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Population Health…. Our Journey

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North Mississippi Health Services

- 650+ bed regional referral center located in Tupelo, MS
- 5 affiliated hospitals
- Behavioral Health Inpatient and Outpatient Services
- Women's Hospital
- 3 Nursing Homes
- Home Health Services
- Hospice Services: Inpatient and Outpatient
- Comprehensive Post-Acute and Rehab Services
- Wellness Centers

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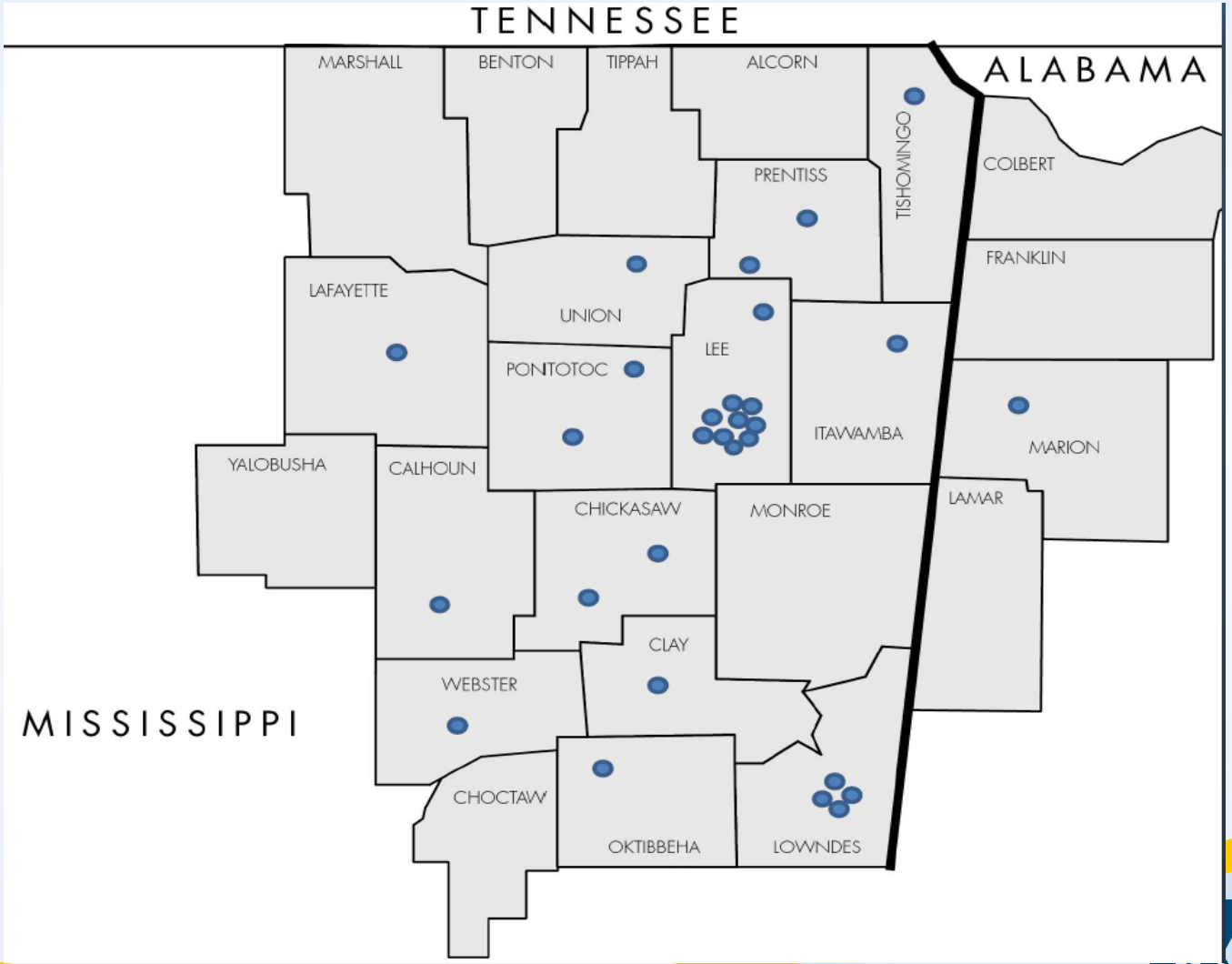
Serving Rural Mississippi and Alabama



