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Financing Integrated Care and Population Health Management

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PHM Priority Programs and Role in Reducing Health Care Costs

		Optimizing Site of Care*	Reducing Resource utilization*	Enabler*
Primary Care	Patient Centered Medical Home (PCMH)	✓	✓	
	High risk care management (+ palliative care, telemonitoring)	✓	✓	
	Mental health integration	✓	✓	
	Virtual visits	✓	✓	
Specialty Care	Active referral management (e-consults)	✓	✓	
	Virtual visits	✓	✓	
	Procedural decision support (appropriateness)		✓	
	Patient reported outcomes (PROMs)		✓	✓
Care Continuum	SNF care improvement (network/waiver/naviHealth)	✓	✓	
	Home care innovation (mobile observation, home hospital)	✓	✓	
Patient Engagement	Shared decision making		✓	
	Customized decision aids and educational materials (Vidscrips)		✓	✓
Infrastructure	Single EHR platform with advanced decision support			✓
	Data warehouse, analytics, performance metrics			✓



Integrated Care Management Program (iCMP)

Problem

- Expenses are concentrated in a small % of patients with multiple chronic conditions (9% of Medicare, 3% of Medicaid, 1% of commercial)
- Self-managing multiple chronic conditions is challenging without assistance

Approach

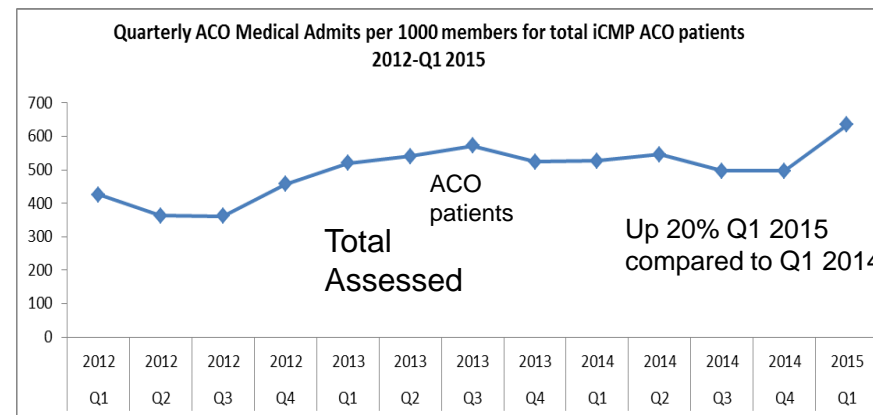
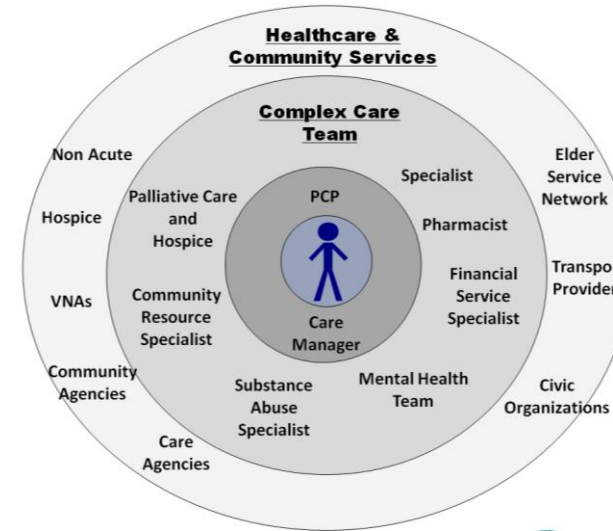
- Identify high-risk patients and provide care management and individualized care management plans
- Demonstrated 7% cost reduction, reduced admissions, and 4% lower mortality

Progress

- 10,560 high-risk patients actively enrolled with a care plan (total iCMP patients)

- Team {
- 84.5 care managers
 - 20 social workers
 - 5 pharmacists
 - 10 community resource specialists

- Lower rates of hospitalizations and ED visits



Behavioral Health Integration

Problem

- High prevalence rate of depression in primary care (10%) with half of patients receiving treatment from their primary care provider
- Behavioral health issues increase the cost for patients with chronic illness 3-5x

