Moving from Volume to Value:
Framework for Population Health Models

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James Yolch
Disclosures

- At today’s session, Mayo Clinic staff will be sharing their vision and framework for implementing a new community care model.

- Based on this topic, there are no known conflicts of interest for the facilitators.
Objectives

- Become familiar with Mayo Clinic’s framework for population health management (PHM)
- Identify 10-key interrelated components to this value-based model
- Learn about Mayo Clinic’s process for operationalizing the model
- Understand lesson’s learned in Mayo Clinic’s transformational path to model implementation
The Case for Change

“This is the threshold we have now come to, but not yet crossed: the threshold from the care we have to the care we need.”

Don Berwick
Aging Population
- Patient with multiple chronic conditions
- End of life care
- Technology
- Drugs & procedures

Affordable Care Act
- ACO’s
- Bundled Payments
- Readmission Initiative
- Value Based Purchasing
- Insurance Exchanges

Federal Deficit
- 2% Medicare reimbursement
Community-based Care (Mayo Clinic Health System)

The shift to Total Cost Of Care (or Pay for Value) is imminent. The pace is uncertain and the reality will be felt as we straddle both models.

Destination-based Care (RST, FL, AZ tertiary care)

Slower shift expected to TCOC model however referring organizations will be impacted.
Economic Drivers
- Recession
- Budget Deficit
- Rising cost of healthcare due to multiple factors
  - Misaligned incentives
  - Patient removed from the cost of care
  - Cost shifting
  - Waste

Social Realities
- Aging population
- US Lifestyle factors contributing to obesity
- Increased number of insured patients
- Decreased supply of primary care providers

Are requiring us to prepare **now** for a model that will reimburse for Outcomes & Efficiency or “Value” – not Volume
“No one is making you do anything you don’t want. I’m just saying we’re all headed for Dodge City and we think you should come along.”
New contracts will pay us to keep people healthy, not for “seeing them” (Volume to Value)
Models

The current models are not sustainable for the future, we need to transform our delivery model to one that:

- Eliminates waste
- Rewards value
- PHM = A FRAMEWORK for VALUE
Waste

WASTE:

$765 Billion

30% of 2009 total health care spending

Adapted with permission from Health Partners Health Plan Choosing Wisely Campaign; 2013
Cutting Waste

Unnecessary Services
$210 Billion

Fraud
$75 Billion

Excessive Administrative Costs
$190 Billion

Inefficiently Delivered Services
$130 Billion

Prices That Are Too High
$105 Billion

Missed Prevention Opportunities
$55 Billion

= $1 Billion

Adapted with permission from Health Partners Health Plan Choosing Wisely Campaign; 2013
Key Elements

- Future State
  - Aligned Financial & Payment Model
  - Information/Knowledge Management
  - Coordinated Care Delivery Model

- Current State
  - Network of Providers
  - Aligned Purpose

- Key Elements
  - Governance, Infrastructure, Culture

OFFICE OF POPULATION HEALTH MANAGEMENT
Population Health

…is the Framework through which we will build out the

MAYO MODEL
OF COMMUNITY CARE
Background

Academic Medical Center
- 500,000 patients/yr.
- 2000 Physicians
- 125 Primary Care Providers
- Primary Care
- At Full Risk for PC

Community & Regional Health System
- 525,000 patients/year
- 1000+ Physicians

Primary care At some Risk for PC

MAYO CLINIC in the MIDWEST

MAYO CLINIC in the SOUTHWEST
- 90,000 patient/year
- ~400 Physicians
- Primary care
- At Risk in Primary Care

MAYO CLINIC in the SOUTHEAST
- 90,000 patient/year
- ~400 Physicians
- Primary care
- At risk in Primary Care

ARIZONA

FLORIDA

OFFICE OF POPULATION HEALTH MANAGEMENT
Office of Population Health Management (OPHM)

- Formed in 2012
- Develop a Mayo Clinic Framework for PHM
  - Strategy
  - Phasing
  - Oversight
  - Coordination
  - Standardization
- Initial focus on Primary Care
- Value-based care
  - Patient-Centered Medical Home
  - Risk based reimbursement
Partnerships

