Nemours Children's Health System

# Managing Population Health as a Health System:

## Value Contracts and How We Think About "Our Patients"


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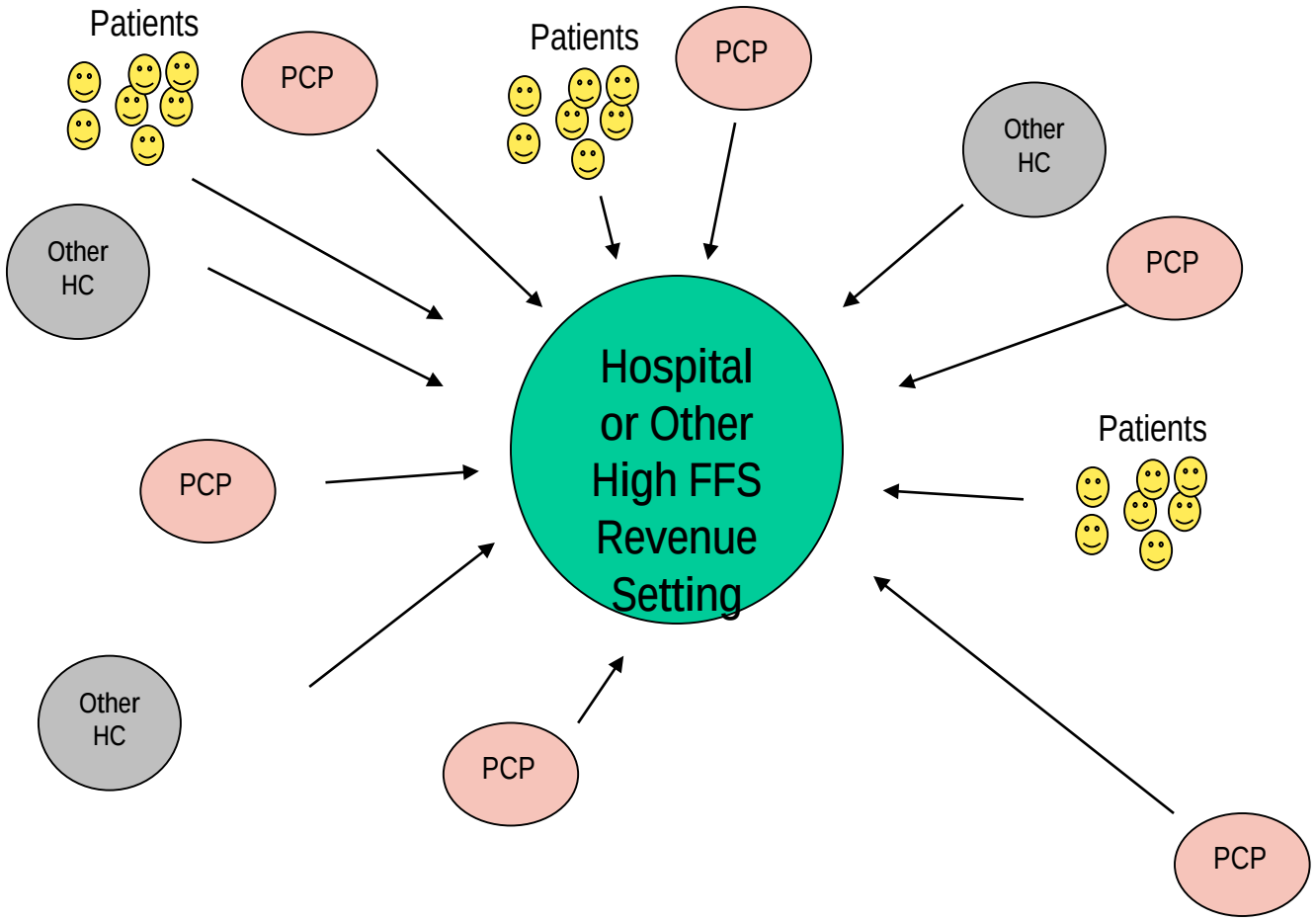
# Goals for this presentation

- To outline historical fee-for-service characteristics
- To provide an overview of P4P and other new alternate payment models
- To explain how value and risk contracts change what we focus on about patients
- To provide examples of the types of interventions that might be developed to support different populations and address disparities

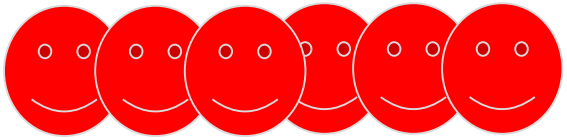
# Where has healthcare been under typical fee-for-service models?

