ebg ADVISORS

EPSTEIN BECKER GREEN

thought leaders in

POPULATION HEALTH

identifying implementation tactics

Moving to an Integrated Population Health Management Model

October 30, 2014

This presentation has been provided for informational purposes only and is not intended and should not be construed to constitute legal advice. Please consult your attorneys in connection with any fact-specific situation under federal, state, and/or local laws that may impose additional obligations on you and your company.

Cisco WebEx can be used to record webinars/briefings. By participating in this webinar/briefing, you agree that your communications may be monitored or recorded at any time during the webinar/briefing.

Attorney Advertising

Upcoming Webinar!

The Impact of Value-Based Purchasing and Other Initiatives on Population Health

- November 20, 2014 at 12:00 p.m. ET
- Featured Speakers:
  - Laurel Pickering, MPH, President & CEO of Northeast Business Group on Health
  - David Lansky, PhD, President & CEO of Pacific Business Group on Health
  - Adam Solander of Epstein Becker Green will moderate the session.

Keep an eye out for the webinar invitation!

Webinar Presenters

- **Julie O'Brien, RN, BSN, MS, Senior Vice President and Chief Operating Officer, Alicare Medical Management**

- **Sarika Aggarwal, MD, Executive Vice President and Chief Medical Officer, Fallon Community Health Plans**

- **Mark Lutes, Chair, Epstein Becker Green**

Presentation Overview

- This session will highlight several approaches to help manage populations to promote better clinical outcomes, more cost savings and enhanced patient satisfaction, and assess how much progress the federal and state governments have made in expanding health care coverage and bending the cost curve. Over the past 10 years, the medical management system has undergone rapid transformation. This session will focus on key strategies to improve population health, including topics like:
  - ✓ The evolution of utilization management programs
  - ✓ An overview of care management interventions to address complex medical, social and behavioral needs
  - ✓ The need to include prevention and wellness services
  - ✓ An integrated approach to health care delivery

Utilization Management (UM)

- UM is the evaluation of the appropriateness and medical need of health care services, procedures and facilities according to evidence-based criteria or guidelines
- UM describes proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals
- Can be used as a method of reducing medically unnecessary admissions or procedures by denying cases that do not meet criteria

The Rise of Utilization Management

- **1980s**: During the rise of managed care, some utilization review organizations earned a less than stellar reputation for denying care based upon subjective review criteria

- **1990s**: Proliferation of state legislation and the rise of URAC as an independent accreditation agency to promote more equitable and evidence-based workflow processes when medical necessity decisions are being made by health plans or their subcontractors

- **2000s-present**: UM programs are now a part of a larger, integrated care management system and platform. Medical necessity determinations often are made within a larger package of medical management services and interventions geared towards optimizing clinical and financial outcomes

Benefits of UM

- RN case ownership model in UM helps personalize treatment plans
- Referral to network providers
  - Review for eligibility and work with specific benefit limitations to maximize coverage
- Average return on investment (ROI) is $5.30 for every $1.00 spent on the UM program

The Role of Utilization Management in Case Management

- Ensure “medical appropriateness” or “medical necessity” of care
- Ensure patients receive the “right care at the right time” and lower costs
- UM’s goal is not meant to limit or restrict care, but to assure that appropriate care is received
- Over- or under-utilization can lead to lower quality of care with higher costs and health risks

Case Management (CM)

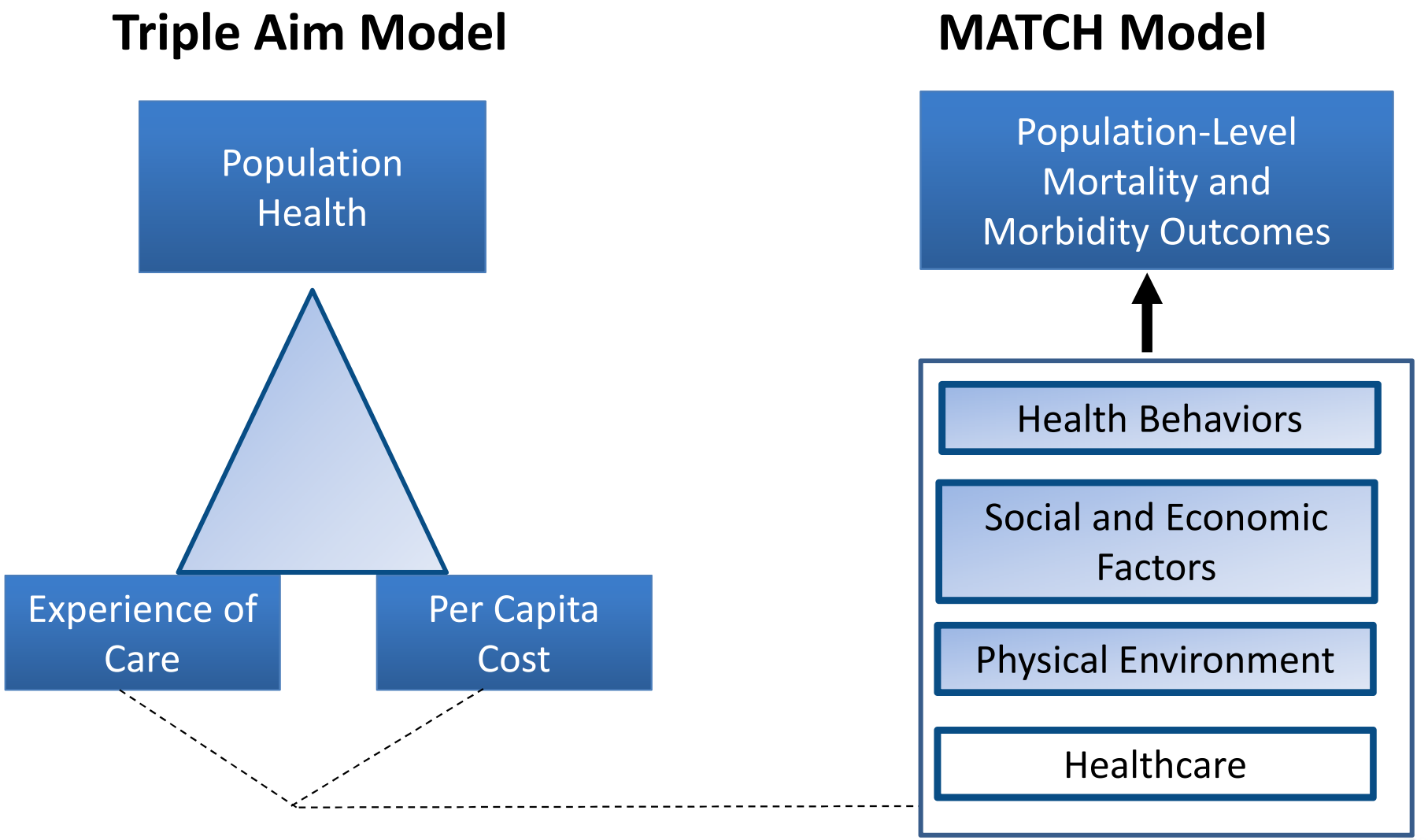
- Personalized intensive intervention designed to reduce costs and improve quality of care for high cost patients
- Certified case managers coordinate care for patients with high cost acute and chronic complex medical conditions
  - Focus on the “super utilizers” through a grand rounds approach
- Achieve cost savings through appropriateness of care, network direction and cost negotiation

