The Next Era of Healthcare: Population Health Management

ACMA Conference: 2015
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What We’ll Be Discussing

• Population Health: The Next Era of Health Care
• Population Health: A Health System View
• MSSP and BPCI Results and Key Learnings
• Discussion
Overview of Catholic Health Initiatives
**Mission:**
The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by research and education. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities.

**Vision:**
Our vision is to live up to our name as One CHI:

**Catholic:** Living our Mission and Core Values

**Health:** Improving the health of the people and communities we serve

**Initiatives:** Pioneering models and systems of care to enhance care delivery
Core Values

Reverence: Profound respect and awe for all of creation, the foundation that shapes spirituality, our relationships with others and our journey to God.

Integrity: Moral wholeness, soundness, fidelity, trust, truthfulness in all we do.

Compassion: Solidarity with one another, capacity to enter into another’s joy and sorrow.

Excellence: Preeminent performance, becoming the benchmark putting forth our personal and professional best.

Core Strategies

People – Develop top talent and a culture of leadership in health care practices.

Quality – Achieve leadership in person-centered care.

Stewardship – Steward resources and invest to innovate and excel in meeting our communities’ needs.

Growth – Grow and diversity locally and nationally to extend our ministry.
Catholic Health Initiatives Today

Overview as of November 2014
Catholic Health Initiatives, a nonprofit, faith-based health system formed in 1996 through the consolidation of four Catholic health systems, expresses its mission each day by creating and nurturing healthy communities in the hundreds of sites across the nation where it provides care.

One of the nation’s largest health systems, Englewood, Colo.-based CHI operates in 19 states and comprises 105 hospitals, including four academic health centers and major teaching hospitals and 30 critical-access facilities; community health-services organizations; accredited nursing colleges; home-health agencies; and other facilities that span the inpatient and outpatient continuum of care.

In fiscal year 2014, CHI provided $910 million in charity care and community benefit – a nearly 20% increase over the previous year – for programs and services for the poor, free clinics, education and research. Charity care and community benefit totaled more than $1.7 billion with the inclusion of the unpaid costs of Medicare. The health system, which generated revenues of almost $13.9 billion in fiscal year 2014, has total assets of $21.8 billion.
AT A GLANCE
CHI Today

OUR SCOPE

OPERATIONS IN 19 STATES

105 HOSPITALS, INCLUDING:

4 ACADEMIC HEALTH CENTERS AND TEACHING HOSPITALS

30 CRITICAL ACCESS HOSPITALS

13 CLINICALLY INTEGRATED NETWORKS

10 INSURANCE PLANS

About 46 million people — or nearly 17% of the US population — live within a 60-mile radius of a CHI hospital.
AT A GLANCE
Fiscal Year 2014 Statistics

CARE INTERACTIONS

HOME VISITS: 969,884

VIRTUAL HEALTH: MORE THAN 80 PROGRAMS OFFERED

PHYSICIAN AND ADVANCED PRACTICE CLINICIAN VISITS: 8.6 MILLION
ACUTE CARE ADMISSIONS: 487,432

OUTPATIENT EMERGENCY VISITS: 1.8 MILLION

OUTPATIENT NON-EMERGENCY VISITS: 5 MILLION

COVERED LIVES: 103,866
AT A GLANCE
Fiscal Year 2014 Statistics

FINANCIAL HIGHLIGHTS

$21.8 BILLION IN ASSETS

$13.9 BILLION IN TOTAL ANNUAL OPERATING REVENUES

$910 MILLION IN TOTAL ANNUAL CONTRIBUTIONS TO CHARITY CARE AND COMMUNITY BENEFIT

MISSION & MINISTRY FUND
MORE THAN $55 MILLION IN GRANTS FOR BUILDING HEALTHY COMMUNITIES
AT A GLANCE
Fiscal Year 2014 Statistics

EMPLOYEE COMMUNITY
APPROXIMATELY 90,500 EMPLOYEES

INCLUDING APPROXIMATELY
3,500
EMPLOYED
PHYSICIANS
AND
ADVANCED
PRACTICE
CLINICIANS
**Population Health:**
What Is It – And Why Should We Care?

