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The Road to Population Health: Key Considerations in Making the Transition

Webinar
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What do we mean by population-based models

What are we seeing from payors?

What does this mean for providers?

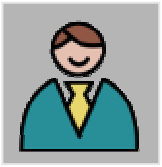
What is our understanding of population-based models?

Goals of population-based models

- **Achieve best** possible **quality** at **minimum** necessary **cost**
- Shift provider's mindsets **from the patient** in front of them **to the population for whom they are responsible**
- Create effective collaborations across settings of care (e.g., PCPs and specialists)
- Reduce unnecessary hospital admissions/ ER visits through proactive outbound care
- Improve wellness and preventative care

What do population-based models of care bring?

For patients



Enable patients live healthier and improve their health care experience

Personalize care to patient's needs and preferences

Prevent avoidable admissions, re-admissions, and ER visits

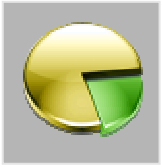
Improve access for patients when they need it most

Enable patients to actively manage their condition through awareness and engagement

Provide more care in the community or at home

For providers

Work together across providers to enable a better quality care for the patient



Ensure most effective possible use of clinical time and resources

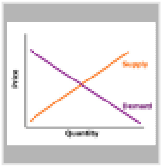
Encourage innovative ways of proactively caring for patients

Avoid duplication of effort in situations where patient is seen by multiple providers

Focus on the end-to-end pathway instead of individual episodes of care or conditions

Maintain financial sustainability of providers and ensure system-wide risk is shared

For the system



Effectively respond to increasing demands while facing pressures of containing costs

Invest more money in proactive care to deliver system savings

Support providers through risk-sharing where appropriate

Ensure efficient and effective management of public and / or private funds

How do population-based models fit with rest of system?

Full alignment of payment to outcomes

Population-based models

- Patient Centered Medical Homes (PCMH)
- Accountable Care Organizations (ACO)
- Health home
- Capitation

Episode-based models

- Retrospective episode-based payment (REBP)
- Bundled payment

Fee-for-service, including "pay for performance"

- Bonus payments tied to quality
- Bonus payment toed to efficiency

Most applicable

- Primary prevention for healthy
- Care for chronically ill (e.g., managing obesity, CHF)

- Acute procedures (e.g., CABG, hips, perinatal)
- Most inpatient stays including post-acute care, readmissions
- Acute outpatient care (e.g., broken arm, URI, some cancers, some behavior health)

- Discrete services provided by entity with limited influence on upstream or downstream costs (e.g., MRI, prescription, medical device, Health Risk Assessment)

Interactive Poll

What do you see as the biggest challenges to transforming practices at scale?

Pick the best answer from the following list

- ☐ Incentivizing providers to improve practice patterns
- ☐ Cultivating clinical leaders to develop a performance culture
- ☐ Generating/integrating credible information into workflows
- ☐ Engaging the consumer through the right incentives

What do we mean by population-based models?

What are we seeing from payors?

What does this mean for providers?

There is tremendous experimentation and buzz in the market on innovative new care delivery and reimbursement models

Payor CEOs are focusing on health care value and payment innovation

Payors and providers are piloting innovative new models (ACOs, PCMH, bundled payments)

Horizon
CareFirst BlueCross BlueShield
CareMore It's what we do.
CHW
Hill Physicians
CalPERS
BlueShield of California
HIGHMARK. Blue Cross Blue Shield
JEFFERSON REGIONAL MEDICAL CENTER
West Penn Allegheny Health System
Aetna
CMS Centers for Medicare & Medicaid Services
Geisinger Health System
BlueCross BlueShield of Minnesota
Massachusetts
Blue Cross Blue Shield of Rhode Island
Arkansas Department of Human Services
Arkansas BlueCross BlueShield
QualChoice
Blue Cross Blue Shield of Michigan
Intermountain Healthcare
WellPoint