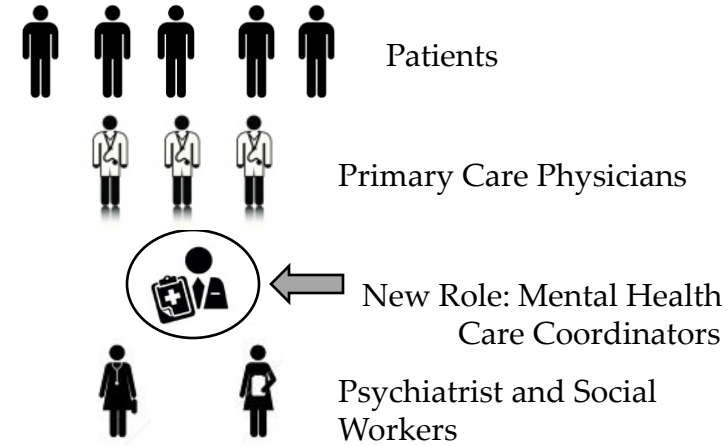
Approach

- Consultations for primary care physicians with behavioral health specialists
- Care management for patients with depression and anxiety offered within primary care setting (Collaborative Care)
- Training and decision aids to support primary care

Progress

- 60% of 151,238 primary care patients seen from 4/1/15-6/30/15 screened for depression
- 3,355 calls from Sept/14 to Sept/15
- 30 Collaborative Care practices with more than 660 patients being actively managed in first 12 months

Collaborative Care Model



"The hard part was pulling my head off the wall and reattaching it to my body."



Virtual Visits

Problem

- Increase in demand for in-person follow-up visits results in long wait times and inconvenience (e.g. travel, time from work) and cost (e.g. parking, co-pays).



Virtual Visits

Approach

- Develop two alternatives for in-person follow-up visits for patients:
 - Virtual Visits – real-time interactions between patients and providers using video.
 - E-Visits – web-based interactions using questionnaires to manage low acuity issues (e.g. cold, ear ache, etc.) and chronic disease.

E-Visits

Interview - Sore Throat

NOT FOR EMERGENCIES.
A webVisit is not for use for medical emergencies or urgent situations. If you think you or your family member may have a medical emergency, call your doctor or 911 immediately.

Have you been exposed to strep throat and/or mononucleosis?

Yes
 No
 Don't know

What have you done to treat your sore throat symptoms?

Over-the-counter cold/flu remedy (name and dose): _____

Over-the-counter pain medication (Tylenol, Advil, Aleve, etc.) (name and dose): _____