Case Management Model Act

- The Case Management Model Act establishes the key elements of a comprehensive Case Management Program that should be implemented on both federal and state levels:
  - CM is a consumer-centric, collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes
  - CM serves as a means for achieving consumer wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation
  - Case management also supports the goals of value-based purchasing by promoting cost-effective strategies that best promote better quality, improved outcomes and higher consumer satisfaction

Source: The Case Management Model Act: Supporting Case Management Programs
http://www.cmsa.org/portals/0/pdf/publicpolicy/cmsa_model_act.pdf

Comparison of the Triple Aim and MATCH Models



Moving Towards a Preventative State: Behavioral Change is Key

- Behavioral change has become a primary objective in health care as the notion of moving towards a preventative state has becomes more prevalent
- Many chronic health conditions are caused by certain habits or behaviors (smoking, drinking, lack of exercise and poor diet)
- By educating patients and encouraging health-enhancing behaviors, the goal is to lower the unhealthy habits and behaviors, thus decreasing the likelihood of chronic diseases that are a result of the behavior–preventing the problem before it occurs

Diabetes: An Overview

- According to the CDC, diabetes impacts 25.8 million people, more than 8% of the U.S. population
- More than 7 million of the people affected by diabetes are undiagnosed
- The seventh leading cause of death in the U.S., diabetes is also a major contributor to heart disease, stroke, kidney failure, limb amputations and blindness
- In addition, the CDC estimates that as many 79 million adults–35% of the entire U.S. population–are pre-diabetic

Diabetes: The Financial Burden

- According to the American Diabetes Association, the total estimated cost of diagnosed diabetes in 2012 was $245 billion, including $176 billion in direct medical costs and $69 billion in reduced productivity

Diabetes: Treatment

- Diet management (Type 1 and Type 2)
- Exercise and lifestyle changes that impact the glucose cycle (Type 1 and Type 2)
- Insulin injections (Type 1)
- The CDC strongly recommends that patients with the disease be assigned a case manager to plan, coordinate and integrate care
  - Case management intervention and monitoring improves glycemic control compliance as well as physician monitoring

Diabetes: Innovative Management

- Innovative diabetes management can help reduce a patient's risk of developing complications from the disease, make them feel better, reduce dependence on medications and live a healthier lifestyle

Diabetic Case Study

- Build Strong Incentive Program – active members only
- Free access to medications and supplies
- Identified through psycho social and clinical assessment
- Care Plan created
- Results

Engaging Consumers in Health and Wellness

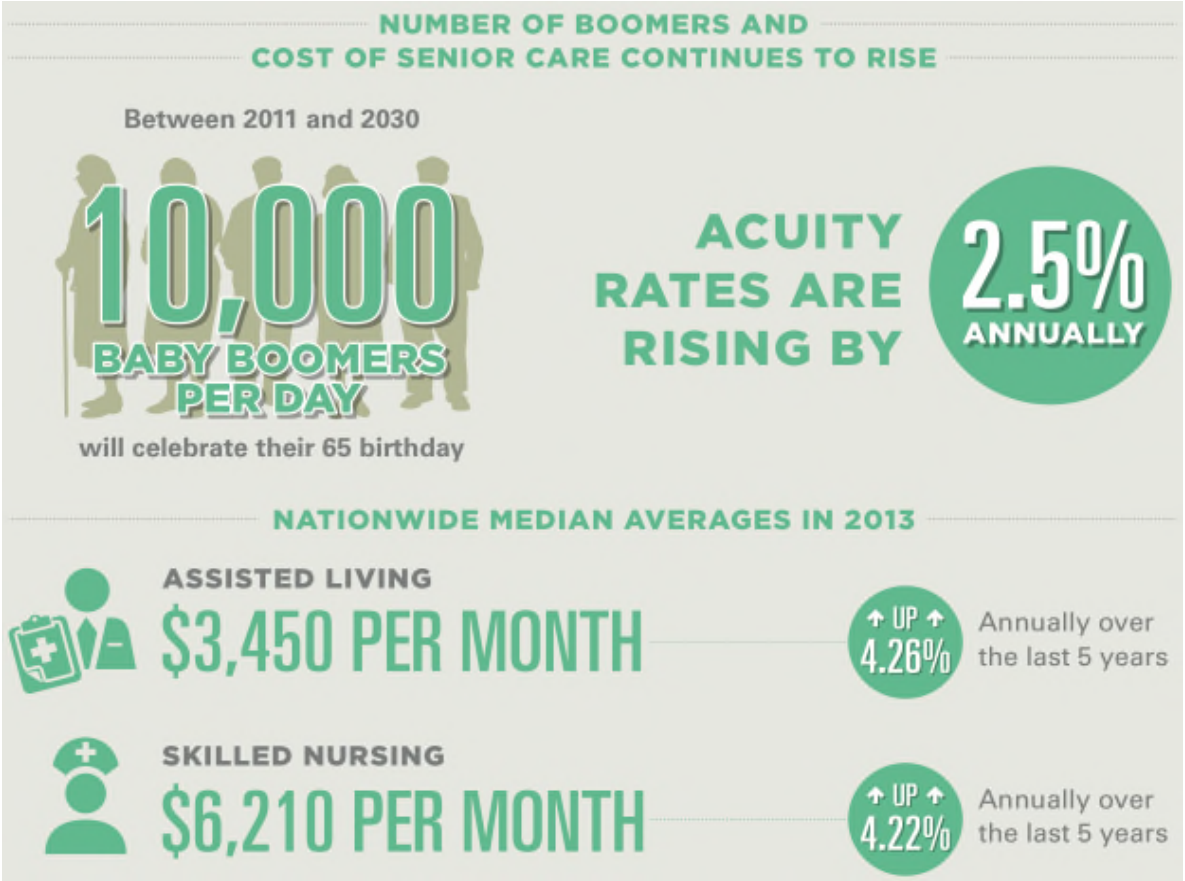
- As chronic diseases continue to drive up health care costs, moving toward a preventative care mentality will not only improve the health of the American public, but also boost the health of our economy.