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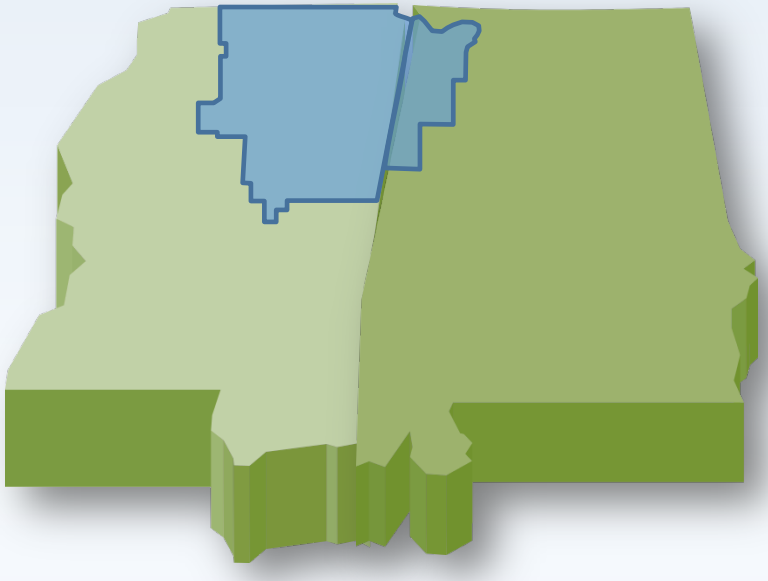
Our Clinic System

- 700+ employees
- 150 physicians
- 60 advanced clinical practitioners
- 600,000+ visits yearly
- 40 full-time clinic locations
  - 8 RHCs
- 14 medical and surgical specialties



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Timeline	
1990	First Clinic
1999	Adoption of Electronic Health Record
2003	Process/Outcomes tracking began
2009	First proactive patient outreach tools
2011	Best Practices and Innovations established
2012	Fall – Population Health Program
2016	Participation in MSSP ACO

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Why Population Health?

- Soaring Cost of Healthcare- Medicare spent $2.6 Trillion in 2014
- Push to Reduce Hospital Readmissions beginning in 2012
- U.S. ranks lowest in quality among other countries and healthcare systems are seen as producing marginal quality
- Patient care growing increasingly uncoordinated- rise in urgent care provider use among commercial plan members
- Burden of chronic disease is continuously growing

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Why are we participating?

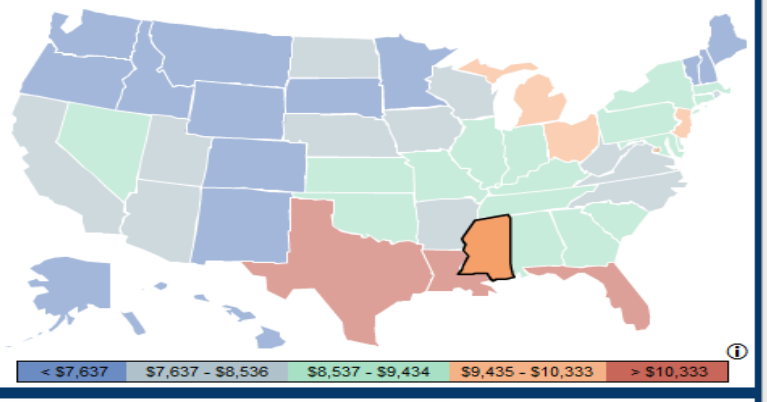
Geographic Variation in Standardized Medicare Spending

Standardized Costs | Information

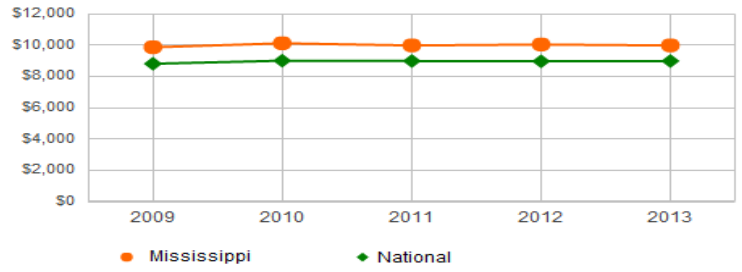
2009 2010 2011 2012 2013

Total Per Capita Costs

* Select a state to see State level data. Unselect states to see National data.



Total Per Capita Costs for Mississippi



Mississippi Standardized Cost Breakdown, 2013

Cost	State	Nation	% Diff to Nation
Total	**$9,972**	**$8,985**	11%
Inpatient	$2,780	$2,579	8%
Post-Acute Care	$2,212	$1,646	34%
Hospice	$420	$309	36%
Physician/OPD/ Tests/Imaging	$3,336	$3,347	0%
Durable Medical Equipment	$290	$213	36%
Part B Drug	$279	$319	-13%
Ambulance	$104	$138	-25%

10%+ under National Avg 10%+ over National Avg

CMS

Produced by the CMS/Office of Enterprise Data and Analytics (OEDA), October 2015

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Population Health Key Items

- Increased access to care
- Patient-centered
- Coordinated Care
- Team-based approach
- Overall patient experience
- "Value" driven care

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How is this done?

