The Value Perspective

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How is “Value” Defined?...It Depends...

University of Utah Health Survey
5,031 Patients, 687 Physicians, 538 Employers

Source: HealthLeaders Media
Meet Joe

- Highest ED user in the Atrium Health System
- 1500+ service visits within Atrium Health
- Jan – April 2018 (120 calendar days) = 104 ED visits
- Other 16 days spent inpatient or observation
- ED, Inpatient, and Observation Facility Charges from 2015-2017 = $1,570,900
- YTD 2018 charges = $366,125

Joe comes to ED because of an overwhelming fear he will die of numerous medical ailments. He lives in his car and moves between Atrium Health parking decks to have quick access to the ED. Joe says that the only thing that helps him feel normal is coming to the ED every day and having a doctor reassure him that he will be okay.

✓ PTSD
✓ Overwhelming anxiety
✓ Hypochondriasis
✓ Major Depressive Disorder
✓ Alcohol Use Disorder
Connecting the Dots for Joe

39
ED Visits since June 2018

And the Results Speak For Themselves

97
Total enrollment of patients in 2017

40
Graduated Patients (defined as achieving maximum goals of the program and/or obtaining insurance)

$1M
Financial Savings in ED Charges

43%
Decrease in Hospital and ED Utilization

AND
Additional Patients are pending for enrollment into the Program
“Yeah, things are now moving in the right direction ...

I finally feel like a human again.

- JOE

Current Landscape
Update
Current Landscape Update - Medicare

- CMS Releases Final Rule on Medicare Shared Savings Program
- Bundled Payments for Care Improvement Advanced (BPCI Advanced).

MSSP Proposed Rule Change

- Released August 9th
- Eliminates Track 1 and Track 2 options
- Establishes **BASIC** and **ENHANCED** (current Track 3) Tracks
- Expands SNF and Telehealth Waivers
- Provides choice in beneficiary assignment methodology
- Establishes beneficiary incentive program
- Comments due by October 16, 2018 with final ruling released in Nov
Advancing Care Models
Bundled Payments for Care Improvement

- BPCIA assists in the elimination of low-value care by engaging providers in risk based models for clinical episodes
- BPCIA encourages high quality, low cost care in alignment with our current initiatives
- The non-binding application process will provide necessary data to evaluate for areas of opportunity
- BPCIA will assist Atrium Health on our journey to value by allowing us to evaluate our systems for efficiency, engage in risk based models, and better understand our total costs of care

Current Landscape Update - Medicaid

MEDICAID
MANAGED
CARE
Background

2015: Session Law 2015-245 directs the Department to transition to managed care

2015-2018: Extensive collaboration with and feedback from stakeholders

Aug 2018: RFP released

Oct 2018: CMS approves 1115 waiver

Feb 2019: Prepaid Health Plans selection announced

Prepaid Health Plans for NC Medicaid Managed Care

• Four Statewide PHP contracts:
  • AmeriHealth Caritas North Carolina, Inc.
  • Blue Cross and Blue Shield of North Carolina, Inc.
  • UnitedHealthcare of North Carolina, Inc.
  • WellCare of North Carolina, Inc.

• One Regional Provider-Led Entity:
  • Carolina Complete Health, Inc. (Regions 3 and 5)
The Journey to Value

Preparation across the organization is on-going to get us ready for this new world by building on the past and into the future

Networks and Partnerships
Risk Readiness Assessments
Population Health Program
Scorecards and Feedback
Data Analytics
MSSP
Integrated Systems of Care

Developing Strategies
Building Networks

Carolinias Physician Alliance
(2,600+ Providers)

IT Infrastructure and Capability
Cross-Continuum Coordination
Network Governance

Value-Based Quality Principles and Measurement

Ensuring Appropriate Utilization
ED High Utilizer Care Management

20+ Visit Cohort

- 339 Patients
- Over 7,000 ED Encounters
- 40% Reduction in Utilization
- 39% Reduction in Cost
Creating Access to Engage Patients
Care Wherever and Whenever Needed

Virtual Health
Virtual Critical Care
TelePsych And Patient Placement
Telestroke
Infectious Disease
Behavioral Health Integration (Primary Care)
Virtual Visits
e-Synchronous Visits

Value Grand Rounds

1. Identify Patients
2. Create A Diverse Interdepartmental Team
3. Meet Regularly to Discuss Difficult Cases
4. Use Existing Resources to Create Intervention
5. Identify Gaps in Care/Processes System-Wide for Improvement
How Do We Work as A Team?