**Improving the health status of a defined population by focusing on health status (quality), cost of care and the experience of care (Triple Aim)**

- Note: Not all members of a defined population are active patients – populations are broader than those currently seeking care
- Examples of defined populations:
  - Employees and dependents
  - Medicare beneficiaries seeking care with physicians (MSSP)
- Measurement of success in MSSP? Receiving a shared savings check

**CHI is committed to Population Health for multiple reasons: Our Mission, Ministry and Legacy**

- Our communities expect us to provide value, not drive volume
- For our own employees, healthcare cost trends are unsustainable
- For physicians, this is the right thing to do for our patients
- Better to develop capabilities now – this takes time – before we are ‘forced’ to change
Population Health: 
CHI’s Strategy

Inter-related Components

Clinically Integrated Network (CIN) – connected providers (hospitals, PCPs, SCPs, home health, others) organized to meet the clinical needs of a population
• Access – geographic, timing, clinical types
• Incentives to address cost, quality, experience
• Sharing of information across the CIN

Care Management
• Support capabilities to 1) improve total cost of care and 2) improve quality of care
• New roles: RN Population Health Coaches, Population Health Care Coordinators (SW), RN Transition Coaches
• Key differences from traditional roles:
  • Follow the patient/consumer, not the provider
  • Motivational Interviewing – working with consumer around THEIR goals
Clinically Integrated Networks

- **Arkansas** – Arkansas Health Network
- **Central PA Health Network** – St Joseph PHO
- **Cincinnati** – TriHealth
- **Chattanooga** – Mission Health Care Network
- **Colorado** – Colorado Health Network
- **Houston/E Texas** – St Luke’s Health System
- **Iowa** – Mercy Health Network
- **Kentucky** – Kentucky One Health Partners
- **Nebraska** – UniNet
- **Roseburg** – Architrave
- **Tacoma** – Rainier Health
- **W North Dakota** – Primecare Select CIN
PPACA Value Based Care Programs for Medicare

**Population** (providers can only participate in one of these programs)

1. **Multi-payer Advanced Primary Care Practice Demonstration**
   - PCP groups or small multi-spec groups (<5,000 Medicare FFS beneficiaries)
   - Medium-sized multi-specialty groups (5,000-15,000 Medicare FFS beneficiaries)
   - Large multi-specialty groups (15,000+ Medicare FFS beneficiaries)
   - Hospital-led systems (15,000+ Medicare FFS beneficiaries)

2. **Comprehensive Primary Care Initiative**

3. **Medicare Shared Savings Program**

4. **Advance Payment Model**

5. **Pioneer ACO Model**

6. **Bundled Payment for Care Improvement Initiative**

**Condition**

**Episode**
### Population Health Programs

- Medicare Shared Savings Program (MSSP) –
  - Added 6\textsuperscript{th} program 1/1/14
  - 4 Additional programs started 1/1/15
  - Current Total of 10 MSSP Programs

- Bundled Payment for Care Improvement (BPCI)
  - 29 hospitals in Phase 1 (no financial risk)
  - 6 in Phase 2 (up/down financial risk)
  - More facilities moving to Phase 2 July 2015

- CHI Medical Plan – 200K employees and dependents
  - 3 markets started 1/1/14
  - 4 additional markets started 1/1/15

- Others: Health Connections Initiative

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**Total Managed Membership with financial risk > 300,000 as of 1/1/15**
Population Health: “Value Generation”

Addressing total cost of care is critical

- Care Management
  - ED visits (per thousand) – frequent visitors and certain diseases
  - Inpatient utilization (per thousand)
  - High Tech Radiology utilization

- Clinical Care
  - Evidence-based clinical care pathways
    - Diabetes, Heart Failure, Back Pain, etc. – driven by data
  - Beyond single encounter
  - Measuring adherence
Area of Focus

Population Health Management Components

- Utilization Management
- Acute Case Management
- Compliance

- LACE/ProjectRED
- Continuing Care Network/SNFists
- RN Transition Coaches

- Advanced Pop Health Analytics
- Coaches & Pop Health Care Coordinators
- Patient Centered Med Home

- Basic Analytics (such as registries)
- RN Pop Health Coaches
- Patient Centered Med Home
## Care Management: Nationally Consistent with Local Flexibility

### Consistent

**People**
- Job Titles/Roles
- Job Descriptions
- Staffing ratios (goal)
- Integrated Care Management Model
- Physician Advisor Services (acute care)

