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

<table>
<thead>
<tr>
<th></th>
<th>Bronx</th>
<th>Westchester</th>
<th>Rockland</th>
<th>Orange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>1.5M</td>
<td>1M</td>
<td>325K</td>
<td>380K</td>
</tr>
</tbody>
</table>

**Economic Indicators**

<table>
<thead>
<tr>
<th></th>
<th>Bronx</th>
<th>Westchester</th>
<th>Rockland</th>
<th>Orange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty</td>
<td>32%</td>
<td>10%</td>
<td>15%</td>
<td>13%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>8%</td>
<td>4%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>16%</td>
<td>12%</td>
<td>11%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Chronic Disease Burden**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Bronx</th>
<th>Westchester</th>
<th>Rockland</th>
<th>Orange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>11%</td>
<td>9%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>Overweight/Obese</td>
<td>68%</td>
<td>59%</td>
<td>60%</td>
<td>67%</td>
</tr>
<tr>
<td>Child Overweight/Obese</td>
<td>32%</td>
<td>29%</td>
<td>33%</td>
<td>36%</td>
</tr>
<tr>
<td>Asthma (per 100K)</td>
<td>58</td>
<td>14</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Cancer (per 100K)</td>
<td>484</td>
<td>494</td>
<td>507</td>
<td>498</td>
</tr>
</tbody>
</table>

Source: U.S. Census, New York State Dept. of Health, NYS Dept. of Labor
Payer Mix: Outsized Gov’t Payer Mix

MMC Payer Mix, 2015
- Medicare: 45%
- Medicaid, Other Government, and Uninsured: 3%
- Commercial: 15%

MHS Payer Mix, 2015
- Medicare: 40%
- Medicaid, Other Government, and Uninsured: 3%
- Commercial: 20%
Montefiore’s Population Health Model: A Strategic and Financial Imperative
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

Premium

Insurance Company

Pay Claims And “Coordinate Care”

Savings

Shareholders

Premium

Insurance Company

Integrated Provider Association

Care Management Organization

Invest in Health and Social Services

Savings

Stakeholders: MD’s/Delivery System

$
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
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
Increasing Accountability for Patient Lives, 1996-2018

- **1 Million Lives**
  - 2018

- **1996**
  - USHC/Aetna

- **1997-1999**
  - Cigna
  - Prudential
  - Sanus
  - United
  - PHS
  - Oxford Medicare Advantage

- **2000-2011**
  - HIP/Emblem Healthfirst

- **2012-2013**
  - Emblem Pioneer ACO
    - Health Homes
    - MLTCP

- **2014**
  - Commercial Shared Savings Arrangements

- **2016**
  - Provider Alignment
    - Additional Commercial Shared Savings Arrangements

- **55,000 Lives**

- **150,000 Lives**

- **195,000 Lives**

- **300,000 Lives**

- **420,000 Lives**

- **420,000 Lives**
Overview of Value-Based Payment Arrangements at Montefiore

<table>
<thead>
<tr>
<th>Source</th>
<th>2015 Population</th>
<th>2015 Est. Revenue</th>
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<tbody>
<tr>
<td>Risk Contracts</td>
<td>220,000</td>
<td>$1,360m</td>
</tr>
<tr>
<td>Shared Risk</td>
<td>165,000</td>
<td>$1,022 m</td>
</tr>
<tr>
<td>Medicaid Health Home (Care Coordination)</td>
<td>10,000</td>
<td>$18 m</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>395,000</strong></td>
<td><strong>$2,400 m</strong></td>
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</table>

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
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
DSRIP funding represents a small piece of transitioning to VBP.
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.A.II Behavioral health community crisis stabilization services
3.B.I Evidence-based disease management strategies - cardiovascular
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
Care Management and Coordination – What do we really mean?
Population Health Management (PHM) Framework

Our holistic methodology for developing and enabling Population Health Management.

