MAYO CLINIC

OFFICE OF POPULATION HEALTH MANAGEMENT

Moving from Volume to Value:

Framework for Population Health Models

September 26, 2013

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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

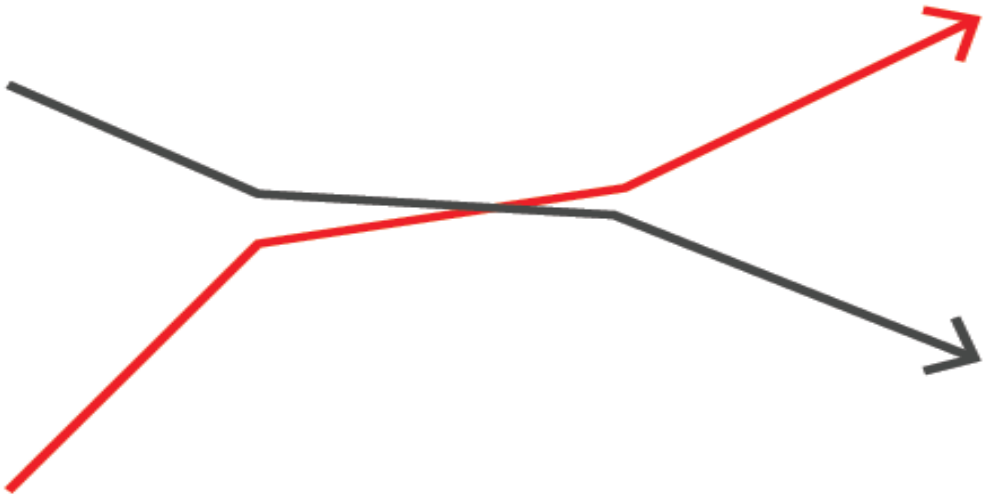
- Become familiar with Mayo Clinic's framework for population health management (PHM)
- Identify 10-key interrelated components to this value-based model
- Learn about Mayo Clinic's process for operationalizing the model
- Understand lesson's learned in Mayo Clinic's transformational path to model implementation

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

Reality



HEALTH CARE COSTS

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

REIMBURSEMENT

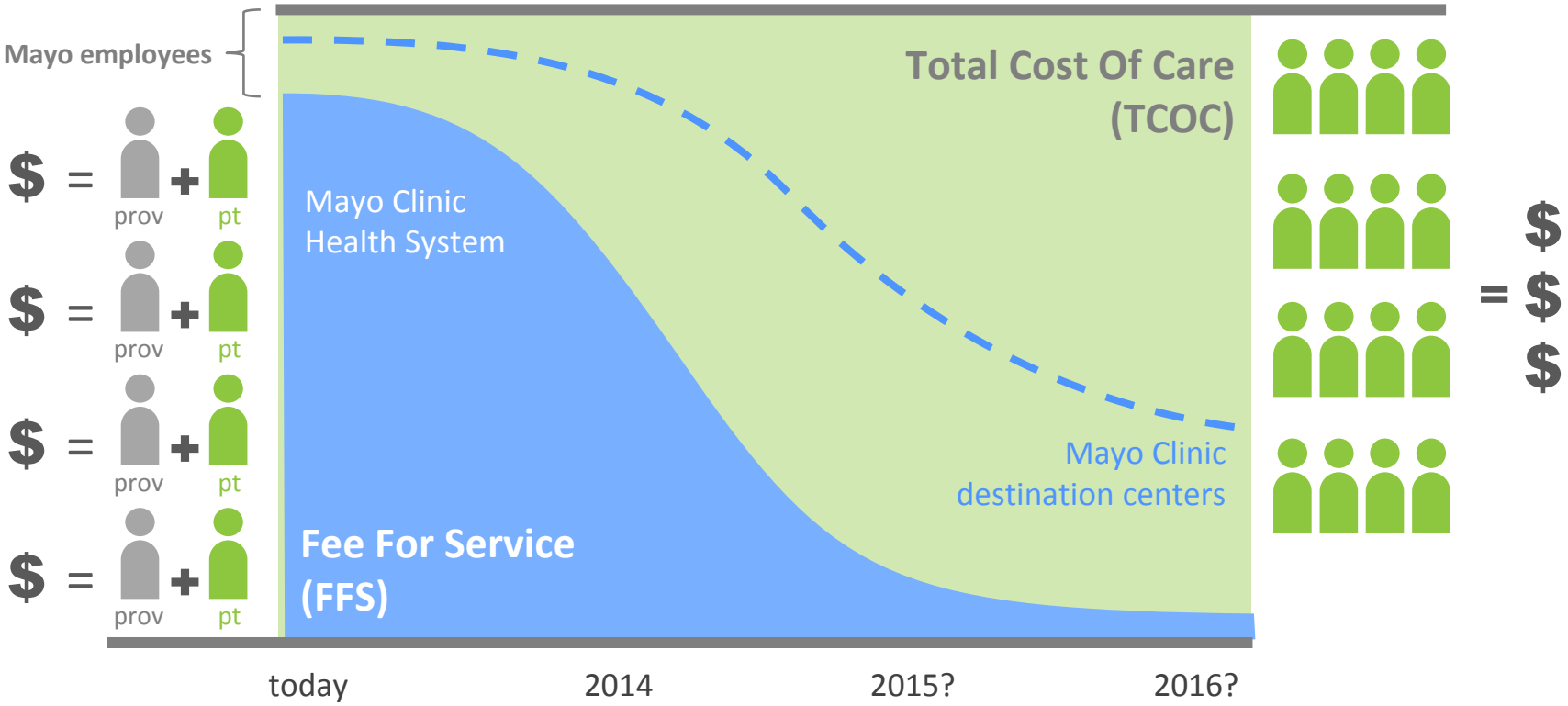
Affordable Care Act

- ACO's
- Bundled Payments
- Readmission Initiative
- Value Based Purchasing
- Insurance Exchanges

Federal Deficit

- 2% Medicare reimbursement

Reform



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

Change

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 <u>now</u> 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."

Cullum, L. *The New Yorker*. May 9, 2005.

Accountability

For outcomes
For the cost of care

Accountability ~ Total Cost of Care ~ Risk

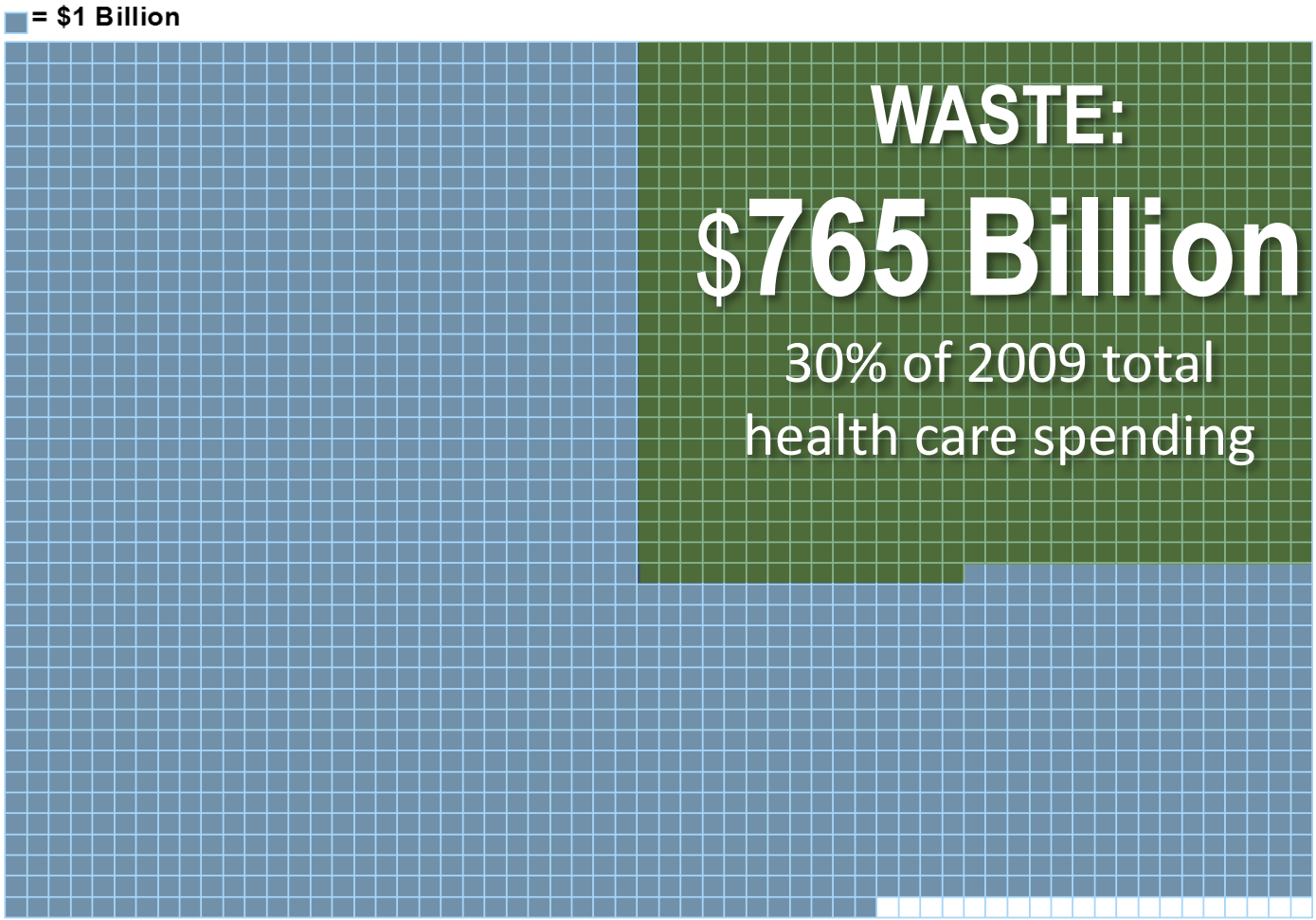
New contracts will pay us to keep people healthy, not for "seeing them" (Volume to Value)