- "Our" patients are those we have seen recently
- Focus on volume of activity
  - Move volume in our system = better because it means more revenue
- Primary Care was the gatekeeper – but the hospital was the hub
- Focus on payer mix
  - We want to attract more patients insured by higher-paying contracts
- Focus on markets/geography to acquire new patients
- Note:  These models still exist today, and will continue to exist/coexist alongside newer models

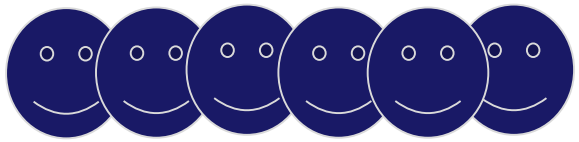



Traditional Fee For Service Model. More volume to higher paying settings

# Fee for Service



- We tend to think of “our patients” as the patients we have treated recently, and we try to deliver the best care possible to them.  We strive for more volume.

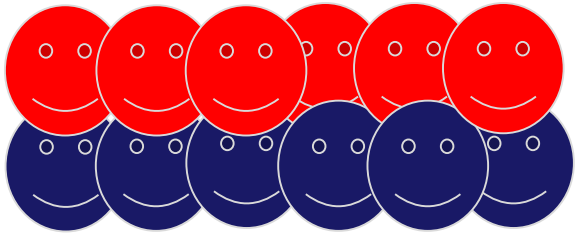


- We may outreach to patients we have not seen recently, but we are not held accountable for them.  We are constantly trying to ‘grow’ to feed our revenue stream.

# So what is the problem with this model

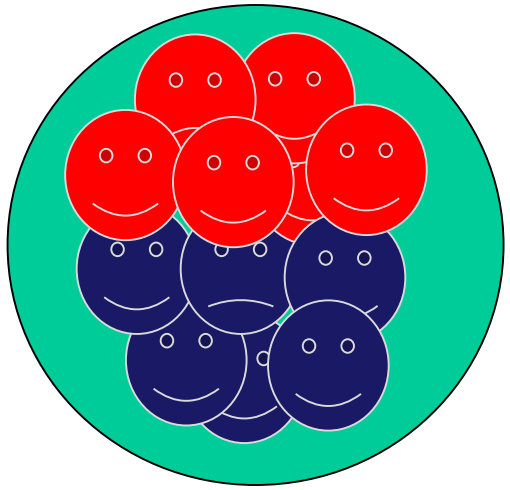
- It costs “the system” too much!!!!  (Consumers, taxpayers, insurers, state & federal agencies)
- It does not necessarily deliver outcomes
- Health systems are incentivized by volume, not health
- Patients do not “see” the “cost” of their choices relating to care
- It does not focus on the patients that should have received care/prevention

