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Population Health NEWS

Social Determinants and Health Inequities' Chilling Effect on Business

by Mark Steffen, MD, MPH, vice president and chief medical officer of Blue Cross and Blue Shield of Minnesota

In Minnesota, our all-season, go-to topic is the weather. Some claim our frigid winters have a Darwinian effect that works to our advantage. Only the strongest survive until spring.

But what has really put people out in the cold are some of the greatest inequities in the nation that are embedded in our state's socioeconomic climate, effecting our health, well-being, and overall way of life.

Today, to our common discredit, social and economic disparities separate those who have health opportunities from those who don't. The strongest predictor of health disparity is race.

As a doctor and chief medical officer in Minnesota's largest health plan, I am troubled by the fact that only 10 percent of health is the direct result of clinical care. So much is beyond the reach of medicine and access to care.

Instead, health is largely shaped by our environment, behaviors – and social and economic factors. The social determinants of health.

For no biological reasons, people of color and American Indians are at much higher risk for serious health conditions like obesity, cancer, diabetes and heart disease – as well as mental health conditions.

(continued on page 2)

Are Alternative Payment Models the Future?

by Moshe Starkman

Ask a dozen people "Has quality care become less expensive in the United States?" and you'll get a dozen answers, ranging from an emphatic "No!," to an equally confident "Yes." All things considered, the most appropriate answer may simply be "Not yet."

One could be curious as to why the question above results in such a broad spectrum of responses. The answer lies in the fact that we haven't figured out what works best for each respective care necessity. For example, let's contrast Medicare's bundled payments initiative.

On the positive side, "a 2019 survey from the *New England Journal of Medicine* compared 280,161 hip- or knee-replacement procedures in 803 hospitals with 377,278 procedures in 962 control-group hospitals, and found a spending decrease of $812, or 3.1 percent, per episode in CJR hospitals."[1]

However, a 2018 study in the *New England Journal of Medicine* suggests that cutting costs with bundling is not as simple for non-orthopedic conditions. Looking at just the five most commonly selected medical conditions in the Bundled Payment for Care Improvement (BPCI) initiative from 2013-2015, which include congestive heart failure, pneumonia, chronic obstructive pulmonary disease, sepsis and heart attack), there was no significant difference in cost reductions or quality changes between participating hospitals and control group hospitals.[2]

(continued on page 3)

In This Issue

Coming in October's Medical Home News Supplement

- **Blue Cross Blue Shield of Michigan updates progress in its medical home initiative**
- **An examination of results from the Multi-Payer Advanced Primary Care Practice demonstration project**

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Editor's Corner

Greetings readers of *Population Health News*! Thank you for subscribing to this important publication. We are pleased to be bringing you another excellent edition filled with insights from industry experts and insiders. As always, if you have any questions, comments or concerns please don't hesitate to contact me personally.

Kind Regards,

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Social Determinants and Health Inequities' Chilling Effect on Business

... continued from page 1

The diabetes rate among American Indians, for example, is 400 percent higher than the general public. For African Americans, the rate is 150 percent higher. American Indian and African American babies are dying at twice the rate of white babies.

And the seeds of health inequity are everywhere. It's in some communities' unsafe water. In neighborhoods without recreational opportunities, housing, reliable public transportation or access to quality daycare and good schools. It's in low-income households where families live in a constant state of food insecurity – and unrelenting anxiety.

That deep disparity is morally repugnant. It flies in the face of basic fairness and speaks to our values.

It also reinforces the need for every sector of society to commit to addressing these challenges, but not just the usual contributors – nonprofits, healthcare organizations and social services – but businesses too.

> ***"The diabetes rate among American Indians, for example, is 400 percent higher than the general public. For African Americans, the rate is 150 percent higher."***

Aside from the profound moral imperative to ensure health equity, our shared success depends on the health of the whole human family. This is because the people and communities most affected by inequity will soon be "the primary demographic engine of the nation's future growth," according to the Brookings Institute.

September 2018 U.S. Census Bureau population projections show that today's racial minorities will tip the demographic scales by 2045. We can't afford to deny equal health opportunities to most of our people: our future community-builders and workers.

The face of Minnesota is changing, too. Today our state has the largest Somali population in the nation. St. Paul has the largest Hmong population per-capita in the nation. We are also home to a thriving Vietnamese community, as well as many emigrants from the former Soviet bloc.

By 2035, one-fourth of our state's population will be people of color. If we do nothing to address the social determinants that are driving such inequities, it will take a toll on 1 in 4 of our state's population in the form of absenteeism, lower productivity and higher healthcare and benefit costs.

Our country is reaching near-record levels of employment. And growing numbers of baby boomers are retiring every day, leaving the workforce. In Minnesota, businesses are projected to face a continuing shortage of skilled workers in the coming years.

We will need more people – from all communities, and from all cultures – to fill jobs, contribute to our communities and support their families.

The interests of the business community intersect those of the community at large. Business will benefit hugely from health equity.

(continued on page 3)

Social Determinants and Health Inequities' Chilling Effect on Business … *continued from page 2*

Blue Cross partnered with the University of Minnesota on the cost of such inequities in 2018 called the "Economic Benefit of Achieving Health Equity in Minnesota." It projects that healthier and more productive workers would save our state $2.26 billion annual in increased employment and decreased absenteeism.

Private-sector employers are in prime position to influence individuals' health, since people spend one-third of their lives in the workplace.

I believe we have the will to level the playing field for health – and companies are finding the way. Some national business leaders are publicly accepting responsibility for their role in health equity.

> ***"Private-sector employers are in prime position to influence individuals' health, since people spend one-third of their lives in the workplace."***

Companies like IBM, Johnson & Johnson, Verizon, Ford, General Motors and Toyota are now collaborating in a joint, multi-year program between Harvard's public health and business schools to advance health equity or focus in on addressing the challenges of the social determinants of health.

