Population Health – What it means, where we are and where we’re going

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Chief Medical Officer
QualCare Alliance Networks, Inc.

July 30, 2015
Your New Healthcare System
## How the Marketplace Works

<table>
<thead>
<tr>
<th><strong>Create an Account</strong></th>
<th><strong>Apply</strong></th>
<th><strong>Pick a Plan</strong></th>
<th><strong>Enroll</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>First you’ll provide some basic information. Sign up for Marketplace emails now and we’ll let you know as soon as you can create an account.</td>
<td>Starting October 1, 2013, you’ll enter information about you and your family, including your income, household size and more. Use this checklist now to help you gather the information you’ll need.</td>
<td>Next you’ll see all the plans and programs you’re eligible for and compare them side-by-side. You’ll also find out if you can get lower costs on monthly premiums and out-of-pocket expenses.</td>
<td>Choose a plan that meets your needs and enroll! Coverage starts as soon as January 1, 2014</td>
</tr>
</tbody>
</table>
Average Spending on Health per Capita
Prevalence of Two+ Chronic Conditions

Figure 1. Prevalence of two or more of nine selected chronic conditions among adults aged 45 and over, by age and sex: United States, 1999–2000 and 2009–2010

1Significantly different from 1999–2000, p < 0.05.
NOTE: Access data table for Figure 1 at: http://www.cdc.gov/nchs/data/databriefs/db100_tables.pdf#1.
SOURCE: CDC/NCHS, National Health Interview Survey.
OLD MODEL
UM/CM/DM
### Siloed Care Management Functions

<table>
<thead>
<tr>
<th>Utilization Management</th>
<th>Case Management</th>
<th>Disease Management</th>
</tr>
</thead>
</table>
| • Reviewing, authorizing, denying/limiting requested services, i.e. inpatient admissions, home healthcare services, outpatient services, pharmacy services, Etc.  
• Prior Authorizations  
• Pre-service Determinations  
• Concurrent Review  
• Discharge Planning  
• Retrospective Review | • Frequent Emergency Room visits  
• Frequent Inpatient Admissions  
• Frequent Inpatient Re-admissions  
• Genetic Complications of a Fetus  
• Transplants  
• High Cost Chemotherapy  
• High Cost Medical  
• Poor Coordination of Care  
• Non-Emergent Emergency Room Usage | Chronic Condition Management  
• Individualized Patient Care Plans/Periodic Adjustments  
• Scheduled outreach calls  
• Coordination of care and services  
• Telephone access support  
• Communication with member’s physician |
Current Model
Population Health Management
The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Improved Outcomes

Developed by The MacColl Institute
® ACP-ASIM Journals and Books
Need to Address the Entire Employee Population, Not Just Chronically Ill

- Manage Members on a Continuous Spectrum
- Leverage Financial Analysis to Hone Individual Member Needs
- Understand that Each Member has Unique Healthcare Story

<table>
<thead>
<tr>
<th>% of Cost</th>
<th>10%</th>
<th>10%</th>
<th>25%</th>
<th>30%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Risk</td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>25%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Risk</td>
<td>4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complex</td>
<td>1%</td>
<td></td>
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</tbody>
</table>
Improving Health and Reducing Mortality is More Than Just “Medical”

- Genetic: 30%
- Medical: 10%
- Environment: 5%
- Behavioral: 40%
- Social: 15%

Schroeder, NEJM 357; 12
What is PHM?

Figure 3: All - Areas Covered by PHM Program

Which areas are covered by your program?

- Care coordination: 82.3%
- DM: 75.8%
- Health & wellness: 71.0%
- Risk stratification: 69.4%
- Patient engagement: 67.7%
- Case management: 61.3%
- Care gap ID: 56.5%
- Other: 11.3%

HIN Population Health Management Survey
June, 2014
What Tools Do We Use in PHM?

Figure 7: All - Tools to Determine PHM Interventions

How do you determine appropriate intervention level?

