Population Health

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Objectives

- Understand what **Population Health** refers to and the various dimensions of Population Health Management
- Appreciate why Population Health is important
- Learn about how Population Health and Value Based Care initiatives are being implemented at OSU

What is Population Health and The Various Dimensions of Population Health

What is Population Health?

It depends on who you are and what you do

- For Clinicians: Clinical Quality Metrics/Care Gap Closures
- For Administration: ACOs/MCO Contracts/MIPS/BPCI/CPC+
- Public Health: Immunizations/Safe drinking water/Disaster Prep
- Community Health: Health Equities/Social Needs/Advocacy

Population Health Management

Population health management refers to

- the process of improving clinical health outcomes
  - of a defined group of individuals
- through improved care coordination, patient engagement and addressing non-medical health determinants
  - delivered in a person-centric manner
- supported by appropriate financial and care models

Adapted from:

American Hospital Association
Advancing Health in America

Value-based care

Key element of overall strategy for promoting safe, equitable, effective, and efficient care

Population Health

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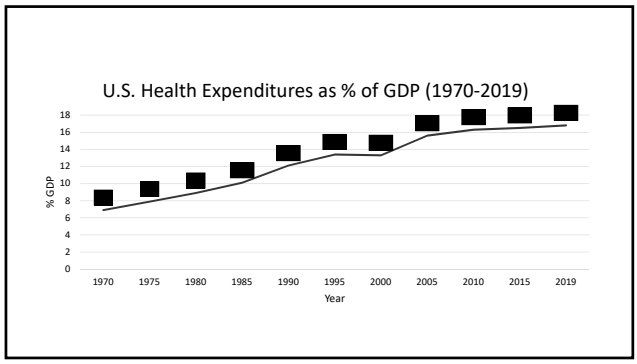
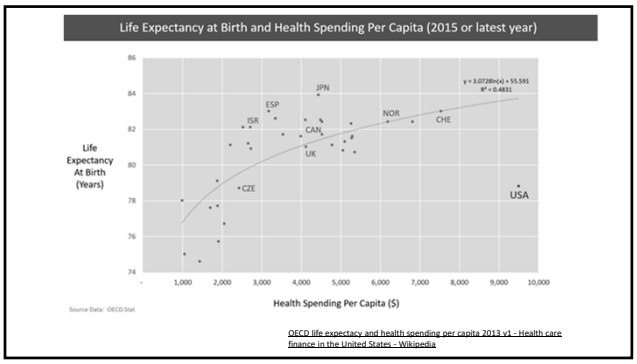
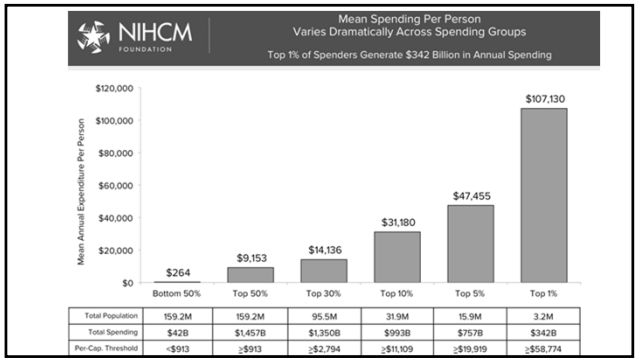
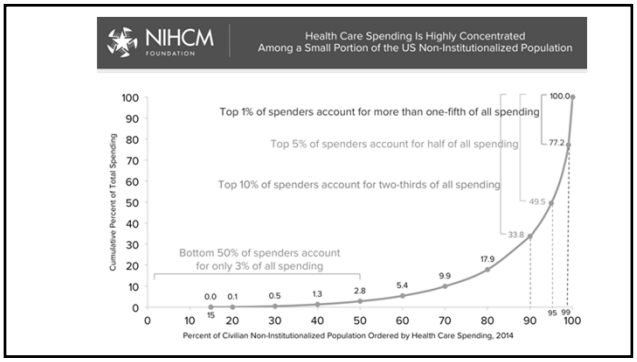
Why Population Health is Important





OECD life expectacy and health spending per capita 2013 v1 - Health care finance in the United States - Wikipedia





Volume vs. Value Based Revenue Models

Managing against predictable inputs
Payment models that reward:
Visits/procedures/RVUs

Managing against outcomes
Payment models that reward:
quality outcomes over volume

Quantity/Volume ← Lower $ Risk / Fee for service — Higher $ Risk / Full Capitation → Quality/Outcomes

ACOs
OCPC
CPC+
BPCI-A

Acronyms:
ACO: Accountable Care Organization
OCPC: Ohio (Medicaid) Comprehensive Primary Care
Comprehensive (CMS/Multi-payer) Primary Care Plus (evolution from PCMH – Patient Centered Medical Home)
Bundled Payments for Care Improvement- Advanced

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Traditional medical care in US is the Fee for Service model
- Payment is tied to providing a service, not to the health outcome
- No payment for work done outside context of a visit/episode of care
- Incentivizes system utilization = increased costs with variable outcomes

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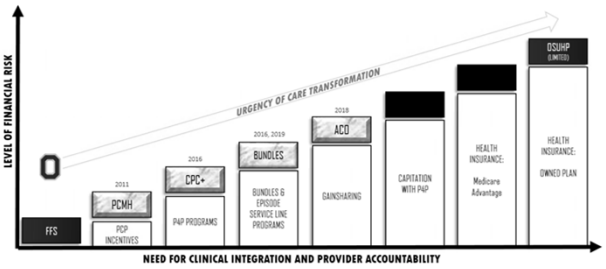
Value Base Care Models:
- Share financial 'risk' of providing care for populations of people
- Reward quality outcomes
- Focus on prevention and care coordination
- Revenues not entirely connected to 'visits' (examples)

How Population Health and Value Based Care Initiatives are being Implemented at OSU

OSU's Population Health Journey



How did we get here?