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



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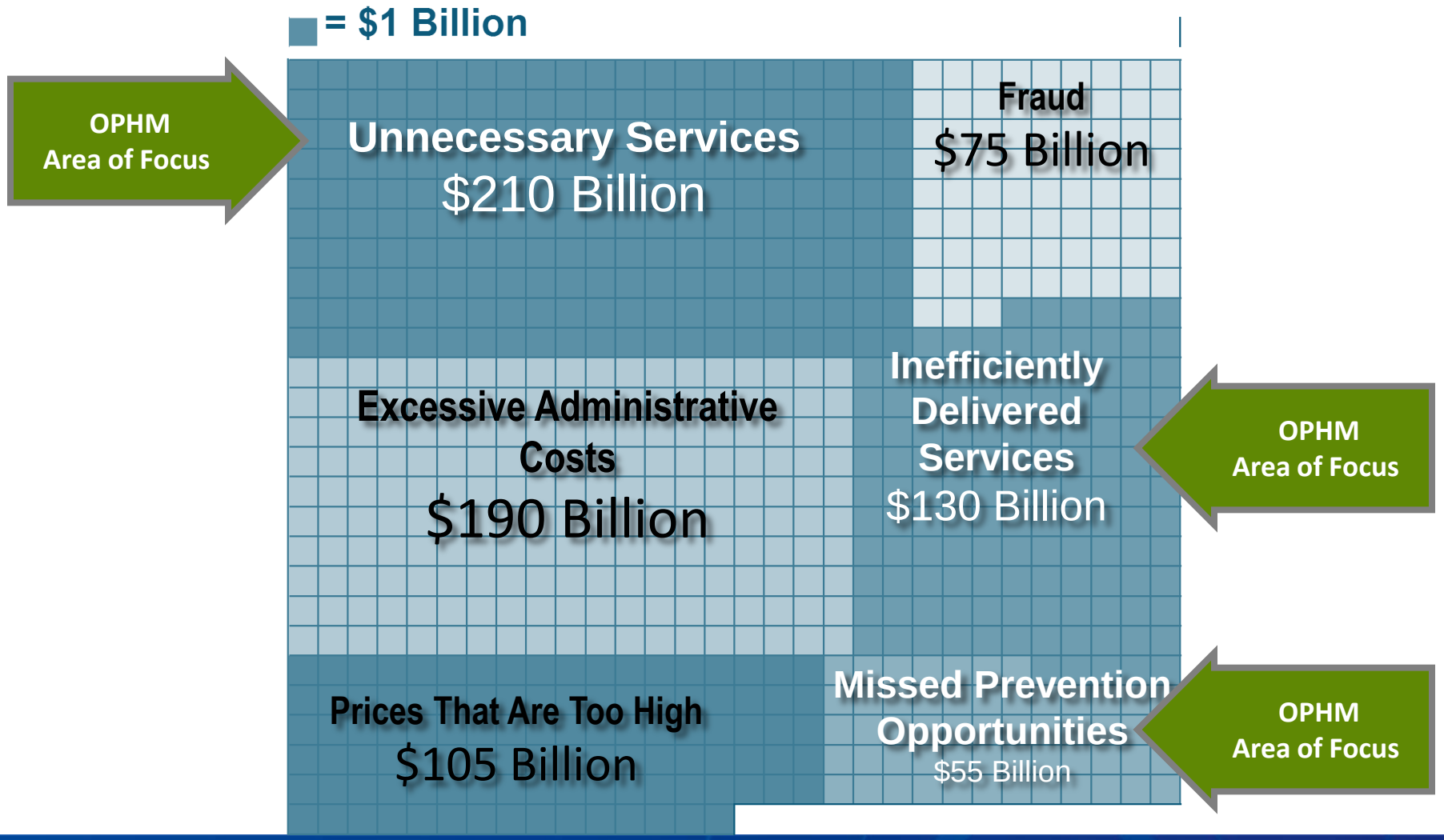
Cutting Waste



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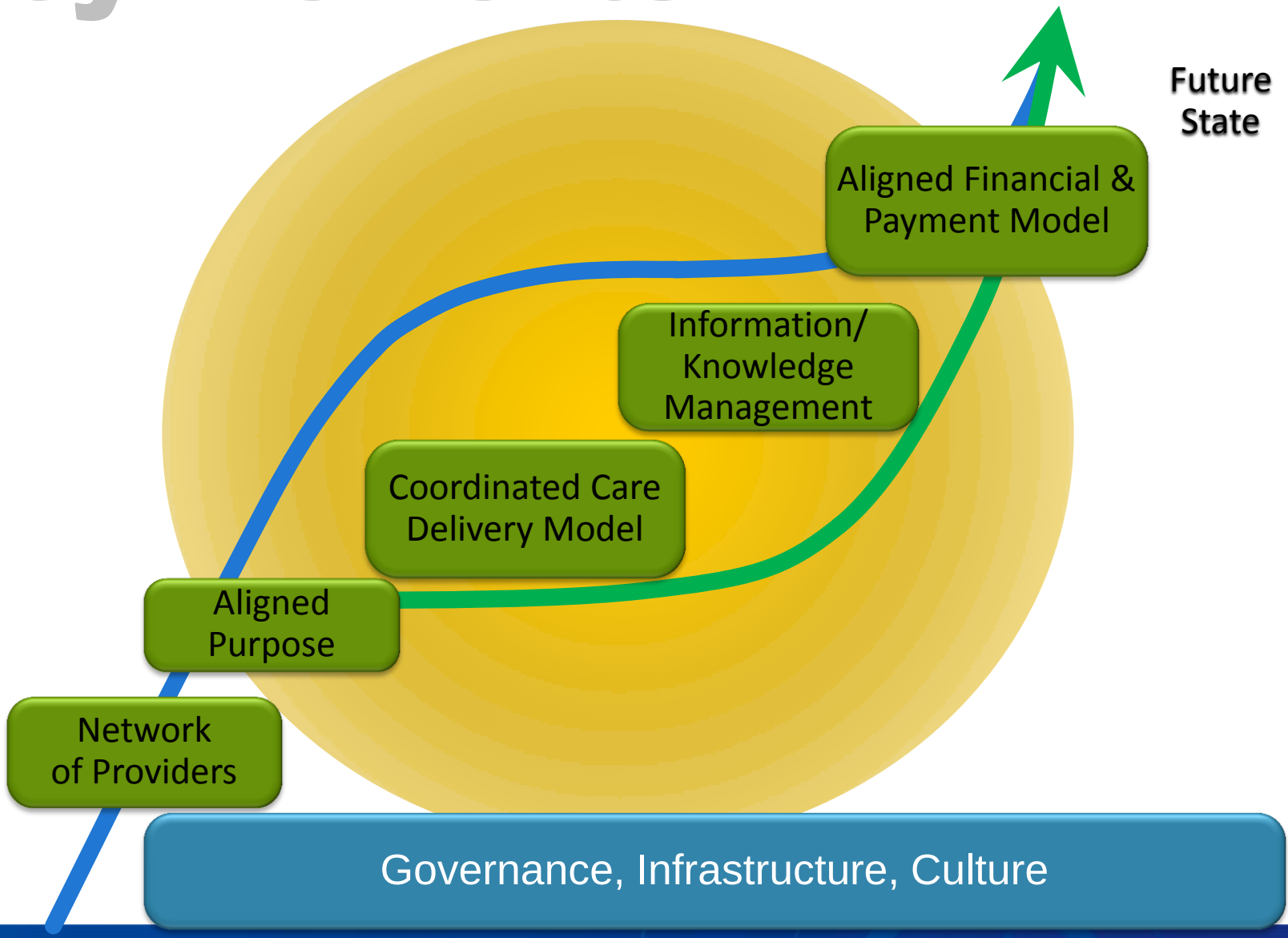
Key Elements