SOURCE: Payor CEO earnings calls; industry experts; McKinsey experience

We see four broad approaches to population-based models

	Example organizations	Example market context/factors favoring model
Payor-led	CareFirst BlueCross BlueShield Horizon Healthcare Innovations	▪ Payor market share & provider materiality ▪ Network strategy includes shift to high-value providers ▪ Payor capabilities exist
Hospital-led	SHARP San Diego's Health Care Leader Advocate Health Care Inspiring medicine. Changing lives.	▪ High physician alignment ▪ Broad spectrum of care continuum ▪ Total cost of care partnerships
IPA led risk-bearing contracts	chenmed	▪ Strong primary care clinical leadership ▪ Sophisticated IPA technology ▪ Transparency on specialist/facility performance
Com-munity-led	Camden Coalition of Healthcare Providers www.camdenhealth.org	▪ Strong primary care clinical leadership ▪ Focus on small geography ▪ Collaborative provider community

SOURCE: McKinsey outside-in interviews

Interactive Poll

Which of the following approaches to population health models do you believe is driving / will drive impact in your market?

Pick the best answer from the following list

- ☐ Payor-led population health model
- ☐ Hospital-led population health model
- ☐ Physician-led population health model
- ☐ A combination of at least two or more of the models above

Case study: Transforming primary care – a great opportunity and a great challenge

Primary care providers are in a position to significantly improve healthcare…

- Primary care is only **3-5% of total cost of care** yet **influences almost all spend** either directly or indirectly via referrals
  - PCPs have the relationship with the patients and families to promote preventative care and wellness programs
  - PCPs have the relationship with downstream providers to refer effectively and to coordinate care delivery
- PCPs also have **great potential to improve their own practices**, e.g.,
  - Practicing more evidence-based medicine guidelines for care coordination
  - Using more technology to improve care coordination

…the conundrum is that they are often least capable of doing so…

- **Small scale** and limited resources for technology that enables transformation (e.g., EMR)
- **Low reimbursement rates** drive providers to take on high volumes of patients to maintain financial solvency
- Daily **small business burdens,** limit longer term thinking and tradeoffs
- Increasing **administrative burden**
- Strong informal and formal **relationships with local providers**
- Minimal “business” training, **limited clinical leadership,** and fewer young primary care physicians

Case study: Three payment streams

		Payor's considerations
1	**Fee for service** 	▪ Increase base FFS rates ▪ Enhance FFS to include "additional services"
2	**Care coordination and transforma-tion support fees** 	▪ Up-front (lump-sum) payment support, PMPMs ▪ In-kind support (e.g., transformation coaches, care coordinators)
3	**Performance-based payments** 	▪ Pay for performance, upside gain sharing only, upside and downside risk sharing ▪ Absolute improvement vs. performance improvement

How should we appropriately embed quality throughout the payment model?

Case study: Four complementary approaches to practice transformation

		Description
Transformation guide book		▪ How-to guide describing specific steps required to achieve specific goals / targets (e.g., decrease avoidable ER visits) ▪ Targets multiple audiences – PCP, care coordinator, office staff
Transformation coaches		▪ Payor-sponsored resources working directly with practices ▪ Provide support to enable physicians – Insights from performance root-cause analysis – Best practices – Tools and resources to initiate new processes / workflows
Learning collaboratives		▪ Forum to exchange ideas and leverage colleagues' experiences to support and accelerate practice transformation ▪ Standing meetings (e.g., monthly), with mix of expert presentations, colleagues sharing learnings, and practice-specific action-planning
Physician "general agents"		▪ High-performing physicians who have demonstrated willingness and ability to transform that are now sponsored by payor ▪ Aim is to help radiate excitement, understanding, and PCMH transformation – e.g., recruit new practices

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Reform driven industry shifts will occur over 3 distinct phases

1 Regulatory "turbulence"

Before 2014

- State and federal regulations and rules are written
- Further legislative activity at state level and potentially federal level happens