Blue Cross through its Center for Prevention and Foundation has a long history of community informed and driven initiatives that address social determinants and strive for greater equity. Investing resources from Minnesota's historic tobacco industry settlement, the Center for Prevention has countless examples of solutions to our state's health conundrum. Its Health in All Policies (HiAP) initiative sought to tackle the social determinants of health by funding multiple communities to incorporate health equity into decision-making, systems and policies across multiple sectors. This community led HiAP funding initiative has been transformative for major institutions like the Minneapolis Parks System, the City of Duluth, health systems, Metro State University and others, promising to promote future positive health outcomes for all Minnesota communities. The Center has also partnered with Minnesota Communities Caring for Children, to increase awareness in American Indian communities about the link between trauma and adverse health outcomes.

Equally the Blue Cross Foundation has honed their resources in early childhood education, community safety, and access to coverage- the social determinants of health that influence future health outcomes long before the need for medical care. Their recent five-year effort to increase access to insurance coverage across the state that profoundly impacted tens of thousands of Minnesotans and their families.

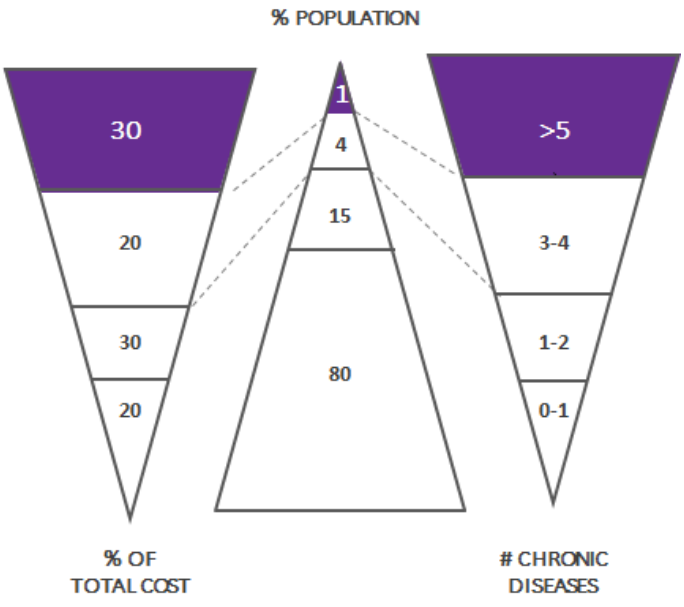
A report on health inequities, published in the *Lancet*, warned that if we do nothing to "decouple income and health," we may be widening the chasm of socioeconomic health inequalities.

We simply have too much at stake to let health disparities rob our nation's vitality. Every sector of society must make it their business to end health inequities now.

Are Alternative Payment Models the Future? … *continued from page 1*

Ask an orthopedist if value-based care (or risk-based contracting) has made a significant impact on cost of care while maintaining the highest levels of quality and you'll get anything from "yes" to "absolutely!" Ask that same question to a cardiologist and you could expect anything from "somewhat" to "not really."

The cost of care in the United States



On the surface, the impact overall on alternative payment models appears disappointing, as U.S. health care spending grew 3.9% in 2017, reaching $3.5 trillion or $10,739 per person. As a share of the nation's Gross Domestic Product (GDP), health spending accounted for 17.9%.[3] (Other industrialized nations spend between nine and 12%.)

A report from the Society of Actuaries (SOA) states that 17% of members included in the Healthcare Cost Institute (HCCI) Database are responsible for nearly 75% of all health care expenditures!

Let's put this in perspective. Using an 80/20 model, 80% of the costs of U.S. health care are generated from 20% of the population.

More specifically, Rand Corporation has found that 28% of the U.S. population – representing three or more chronic conditions – account for over 67% of the overall $3.5 trillion cost of care in the United States.[4]

Reflecting on the bundled payments example above, any failure to address chronic disease or otherwise identify an alternative payment model (APM) that demonstrates significant and reliable costs savings among the multiple-comorbidity population is an opportunity to innovate a new and possibly better APM.

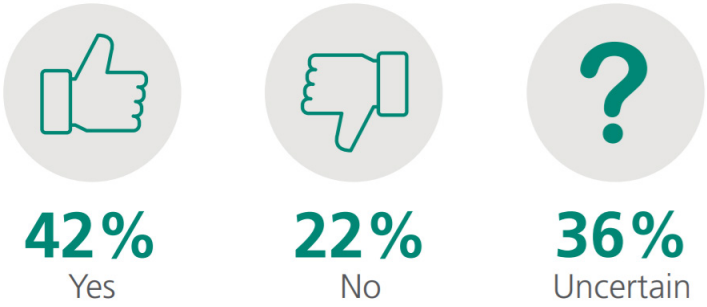
(continued on page 4)

Are Alternative Payment Models the Future? … *continued from page 3*

Value-based reimbursements are the future!

Given that almost no contracts incorporated value even 15 years ago, value-based care has actually achieved remarkable traction.

Will value-based reimbursements become the predominant payment model for U.S. health care?



Forty two percent of respondents from a NEJM Catalyst Insights Council survey in July 2018 said they think value-based reimbursement models will be the primary revenue model for U.S. health care.

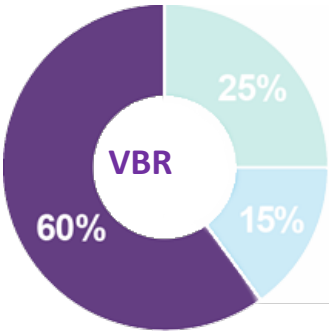
A 2018 survey by Damo Consulting on "Healthcare IT Demand in 2018" found that more than 60 percent of U.S. health care provider technology investments were attributed to value-based care initiatives.

Thinking outside the box!

Health data analytics can make a huge impact on pricing and planning for prospective care needs. In fact, predictive analytics already is being used to determine likely costs of a given patient, based on spending history, prescription drug coverage, age and gender.[5] But not all solutions need to be technology-oriented, or a drastic change from current practices.

According to US News & World Report, South Carolina's Beaufort Memorial Hospital found that it could save an estimated $435,000 annually by discharging patients just a half-day early.

In Minnesota, the Department of Health discovered there were 1.3 million unnecessary trips to hospitals and ERs in the state every year – at a cost of some $2 billion. They were then able to work with health care providers to ensure individuals were getting care in a more appropriate setting.[6]



Social workers, compliance specialists - a term that I use for care support staff who follow up with patients to ensure they're taking their prescribed medicines and/or seeing a benefit from said medicines, outpatient services, telehealth and better life conditions (living space, sobriety, work/job opportunities, mental health support and more) have all shown initial promise in reducing trips to the emergency room and/or other high-cost, high-frequency services such as dialysis.