Population Health

…is the Framework through which we will build out the

MAYO MODEL OF COMMUNITY CARE

Background

ROCHESTER

Academic Medical Center

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

MAYO CLINIC in the MIDWEST

Community & Regional Health System

- 4 Regions
- 18 hospitals
- 75 communities in MN, IA& WI
- 525,000 patients/year
- 1000+ Physicians
- Primary Care
- At *some* Risk for PC

HEALTH SYSTEM

MAYO CLINIC in the SOUTHWEST

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

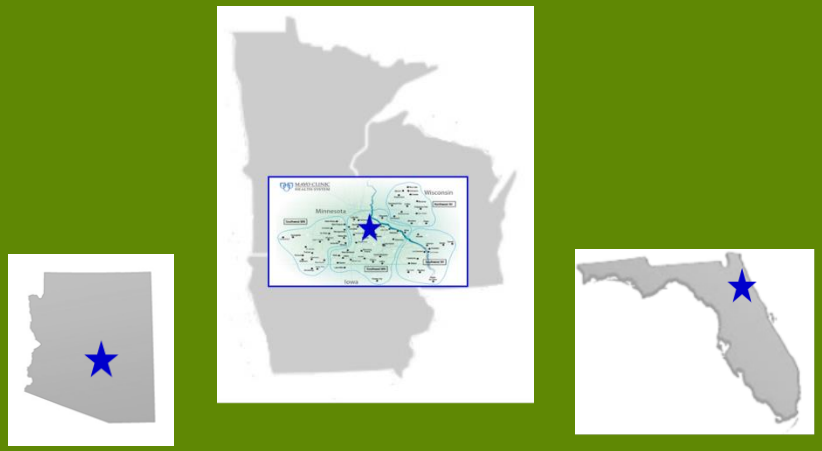
ARIZONA

MAYO CLINIC in the SOUTHEAST

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

FLORIDA

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

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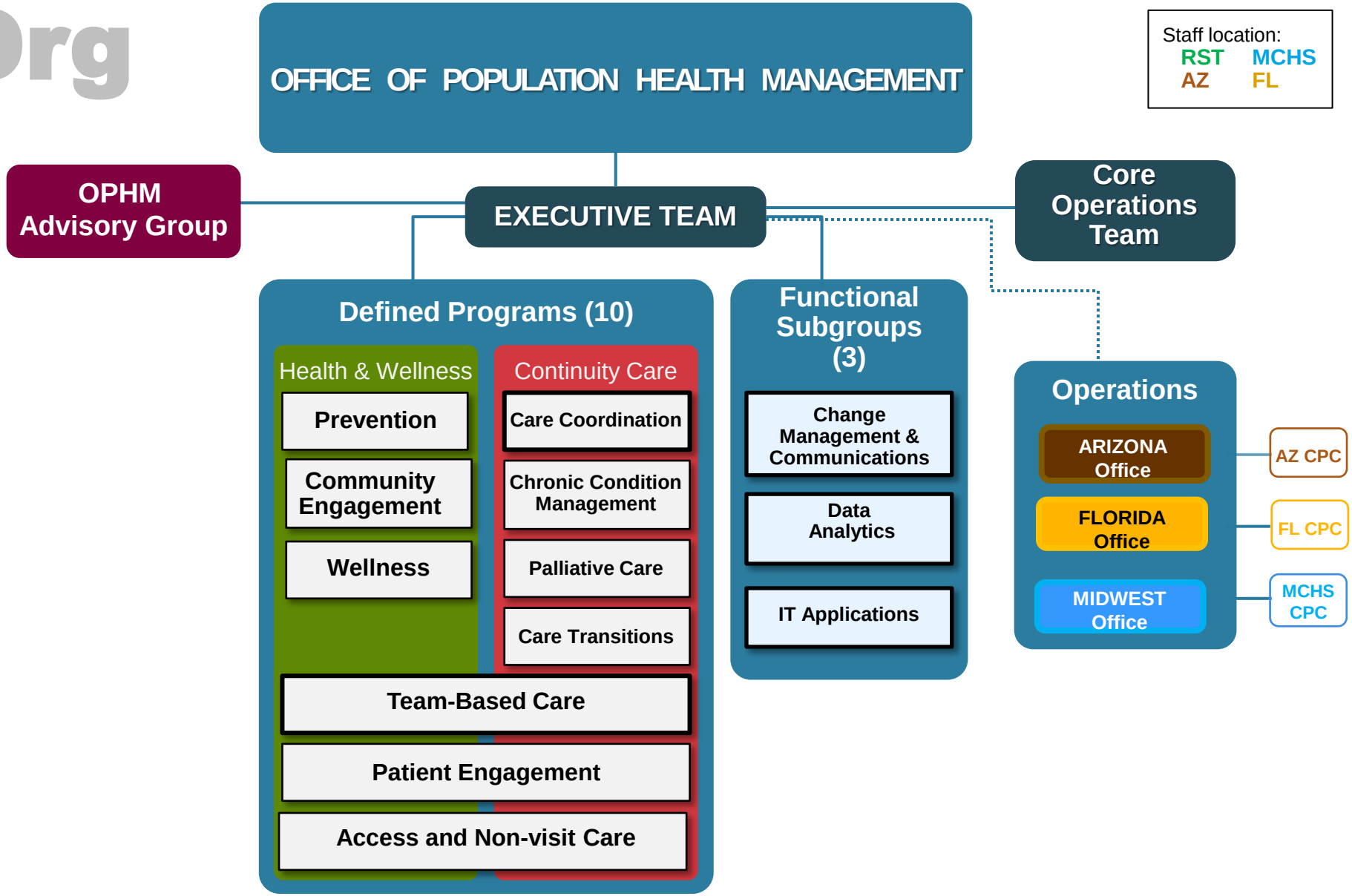
OFFICE OF POPULATION HEALTH MANAGEMENT
Staff location:
RST
MCHS
AZ
FL
OPHM Advisory Group
EXECUTIVE TEAM
Core Operations Team
Defined Programs (10)
Health & Wellness
Prevention
Community Engagement
Wellness
Continuity Care
Care Coordination
Chronic Condition Management
Palliative Care
Care Transitions
Team-Based Care
Patient Engagement
Access and Non-visit Care
Functional Subgroups (3)
Change Management & Communications
Data Analytics
IT Applications
Operations
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FLORIDA Office
MIDWEST Office
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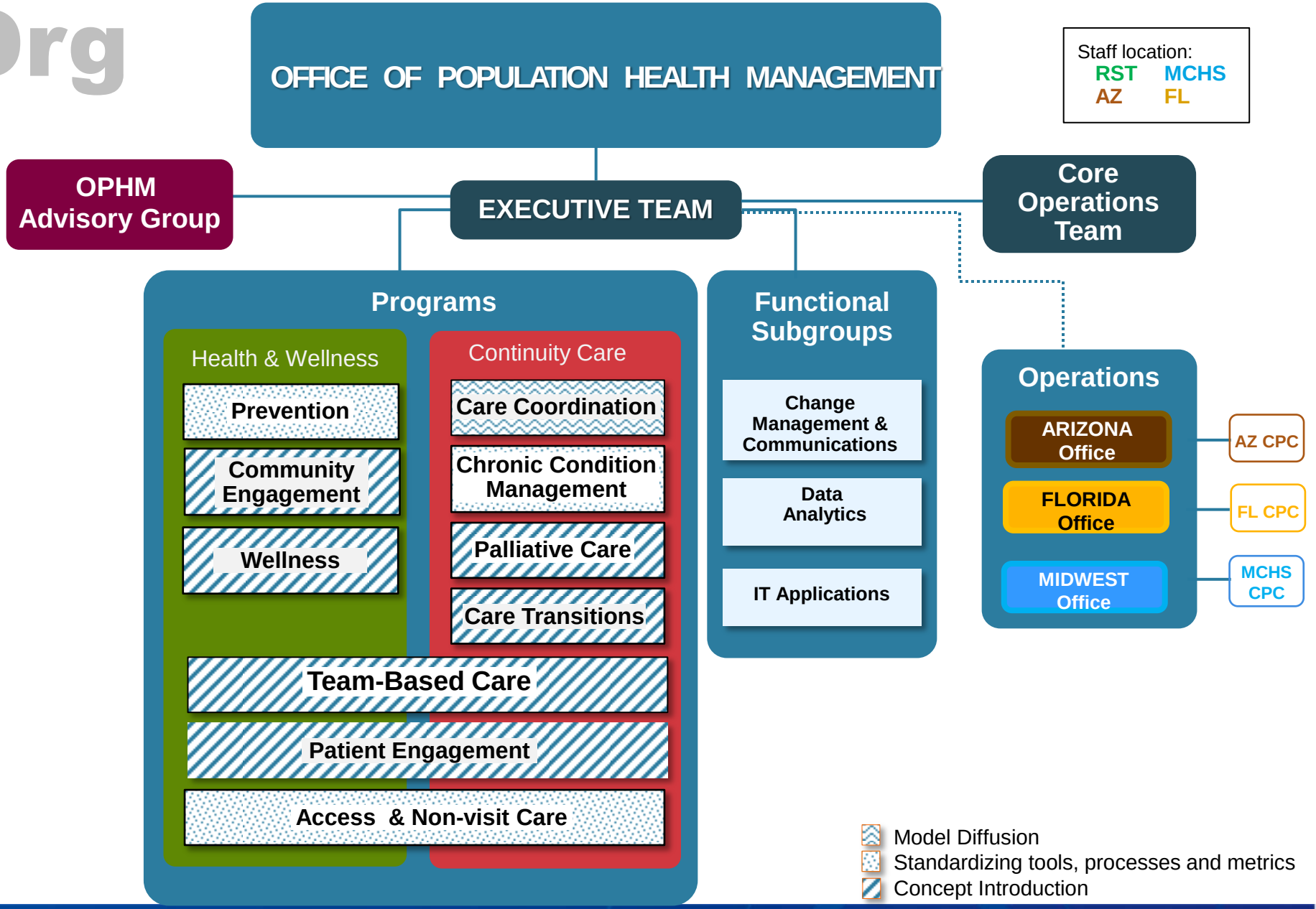
MCHS CPC