An Integrated Approach to Delivery

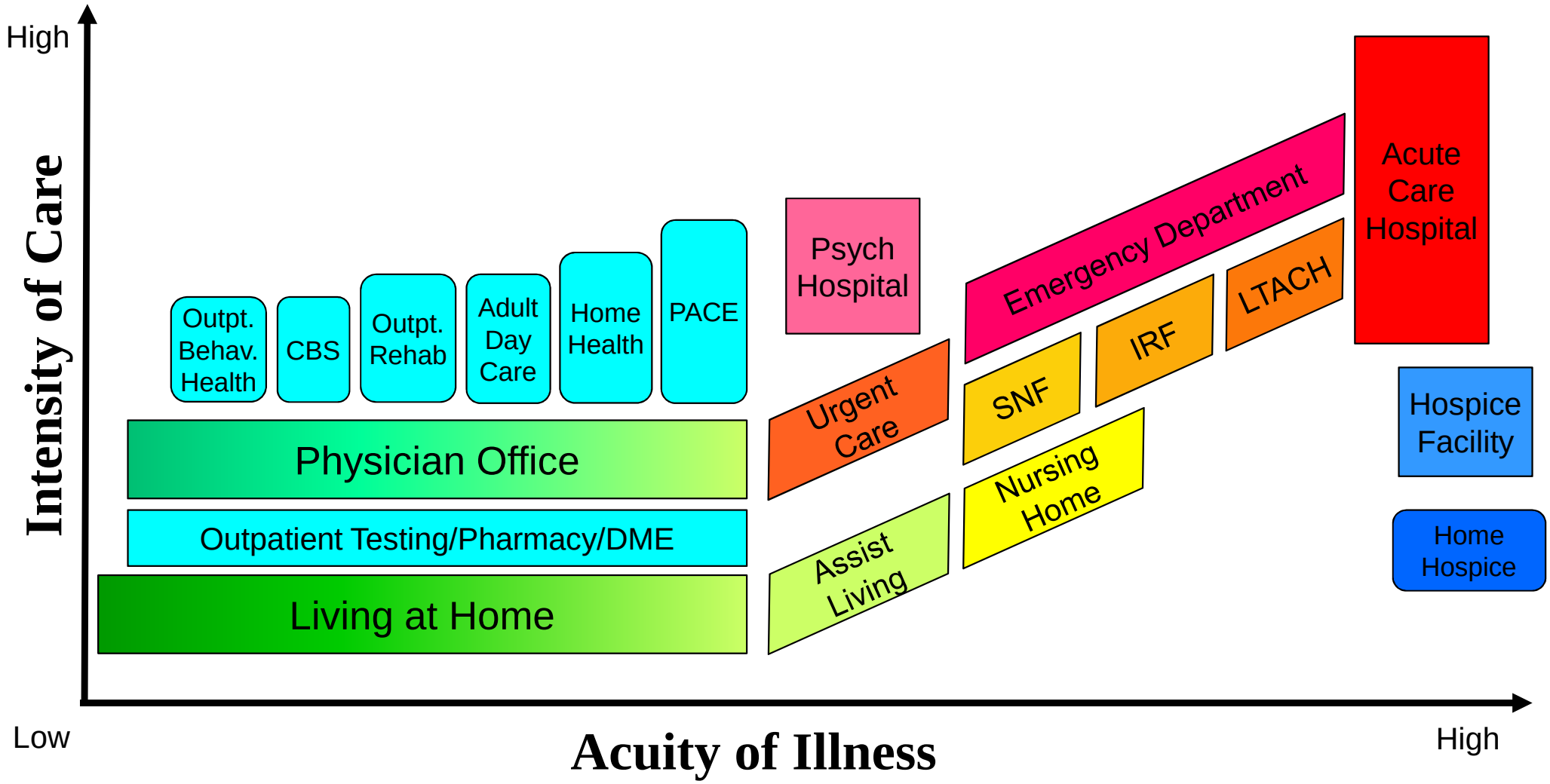
Health Care Trends

US Health Care costs $ 2.4 Trillion annually

- Rapidly growing senior population
- Rising acuity rates
- Higher cost of care
- Caregiver shortage
- Higher expectations of care