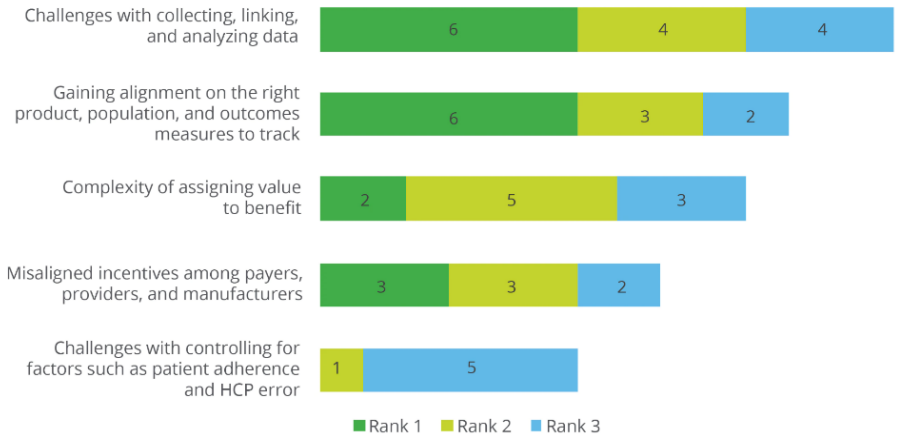
All said, strong analytics and the ability to accurately determine populations most likely to generate the highest care costs is key to effective preventative care initiatives, keeping people healthier longer, mitigating chronic disease complications and ultimately reducing costly acute medical episodes.

Barriers to Value-based Reimbursements, aka Risk-based Contracts

A 2018 study published by Deloitte highlights the challenges facing hospitals and health networks as they transition to a greater value-based contracts orientation.

In *Figure 6*, you may notice that both the first and third bar relate to analytics and maintaining a comprehensive data management solution, whereas the second bar relates to clinical considerations and identifying appropriate measures.

Figure 6. What do you believe is the biggest barrier to value-based contracting (rank top 3)?



Source: Deloitte's 2018 RWE Benchmarking Survey.

This isn't news. Commanding actionable data and coupling clinical performance to operational costs has been a goal in our industry for over three decades. What's different today is the level of specificity in our billing codes, a more uniform standard of documentation, the internet and Health Information Technology that can meet the data collection and processing needs of contemporary health data. While the internet of things (IoT) will require further evolution and greater data processing, we have what we need today to move closer towards achieving the Triple Aim of Population Health, which includes: (1) Quality care that is accessible and affordable, (2) a good experience, and (3), is patient centric.

(continued on page 5)

Are Alternative Payment Models the Future? … *continued from page 4*

Alternative Payment Models ARE the future!

The U.S. health care fee-for-service payment model is not broken, it works exactly the way it was designed. The problem is that professional medical care was designed as a for profit enterprise that considered patients more as consumers than beneficiaries.

There are a myriad of examples demonstrating the high costs of U.S. care. According to researchers at Harvard Chan School, our drugs are more expensive, our doctors get paid more and our hospital services and diagnostic tests cost more. Additionally, we spend substantially more money on planning, regulating and managing medical services at the administrative level.[7]

The net result of this is that the cost of care in the United States is sky high. Our hospitals and care centers are world-class but debilitatingly unaffordable for many people[8] and/or not a financial priority for those who can absorb the cost.

It is for these and countless factors, not the least of which is an increasingly strong patient voice, that current volume-based payment models will yield to more patient-centric value-based care models. It is not a question of "if" Alternative Payment Models will become the predominant basis, but simply "when" and in what form.

If your health system does not have a strategic path forward to risk-based contracts and value-based care, you're falling behind the U.S. health care revenue cycle management curve. Now is the time to step up and begin integrating APMs into your organization.

[1] https://www.hfma.org/topics/news/2019/01/62800.html
[2] https://lowninstitute.org/news/are-bundled-payments-working-yes-and-no/
[3] Centers for Medicare & Medicaid Services
[4] Rand Corporation "Multiple Chronic Conditions in the United States" (2014)
[5] https://healthitanalytics.com/news/predictive-analytics-with-claims-data-can-identify-high-cost-patients
[6] https://wp.nyu.edu/dispatch/2018/09/03/technology-lowering-healthcare-costs-through-analytics/
[7] https://www.hsph.harvard.edu/news/press-releases/labor-pharmaceuticals-administrative-costs-health-costs/
[8] https://m.nasdaq.com/article/medical-bankruptcy-is-killing-the-american-middle-class-cm1099561

Targeting Transitions of Care to Reduce Readmissions: More is Not Always Better

by Robyn A. Tamboli, PhD – Program Manager, Center for Clinical Quality and Implementation Research

Neesha N. Choma, MD, MPH – Assistant Professor of Medicine; Executive Medical Director of Quality and Safety, Vanderbilt University Hospital and Clinics; Associate Chief of Staff, Vanderbilt University Hospital

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Every healthcare system is experiencing increased pressure to reduce costly hospital readmissions, and most are engaged in identifying and implementing best-practice approaches to prevent readmissions in a cost-effective manner. Transitions of care from the inpatient to the outpatient setting are a vulnerable period where inadequate care coordination can lead to avoidable hospital readmissions. Implementing programs to improve care transitions are effective in reducing readmission rates, and success is dependent upon interventions that target multiple components of the care transition. What remains unclear is the ideal combination of interventions, as well as the optimal mode and intensity. Sorting this out would have important implications for optimizing patient outcomes while balancing considerations of resource allocation.

Despite We recently evaluated a transitional care intervention at Vanderbilt University Medical Center that focused on patient engagement, anticipatory care, and bridging the continuum of care.[1] One facet of this multi-component, evidence-based initiative was implementing a Transition Care Coordinator (TCC) model to facilitate a structured yet patient-centered approach to address the varied needs of each patient during and after hospital discharge.[2]

The TCC quality improvement initiative aimed to reduce readmissions through supplementing usual discharge planning by the primary care team. The implemented intervention bundle was based on the Ideal Transition in Care framework and incorporated 7 of its 10 domains to foster smoother care transitions.[3] Experienced Registered Nurses were trained as TCCs to develop a tailored, comprehensive transitional care plan through partnership with the patient and an interdisciplinary care team.