# Pay for Performance (P4P) - shifting from who we have seen to who we are responsible for. . .

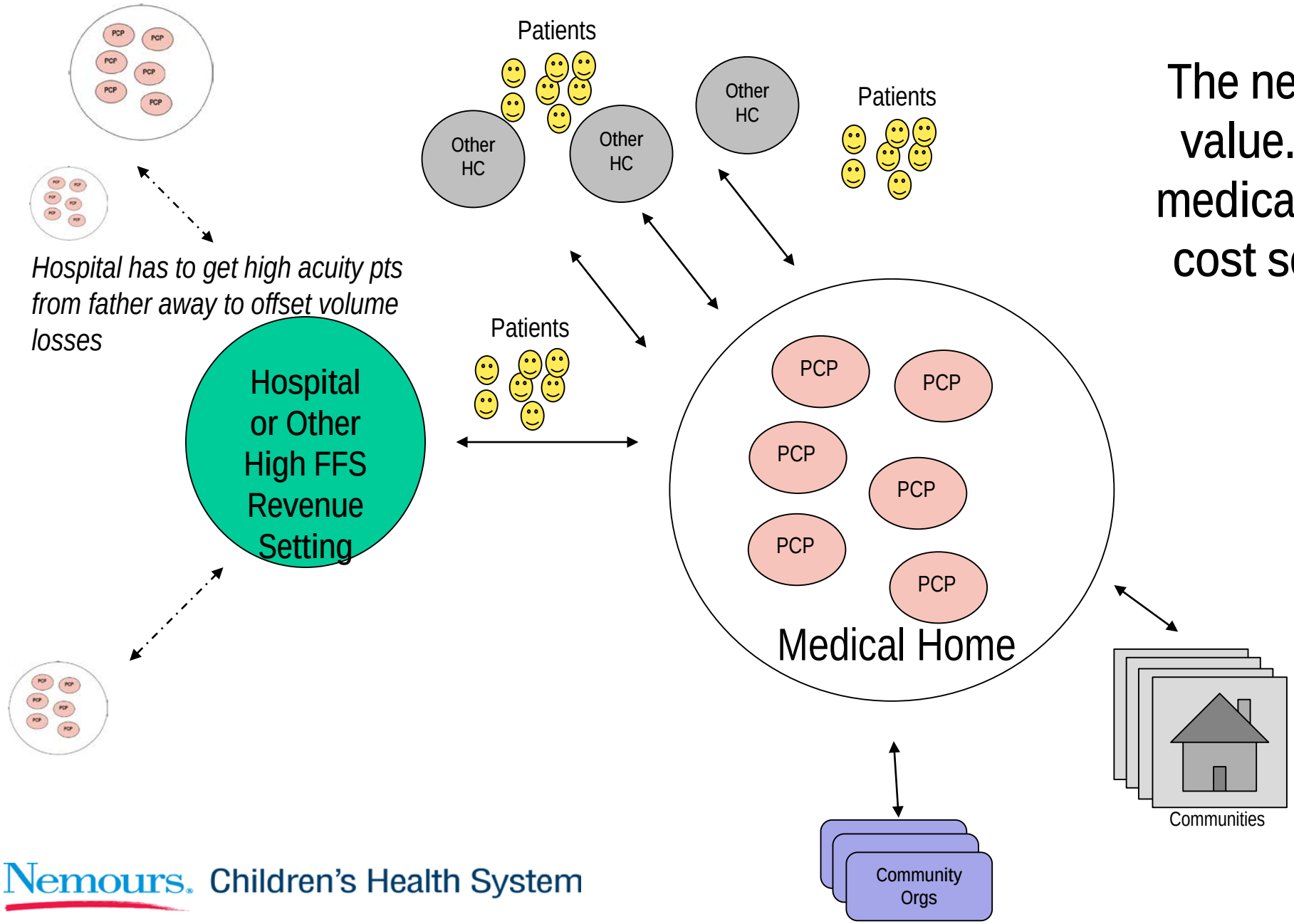


- Under P4P, we are held accountable for quality measures on children we are responsible for (based on assignment or attribution) WHETHER we have seen them recently or not. We are basically responsible for a population of children, and are rewarded based on how well that population has complied with quality measures
- This model can exist alongside our FFS Model
- Increasingly this is how health systems receive additional dollars, in lieu of rate increases

# Move to Risk



- As we move to risk (under a variety of different types of contracts), we are increasingly responsible for that same, unified set of patients.
- In addition to quality measurement we (health systems) now are also responsible for their total cost of care, *no matter where care was given.*
  - *We may lose money because of patients assigned to us that we have not seen recently, whose cost is incurred at a facility that does not belong to us*
  - *We need to manage where care is delivered as much as whether it is delivered*




The new paradigm of value. Focus on the medical home & lower cost settings of care

