Institute for Healthcare Improvement

# Innovation Project Final Report:
# Healthcare Organizations and Population Health Management IV
# Wave 33
# December 31, 2014

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**Intent & Aim:**
The intent of this work is to help health care organizations make the transition from their present state to the next step in the their population health management journey. Regardless of the financial models, which may change over time, population health management is here to stay for health care organizations.

**Why IHI:**
IHI uses a collaborative style and model that helps organizations learn their way through issues and build skills. We bring experts in the field and organizations together, guided by a flexible model that will produce results over time.

**Background:**

The US health care system is changing because of both national and state level initiatives that are impacting payment models. These payment changes are occurring in both public and private insurance. One current example is an accountable care organization (ACO), which has some small rewards or penalties, depending on the specifics of the plan, for health systems and physician groups. The ACO provides some incentive for population management/medicine.

In support of population management for health systems, we proposed some basic components in earlier work: primary care, care management of complex patients, data support, governance, contracting, physician network management and community involvement. However, these basic components will be inadequate without an overall strategic approach. Our work with health systems directly, plus research and development at IHI have helped us develop an approach that starts with identifying a population, creating governance and purpose to support that population, understanding the needs and assets of populations which will lead to a portfolio of projects and finally developing a learning system to manage the projects and the overall work.

## Financial and Care Model to Support Population Medicine

Another important aspect for making the transition from health care to population management/ medicine is leadership for this transition. A team at IHI successfully developed a population management executive development program. That course focused on 5 high level drivers for leaders:

Demonstrating effective leadership
Integrating data systems to support performance improvement
Building a robust improvement infrastructure
Engaging providers and community stakeholders
Leveraging financial models to achieve cost and quality targets

This work is set in the backdrop of what is occurring in health care systems today.
Over the years there has been consolidation of health systems, and hospitals and organizations and they are still working through those issues. There is cost pressure on these organizations. Many have invested capital in population health management but so far have had little or no financial return. Some continue to bear substantial cost from physician practices, anywhere in the order of $100,000 to $200,000 loss per physician. There are significant pay issues for physicians, particularly primary care doctors. They are still being paid on RVU basis, which does not work well when you are asking for population health management. Lastly some Insurance payers do not want to change their financial models, particularly when they have a dominant market share.

**Results:**
Based on interviews, prior work with organizations through the Triple Aim collaborative and ongoing work with organizations, we do not think that there is one common path for health systems as they develop population health management. Some have argued that health care payments might progress from pay for performance to medical home payments to bundled payment then risk sharing and finally full capitation. However health system may choose to start in different places and jump around with different types of payment models. There are at least four high level issues that health systems should consider: What population do they want to work with? What type of financial model makes sense for the chosen population? Do they have enough clinicians, particularly primary care support, for this population? And can they get access to enough data to assist their work?

**Example one**
A health care system started by working with their own employees. They are self-insured and use a third party administrator to handle their claims. The financial model is full risk since they are self-insured. Any potential savings will go directly to decreasing overhead cost for this organization. Their first step would be to gather more information on needs of their own employees through interviews, claims data and clinician input. It might be surprising to learn that

it is often difficult to get data back from a TPA. From the data they can segment the population into three or more risk segments and do a more detailed needs assessment for each of the groups. Based on this detailed assessment, a set of projects will arise. Some of the projects may impact all segments and some may impact just one segment. A sample set of projects; benefit design of health insurance, employee health coaches and intensive support for high cost individuals with an ambulatory ICU model. One of the particular issues that is likely to turn up for an employed population is a significant use of specialty care. If not managed well, this will lead to higher cost and fragmented care. Here is where primary care can make a difference in managing the coordination of specialty care.

The question for each example is: If you are successful with population health management for your initial population, health systems, employees, what is the next logical population to extend your model to? In this case, it may be to work with other employers to help care for their employees.

**Example 2**

The State of Oregon created 15 regional Coordinated Care Organizations (CCO) to control Medicaid health care spending. A health system in a CCO used this opportunity to take on full capitation for all hospitalization for 50,000 Medicaid recipients in their community. They also had some successful prior experience with managing their own employees' healthcare. The Healthcare System saw the CCO risk contract as another opportunity to expand their population management skills. A Medicaid population has some different needs than a commercial population. After doing interviews of patients, reviewing claims data and talking with clinicians, they will find some significant behavioral health and social support needs. . As the health system segments the population and develops their portfolio of work they will need to consider these specific needs. With a population this large, it would be good to consider physician alignment to support this population. So a sample portfolio for this population might include: primary care integration with behavioral health, community health workers to support complex care patients, integration of social supports systems, capitation payments to primary care along with value based pay to specialists.

The next step for this organization could be further expansion into the employer market because they had some past experience or a Medicare ACO.

**Example 3**

The starting place for some health systems is a Medicare Shared Saving Program (MSSP). The Medicare Shared Saving Program initially has less risk because at least in the beginning you share the savings if there are any and if there is loss Medicare covers that. However even with a plan like this you still have risk because of the capital that you need to invest before you save money. At this point in time 25 % of participants are achieving enough savings to be rewarded.

A big opportunity with a Medicare population is post-acute care. There is a great deal of variability in this area that leads to a significant amount of spending in post-acute care. Better management of this can lead to significant savings. Therefore one part of a portfolio of work with a Medicare Population should be post-acute care because that is a high spend location. Another part of the portfolio could be to look at high spending individuals and their needs. These individuals will have some different needs than either the commercial or Medicare population. Many of these individuals will be in the last two years of their life. They will have a unique set of needs and by supporting them better you have an opportunity to improve care and manage cost. Other parts of the portfolio will include specific work with primary care to support this population and like all populations you will need good data.
The next step for a system that takes on MSSP and is successful is to expand the level of risk they take. The original rules for MSSP stated that after three years they were required to share both loss and gain. Some new changes may make it easier for poor performers to postpone taking on downside risk for another year and for a good performer to receive a higher percentage of the savings when they take on upside and downside risk.

