The Journey to Value-Based Care

AHA- Governing Council
Section for Psychiatric and Substance Abuse Services
February 5th, 2015

Joseph M. Schulman
Executive Director,
NSLIJ Care Solutions
Key Facts

- 8 million people in service area
- Over 4 million patient contacts
- 141,345 ambulatory surgeries
- 282,044 hospital discharges
- 27,368 births
- 664,915 emergency visits
- 688,660 home care visits
- 102,277 ambulance transports
- $7.8 billion annual operating budget
- 14th largest healthcare system in the US
- More than 51,000 employees
  - More than 10,000 physicians
  - More than 10,000 nurses
  - More than 1,500 medical residents and fellows

-More than $686.4 million in community benefit (10.9 percent of operating expenses) by participating in 1,966 unique programs, serving more than 1.9 million community members and training 24,862 health professionals.
Our System Today

Clinical Enterprise
- Inpatient facilities
- Ambulatory/outpatient
- Long Term/Home Care
- Hospice
- Joint ventures
- Medical transport
- Medical Group

Educational Enterprise
- GME/CME
- School of Medicine
- Elmezzi Graduate School
- Center for Learning and Innovation

Research Enterprise
- Bioelectronic medicine
- Clinical research management
- Health services/outcomes research

Insurance Enterprise
- CareConnect
- Risk
- Capitation-bundled payments
- Product offerings
- Joint product offerings
- Employer products

Community Health Enterprise
- Community benefit
- Access and education programs
- Veterans’ programs
- Children’s programs

North Shore Ventures
- New businesses
- Consulting
- Partnerships

Shared Support Services
- Management Services
- Clinical Services
- Support Services

Partnerships
Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value

**Alternative Payment Models**

- **Today:** 20%
- **2016 Goal:** 30%
- **2018 Goal:** 50%

**Hospital Payments Through Programs**

- **2016 Goal:** 85%
- **2018 Goal:** 90%

20 major health systems, payers pledge to convert 75% of business to value-based arrangements by 2020

Written by Emily Rappleye (Twitter | Google+) | January 28, 2015

A group of the top U.S. health systems, payers and stakeholders announced Wednesday the formation of the Task Force...responds to HHS announcement that half of Medicare reimbursement will shift to alternative payment arrangements by 2018."

Source: Becker’s Hospital Review, 1/28/2015
Location of Medicare Shared Savings and Pioneer ACOs

23 Pioneer and 343 Shared Savings Program ACOs as of April 2014

Source: CMS; Advisory Board analysis. Learn more at advisory.com/MedicarePaymentInnovationProject

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Location of Medicare Shared Savings and Pioneer ACOs

23 Pioneer and 343 Shared Savings Program ACOs¹ as of April 2014

January 2015

Meet Medicare's 89 newest ACOs

More than seven million beneficiaries are now covered by shared savings program

9:27 AM - January 5, 2015

¹ Accountable care organization.

Source: CMS; Advisory Board analysis.

Learn more at advisory.com/MedicarePaymentInnovationProject

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<table>
<thead>
<tr>
<th>Program Type</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Risk</td>
<td>• Receive all or portion of premium.</td>
</tr>
<tr>
<td></td>
<td>• Responsible for total cost of care.</td>
</tr>
<tr>
<td>Shared Risk</td>
<td>• Share in upside/downside savings/losses relative to pre-established spending target.</td>
</tr>
<tr>
<td></td>
<td>• Responsible for all or portion of medical spend.</td>
</tr>
<tr>
<td></td>
<td>• Quality Gate</td>
</tr>
<tr>
<td>P4P</td>
<td>• Eligible for incentive payments based on meeting program criteria.</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>• Eligible to share upside savings with payer relative to pre-established spending target.</td>
</tr>
<tr>
<td></td>
<td>• Quality Gate</td>
</tr>
</tbody>
</table>
## 2015 Attributed Lives by Model

<table>
<thead>
<tr>
<th>Payment Model</th>
<th>2015*</th>
<th>2014</th>
<th>2015</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Covered Lives</td>
<td></td>
<td>Percent of Total</td>
<td></td>
</tr>
<tr>
<td>Full Risk</td>
<td>109,500</td>
<td>101,500</td>
<td>21%</td>
<td>38%</td>
</tr>
<tr>
<td>Shared Risk</td>
<td>173,000</td>
<td>150,000</td>
<td>33%</td>
<td>56%</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>231,850</td>
<td>15,000</td>
<td>45%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>250</td>
<td>0</td>
<td>&lt;1%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>514,600</td>
<td>266,500</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Includes new Value-Based Agreements currently under negotiation. Figures represent preliminary estimates pending formal patient attribution.
We Must Find a Way....A Better Way!
The Relentless Pursuit….