- Requires change in primary care delivery model; the change is not easy
- Needs active, engaged providers and active, empowered team
- Critical to have case management embedded in primary care site
- Linkage to every system of care is needed
- Payor/provider partnership essential to success

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Transforming Care Delivery

Today's Care	ACO/Medical Home Care
My patients are those who make appointments to see me	Our patients are those who are seen within our ACO/Medical Home
Care is determined by today's problem and time available today	Care is determined by a proactive plan to meet health needs, with or without visits
Care varies by scheduled time and memory or skill of the doctor	Care is standardized according to evidence-based guidelines
I know I deliver high quality care because I'm well trained	We measure our quality and make rapid changes to improve it
Patients are responsible for coordinating their own care	A prepared team of professionals coordinate all patients'
It's up to the patients to tell us what happened to them	We track tests and consultations, and follow-up after ED and hospitalization
Clinic operations center on meeting the doctor's needs	An interdisciplinary team works at the top of our licenses to serve patients

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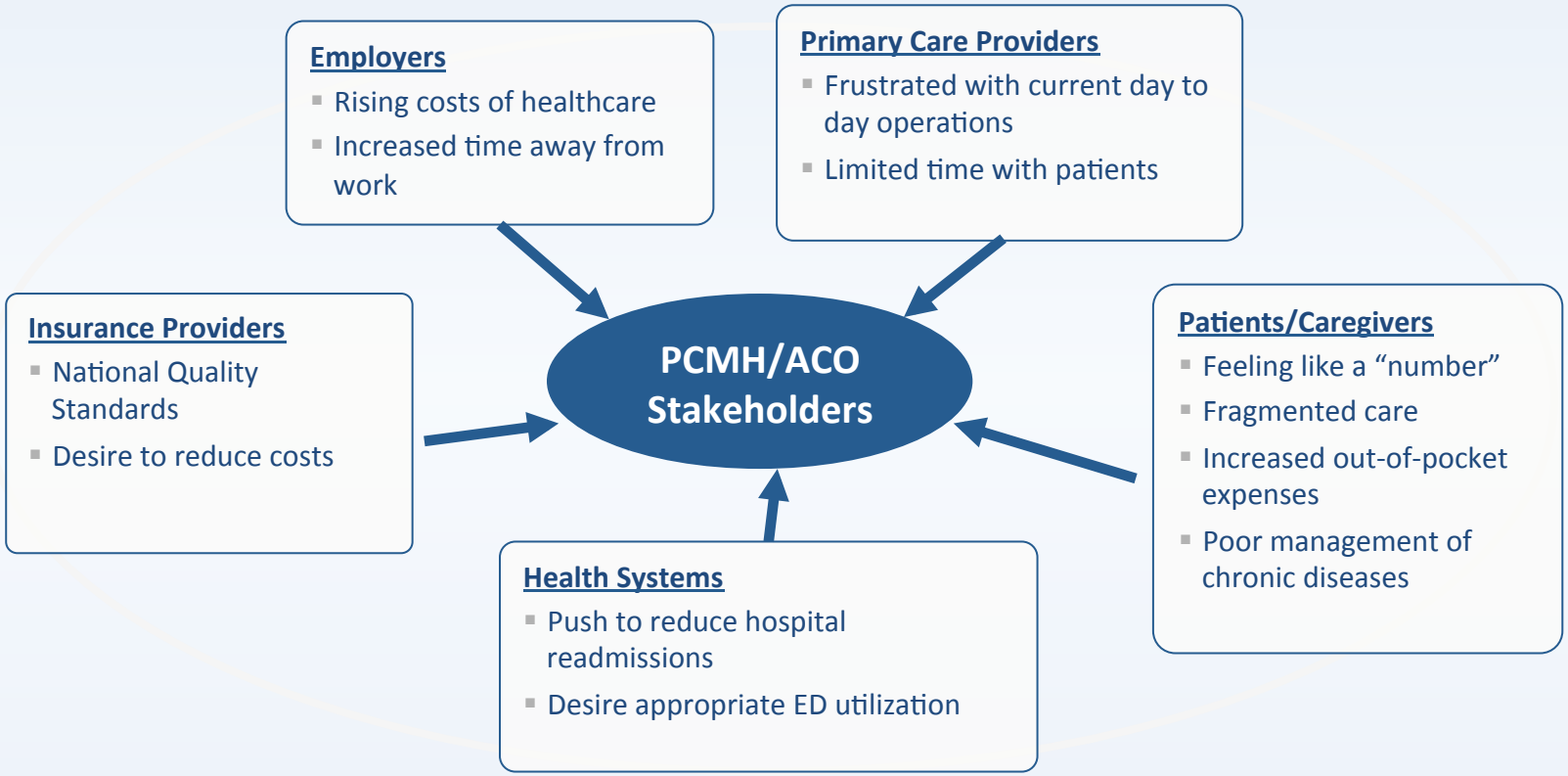
Primary Stakeholders



