Bridging the IT Functionality Divide in Care Coordination
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Anne Meara
AVP, Network Care Management

Dave Kim
Strategy Advisory Service Line Executive

DISCLAIMER: The views and opinions expressed in this presentation are those of the author and do not necessarily represent official policy or position of HIMSS.
Conflict of Interest Disclosure

Anne Meara, RN, MBA
David Kim, MBA

Have no real or apparent conflicts of interest to report.
PJ2  Changing all body text from gray to black for readability  
Patricia Johnson, 4/14/2015

PJ3  Putting all titles in the same place with the same font  
Patricia Johnson, 4/14/2015

PJ5  HIMSS gave out a really defective template that was impossible to use...I'm fixing for title and font placement and consistency  
Patricia Johnson, 4/14/2015
Learning Objectives

Learning Objective 1: Discuss Montefiore’s extensive history with population health / care coordination including the IT challenges faced by an operationally advanced Pioneer ACO.

Learning Objective 2: Describe the complex operational environment required to support multiple risk-based programs and lines of businesses.

Learning Objective 3: Discuss the maturity of the population health and care management vendor marketplace.

Learning Objective 4: Explain the key gaps in functionality that vendors will need to develop in order to support advanced care coordination.

Learning Objective 5: Summarize how Montefiore has creatively deployed IT solutions in the absence of robust vendor offerings.
added period to second bullet to be consistent.
Patricia Johnson, 4/14/2015
Benefits Realized for the Value of Health IT

- **Value of Health IT**
  - SATISFACTION
    - Patient, Provider, Staff, Other
  - TREATMENT/CLINICAL
    - Safety, Quality of Care, Efficiency
  - ELECTRONIC INFORMATION/DATA
    - Evidence-Based Medicine, Data Sharing and Reporting
  - PREVENTION & PATIENT EDUCATION
  - SAVINGS
    - Financial/Business, Efficiency Savings, Operational Savings

http://www.himss.org/ValueSuite
The Bronx

- 1.4 million residents in the poorest urban county in the nation
- Median household income $34,000
- 54% Hispanic, 37% African-American
- High burden of chronic disease
- Per capita health expenditures 22% higher than national average
- 80% of health care costs paid by government payers
Montefiore Medical Center

• Teaching hospital for Albert Einstein College of Medicine
• 7 acute care hospitals plus a children’s hospital
  – 2,597 beds: >126,000 discharges
  – 6 emergency departments: >513,000 visits
• 3,900 providers
• 22 community primary care centers:
  – >1 million visits
• Home care agency: 500,000 visits
• Nursing home: 150 beds
• School of nursing
Montefiore IPA & CMO

**Montefiore IPA**

- Formed in 1995
- MD/ Hospital Partnership
- Contracts with managed care organizations to accept and manage risk
- Over 3,900 providers
  - 3,000 physicians
  - 1,900 employed
  - 500 PCPs

**CMO**

- Established in 1996
- Wholly-owned subsidiary of Montefiore Medical Center
- Performs care management delegated by health plans as well as other administrative functions, (e.g. claims payment, credentialing)
Overview of Value-Based Payment Arrangements at Montefiore

<table>
<thead>
<tr>
<th>Source</th>
<th>2015 Population</th>
<th>2015 Est. Revenue</th>
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</thead>
<tbody>
<tr>
<td>Risk Contracts</td>
<td>170,000</td>
<td>$1,043 m</td>
</tr>
<tr>
<td>Shared Risk</td>
<td>165,000</td>
<td>$1,022 m</td>
</tr>
<tr>
<td>Medicaid Health Home (Care Coordination)</td>
<td>10,000</td>
<td>$18 m</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>345,000</strong></td>
<td><strong>$2,083 m</strong></td>
</tr>
</tbody>
</table>

**Goal:** To reach 1,000,000 covered lives
Pioneer ACO Overview

- One of original 32 selected by CMS in 2011
- Only one in New York State
  - Montefiore plus 5 other hospitals, 3 FQHCs
  - 3,400 physicians
- 49,000 attributed beneficiaries in PY4
  - ~15,000 duals
  - Estimate that 9% = 55% of spend
- Most financially successful Pioneer ACO in PY1 and PY2—$48 million savings to Medicare
  - Montefiore ACO share: $28 million

Source: Centers for Medicare & Medicaid Services
Montefiore’s Journey to Accountable Care

1996
Established the Montefiore IPA and CMO to facilitate risk contracts

2000
Major expansion of risk membership

2009
Montefiore leads creation of Bronx RHIO

2011
Montefiore selected as Pioneer ACO

2012
Formation of Montefiore-led Medicaid Health Home Program

2013
Creation of Montefiore HMO (MLTC) and expansion of Pioneer ACO

2014-2015
DSRIP planning and implementation; development of commercial ACOs

Sunset of NYS all-payer hospital reimbursement

Managed Care Expansion

Affordable Care Act

Performance-Based Culture

Development of care management infrastructure; extension of care management core competencies into network
PJ6  Cleaned up pictures a bit (removed white border).
     Patricia Johnson, 4/14/2015

PJ7  Changed font to Arial for text (standard)
     Patricia Johnson, 4/14/2015
Population Health Management – A Baby Unicorn?