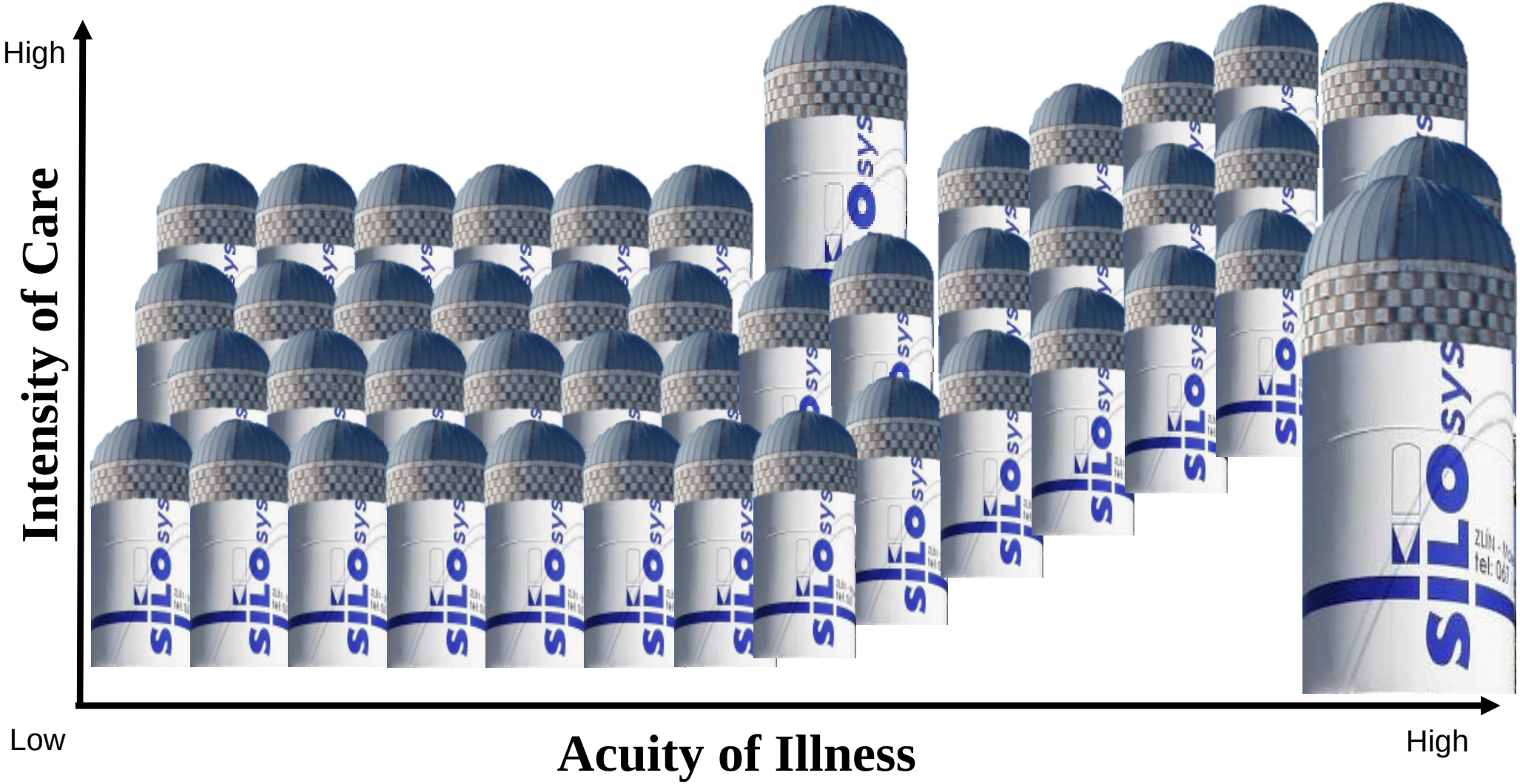


The Spectrum of Care is Vast…



Adapted from Derr and Wolf, 2012

…as are the Barriers to Care Coordination



Adapted from Derr and Wolf, 2012

Populations most at risk needing tailored care coordination

Frail elders, homebound	Individuals with social-environmental factors	Individuals with High Utilization	People with complex medical and/or behavioral needs
• High prevalence of chronic disease • Risk for falls • Risk for Neglect • Risk for institutionalization	• Low literacy and limited English • Food insecurity • Unstable housing • History of abuse or current abusive situation • Adults and children with lack of social supports	• Individuals with, or at risk for extensive pharmacy • Multiple ER visits • Multiple inpatient stays • Multiple stays in detox programs	• Severe physical disability • Multiple medical and behavioral comorbidities • Major medical issues • Severe mental illness • High risk pregnancy

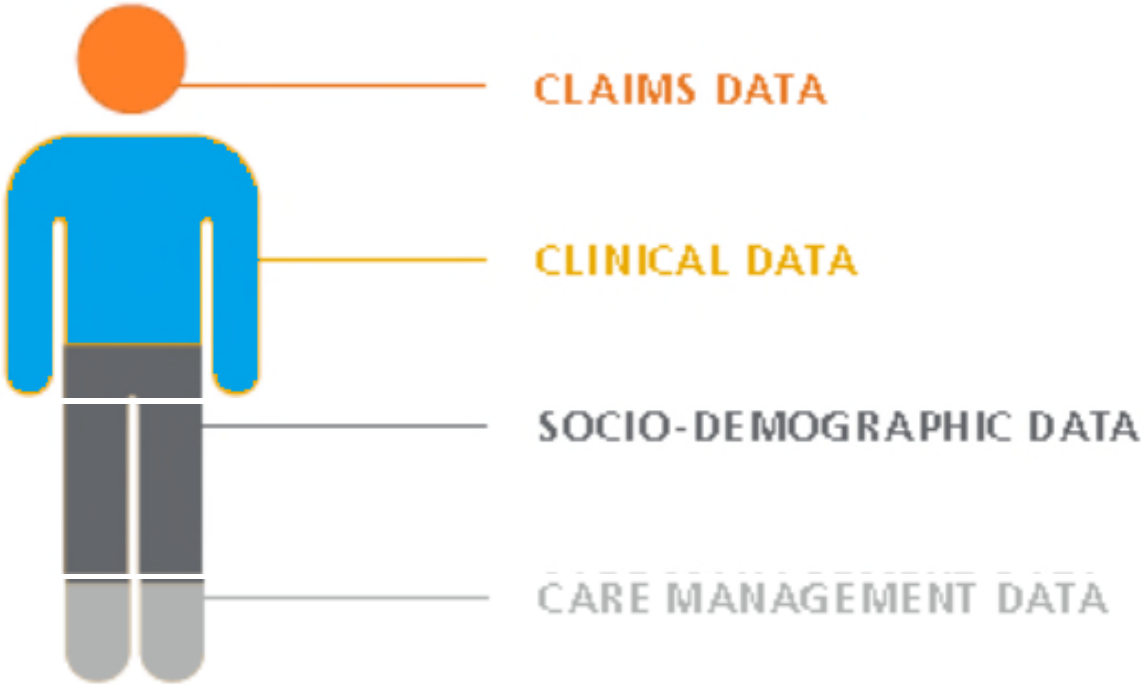
Identifying the Individuals

	Duals	MassHealth	Medicare	Commercial
Mode of Entry	HRA Tool	Multiple • HNA-C • Provider • Data mining • UM referral	• Multiple • Provider • Data Mining • UM referral	• Multiple • Provider • Data mining • UM referral
Membership	Medically complex • 21 through 64 • 65 and over	Across the continuum Birth through 64	65 and over	18-64
Case Management	Required	Voluntary	Voluntary	Voluntary
Individualized Care Plan	Required for all	Care Management Complex Case Management	Complex CM and Care Management	Complex CM and care management