Herbal remedies or other supplements (name and dose): _____

Gargle with warm salt water

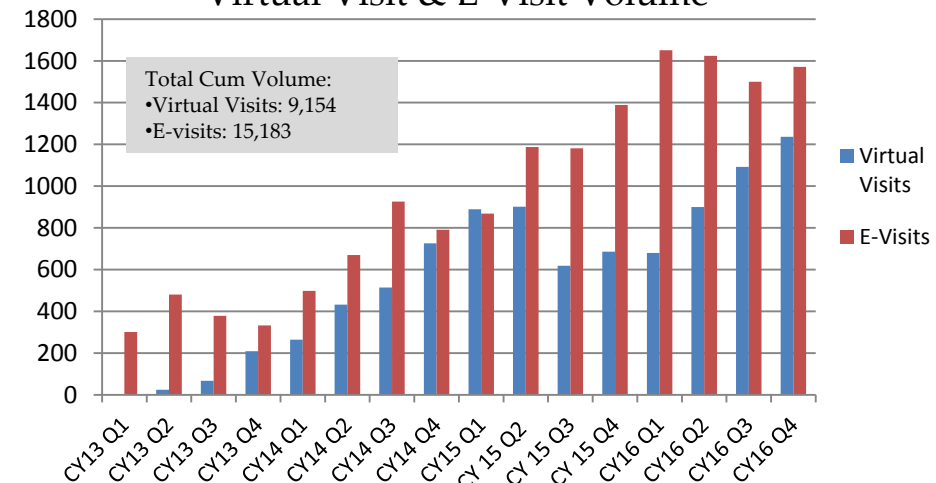
Getting more rest, drinking more fluids

Other (please describe): _____

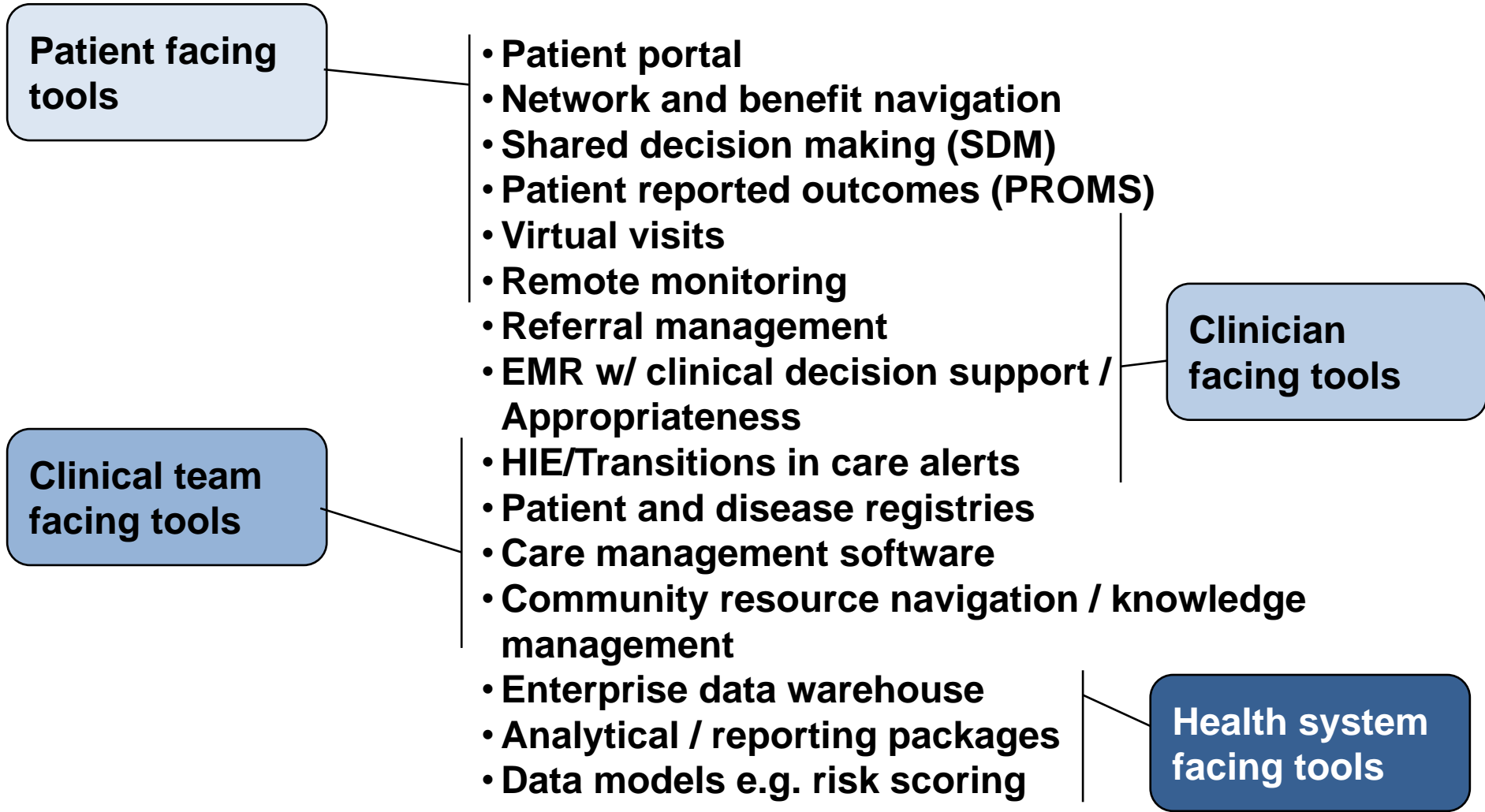
Progress

- 560 clinicians conducted Virtual Visit/E-Visit
- 15,183 E-Visits performed
- 9,154 Virtual Visits performed