TCCs initiated the intervention through chart screening to identify patients with the diagnoses of interest early during the hospital admission. We focused on patients hospitalized with diagnoses of heart failure, pneumonia, or chronic obstructive pulmonary disease. The TCCs then engaged patients to anticipate their needs at discharge through a structured needs assessment and led daily transition huddles with inpatient clinical teams to coordinate and deliver discharge services to meet each patient's needs. At the time of discharge, TCCs performed a detailed medication reconciliation and helped patients prepare for their next stage of care with patient-specific education (teach-back method) and discussion of potential post-discharge problems and related plans. TCCs bridged the gap between inpatient and outpatient care through a structured phone call with the patient to monitor and manage symptoms after discharge, reinforce education, facilitate follow up on outpatient appointments, and resolve any pending issues.

(continued on page 6)

Targeting Transitions of Care to Reduce Readmissions: More is Not Always Better … *continued from page 5*

An integral strategy in the TCC model was continual program evaluation involving leadership and TCCs to identify barriers and refine processes. The initial program evaluation found that the screening process during hospitalization was unable to identify all potentially eligible patients. This led to the addition of a pathway in which patients were screened for eligibility by diagnosis codes assigned at time of discharge. In these patients, TCCs conducted a partial intervention via a post-discharge phone call only. The partial intervention differed from the full invention in that the TCCs did not perform the structured needs assessment or in-depth medication reconciliation in the hospital, nor did they interact with patients and care teams during hospitalization, but they did perform a medication review, provide education, and help troubleshoot any issues post-discharge.

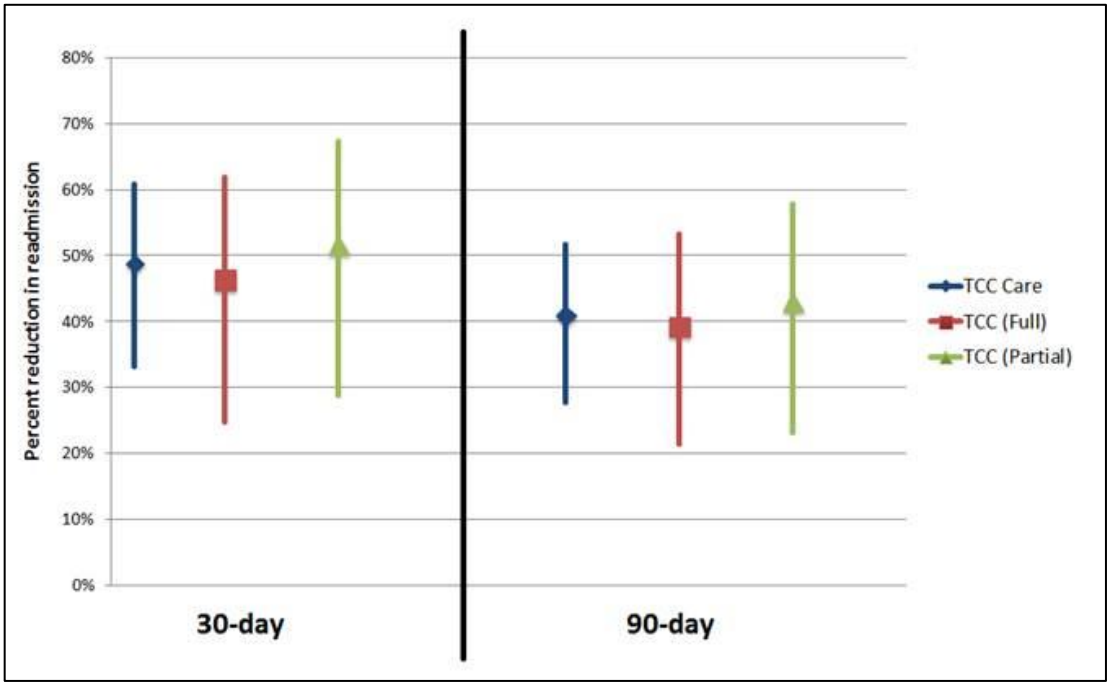
Adding the partial intervention provided the unique opportunity to evaluate the effectiveness of two forms of a transitional care intervention which differed in intensity and mode of delivery. We retrospectively identified a comparison group of patients with the same diagnoses who did not receive either TCC intervention, but received Usual Care consisting of discharge planning according to standard hospital procedures without a structured needs assessment or follow-up phone call. The study group included 6276 hospitalizations with Usual Care and 762 with TCC Care, of which 460 patient hospitalizations received the full intervention and 302 received the partial intervention.

> ***"Patients receiving TCC Care had unadjusted 30-day readmission rates of 9.4%, which was significantly lower than the 18.8% 30-day readmission rates for Usual Care."***

Overall, the TCC intervention demonstrated effectiveness to reduce hospital readmissions. Patients receiving TCC Care had unadjusted 30-day readmission rates of 9.4%, which was significantly lower than the 18.8% 30-day readmission rates for Usual Care. Importantly, the beneficial impact of TCC care on hospital readmissions was sustained at 90 days, with unadjusted readmission rates of 19.8% for TCC Care and 31.5% for Usual Care. After adjustment for confounding variables, such as baseline demographics, health literacy, primary diagnosis, comorbidities, readmission risk scores, and prior hospitalizations, patients receiving TCC Care had a 49% reduction in 30-day readmissions and a 41% reduction in 90-day readmissions.

Contrary to our expectations, adopting the lower-intensity partial intervention of the post-discharge phone call provided a similar effectiveness to the full in-hospital program. Unadjusted readmission rates between the partial and full TCC interventions were comparable at both 30-days (10.3% vs. 8.9%) and 90-days (21.5% vs. 18.7%). After adjusting for other variables, the reduction in readmission rates was similar for the full and partial TCC interventions (*Figure*). The amount of time to deliver the partial intervention was approximately 30–45 min compared to 2–4 h for the full intervention, demonstrating a more efficient use of resources to achieve the same benefit. Additionally, the post-discharge intervention group was identified more efficiently through automated reports sent to the TCCs after discharge as opposed to manual screening of electronic health records for the full intervention.

