Montefiore
THE UNIVERSITY HOSPITAL FOR
ALBERT EINSTEIN COLLEGE OF MEDICINE

# Montefiore Medicine Population Health Management


*Presentation by*

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*Montefiore Medicine*


June 22, 2016

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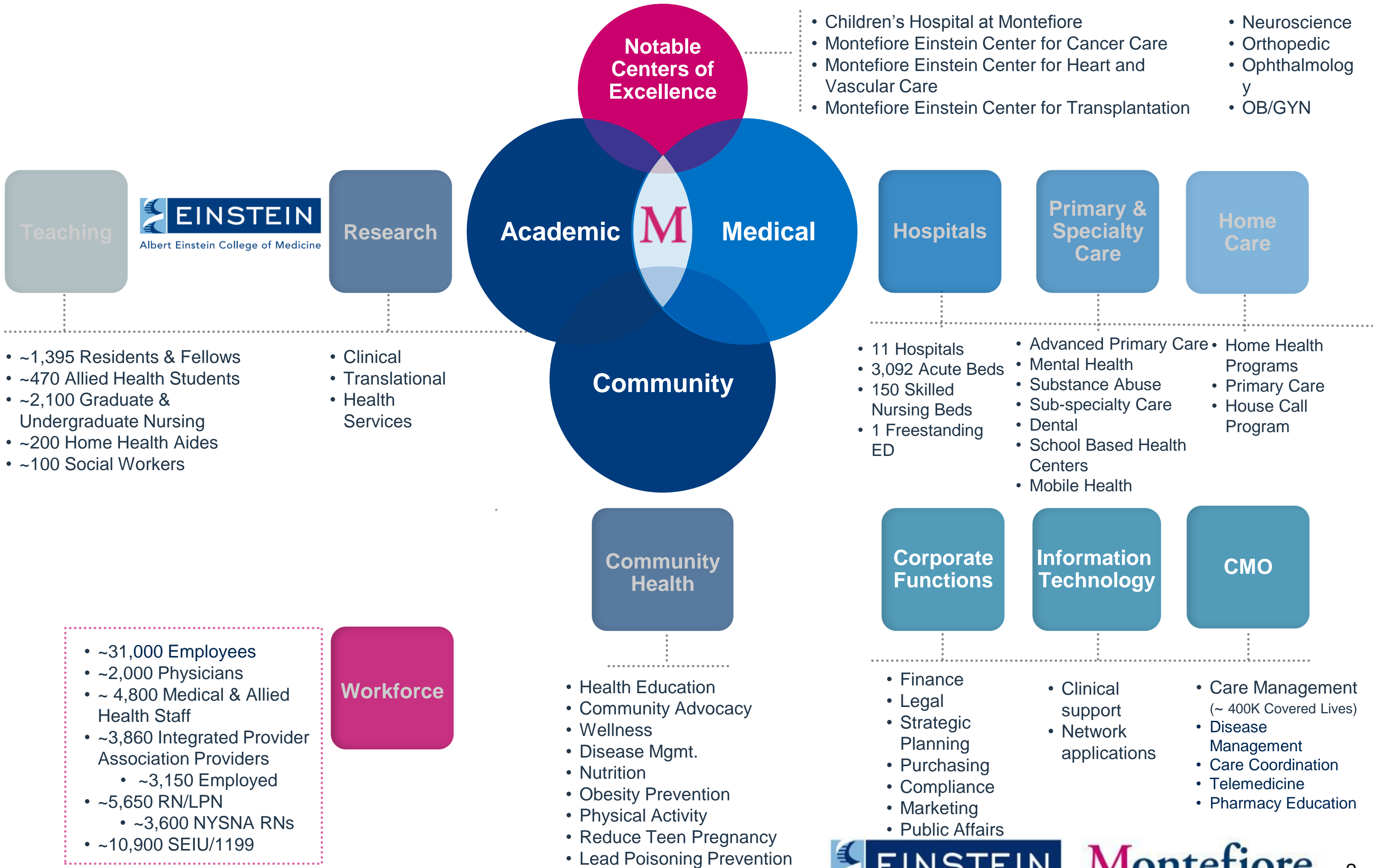
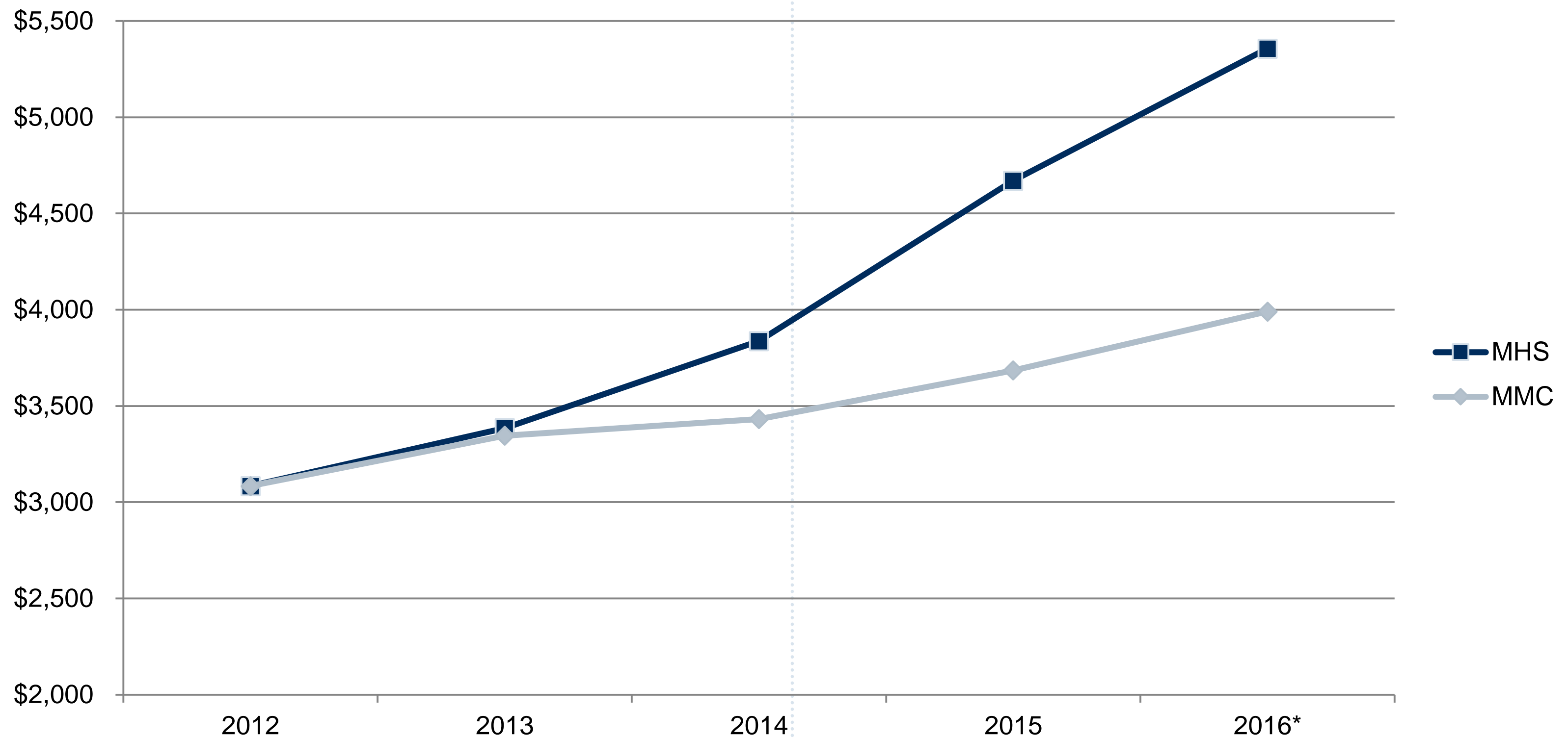
Montefiore



# Montefiore Health System Economy




*Of Note, Montefiore Medicine was created in 2015 and the introduction of the Albert Einstein College of Medicine adds approximately $350M in operating revenue not reflected on the graph*



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# The Bronx

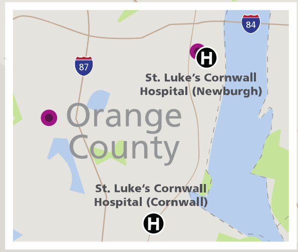
- 1.4 million residents in the poorest urban county in the nation
- Median household income $34,000
- 54% Hispanic, 37% African-American
- High burden of chronic disease
- Per capita health expenditures 22% higher than national average
- 80% of health care costs paid by government payers

# Our Communities

*Bronx, Westchester, Rockland, and Orange, NY – 3.1 Million People*

| | Bronx | Westchester | Rockland | Orange |
|---|---|---|---|---|
| **Population** | 1.5M | 1M | 325K | 380K |
| **Economic Indicators** | | | | |
| **Poverty** | 32% | 10% | 15% | 13% |
| **Unemployment** | 8% | 4% | 4% | 4% |
| **Uninsured** | 16% | 12% | 11% | 11% |
| **Chronic Disease Burden** | | | | |
| **Diabetes** | 11% | 9% | 11% | 13% |
| **Overweight /Obese** | 68% | 59% | 60% | 67% |
| **Child Overweight /Obese** | 32% | 29% | 33% | 36% |
| **Asthma (per 100K)** | 58 | 14 | 12 | 13 |
| **Cancer (per100K)** | 484 | 494 | 507 | 498 |

*Source: U.S. Census, New York State Dept. of Health, NYS Dept. of Labor*



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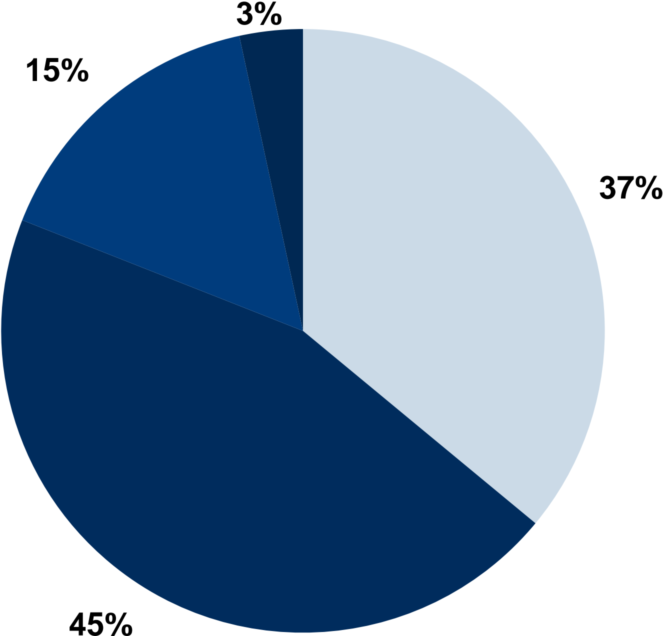
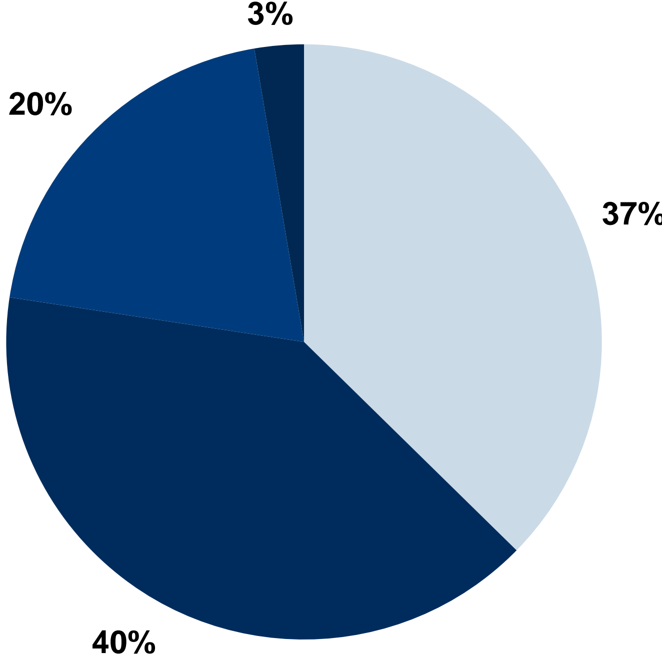
# Payer Mix : Outsized Gov't Payer Mix