**Pop Health Analytic Tools – CHI-only**
- MCCM
- McKesson

**Process/Models**
- LACE/ProjectRED
- PCMH
- Disease Care Pathways

**Key Performance Indicator (KPI) metrics**

### Flexible

**People**
- Hiring/Firing
- Salaries
- Clinic-based vs. virtual/shared

**Process/Models**
- Implementations

**Pop Health Analytic Tools – JVs and collaborations**
- Guiding principles
- Add-on Metrics (brought to Pop Health Data Governance)
- Pilots: such as telehealth, disease management, innovative care management models

**Other items – open to discussion**
Population Health:
Ambulatory Care Management

• RN Population Health Coaches – 1:5,000 members
  • Focus on clinical gaps in care, not just ‘recruiter’ for new patient visits. Diabetes, COPD, asthma, CHF
  • Follow the patient, not the physician
  • May be embedded in practice, virtual or hybrid

• Population Health Care Coordinators (SW) – 1:3,000 members
  • Focus on financial, transportation, social barriers
  • Follow the patient, not the physician
  • May be embedded in practice, virtual or hybrid

• RN Transition Coaches
  • Focus on patients with LACE 9 or above
  • 30 days after discharge – transition to ambulatory if continued needs

• Admin staff – to allow nurses and social workers to work at the top of their license
## Population Health: Ambulatory Care Management

<table>
<thead>
<tr>
<th>Care Team**</th>
<th>Care Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician APC</strong></td>
<td></td>
</tr>
<tr>
<td>Evidence-based medical care</td>
<td>Collaborative</td>
</tr>
<tr>
<td>Disease/condition treatment</td>
<td>Staff complicated patients with care management staff</td>
</tr>
<tr>
<td>Care team lead</td>
<td>Direct referral to CM for complex high-risk consumers</td>
</tr>
<tr>
<td><strong>Registered Nurse (RN)</strong></td>
<td></td>
</tr>
<tr>
<td>Triage</td>
<td>RN Population Health Coach</td>
</tr>
<tr>
<td>Complicated Test Results</td>
<td>• Complex High-risk</td>
</tr>
<tr>
<td>Medical emergency</td>
<td>• Close gaps in care</td>
</tr>
<tr>
<td>Clinical Assessment</td>
<td>• Coaching/Education</td>
</tr>
<tr>
<td>Medication reconciliation</td>
<td>• Self-management techniques</td>
</tr>
<tr>
<td>IVs</td>
<td>• Identify and eliminate barriers</td>
</tr>
<tr>
<td>Phlebotomy</td>
<td>• Care Management assessment, planning</td>
</tr>
<tr>
<td>Quality Improvement</td>
<td>• Assess readiness to change</td>
</tr>
<tr>
<td>Risk Management</td>
<td>• Chronic disease management</td>
</tr>
<tr>
<td>Supervisory of non-licensed staff</td>
<td>• Post ED visit calls</td>
</tr>
<tr>
<td><strong>Social Work</strong></td>
<td></td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Population Health Care Coordinator</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>• Psychosocial support</td>
</tr>
<tr>
<td><strong>Medical Assistant (MA)</strong></td>
<td></td>
</tr>
<tr>
<td>Room patient</td>
<td>• Community resources</td>
</tr>
<tr>
<td>Vital signs</td>
<td>• Financial resources</td>
</tr>
<tr>
<td>Current medication list</td>
<td>• Advanced Directives</td>
</tr>
<tr>
<td>Prepare specimens</td>
<td></td>
</tr>
<tr>
<td>Record keeping</td>
<td><strong>Care Management Focus</strong></td>
</tr>
<tr>
<td>Call patient panel due for preventive care</td>
<td>Care Management Associate</td>
</tr>
<tr>
<td>Point of care reminders</td>
<td>• Administrative</td>
</tr>
<tr>
<td>Scheduling</td>
<td>• Initial outreach to high-risk consumers</td>
</tr>
<tr>
<td>Phlebotomy (if certified)</td>
<td>• Mailings</td>
</tr>
<tr>
<td>Education (low to moderate risk)</td>
<td>• Monitor pharmacy and diagnostic compliance</td>
</tr>
<tr>
<td>Reporting</td>
<td></td>
</tr>
<tr>
<td><strong>Key Elements</strong></td>
<td></td>
</tr>
<tr>
<td>Clinic Focus</td>
<td></td>
</tr>
</tbody>
</table>

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Catholic Health Initiatives / Population Health
# Population Health: Ambulatory Care Management

## Disease Registry
- **Clinic data**
  - Consumer and treatment management
  - Low to Moderate-risk
  - Wellness/Preventive
  - Gaps in care (low to mod risk)
- **Claims data**
  - Risk stratification
  - Predictive modeling
  - High-risk and Complex Consumer
  - Gaps in care (high-risk)