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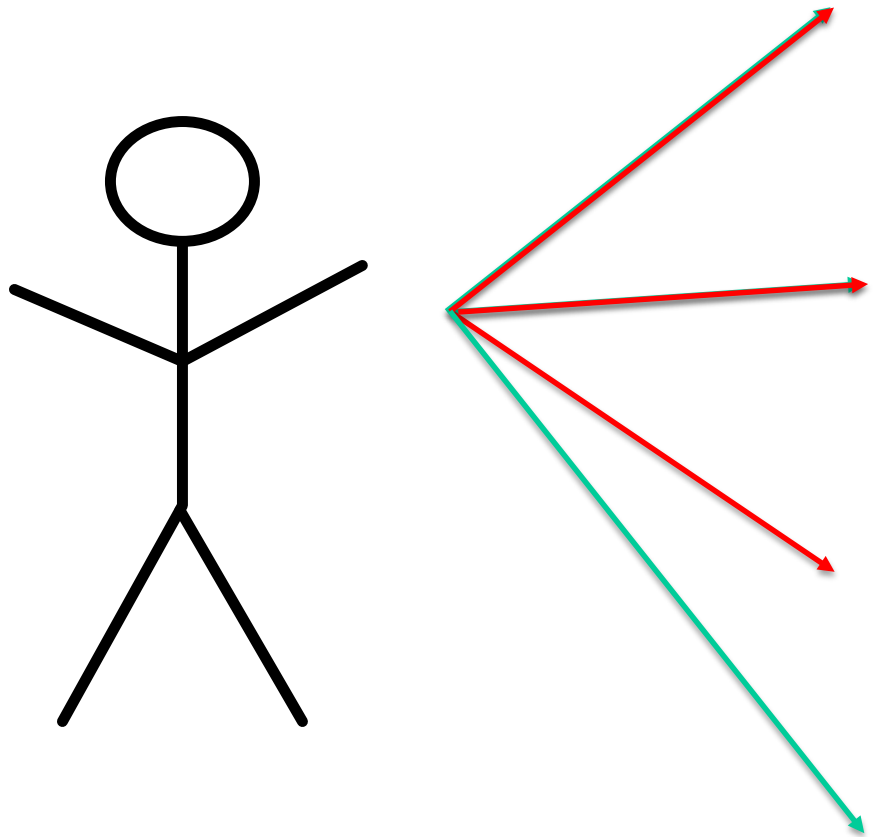
# What are patients experiencing?



Higher deductibles, pressuring patients to look for lower cost services

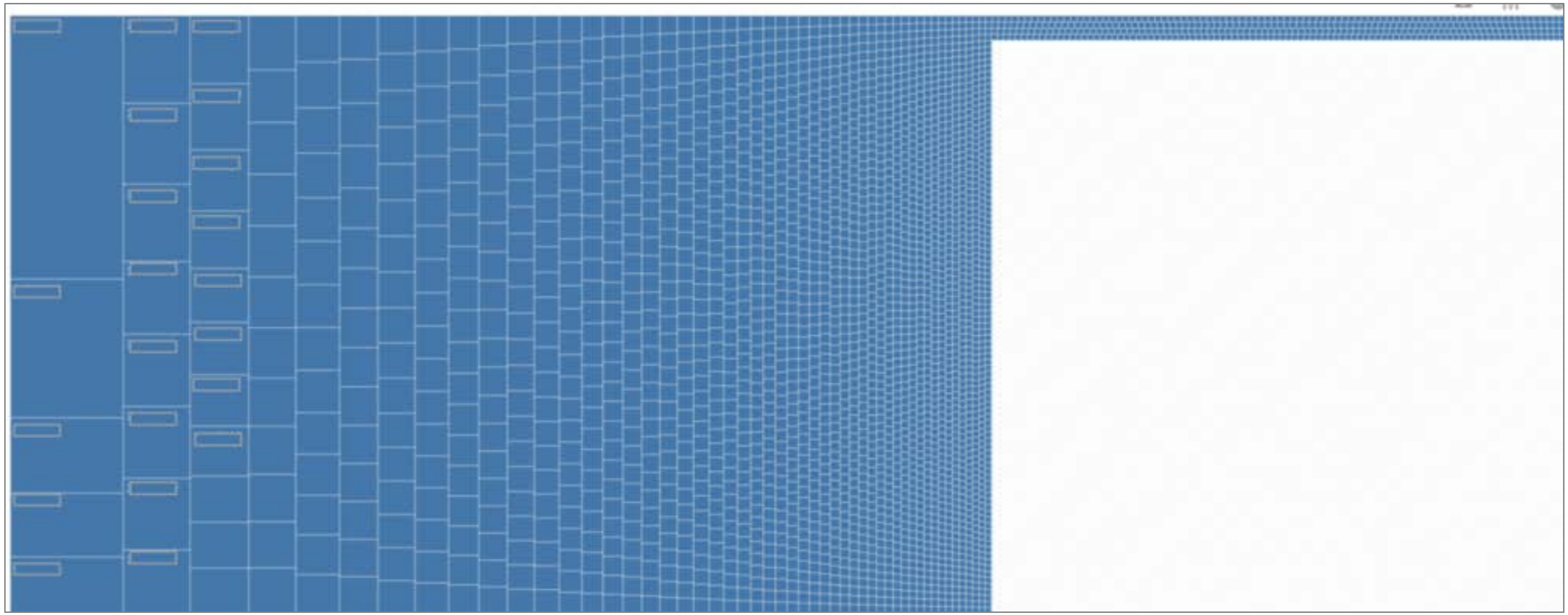
Narrower networks that dictate where services can be obtained