## MMC Payer Mix, 2015




MEDICARE
MEDICAID, OTHER GOVERNMENT, AND UNINSURED *
COMMERCIAL
1199 AND SELF INSURED

## MHS Payer Mix, 2015

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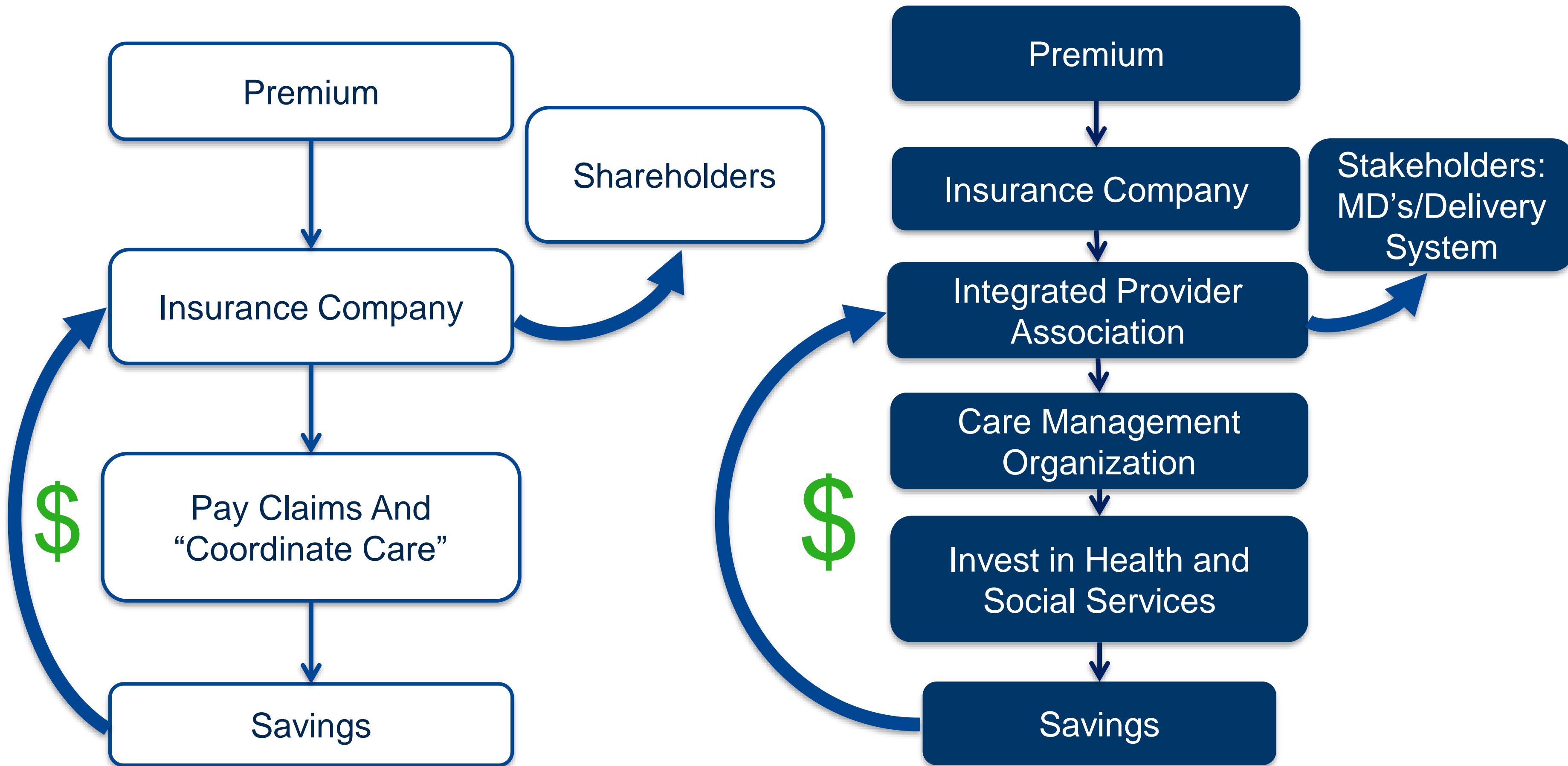
# Montefiore's Population Health Model : A Strategic and Financial Imperative

# Strategic goals

Strategic Goals

1. Advance our partnership with the Albert Einstein College of Medicine
2. Create notable Centers of Excellence
3. Build specialty care broadly
4. Develop a seamless healthcare delivery system with superior access, quality, safety and patient satisfaction : Population Health- Triple Aim
5. Maximize the impact of our community service

# New Era of Population Health; Transition From Managing Price to Managing Care

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# Montefiore Integrated Provider Association (IPA)

*The IPA was formed in 1995 and operates as an physician/hospital partnership, contracting with managed care organizations to accept and manage risk under Value Based Arrangements.*

**Membership: 3,871**

- 2,691 physicians
- 618 PCPs

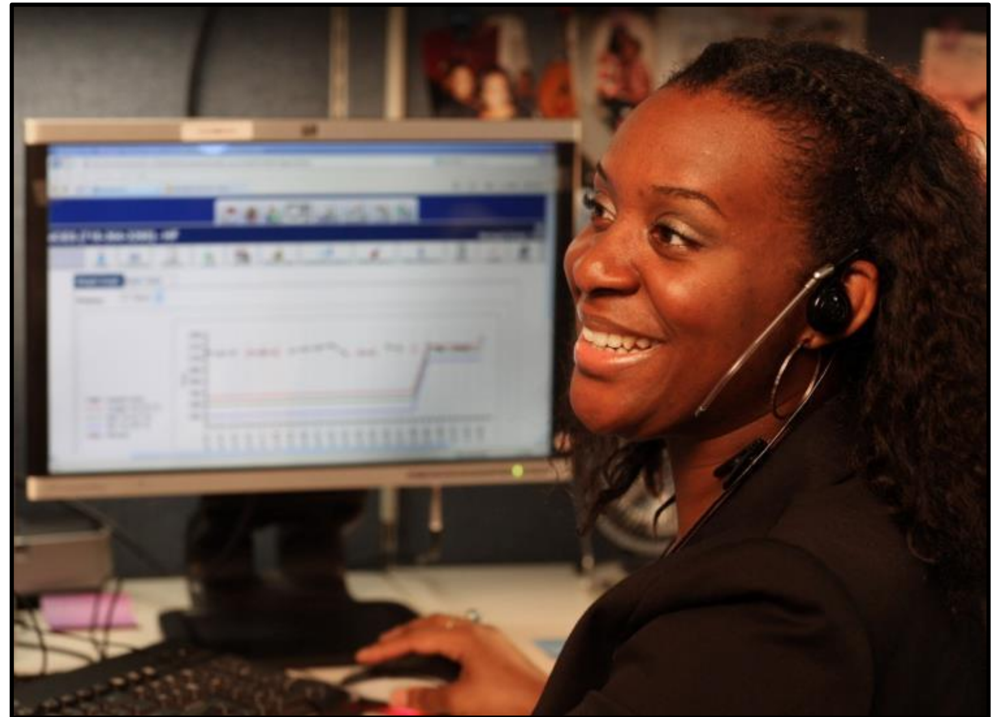
  Of those providers:
  - 2,043 employed
  - 1,823 private practice

**Governance**

- Board membership includes 14 physicians and 5 system executives
- Requires consensus due to 1/1 vote split

**January 2015**

- NYS approved new regulations
- IPAs may now contract for all lines of business and products, supporting establishment of the **Hudson Valley IPA**





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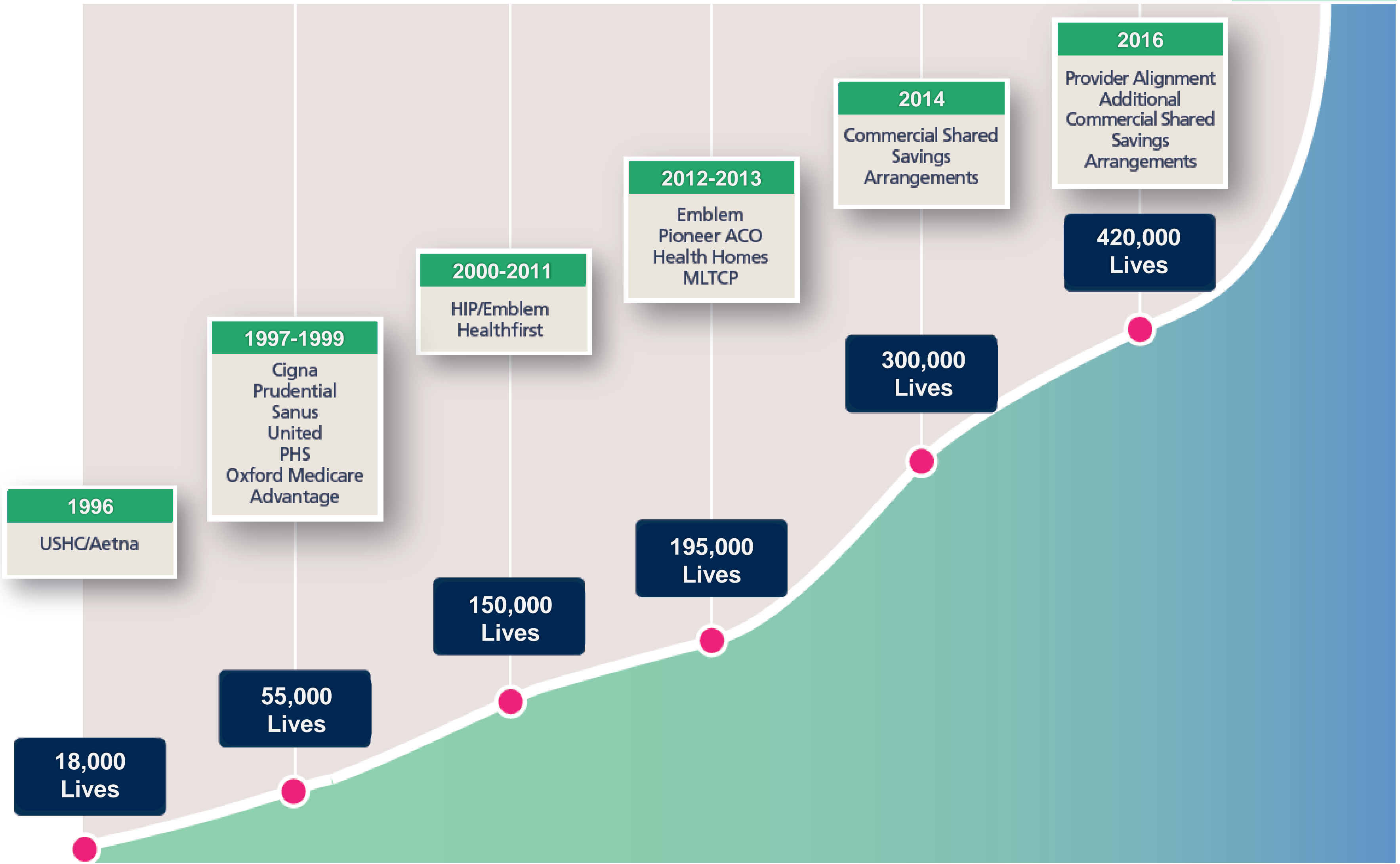
# Montefiore Care Management Organization (CMO)