## Patient-centered
- **Clinical management**
  - Decision-making about treatment options
  - Whole person care
- **Needs-based management**
  - Incorporate physical, psychosocial, spiritual and vocational needs
  - Care Coordination of multiple providers and treatment

## Goal-oriented
- **Triple Aim**
  - Clinical metrics
  - Outcome measures
  - Aligning treatments
- **Collaborative with consumer and family**
  - Health care goals
  - Motivational interviewing (MI)
  - Span conditions

## Relationship-oriented
- **Medical Home**
  - One provider/one care team
  - Trust
- **Care navigation through care continuum**
  - Understand individual health expectations, barriers and goals
  - Trust
  - Additional time to provide open communication - MI
  - Continuity of care

## Assessment
- **Physical exam**
  - Diagnostic assessment
  - Clinical metrics
  - Preventive measures
- **Needs assessment**
  - Identify barriers to care
  - Continuous re-evaluation of needs and service options
  - Consumer’s value system and culture
  - Spiritual beliefs

## Care Plan
- **Evidence-based Care**
  - Medical Diagnosis
  - Treatment focused
  - Relates to here and now
- **Nursing diagnosis (actual, risk and health promotion)**
  - Nursing interventions focused on etiologic or risk factors
  - Goal and health expectation focus
  - Barrier focus
  - Relates to the future
Many physicians are skeptical about Population Health efforts
• Failed in the 1990’s – why will it work now?
• This is just a way to decrease payment to providers/hospitals/etc.
• Patients won’t do what we say – why should we take responsibility?

CHI’s Approach to Provider Engagement:
• Providing a vision – physicians are interested in better patient care and leaving a legacy.
• Providing information – transparent, timely, reasonably accurate, unblended
• Aligning Incentives – challenging, incremental, though critical
• Physician Leaders – develop internally or hire, physicians follow physicians
Population Health:
Change Management is Critical

• Strong and effective leaders are required, though not sufficient for success
  • Business and Clinical leaders
  • Skills that drive success within hospitals may not translate into ACO and Population Health work
  • Internal, external and developing leaders
• Culture can be a killer, or an enabler – Consensus driven? Does everyone need to be happy? Are you nimble and flexible?
• Aligning incentives is a challenge – it’s OK to have different incentives if you can align for a Win-Win
Population Health: The Data Dilemma

• Data is a ‘must have’ – though don’t let perfect be your goal
  • Sources
    • Claims: required – ‘leakage’ and standardized benefits
    • AEHR: nice, though very, very challenging
    • Lab: nice, though limited
    • Pharmacy: very beneficial, timing is the key
  • Data versus information versus knowledge – turning raw data into knowledge that will drive change is a long process

• Population Health Analytics
  • CHI’s Strategy: Focus on Risk Stratification for total population, using best-in-breed tool(s)
  • McKesson’s Risk Manager and Population Manager tools are used by RN Population Health Coaches to outreach to top 5%
### Population Health: Information to Knowledge – Operational Management

<table>
<thead>
<tr>
<th></th>
<th>Member Months (PIT)</th>
<th>PMPM (Quarterly)</th>
<th>Acute Admits/K (Quarterly)</th>
<th>Acute Bed Days/K (Annual)</th>
<th>ALOS (Quarterly)</th>
<th>Readmit % (Quarterly)</th>
<th>ED Visits/K (Quarterly)</th>
<th>CT Visits/K (Quarterly)</th>
<th>MRI Visits/K (Quarterly)</th>
<th>CIN Spend % (Annual)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACO 1</td>
<td>19,468</td>
<td>$ 744.94</td>
<td>269.6</td>
<td>1290.2</td>
<td>4.79</td>
<td>16.4%</td>
<td>422.2</td>
<td>841.4</td>
<td>275.3</td>
<td>47.0%</td>
</tr>
<tr>
<td>ACO 2</td>
<td>20,856</td>
<td>$ 602.59</td>
<td>260.3</td>
<td>1230.9</td>
<td>4.73</td>
<td>14.2%</td>
<td>395.3</td>
<td>550.7</td>
<td>200.7</td>
<td>50.3%</td>
</tr>
<tr>
<td>ACO 3</td>
<td>16,599</td>
<td>$ 672.56</td>
<td>290.7</td>
<td>1351.8</td>
<td>4.65</td>
<td>17.8%</td>
<td>403.9</td>
<td>869.9</td>
<td>279.5</td>
<td>32.4%</td>
</tr>
<tr>
<td>ACO 4</td>
<td>26,085</td>
<td>$ 726.46</td>
<td>317.3</td>
<td>1365.2</td>
<td>4.30</td>
<td>18.5%</td>
<td>521.8</td>
<td>609.4</td>
<td>262.3</td>
<td>52.7%</td>
</tr>
<tr>
<td>ACO 5</td>
<td>8,471</td>
<td>$ 657.15</td>
<td>210.8</td>
<td>911.8</td>
<td>4.33</td>
<td>16.2%</td>
<td>471.1</td>
<td>640.4</td>
<td>244.4</td>
<td>33.6%</td>
</tr>
<tr>
<td>Total/Unweighted Average</td>
<td>91,479</td>
<td>$ 680.74</td>
<td>269.7</td>
<td>1230.0</td>
<td>4.56</td>
<td>16.6%</td>
<td>442.9</td>
<td>702.4</td>
<td>252.4</td>
<td>43.2%</td>
</tr>
</tbody>
</table>