Org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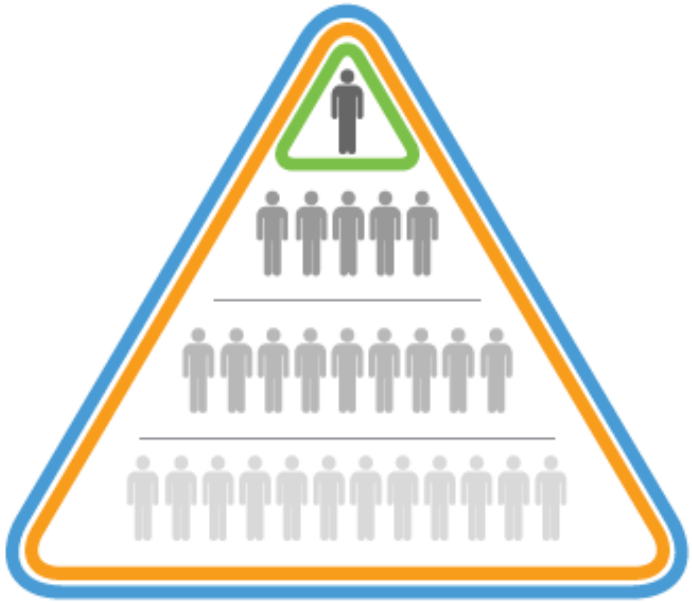
Model Diffusion
Standardizing tools, processes and metrics
Concept Introduction

Principles



DEFINE | ASSESS | STRATIFY | ENGAGE | MANAGE

Once the population served by the clinic has been defined, assessed and stratified we can focus our engagement efforts based on who the patient is, where they are in their life.

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

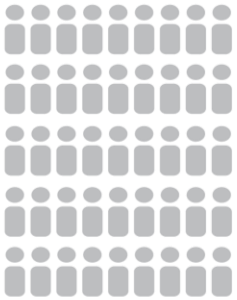
- **Polychronic, frail and elderly, and the underserved**
- **More proactive care delivered beyond bricks and mortar, using predictive analytics**

Principle/Program Alignment

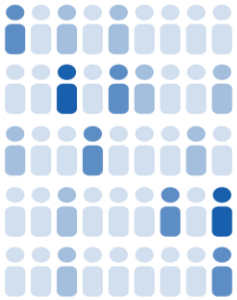
Principles & Functions	OPHM Program Owners
1. Partnerships	Community Engagement
	Patient Engagement
2. Caring for Patient Everyday	Team-Based Care
	Access & Non-visit Care
	Wellness
	Prevention
3. Additional Services for High-Risk	Care Coordination
	Chronic Condition Management
	Palliative Care
	Care Transitions

Process

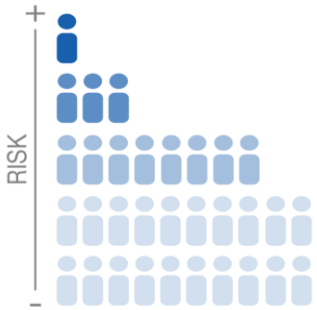
1 DEFINE
Population Identification



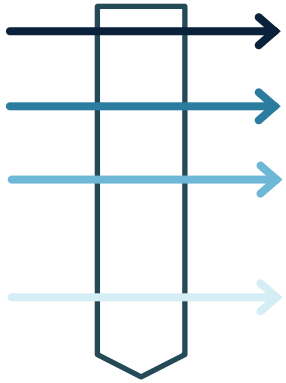
2 ASSESS
Health Assessment



3 STRATIFY
Risk Stratification



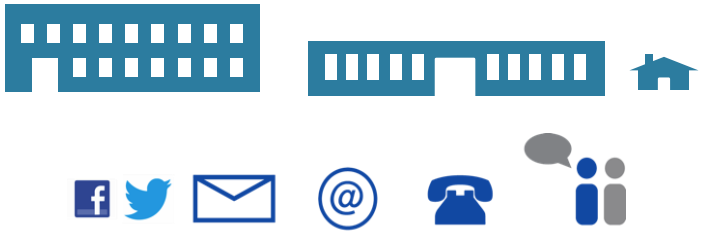
4 ENGAGE
Enrollment/Engagement Strategies



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

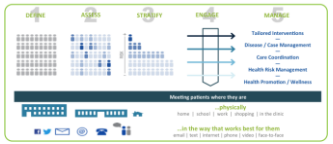
…in the way that works best for them
email | text | internet | phone | video | face-to-face

