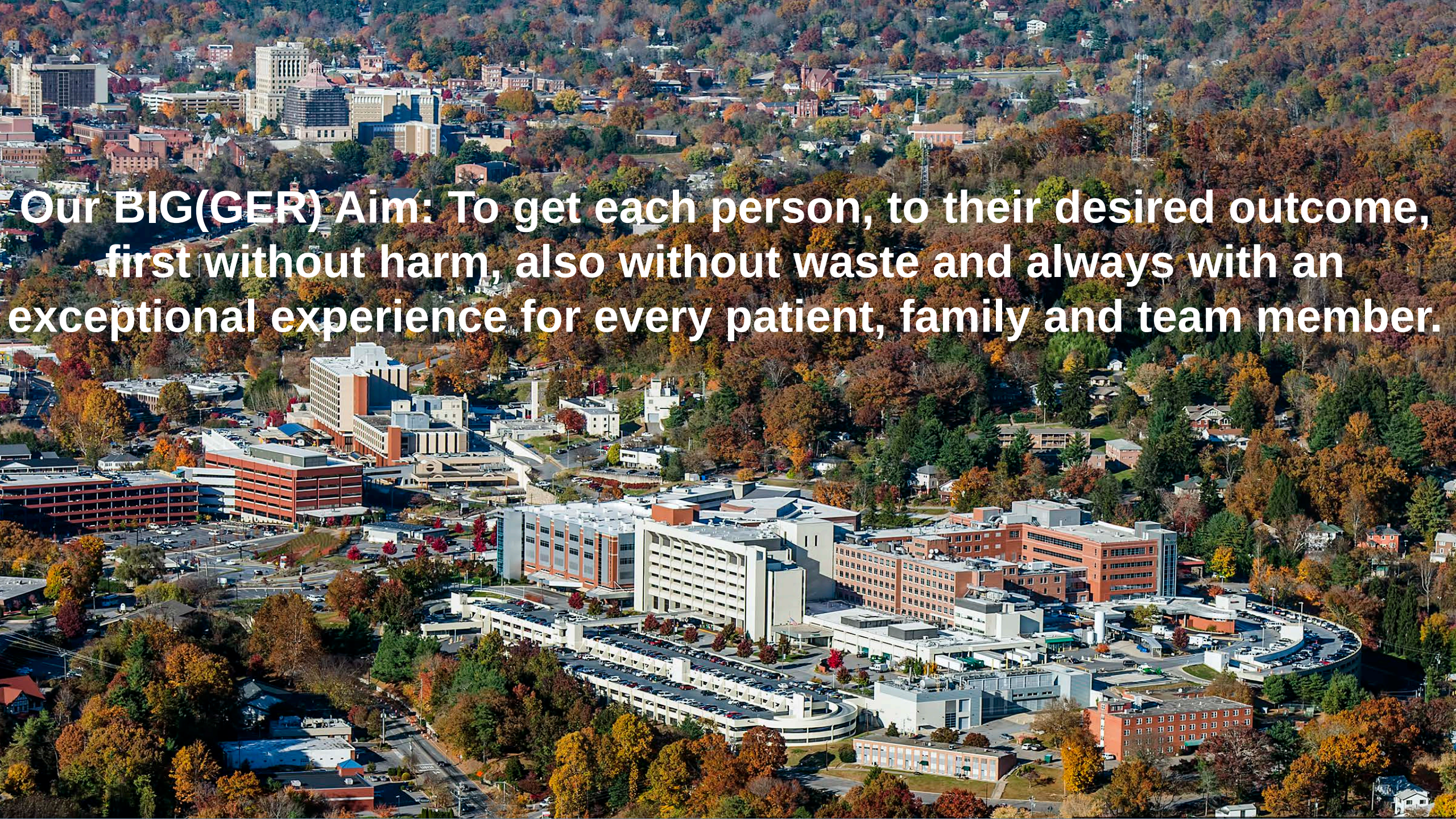
Mission Health's Journey to Accountable Care

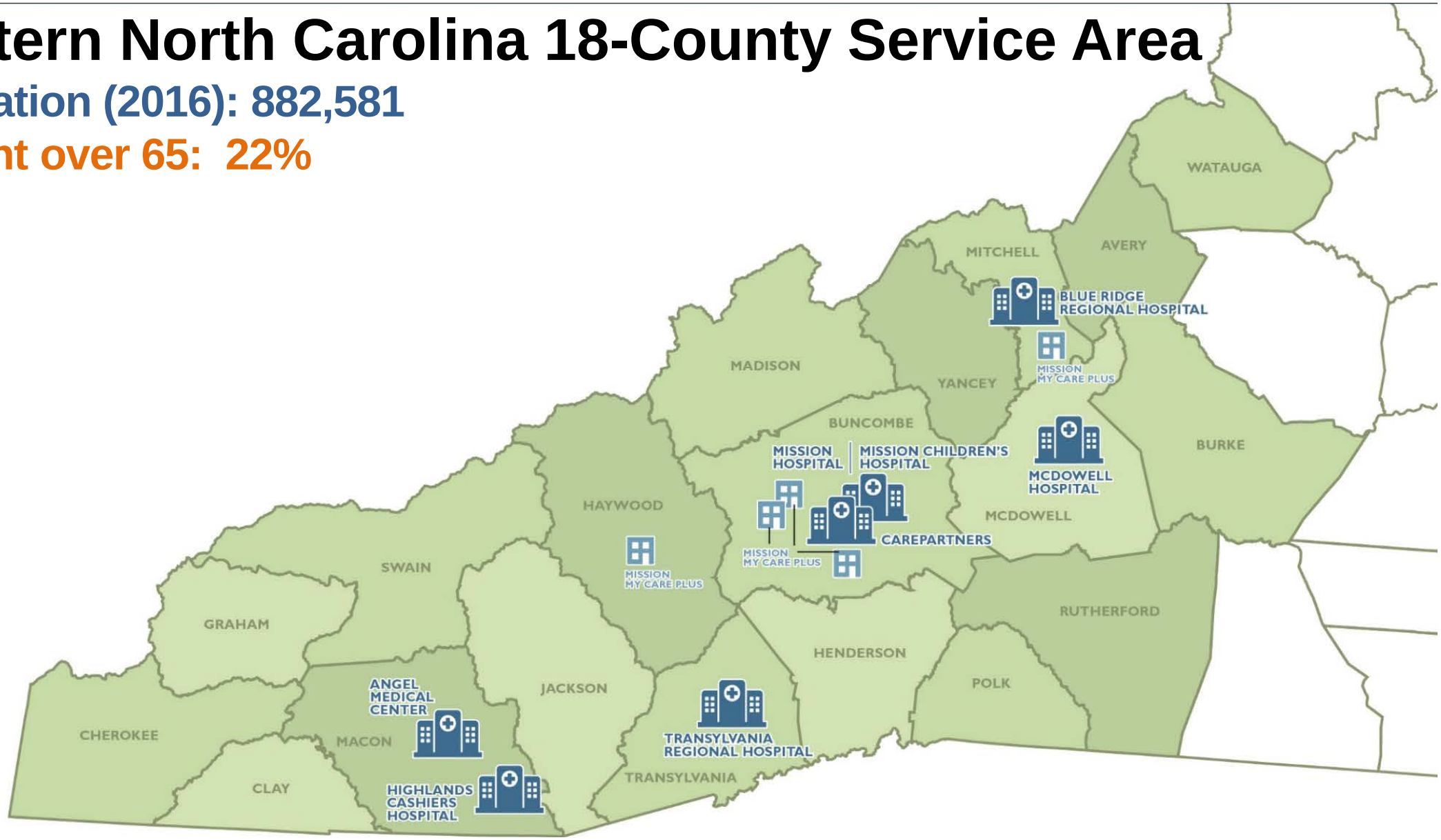
Ronald A. Paulus, MD
President and CEO
September 25, 2017


Our BIG(GER) Aim: To get each person, to their desired outcome, first without harm, also without waste and always with an exceptional experience for every patient, family and team member.