**Strategic**
- Business Case / ROI
- Network Development
- Legal Structure

**Operational**
- Organizational Governance
- Care Management Model
- Process Architecture

**Information Technology**
- EMR Strategic Alignment
- Care Management Platform
- Workflow / Rules Enablement
Care Management Process Lifecycle

- Identify & Prioritize
  - Identify members requiring care coordination services

- Monitor & Update Care Plans until Discharge
  - Link individual to services and organizations to provide care coordination

- Develop Personalized Care Plans
  - Develop personalized care plan based on intensity of services needed
  - Stratify into Programs

- Enroll
  - Enroll highest risk individuals and educate about care coordination

- Assess Needs (Baseline and Ongoing)
  - Understand member’s medical, behavioral, and social needs

Primary Care Provider, PCMH
Frail ill / High Utilizers

Functional Chronically ill

Well and Worried Well

Preliminary Screening Logic

Identify & Prioritize

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

Cohort Identification

Attributed Population

Personalized Care Plans

Identify & Prioritize

Monitor & Update Care Plans until Discharge

Develop Personalized Care Plans

Stratify into Programs

Assess Needs (Reinforce and Discharge)

Enroll

Identify & Prioritize

Preliminary Screening Logic

Cohort Identification

Frail ill / High Utilizers

Functional Chronically ill

Well and Worried Well
Care Management Process Lifecycle: High-Level Workflow

**Identify & Prioritize**
- Preliminary identification of cohorts
  - Conduct analytics to segment attributed populations
  - Segment based on utilization, cost, and available clinical information

**Enroll**
- High utilizers/High risk
  - Make contact
  - Opt-in to care management
  - No contact
  - Opt out
- Functionally ill
  - Self-management
  - Customized assessments
- Healthy/worried well
  - Access to information as needed (e.g., PHR, general health info)

**Assess Needs**
- Telephonic interview to determine medical and psycho-social needs
- “Problem list” developed

**Develop Personalized Care Plans**
- Care plan developed (based on problem list)
- Stratification of service levels
- Accountable care manager assigned

**Monitor & Update Care Plans**
- Inter-disciplinary team assigned

**Care Planning**
- Care team
  - Accountable Care Mgr (RN, LPN, SW)
  - Behavioral Care Mgr

**Care Guidance**
- Support resources
  - Clinical SMEs
    - MD
    - Pharmacist
    - Disease-specific SMEs
  - Programs
    - SNF
    - Palliative Care / Hospice
    - House Calls

**Care Management Process Lifecycle: High-Level Workflow**

**High-level Workflow**
- Preliminary identification of cohorts
- Conduct analytics to segment attributed populations
- Enroll
  - High utilizers/High risk
    - Make contact
    - Opt-in to care management
    - No contact
    - Opt out
  - Functionally ill
    - Self-management
    - Customized assessments
  - Healthy/worried well
    - Access to information as needed (e.g., PHR, general health info)
- Assess Needs
  - Telephonic interview to determine medical and psycho-social needs
  - “Problem list” developed
- Develop Personalized Care Plans
  - Care plan developed (based on problem list)
  - Stratification of service levels
  - Accountable care manager assigned
- Monitor & Update Care Plans
  - Inter-disciplinary team assigned

**Care team**
  - Accountable Care Mgr (RN, LPN, SW)
  - Behavioral Care Mgr

**Support resources**
- Clinical SMEs
  - MD
  - Pharmacist
  - Disease-specific SMEs
- Programs
  - SNF
  - Palliative Care / Hospice
  - House Calls

**Community Services Specialists**
Care Management Process Lifecycle: Resources requiring varying skill sets – Patient Centered Medical Home

**Identify & Prioritize**
- Preliminary identification of cohorts

**Enroll**
- Initial engagement

**Assess Needs**
- Comprehensive needs assessment

**Develop Personalized Care Plans**
- Care Planning

**Monitor & Update Care Plans**
- Care Guidance

**Care Team**
- Accountable Care Mgr (RN, LPN, SW)
- Behavioral Care Mgr

**Support resources**
- Clinical SMEs
  - MD
  - Pharmacist
  - Disease-specific SMEs
- Programs
  - SNF
  - Palliative Care / Hospice
  - House Calls