Phased Strategy

10 Programs

3 Key Principles

Process



Mayo Model of Community Care

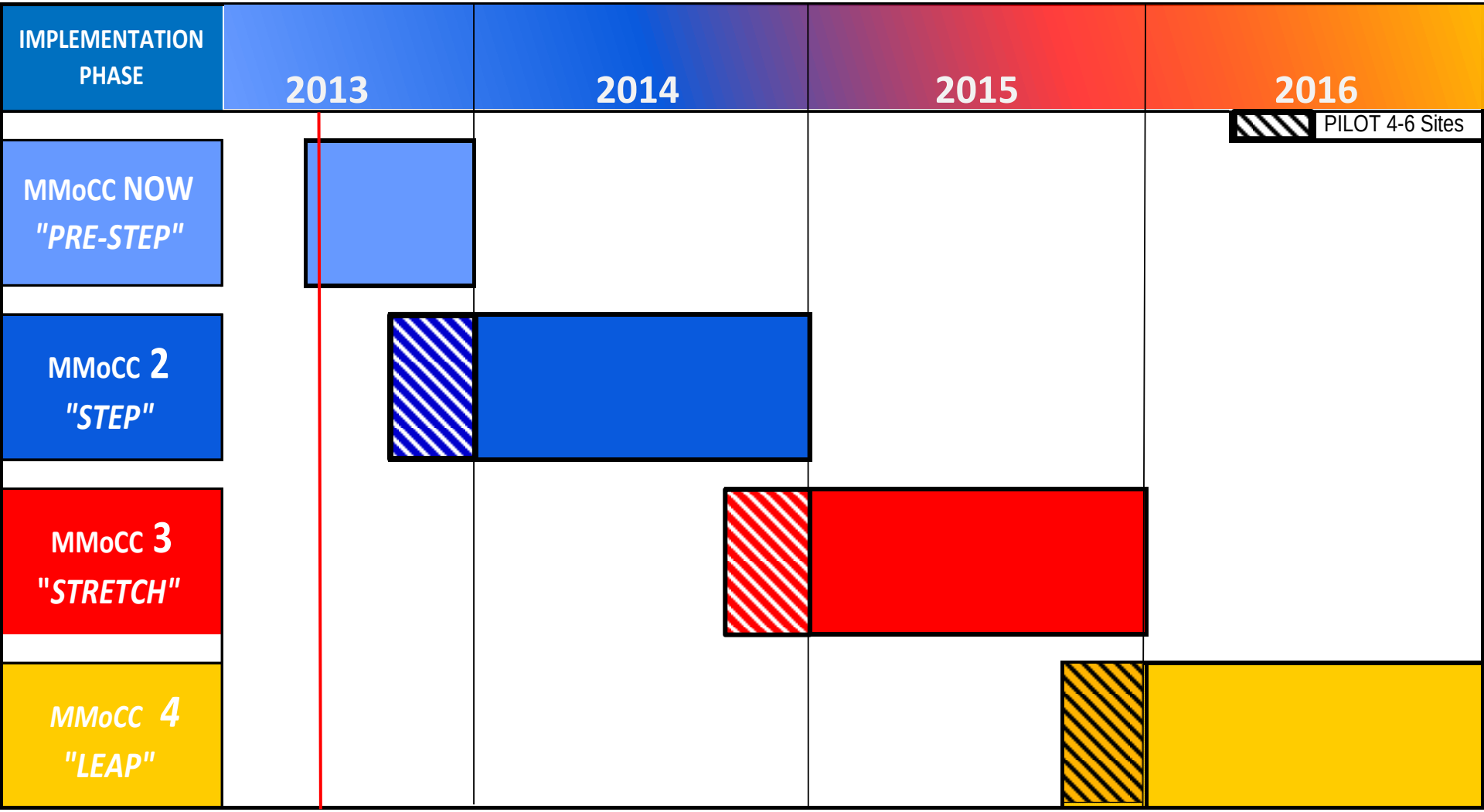
1	2	3	4
PRE-STEP	STEP	STRETCH	LEAP

Elements

			MMoCC 1 = MOC NOW	MMoCC 2	MMoCC 3	MMoCC 4
			PRE-STEP	*Step*	*Stretch*	*Leap*
OPHM vs Site		OPHM Accountable group	2013	2014	2015	2016
Care Management						
	Patients Everyday	Team Based Care	* Co Locate MD/Nurse * *General* Pre-visit Planning * Nurse only MC annual wellness visits * Problem list updating	Shared Care plan Team member roles Process strategies Co-location Strategies Promo full-scope of licensure for team members	Integrated disciplines for single visit Team based attribution integrate Behavioral health increased nurse only visits	Full team model
		Access	* current process attribution * POS promo kit * Pt educ re care teams *PCP assignments, ex. ED hi-utilizers	attribution phase A support protocols for nurse triage	Attribution phase B increased use of TeleHealth tools Remote monitoring tools Portal tools hardwired	Attribution Phase C = teams Advanced Non visit care processes
		Prevention	list of current Mayo CPM's for prev	* Onsight Work Wellness	Employee work wellness	
	Additional for high risk patients	Complex Care Coordination	*intro to complex CC curriculum * "who to CC" guideline *targeting CHF hi risk pts in Humedica	Cerner CC plan & regis Complex Patie Advanced	*integrte all CC programs (diamond, compass)	medication therapy mgmt expanded care teams to include prn specialty
		Chronic Condition Mgmt		chr conditions ID in tools panel mgrs		
		Care Transitions	30 Day readmission process alrea			
		Palliatiive Care Program		* Introd are	expand palliative care	
Partner Management						
	Community Engagement	Community Engagement Program	to patients	communic. Tools for pts. Community Health Events *Community Resource specialist ideas for working on * Identify current community resources		
	Provider/Staff Engagement	Communicatio Mgmt & *Geogra* *Office*	*Intro concept into internal messaging * Identify efficiencies and get lean * Small tests of reduced utilization, ex. MRIs and back pain Initial communication packet			
	Patient Engagement	Patient Engagem ogra	* Promote enrollment in POS *initial Shared Decidsion m	motivational interviewing health coaching expanded use of shared decision making tools		
Finance Management						
	Contracting ("Plan") Engagement	*Geographic Offices*	pilot target marketing to empolyers	MMSI data in Humedica? Comm Resource specialist?	incentives for Non ED utilization Incentives for non-visit care	
	Provider Compensation	*Geographic Offices*		Small portion of quality & service at risk	mixed FFS/TCOC focus	TCOC focus/incentives
Operational Management						
	Infrastructure	*Geographic Offices*	Workflow analysis/change mgmt team	co-location space owner for Sharing of Humedica Reports	Expanding shared space for team	
	Metrics	Exec & Data Analytics		? eConsult bonus ? Messaging/portal use bonus	Non visit care metrics	
	IT pre-requisites for phase	IT	current state attribution	* Clinical PHM Registry * Care Plan in EMR * Pt. facing care plan	integrated panel management tool Shared Care Plan (patient facing) Value Dashboard	
	Cultural Readiness	Comm/Change Mgmt.	Initial communication packet	Staff & providers understand the "why" move to MMoCC	Team based culture is valued	

DRAFT

Timeline


IMPLEMENTATION PHASE
2013
2014
2015
2016
PILOT 4-6 Sites
MMoCC NOW
"PRE-STEP"
MMoCC 2
"STEP"
MMoCC 3
"STRETCH"
MMoCC 4
"LEAP"

