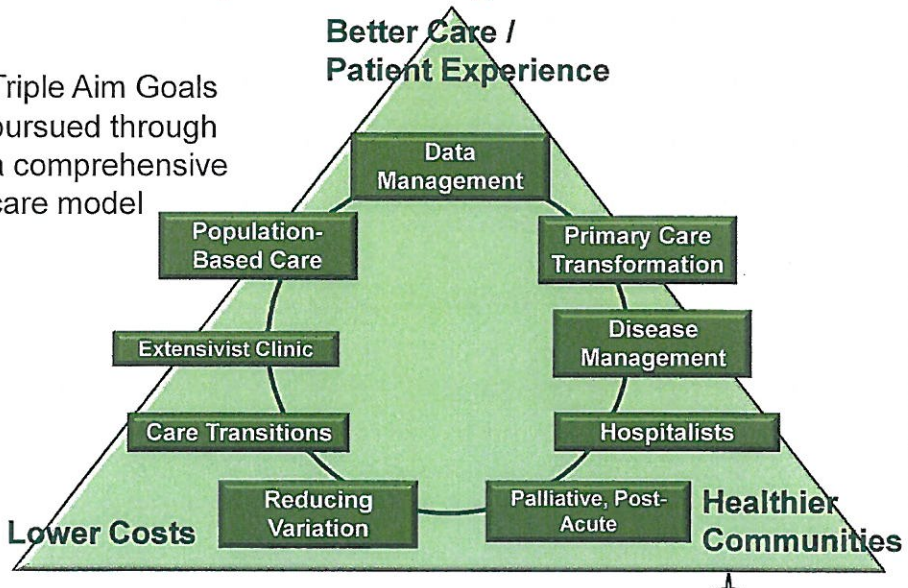
Mercy Care Management Model

Triple Aim Goals pursued through a comprehensive care model



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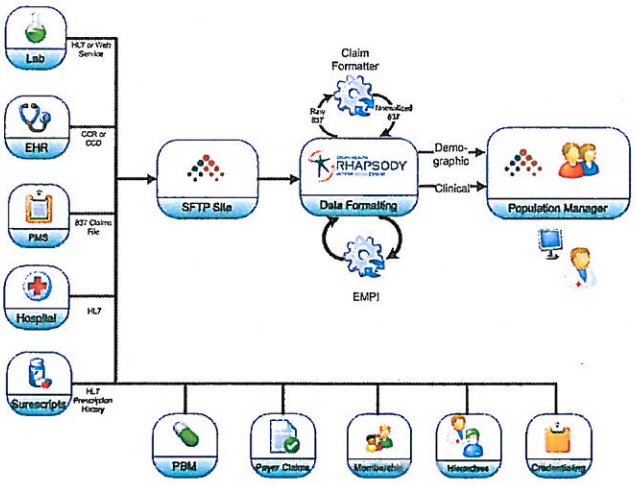
MedVentive Population Manager: Robust Data Acquisition and Management



MedVentive Reports:

1. Quality
2. Utilization
3. Efficiency
4. Pharmacy
5. Outflow

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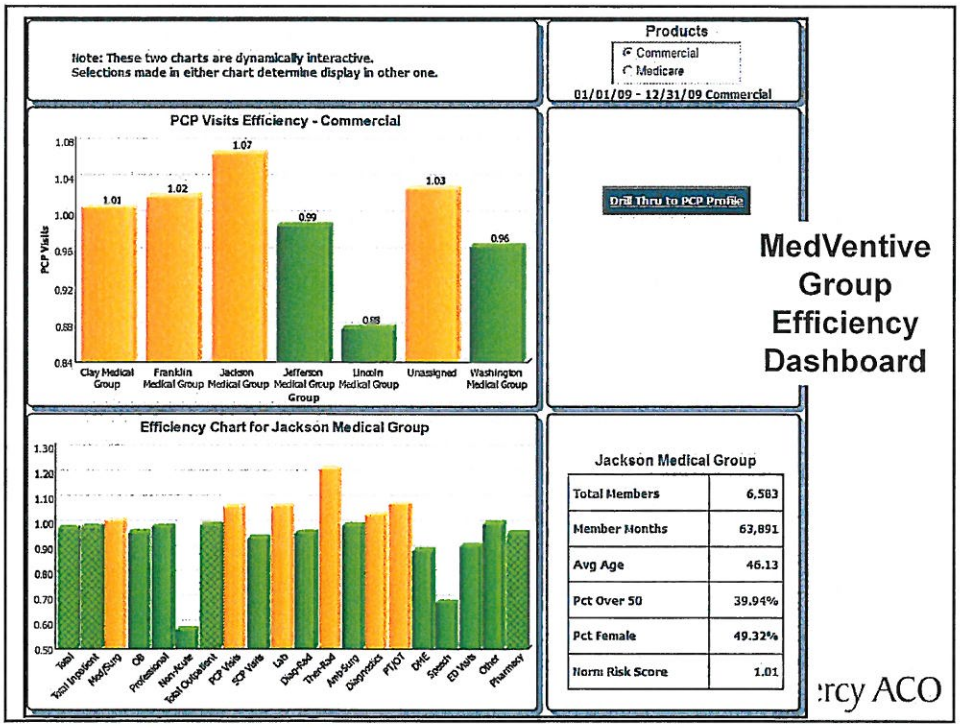