*The CMO was formed in 1996 as a subsidiary of MMC and is the contracted entity by which Montefiore conducts care management and plan administration.*

- Serves **administrative** functions (e.g. claims payment, credentialing)
- Performs **care management** as delegated by health plans
    - Risk stratification
    - Predictive analytics
    - Social Service partnerships, (e.g. housing at risk)
- Over 1,200 staff

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# Overview of Value-Based Payment Arrangements at Montefiore

| Source | 2015 Population | 2015 Est. Revenue |
|---|---|---|
| **Risk Contracts** | 220,000 | $1,360m |
| **Shared Risk** | 165,000 | $1,022 m |
| **Medicaid Health Home (Care Coordination)** | 10,000 | $18 m |
| **Totals** | 395,000 | $2,400 m |

***Goal: To reach 1,000,000 covered lives***

# New York State Medicaid Redesign

**Significant challenges**

- ***NY State's Medicaid health care spending significantly greater than the National Average***
- ***Prevalence of preventable chronic conditions continues to rise***
- ***NY one of the highest States for avoidable hospital use.***

**Requiring a range of recent State initiatives**

- ***Delivery System Reform Incentive Payment (DSRIP) program - $8B over 5 years***
- ***DSRIP Goals:***
  - ***Improving access to high quality integrated***
  - ***"Care Management for all"***
  - ***Transition from FEE FOR SERVICE to VALUE BASED PAYMENTS (VBP) – Goal 90% VBP by end of decade***
  - ***Promote regional provider collaborations across the Care Continuum - PPS***

Source New York State Health Innovation Plan, Medicaid Redesign Team Final Report

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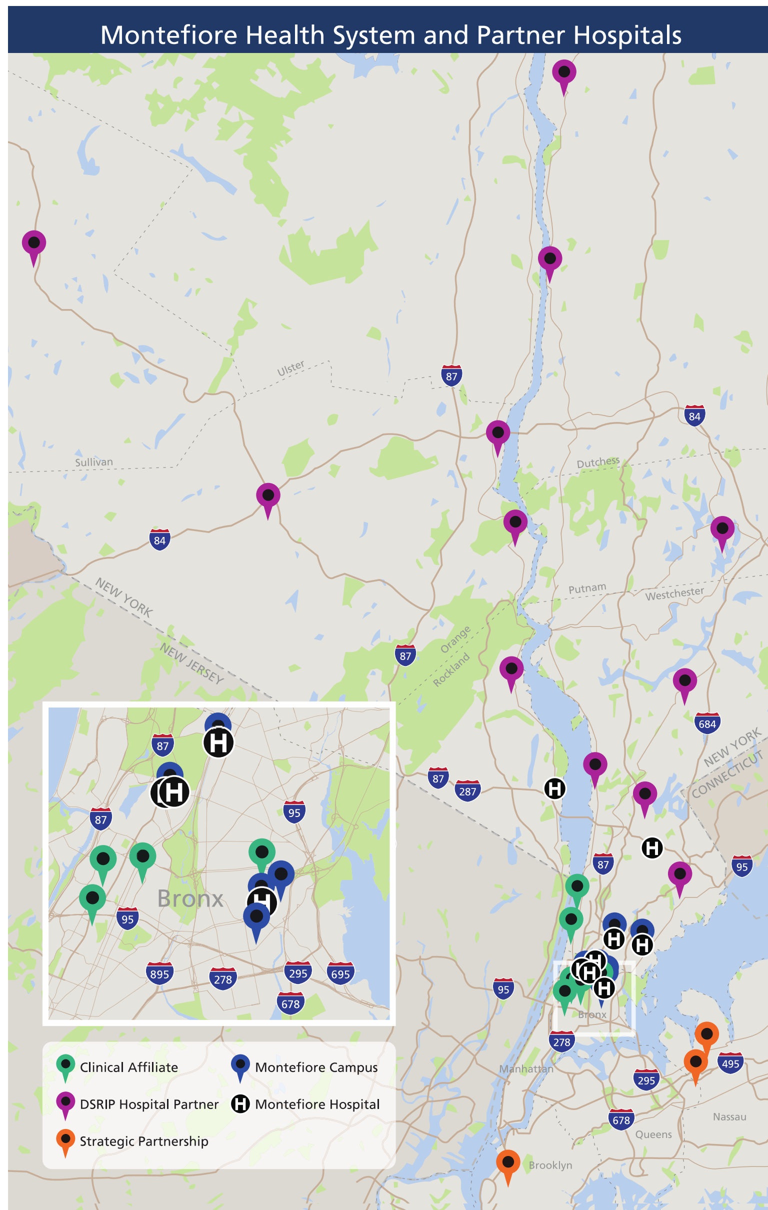
# Regional Approach: 1 Million Lives +




## Strategic partnerships support population health imperative

- **Delivery System Reform Incentive Payment (DSRIP)**
  - Lead the Hudson Valley Performing Provider System, with over 500 partner organizations, including:
    - 19 Hospitals, 4 FQHCs with 29 sites and 59 Skilled Nursing/Long Term Care/Hospice
  - Lead participant in the Bronx Partners for Healthier Communities Performing Provider System
- **Clinical Affiliations**
  - Jacobi Medical Center, Bronx, NY
  - Morris Heights Health Center, Bronx, NY
  - St. Barnabas Hospital, Bronx, NY
  - St. John's Riverside Hospital, Yonkers, NY
  - St. Joseph's Medical Center, Yonkers, NY
- **Strategic Partnerships**
  - Northwell Health, Multiple Locations
  - Maimonides Medical Center, Brooklyn, NY

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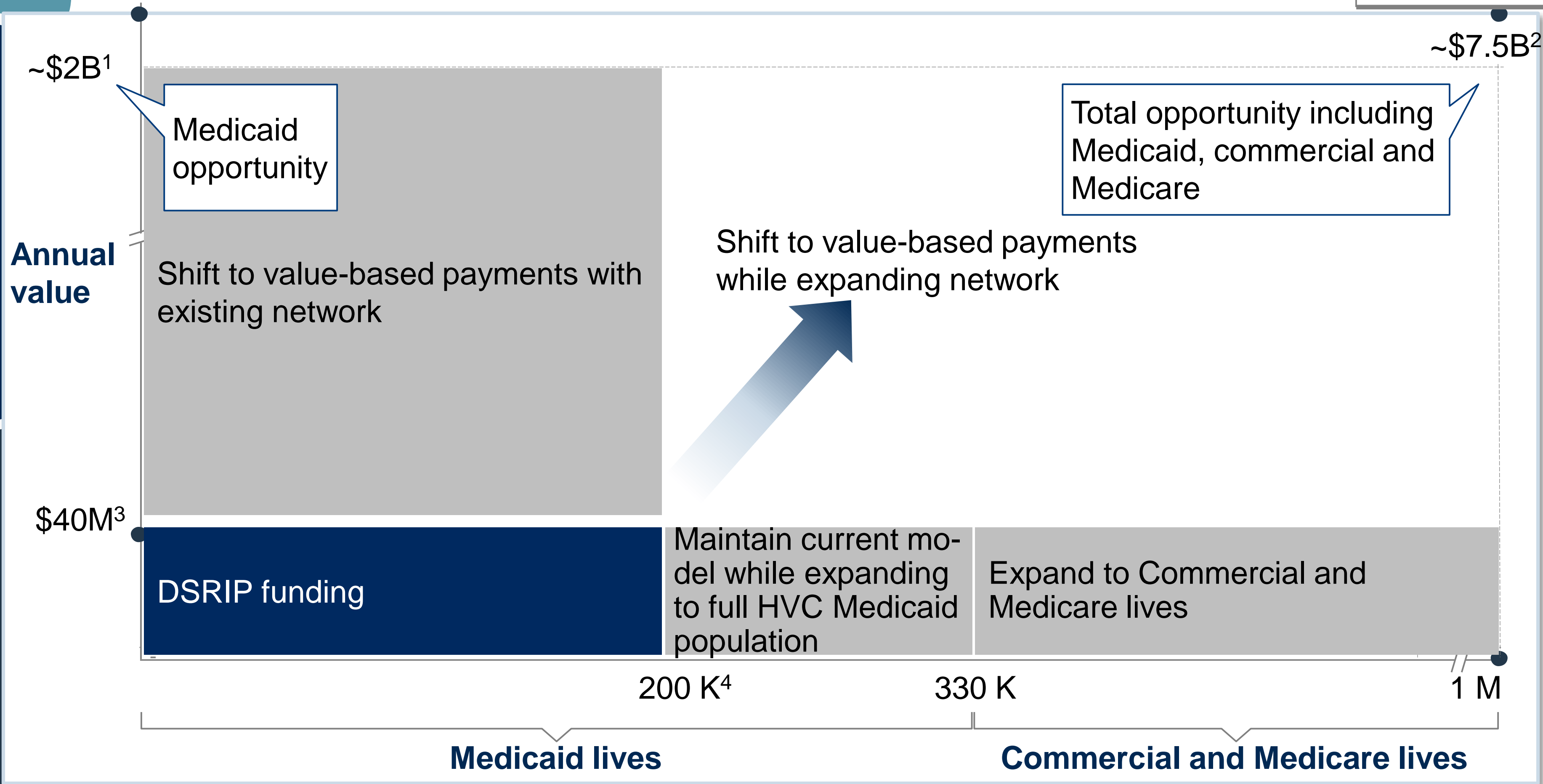
# DSRIP funding represents a small piece of transitioning to VBP

PRELIMINARY




1 Based on Medicaid PMPY of $6000 and 330 K lives in HVC;
2 Based on Medicare PMPY of $12,000 and 170 K lives in HVC and commercial PMPY of $7,000 and 500 K lives;
3 Assume max DSRIP payment at $40m/year;
4 Performance attribution

# DSRIP Projects

## System Transformation

- **2.A.I** Integrated delivery system focused on evidence-based medicine and population health
- **2.A.III** Health home at-risk intervention program
- **2.A.IV** Medical village using existing hospital infrastructure
- **2.B.III** ED care triage for at-risk populations

## Clinical improvement

- **3.A.I** Integrated primary care and behavioral health
- **3.B.I** Evidence-based disease management strategies- cardiovascular
- **3.A.II** Behavioral health community crisis stabilization services
- **3.D.III** Evidence-based asthma management strategies

## Population-wide Projects

- **4.B.I** Tobacco use cessation efforts focused on populations with low SES and poor mental health
- **4.B.II** Increased access to high quality chronic disease preventive care and management