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

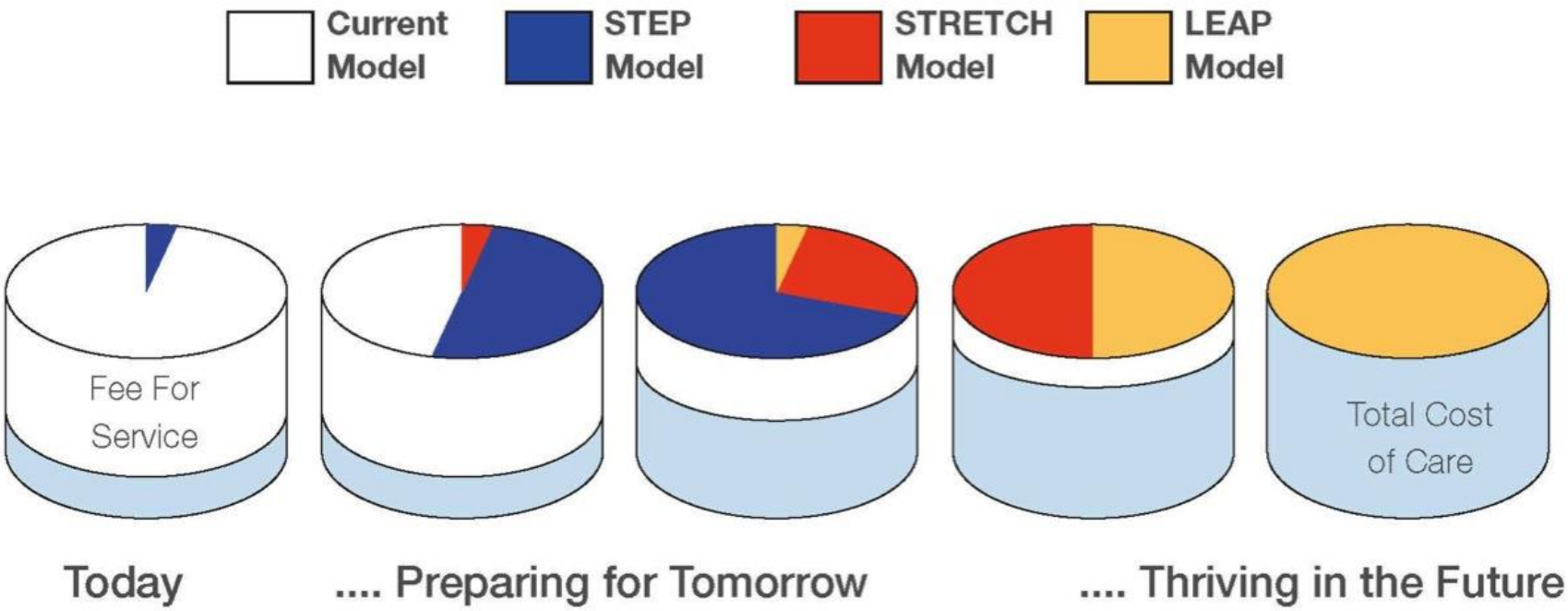
LEAP | Requires strategic investment of resources; needs further validation

- 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



Evolution

Loose confederation of large sites, medium sites, small sites

Regionalized common systems and closer relationships

Centralized model of MHS with singular system and process attributes

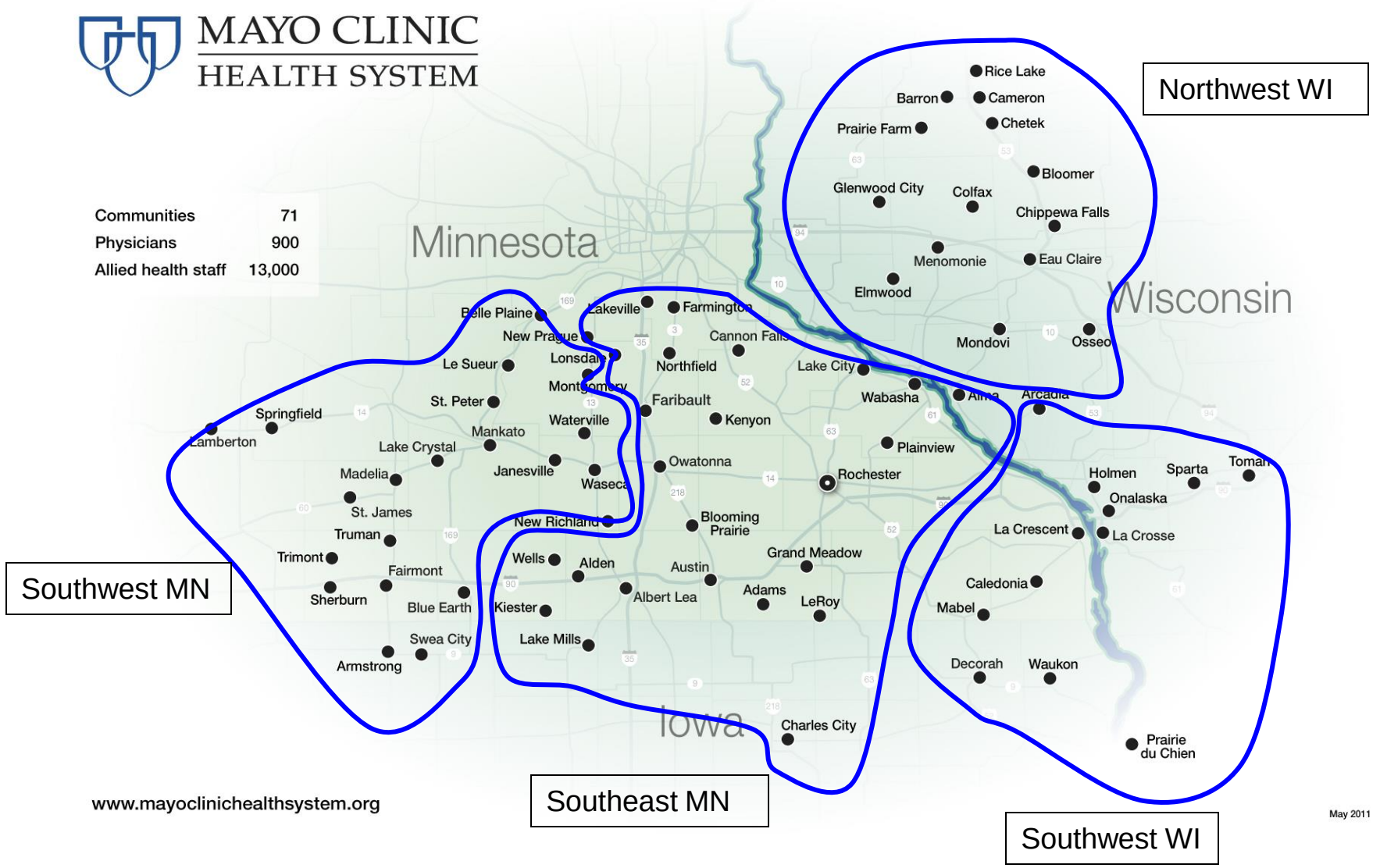
Centralized model with tight system attributes as one with Mayo Clinic