Figure. Reduction in readmissions with Transition Care Coordinator intervention



In the current climate of value-based care and financial penalties for excess hospital readmissions, any initiative aimed at reducing hospital readmissions must also be worth the financial cost. The total cost incurred to implement the TCC intervention was estimated at $321,963 during the 28-month implementation period and consisted of salary and benefits for nurse TCCs. Overall, the cost of TCC Care per patient was $381, producing an estimated per-patient savings of $3969 at 30 days and $5684 at 90 days. This return on investment was similar for the full and partial interventions.

(continued on page 7)

Targeting Transitions of Care to Reduce Readmissions: More is Not Always Better ... *continued from page 6*

We also evaluated how the effects of the program varied between low- and high-risk patients. One widely used approach to prioritize resource allocation for readmission reduction is to focus efforts on patients with the highest risk of returning to the hospital. However, there is very little evidence to guide such a strategy. The TCC intervention did not specifically target high-risk patients, but we calculated patients' readmission risk using the LACE index and determined the "number needed to treat" (NNT) to prevent 1 readmission for low-, medium-, and high-risk patients (Table). We found that among higher-risk patients, it was necessary to deliver the intervention to fewer patients to prevent 1 readmission.

Table. Number needed to treat with care transition intervention to prevent 1 readmission

LACE score	Risk of 30-day readmission based on LACE	Number needed to treat to prevent 1 readmission
5	5%	28
10	12%	14
15	27%	9

The TCC intervention was supported by an award from CMS, and although it was not sustained in its original form after the funding ended, many service lines at our hospital, particularly in the Department of Medicine, have continued and expanded several elements of the program that were performed by TCCs. Discharge huddles are conducted daily to bring together a multidisciplinary care team to discuss the anticipated date of discharge, coordinate care, and arrange post-discharge services. Medication reconciliation is now facilitated by pharmacy staff who round with medical teams. A centralized office for appointment scheduling has been expanded to arrange timely follow-up both within and outside of the health system. Focused programs are also in place to provide bundled episodes of care services for certain conditions, and to assist patients who are frequently admitted to the hospital.

A key component to realizing the benefits of this quality improvement initiative was consistent program evaluation, which led to a more efficient intervention model that seemed to have a similar effect on readmission outcomes. While we were not able to examine the specific components of the bundled intervention that were key contributors to reducing readmissions, the direct comparison of the two different structures of the Transition Care Coordinator program was valuable. As we develop and deploy additional transitional care initiatives, we continue to evaluate new programs to determine their effectiveness and learn from their implementation.

This work was supported by the Centers for Medicare and Medicaid Services (1C1CMS330979) and in part by the National Center for Advancing Translational Sciences (2 UL1 TR000445-06). A full evaluation of the intervention was reported in Contemporary Clinical Trials 81 (2019) 55-61.

[1] Kripalani S, Chen G, Ciampa P, Theobald C, Cao A, McBride M, Dittus RS, Speroff T. A transition care coordinator model reduces hospital readmissions and costs. Contemp Clin Trials 2019; 81: 55-61
[2] Hatch M, Bruce P, Mansolino A, Kripalani S. Transition care coordinators deliver personalized approach. Readmissions News 2014;3(9):1-3
[3] Burke RE, Kripalani S, Vasilevskis EE, Schnipper JL. Moving beyond readmission penalties: creating an ideal process to improve transitional care. J Hosp Med 2013; 8(2):102-109

Thought Leaders' Corner

Each month, *Population Health News* asks a panel of industry experts to discuss a topic suggested by a subscriber. This month, there are two questions.

Q. How Can Technology Improve Population Health?

Technology holds great promise when it comes to improving population health. Advances like Artificial Intelligence (AI) and Machine Learning can be applied to uncover key data insights that may be used to impact decision-making and ultimately improve short- and long-term health outcomes.

A major southeastern health system has integrated AI directly into cardiac patient care workflows, giving them the ability to predict when a patient is about to code, so they can take action to preempt the event. This groundbreaking technology continuously analyzes lab values, vital signs, and other data. When indicators point to a patient headed for trouble, it triggers "pre-code" alerts, which are automatically sent to care teams, giving them the ability to proactively treat patients, rather than rushing into action after the fact, when it may be too late. In a 90-day pilot, the number of codes was reduced by 44 percent, leading the health system to expand the technology to more hospitals in its network.

In the Social Determinants of Health (SDH) world, the problem used to be not having enough data to empower this sort of predictive model – which frankly requires massive amounts of data. That all changed with the proliferation of social media and a generational change in the ethos of personal information-sharing. Seemingly overnight, the challenge morphed from a lack of data to figuring out how to manage vast "lakes" of information.

Another set of notable tools and technologies that are creating new inroads in population health are consumer engagement tools under the umbrella of Digital Health. Health systems that previously could be considered parsimonious in their investments in patient engagement techniques are now investing more substantially in engaging the individual consumer in their health management. At the same time, they are recognizing the value of learning from other industries, such as Retail and Banking, which have been leading the way in this arena.

Population health is also likely to benefit from Amazon Comprehend Medical, a machine learning service that helps healthcare providers, insurers, researchers, clinical trial investigators, healthcare IT, biotech, and pharmaceutical companies improve their clinical decision support, streamline revenue cycle and clinical trials management, and better address data privacy and protected health information (PHI) requirements. Meanwhile, a new partnership combines Google's cloud and AI capabilities with The Mayo Clinic's clinical expertise to transform patient and clinician experiences, improve diagnostics and patient outcomes, and enable unparalleled clinical research.

Such innovations demonstrate that Big Tech has indeed stepped up to help bring the application of computing power, data science, and associated algorithms to make sense of the data noise. Granted, patient portals remain basic at best – certainly not comparable to the Zappos, Amazon or Apple consumer engagement and care models – but consumers now willingly provide actionable data garnered from wearable fitness trackers and smart watches. This data can be employed to help verify identity, monitor vitals, and transform the traditional Enterprise Master Patient Index (MPI) operations that have not changed substantially in decades.