“… it all just works.”

Steve Jobs, June 6, 2011, announcing the launch of iCloud
Defining Value....

“The health outcomes achieved that matter to patients relative to the cost of achieving those outcomes.”

-Thomas H. Lee, MD and Michael E. Porter
What is NSLIJ Care Solutions?

Our health system’s care management organization that serves as the steward of high-value care-delivery for all risk-based programs.
Program success requires execution via a high degree of collaboration between the above matrixed functional areas.
Our Differentiators

• Health System/provider-born
• Inspired by national leaders....engineered for us
• Respectful of the provider community
• Broad perspective across the full care-continuum
• Trusted brand
Overview of Care Management

1. What is care management?

2. How are patients identified for NSLIJ care management programs?

3. What programs are currently deployed? How is success in these programs measured?

4. What partnerships are critical to our success as a care management organization?

5. How are we working towards integrating Behavioral Health services within care management/accountable care activities?
Care Management Domains

**EXAMPLES OF OUR CURRENT CAPABILITIES:**
- Recent go-live of claims-based analytics engine
- 24/7 Telephonic Care Coordination
- Practice and Community Based Care Coordination
- Advanced Illness Clinical Programming
- Risk Contract Implementation Program Management
- P4P program management
What is the Goal of Care Management?

To achieve an optimal level of wellness & to improve coordination of care while providing cost effective, non-duplicative services

Source: Center for Health Care Strategies, Inc, adapted from Robert Mechanic, “Will Care Management Improve the Value of U.S. Health Care?” 2004
1. Maintain or improve patients’ functional status
2. Improve ability to self-manage their condition
3. Reduction of unnecessary utilization
4. Reduction of unwanted care
5. Shifting necessary utilization into the network
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Initial care management programs should be targeted to people with *multiple disease conditions*, who are at *high-risk for unnecessary care*, and who have the greatest opportunity for reducing health care costs.

**Top of the Pyramid**

≥2 chronic conditions in an advanced state with functional impairment

Provide both curative and comfort care to patients at home and in the community to patients with 18-36 months to live.

> 1 chronic (incurable, but controllable) conditions

Provide proactive disease management to maximize quality of life and postpone complications.

Services typically provided for a minimum of 12 months, and can continue for decades.
Identify and Stratify by Risk

**Case Level: Identified at the time of high risk event**

- Specific DRGs (e.g. Bundled Payments for Care Improvement)
- Health risk assessment
- Referral by physician or staff, or patient self-referral

**Population Level: Identified by clinical or claims data**

- Quantitative risk-prediction
- Acute-care utilization focused
- High-risk condition or medication-focused (e.g. HCC score)
**Community/Practice Based Care Coordination**

**Model:** Complex care management for Healthfirst members (adult and child), 91% of whom are managed Medicaid beneficiaries. NSLIJ bears full-risk for the spend. Care managers are located in high-volume physician practices in Staten Island, Queens, Nassau and Suffolk counties to identify and engage high-risk patients and achieve P4P targets.

- **Number of Lives:** 53,600 total Healthfirst members; 2,900 patients with a HCC above 1.5 (high-risk)
- **Duration:** Care Managers deployed June 2014
- **Current Staffing:** 6 Care Managers (RN)
- **Current Sites:** LIJ ACU, Glen Cove Hospital Family Med, 865 Northern Blvd, Dolan Family Health Center, SIUH Clinic*

**Key Components:**

<table>
<thead>
<tr>
<th>High-Risk Care Management</th>
<th>Real-Time Notifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4P Preventive Health Services</td>
<td>24/7 RN Triage Call Center</td>
</tr>
</tbody>
</table>

**Key Performance Indicators**

<table>
<thead>
<tr>
<th>Manage PMPM Spend</th>
<th>Encourage appropriate utilization of healthcare services and proper care setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shift Volume In-Network</td>
<td>Increase referrals to NSLIJ Facilities, Post Acute Providers and Services</td>
</tr>
<tr>
<td>Reduce Avoidable Admissions</td>
<td>Reduction of preventable hospital admissions/readmissions and avoidable emergency department visits</td>
</tr>
<tr>
<td>Reduce Post-Acute Utilization</td>
<td>Utilize Milliman Guidelines to inform discharge planning at every stage</td>
</tr>
</tbody>
</table>
### Healthfirst Stratification