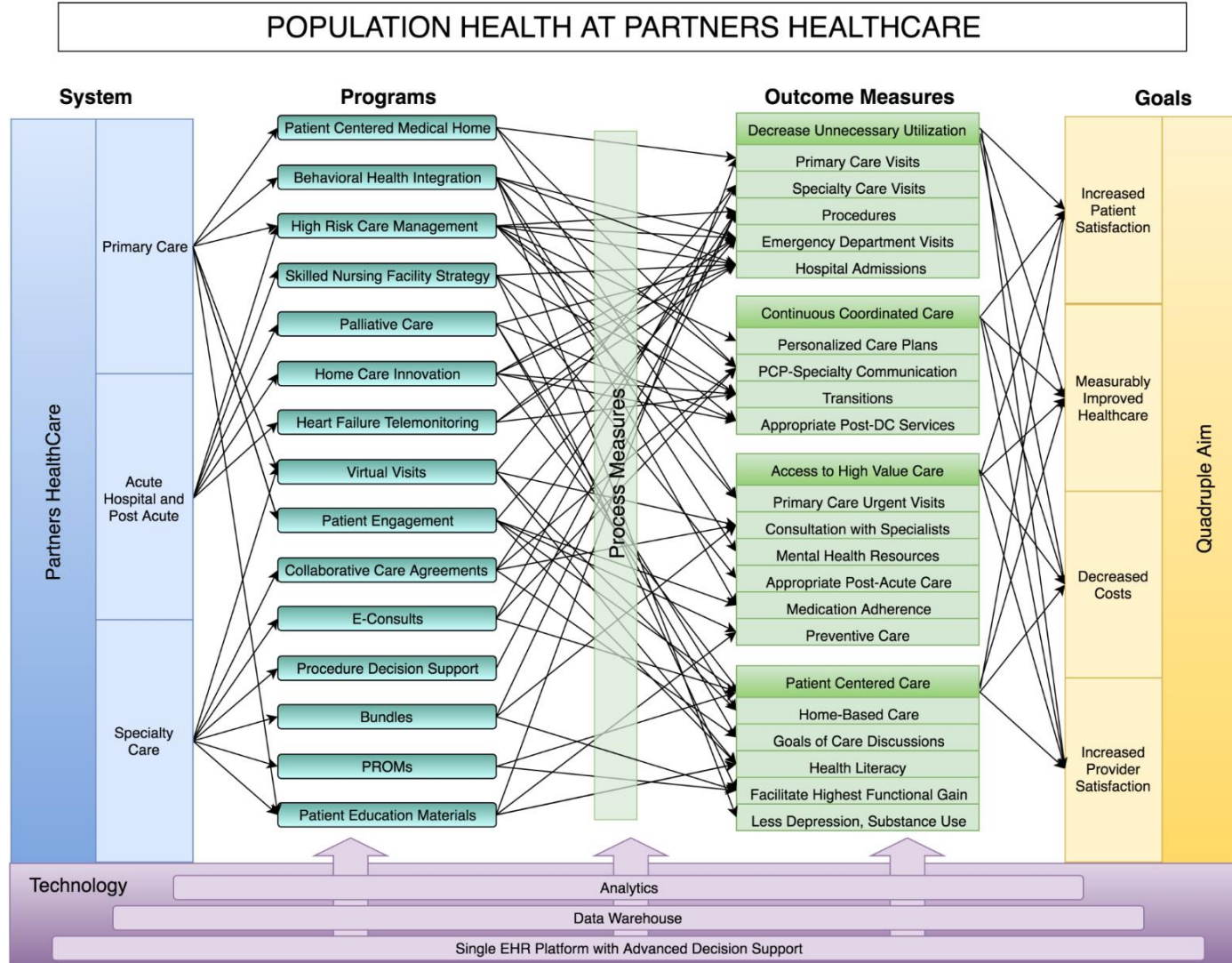
Virtual Visit & E-Visit Volume



What IT tools are required for PHM?