Clearly, technology presents tremendous opportunities to apply targeted analysis to revolutionize healthcare, improve patient outcomes, and save lives. Perhaps even more crucially, it enables healthcare systems to redesign the consumer experience to better engage patients in managing their own health on a proactive basis. The resulting impact on population health will undoubtedly be substantial.

Liam Bouchier
Principal, Impact Advisors
New Orleans, LA

More than half the country receives pharmacy benefits via their employer. As drug prices continue to escalate and utilization continues to increase, these employers struggle to provide a pharmacy benefit that is affordable to their employees while also sustainable for the employer to fund. Thus far in 2019, over 3,400 drugs have increased prices by 10.5 percent, more than five times the rate of inflation. (CBS News 7/1/19)

While the industry points fingers at drug manufacturers, prescription benefit managers (PBM), pharmacies, insurance companies, hospitals, health plans, and even doctors for these skyrocketing pharmacy benefit costs, no one disagrees that the demand for prescription drugs is ever increasing and that prescription drugs are the fastest growing segment in healthcare. To wit: 60 percent of America suffers from a chronic disease (diabetes, hypertension, heart disease, asthma, high cholesterol, etc.), requiring prescription medication. More than 14 percent of patients avoid medication altogether based upon cost alone. It's hard to go a single day without seeing a headline in the media about this topic.

(continued on page 9)

Thought Leaders' Corner *...continued*

As we all acknowledge, the stakes are high. All employers want healthy, productive employees. Strong health benefits and employee support of their benefits help companies stand apart from the competition when competing for top talent. Those on the front lines, such as HR and benefit directors, as well as brokers and consultants, have an obligation—in fact, a fiduciary duty to better understand, monitor and control their rising prescription costs and to keep benefits sustainable.

One of the current struggles an employer faces with their pharmacy benefit is its limited line of sight and lack of control over prescription drug costs. Employers enter into a complicated financial contract with their PBM, which sets the price for drugs at which that the employers pay for them. This contract does not readily correlate to the invoices that employers are expected to pay for the prescription drug claims. When employers pay the bill associated with their members filling prescriptions, they are asked to remit funds with no reasonable way to analyze and validate the price paid for each prescription. These payments typically happen frequently (weekly) and automatically (often via direct debit) without the employer's ability to ensure that the claims have been adjudicated properly and in accordance with the underlying contract terms. As a side note: it is critical for HR professionals, who are subject to ERISA compliance, to regularly monitor claims, as failure to perform this duty is a potential legal landmine.

The cost of prescription drugs is a troublesome issue that is only getting worse. None of us can directly control the demand for prescriptions or the manufacturing cost of those drugs; however, those of you on the healthcare program administration front line have the opportunity to reap the benefits of deep analytics and, thus, have the power to optimize the price paid for medications and the ensure appropriate utilization of each drug.

Here's how: Every time a prescription is filled at a pharmacy or mail order facility, up to 600 data fields are generated by that claim. These data fields can, and should, be assessed and used by employers to better understand their prescription spend and to therefore identify opportunities for better management. Heretofore, employers have been unable to find the technology and tools to decode, analyze and apply the rich set of information contained within their members' pharmacy claims. Absent such tools, employers rely on intermediaries to provide them with insight into this information on their behalf. However, these intermediaries often share limited, highly derived information and does not dig deep into the data to provide employers with detailed, unbiased analytics.

PBMs perform an integral service by adjudicating millions of claims a day. In a matter of a second, a PBM determines who the purchaser is, where they work, what the benefits program and plan details are, who owes what percentage of the cost, what clinical programs are in force, what prior authorizations exist, what potential drug interaction risks, and many more issues and considerations. This work is accomplished 24 hours a day, seven days a week. It is a complex and detailed process filled with lots of small details and inconspicuous data. This data, however, is rarely digested into unbiased analytics, accessible and queriable through a customized, user-friendly platform.

Clear direction for the best path employers to gain this line of sight into the complexities of PBM data—and in turn take control over prescription drug spend and utilization—exists today. Technology advancements are enabling employers to see what was previously hidden and use it to their advantage. By adopting the ethos of technology, employers can focus on, and benefit from, the capabilities, systems and philosophies set forth below.

Employers must identify a technology partner with the right platform to analyze pharmacy claims, PBM contracts and plan details together to identify existing costs, the rationale behind the costs, opportunities for savings, management, and data-driven insight. However, even when armed with the most powerful, advanced technology, for any kind of analysis to work, the ideal partner needs to be 100 percent agnostic in its assessment and recommendations. An independent, objective technology provider should be able to show employers how to identify or solve the underlying problems, without the potential bias of either being the entity who process the claim and controls the pricing or from receiving payment directly from the PBM itself for access to savings opportunities.

Just any technology isn't the answer. The chosen platform should allow the employer to collect and break down every single claim and data field to use as evidence to uncover what is not optimal with its prescription drug program, what it is costing it, and the opportunities to fix it. An employer's technology partner should have the ability to agnostically police it and measure the pharmacy spend on an ongoing basis to track performance and to optimize utilization to help improve outcome management. The capabilities should include the contractual structure, the clinical assessment, and analysis of all other elements of a benefits program. This kind of data insight enables a more fruitful relationship between the PBM and the employer, regardless of whether it is the incumbent or a new PBM partner. The ideal technology solution enables the employer to easily understand voluminous and otherwise convoluted prescription drug data to work in partnership with its PBM and make intelligent decisions that encourage healthy employee behavior while ensuring affordability of costs.

Finally, but not unimportant, the ideal technology partner is able to educate the employers' benefits team to attain the same level of industry knowledge as that of its own experts so that, together, they can work to implement cutting-edge, yet flexible, solutions.

Scott Martin
Chairman and CEO, Remedy Analytics
New York, NY

Industry News

Evolent Health First Organization Ever to Achieve NCQA Population Health Program Accreditation

Evolent Health, a company providing an integrated value-based care platform to the nation's leading providers and payers, today announced it is the first company ever to achieve Population Health Program Accreditation from the National Committee for Quality Assurance (NCQA), an independent, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans, managed behavioral healthcare organizations, preferred provider organizations, new health plans, physician organizations, credentials verification organizations, disease management programs and other health-related programs.