The term “Population Health” has been around for nearly two decades,

- Recently popularized by movement towards value-based reimbursement
- Countless definitions have been developed by different organizations and individuals
- Largely equated with “Big Data” and Analytics
- Focus and perspective vary with factors such as:
  - Organizational type (provider, payer, etc.)
  - Health outcome-related metrics
  - Technology
  - Social, Economic, Physical Environment
Adjusted layout and made the subheader at top colored
Patricia Johnson, 4/14/2015
# Population Health Management: Organizational Maturity Continuum

## Early Development

- Shared Savings (upside only)
- Care Coordination Fees
- Pay for Performance

## Mature Environment

- Shared Savings (upside, downside risk)
- Full capitation
- Insurance license

## Program / Payer Mix

- MSSP
- Commercial ACO
- Pioneer
- DSRIP

## Risk Level

- Numerous tasks consolidated among few number of roles

## Care Coordination Organizational Model

- Care Manager functions in clinical and non-clinical capacities
- PCMH-centric model with embedded care managers
- Specialized, multi-disciplinary team performing to top of license
- Resources focused on clinical and non-clinical activities based on license and subject matter expertise
- Centralization of routine, repeatable tasks
- Strategic deployment of resources across care venues

Doesn’t read right. How about, “Numerous tasks consolidated among a few roles”
PJ9  Made font Arial for consistency. Changed color of arrows to match presentation color palette
Patricia Johnson, 4/14/2015

PJ26  Made graphic fit better on page
Patricia Johnson, 4/14/2015
Population Health Management Begins With Robust Data Analytics

- 8% Generate 55% of Medical Expense
- 5% Dual Eligible
- 12% Diabetes
PJ11  Made all boxes the same size
Patricia Johnson, 4/14/2015

PJ24  Also, bought stock image so people wouldn't look pixelated.
Patricia Johnson, 4/14/2015

PJ23  Patricia Johnson, 4/14/2015
Population Health Management – “Big Data” Is Not Enough

Analytics alone will not be able to identify underlying drivers influencing diabetic condition

- Unstable Housing
- Substance Abuse
- Mental Health
- Financial Distress
Did this one with unpixelated graphic as well
Patricia Johnson, 4/14/2015
Social Determinants of Healthcare Costs

- Lacks Social Support: 10% higher costs
- Lacks a Primary Care Physician: 12% higher costs
- Has Physical Limitations: 9% higher costs
- 16% Report Unstable Housing Situation
- Substance Abuse: 89% higher costs
- Financial Distress: 25% higher costs
- Mental Health Diagnosis: 38% higher costs

Based on results of over 4,000 assessments of high-risk patients conducted at Montefiore CMO
Great diagram but I made the title and footnote font consistent with other slides. Otherwise, this sticks out badly.
Patricia Johnson, 4/14/2015
PHM Across the Care Continuum – Connecting the Dots with Care Coordination

Care Coordination

Structured Clinical Content

Primary Care Provider, PCMH

Housing

SNF/Rehab/Hospice

Community-Based Organizations / Social Work

RX/Lab/Rad

Specialists, Referring Providers

Hospital

ED
PJ13  Changed color to be consistent with other slides
Patricia Johnson, 4/14/2015

PJ14  Also increased label font to make it easier to read
Patricia Johnson, 4/14/2015
Care Coordination Process Lifecycle

1. Identify & Prioritize
   - Identify members requiring care coordination services

2. Enroll
   - Enroll highest risk individuals and educate about care coordination

3. Monitor & Update Care Plans until Discharge
   - Link individual to services and organizations to provide care coordination

4. Develop Personalized Care Plans
   - Develop personalized care plan based on intensity of services needed

5. Assess Needs
   - Assess Needs (Baseline and Ongoing)
   - Understand member’s medical, behavioral, and social needs

6. Stratify into Programs
   - Patient
   - Primary Care Provider, PCMH

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**PJ15**
Changed colors and fonts to make this consistent with rest of template. Also made ovals true circles and removed bevel.

Patricia Johnson, 4/14/2015
Frequent member transitions occurring across multiple programs. Each program has unique requirements impacting workflow.

<table>
<thead>
<tr>
<th>Member</th>
<th>Fee-for-Service</th>
<th>Pioneer ACO</th>
<th>Health Homes</th>
<th>Managed LTC</th>
<th>Medicare Adv.</th>
<th>Shared Savings (Commercial)</th>
<th>DSRIP</th>
<th>Oxford, Healthfirst Medicare</th>
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</tbody>
</table>
changed subheader into colored text box. Made colors of table match presentation colors

Patricia Johnson, 4/14/2015
PHM Operational Deployment

Standardized Processes Regardless of Programs……

- Pioneer ACO
- Health Homes
- Managed LTC
- Medicare Adv.
- Shared Savings (Commercial)
- DSRIP
- Oxford, Healthfirst Medicare

Supported by Specialized Resources Performing to Top-of-License….. ….within and Across Organizations.