Putting The Pieces Together



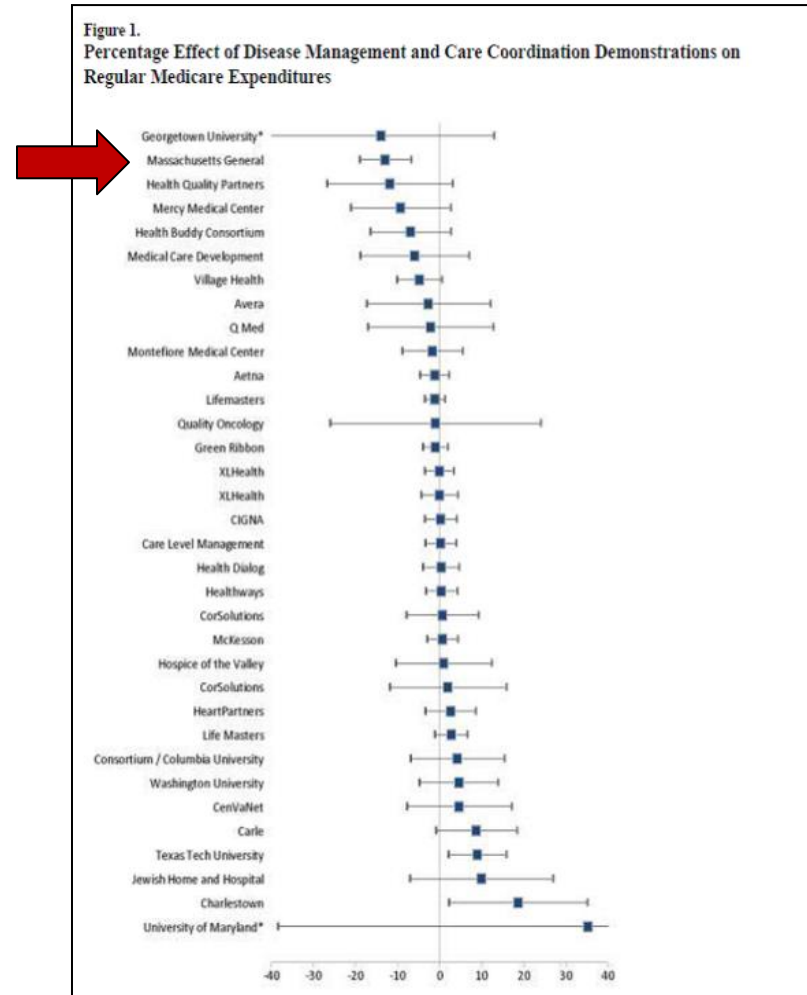
MGH Care Management Medicare Demonstration: Results

Patient Outcomes

- Hospitalization rate: 20% lower
- ED visit rate: 25% lower
- Mortality rate: 4% lower

Savings

- 7.1% net savings (12.1% gross)
- Approximately 4% annual savings for the total population
- For every \$1 spent, the program saved at least \$2.65



Source: *Lessons from Medicare's Demonstration Projects on Disease Management and Care Coordination*, Lyle Nelson, Congressional Budget Office, January 2012, Working Paper 2012-01

Partners Population Health Budget

Category	Budget
Care Coordination – Adult & Pediatric	\$27.39
Behavioral Health / Substance Use	\$10.36
Primary Care / PCMH	\$11.45
Care Continuum / Palliative Care	\$8.36
Ambulatory Quality	\$2.52
Telehealth / Patient Engagement	\$2.33
Risk Capture	\$1.63
Infrastructure – Central & Local	\$7.34
Innovation Pilots	\$0.080
Ambulatory ICU / Medicaid Specific Programs	\$3.42
Total	\$75.59

Funding

Hospital and
Provider
contributions
*1.6% of
commercial
revenue*



Federal / State
DSRIP dollars
allocated for
Medicaid

Numbers in Millions. PHS total budget is ~\$12B