**Community Services Specialists**

**Analyst, utilizing the following enablers:**
- Patient list from State
- Claims, administrative, clinical data
- Risk stratification software/applications

**Coordinator**
- Non-clinical staff with minimum high school education
- Knowledge of community members, sensitive to local needs
- Bilingual preferred

**Interviewer**
- Trained and experienced in motivational interviewing
- Clinical background (RN, LPN, SW)

**Accountable Care Manager**
- Clinical understanding and knowledge of local community resources
- Clinical background (RN, SW)
Enrollment and Outreach Patient Engagement

1. Identify & Prioritize
2. Assess Needs (Baseline and Ongoing)
3. Enroll
4. Develop Personalized Care Plans
5. Stratify into Programs
6. Monitor & Update Care Plans until Discharge

Primary Care Provider, PCMH
Medical/“Big Data” Is Not Enough

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

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

8% Generate 55% of Medical Expense
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

The Provider View

Medical Conditions

Care Coordination

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

The Patient View

Medical Conditions

Food
Housing
Finances
Literacy
Transportation

Literacy · Transportation
Finances · Housing · Food
Care Coordination: Similarities to the Airline Industry

Air Traffic Control

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

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

Care Coordination

Patient Portals
Analytics
Hospital
EMR
ED
Specialists, Referring Providers
HIE
Tele-Health
RX/Lab/Rad
Community-Based Organizations / Social Work
SNF/Rehab/Hospice
Housing
Primary Care Provider, PCMH
EMR
Patient
EMR
Benefits Realized for the Value of Health IT

- **SATISFACTION**
  - Patient, Provider, Staff, Other

- **TREATMENT/CLINICAL**
  - Safety, Quality of Care, Efficiency

- **ELECTRONIC INFORMATION/DATA**
  - Evidence-Based Medicine, Data Sharing and Reporting

- **PREVENTION & PATIENT EDUCATION**

- **SAVINGS**
  - Financial/Business, Efficiency Savings, Operational Savings

http://www.himss.org/ValueSuite
Care Management Organization - Past

- Redundant processes
- “Siloed” across programs
- Manual workflow management

Automation Layer

- Disparate systems
- Multiple access points
Care Management Organization - Vision

- Standardized processes across programs
- Focused around patient, not disease or condition
- Centralized technology platform
- Robust data model (problem / intervention data sets)
- Access to real-time data
- Interoperability with disparate systems across care continuum

Automation Layer

Pioneer ACO
- Risk Programs
- Disease Management Programs

Population Health Management Automation
- Workflow-driven Care Management Functionality
- Patient and Provider Engagement
- Health Information Exchange
- Business Process and Rules Management
- Advanced Health Analytics

- Care Coord
- Care Coord
- Case Mgmt
- EMR
- Lab
- Claims
- Tele-Health
- Rad
- Lab
Practice Transformation and EHR Optimization

- Provider Engagement
  - Provider education/ Evidence based guidelines
  - Patient Lists/Patient outreach
- EHR Optimization
  - Planned Visits
  - Referrals for patient education/self-management
- Decision Support Tools
  - Dashboards/ Public health reporting
- Gap Analysis/ Readiness Assessment
- Analytics
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

<table>
<thead>
<tr>
<th>Month</th>
<th>EmmiPrevent Campaign</th>
<th>Transfer? (Y/N)</th>
<th>EmmiEngage Program</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>February</td>
<td>Asthma</td>
<td>No</td>
<td>Asthma</td>
<td>Complete!</td>
</tr>
<tr>
<td>March</td>
<td>Dental Health</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>Diabetes</td>
<td>No</td>
<td>Diabetes High blood Pressure Diabetes Nutrition &amp; Healthy Eating Diabetes Overdue A1c Diabetes Smoking</td>
<td>Complete!</td>
</tr>
<tr>
<td>May</td>
<td>Wellness Visit – Adult (English/Spanish) - MMG</td>
<td>Yes</td>
<td></td>
<td>June 7th (tentative)</td>
</tr>
<tr>
<td>June</td>
<td>Wellness Visit – Adult (English/Spanish) - CMO</td>
<td>Yes</td>
<td></td>
<td>June 14th</td>
</tr>
<tr>
<td>June</td>
<td>Heart Failure</td>
<td>No</td>
<td>Heart Failure Heart Failure next apt with Doc</td>
<td>June 28th</td>
</tr>
<tr>
<td>June</td>
<td>CAD</td>
<td>No</td>
<td>Coronary Artery Disease</td>
<td>June 28th</td>
</tr>
<tr>
<td>July</td>
<td>Childhood Vaccinations</td>
<td>No</td>
<td></td>
<td>July 19th</td>
</tr>
</tbody>
</table>
Streamlined Referral Management Workflow: Improve Access, Reduce Leakage