<table>
<thead>
<tr>
<th>HCC Group</th>
<th>Active Members</th>
<th>%</th>
<th>July 2013 – June 2014 Spend</th>
<th>%</th>
<th>July 2013 – June 2014 Admits</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duplicate Name</td>
<td>244</td>
<td>0%</td>
<td>$340,118</td>
<td>0%</td>
<td>13</td>
<td>0%</td>
</tr>
<tr>
<td>No HCC</td>
<td>12,824</td>
<td>25%</td>
<td>$3,782,078</td>
<td>3%</td>
<td>91</td>
<td>3%</td>
</tr>
<tr>
<td>Less than 1</td>
<td>33,820</td>
<td>65%</td>
<td>$48,818,791</td>
<td>41%</td>
<td>974</td>
<td>30%</td>
</tr>
<tr>
<td>1-1.5</td>
<td>2,274</td>
<td>4%</td>
<td>$12,548,721</td>
<td>11%</td>
<td>348</td>
<td>11%</td>
</tr>
<tr>
<td>1.5-2</td>
<td>1,072</td>
<td>2%</td>
<td>$10,367,738</td>
<td>9%</td>
<td>270</td>
<td>8%</td>
</tr>
<tr>
<td>2-3</td>
<td>1,004</td>
<td>2%</td>
<td>$13,191,691</td>
<td>11%</td>
<td>526</td>
<td>16%</td>
</tr>
<tr>
<td>3-4</td>
<td>414</td>
<td>1%</td>
<td>$9,177,030</td>
<td>8%</td>
<td>331</td>
<td>10%</td>
</tr>
<tr>
<td>4-5</td>
<td>205</td>
<td>0%</td>
<td>$6,857,361</td>
<td>6%</td>
<td>205</td>
<td>6%</td>
</tr>
<tr>
<td>5+</td>
<td>222</td>
<td>0%</td>
<td>$13,956,087</td>
<td>12%</td>
<td>477</td>
<td>15%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>52,079</td>
<td>100%</td>
<td>$119,039,617</td>
<td>100%</td>
<td>3235</td>
<td>100%</td>
</tr>
</tbody>
</table>

6% of the members (~3,000 people) accounted for 45% of the total spend.

- Using claims data from January 2012 – June 2014
## Healthfirst Program Enrollment

### High Risk Patient Spend by Practice

<table>
<thead>
<tr>
<th>Practice Affiliation</th>
<th>July 2013 -June 2014 Spend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice A- CIIPA</td>
<td>$7,684,814</td>
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<td>Practice D- Premium IPA</td>
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<tr>
<td>Practice G- MG</td>
<td>$381,613</td>
</tr>
<tr>
<td>Practice H- MG</td>
<td>$237,916</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$23,122,413</strong></td>
</tr>
</tbody>
</table>

43% of the High-Risk spend is at practices with a currently deployed care manager.
Overview of Care Management

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2. How are patients identified for NSLIJ care management programs?

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Current Care Solutions Geography

- LIJ Bundles
- LIJ ACU
- 865 Northern Blvd
- Glen Cove Family Medicine
- Dolan Family Health Center
- Huntington Bundle
- 24/7 Clinical Call Center
- NSLIJ Health Home
- Community Paramedicine & CEMS
- SSIDE Bundle
- Pioneer ACO*
- SIUH Clinic*
- NSLIJ House Calls
- NSLIJ Care Solutions Headquarters
- CKD Program

* Start Date December 1, 2014
### Bundled Payments for Care Improvement

**Model:** Transitional care management for Medicare Fee-For-Service beneficiaries with specific diagnoses (COPD, Stroke, CABG/Valve, Hip and knee replacement) at specific hospitals.

<table>
<thead>
<tr>
<th><strong>Number of Lives:</strong></th>
<th>~ 1,200 / year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration:</strong></td>
<td>January 1, 2014 – December 31, 2016</td>
</tr>
<tr>
<td><strong>Current Staffing:</strong></td>
<td>Medical Director (Zena Brown), 5 Nurse Practitioner ‘Care Navigators’</td>
</tr>
<tr>
<td><strong>Current Sites:</strong></td>
<td>LIJ [CABG, Valve, COPD], NSUH [CABG, Valve, Stroke], SSH [CABG, Valve], Hunt [Total Joint]</td>
</tr>
</tbody>
</table>

**Key Components:**

- Inpatient Introduction
- 24-Hour Follow-Up Call
- 72-Hour Follow-Up Visit
- Weekly Calls or Visits

**Real-Time Notifications**

- 24/7 RN Triage Call Center
- Physician Gainsharing (No downside risk)

**Key Performance Indicators**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Days at Home</td>
<td>Number of days after discharge(out of 30/60/90) patients spend at home</td>
</tr>
<tr>
<td>Shift Volume In-Network</td>
<td>Increase referrals to NSLIJ Physicians, Post Acute Providers and Services</td>
</tr>
<tr>
<td>Reduce Readmission Rate</td>
<td>Improve post-discharge care to reduce preventable readmissions</td>
</tr>
<tr>
<td>Reduce Post-Acute Utilization</td>
<td>Utilize Milliman Guidelines to inform discharge planning at every stage</td>
</tr>
</tbody>
</table>
Consult with Surgeon → Pre-Surgical Testing & Pre-Op Class → Total Knee Replacement Surgery