- HRA: 63.8%
- Claims: 58.6%
- EHR: 56.9%
- Physician referral: 50.0%
- Predictive model: 36.2%
- Self-report: 34.5%
- Biometrics: 27.6%
- Registry: 24.1%
- Chart review: 22.4%
- Other: 3.4%

HIN Population Health Management Survey
June, 2014
What Interventions Do We Use in PHM?

![Figure 8: All - PHM Program Components](image)

**Which of the following are part of your program?**

- Health coaching: 84.5%
- Care gap feedback: 51.7%
- Home visits: 43.1%
- Remote monitoring: 41.4%
- Support group: 20.7%
- Group visits: 17.2%
- Other: 6.9%

*HIN Population Health Management Survey June, 2014*
## Why Use Lifestyle Coaching?

### These Health Issues Really Do Drive Cost

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Cost Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>An individual with hypertension</td>
<td>$1,400 more</td>
</tr>
<tr>
<td>An individual with cardiovascular disease</td>
<td>$3,614 more</td>
</tr>
<tr>
<td>An individual who uses tobacco products</td>
<td>$5,816 more</td>
</tr>
<tr>
<td>An individual with high glucose levels/diabetes</td>
<td>$1,600 more</td>
</tr>
</tbody>
</table>

### Table:

<table>
<thead>
<tr>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Cholesterol</th>
<th>Tobacco / Nicotine</th>
<th>Glucose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annually an obese individual costs almost</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$1,100 more</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


1. [www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm](http://www.cdc.gov/chronicdisease/resources/publications/AAG/dhdsp.htm) - 83 million US adults with cardiovascular disease contribute to the $300 billion annual healthcare costs.
2. [http://tobaccocontrol.bmj.com/content/early/2013/05/25/tobaccocontrol-2012-050888.abstract](http://tobaccocontrol.bmj.com/content/early/2013/05/25/tobaccocontrol-2012-050888.abstract) - Statistic is the sum of excess absenteeism, presenteeism, smoke breaks, and health care costs.
QualCare’s Population Health Management Model

Data Collection
Predictive Modeling
Risk Stratification

Care Continuum

No or Low Risk
Moderate Risk
High Risk

Health Management Interventions

Focus
Wellness
Health Risk Management
Care Management
Chronic Condition Management

Objective
Maintain Healthy Status and Prevent Illness
Reduce Risk Through Behavior Modification
Right Care
Optimize Care of Chronic Condition

Interventions
Lifestyle Coaching
PCP Selection
HRA Completion
On-line Education Tools
Health Screening
Reminders
24/7 Nurse Line

Health Risk Management
Behavioral Modification
Biometric Screenings
Targeted Outreach
Telephonic/Written Communication
Health Coaching
Support Tools

Coordination of Care
Network Steerage
Care Transition Management
ER/Readmission Avoidance

Health Risk Management
Reduce Risk Through Behavior Modification

Improve Outcomes
Reduce Costs
Enhance Member Experience

Focus Objectives Interventions

Wellness
Health Risk Management
Care Management
Chronic Condition Management

Maintain Healthy Status and Prevent Illness
Reduce Risk Through Behavior Modification
Right Care
Optimize Care of Chronic Condition

Lifestyle Coaching
PCP Selection
HRA Completion
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Biometric Screenings
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Support Tools

Network Steerage
Care Transition Management
ER/Readmission Avoidance

Improve Outcomes
Reduce Costs
Enhance Member Experience

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POD Service Delivery Model

Provider Services Representative

Care Management Nurse(s)

Member/Provider

Customer Service Advocate

Medical Director

Social Worker/Physical Therapist

Claims Specialist
Challenges of Population Health Management

What is the greatest challenge of population health management?