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Stakeholder Benefits

- For the Patient
  - Engaged, happier, and more satisfied
  - Better coordinated, more comprehensive, and personalized care
  - Improved access to medical care and services
  - Improved health outcomes, especially for patients who have chronic conditions

- For the Practice
  - Increased physician staff member satisfaction
  - Physicians and staff members who practice at the top of their licenses
  - Improved safety and quality of care

- For the Bottom Line
  - More efficient use of practice resources, resulting in cost savings
  - Opportunities to participate in payment incentives
  - Practices better prepared for future payment reform and value-based payment models

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Our Goal: Triple Quadruple Aim

- Quality Care
  - Long, healthy, and productive lives
  - Access, efficiency, equity
- Cost
  - Moderate medical expense
- Patient experience
- *Provider experience*

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What's in a name?

Guided Care Nurse

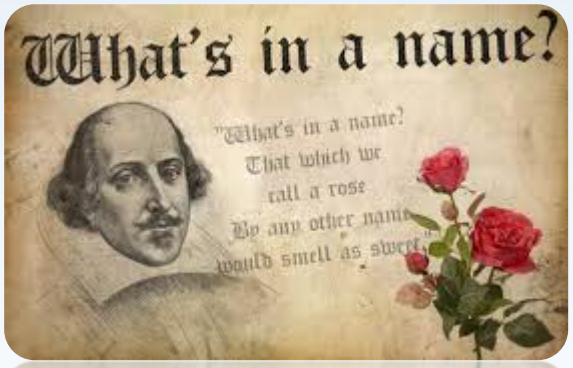
Care Manager

Health Advocate

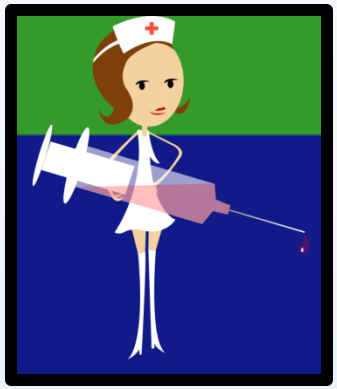
Transition Coach

Disease Manager

Health Coach



Population Health Manager



Case Manager

Patient Advocate

Health Navigator

Care Coordinator

Practice Coach

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Who Receives Health Management/Care Coordination?

- **Focus on high risk/high cost patients, which will ensure appropriate alignment in use of healthcare services**
  - "The right patient gets the right care at the right place and right time."
  - 10% of Medicare beneficiaries contribute to 60% of costs
  - 20% of Medicare beneficiaries contribute to 80% of costs
- **Build trusting relationships with patients and families**
- **Close the gaps in care delivery**
  - Reduce cost of care by 20%
- **Ensure effective mobilization of resources and appropriate alignment**
  - Avoid duplicative services
  - Ensure a smooth "hand-off" and transition of care from one environment to another
  - Ensure adequate follow-up and "closing the loop"

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Health Management at a Glance

Ambulatory Case Manager- The next generation of care coordination-- "Hybrid Geisinger Model"

- **Acute and Chronic disease management**
- **Transitions of Care**
- **Wellness and disease prevention**
- **Engagement of patients to drive ownership**
- **Patient education/resources**
- **Leveraging EHR to data mine and fill care gaps**
- **Track quality and outcomes**

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Identifying Our Target Population

- **Co-Morbid Conditions**

Asthma	Smoking Cessation	CAD
Hyperlipidemia	Hypertension	COPD
Diabetes	Weight Management	CHF
TOC	End-of-Life Care	

- **Transitions of Care**
- **Physician Referral**
- **Internal Chart Review or Risk Model- manual work**
- **Hospital Referral/SNF Referral**
- **Predictive Modeling Software**

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Predictive Modeling

- Technology that allows payors and care management organizations to:
  - Proactively stratify insured individuals at risk
  - Identify cost-drivers for their high-risk population
  - Forecast future health plan costs
  - Evaluate insured individual patterns over time
  - Improve clinical and financial outcomes

**For most payers, identifying and managing about 1% of their covered lives can generate significant savings. **

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Disease Registry: Meridios

- Customized containers for identifying “at risk” individuals
- Filter based on clinic, provider, payor
  - Acclaim and Medicare Population Health Views
- Filter based on specific disease states and quality, such as:
  - Diabetes: A1C >9, Eye/Foot Exams
  - Hyperlipidemia: LDL >150
  - CAD: BP <150/90
  - Tobacco Abuse: Smoking cessation material given
  - Preventive Wellness Needs: Flu, Mammo, Colonoscopy, Pneumonia

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Payer Partnership Project Focus