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Reduction in Variation

- Identification of cost variation using MedVentive
  (risk manager currently being installed)
  - Claims data allows analysis of all settings and across the continuum
  - Drill down to identify drivers of variation
    - i.e. wide variation in the cost of ENT sinusitis evaluation based on the use or non use of naso-pharyngeal endoscopy
  - Physician committees will create guidelines to reduce variation
    - Tracking and communication with outliers

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Patient Stratification and Segmentation

Top 1% of CMS patients account for 29% of health care costs
Top 5% of CMS patients account for 50% of health care costs

- Stratify by using:
  - Billing data in MedVentive to risk adjust patients based on diagnosis and utilization history
    - Currently evaluating patients with 3 or more ED visits
  - Assessment at hospital discharge for risk status
  - Health risk assessment (How's Your Health)
  - Physician review and referral
- Plan patient interventions by segment
  - Healthy
    - Preventive health, access for acute problems
  - Stable chronically ill
    - Intensity of services will vary with degree of risk
    - Advanced primary care or Internal Medicine centers of excellence
  - High risk chronically ill
    - Extensivist clinic

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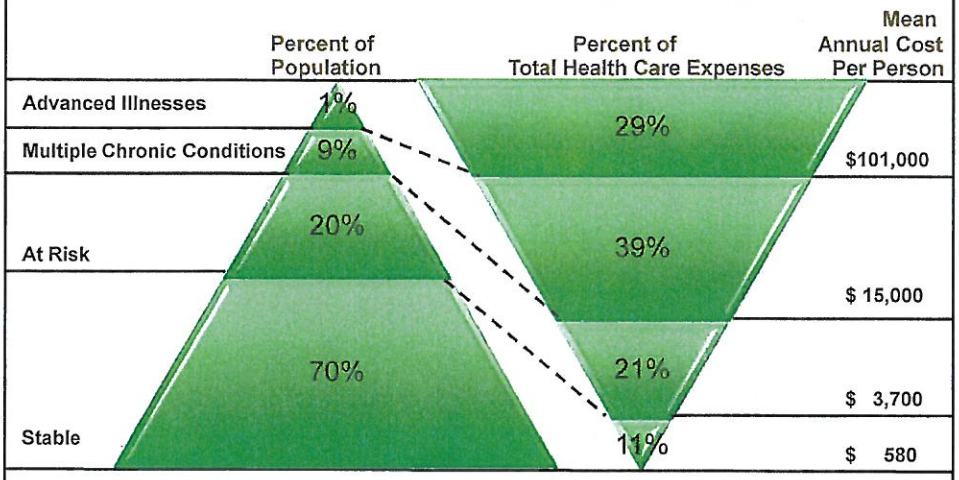
Stratification of Patients – Another Way to View Why It's Essential

10% of the Population Accounts for 68% of All Health Care Expenditures



National Sample of 21 Million Americans Between 2003 and 2007

Source: Truven Health Analytics, Market Scan, 2012

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Patient Stratification and Segmentation:

Everything Must Change – But Not for Every Patient

Focus on the Highest Cost Chronic Patients

Clinical Risk Group	Distinct Members	Plan Distribution	Cost to Plan PMPM
10 - Healthy	7,217	31.38%	$ 62.27
12 - Delivery w-out Other Significant Illness	118	0.51%	$ 856.15
15 - Evidence of Significant Chronic or Acute Diagnosis without Other Significant Illness	908	3.95%	$ 247.88
20 - History Of Significant Acute Disease	981	4.27%	$ 157.82
25 - Evidence of Significant Chronic or Acute Diagnosis with History of Significant Acute Illness	409	1.78%	$ 434.26
30 - Single Minor Chronic	2,477	10.77%	$ 229.78
40 - Multiple Minor Chronic	734	3.19%	$ 421.33
50 - Single Dominant or Moderate Chronic	3,836	16.68%	$ 375.41
60 - Pairs - Multiple Dominant and/or Moderate Chronic	3,220	14.00%	$ 955.49
70 - Triples - Multiple Dominant Chronic	257	1.12%	$ 2,284.32
80 - Malignancies - Metastatic, Complicated or Dominant	187	0.81%	$ 3,845.95
90 - Catastrophic	58	0.25%	$ 6,233.36
Total Number - Average Cost	**23,000**		**$ 398.43**
Aggregate			**$ 109,967,794**