- Accountable Care Managers
- Behavioral Care Managers
- Clinical Subject Matter Experts
  - Physicians
  - Pharmacists
  - Palliative Care / Hospice
  - SNF Team
- Community Resource Experts
- Baseline Assessment Group
  - Hospital-Based Resources
    - ED navigators
    - Social Workers
- Post-Discharge Follow Up Unit
Put in recolored lifecycle. Also, changed box to make white text contrast better

Patricia Johnson, 4/14/2015
Sophisticated Workflows and Organizational Complexity Require Robust IT Support

- **Automated surveillance and stratification** of members to determine resource intensity
- **Dynamic assessment functionality** with branching logic, algorithm design, expand/collapse capable
- **Robust data model** focused around complex eligibility, problem, goals, interventions hierarchy
- **Best-practice workflows** configured to span medical and psychosocial domains
- **Personalized care plan** that can be reassessed and updated longitudinally and episodically
- **Multi-disciplinary care team access** to care plan and member data across continuum of care
PJ18 did title in caps.
Patricia Johnson, 4/14/2015

PJ19 put in redone diagram
Patricia Johnson, 4/14/2015
## Key PHM Organizational Drivers

<table>
<thead>
<tr>
<th>Business Requirements</th>
<th>IT Enablement Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex Care Management Workflows</td>
<td>• Strong process/workflow management capabilities</td>
</tr>
<tr>
<td>Advanced Care Management Resourcing Model</td>
<td>• Robust rules engine platform</td>
</tr>
<tr>
<td>Multi-program/population environment</td>
<td>Clear delineation of roles and assignment of tasks for end users via dynamic worklists</td>
</tr>
<tr>
<td>Evolving value-based program requirements (“moving target”)</td>
<td>Flexible eligibility and coverage hierarchies</td>
</tr>
<tr>
<td>Cross-continuum care coordination and data-sharing</td>
<td>Highly agile, configurable solutions with rapid speed-to-deployment</td>
</tr>
<tr>
<td></td>
<td>Advanced security and user-level permission configurability (regardless of frequency)</td>
</tr>
</tbody>
</table>
adjusted table spacing, changed arrow color, and removed bullets where there was only one item in a cell

Patricia Johnson, 4/14/2015
PHM Across the Care Continuum – Enabling Care Coordination Leveraging IT

Care Coordination

Patient Portals
Analytics
HIMSS15

EMR
SNF/Rehab/Hospice
Community-Based Organizations / Social Work

Patient
Primary Care Provider, PCMH

Housing

ED
Specialists, Referring Providers

RX/Lab/Rad

HIE

Tele-Health
made color consistent with previous slide; adjusted DB names to fit better in cylinders. Adjusted DB colors
Patricia Johnson, 4/14/2015
Care Management Organization – IT Vision

- Standardized processes across programs
- Focused around patient, not disease or condition

Automation Layer

- Consolidated technology platform
- Access to real-time data
- Interoperability across care continuum

Population Health Management Automation

- Workflow-driven Care Management Functionality
  - Patient and Provider Engagement
  - Health Information Exchange
  - Business Process and Rules Management
  - Advanced Analytics

- Pioneer ACO
- Risk Programs
- Other Value-Based Programs

- Monitor & Update Care Plans until Discharge
- Identify & Prioritize
- Enroll
- Develop Personalized Care Plans, Stratify into Programs
- Assess Needs (Baseline and Ongoing)

PJ22
made all text black for readability. Put in new care cycle (new colors). Toned down the gradient for readability.

Patricia Johnson, 4/14/2015
New Care Models Are Creating Significant Activity in the Vendor Marketplace

Vendors are evolving to meet PHM/Care Coordination requirements necessary to support Value-Based Care Delivery.
Where to Start?

- What is your organization’s current and future growth strategy for Value-Based Care?
- How is your organization operationalizing value-based contracts with your current payer partners (commercial, CMS)?
  - Organizational structure, processes, staffing
- What systems and platforms can you leverage for care coordination (build vs buy)?
- Who else might you be sharing and exchanging data with outside of your organization?
- You’ve identified and stratified a number of patients that need to be managed…now what?
An Introduction to the Benefits Realized for the Value of Health IT

- **SATISFACTION**
  - Patient, Provider, Staff, Other
  - Improved communication with providers, patient and among internal staff
  - High levels of patient satisfaction

- **TREATMENT/CLINICAL**
  - Safety, Quality of Care, Efficiency
  - Improved population health data-sharing and information exchange

- **ELECTRONIC INFORMATION/DATA**
  - Evidence-Based Medicine, Data Sharing and Reporting
  - Reduction in inpatient readmissions (heart failure, diabetes)

- **PREVENTION & PATIENT EDUCATION**

- **SAVINGS**
  - Financial/Business, Efficiency Savings, Operational Savings
  - Improved population health data-sharing and information exchange

http://www.himss.org/ValueSuite
Questions?

Thank You!

Anne Meara
ameara@montefiore.org
914-377-4731

Dave Kim
dkim@encorehealthresources.com
917-514-2958