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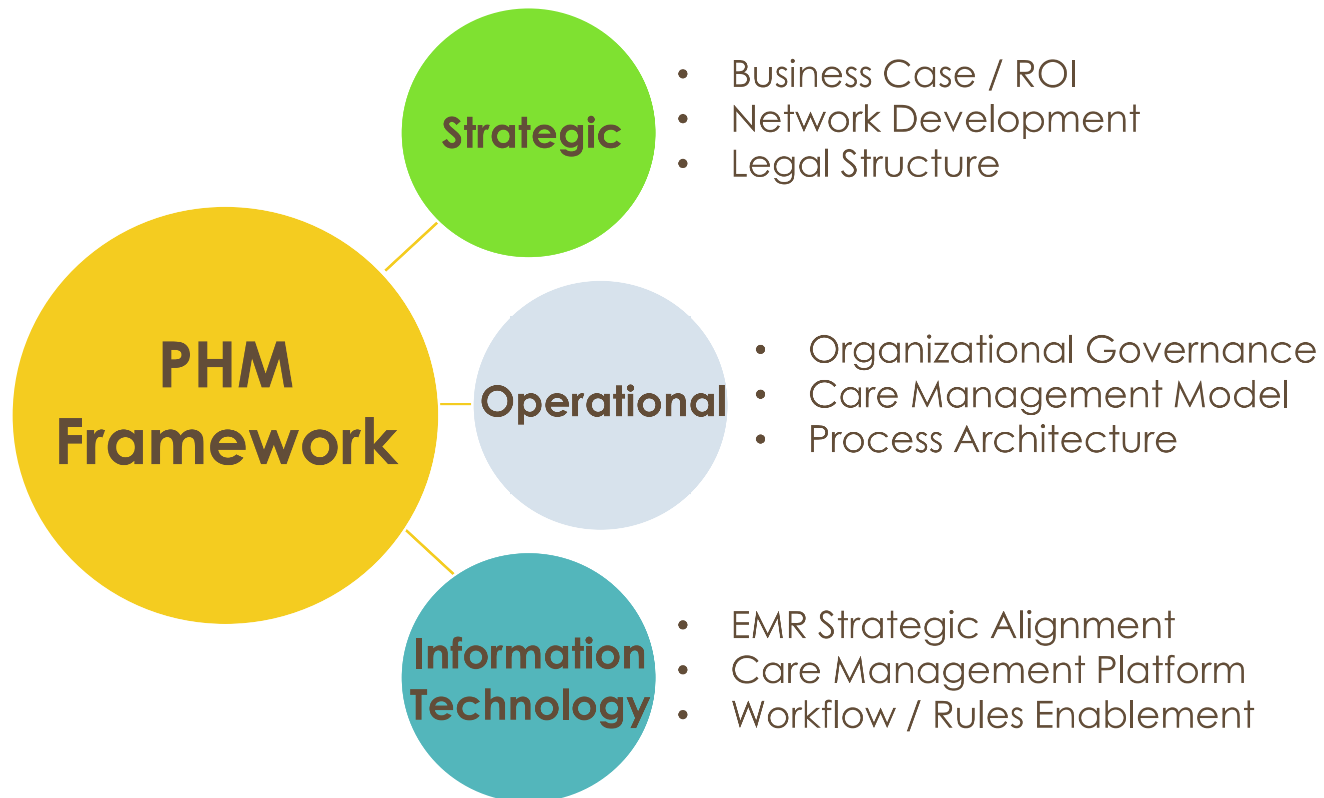
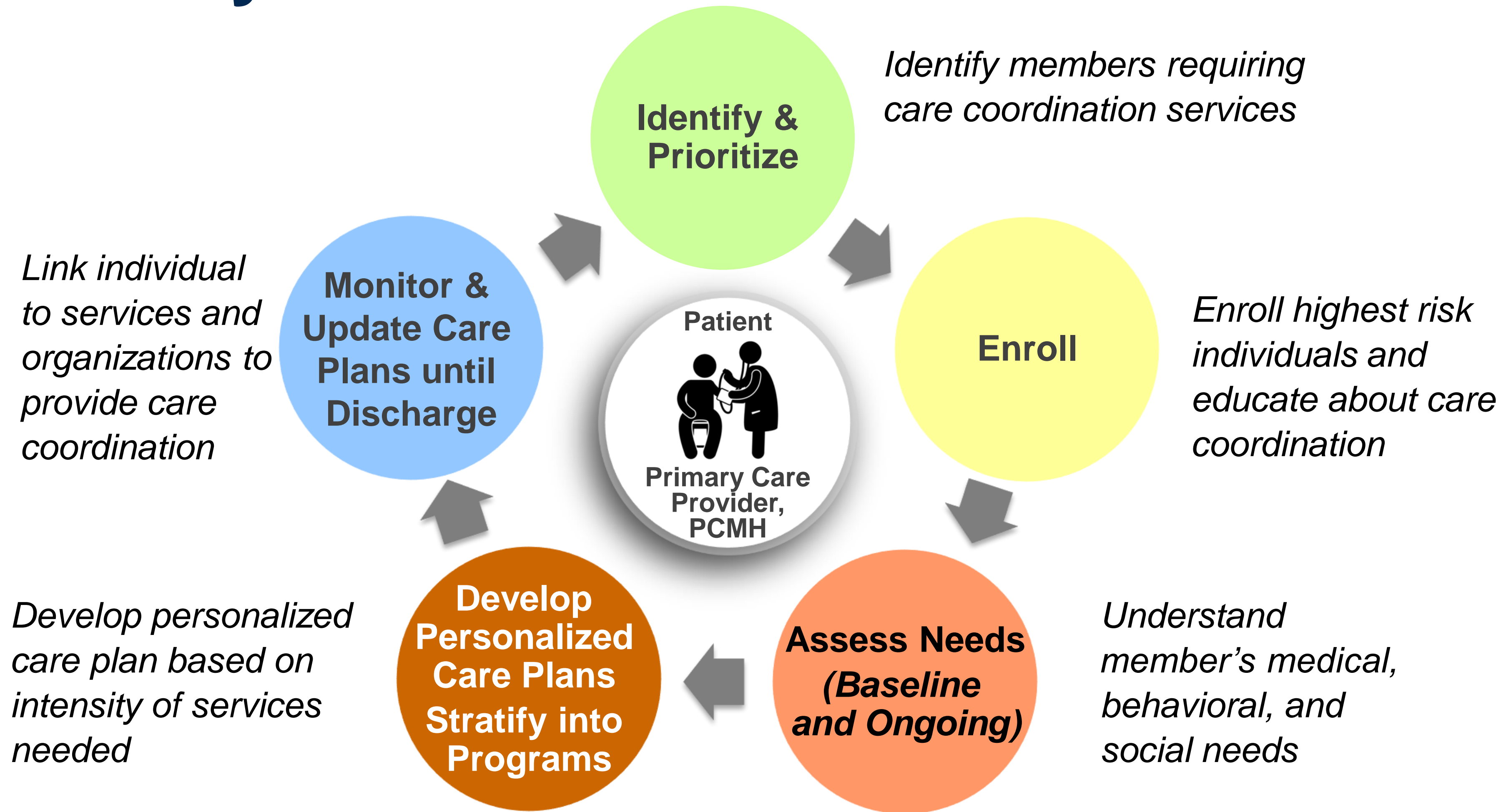
# Care Management and Coordination – *What do we really mean?*

# Population Health Management (PHM) Framework

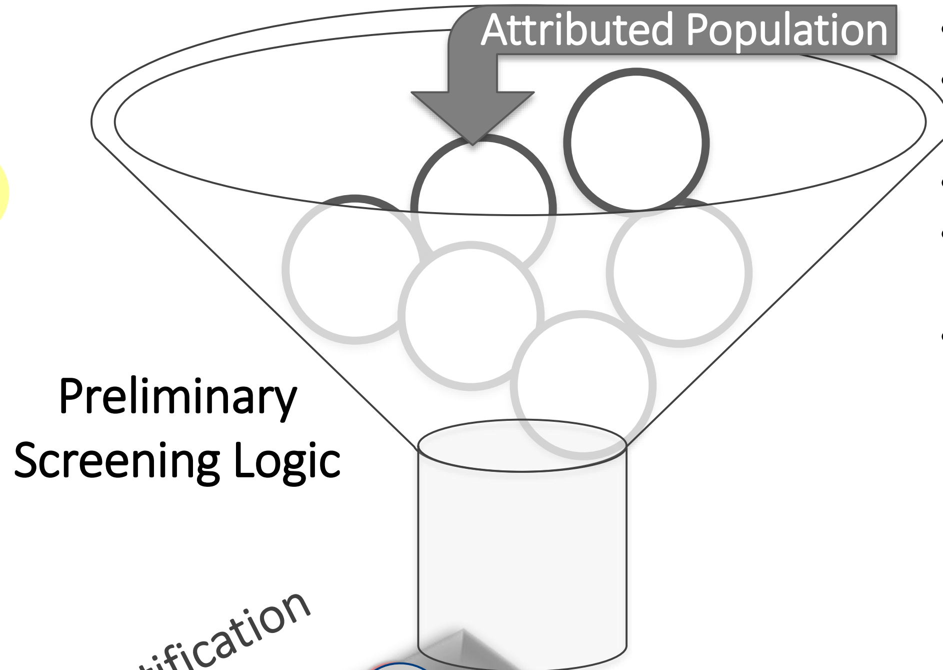
Our holistic methodology for developing and enabling Population Health Management.



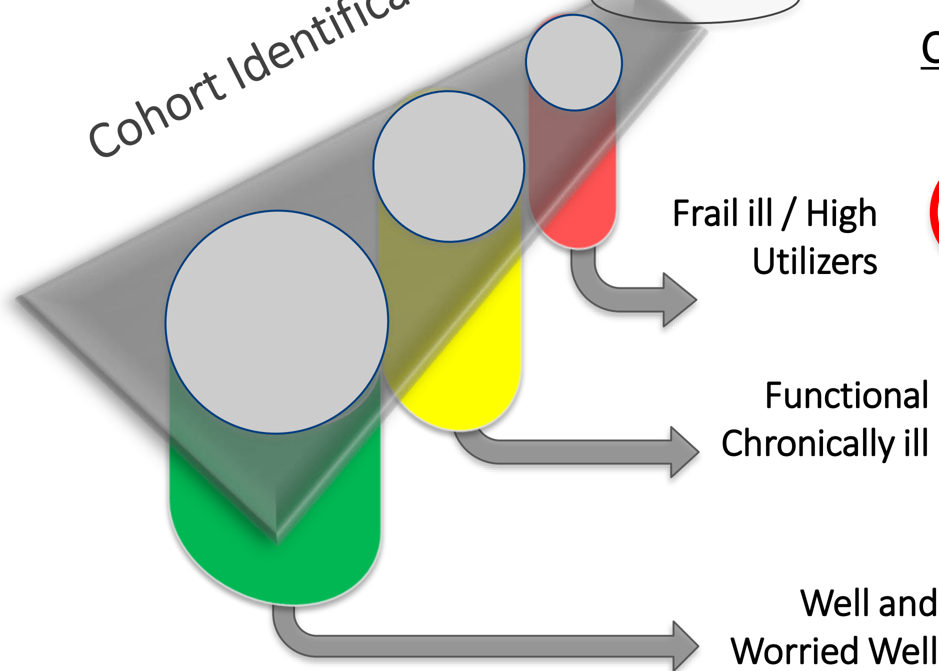
# Care Management Process Lifecycle



Personalized Care Plans




- Data Mining
- Provider Referral
- Sentinel Events (e.g., Post-Discharge)
- Self-Identification
- Virtual Healthcare : Telehealth, Telemedicine
- Precision Medicine