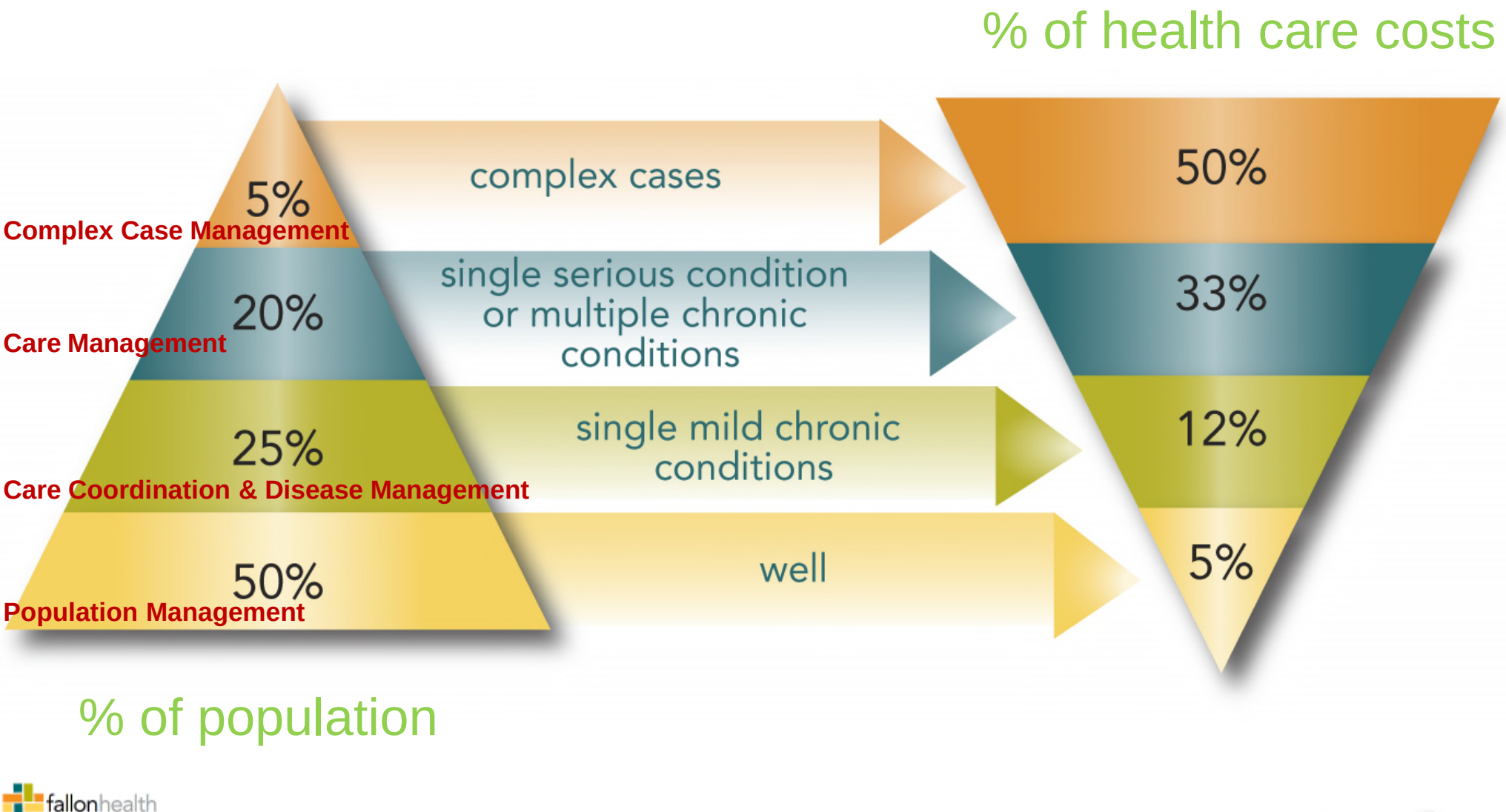
An Integrated Approach

An integrated approach to complex conditions management includes chronic disease management and wellness and health promotion using a case management/health coaching model

An Integrated Approach
Marrying Data Enhances Insight !



Program Pathways



fallonhealth

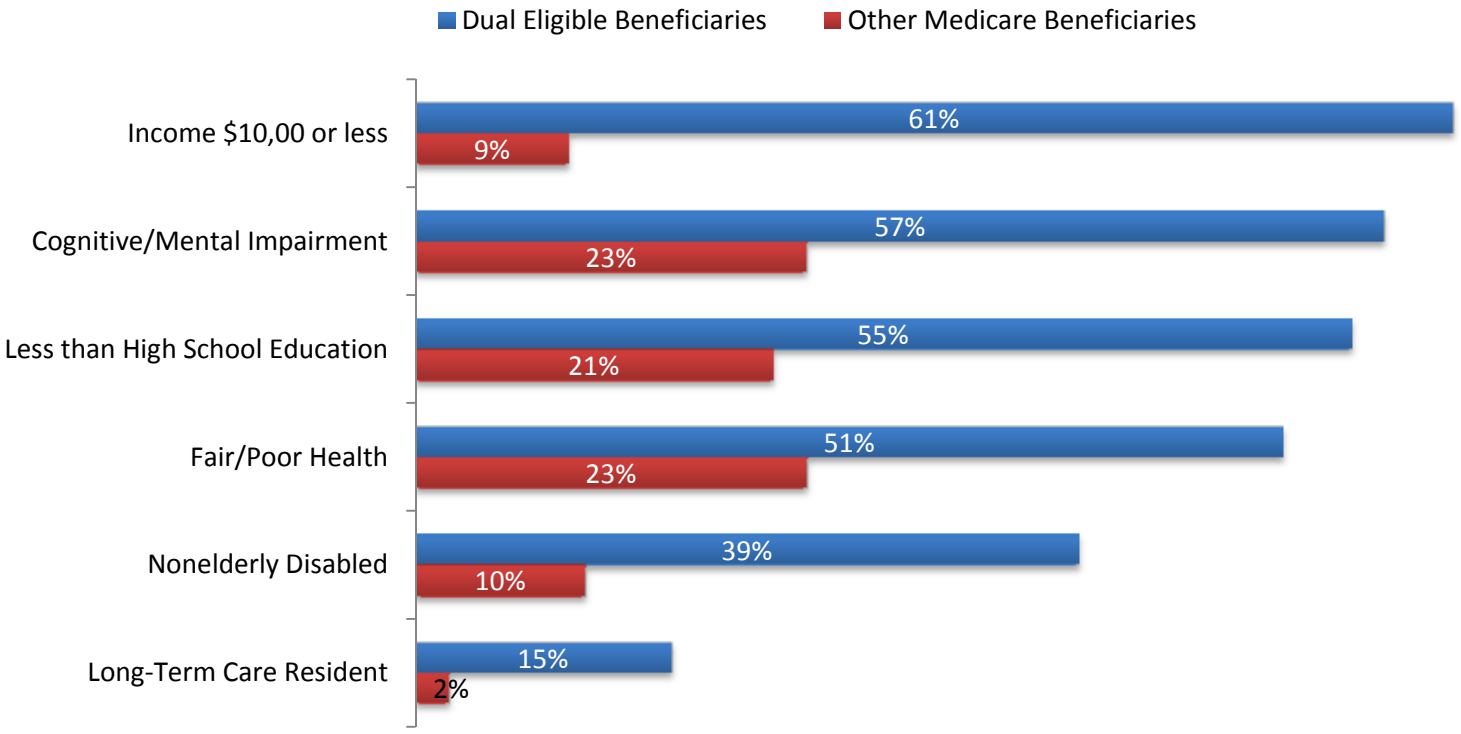
ebg ADVISORS EPSTEIN BECKER GREEN

thought leaders in
POPULATION HEALTH
Identifying implementation tactics

The Dual Eligible Problem

- What are the duals and what is the problem?
  - Duals: Medicare and Medicaid eligible (population of 9 million)
  - 13% of Medicare and 34% of total costs of the two programs' total spending on those enrollees ($250 billion)
  - 61% have income below $10,000 compared to 9% of Medicare