Western North Carolina 18-County Service Area

Population (2016): 882,581

Percent over 65: 22%



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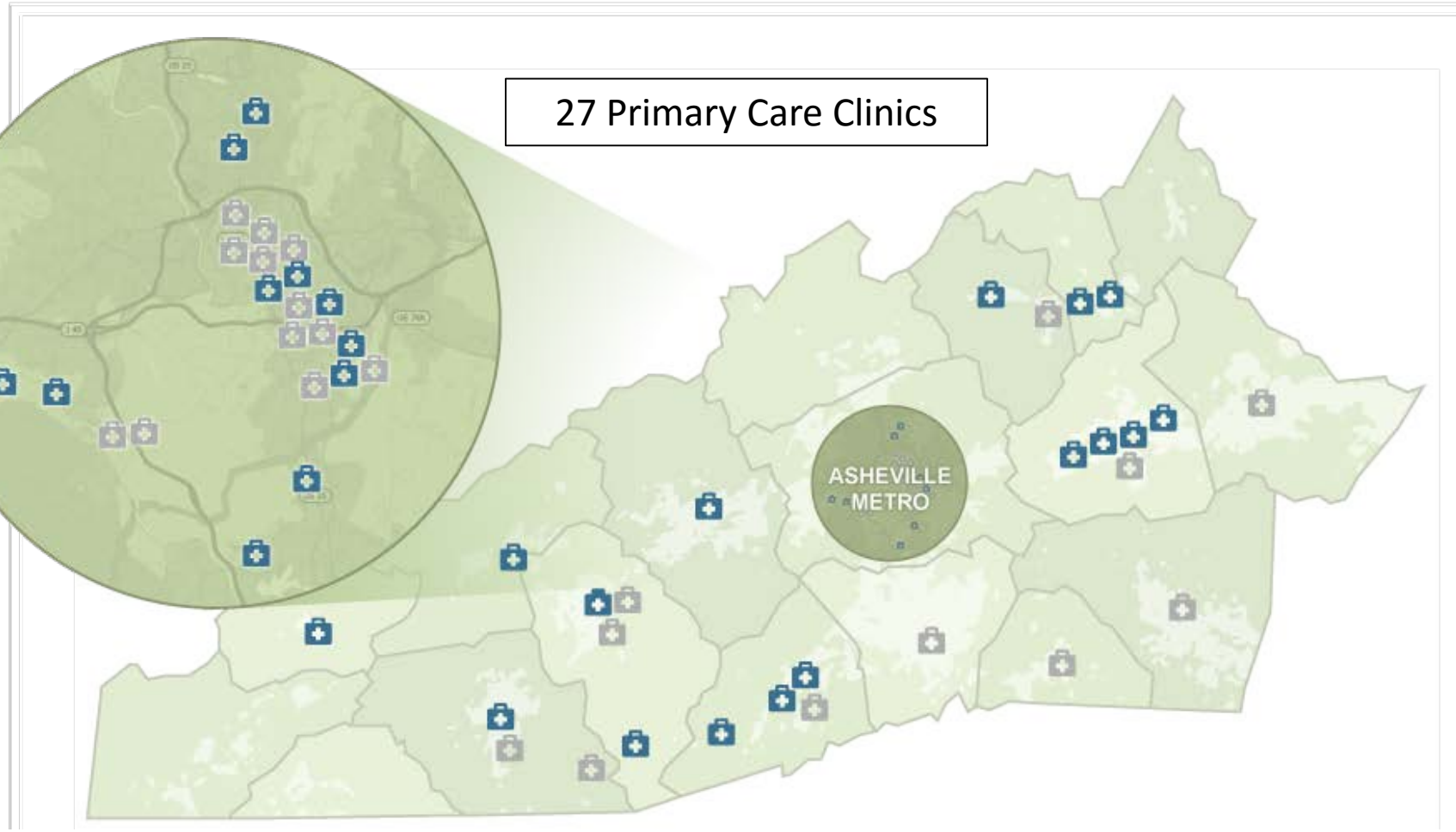
Primary Care Sites



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