Monthly monitoring of utilization metrics drives performance improvement and accountability. Don’t wait for CMS or others to tell you how you’re doing.
Population Health: 
Generating a “Win-Win” Scenario

Integrated Health Systems feel torn in different directions – do organizations like CHI focus on volume or value? Does a successful ACO (bending cost curve) require a hospital to see decreased volumes?

• 2 Key Factors will deliver value for an Integrated System:

  1. Bending the Cost Curve – Total Population
  2. Portion of Care Provided by ACO/Hospital

By bending cost curve and coordinating care better, both the ACO and hospital can succeed financially. And patients will receive better care/more value.
Population Health: MSSP Results – Year 1

- 5 ACOs received final reconciliation for Year 1
  - 2 ACOs lowered costs, only 1 of which met threshold (Des Moines)
  - 3 ACOs increased costs
  - All ACOs reported quality metrics

- 2-3 ACOs had functional Population Health coaches during at least part of the year. Others did not have dedicated and trained staff in place.

- Focusing on high risk members, addressing clinical gaps that led to lower ED and inpatient utilization drove positive results. Quality activities alone did not bend cost curve.
Population Health:
MSSP Programs & CHI’s Experience to Date

Official Results are In!

• Mercy ACO (IA) achieved savings = $4.4M ‘bonus’

• Other ACOs did not reach savings threshold
  • Leadership and continuity issues
  • Operational issues – hiring, training and retaining good health coaches
  • Turning data into information into knowledge and action
  • Perception of ‘hospital versus ACO’

CHI markets participate in local ACOs through Track 1 – results above are for Year 1. All successfully reported Quality metrics.
Population Health: MSSP Year 1 Learnings

- CIN clinical leader is required – to hire, train, manage coaches and CM staff
- Hiring the right coaches is challenging – this is new work, not all nurses have skill set without training and support
- Coaches support the patient/member – they are not there to coach physicians. Education of staff is important – otherwise clinic staff think coaches should be giving shots and rooming patients.
- Data/Information must be paired with staff – data without staff (or vice versa) won’t work
- Worry about MSSP members who are NOT coming into the office – they frequently have the highest needs.
Population Health:
BPCI Programs & CHI’s Experience to Date

Official Results are In!

• Alegent Mercy Council Bluffs: IA: Jan-March 2014: Savings Achieved

• Other 2 BPCI programs did not achieve savings in first Q. of participation:
  • Post-Acute Utilization
  • Physician practice did not adapt to program
  • Operational issues – hiring, training and getting dedicated navigators on board
  • Turning data into information into knowledge and action
**Population Health:**

**BPCI: Phase 2 Facility Compare**

Here is a breakdown of the data:

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Facility 1</th>
<th>Facility 2</th>
<th>Facility 3</th>
<th>Facility 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute LOS</td>
<td>4.25</td>
<td>3.79</td>
<td>4.82</td>
<td>4.46</td>
</tr>
<tr>
<td>Readmission</td>
<td>10%</td>
<td>16%</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>SNF Utilized</td>
<td>36%</td>
<td>11%</td>
<td>52%</td>
<td>57%</td>
</tr>
<tr>
<td>SNF LOS</td>
<td>27d</td>
<td>24d</td>
<td>18d</td>
<td>18d</td>
</tr>
<tr>
<td>HH Utilized</td>
<td>30%</td>
<td>26%</td>
<td>21%</td>
<td>41%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q1 2014</th>
<th>Facility 1</th>
<th>Facility 2</th>
<th>Facility 3</th>
<th>Facility 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute LOS</td>
<td>4.09</td>
<td>2.60</td>
<td>3.97</td>
<td>4.49</td>
</tr>
<tr>
<td>Readmission</td>
<td>4%</td>
<td>9%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>SNF Utilized</td>
<td>28%</td>
<td>10%</td>
<td>47%</td>
<td>62%</td>
</tr>
<tr>
<td>SNF LOS</td>
<td>19d</td>
<td>29d</td>
<td>21d</td>
<td>17d</td>
</tr>
<tr>
<td>HH Utilized</td>
<td>36%</td>
<td>14%</td>
<td>16%</td>
<td>30%</td>
</tr>
</tbody>
</table>

**Findings:** Programs that significantly lowered post-acute costs (specifically SNF costs) achieved savings.

- **Programs Achieving Savings:** Avg. Post-Acute Costs: $4957; SNF Costs: $2185
- **Programs Not Achieving Savings:** Avg. Post–Acute Costs: $9555; SNF Costs: $7360
BPCI: Phase 2
Critical Factors for Success

• Bending the Cost Curve
  – Acute admission—ICS opportunities; Focused planning
  – Decreasing Readmissions
  – Decreasing post-acute spend
  – Need for Pre-Op Education/Optimization/Coordination
  – Aggressive post-op LOS/post-acute utilization management
  – Nurse Navigators: Starting at acute care with follow-up to 120 post-episode; 24 hour call back available
  – Integrated Care Management model
  – Workflow management tool
  – Post-Acute: CCN network/relationships critical to succeed
  – Engaged Physician Leadership/ Active Steering Committee

• Most successful programs: Focused to decrease readmissions and post-acute spend
Population Health:
BPCI Key Learnings

- Engaged physician leadership is key to success—physicians must change their practice patterns for success in this model.

- Decreased utilization of post-acute services was largest revenue reduction for the programs.

- Data/Information must be paired with staff—data without staff (or vice versa) won’t work.

- Care Management/Navigation beginning at pre-op and continuing through entire episode of care is required; Patients must have access to providers 24/7 to prevent ED use and hospital readmissions.

- Robust patient optimization/education program to identify issues/set expectations early was critical to early identification of potential.
Population Health: Top 5 ACO Mistakes

1. Focusing only on quality initiatives – not addressing cost of care
2. Confusing activities with outcomes
3. Assuming skills that are successful within a hospital translate into Population Health
4. Thinking that establishing a CIN is enough – it’s just the beginning
5. Underestimating the value, and complexity, of data and analytics in Population Health
Population Health:
Top 5 Challenges for CHI

1. Fee for Service persists as primary payment model – inpatient and outpatient

2. Generally, we think like hospitals – and bring hospital solutions

3. We can’t ‘own’ it all – partnerships and collaborations are critical

4. Moving at the right pace – reactive versus proactive

5. Disruptors and leapfrogs
Population Health:  
Turning Strategy into Tactics

High Risk Individuals

- Prospective, not retrospective (predictive analytics)
- Top 3-5% of population
- Claims-based data as primary source, plus ad hoc referrals
- Some of high risk will have minimal connection with PCP(s) – seeking care through ED, specialists and frequent hospitalization - Clinic-based coaches may be ‘blind’ to patients not seeking care

Tactics
1. Run risk stratification report once monthly for ‘very high risk’
2. Provide lists to coaches – by PCP and ‘all others’
3. 1st Telephonic outreach by coach within 1 week of receiving list – initiate telephonic coaching or schedule appointment
4. At least 3 attempts to reach with ‘unable to reach’ letter within 30 days
Readmission Reduction

• LACE tool to determine high risk, plus ad hoc referrals
• Roughly 30% of discharges
• Multiple owners – hospital (floor nurses, hospitalists/physicians, discharge planners), transition coaches, ambulatory Population Health coaches
• Any/all conditions and facilities

Tactics
1. Implement LACE tool, if not already – manual, if needed
2. ProjectRED – train hospital staff, monitor compliance
3. Determine who makes first outreach (within 24 hours) – hospital nurse, transition coach, ambulatory coach
4. Monitor results monthly – incentives and transparency
Questions?