Population Health Trajectory – VBP and Beyond

DSRIP Statewide Learning Collaborative
August 30, 2016
DEVELOPING ACCOUNTABLE HEALTH COMMUNITIES AT THE PROVIDER LEVEL

- Network Overview & Relevance
- Success Drivers for Volume to Value Transition
- Mission Critical – Communication Cycle & JOCs
- A2B – Taking Analytics to the Bedside for Practice Transformation Yields Results
- Comprehensive Care Management Resource Support
- Accountable Healthcare Communities
- Glide Path for Transition to Value-Based Care Delivery
Network Overview & Relevance

CIN Value-based Contracts Contributing to Appropriate Hospital Admissions

12% (up from 1%) of hospital admissions occur within CIN Value Based population

CIN Inpatient Admissions

<table>
<thead>
<tr>
<th>Regional Hospitals</th>
<th>CIN admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>25%</td>
</tr>
<tr>
<td>Hospital B</td>
<td>20%</td>
</tr>
<tr>
<td>Hospital C</td>
<td>18%</td>
</tr>
<tr>
<td>Hospital D</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital E</td>
<td>14%</td>
</tr>
<tr>
<td>Hospital F</td>
<td>13%</td>
</tr>
<tr>
<td>Hospital G</td>
<td>10%</td>
</tr>
<tr>
<td>Hospital H</td>
<td>9%</td>
</tr>
<tr>
<td>Hospital I</td>
<td>8%</td>
</tr>
<tr>
<td>Hospital J</td>
<td>4%</td>
</tr>
<tr>
<td>Hospital K</td>
<td>4%</td>
</tr>
<tr>
<td>Hospital L</td>
<td>2%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>12%</td>
</tr>
</tbody>
</table>

Increased from 3% to 31%
Success Drivers for Volume to Value Transition

Transparency • Engagement • Consistency • Optimization • Variation Reduction

Data: You don’t know what you don’t know

Outcome: If you keep doing what you’ve always done, you’ll get the same outcome you’ve always gotten

Data Driven Performance

Evaluate Goals

Develop Best Care Guidelines

Determine Actionable Data

Build Data Collection Routines

Operationalize Resource Allocation

Apply Analytics

Transparency

Engagement

Consistency

Optimization

Variation Reduction
BSWQA Member Communication Cycle

**Data Transparency**
- Nightly Refresh of PM-EHR Data
- Monthly Refresh of Claims Data
- Member website
- Provider Performance Dashboard

**Provider Messaging**
- Network Field Advisor
- eNewsletter
- eCME and other Education
- Ad Hoc Virtual Committee

**Practice Messaging**
- Practice/Provider Joint Operations Council (JOCs)
- Practice/Provider Rapid Response Team
- Regional Open Forum POE/POD

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**JOC: What It Is**
A Medical Executive Committee Joint Operations Council is a multi-disciplinary meeting with those who make co-create solutions and implement them.

**Goal:**
- Optimize the spread of initiatives
- Increase performance awareness
- Celebrate quality achievement
- Monitor opportunities for improvement
- Share corporate messages in the field

**Considerations:**
- Network Utilization Management
- Risk Adjustment Factor
- Clinical Quality
- Clinical Efficiency
- Patient Experience
- Clinical Integration
Analytics to Bedside (A2B) Yields Results

Quality Improvements

BSW NTX Employee Health Plan PMPM Allowed Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Actual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$432.90</td>
</tr>
<tr>
<td>2013</td>
<td>$480.83</td>
</tr>
<tr>
<td>2014</td>
<td>$468.23</td>
</tr>
<tr>
<td>Projected</td>
<td>$460.03</td>
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</table>

12% FEWER HOSPITAL ADMISSIONS
Controlling costs through the reduction of inappropriate admissions

6% REDUCTION IN MEDICAL COSTS

Medical trend continues to outperform the market and remain flat over first 3 years

Zero Trend in total medical costs

Admissions Per Thousand BSW NTX Employee Plan

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions/1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>74</td>
</tr>
<tr>
<td>2013</td>
<td>68</td>
</tr>
<tr>
<td>2014</td>
<td>67</td>
</tr>
<tr>
<td>2015</td>
<td>65</td>
</tr>
</tbody>
</table>
Glide Path for Transition to Value-Based Care Delivery

Year 1
Process of moving from: 
FFS → P4P → FFV

Year 2
Infrastructure
Wellness
Disease Management
TCM Trending

Year 3
Phase 1: Beginning Risk
Applied Analytics
Resource Allocation
Dashboard Trending

Year 4
Phase 2: Increasing Risk
Workflow Performance
Compliance Rates
Data and Process Gap Refinement

Population Health
Risk Documentation
Disease Management
Standardization
Network Utilization
Transition of Care