Becoming Accountable:
Achieving Success in
Population Health
Management

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Agenda

• Accountable Care
• Population Health Management
• Physician-Hospital Collaboration
Learning Objectives

1. Understand key success factors for effective population health management
2. Discuss innovative physician-hospital collaboration approaches for becoming accountable

Bio

Bob Edmondson has more than 20 years experience in guiding physicians, hospitals and health systems through strategy, integration, and business development. He currently, serves as Chief Strategy Officer for Carroll Hospital Center in Westminster, Maryland. Bob’s experience includes executive leadership with healthcare systems and professional services firms, including Endeavor Health Group, Catholic Healthcare Partners, and Ernst and Young
Transforming the Patient Experience: Healthcare Today

Segment of community at high-risk for health services

Community member experiences healthcare event and accesses the healthcare system

Patient receives unit of service

Patient discharged with minimal transition assistance

Limited resources and incentive for health improvement and wellness

Health Care Costs Concentrated in Sick Few: Sickest 5% Account for 50% of Expenses

Distribution of health expenditures for the U.S. population, by magnitude of expenditure, 2009

Source: Agency for Healthcare Research and Quality analysis of 2009 Medical Expenditure Panel Survey.
Population Health Management Concept

<table>
<thead>
<tr>
<th>Perceived Health</th>
<th>Objective Health</th>
<th>Up to 50% of Medical Costs</th>
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</thead>
<tbody>
<tr>
<td>High</td>
<td>Healthy 80%</td>
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<tr>
<td></td>
<td>Undiagnosed 5%</td>
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<tr>
<td>Low</td>
<td>Worried Well 10%</td>
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<tr>
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<td>Ill 5%</td>
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Focusing on the Frequent Flyers: The Ill 5%

- **Perceived Health Low**
- **Objective Health Low**

Ill 5% membership

- Don’t Get Worse
- Chronic Disease Management Modules
- High Risk Management Program
- Physician Management
Transforming the Patient Experience: A Model for the Future

Physicians and hospitals assume responsibility for managing health of entire population

Community members screened for health risk factors

Low-Risk Community Members
- Wellness and screening
- Healthy lifestyles
- Track health status
- Convenient access to multiple sites
- Patient portals

Objective: Keep people healthy and appropriately manage utilization

High-Risk Community Members
- Disease management
- Teams of physicians, physician extenders, care coordinators, and patient coaches develop care plans
- Weight loss, smoking cessation, medication management
- Post-discharge transition management

What the population health manager is looking for--

- All hands on deck with frequent flyers
- Coordinated information systems
- Obsessive focus on the continuum of care
- Drive care to the lowest level
- Reduce readmissions
- Provide wellness at every healthcare “touchpoint”
Coordinated Systems of Care Can Manage Complex Patients Across the Continuum

- Information Technology
  - HIS/RIS/PACS
  - Electronic Medical Record
  - Health Information Exchange
  - Patient Portals
  - Tracking and Reporting

- Patient Centered Medical Home
  - Primary Care Physicians
  - Specialists
  - NP/PA's
  - Patient Coaches
  - Pharmacists
  - Mental Health Providers

- Chronic Disease Management
  - Care planning
  - Transitions Management
  - 24/7 Call Center
  - Medication Reconciliation
  - Referral Management
  - Telehealth
  - Routine checks
  - Education
  - Healthy behaviors

Disease Management Outcomes

Top 3% Users as % of Budget:

49% → 43% = $5,000,000/year savings
Volume versus Value: Balancing Two Worlds

Solution: Fee-For-Service + Shared Savings Incentives

Key Components of a Population Health Management Delivery System

<table>
<thead>
<tr>
<th>Community</th>
<th>Health System</th>
<th>Post Acute</th>
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<tbody>
<tr>
<td>Disease Management</td>
<td>Access</td>
<td>Transition Management</td>
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<tr>
<td>Behavioral Health</td>
<td>Patient Navigation</td>
<td>Long-Term Care/Rehab</td>
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<tr>
<td>Pharmacy</td>
<td>Case Management</td>
<td>Home Health</td>
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</tbody>
</table>
Community Services

**Disease Management**
- Risk stratification
- Chronic population identification
- DM program enrollment
- Care planning
- Prevention and wellness
- Disease protocols
- Preferred physician visits

**Behavioral Health**
- Government and community agencies
- Drug-seeking guidelines
- ED case management
- Substance abuse assistance
- Socio-economic factors

**Pharmacy**
- Medication reconciliation
- Medication assistance and compliance
- Discharge meds

Health System Services

**Access**
- Call centers
- Patient portals
- Primary care
- Specialty care
- Retail clinics
- Urgent care
- Emergency services
- Inpatient intake
- Post-discharge follow-up

**Patient Navigation**
- Coordination of services
- Patient education
- Care planning
- Follow-up and tracking
- Scheduling
- Resource assistance

**Case Management**
- Emergency department
- Inpatient services
- Discharge planning
Post Acute Services

**Transition Management**
- Post-discharge planning
- Readmission risk identification
- Medications
- Follow-up call center
- Physician scheduling

**Long-Term Care/Rehab**
- Skilled nursing clinical management
- LTACH
- Rehabilitation

**Home Care/Hospice**
- Home visits
- Telehealth
- Hospice and palliative care

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Putting it All Together

**Community**
- Self Care
- Primary Care/PCMH
- Retail Clinics
- Specialty Care

**Health System**
- Urgent Care
- Emergency Department
- Hospital

**Post Acute**
- Skilled Nursing
- Rehabilitation
- Home Care

*Objective: Drive care to the lowest cost/most convenient setting*
Avoidable Readmissions: The Epic Fail

Emergency Department → Hospital → Rehabilitation → Home Care

Objective: Drive care to the lowest cost/most convenient setting

Putting it All Together

Community
Self Care

Disease Management
Care Plans
Call Centers

Health System
Urgent Care
Emergency Department → Hospital

Post Acute
Skilled Nursing
Rehabilitation
Home Care

Objective: Drive care to the lowest cost/most convenient setting
Putting it All Together

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Putting it All Together

Objective: Drive care to the lowest cost/most convenient setting
Integration for Accountable Care: Who, what and how?

Key Strategic Issues for ACO Development

- Who will take the lead?
- What are the essential components of an ACO?
- How should we aggregate the components and structure the organization?
- What components should be:
  - Incorporated into structure?
  - Purchased?
  - Partnered?
- What is the role of the Payor?
Physician-driven models are taking lead in building patient-centered care
The Emerging Healthcare Industry

- Large consolidated providers
- Focus on coordination, collaboration, communication
- More comprehensive continuum of care
- Population health management vs. volume