2 Market "turbulence"

2014-2016

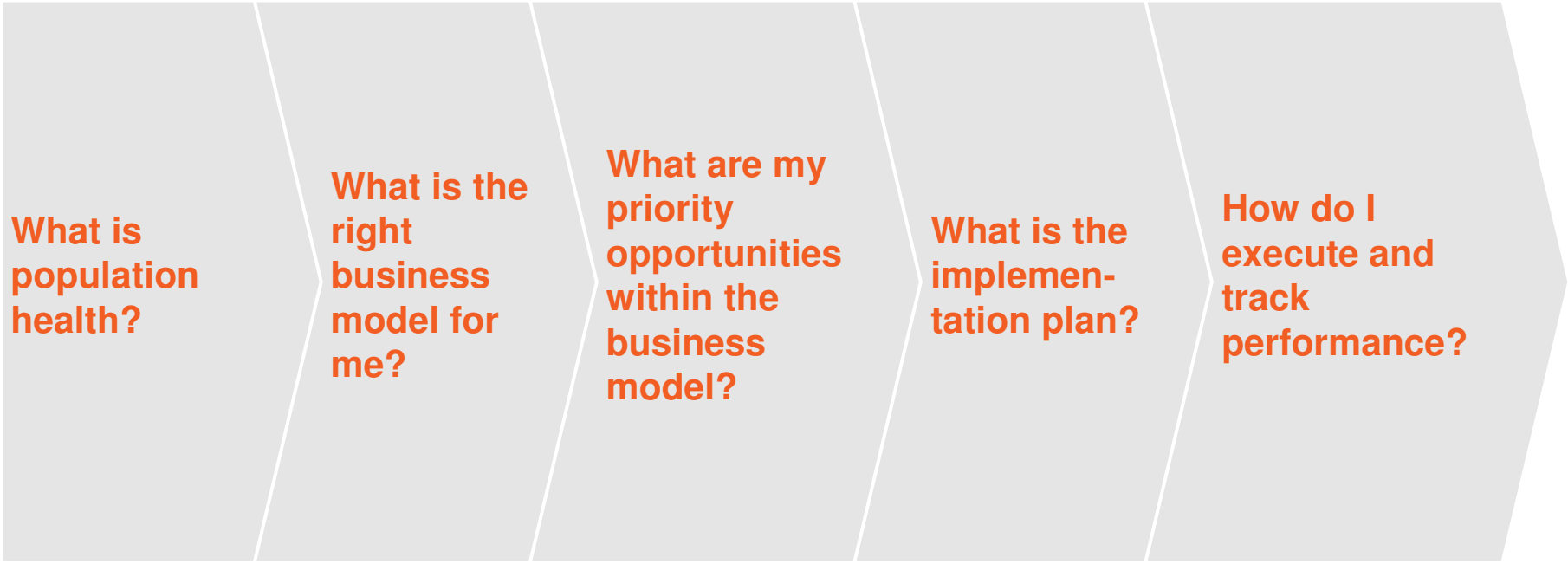
- Exchanges open
- Employers and individuals make decisions
- Industry players act and react
- Regulators refine rules
- Potentially further corrective legislative action

3 *"New Normal"* competition

Post 2016

- Market pricing and enrollment levels settle
- Market participant postures become stable
- Rules periodically adjust

Hospitals are preparing to compete in the emerging landscape



As providers think through the implications of population health management, they are realizing they need a new set of capabilities to succeed

Past		Future
Physician recruitment	1 →	Clinical integration
Acute care excellence	2 →	Managing the care continuum
Payor contracting	3 →	Risk management
Cross subsidization	4 →	Focused lines of business management
B2B	5 →	B2C