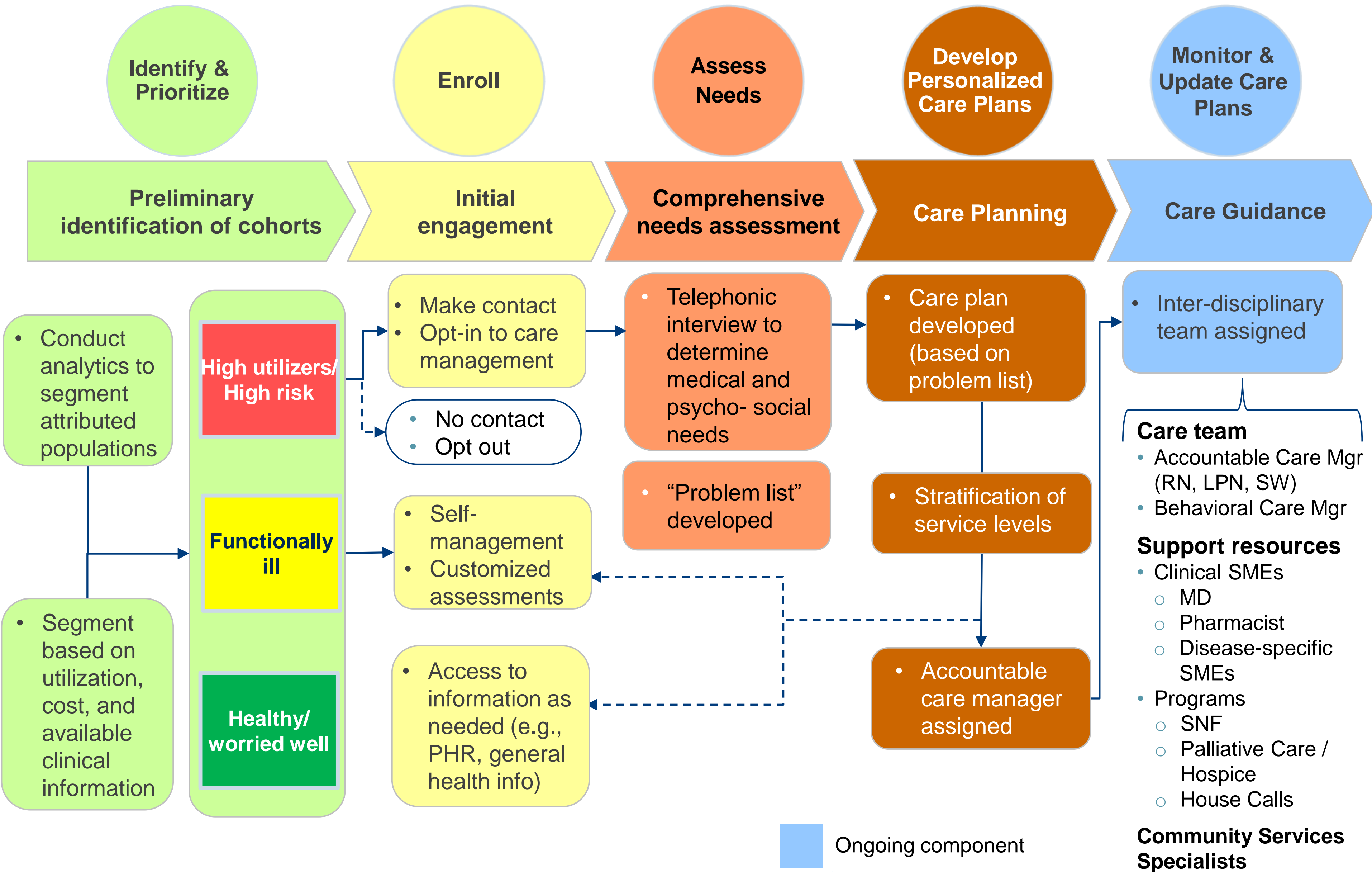

Care Management Intensity

High
- Intensive, complex case management
- Palliative Care

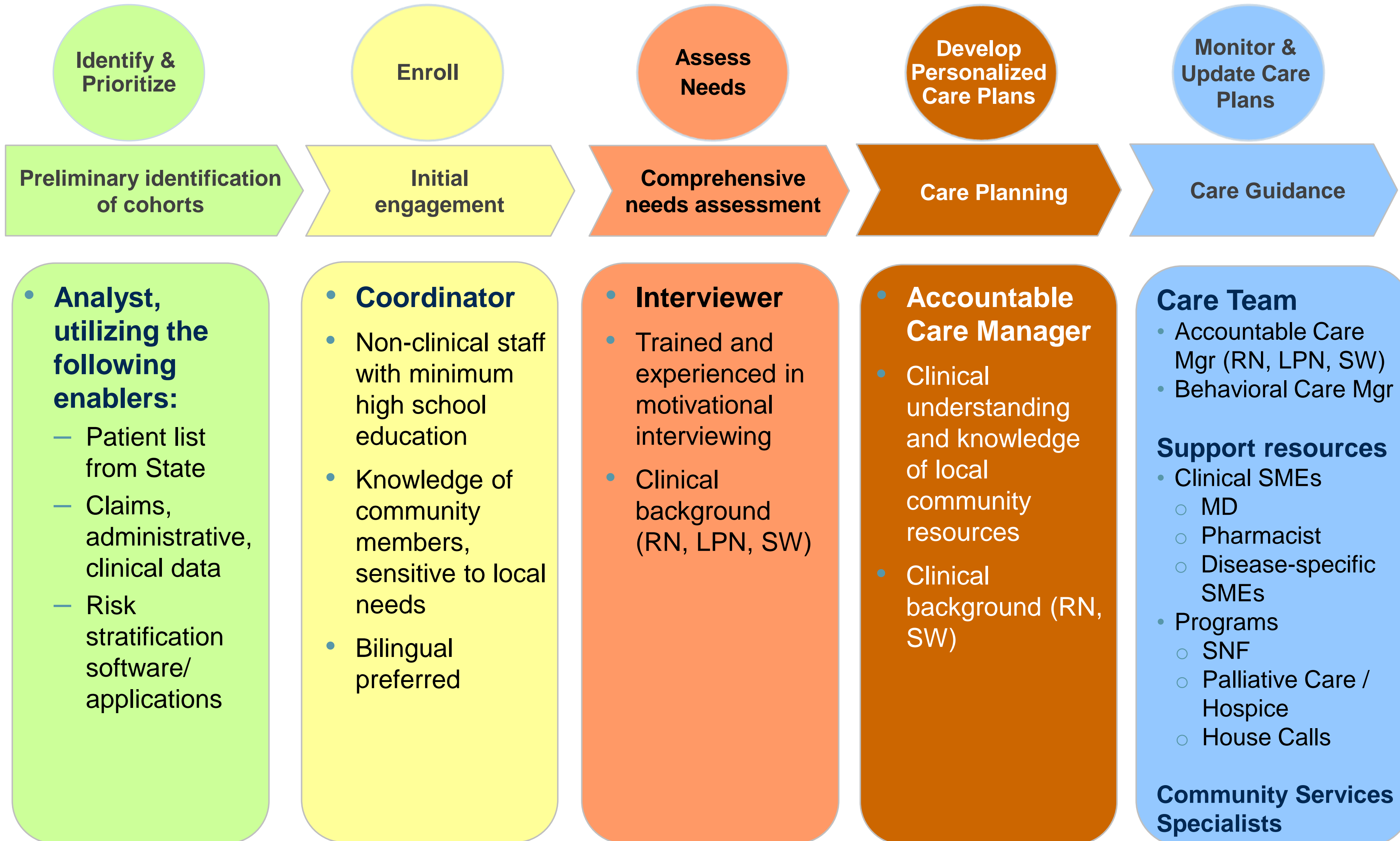
Medium
- Targeted health education and interventions
- Self-management / empowerment

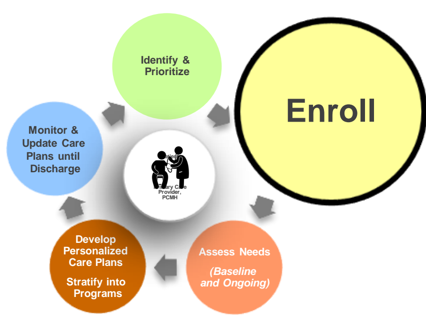
Low
- Members access information, as needed

# Care Management Process Lifecycle: High-Level Workflow

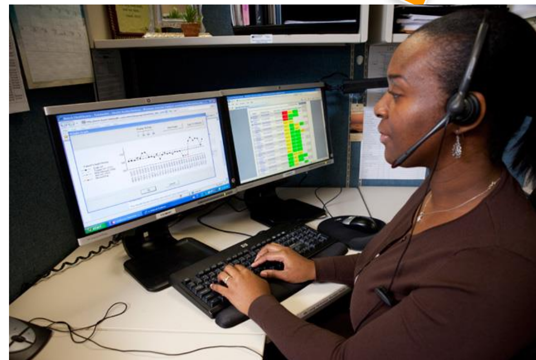


# Care Management Process Lifecycle: Resources requiring varying skill sets – Patient Centered Medical Home






# Enrollment and Outreach Patient Engagement



# Assessment

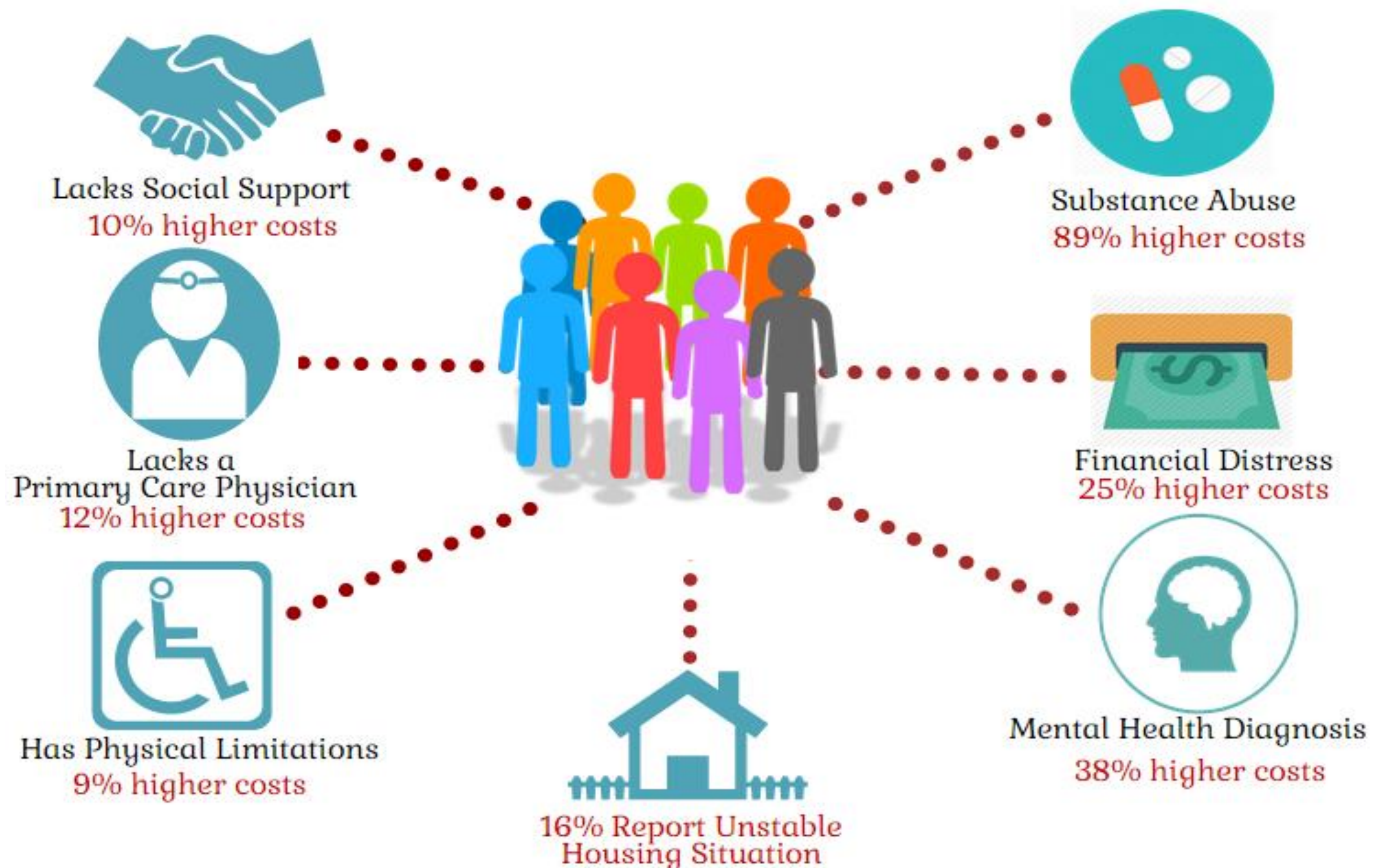
## Medical/“Big Data” Is Not Enough

8% Generate 55% of Medical Expense

**Analytics alone will not be able to identify underlying drivers influencing diabetic condition**

- **Unstable Housing**
- **Substance Abuse**
- **Mental Health**
- **Financial Distress**