- Improve the Triple Aim: health, cost, and experience
- Reduce inpatient admissions or readmissions
- Reduce unnecessary ED visits
- Increase participation with Wellness Visit utilization
- Increase post-hospital follow up appointments
- Increase generic drug utilization
- Reduce PMPM cost across the board

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Program Performance Measures

Inpatient admissions	Readmissions	ER visits Avoidable visits
Post admission visits	Wellness Visit utilization	Biometrics
Primary Care (HEDIS measures)	Generic Rx Utilization	PMPM Cost

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Outreach, Tracking and Follow Up

- Health manager “touches”
- Registry monitoring
- Remote Patient Monitoring (CHF, HTN, DM)
- Daily hospital discharge/ED discharge report
- Transitions of Care Management
- Pre/Post Visit Planning
- Medication Management

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Target Population & Outcomes

- 137 members enrolled in program
  - 121 followed by embedded care manager
  - 16 followed by care coordinator
- Averaged 9.1 contacts per patient with over 900 patient contacts
- Reduced pharmacy costs of over 15% PMPM
- All service categories saw a decrease in PMPM costs except ancillary services

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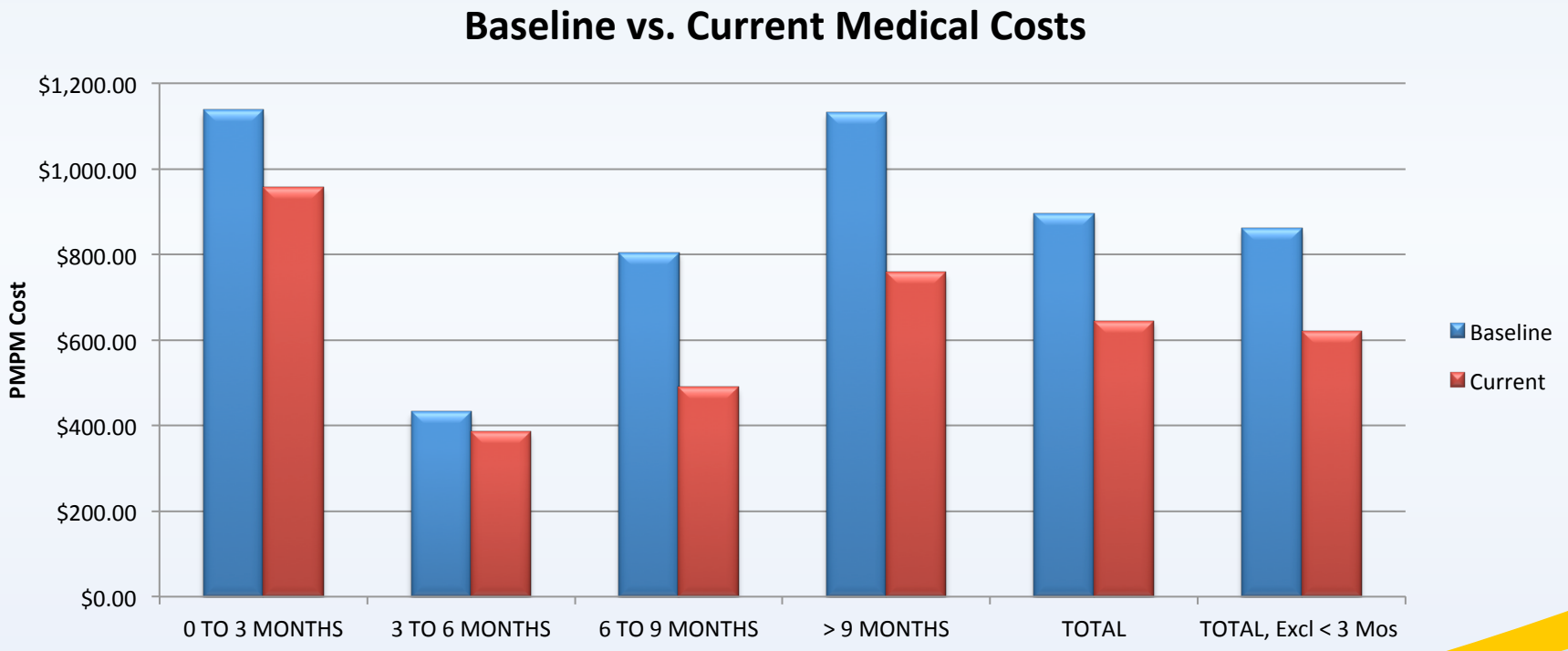
PMPM Cost Comparisons

- Decrease in total medical costs by nearly 27.8%.
- Continued decrease by 28% post PHM enrollment.