Comorbidity among Duals



Total = 7.5 Million Dual Eligible Medicare Beneficiaries

Source: Kaiser Foundation analysis of the Medicare Current Beneficiary Survey, 2006

fallonhealth

Dual Eligible Targeted Populations

Fallon Total Care: 21-65 years

- Community Dwelling: 96 %
- Use of Institutional LTSS: 30 %
- Behavioral Diagnosis 70 %
- Serious Mental illness 35 %
- Developmental disabilities: 13 %
- Substance use disorders: 28 %
- Asthma 26 %
- Diabetes 23 %
- CAD 16 %
- Data by EOHHS

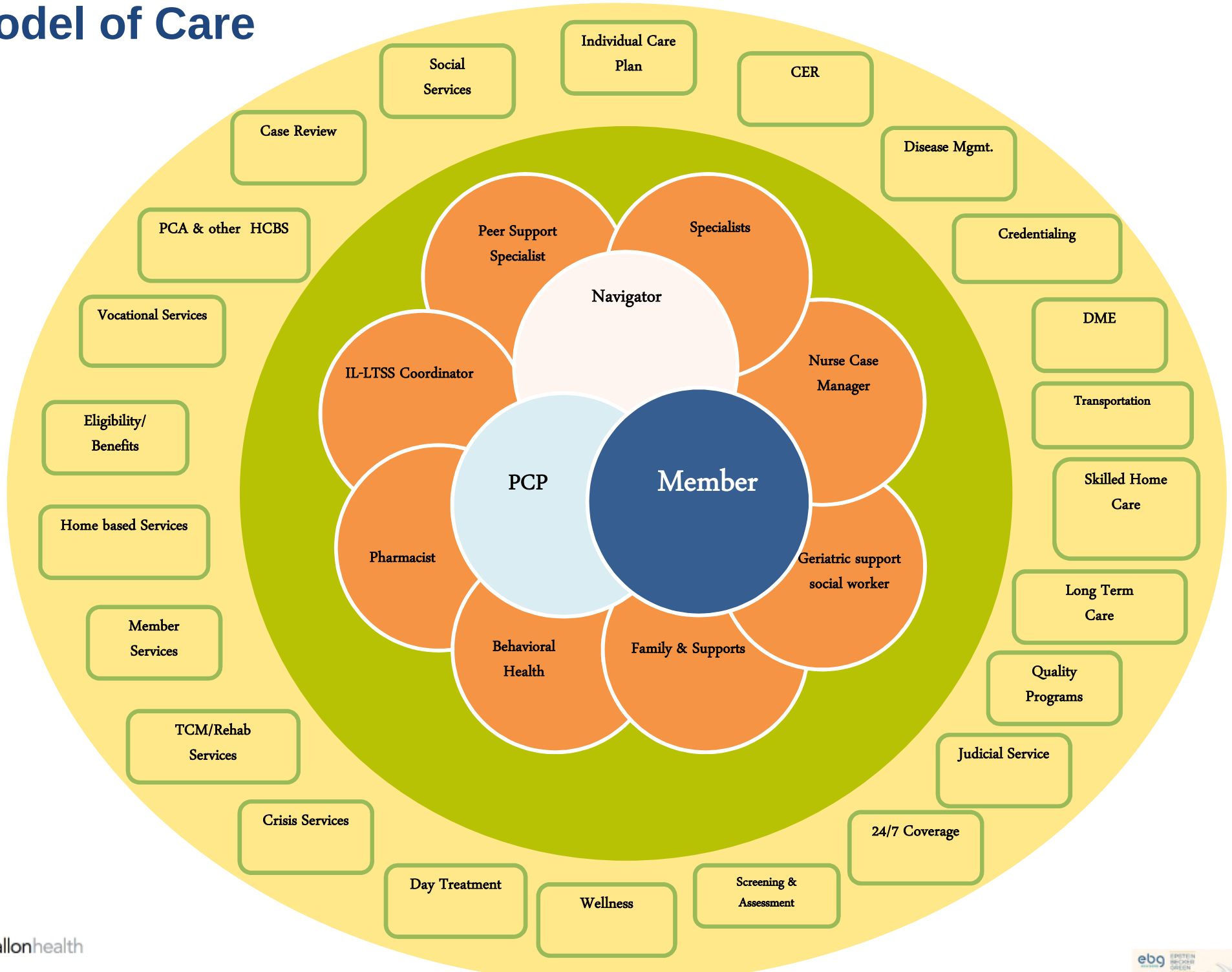
Navicare: > 65 years

- Community well: 10 %
- Nursing home certifiable: 65 %
- Institutional: 10%
- Chronic mental illness/Alzheimer: 10%
- Diabetes: 45%
- COPD: 35%
- CHF/CAD: 25%
- Depression: 30%
- Data by Navicare

Program Goals
Member Centric to Member Directed

- Coordinate Medicare and Medicaid benefits
- Integrated medical and behavioral health care management
- Support keeping members independent in the community
- Highly collaborative provider relationships
- Increase access , quality and member satisfaction
- Transitions of care tightly managed
- Increase cost effectiveness