# Social Determinants of Healthcare Costs




Based on results of over 4,000 assessments of high-risk patients conducted at Montefiore CMO

# Care Coordination Bridges the Gap

Food
Housing
Finances
Literacy
Transportation

Medical Conditions

Care Coordination

Biopyschosocial Assessment • Care Transitions • Intensive Care Mgmt • Chronic Care Mgmt • Palliative and Hospice Care • Behavioral Health Mgmt • Telemonitoring

Medical Conditions

Literacy · Transportation
Finances · Housing · Food

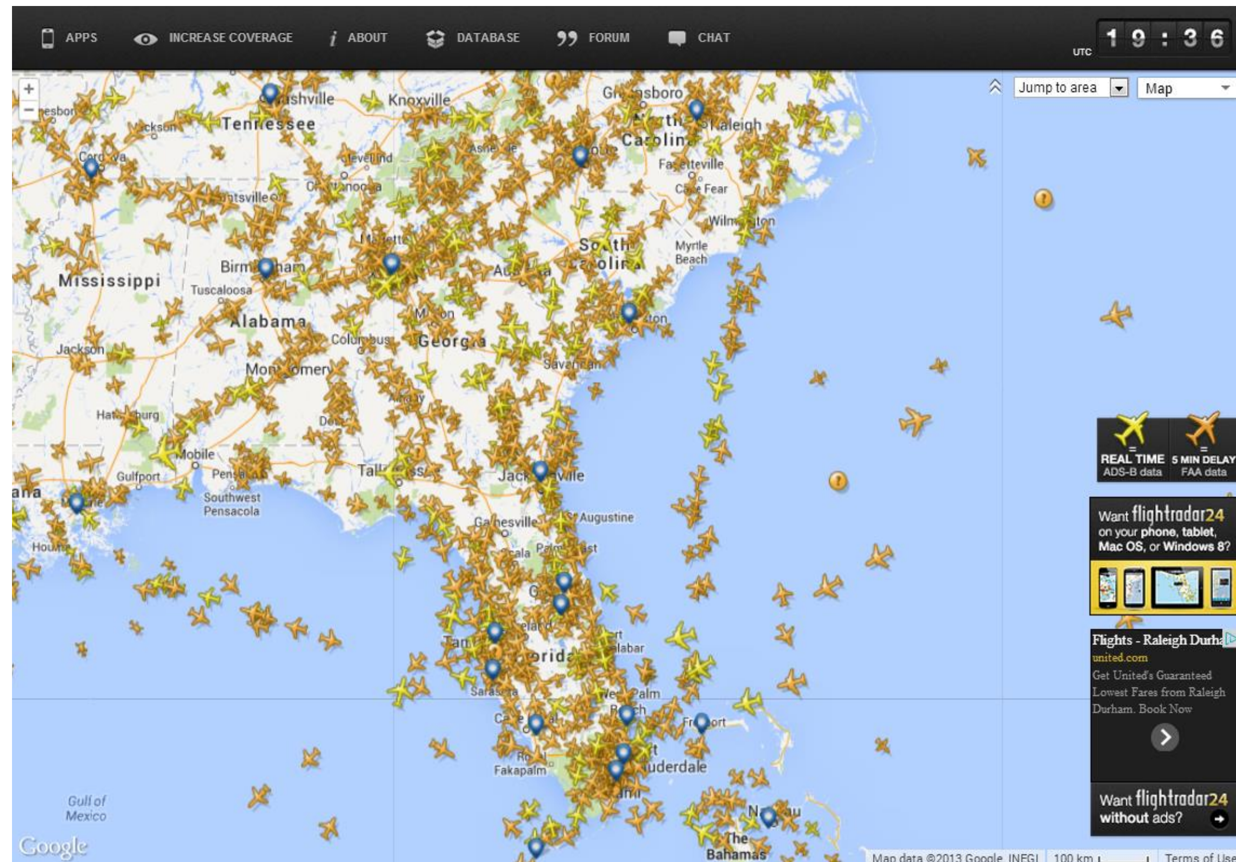
**The Provider View**

**The Patient View**

# Care Coordination:
# Similarities to the Airline Industry
# Air Traffic Control

- 1,140 planes in this snapshot
- 87,000 flights daily in the US

- **Managing activities across multiple resources**
- **Numerous variables impacting process**
- **Constant monitoring & adjustment**

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# Care Coordination Is Equivalent to Air Traffic Control……

**Requires precision for safety and efficiency**

**Careful, detailed planning that rarely follows initial design**

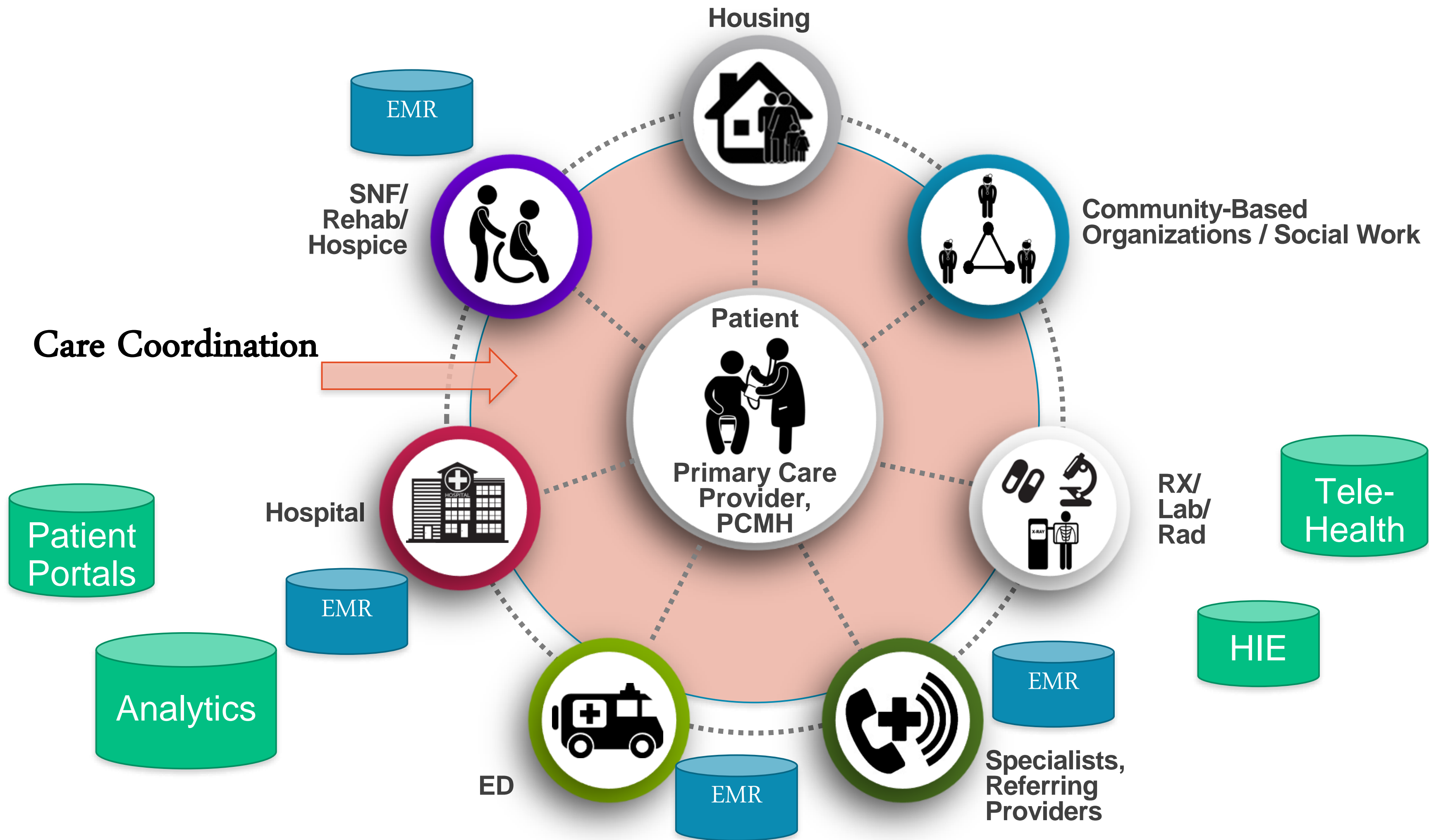
**Significant number of variables can impact care**

- Patient condition: Subjective and objective data
- Flow and demand of patient population
- System / Technology
- Resource Availability (physician, hospital, pharmacy)