1 Population health management organizations integrate across care settings, but approaches vary widely

Full integration
Some integration

Primary care

Community care

Acute and specialist care

Social care

Payor

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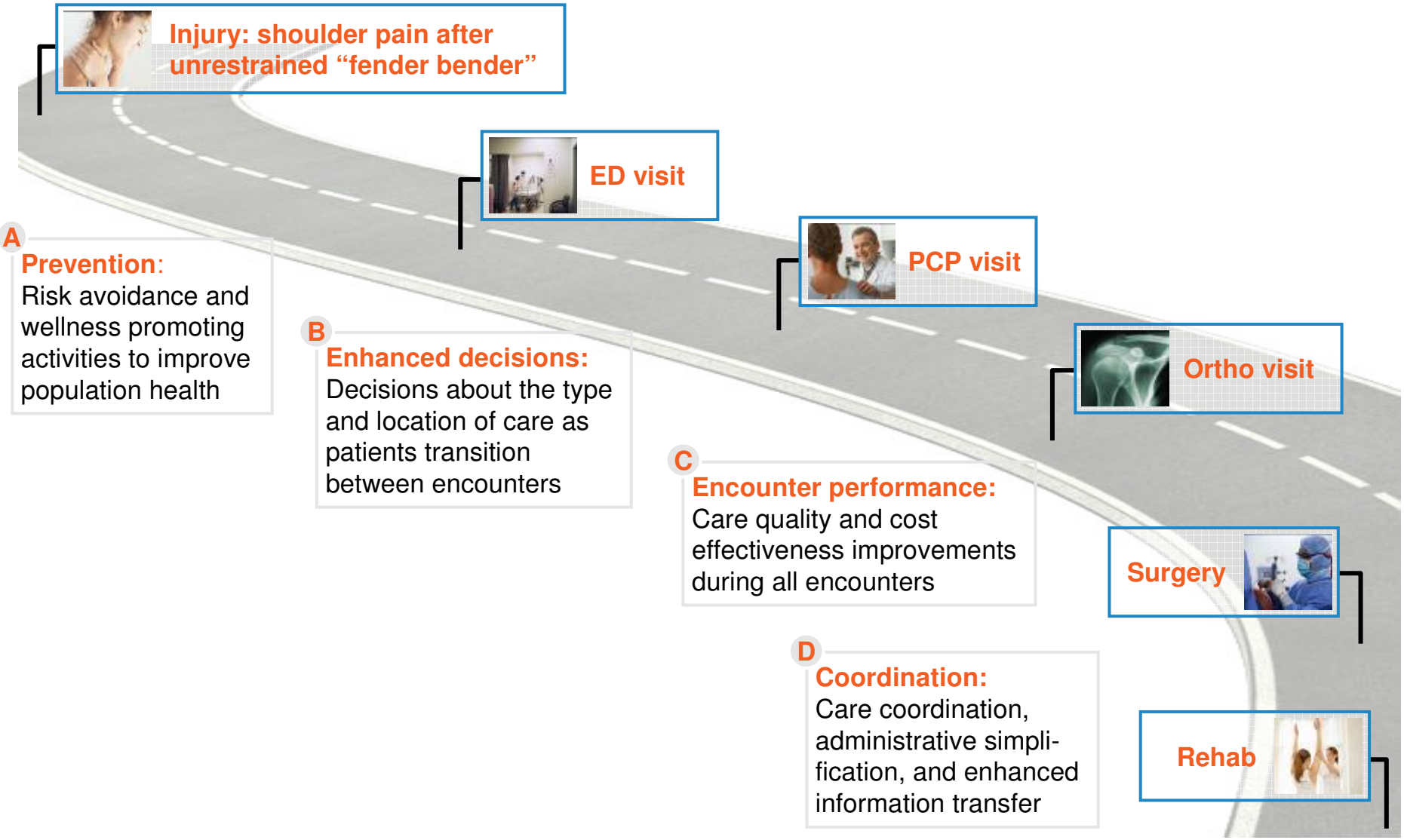
2 Providers need to work across the continuum of care to manage the health of their populations

Typical care pathway



A **Prevention**: Risk avoidance and wellness promoting activities to improve population health

B **Enhanced decisions:** Decisions about the type and location of care as patients transition between encounters

C **Encounter performance:** Care quality and cost effectiveness improvements during all encounters