Evolent received NCQA's Population Health Program Accreditation with the status of Accredited–3 years for Evolent's Complex Care, Transition Care, Asthma, Coronary Artery Disease (CAD)/Hypertension, Chronic Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD) and Diabetes programs. The Population Health Program Accreditation is the third NCQA Accreditation Evolent has achieved in 2019, with Evolent having also earned 3-Year Accreditation in both Utilization Management and Case Management in 2019. Three years is the longest accreditation time period NCQA designates for organizations.

"We are honored to be the first organization ever to achieve Population Health Program Accreditation from NCQA," said Evolent Health Chief Executive Officer Frank Williams. "This reflects our focus on doing what's right for the patient regardless of how they enter the health care system, and our commitment to working with payers and providers to significantly improve care quality and the care experience. I commend the NCQA for taking the step to evolve its Disease Management programs into this Population Health Program accreditation because it encourages the industry to advance the way we care for people through earlier interventions, preventive care and a view of the whole person beyond a disease state."

"The Population Health Management program moves us in greater alignment with the increased focus on person-centered population health management," said NCQA President Margaret E. O'Kane. "Not only does it add value to existing quality improvement efforts; it also demonstrates an organization's highest level of commitment to improving the quality of care that meets peoples' needs."

NCQA awards the status of Accredited–3 years to organizations that demonstrate strong performance of the functions outlined in the standards for Population Health Program Accreditation. The Population Health Program Accreditation is organized into nine standards:

1. **Program Description:** The organization describes its population health management program, including its evidence base, and reviews and adopts new findings that are relevant to its program as they become available, as appropriate.
2. **Data Integration:** The organization collects and integrates data sources to conduct population health management functions.

Evolent Health First Organization *…continued*

3. **Population Assessment:** The organization conducts a population assessment to identify needs and characteristics of the population.
4. **Population Segmentation:** The organization segments or stratifies the population into actionable categories for intervention.
5. **Targeted Interventions:** The organization provides targeted interventions based on the individual's needs.
6. **Practitioner Support:** The organization involves practitioners by providing them with information.
7. **Measurement and Quality Improvement:** The organization evaluates the effectiveness of the population health programs.
8. **Individuals' Rights and Responsibilities:** The organization communicates the individual's rights and responsibilities.
9. **Delegation of Population Health Management:** The organization carefully monitors functions performed by other organizations.

NCQA Accreditation standards are developed with input from various stakeholders and resources: health plans, population health management industry leaders and organizations, an expert panel and standing committees. NCQA Accreditation standards are purposely set high to encourage organizations to continuously enhance their quality; the standards are intended to help organizations achieve the highest level of performance possible and create an environment of continuous improvement.

Papa Announces $10 Million Series A Round and Partnerships with Large Health Insurance Plans to Curb Loneliness and Social Isolation in Seniors

Papa, a company committed to helping seniors throughout their aging journey by providing "Grandkids on Demand," today announced the completion of a $10 million Series A round led by Canaan, with additional investment from Pivotal Ventures, an investment and incubation company created by Melinda Gates. Initialized Capital, Y Combinator, and Sound Ventures re-invested in the round. In addition, Papa announced partnerships with multiple large health insurance plans, including Humana, Aetna, Priority Health and Alignment Healthcare. Papa will use the proceeds from the financing to expand its services to a broader population of older adults, via partnerships with additional insurance plans and employee benefit providers. Papa will also expand its service footprint in 2020 to 25 states to address demand from new health plan commitments. As part of the financing, Canaan principal Byron Ling will join the company's board.

Papa was founded in 2016 to connect college and nursing students, known as "Papa Pals," to older adults who need assistance with transportation, house chores, technology lessons, and other services. By providing companionship to seniors who lack access to social networks, Papa seeks to curb social isolation and loneliness, which researchers have shown has the same impact on health as smoking 15 cigarettes per day.

(continued on page 11)

Industry News

Papa Announces $10 Million Series A *…continued*

"Our mission at Papa is to end the loneliness epidemic among seniors by connecting two distinct generations – energetic, enthusiastic college students, and older adults in need of companionship and assistance," said Andrew Parker, Papa's founder and chief executive officer. "The idea behind Papa came from an experience my family had helping my aging grandfather, who we called Papa. We hired a college student to assist him and provide social interaction. Since then, we have grown rapidly, filling a massive void in care for seniors who want to live independently and need some support, which previously had no obvious solution. The Series A funding and our partnerships with insurance providers will allow us to expand and support more older adults with a positive experience."

"Papa is an early leader in the elder tech field, developing a truly unique solution to the loneliness epidemic," said Alexis Ohanian, co-founder and managing partner at Initialized Capital. "Initialized was an early investor in Papa and we continue to be impressed by the enthusiasm and creativity of Andrew and the Papa team. We're inspired by their efforts to bring the benefits of digital healthcare to an older generation of Americans all over the United States."

Papa Pals undergo a rigorous screening and training process, before being matched to seniors enrolled in the program. Once enrolled, Papa provides the technology for both groups to manage their experience, including a member app that enables seniors and their caregivers to request visits; and an app for Papa Pals to track and manage visits. Additionally, the company's logistics platform includes an administrative tool for managing its members, onboarding new Papa Pals, and managing billing.

Papa is currently available in 14 states, including Ark., Calif., Fla., GA., Ill., Kan., Ky., La., Mich., Miss., Mo., Pa., S.C., and Texas, and will expand to a total of 25 states in 2020. By partnering with Humana, Aetna, Priority Health and Alignment Healthcare, Papa services available to members can include companionship, non-emergency transportation to medical appointments and food shopping, basic house help, and general organizational assistance.

"A broad, diverse, and growing number of stakeholders and policymakers recognize that Social Determinants of Health like loneliness are important to health outcomes," said Caraline Coats, VP, Bold Goal and Population Health Strategy at Humana. "We're very excited to partner with Papa to further review how this type of intervention may be beneficial to members in our Medicare Advantage markets. We know that living conditions significantly influence health outcomes, and Papa is both helping seniors improve their day-to-day lives while also providing relief to the family members who help care for them."