Referral Order Placed by Provider

Directed to External Provider?

Yes

Referral Sent To Crimson Medical Referrals

Crimson Used To Identify Provider With Appropriate Subspecialty, Insurance

No Change To Existing EHR Workflow

No

Sending Out Of Network Document For Reporting Purposes

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

No

Provider Within Preferred Network?

Yes

Receiving Practice

Referring Practice

Patient Locator banner
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

<table>
<thead>
<tr>
<th>Preventive Health</th>
<th>Adult Quality Metrics</th>
<th>Medicaid Performance</th>
<th>Medicare Performance</th>
<th>Commercial Performance</th>
<th>Overall Performance</th>
<th>Last Quarter Performance</th>
<th>75th Percentile</th>
<th>% Target Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults’ Access to Preventive/Ambulatory Health</td>
<td>44.05%</td>
<td>28.25%</td>
<td>70.27%</td>
<td>51.02%</td>
<td>3.00%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adult BMI Assessment</td>
<td>SS</td>
<td>SS</td>
<td>SS</td>
<td>41.18%</td>
<td>90.0%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>SS</td>
<td>SS</td>
<td>0.00%</td>
<td>0.16%</td>
<td>90.0%</td>
<td></td>
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</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>0.00%</td>
<td>1.03%</td>
<td>0.84%</td>
<td>90.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>1.89%</td>
<td>1.07%</td>
<td>1.13%</td>
<td>90.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care</td>
<td>SS</td>
<td>0.15%</td>
<td>0.17%</td>
<td>0.16%</td>
<td>91.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HBV Testing</td>
<td>SS</td>
<td>0%</td>
<td>0%</td>
<td>66.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nephropathy Monitoring</td>
<td>SS</td>
<td>88.21%</td>
<td>42.51%</td>
<td>58.95%</td>
<td>86.0%</td>
<td></td>
<td></td>
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</table>

Overall Domain Performance

<table>
<thead>
<tr>
<th>Pediatric Quality Metrics</th>
<th>Medicaid Performance</th>
<th>Medicare Performance</th>
<th>Commercial Performance</th>
<th>Overall Performance</th>
<th>Last Quarter Performance</th>
<th>75th Percentile</th>
<th>% Target Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and Adolescents’ Access to Primary Care</td>
<td>82.44%</td>
<td>78.80%</td>
<td>80.45%</td>
<td>67.5%</td>
<td>3.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent Well Care</td>
<td>51.76%</td>
<td>48.13%</td>
<td>48.24%</td>
<td>87.5%</td>
<td>8.00%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child Visits 0 - 15 Months (5 Visits)</td>
<td>12.01%</td>
<td>14.29%</td>
<td>12.32%</td>
<td>87.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well Child Visits 3 - 6 Years</td>
<td>69.35%</td>
<td>62.86%</td>
<td>66.40%</td>
<td>87.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall Domain Performance

<table>
<thead>
<tr>
<th>Project Metrics</th>
<th>% Patients engaged in EMMI outreach up to date?</th>
<th>% in Referred to Heal pros program % Screened</th>
<th>% Response to HCC care alerts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Domain Performance</td>
<td>3.00%</td>
<td>8.00%</td>
<td>5.00%</td>
</tr>
</tbody>
</table>

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

Overall Score 91%
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?
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!!!**