Ensuring Access by Eliminating Barriers to Care:

- $3 Copays at Urgent Care
- Presumptive Eligibility Scores for Regional Partners
- Barriers to Financial Assistance
- Encouraging Appropriate Utilization
- Identification of Patients in Need

How do we need to work differently with our communities to improve health—for all?
Creating a Supportive Infrastructure

Community Resource Hub
Regional Team Deployment
Health Equity Strategy
Measurable Impact
Community Partnerships
Better Health Outcomes

Community Resource Hub

1,455 Programs
339 Activated Community Service Providers

15 organizations are partnering with Atrium Health's Community Resource Hub, bringing nearly 1,000 engaged programs to serve the greater Charlotte area.
GOAL I: Collection, Stratification & Use of Data
- Demographic Data Platform
- For All Health Equity Goal

GOAL II: Cultural Competency Training
- Physicians & ACPS
- RNs
- Other Clinical Professionals
- Non-Clinical, Patient-Facing Teammates

GOAL III: Diversity in Leadership & Governance
- Men’s Diversity Leadership Program
- Women’s Executive Leadership Program

GOAL IV: Community Partnerships
- ONE Charlotte Health Alliance

Atrium Health’s Pledge
Scale Focused Programs to Measure Impact

Mental Health First Aid  Tobacco Cessation  Obesity  Access

Connecting the Dots by Capturing New Data

Standardized Social Determinants of Health Screening for Physician Workflows

1. In the past 12 months, were you worried that your food would run out before you got money to buy more?

2. In the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non medical meetings/appointments or getting things that you need?

3. Are you worried or concerned that in the next two months, you may not have stable housing?
What do we need to do differently to successfully manage the populations we are at risk for today?
Focus on ‘At-Risk’ Population

Why Focus on ‘At-Risk’ Populations?
• No Regret Strategy
• Access to comprehensive data sets
• Tracking and monitoring of performance across defined measures
• Focused direction for initial deployment of limited system resources (i.e. care managers & coders)
• Foundation from which to Scale

Investing in new IT capabilities
To support our population health priorities

To effectively manage a population requires more than interoperable data. It requires
• Data -> Insight
• Insight -> Action
• Action -> Outcomes across the continuum.
Assembling Clinician-Led Workflow Integration

Performance Dashboards
Care Management

Iterating Current Initiatives
Caring for Large Populations

With over 99,000 assigned Medicare Beneficiaries, the Carolinas HealthCare System ACO, LLC is one of the largest ACOs in the country.

Success or Luck?

[Diagram showing performance over time with a line graph comparing expectations to reality.]
Continuing to Innovate

Focusing on Readmissions
Post Discharge Follow Up

Discharge Order
Generated from Acute Care Physician

Automated Order for Scheduling

Discharge Follow-Up Appointment Scheduled and Sent to Patient (Text or RoboCall)

Follow-Up Appointment

Status Report:
Scheduled Discharge Follow Up with PCP: 70-80%
Arrival Rate within All Risk Bands:
- 81.9% Within 30 Days of Discharge (20% Baseline)
Examining the Post Acute Skilled Nursing Facility Network

To improve outcomes and overall Medicare spend
To establish the largest, best network
To focus on partnership and shared accountability
To proactively address opportunities for improvement

We want to partner with facilities that share a **Vision** and **Commitment** to **Quality**

Focusing on the Future
Medicaid Strategy: Preparing for Additional Risk

Next Steps

• Continued Infrastructure Development
• Care Management Alignment
• Partnerships with Community Organizations

• Enhanced Benchmarking
• Improving Outcomes
• Fostering an Accountable Community
Disruptive Developments

Source: Modern Healthcare

Keys to Staying Ahead

Sticking to our Strategic Beliefs:

- Value is defined by the customer – those who consume care and those who pay for it
- Long-term financial viability requires delivering value through sustainable models
- The ability to keep individuals and populations healthy is a key determinant of future success
Destination 2020

Improving Lives within Sustainable Value Based Care Models

250K By 2018
275K By 2019
300K By 2020

Any Questions?