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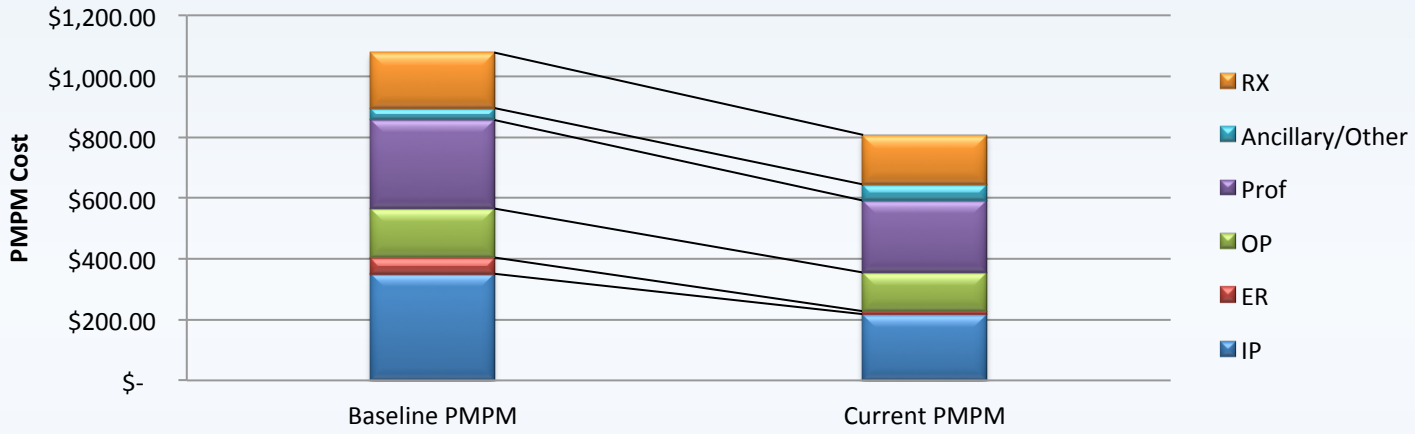
Baseline vs. Current Costs by Major Service Category

Total PHC Target Population (N=100)



- ER costs reduced by over 81%
- Outpatient costs reduced by over 21%
- Professional services reduced by over 18%

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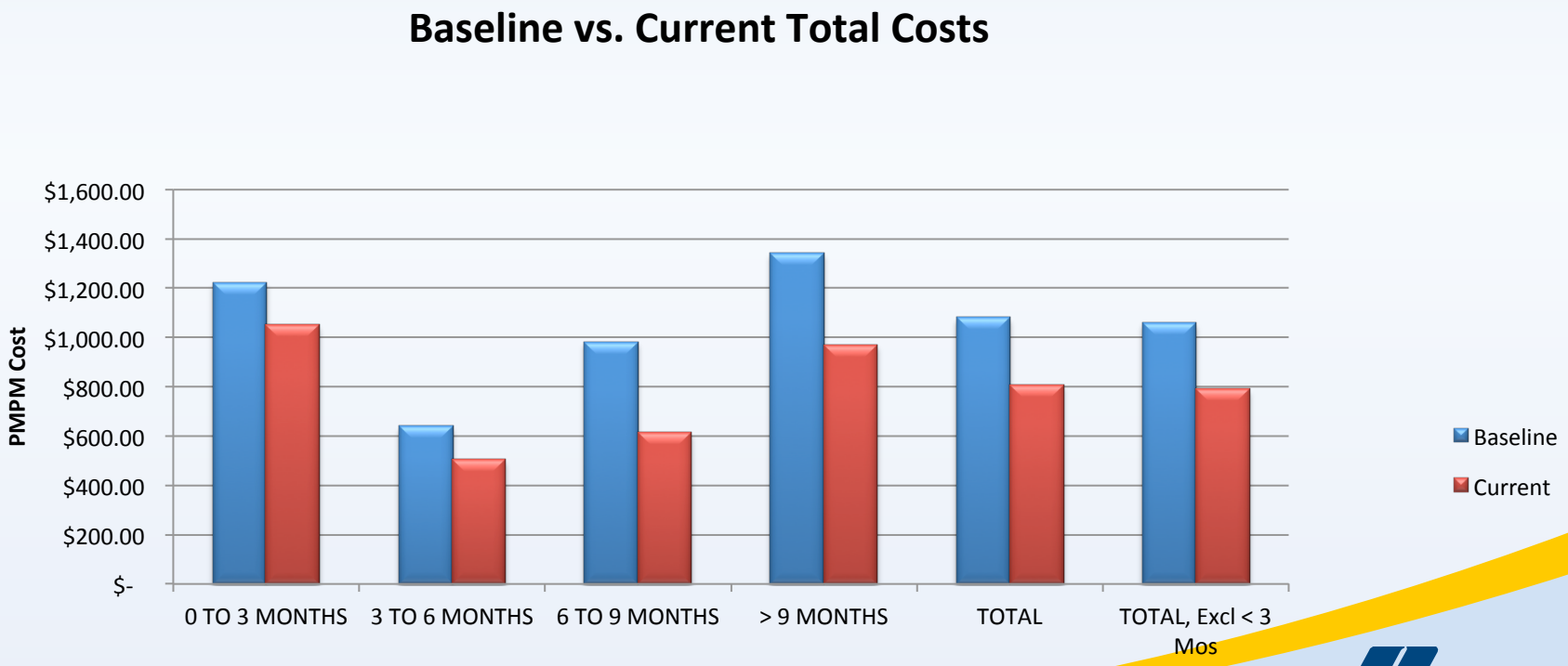
Overall Costs