**Effective care coordination needs to be dynamic, subject to continuous reassessment and adjustments**

**Use of accurate, real-time data to support workflow**

# PHM Across the Care Continuum – Leveraging IT to Enable Care Coordination



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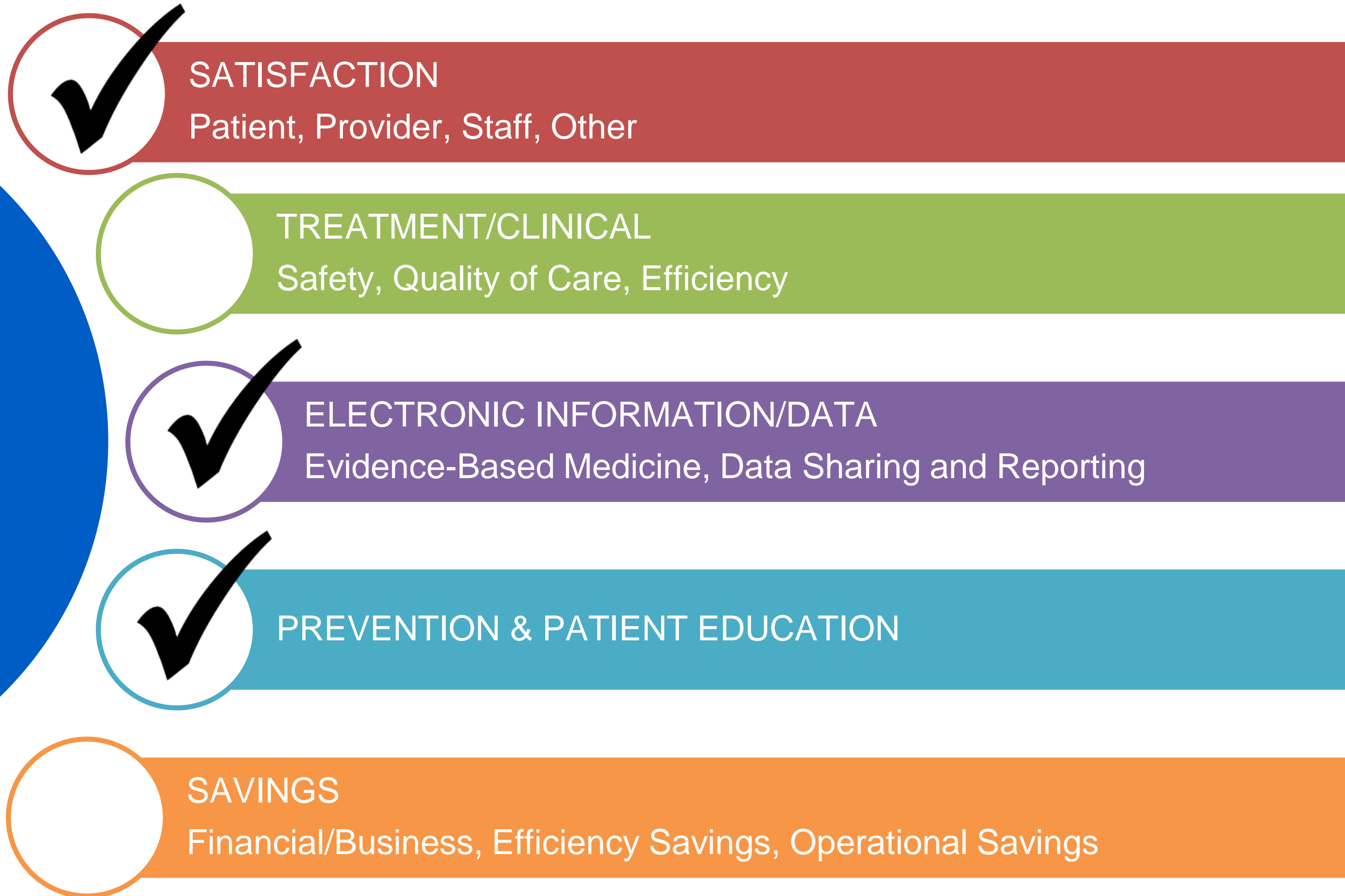
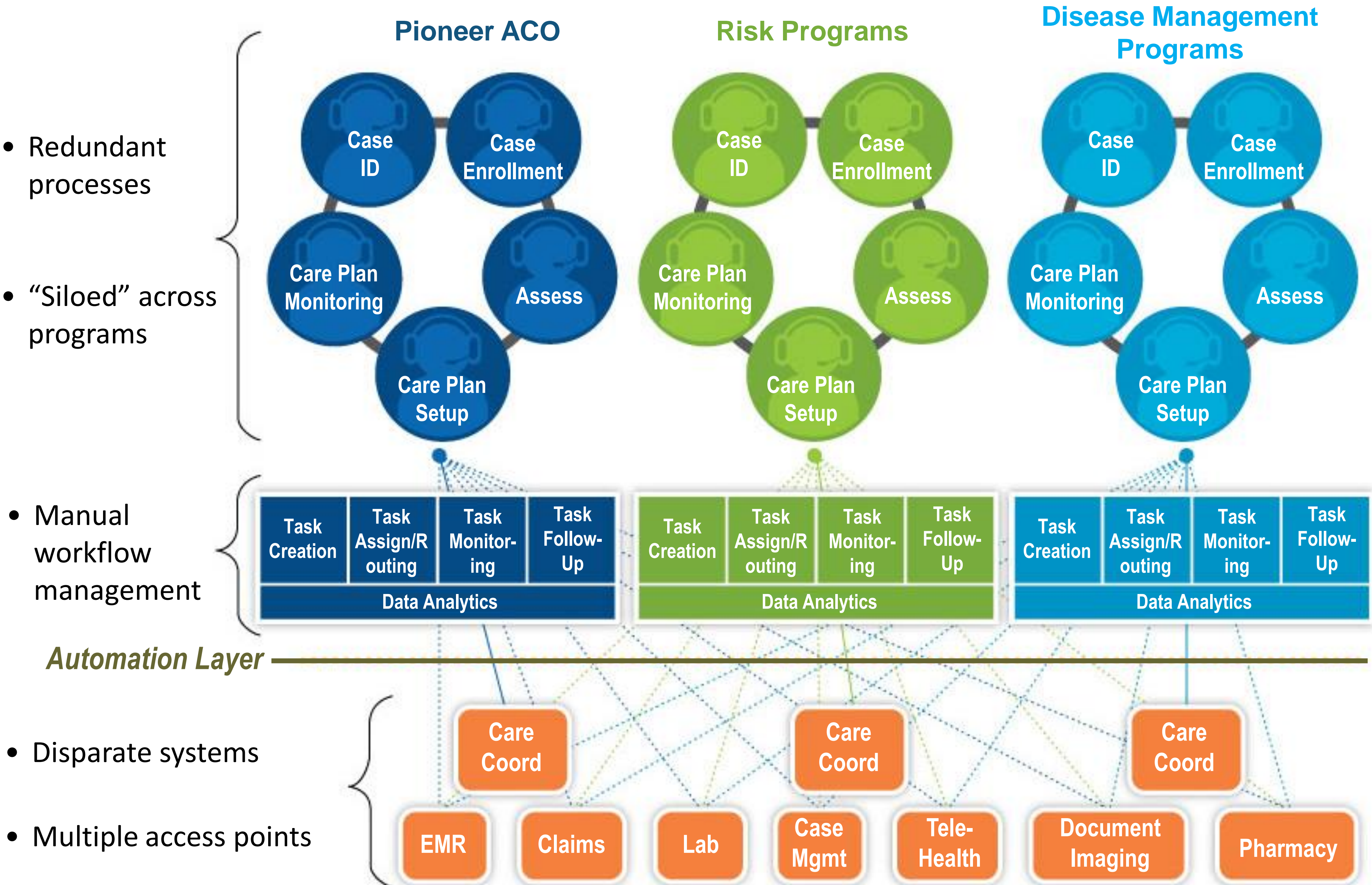
# Benefits Realized for the Value of Health IT



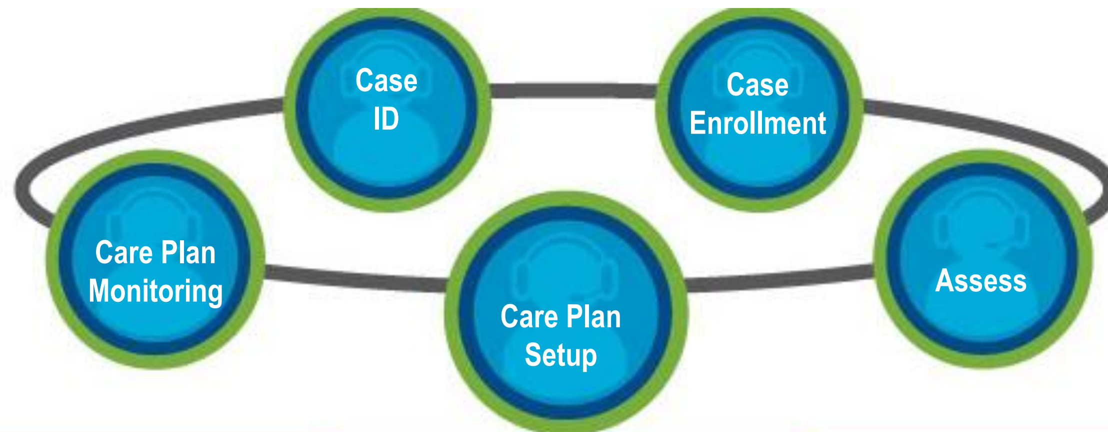

http://www.himss.org/ValueSuite

# Care Management Organization - Past



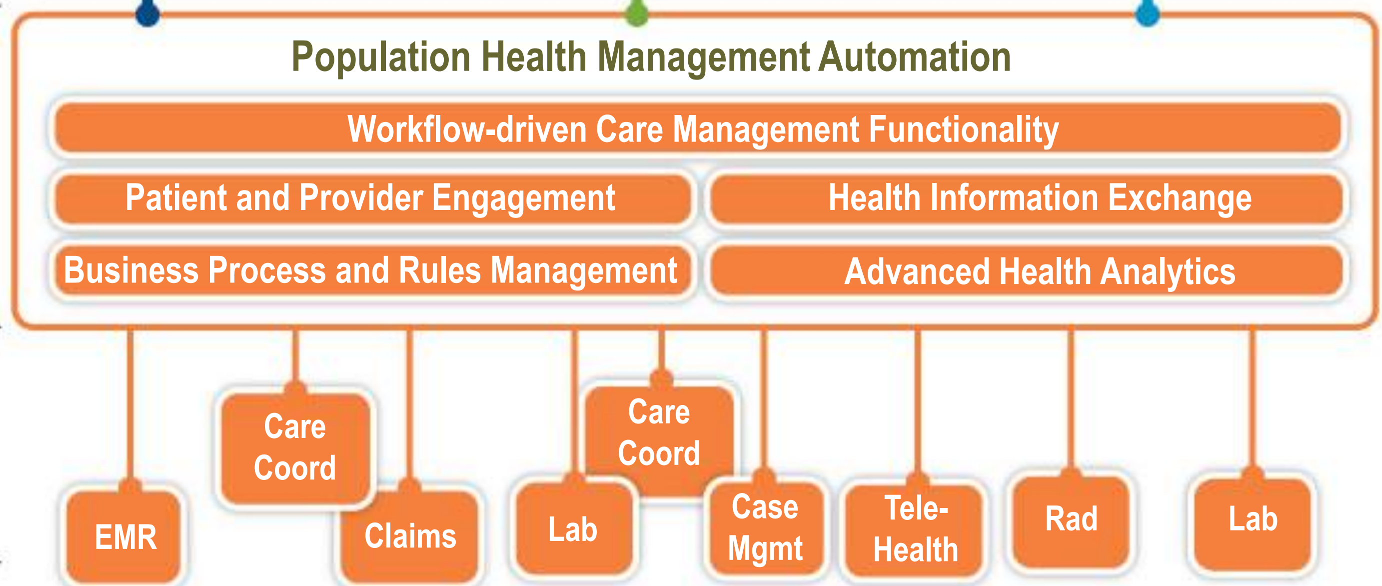
# Care Management Organization - Vision

- Standardized processes across programs
- Focused around patient, not disease or condition