More approvals/authorizations needed

A lot more alternate/non traditional ways to seek care!

# We need to understand patients better

- Patients as Consumers
  - How do they use healthcare
  - What do they buy/don't buy
  - What is the best way to reach them
  - What products or services would be attractive?
- Patients as part of populations we manage
  - Why are they non compliant?
  - Why do/don't follow treatment plans?
  - What drives use of high cost services?
  - What are characteristics of patients that drive our success reducing cost?



Each box is one patient. The size of the box represents how much their care has cost during the last year

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# Patterns of Use & Impact

- In general, a small percentage of patients assigned or attributed to a patient panel will account for a very large percentage of the overall cost (a few patients have very large “boxes”)
- 5% of patients = 50% of $$ is a good way to think of this, though it may vary a bit
- These 5% will tend to be more medically complex, require longer periods of inpatient hospitalization and/or more expensive medications

WHY THIS MATTERS

- Most spend for these patients will happen OUTSIDE of the Primary Care setting, and OUTSIDE of the guidance of the PCP

# The role of risk scoring

- The reason we have started using risk scoring tools is to understand who might make up those “bigger boxes”
- Not all complex patients are very high cost, but all very high cost patients are complex
- Appropriate coding is needed to get the right risk score assigned to patients
- Better coding of underlying conditions means better projections of how much our patients ‘should’ cost.

# What are control points?

- Ask for a clause in our contract to exclude high cost patients from calculations or exclude dollar amounts in excess of a specific dollar limit
- Negotiate what services (sources of spend) are included or not (exclude newborns?)
- Manage unnecessary utilization of high cost services
- Manage preventable utilization of high cost services
- Direct patients to lower cost settings of care (Nemours or not)
- Manage how much it costs US to deliver services, which then translates into costs passed on to the patient/insurer

# Value Based Care through the Lens of Population Health

- Once the contract models are resolved, organizations need to develop and execute plans for addressing any barriers to success
- Since these contracts tend to focus on reducing total cost of care as well as achieving specific quality goals, these efforts should factor in population specific approaches
- Driving improvements in prevention, utilization and overall health with a one-size-fits-all model will result in a lot of failures and inefficient resource utilization on the part of a health system

# How well do we understand our patients and what factors influence their care and health outcomes?

- As a health system, we need to explore barriers to care that affect our patients
- Factors that influence health and health outcomes
  - Clinical Complexity
  - Social Needs/Poverty
  - Geography
  - Demographics (language, race, culture, etc.)
- Are there areas where these factors intersect and we can intervene?

# Clinical Complexity

- Providing the correct level of management and outreach
- Example: Readmission rates
  - Clinically complex patients and non-clinically complex patients
  - All cause 30 day readmission rates are over 2.5x higher among complex patients than non complex patients

# Social Needs

- Identifying Social Determinants of Health
  - Standardized screening
  - Visible to care teams
  - Support the individual patient and large scale population analysis
- Models to Address Needs
  - Community Integration vs. Medical Lens
  - Does the need have a direct medical impact?
  - Different ways to address a need and render services
    - Handouts
    - Warm handoffs to community organizations
    - Medical-Legal partnerships

# Clinical Complexity & Social Needs

- Social needs are an important predictor of utilization and adverse outcomes
- We need to look at the patient's need through different lenses
- For example: Housing Quality
  - Asthma patient has completed the SDOH screener and is positive for a housing need
  - Is this a clinical or social need? Both.
  - Available interventions
    - Clinical: Community Health Worker investigates the home's air quality and other areas for direct impact on asthma
    - Social: Care Coordinator to connect patient's family with a support service to help with new housing/ rent assistance or home remediation programs

# Social & Geography Example

- Geography as a boundary has a different meaning depending on the social need
- For example: Access to Transportation
  - Does the patient have reliable access to transportation?
  - How far does the patient live from our sites?
  - Available Interventions
    - Telehealth access to specialists
    - Access to transportation services
    - Frequent outreach from clinic staff

**Amber** is a 13-year-old girl with Type 1 diabetes. She resides with her grandmother in Alabama (over a two-hour drive). The family struggles with transportation and financial issues. These issues have caused several cancelled/no-show appointments. The patient is covered by Alabama Medicaid, which will not transport across state lines.