**Example 4**
A large health system with many hospitals nationwide had tried working with Medicare Shared Savings but had minimal success. They found that managing the provider side of their organization was very challenging. They felt that an alternative approach was to create a series of Medicare Advantage Insurance plans across the US. The thinking was that they would be better able to manage population risk by owning the insurance for the population. This is still a work in progress so it is not clear how successful this work will be.

These four examples illustrate that there are different starting point for a health system. The key is to start with a population and have a financial model that will reward the system for population health management**.**

**Guidance on what will lead to sound population health management.**

A lot of good material has been written around how to manage population health including work we have done for IHI. The items we list below are meant to be a short list of key items for consideration as you work with populations.

1.A financial model in which to learn how to manage populations and receive financial reward

2.Acess to the data and a team who can use this data to support populations.

3. Robust primary care relationships along with specialty care relationships that are rewarded for population management and have the ability to manage populations.

4. Off-the-shelf programs/planned care methods that can address various population segments that you can customize to your local environment for at least Medicare, Commercial and Medicaid populations

5. A learning/leadership system that can pull all this together and that creates adaptive learning. The work of Tom Nolan and Derek Feely around distributed leadership and the learning system would be very important .

6. A mental model that sees population management as important for the future of the health system.

**Conclusions and Recommendations:**

The important learning that IHI has from our work is that you need to begin this work a focus on populations and complimentary payment models that reward population health management

IHI has present products that can help systems make the transition.

1. Executive Course on Population Management
2. Population management Core Issues - formerly Triple Aim Seminar
3. Web in Action series for Triple Aim
4. BHLC

***IHI could introduce two new products***

We could have a course on population data management for health systems. Even though we don't spend too much time in this paper on this subject we do have some expertise in this area. Jacquelyn Hunt a former IHI fellow spent a year putting together a paper which will be published

soon on this subject. The work that Bellin has been doing in this area is important. We have contact with other faculty like Susan Knudson at HealthPartners and  Gordon Moore.

The second and I think most important new offering would be a collaborative learning network for health systems and IPA's on population management. Appendix A is a simple self-assessment questionnaire to help organizations think through a few  issues. Appendix B is a set of requirements for organization that would be part of this collaborative work. Based on work from the Triple Aim we could frame out a learning structure for this collaborative if this work is supported by leadership

Open Questions:
1.What knowledge or skill is IHI lacking to help health systems transition from fee for service to some form of risk sharing?

**Appendices:**

*Appendix A Assessment tool*

Health systems are being pressured for change on multiple fronts. Probably one of the biggest challenges deals with new payment models. The new payment models are encouraging health systems to manage populations. There are a lot of detailed surveys available to see if you have the necessary components to take on population management such as: primary care, care coordination, data systems, physician networks etc. These types of surveys are important, but we wanted to provide some questions to help you think through the issues you face.

1. What business are we really in, health care production or health production?

2. Does managing population health/ population medicine fit with our mission, vision and values?

3.How much of our present payment is some form of fee for service? And what % of our revenue comes from risk-based contracts?

4. How long do we anticipate the fee for service model will continue at this rate?

5. What population management skills do we think we need today and into the future?

6. Why we think managing populations is important to our future?

We believe that there is a series of "transition states" as you move from fee for service to better population management skills. These transition states deal with payment models, populations, providers and infrastructure. We won't be asking about infrastructure in this short questionnaire. There are a number of good survey tools that can help you with that.

7. Do we have strong provider relationships that can deal with change?

8.What payment opportunities do we have to work with for population management: ACO's (either public or private), develop our own Medicare Advantage plan or manage populations that we are already at risk for like our own employees?

9. Every payment model supports the care for a particular population: Medicare, Medicaid, commercially insured and special opportunities like your own employees. How much do we know about the needs and assets of those populations? For example a commercial population may overuse specialty care, a Medicaid population may need more behavioral health support and a Medicare population would have more end of life issues.

10 Some important business considerations that we should answer as we move forward with this work

A. Sequencing: What do we take on first?
B. Contracting: What will the payers support?
C. Cash flow: How will we fund new initiatives? How much do we have to invest up front? How long will we have to wait for return?
D. Scope: Single payer or multi-payer?
E. Compensation: How will we incent performance? [1]
F. What will we do with the money that we save? Probably should have a plan up front.

*Appendix B Learning Network on Population Medicine/ Management*

Objective: To start or accelerate the work of Health Systems and IPAs on Population Medicine/ Management

Population and business model: All organizations that participate would need to select at least one population and a financial vehicle that will reward them for improvements in health, health care experience and per capita cost.

Data: Ideally, each organization would have access to claims data for their population. If they don't have actual claims data, they would need utilization data. It would be good if they had a risk stratification tool to sort populations into different risk-based segments. They need to be prepared to interview and work with patients in the specific population to gain a better understanding of needs and assets of the given population.

Physician Network: The organization will need both primary care relationships and specialty network that are rewarded for managing populations. This network will need to adapt to the needs of specific populations.

Leadership Issues that need to be worked out: Governance, Purpose, creating a portfolio of work and overseeing the execution of this work by developing a strong learning system.

1. Presentation at the Population Management Executive Development Course presentation by Al Kurose, MD, FACP on Leveraging Payment Models to Achieve Clinical and Financial Targets