- Provider alignment: 5.9%
- Team collaboration: 7.8%
- Patient engagement: 11.8%
- Data analytics: 13.7%
- Risk assessment: 11.8%
- Access to care: 29.4%
- Incentives/reimbursement: 3.9%
- Performance measurement: 5.9%
- Other: 3.9%

HIN Population Health Management Survey
June, 2014
Strategies to Maximize Active Engagement

- Use of Dialer technology which allows us to contact more individuals in a shorter period of time
- Best time-to-call identification – to make sure that we are calling at the times that will maximize success
- Staffing six days a week
- Engagement training with our staff to maximize their ability to achieve engagement
- 1:1 Nurse model where clinicians build trusting relationships
- Encouraging inbound returned calls from participants
- Mailing of reminders and standards of care materials to participants
- Focused on the total health care needs of each participant, including co-morbidities
Engagement and Intervention: Tools and Support

MyPathwaytoHealth.com provides a single-location link to:

- Secure Personal Health Information
- Personal Health Coach contact
- Health trackers and calculators
- Personal Health Profile/biometrics
- Extensive health library and resources
Participants can use trackers and send and receive messages from their Health Coach using our mobile app.
Metrics

Clinical
- HEDIS Measures
- Disease specific clinical indicators
- Member risk levels

Operational
- Member engagement
- Call Center statistics

Financial
- Utilization metrics
- PMPM costs
- Cost Trend Analysis
Chronic Condition Management Outcomes

Our chronic condition management programs have had positive financial impacts as well; such as achieving a 2.2% reduction in PMPM for engaged members vs. a 14% increase in non engaged members during the same time period (2013).
THE FUTURE
Maybe?
What portion of value-oriented payments place doctors and hospitals at financial risk for their performance?

Of the 40% of payments that are value-oriented, most put providers at financial risk for their performance, though almost 50% only after a potential financial upside.

- 53% of value-oriented payments are “at risk”
- 47% of value-oriented payments are “not at risk”

Only
- 38% of all hospital payments
- 10% of all outpatient specialist payments
- 24% of all outpatient PCP (primary care physician) payments are value oriented

2014: 40%

Value-Based Models
Outcomes-Based Programs are Growing

Employers planning to reward or penalize based on biometric outcomes other than smoker, tobacco-use status

(Towers Watson/National Business Group on Health Annual Survey 2013)
Demand for Transparency

97% of plans offer or support a cost calculator

Hospital Readmissions*

8% of hospital admissions are readmissions

*Derived from data submitted to Eurocare using NCDQ's of care readmission measure. Not an official NCDQ benchmark.
Transitions to Value-Based Payment Models

Figure 2. Transitions to value-based payment models will likely vary by market. 

- High Market pressure—Dominant provider
  - Gain sharing
  - Optimize: Outcome and value
  - P4P*
  - Medical home
  - Condition or population-focused ACO
  - Global ACO

- Low Market-balking—Hold the line
  - Fee for service
  - Optimize: Rate and volume
  - P4Q
  - Market pressure—Dominant payer

Graphic: Deloitte University Press | DUPress.com

* Includes payment for episode of care. Source: Deloitte analysis of models.
Our Delivery System Engagement Models

Low

Degree of Collaboration / Provider Risk/Operational and Clinical Integration

High

TRADITIONAL NETWORK PARTNER
• Fee for service
• Traditional contracting relationship
• Unit cost and utilization focus

ENHANCED NETWORK PARTNER
• Expanded fee for service
• Cost and quality tools
• Clinical data sharing
• Flexible network solutions

CLINICAL COLLABORATOR
• Quality bonus and cost targets
• Embedded care resources for coordination
• Data aggregation and exchange

DELIVERY SYSTEM ORGANIZER
• Shared risk
• Population health
• Management services
• Shared governance

DELIVERY SYSTEM ALLIANCE (DSA)
• Shared/full risk
• Access to capital
• Alliances and joint ventures
• Go-to-market, product, service components
• Data aggregation and exchange
• Population health

OWNED/EXCLUSIVE DELIVERY SYSTEM
• Ownership or exclusivity

Our Delivery System Engagement Models
How Do We Enhance Our Existing Programs to Meet the Changing Needs?

• Increasing Transparency
• Enhanced Wellness/Prevention - Personalized lifestyle management health coaching
• Emerging Health Risk Management- Tailored interventions at the member level based upon individual risk assessment
• Focus on the health risks associated with rare and specialty diseases
• Multimodal interventions (phone, SMS, email, video, etc.)
• Pushing care out at the point of services (ie: provider engagement)
• Aligned incentives
Thank You

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