- Wellness and prevention are critical to long-term cost reduction
- Building relationships with patients and their communities is critical

Caring for Patients Everyday

- Attributing a population of patients to a specific location, care team
- Creating a team around the patient who support all of the patient’s needs

Additional Services for High-Risk

- Polychronic, frail and elderly, and the underserved
- More proactive care delivered beyond bricks and mortar, using predictive analytics
<table>
<thead>
<tr>
<th>Principles &amp; Functions</th>
<th>OPHM Program Owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Partnerships</td>
<td>Community Engagement</td>
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<tr>
<td></td>
<td>Patient Engagement</td>
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<tr>
<td>2. Caring for Patient Everyday</td>
<td>Team-Based Care</td>
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<td></td>
<td>Access &amp; Non-visit Care</td>
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<tr>
<td></td>
<td>Wellness</td>
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<td>Prevention</td>
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<td>3. Additional Services for High-Risk</td>
<td>Care Coordination</td>
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<td>Chronic Condition Management</td>
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<td>Palliative Care</td>
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<td>Care Transitions</td>
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</tbody>
</table>
Process

1. DEFINE
   Population Identification

2. ASSESS
   Health Assessment

3. STRATIFY
   Risk Stratification

4. ENGAGE
   Enrollment/Engagement Strategies

5. MANAGE
   Management/Interventions
   - Tailored Interventions
   - Care Coordination
   - Disease / Case Management
   - Health Risk Management
   - Health Promotion / Wellness

Meeting patients where they are

...physically
   home | school | work | shopping | in the clinic

...in the way that works best for them
   email | text | internet | phone | video | face-to-face

OFFICE OF POPULATION HEALTH MANAGEMENT
Phased Strategy

10 Programs  3 Key Principles  Process

Mayo Model of Community Care

1 2 3 4

PRE-STEP  STEP  STRETCH  LEAP
<table>
<thead>
<tr>
<th>Category</th>
<th>Elements</th>
<th>MMOCC 1 = MOC NOW</th>
<th>MMOCC 2</th>
<th>MMOCC 3</th>
<th>MMOCC 4</th>
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</thead>
<tbody>
<tr>
<td>OPHM Accountable group</td>
<td></td>
<td>2013</td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>Care Management</td>
<td></td>
<td>PRE-STEP</td>
<td>Step</td>
<td>Stretch</td>
<td>Leap</td>
</tr>
<tr>
<td>Patients Everyday</td>
<td></td>
<td>* Co Locate MD/Nurse</td>
<td>* Process strategies</td>
<td>* Integrated disciplines for single visit</td>
<td>* Full team model</td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td>* Current process attribution</td>
<td>* Attribution phase A</td>
<td>* Attribution phase B</td>
<td>* Attribution Phase C = teams</td>
</tr>
<tr>
<td>Prevention</td>
<td></td>
<td>* Onsite Work Wellness</td>
<td>* Team based attribution</td>
<td>* Increased use of teleHealth tools</td>
<td>* Advanced Non visit care processes</td>
</tr>
<tr>
<td>Additional for high risk patients</td>
<td></td>
<td>* Integration for conditions</td>
<td>* Improved care coordination</td>
<td>* Medication therapy mgmt</td>
<td>* Expanded care teams to include pm</td>
</tr>
<tr>
<td>Chronic Condition Mgmt</td>
<td></td>
<td>* Intro to complex CC curriculum</td>
<td>* CC plan &amp; goals</td>
<td>* Advancement</td>
<td>* Integrate all CC programs (diamond, compass)</td>
</tr>
<tr>
<td>Care Transitions</td>
<td></td>
<td>30 Day readmission process area</td>
<td>* MCCM day care</td>
<td>* MCCM day care</td>
<td>* MCCM day care</td>
</tr>
<tr>
<td>Palliative Care Program</td>
<td></td>
<td>* Integrate care</td>
<td>* Expand palliative care</td>
<td>* MCCM day care</td>
<td>* MCCM day care</td>
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<tr>
<td>Partner Management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community Engagement</td>
<td></td>
<td>* Communicable Diseases Tools for pts</td>
<td>* Community Health Events</td>
<td>* Community Resource Specialist Ideas for working on</td>
<td>* MCCM day care</td>
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<td>Provider/Staff Engagement</td>
<td></td>
<td>* Communicable Diseases Tools for pts</td>
<td>* Community Health Events</td>
<td>* Community Resource Specialist Ideas for working on</td>
<td>* MCCM day care</td>
</tr>
<tr>
<td>Finance Management</td>
<td></td>
<td>* Identify current community resources</td>
<td>* Identify current community resources</td>
<td>* Identify current community resources</td>
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<tr>
<td>Contracting (&quot;Plan&quot;) Engagement</td>
<td></td>
<td>* Implement concept into internal messaging</td>
<td>* Identify efficiencies and get lean</td>
<td>* Implement concept into internal messaging</td>
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<tr>
<td>Provider Compensation</td>
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<td>* Implement concept into internal messaging</td>
<td>* Identify efficiencies and get lean</td>
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<tr>
<td>Operational Management</td>
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<td>* Identify efficiencies and get lean</td>
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<tr>
<td>Infrastructure</td>
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<td>* Implement concept into internal messaging</td>
<td>* Identify efficiencies and get lean</td>
<td>* Implement concept into internal messaging</td>
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<tr>
<td>Metrics</td>
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<td>* Implement concept into internal messaging</td>
<td>* Identify efficiencies and get lean</td>
<td>* Implement concept into internal messaging</td>
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<tr>
<td>IT Pre-requisites for phase</td>
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<td>* Implement concept into internal messaging</td>
<td>* Identify efficiencies and get lean</td>
<td>* Implement concept into internal messaging</td>
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<tr>
<td>Cultural Readiness</td>
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<td>* Implement concept into internal messaging</td>
<td>* Identify efficiencies and get lean</td>
<td>* Implement concept into internal messaging</td>
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</table>
## Timeline