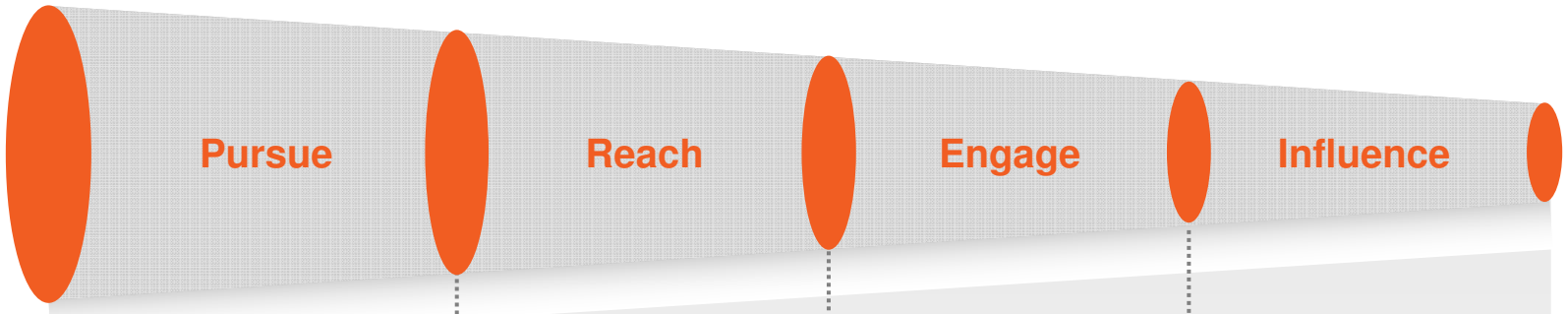
D **Coordination:** Care coordination, administrative simplification, and enhanced information transfer

3 Designing business models is both complex and risky

1 **Targeted areas of spend**	▪ Which patient populations, conditions, provider types, or opportunities will be prioritized?
2 **Level of provider integration**	▪ How integrated is the delivery system? ▪ What is the appetite among providers for establishing new legal and financial relationships?
3 **Alignment among payers**	▪ How excited would other payers be to collaborate/coordinate? ▪ What are their priorities?
4 **Design and implementation complexity**	▪ How much detailed design is required? ▪ What are the IT and organizational requirements to implement? ▪ What is the current capacity/capability?
5 **Regulatory and legal constraints**	▪ What regulatory/legal changes are needed to support innovation? ▪ What are the payers able to do without additional approval (e.g., new legislation, or CMS Waiver)?
6 **Stakeholder preferences**	▪ What does the payment or care delivery model require of key stakeholders (patients, employers, providers, etc.)? ▪ What are the stakeholders' preferences?