Model of Care

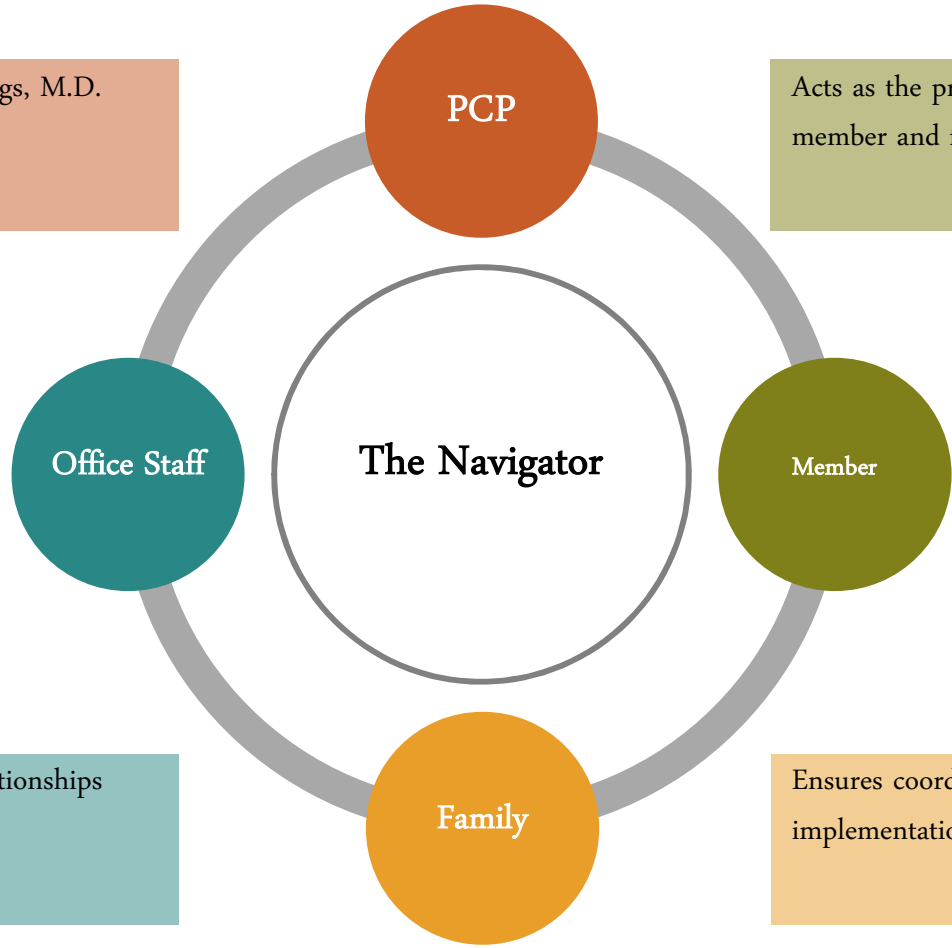


fallonhealth

ebg EPSTEIN BECKER GREEN thought leaders in POPULATION HEALTH

Reach and engage → Home visit assessment → Plan of care development → ICT meeting → Plan of care implementation

Facilitates Primary Care Team meetings, M.D. appointments, referrals



Acts as the primary contact for PCP, office staff, member and family members

Makes in-home visits to establish relationships with both the member and the family

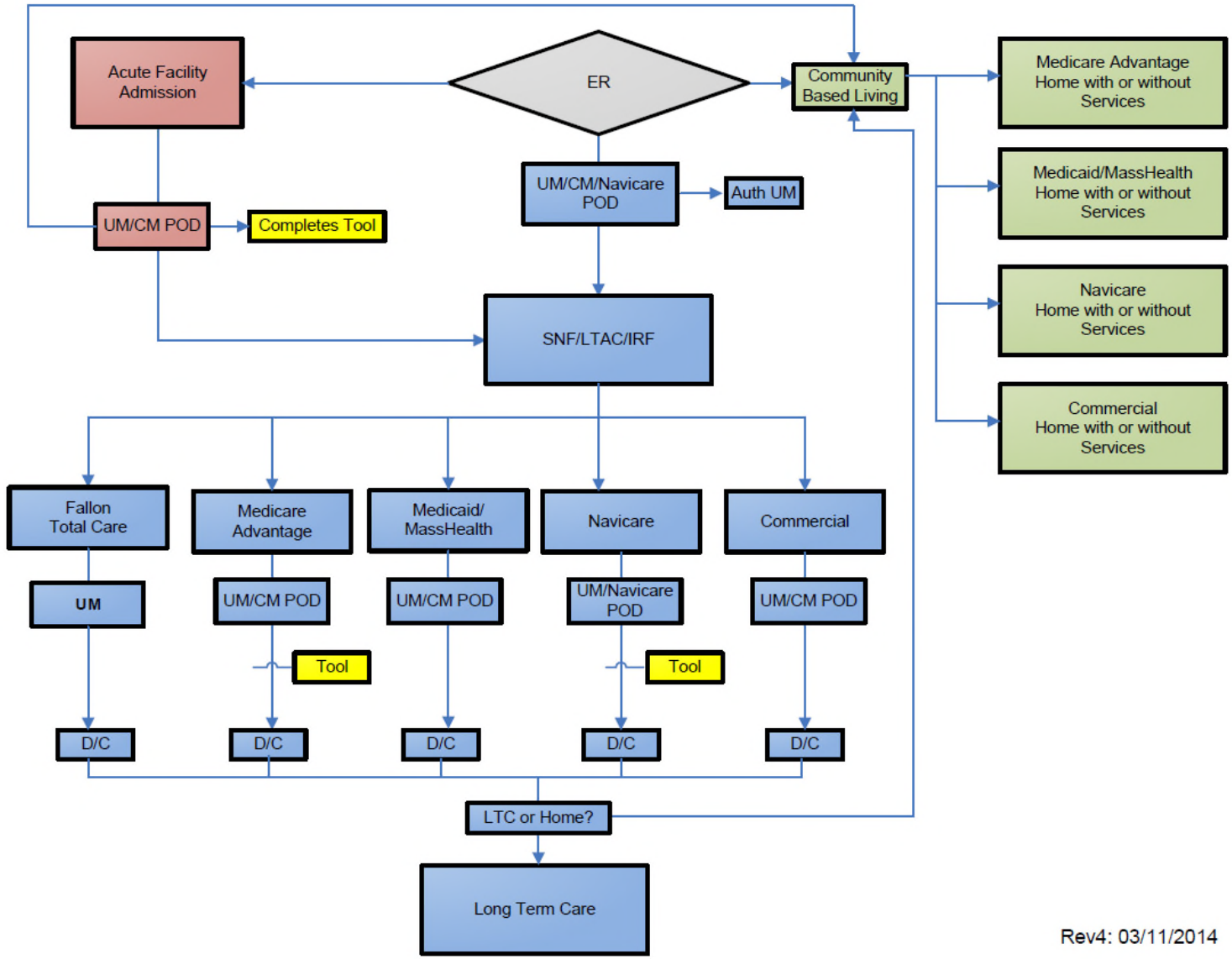
Ensures coordination of care, implementation of services

fallonhealth

eNeighbor® Remote Monitoring and Healthsense Technology

- Call pendant & 10 sensors
- 24/7 oversight
- No cameras or microphones
- Telephone & email alerts
- Check-in or reminder calls
- Early care intervention

Transition of Care: Integrated UM/CM Model



Rev4: 03/11/2014

Transitions of Care: Acute to Home

NAVIGATOR DUTIES

- Notify PCT
- Assist w/ F/U appt. (w/in 30 days).
- CER Task to self – Member kept f/u appt.?
- Resume Home services
- PCT meeting w/in 7 days (initiated by RN)

RN DUTIES

- F/u w/ member in 2 business days via phone/home visit
- Medication Reconciliation
- Assessment of member knowledge/understanding of d/c plan.
- Teaching as appropriate.
- Re-Assessment of home services and needs