- Average PMPM costs decreased by 25%.
- Decrease in inpatient costs (49% of the total decrease).
- All service categories saw a decrease in PMPM costs except ancillary/other medical services



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Can there be a positive ROI?

Financial Impact	
$64,338	Acute Members
$151,035	Chronic Members
25% or $271	PMPM Reduction in costs

Improved Health Outcomes	
17%	Members moved to lower risk category
57%	Improvement in Diabetes Control
86%	Improvement in Blood pressure

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Success through the "Three E's"

- Engagement
  - What are the patient goals?
  - Barriers to success
  - Building Relationship
- Empowerment
  - Encouragement
  - Support
  - Self-management Action plan
- Education
  - Treat each patient individually

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Ever Changing World of Healthcare

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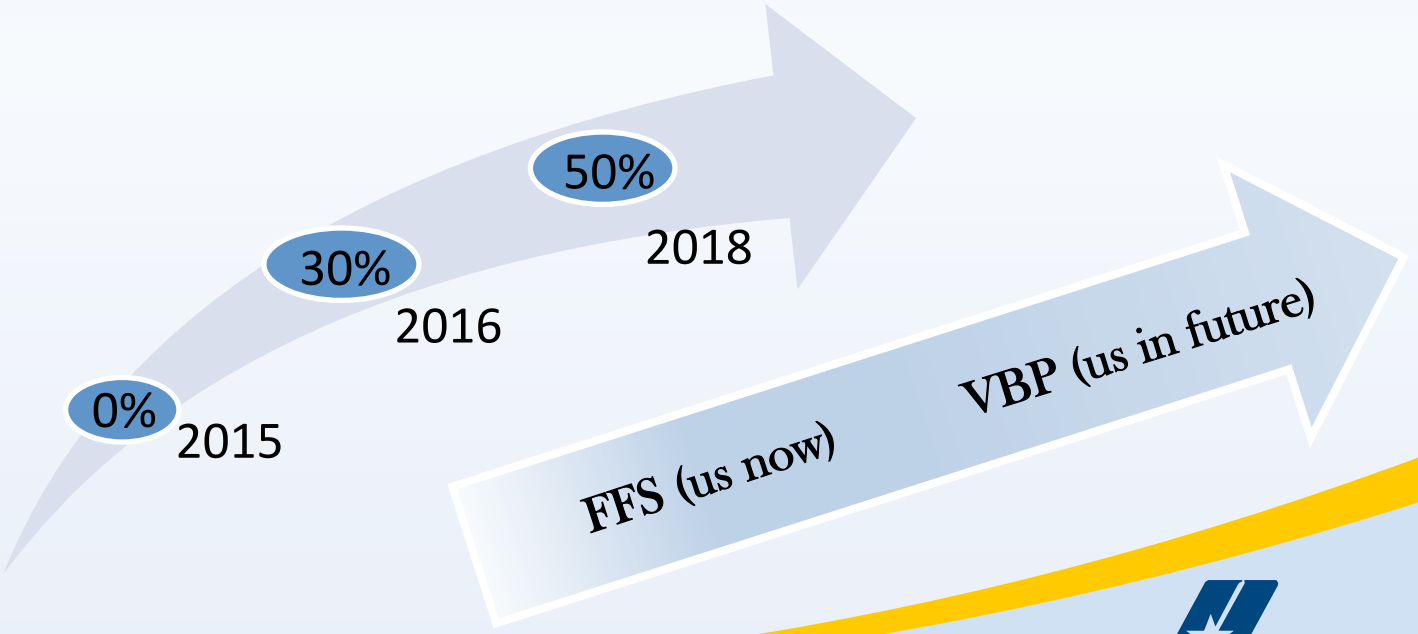
In early 2015, the Department of Health and Human Services announced a timeline to move the Medicare program toward paying providers based on the *quality*, rather than the *quantity* of care they give patients.



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NMMCI Moves Toward Advanced Payment Models (APMs)

- Partnerships over the last 4.5 years
  - Commercial Payor
  - Local Industries
  - Acclaim (NMHS' health plan)
- Quality Dashboards and PQRS
- Population Health Based Software
  - Disease Registry- data mining
  - Outreach Calls- patient engagement
  - Telehealth technology- increase in accessibility
- Growth Mindset: ACO/PCMH

The ACO infrastructure was an essential step on our pathway to sustainability and our ultimate goal of achieving the "Quadruple Aim."