# Geography

- How do our patients get to us?
- Where are our patients?
  - How far do they live from our clinics
  - Are there more accessible days/ hours for them to travel
  - Can their services be delivered via Telehealth?
  - Could patients access telehealth or remote services?
- How can we better interact with these patients?

# Demographics

- Different populations experience healthcare differently
  - Different outcomes
  - Different levels of trust in health system
  - Experiences with institutional or even direct racism, language barriers, lack of cultural context or sensitivity
- Positive health outcomes cannot be achieved without first understanding the populations being served, their communities and needs
- We are committed to capturing Race, Ethnicity, and Language (REaL) data for every patient we serve, and using that data to assess and address disparities in care and outcomes

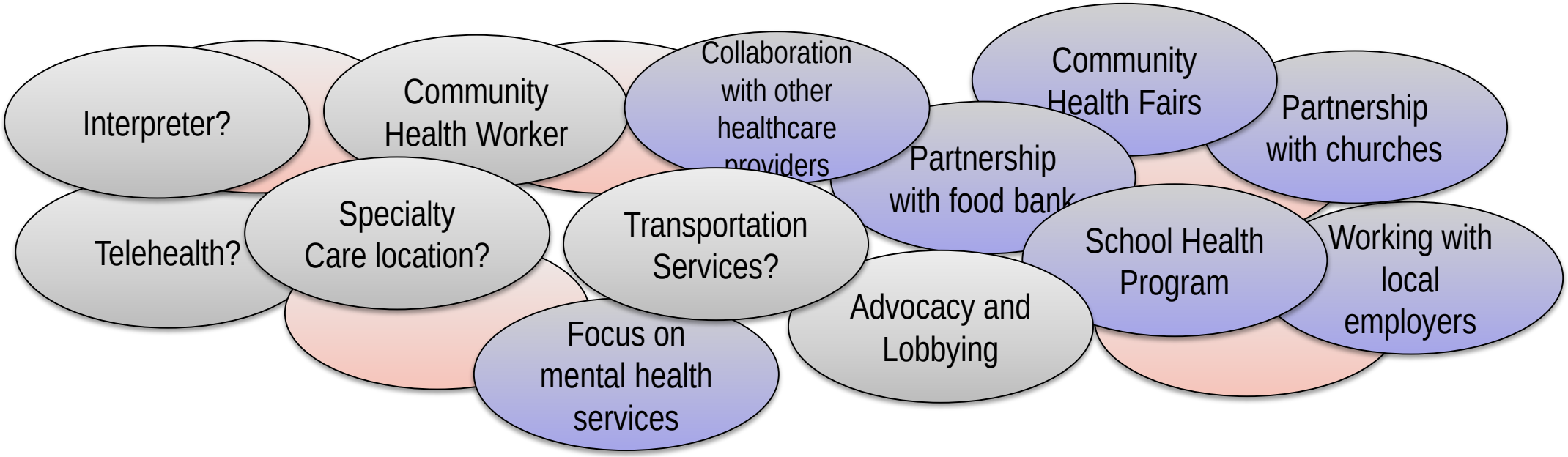
# Demographics Example

- Effectively capture demographics across populations and explore the why
- Example: HPV vs. Flu rates
  - Why do certain locations/ populations accept one vaccine but not the other?
  - Available interventions
    - More analysis
    - Explore possible language, racial, cultural factors

# Understanding our patients & Interventions

- The true power of intervention is to explore the intersection of clinical, social, geographic, and social influences
- When only focusing on patient attribution, ignoring these needs may negatively impact the care of other patients
- It is important to understand
  - How to better engage patients
  - How to analyze that these disparities exist
- Through understanding our patients better, we are able to treat the “whole patient”

# When and where to intervene?



# Thank you!

## Questions or comments?:

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