What's MACRA?
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan legislation signed into law on April 16, 2015.
MACRA created the Quality Payment Program that:
•Repeals the Sustainable Growth Rate (PDF) formula

•Changes the way that Medicare rewards clinicians for value over volume by creating a quality payment program with two tracks:

- •Streamlines multiple quality programs under the new Merit Based Incentive Payments System (MIPS) – Similar to Meaningful Use
- •Gives bonus payments for participation in eligible alternative payment models (APMs)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs

The CMS Quality Payment Program Has Two Participation Tracks

MIPS: Merit-based Incentive Payment System.
In MIPS, you may earn performance-based payment adjustments for the services you provide to Medicare patients.

You generally have to report on measure and activity data for the Quality, Improvement Activities, and Promoting Interoperability performance categories, collected during the performance year.

Payments are adjusted up or down based on these scores

Alternative Payment Model: An **APM** is a customized payment approach developed by CMS, often designed to provide incentives to clinicians who are providing high-quality, high-value care. APMs can focus on specific clinical conditions, care episodes, or populations.

Examples include:

Medicare Shared Savings Plan (ACO)
Under an MSSP, if the organization can realize savings by providing high-quality and low-cost care to a defined group of Medicare beneficiaries seen by the providers participating in the MSSP, Medicare will share the savings with the ACO.

BPCI-A/CPC+/PCF/ESRD/ etc.

https://qpp.cms.gov/about/qpp-overview

Population Health Key Cost Saving Strategies

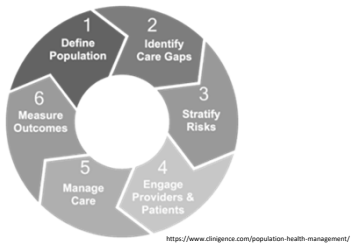
Strategic Goal

Reduce Total Cost of Care for Risk Stratified Populations and Enhance Capture of Risk Scores

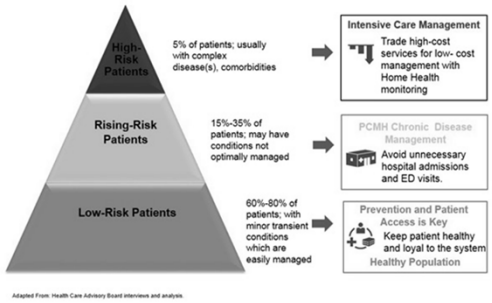
Domains

Cost Control Activities	Right Place of Care	Patient Centric Care	Health Equity	Risk Adjustment
Engage key stakeholders to identify and act on opportunities around controllable costs	*Transform care delivery model To encourage patient centered cost effective locations of care*	*Patient engagement to provide meaningful patient centered care*	*To lead, in awareness of, and in addressing inherent inequities in health care*	*Optimize Risk Scoring to Capture Reimbursement opportunities*
• PCP Attribution • Primary-Oncology Care • High Cost Imaging • Reduced Readmissions	• Reduced High ED Utilization • Ambulatory Sensitive Admissions • Home Enabled Care	• Home Enabled Care • Post-Acute Care Options • Length of Stay • Disease Management • SDoH Screenings	• Public Policy Advocacy • Health Outreach • Community Engagement • Bias Training	• Annual Wellness Visits • Risk Adjustment Factor optimization • Maximize Accuracy of HCC capture

Care Management: Populations



Built on foundation of Data Analytics



Coordination matters

A coordinated model enhances patient focus, financial value, and can boost OSU's reputation

Coordination is a critical element of a robust coordinated value-based care platform

- Facilitates **highly patient-centric** care:
  - Positively impacts quality, outcomes and experience
  - Seamless care transitions resulting in care at right time, place and cost
  - Enables implementation of innovative care delivery models leveraging technology and digital advances
- Enhances **financial value**:
  - Impacts internal operations and efficiencies (e.g. reduces readmissions)
  - Potential revenue centers for the Medical Center
  - Important to realize full value in risk-based contracts
- Enhances Ohio State's **reputation** as a true integrated care delivery system

Patient Case: Power of Care Management

John – 62 year old male patient. has T2DM, CHF and COPD.

Multiple hospitalizations (8 in 12 months) for combo of above co-morbidities

Smokes 1-2ppd/drinks 4-8 Pepsi's a day/most meals are fast food or reheat microwave meals

Has intellectual impairments. Lives with mom. Is function in most ADLs

Adherence to recommended prescriptions is challenging

Solution: HHN (med setup, admin, education, food resources)

Result: one hospitalization in last 24 months.