1980's **1990's** **2000's** **Future State (2015)**

MAYO CLINIC HEALTH SYSTEM

MAYO CLINIC
OFFICE OF POPULATION HEALTH MANAGEMENT

MAYO CLINIC
HEALTH SYSTEM



www.mayoclinichealthsystem.org

May 2011

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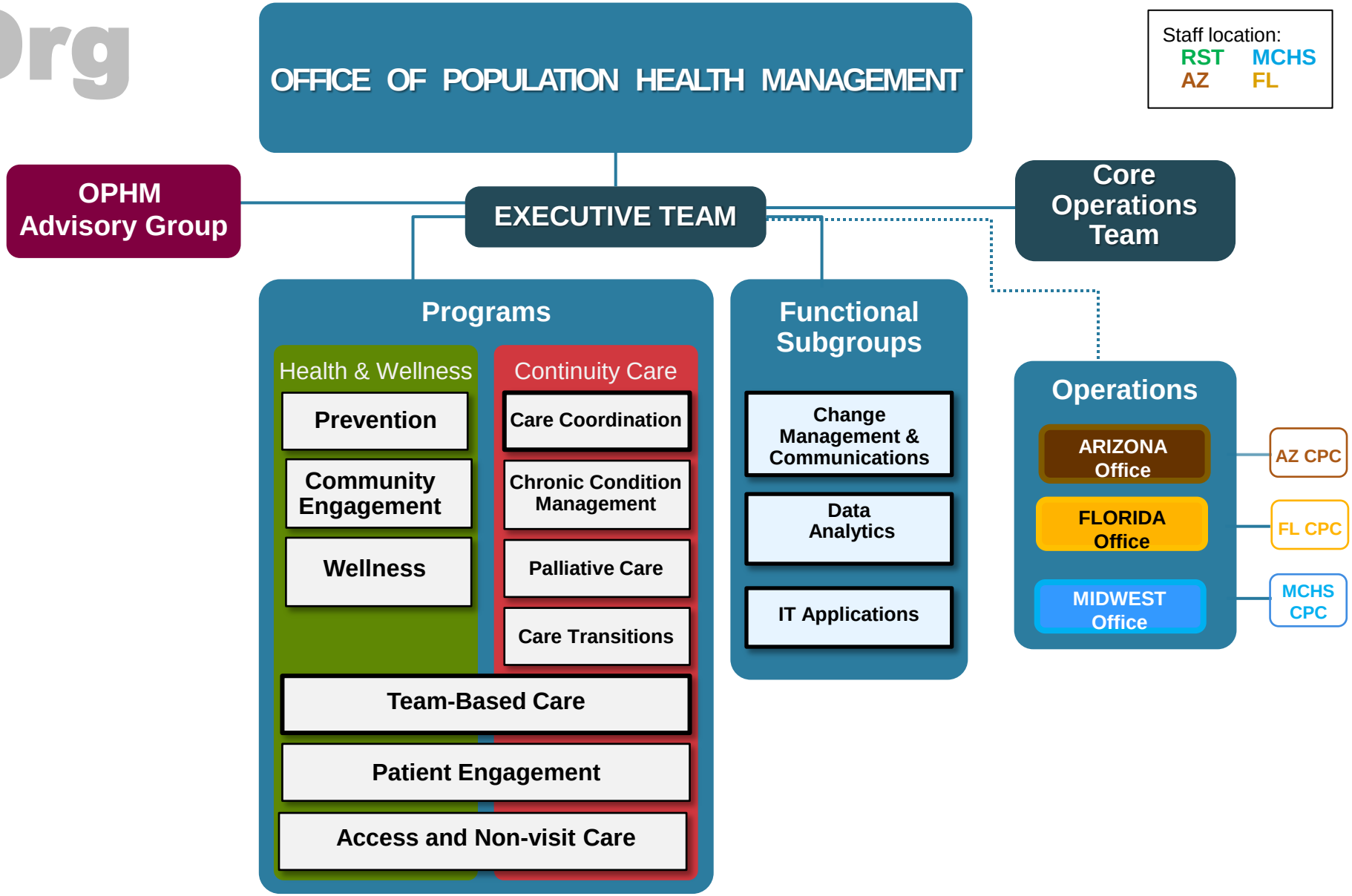
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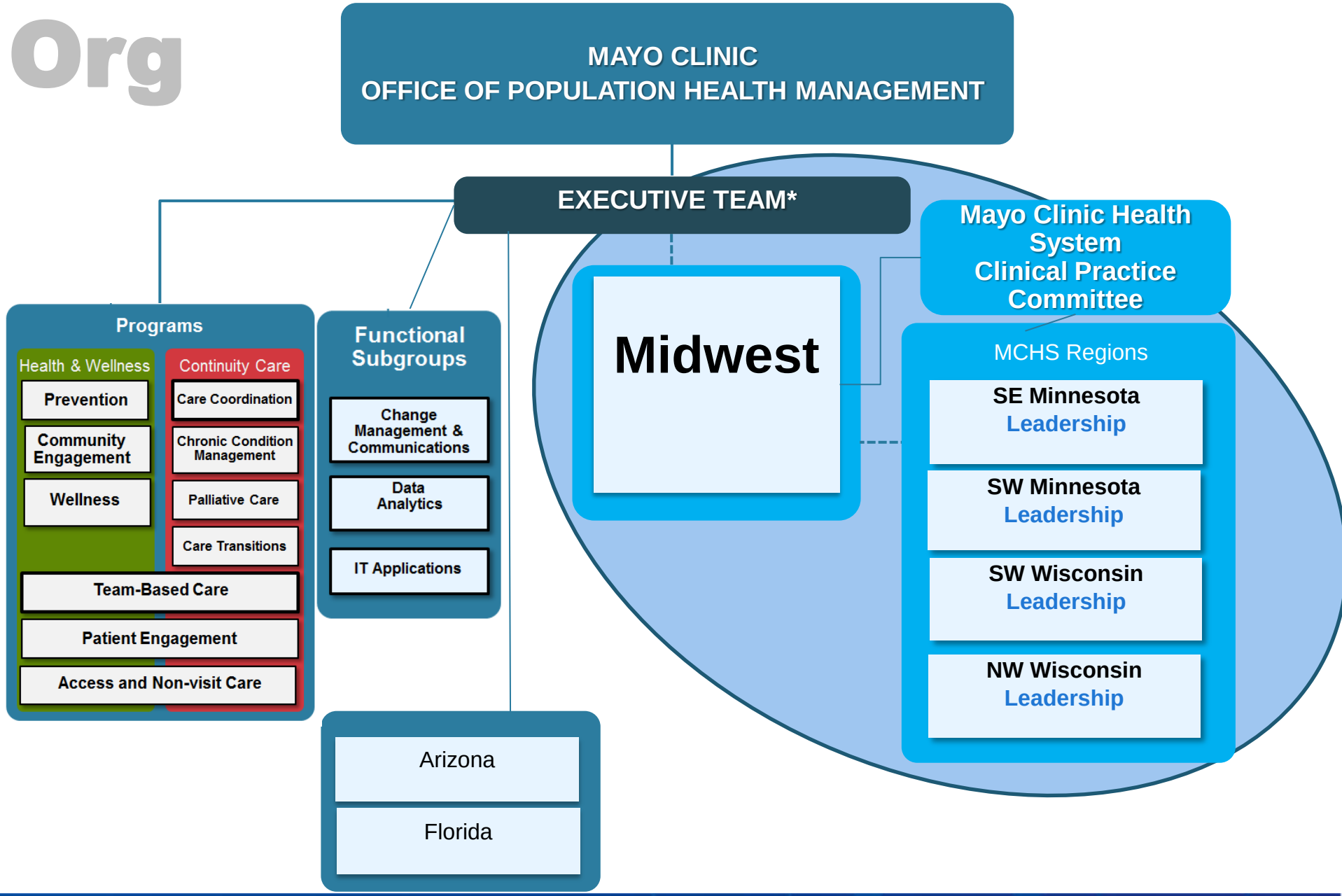
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OFFICE OF POPULATION HEALTH MANAGEMENT
EXECUTIVE TEAM*
Mayo Clinic Health System Clinical Practice Committee
Midwest
MCHS Regions
SE Minnesota Leadership
SW Minnesota Leadership
SW Wisconsin Leadership
NW Wisconsin Leadership
Programs
Health & Wellness
Prevention
Community Engagement
Wellness
Continuity Care
Care Coordination
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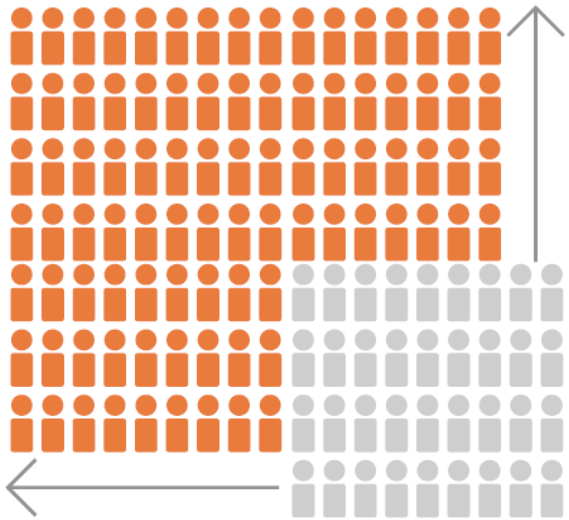
Functional Subgroups
Change Management & Communications
Data Analytics
IT Applications
Arizona
Florida

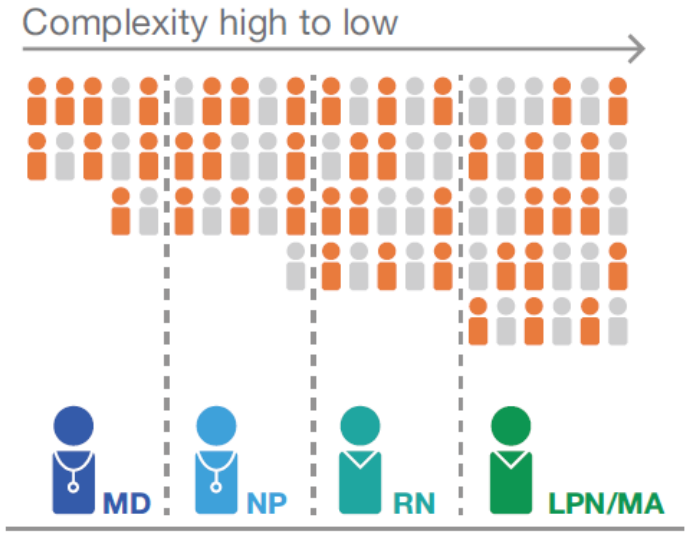
Optimizing the Care Team

- Clinicians, nurses, schedulers, and other specialized staff around the patient
- Work together in ways that allow each to add value at every touch-point
- 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