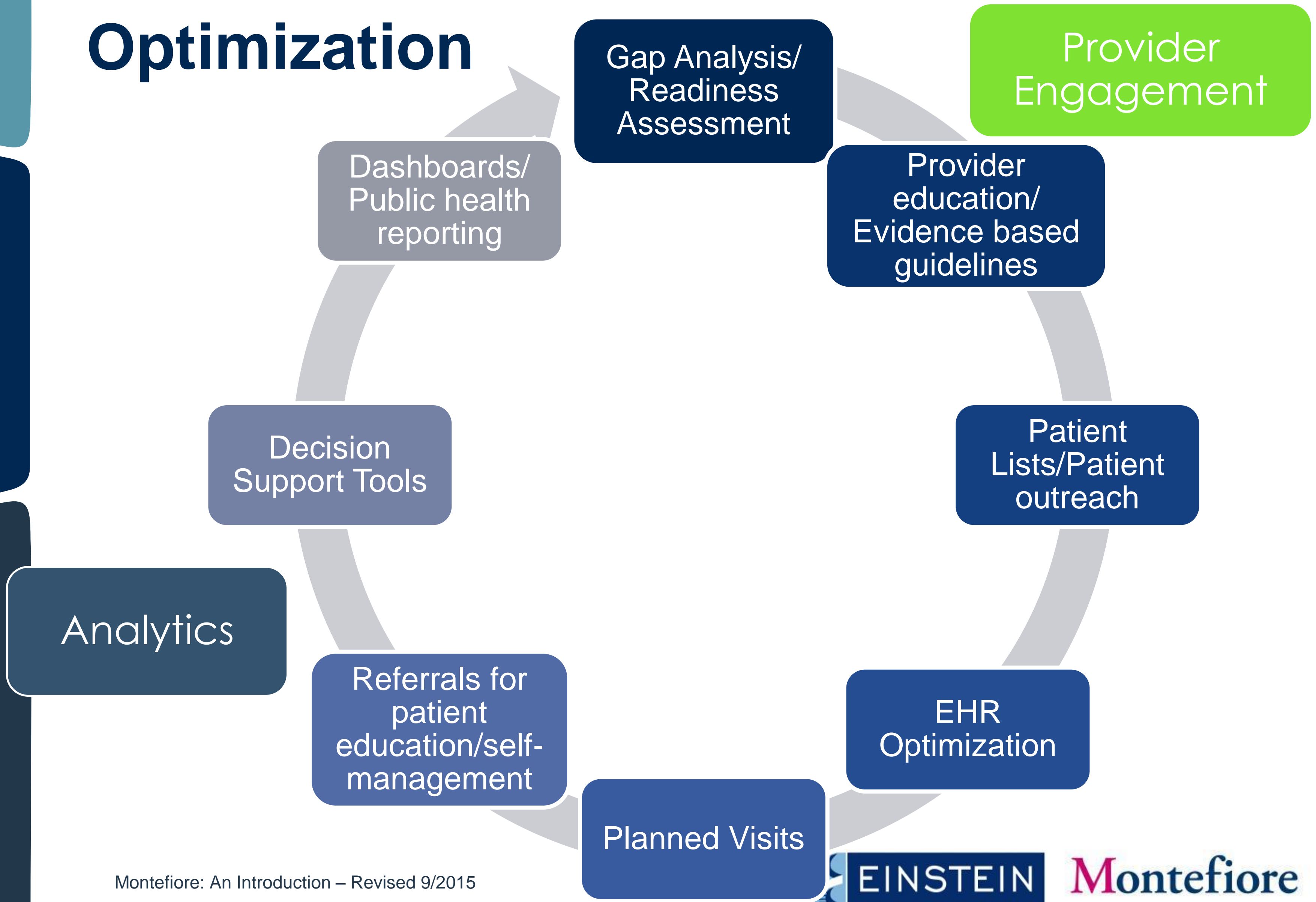


*Automation Layer*

- Centralized technology platform
- Robust data model (problem / intervention data sets)
- Access to real-time data
- Interoperability with disparate systems across care continuum



# Practice Transformation and EHR Optimization



# Patient Engagement Program Goals and Objectives

Improve quality performance

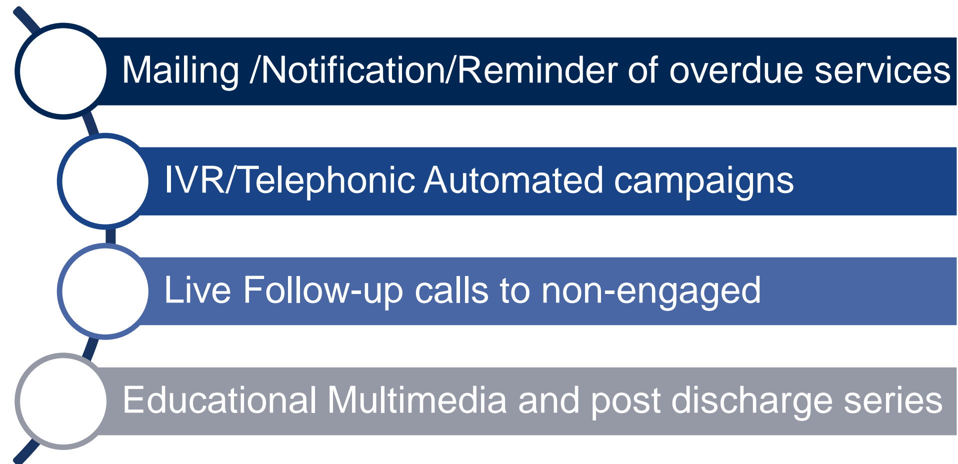
- Improve adherence to clinical guidelines and quality measures i.e. HEDIS/ACO
- Convert 'non-users' to 'users'.
- Chronic fallout (at risk members previously identified as having a chronic, catastrophic, or malignant condition that are no longer flagged with this health status for a subsequent reporting year).

Improve patient access to services, experience, and promotion of healthcare education

Use claims, clinical and appointment sources to identify patients with gaps in care in need of outreach

# Patient Engagement via EMMI Recent/Upcoming Campaigns

- Patients missing services are identified via claims and clinical data
- Campaigns focused on preventive care services and chronic conditions management patient education

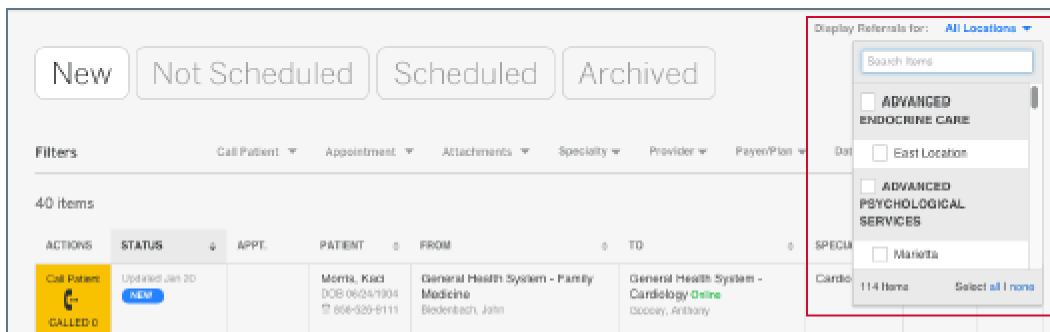



| Month | EmmiPrevent Campaign | Transfer? (Y/N) | EmmiEngage Program | Date |
|---|---|---|---|---|
| *February* | *Asthma* | *No* | *Asthma* | *Complete!* |
| *March* | *Dental Health* | *No* | - | *Complete!* |
| *April* | *Diabetes* | *No* | *Diabetes High blood Pressure*<br>*Diabetes Nutrition & Healthy Eating*<br>*Diabetes Overdue A1c*<br>*Diabetes Smoking* | *Complete!* |
| May | Wellness Visit – Adult (English/Spanish) - MMG | Yes | - | **June 7th *(tentative)*** |
| June | Wellness Visit – Adult (English/Spanish) - CMO | Yes | - | **June 14th** |
| June | Heart Failure | No | Heart Failure<br>Heart Failure next apt with Doc | **June 28th** |
| June | CAD | No | Coronary Artery Disease | **June 28th** |
| July (early) | Childhood Vaccinations | No | - | **July 19th** |

# Streamlined Referral Management Workflow: Improve Access, Reduce Leakage

- Referral Order Placed by Provider
- Directed to External Provider?
  - No → No Change To Existing EHR Workflow
  - Yes → Referral Sent To Crimson Medical Referrals
- Crimson Used To Identify Provider With Appropriate Subspecialty, Insurance
- Provider Within Preferred Network?
  - No → Sending Out Of Network Document For Reporting
  - Yes → Referral and Clinical Information Delivered Electronically To Receiving Practice
- Receiving Practice Opens & Updates Referral With Appointment Info When Scheduled
- Referring Practice Easily IDs, Follows Up On Unresponsive Receiving Practice
- Upon Completion of Appointment, Clinical Information Returned Electronically

## Patient Locator banner



# Sample Practice/Group Report

**Montefiore ACO Provider Profile**
**Calendar Year 2016**

**Product Name [Medicare, Medicaid, Commercial]**

| | |
|---|---|
| **Provider Name** | All |
| **Facility** | Practice Name |
| **Specialty** | All |
| **Total Population** | 758 |
| **Attributed Population** | Pioneer ACO(Medicare) and Emblem (Medicaid, Medicare, Commercial) |
| **Risk Score (Avg)** | 1.1 |

| Overall Score |
|---|
| **91%** |

Line of Business, Risk Score and Additional demographics

1) Aggregate Performance and 2) by Line of Business, 3) 90th/75th Percentiles benchmark and 4) recommended improvement target

5) Last Quarter Performance and 6) Peer comparison

| | Cost | | | | Overall Performance | Last Quarter Performance |
|---|---|---|---|---|---|---|
| Financial | PMPM | | | | | |
| **Overall Domain Performance** | | | | | | |

| Adult Quality Metrics | | Medicaid Performance | Medicare Performance | Commercial Performance | Overall Performance | Last Quarter Performance | 75th Percentile | % Target Improvement |
|---|---|---|---|---|---|---|---|---|
| Preventive Health | Adults' Access to Preventive/Ambulatory Health | 44.05% | 28.25% | 70.27% | 51.02% | | | ↓ 3.00% |
| | Adult BMI Assessment | SS | SS | SS | 41.18% | | 90.0% | ↓ 3.00% |
| | Breast Cancer Screening | SS | SS | 0.00% | 0.16% | | 90.0% | ↑ 8.00% |
| | Chlamydia Screening in Women | 0.00% | | 1.03% | 0.84% | | 90.0% | ⇨ 5.00% |
| | Colorectal Cancer Screening | | 1.89% | 1.07% | 1.13% | | 90.0% | ↑ 9.00% |
| | Comprehensive Diabetes Care | | | | | | | ↑ 9.00% |
| | HBA1C Testing | SS | 0.15% | 0.17% | 0.16% | | 91.0% | ↑ 9.00% |
| | Dilated Eye Exam | SS | 0% | 0% | 0% | | 66.0% | ↑ 9.00% |
| | Nephropathy Monitoring | SS | 88.21% | 42.51% | 58.95% | | 86.0% | ↑ 9.00% |
| **Overall Domain Performance** | | | | | | | | |

| Pediatric Quality Metrics | | Medicaid Performance | Medicare Performance | Commercial Performance | Overall Performance | Last Quarter Performance | 75th Percentile | % Target Improvement |
|---|---|---|---|---|---|---|---|---|
| Preventive Health | Children and Adolescents' Access to Primary Care | 82.44% | | 78.80% | 80.45% | | | ↓ 3.00% |
| | Adolescent Well Care | 51.78% | | 48.13% | 49.24% | | 67.5% | ↑ 8.00% |
| | Well Child Visits 0 - 15 Months (5 Visits) | 12.01% | | 14.29% | 12.32% | | 87.5% | ⇨ 5.00% |
| | Well Child Visits 3 -6 Years | 69.35% | | 62.86% | 66.40% | | 87.5% | ↑ 9.00% |
| **Overall Domain Performance** | | | | | | | | |

| Project Metrics | | | | | | | | % Target Improvement |
|---|---|---|---|---|---|---|---|---|
| Program Engagement | % Patients engaged in EMMI outreach up to date? | | | | | | | ↓ 3.00% |
| | % in Referred to Heal pros program % Screened | | | | | | | ↑ 8.00% |
| | % Response to HCC care alerts | | | | | | | ⇨ 5.00% |
| **Overall Domain Performance** | | | | | | | | |

# Keys to Success in Value-Based Care

- Overarching vision, clear governance structure, and aligned operations
- Must define and understand the population
- <20% of the population drive the costs, 100% determine the quality of care
- Developing an ongoing care and population management organizational strategy
- Ensure IT strategy incorporates full breadth of population health and care coordination operational needs
- Need for Continuous Quality and Performance Improvement and Innovation:

# Final Thoughts – Know Where You're Headed

**Understand your organization's long-term vision and near-term strategy  for value-based care delivery.**

Who are your payer partners (commercial, CMS)?

What other provider organizations are you aligning with?

What strategic imperatives are impacting your timeline?

Which services have the highest market demand?

How much of your "infrastructure" (organizational & IT) are you going to build vs. buy?

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# Final Thoughts – Invest Wisely

**Develop your IT strategy for Population Health / Care Coordination around your organizational strategy & operational model**

- Who will you be sharing and exchanging data with?
- What are the key processes and workflows that IT needs to support?
- What systems (EMR, HIE) can you leverage for population health / care coordination?
- How will your current BI/Analytics strategy and solutions enable care coordination?
- **Push the vendor marketplace to develop innovative, agile, interoperable solutions and flexible platforms**
  - Do not force fit workflow to accommodate inflexible solution functionality

**Think process first!!!**