<table>
<thead>
<tr>
<th>IMPLEMENTATION PHASE</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<tbody>
<tr>
<td>MMoCC NOW &quot;PRE-STEP&quot;</td>
<td></td>
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<tr>
<td>MMoCC 2 &quot;STEP&quot;</td>
<td></td>
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<td></td>
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<tr>
<td>MMoCC 3 &quot;STRETCH&quot;</td>
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<td></td>
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<tr>
<td>MMoCC 4 &quot;LEAP&quot;</td>
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2016 - PILOT 4-6 Sites

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**OFFICE OF POPULATION HEALTH MANAGEMENT**
Population Health Framework

Example: Mayo Clinic Midwest
Framework

Structural framework for concepts

STEP | What can be done in the near term
- Aggregates existing innovations
- Creates significant overall efficiencies and improved patient experience
- Creates a solid foundation for the shift to Total Cost of Care

STRETCH | Requires some experimentation and robust piloting
- Shifts from individual practice to team based care
- Increased focus on patient important outcomes
- Strong shift to TCOC drivers

LEAP | Requires strategic investment of resources; needs further validation
- Adds focused care coordination teams, specialty integration
- Full community engagement
- Optimizes clinics to excel in TCOC environment
Phased Transformation

Complete system transformation to LEAP
accompanying the shift to a total cost of care environment

- Current Model
- STEP Model
- STRETCH Model
- LEAP Model

Today

.... Preparing for Tomorrow

.... Thriving in the Future
Evolution

1980’s

Loose confederation of large sites, medium sites, small sites

1990’s

Regionalized common systems and closer relationships

2000’s

Centralized model of MHS with singular system and process attributes

Future State (2015)

Centralized model with tight system attributes as one with Mayo Clinic
Academic Medical Center

- 500,000 patients/yr.
- 2,000 Physicians
- 125 Primary Care Providers

Primary Care
At Full Risk for PC

Community & Regional Health System

- 4 Regions
- 18 hospitals
- 75 communities in MN, IA, WI
- 525,000 patients/year
- 1,000+ Physicians