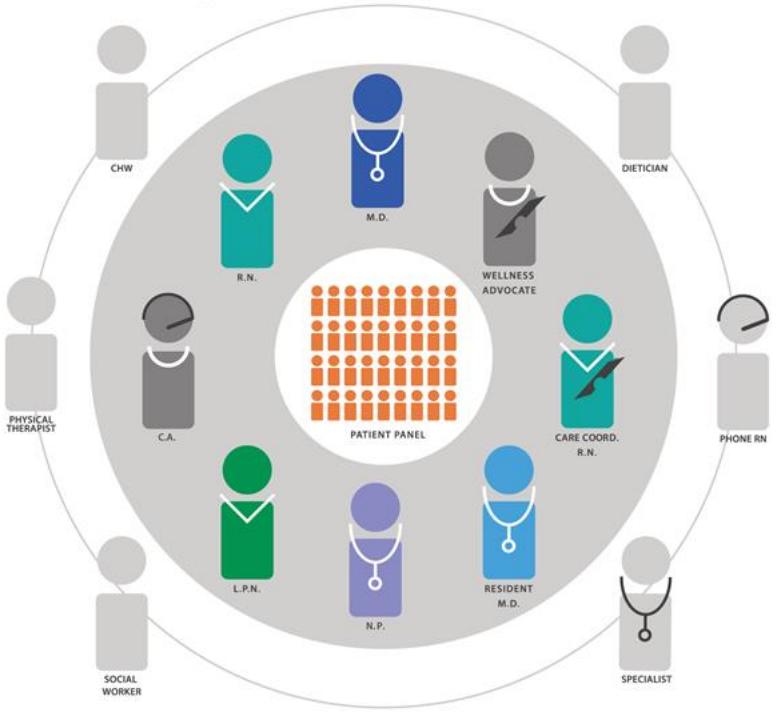


THE OPTIMIZED CARE TEAM ENABLES CARE RESPONSIBILITES TO BE DISTRIBUTED ACROSS THE TEAM

Priority #2

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,[1] 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

Summary

- 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

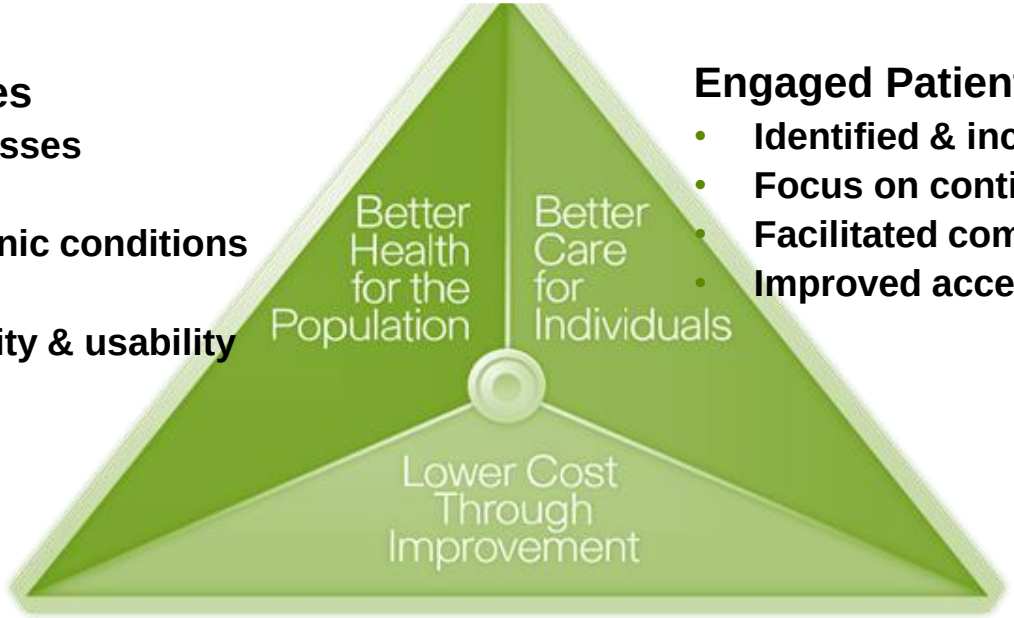
Action Plan

- Patient Attribution
- Understand Access
- Find Analytics Solution
- Program for System Automation
- Start with a Focus
  - Team-Based Care
  - Chronic Conditions
- Continue to Communicate

Success

Engaged Communities

- Proactive care processes
- Identified patients
- Management of chronic conditions
- Wellness focus
- Information availability & usability

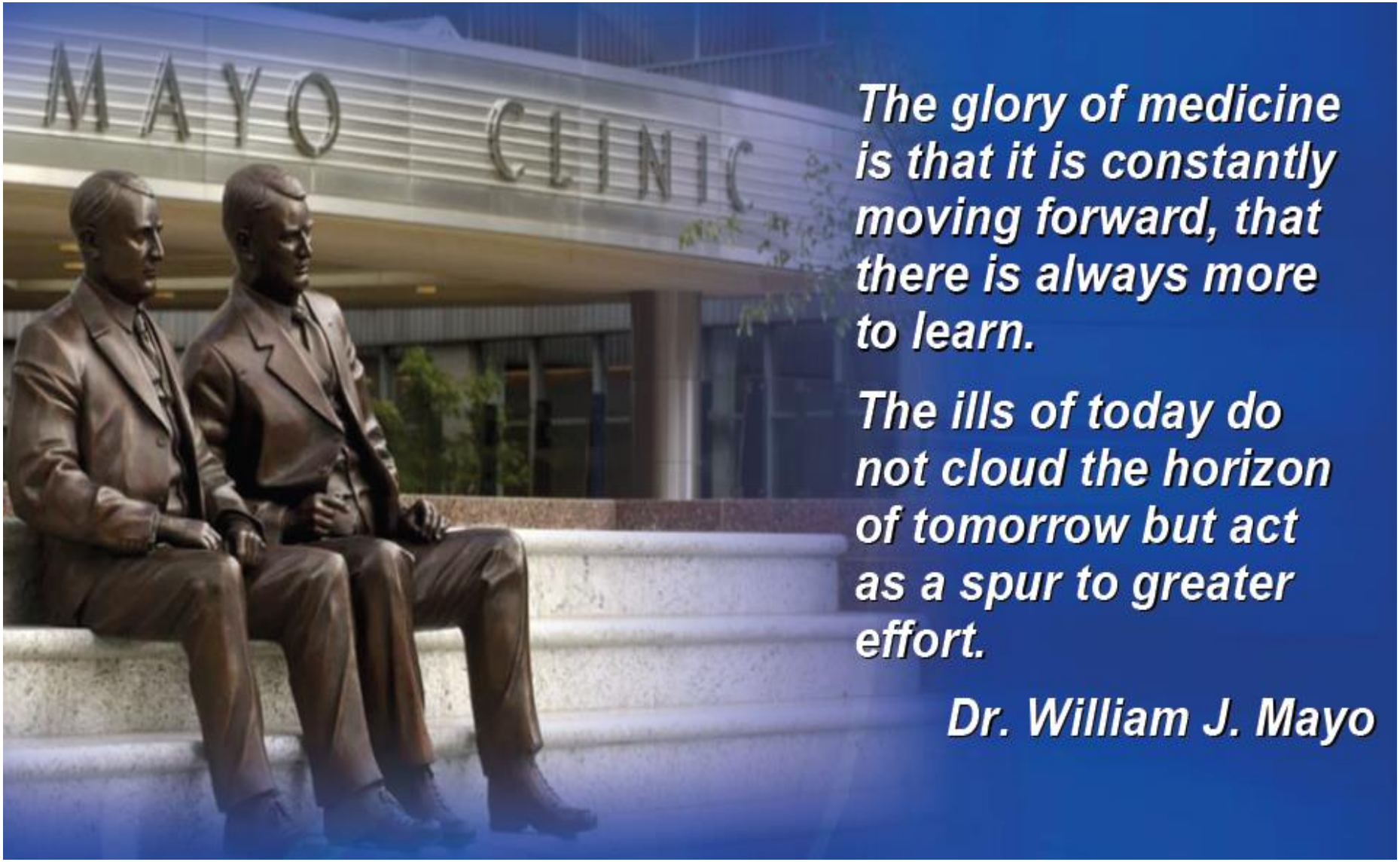


Engaged Patients

- 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