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Journey to ACO

- **North Mississippi Connected Care Alliance ACO formed in Jan 2016**
- **ACO Investment Model (AIM)**
  - Medicare pre-pays shared savings for 2 years
  - If no savings, then no repayment at long as the ACO complies with the program for 3 years.
- **Medicare Shared Savings Program**
  - Requires 5,000 attributed lives in all 3 benchmark years
  - If successful, Medicare shares up to 50% of savings.
  - If not successful, no penalty
- **All existing reimbursement stays the same.**
- **18,000+ attributed Medicare lives.**

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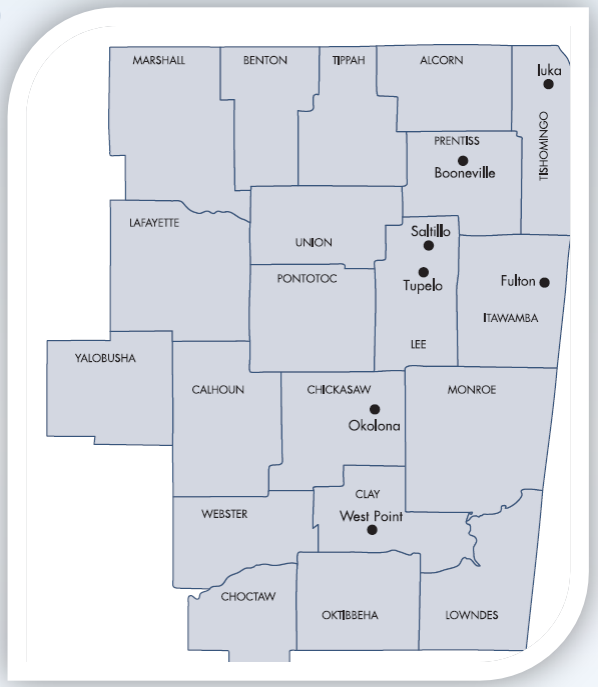
NMMCI Population Health Strategy

- Focus on NMHS Acclaim members and Medicare ACO
- Embedded RN's located in the following clinics:
  - IMA-Tupelo
  - Booneville
  - Fulton
  - Iuka
  - Saltillo
  - West Tupelo
  - Okolona
  - West Point Internal Medicine
  - West Point Medical
  - Future – Eupora & Hamilton
- Centrally located LPN team completing initial TCM call and working on care gap coordination
- Industry Health Managers- Franklin, Mossy Oak, Hunter Douglas, Provia



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Current ACO Initiatives

- HCC Scores
- Continued Annual Wellness Visit focus with emphasis on the new G Codes for preventive care
- Transitional Care Management & Chronic Care Management
- Care Gap Closure
- Post Acute Review
  - Partnerships with local nursing facilities
  - Partnerships between Health Manager/Home Health
  - Referral Leakage Reduction
  - Rehab Opportunities in other open markets

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Current Challenges to Population Health Management

- Identification of patients with high risk or chronic diseases
- Gaps and duplication of services in care exist
- Poor transitions upon hospital discharge and increased risk for readmission
- Navigation within the ambulatory setting can be complex
- Primary care access may be limited, and expansion and changes can be challenging

Benefits to Providers

- **Improves patient understanding & mutual commitment to health goals**
- **Improves communication between clinicians & various points of care**
- **Identifies obstacles to effective patient care, such as:**
  - Medication adherence
  - Psychosocial barriers
  - Socioeconomic barriers
  - Overutilization of ER, "easy access" urgent cares, and imaging
  - Complex care coordination
  - Transitions of care
  - Assists with "end of life" care planning and referrals

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Keys to Success

- Embedded Population Health Managers within clinic sites
- Medication reconciliation (paramount to reduce med errors)
- Follow-up appointment scheduled within 5-7 days of discharge (capitalize on TCM visit reimbursement)
- Coordination of Care- The team understands care plan and care gaps identified quickly and addressed
- Patient/Caregiver education and understanding (patient engagement)

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Best Practices

- Engagement of all staff at each clinic
  - Health Managers work with patients and providers equally
  - Clinical efficiency team adjusts workflow- "hard-wired" practices
  - Promote clinician engagement continuously to improve care

- Integrate "growth mindset" into culture of organization
  - ACO work is not "extra" work *(every patient, every time)*
  - Purpose – growing business and providing better care for patients
  - Maximize reimbursement - "Don't leave money on the table."
    - Medicare Wellness Visits
    - CCM/TCM
    - New G codes (e.g. depression screening, smoking cessation)

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"Without continual growth and progress, such words as improvement, achievement, and success have no meaning."

-Benjamin Franklin

Thank You!

Questions??

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