Primary Care
At some Risk for PC

- 90,000 patient/year
- ~400 Physicians

Primary care
At Risk in Primary Care

Background

MAYO CLINIC IN THE MIDWEST

ROCHESTER HEALTH SYSTEM

ARIZONA

FLORIDA

MAYO CLINIC IN THE SOUTH WEST

MAYO CLINIC IN THE SOUTH EAST

Communities 71
Physicians 900
Allied health staff 13,000
MAYO CLINIC
OFFICE OF POPULATION HEALTH MANAGEMENT

EXECUTIVE TEAM*

Midwest

Programs
- Health & Wellness
  - Prevention
  - Community Engagement
  - Wellness
- Continuity Care
  - Care Coordination
  - Chronic Condition Management
  - Palliative Care
  - Care Transitions
- Team-Based Care
- Patient Engagement
- Access and Non-visit Care

Functional Subgroups
- Change Management & Communications
- Data Analytics
- IT Applications

Mayo Clinic Health System Clinical Practice Committee

MCHS Regions
- SE Minnesota Leadership
- SW Minnesota Leadership
- SW Wisconsin Leadership
- NW Wisconsin Leadership

Arizona
Florida
Optimizing the Care Team

- Clinicians, nurses, schedulers, and other specialized staff around the patient
- Work together in ways that allow each to add value at every touchpoint
- Co-located to foster teamwork and communication
- Collectively addresses the patient’s needs every time
Why does optimizing the care team matter?

As demand for primary care services increases, the optimized care team enables care responsibilities to be distributed across the team.
Complex Care Coordination

- Nearly 3 in 4 people 65 years or older have multiple chronic conditions
- Account for 93% of prescriptions and nearly 80% of physician visits and hospital stays
- Caring more effectively and efficiently for these high-cost patients represents a clear opportunity to implement the IHI Triple Aim
Why does complex care coordination matter?

Primary Responsibilities Navigating and Activating Patients Across the Continuum

**Navigation**

**Coordinates Across Sites**
- Facilitates access to services
- Develops care plan with physician, embedded in PCP practices

**Manages Referrals**
- To disease management
- To specialists
- To medication management support
- To psychosocial support

**Tracks Patient Activity**
- IT system alerts care manager to inpatient, ED utilization
- EMR “icon” alerts system physicians when patient is assigned to a care manager

**Activation**

**Provides Education**
- Coaches patients on disease management goals, monitors progress, offers encouragement
- Supports symptom management

**Supports Patient Self-Management**
- Encourages adherence to care plan, improvement through patient-centric goal setting
- Fosters patient and caregiver activation, offers education

**Encourages Frequent Communication**
- Promotes open communication through consistent monitoring, feedback, and follow up
- Forges one-on-one relationship with patient to promote two-way communication

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10 Key Interrelated Model Components

1. Prevention
2. Community Engagement
3. Wellness
4. Team-Based Care
5. Patient Engagement
6. Access
7. Care Coordination
8. Care Transitions
9. Chronic Condition Management
10. Palliative Care
Summary

- 3 Key Principles
  1. Partnering
  2. Caring for Patients Everyday
  3. Additional Service for High-Risk Groups

- Process (5 steps)
  1. Define
  2. Assess
  3. Stratify
  4. Engage
  5. Manage

= phased strategy
Lessons Learned

Communicate early on
• Patient expectations
• Staff change management
• Process before incentives

Get started with incomplete data
• Expect variation

Decision Rights
• Integration
• Governance

Only works if all pieces are in place

Action Plan

• Patient Attribution
• Understand Access
• Find Analytics Solution
• Program for System Automation
• Start with a Focus
  • Team-Based Care
  • Chronic Conditions
• Continue to Communicate
Engaged Communities
- Proactive care processes
- Identified patients
- Management of chronic conditions
- Wellness focus
- Information availability & usability

Engaged Patients
- Identified & incorporated patient goals
- Focus on continuity & coordination
- Facilitated communication channels
- Improved access to care

Identified Opportunities to Reduce Waste
- Avoid duplication
- Improved coordination/transitions
- Use of automation to reduce resource needs
- Improved screening & prevention
- Palliative options
- 4 Rights
- Alignment of incentives to drive value
The glory of medicine is that it is constantly moving forward, that there is always more to learn.

The ills of today do not cloud the horizon of tomorrow but act as a spur to greater effort.

Dr. William J. Mayo