Elements of Safe & Effective D/C

- Education/training
- Accurate information
- Medication Reconciliation
- Transportation
- DME
- Transition of care between providers
- Auditing of transitions

NaviCare Case Study

- 77 year-old male enrolled in NaviCare program in May 2012
- PMH of COPD, HTN, CAD, A-Fib, history of alcohol abuse
- Member hospitalized monthly and seen frequently in the ER from August–December 2012
  - Multiple risk factors for ER visits include: poor symptom control and limited support
- Hospitalizations due to pneumonia, MI and bronchial infections
- Member wishes, "I want to enjoy the life I have left"
  - Better symptom management and to live independently as long as possible

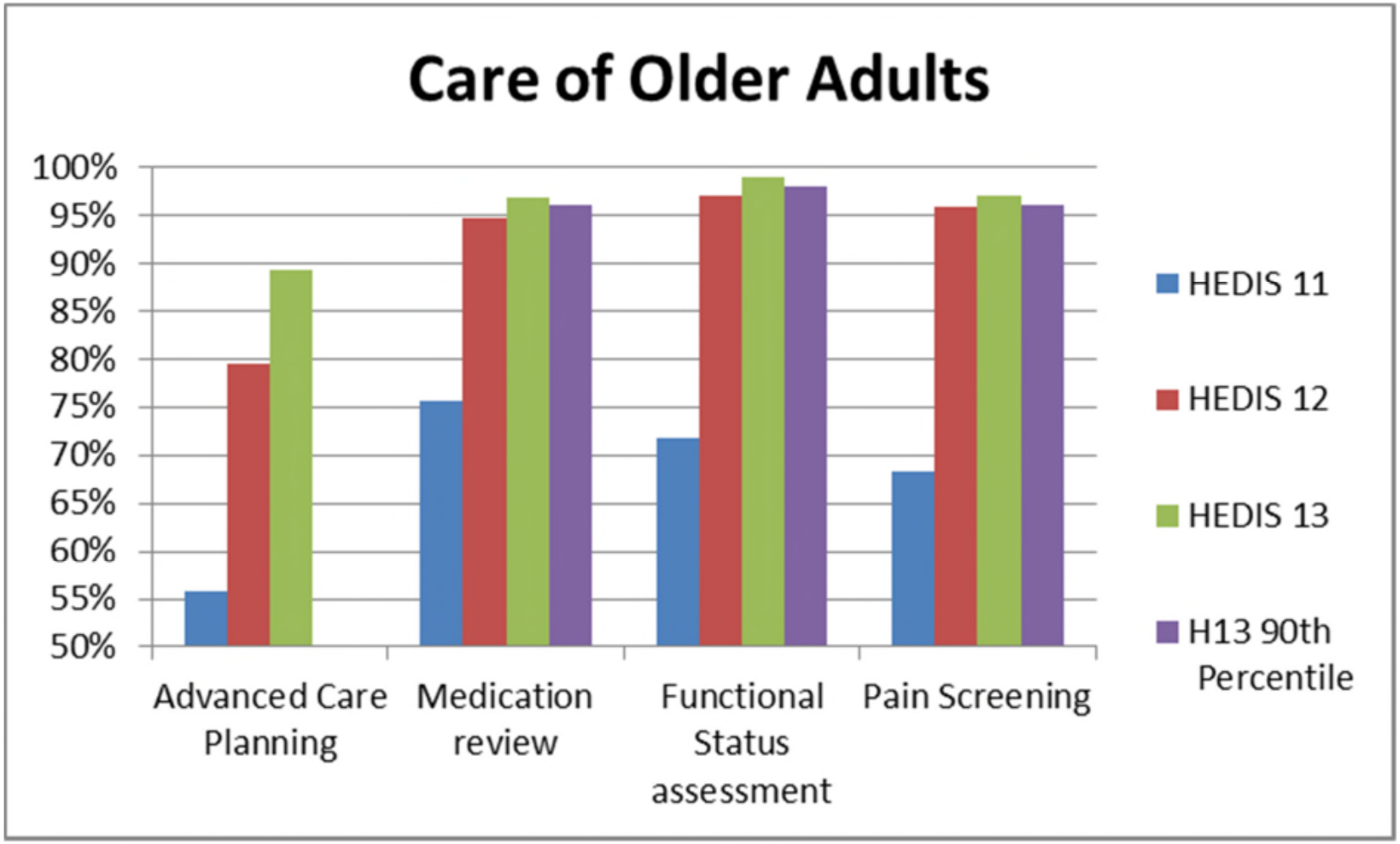
Comparison of NaviCare vs MA Duals > 65

NaviCare		
Acute	Admits/1,000	323
Acute	30 day readmission %	19.5%
SNF	Days/1,000	2,090
CMS RAF Score	Normalized	1.00

5% Massachusetts Dual, institutional and non-institutional, weighted to NaviCare institutional mix, members age 65+		
Acute	Admits/1,000	334
Acute	30 day readmission %	n/a
SNF	Days/1,000	3,782
CMS RAF Score	Normalized	1.00

Average RAF Score for NaviCare Patient: 1.76
Average RAF Score for Dual > 65 per Milliman: 1.48
ALOS SNF for NaviCare 2013 Calendar Year: 14.8 Days

HEDIS Outcome Measures for NaviCare



Clinical Rounds for Clinical team

- SNF rounds, Family team meetings
- Interdisciplinary rounds
  - Behavioral health
  - ED utilization rounds
- Acute Inpatient huddles
- Didactic rounds on medical topics
- Huddles with the provider groups

Questions

Upcoming Webinar!

The Impact of Value-Based Purchasing and Other Initiatives on Population Health

- November 20, 2014 at 12:00 p.m. ET
- Featured Speakers:
  - Laurel Pickering, MPH, President & CEO of Northeast Business Group on Health
  - David Lansky, PhD, President & CEO of Pacific Business Group on Health
  - Adam Solander of Epstein Becker Green will moderate the session.

Keep an eye out for the webinar invitation!

ebg ADVISORS

EPSTEIN BECKER GREEN

thought leaders in

POPULATION HEALTH

identifying implementation tactics

Mark Lutes
Epstein Becker Green
mlutes@ebglaw.com
(202) 861-0900

1227 25th Street, NW
Washington, DC 20037
www.ebglaw.com

Julie O'Brien, RN, BSN, MS

Sarika Aggarwal, MD

ebg ADVISORS

EPSTEIN BECKER GREEN

thought leaders in

POPULATION HEALTH

identifying implementation tactics

THANK YOU

www.ebglaw.com
www.ebgadvisors.com