Primary Care Transformation

- Access
  - Measure third next available appointment by provider monthly
- IT: AEHR / Data Warehouse
- Coordination of care
  - Measure documentation of f/u for testing and referrals
- Population based delivery of preventive and chronic disease services for low risk patients
  - Immunizations, screening, BP control
  - Assistance Programs
- Health Coaches
  - Function as Case Managers and care coordinators
- Disease management for higher risk patients

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RN Health Coaches

- Self-Management Support
  - Health Behavior change and Motivational interviewing
    - Start with the patients goals; not our clinical goals
  - Connection to community resources
- Coordination of care
  - Closing the loop on referrals and transitions
- Review population data for opportunities
- Shared decision making
  - Distribution of decision aids and f/U
- Quality Improvement
  - Point person for introduction of new care processes
- ACO link into primary care offices
  - Communicate performance metrics
- High Risk Patient case manager

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Coach Intervention for High Risk Patients

- High Risk Patients are assigned to an RN Health Coach
  - Currently we have 24 office based Health Coaches
  - Coaches become access point for these patients
    - Patients have coach direct phone and e-mail
  - Coaches f/u proactively by phone to assess status
  - Coaches provide motivational interviewing to increase treatment plan adherence

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Population Based Care
Clinic or Centrally Based

- Systems and protocols to track patient care
  - Registry tracking to identify patients with gaps in preventive services and chronic disease care
  - Protocols for addressing the gaps in care
- Clinics are responsible for managing their populations of patients
  - Care Management command center will support this
    - Health coach supervisors currently provide this function
- Useful to address the large healthy and stable chronic disease population

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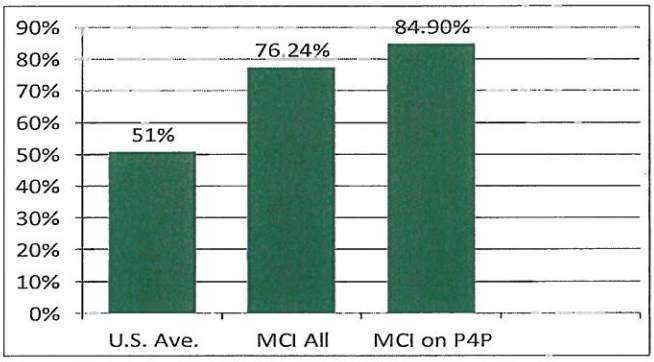
Mercy Clinic Example: Health Coaches Using Disease Registries and Protocols to Improve BP Control

- **Process: Develop Clinical Process Map; Coaches follow process map by contacting patients monthly until BP controlled**
- Results: Significantly out-performed U.S. averages & HEDIS goal of 63%
- Conclusion: Tracking results can show if a process is working for a population in just 3 months; Process more important than individuals; Physicians perform best when rewarded for their efforts; BP Control results in dramatic health improvement



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Approach For All Patients With Multiple Chronic Diseases

These are more important than most disease-specific interventions

1. Registry tracking: Immunizations, standards of care, cancer screening
2. Preferred access (through the health coach)
3. Individualized written care plans *(in planning)*
4. Health Risk Assessment - "How's Your Health" *(piloting at three sites)*
   - Includes screens for depression, adherence, and functional status
5. Assessment of home and family support
   - Access to community services
6. Health behavior change interventions - Coaching
   - Medication adherence, diet, exercise, smoking
7. Shared decision making – decision aids
8. Palliative Care
9. Extensivist Clinic - Rapid response team for outpatients *(in planning)*
10. Track patients through transitions in care with coaches
11. Consistent advice especially after hours
12. Disease specific interventions in partnership with specialists

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Transition Coach
Currently staffed at 3 FTEs

- See ACO patients while in the hospital
  - Teaches warning symptoms and what to do if they occur
  - Assesses medication issues
  - Facilitate the transition back to the medical home
    - Makes appointment for joint F/U with doctor and coach
    - Encourages patient to bring all meds to the visit
- Tracks the patient until seen back in the medical home
- Communicates discharge info to the medical home Health Coach
- Collaborates with the hospital care team on high utilizing patients

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Mercy ACO - Mission and Values

- Mission:
  - Mercy ACO will improve health, improve patient satisfaction, and lower healthcare costs for our community
- Values:
  - Patient centeredness
    - All decisions will be made in the context of what is best for the patient
  - Continuous Improvement
    - Mercy ACO will continually improve the value it creates

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THANK YOU!!

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