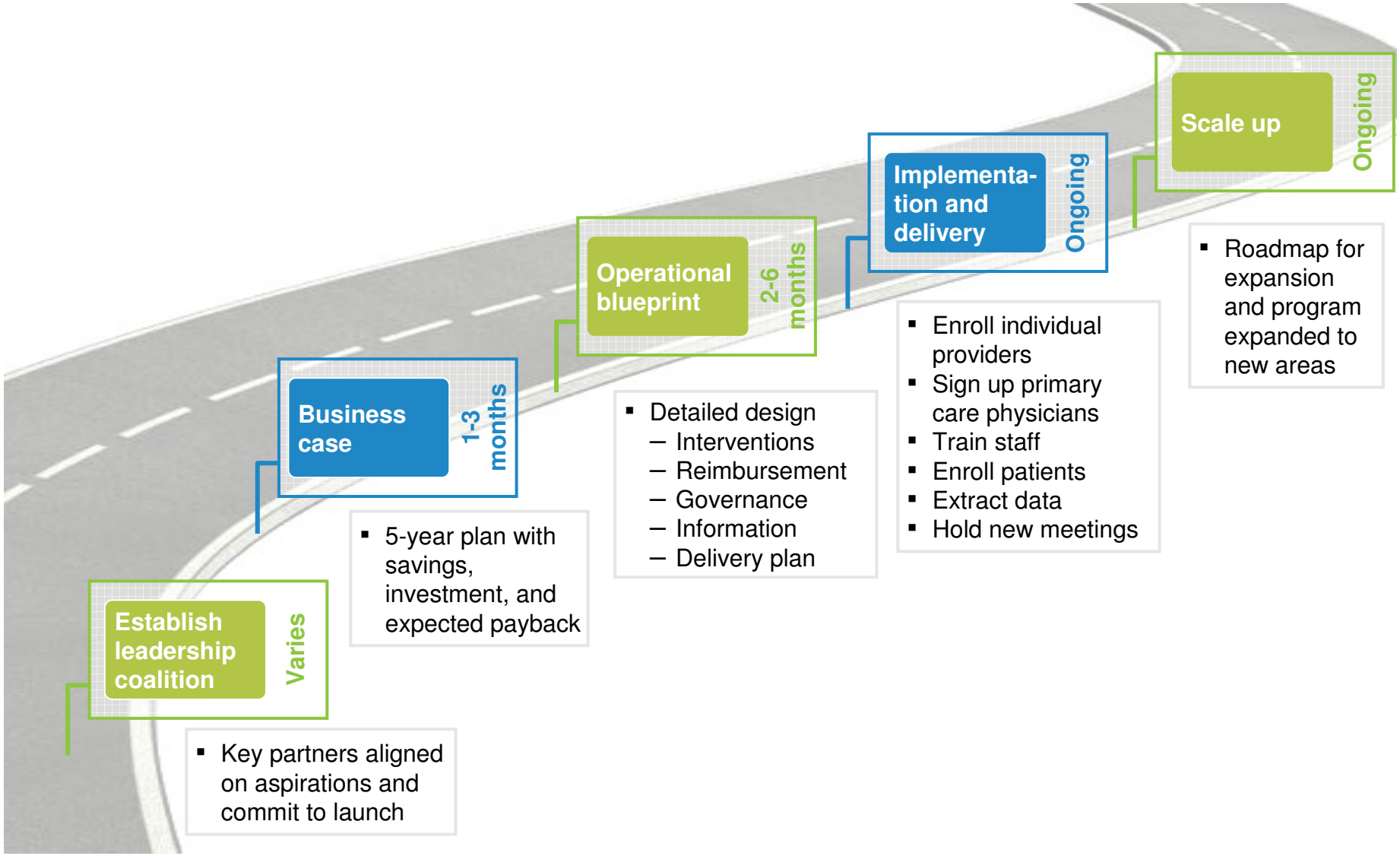
5 Engaging consumers requires providers to think like retailers

Consumer engagement funnel



	Pursue	Reach	Engage	Influence
Consumers who…	…are targeted by intervention	…receive intervention (e.g., answer call, obtain information from provider)	…respond to intervention (e.g., attend lunch and learn, sign up for intervention)	…take repeated action based on intervention
Potential measures	▪ Investment/ # pursued ▪ Expected impact from behavior change of pursued	▪ % reached ▪ Investment/ # reached	▪ # of newly engaged consumers ▪ Engaged as % of pursue and/ or reach ▪ Investment/ # engaged	▪ Relevant health outcomes (e.g., HbA1c) ▪ Consumer survey (satisfaction, knowledge, etc.)

What are the steps in the journey to population-based care?

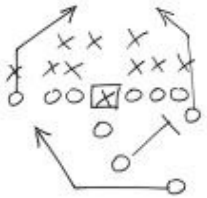


Interactive Poll

Where are you in your journey to population health? Please pick one.

Pick the best answer from the following list

☐ **THINK**: Thinking about it, haven't got leadership support yet



☐ **DESIGN**: We have leadership coalition, we're in design phase

☐ **IMPLEMENT**: Designed system and are implementing it

☐ **GROW**: System is mature and working, we are focused on scale

Join us for our follow-up webinar:

The Road to Population Health: Key enablers in implementing value-based approaches

Wednesday, January 23, 2013
1pm – 2pm EST

Presenters:
- James Stanford, Objective Health
- Peter Groves, McKinsey & Company

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Q & A

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