3 Days Inpatient at 2 North → Patient Discharged to SNF → Patient Discharged to Home with Home Care
Patient Pathway w/Care Management

- Consult with Surgeon
- Pre-Surgical Testing & Pre-Op Class
- Pre-Hospital Call / Visit - Home Assessment - Education
- Total Knee Replacement Surgery

- 3 Days Inpatient at 2 North
- NP Inpatient Visit - Collaboration on Discharge Plan
- Patient Discharged to SNF
- NP Visit at SNF - Collaboration on Discharge

- Patient Discharged to Home
- NP Visit at Home - 24 Hour Call - 72 Hour Visit - Coordination with Surgeon, Home Care
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Success in the accountable care and value-based arena will require collaboration across the entire organization.
Key Internal Partnerships (examples)

- **OCIO**: Population Health IT, Explorys, CareTool Production, Optum Implementation
- **Medical Group & Network**: Provider alignment, engagement with care management team
- **Finance**: Financial Performance Monitoring, Programmatic Valuation
- **Post Acute**: Partnership for care management in Skilled Nursing and Home Care
- **CEMS**: Emergent transport strategies, Community Paramedicine Program
Key External Connections (examples)

Best practices, organizational structure and lessons learned

Care Manager recruitment & training, Practice engagement

Population health analytics, risk stratification, modeling

Automated support and outreach

Predictive modeling care pathways and interventions

Text-based engagement and reminders

Best practice and scaling for advanced illness
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5. How are we working towards integrating Behavioral Health services within care management/accountable care activities?
“The US mental health system fails to reach and/or adequately treat the millions of Americans suffering from mental illness and substance abuse. These unmet needs can be met through the integration of primary care and behavioral health care.”

-Milbank Memorial Fund Commission
Evolving Models of Behavioral Health Integration in Primary Care
2010
Key Reasons for BH Integration Efforts

i. The burden of mental illness is great
ii. Mental and physical health problems are interwoven
iii. The treatment gap for mental disorders is enormous
iv. Primary care settings for mental health services enhance access
v. Delivering mental health services in primary care settings reduces stigma and discrimination
vi. Treating common mental disorders in primary care settings is cost-effective
vii. The majority of people with mental disorders treated in collaborative primary care have good outcomes

-Funk M, Ivbijaro G, Integrating Mental Health into Primary Care – A Global Perspective, WHO, 2008
<table>
<thead>
<tr>
<th><strong>QUADRANT II</strong></th>
<th><strong>QUADRANT IV</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with high behavioral health and low physical health needs</td>
<td>Patients with high behavioral health and high physical health needs</td>
</tr>
<tr>
<td>Served in primary care and specialty mental health settings</td>
<td>Served in primary care and specialty mental health settings</td>
</tr>
<tr>
<td>(Example: patients with bipolar disorder and chronic pain)</td>
<td>(Example: patients with schizophrenia and metabolic syndrome or hepatitis C)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>QUADRANT I</strong></th>
<th><strong>QUADRANT III</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with low behavioral health and low physical health needs</td>
<td>Patients with low behavioral health and high physical health needs</td>
</tr>
<tr>
<td>Served in primary care setting</td>
<td>Served in primary care setting</td>
</tr>
<tr>
<td>(Example: patients with moderate alcohol abuse and fibromyalgia)</td>
<td>(Example: patients with moderate depression and uncontrolled diabetes)</td>
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Adapted from Mauer 2006.
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_Behavioral Health Consultant Program^1_

Focus (approx. 25% time) on Identified Patients in NSLIJ Risk Contracts (e.g. HealthFirst patients)

Brief Initial Screen in Primary Care

Next-level (Secondary) Screen for Patients Screening Positive to Brief Initial Screen

Evidence-Based Treatment Algorithms and Psychopharmacological Practice Principles

Behavioral Health (psychiatric/substance abuse) f/u of patients’ treatment in the Primary Care Practice

Brief Treatment Interventions

Other Health Care/BH Care Resource Utilization/Mobilization, including Technology Innovations, to Achieve Optimal and Cost-Effective Outcomes

Telepsychiatry

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^1^BHC = Behavioral Health Consultant

^2^Collaborative Care = BH Integration into Primary Care
Examples of Upcoming Obligations and Plans

- Scaling of BH Collaborative Deployment
- Risk-based program expansion
- Scaling of current care coordination programs
- Response to Competitor ACOs
- NYS DSRIP