"Papa is using technology to create a new class of caregiving that empowers the lives of seniors through enhanced mobility, reduced loneliness, and greater autonomy. With a novel approach that connects seniors with vetted and trusted talent seeking flexible employment, Papa's platform allows health plans and families to impact health outcomes while radically improving the day to day lives of seniors," said Byron Ling, principal at Canaan.

"Andrew and the Papa leadership team are pioneering the elder technology market, a category of products and services being built today that will represent a paradigm shift in how seniors and their families live tomorrow."

In addition to its insurance plan partners, Papa also announced a partnership with New Benefits, an employee benefits provider. Through the partnership, employees can enroll in Papa and use the service to provide care to the older adults in their families.

swisslog
inspired solutions

Facing an Aging Inmate Population, Correctional Facilities Seek Solutions to Streamline Medication Management, Control Costs and Minimize Risk

Meeting the medication needs of inmate populations in the United States is becoming increasingly more challenging. Correctional facilities are faced with common population health management issues, including an aging populace and the rising cost of drugs, as well as challenges more unique to the correctional care setting, such as managing the legal rights of inmates, inadequate staffing and frequent patient movement that leads to expensive medication waste. To mitigate the financial and productivity impact of these challenges, correctional facilities are partnering with Swisslog Healthcare to deliver automated packaging and dispensing technology that saves valuable employee time, eliminates expensive waste and ensures accuracy in medication administration.

Approximately 11.6 million people move through U.S. corrections facilities every year. Of that population, 80% have chronic, untreated medical conditions and 68% have substance use disorders (Substance Abuse and Mental Health Services Administration, 2003). The medication needs of this population are stretching the limits of today's cash-strapped corrections facilities, which struggle to provide inmates with the level of care the law entitles them to.

According to a PEW article, "Aging Prison Populations Drive Up Costs," prison populations are decreasing, but older inmate populations are growing. "From 1999 to 2016, the number of people 55 or older in state and federal prisons increased 280 percent." These older inmates require more medications due to chronic medical conditions. Additionally, it stated that the Justice Department's inspector general found that, "within the Federal Bureau of Prisons, institutions with the highest percentages of aging individuals spent five times more per inmate on medical care—and 14 times more per inmate on medication—than those with the lowest percentages."

Higher medication utilization of an aging inmate population causes an increased medication cost for correctional facilities and it intensifies the existing issue of medication waste in corrections. Due to the transient nature of incarceration, such as inmates being transferred to other facilities, paroled or released, many prescriptions go unused. With traditional 30-day blister cards, the inmate's remaining medications must be destroyed to ensure regulatory compliance. To minimize the impact of these challenges, correctional facilities are streamlining their medication management processes by packaging and dispensing medications on demand.

Catching Up With ….

Answers Provided by Representatives of SSM Health and Navvis.

SSM Health and Navvis partner to rapidly advance population health and reinvent the health care experience. Navvis Marketing. September 26, 2019. Organizations to deliver an industry-leading value-based care delivery model that improves the lives of patients and the health of communities across the Midwest ST.

***Population Health News**: How will the strategic partnership between SSM Health and Navvis help patients manage their health and wellbeing through every stage of life?*

Our partnership will develop and implement an industry-leading value-based care delivery model. This model will help all patients better manage their health including Medicare and Medicaid populations.Patients will experience personal and present care that addresses what's most important to them. Patients will have a clinically driven care team focused on addressing not just their physical needs, but their social needs as well.

The care team will engage each patient to coordinate and manage their care. This team-based care model is multi-disciplinary and may include physicians, nurses, nutritionists, care managers or social workers, as well as family members, friends, and community partners. Ultimately, this value-based care model will ensure all people have access to the care they need.

"Next generation population health is led by clinicians, leveraging their leadership, expertise, buy-in and trust. It's not about asking physicians and nurses to do more, but about giving them the system and resources to enable them to do their best work. To truly maximize engagement with both clinicians and their patients is hard work, but programs like the ones announced by SSM Health and Navvis are the exact models we hope become the industry standard."

—Jan Berger, MD, MJ
CEO, Health Intelligence Partners
Editorial board for the American Journal of Managed Care (AJMC) and Population Health Management Journal

***Population Health News**: Can you describe how this new and holistic model of care will eliminate barriers that fragment care?*

There are several areas that are instrumental to developing the new and holistic model, and these areas will ultimately help eliminate barriers that fragment care. SSM Health and Navvis will develop and implement:

- care models and high-performing networks that provide consistent and patient-centered care coordination (across primary, specialty, acute and post-acute care, home-based care and behavioral medicine);
- enhanced centralized and in-market care management that expands access and better support to patients with chronic disease;
- care models that support both medical and social needs, leveraging services to address social determinants of health like safe housing, transportation to access health services, and food security;
- strategies and leadership development programs to engage, enable and empower health care providers;
- new technology that enables clinical data to be integrated to help providers better identify high-risk patients and apply appropriate interventions; and
- enhanced payment and compensation models that aligns payments with value-based care performance.

***Population Health News**: How will this new partnership make care more affordable and sustainable?*

"It's very encouraging to see industry announcements like this one today from SSM Health and Navvis, who together are embarking upon value-based care delivery for patients in the midwest. From our experience in Hawaii, where HMSA recently moved all of its primary care physicians to value-based payments, we know that these types of initiatives yield clinically important increases in quality."

—Amol Navathe, MD, PhD
Co-Director, Healthcare Transformation Institute, University of Pennsylvania

Through care coordination and also through identification of the highest risk patients, the partnership will better manage patients and prevent unnecessary utilization of health services. Patients will receive more proactive care and receive services in the most optimal place. This coupled with an emphasis on preventive care and closing gaps will improve health outcomes and reduce costs for patients and the system as a whole.

***Population Health News**: How will this new care partnership specifically improve population health?*

In this value-based model, all patients will have a primary care physician, and clinicians will be aligned to quality and population health outcomes. Providers will be empowered with information to better manage their patients, allowing them to more effectively close gaps in care and coordinate the care of their patients across all care settings. These models have been shown to improve population health outcomes and deliver more personalized care.