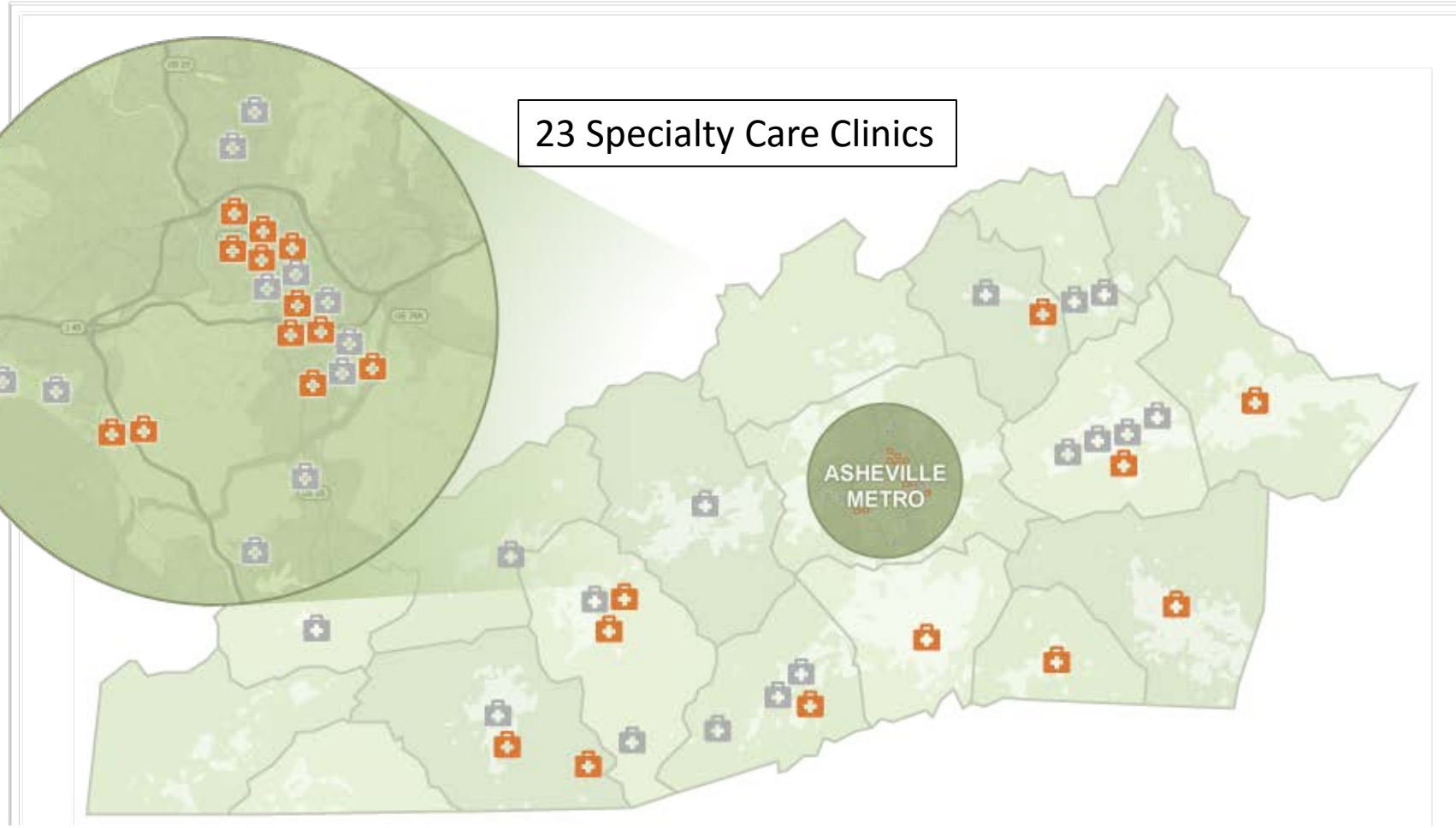
Specialty Sites



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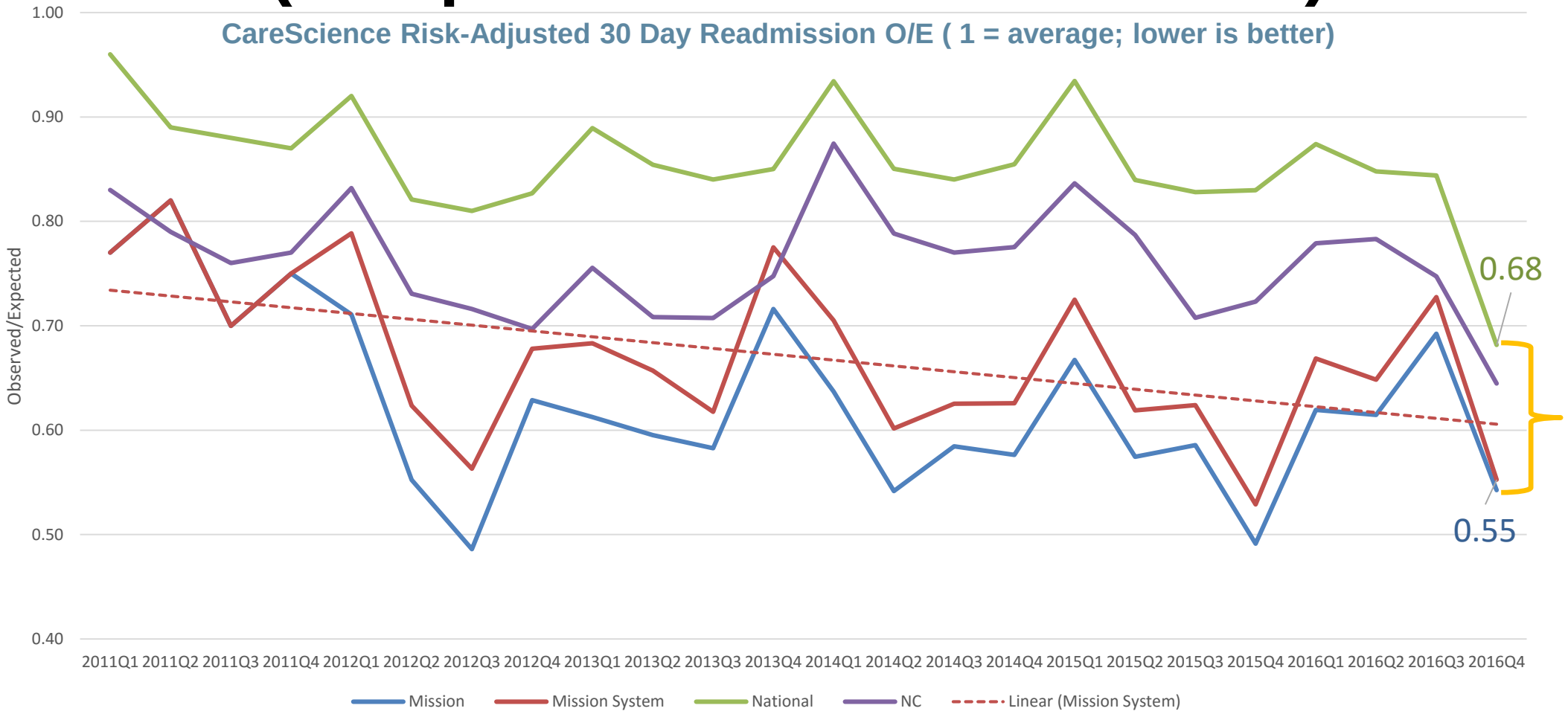
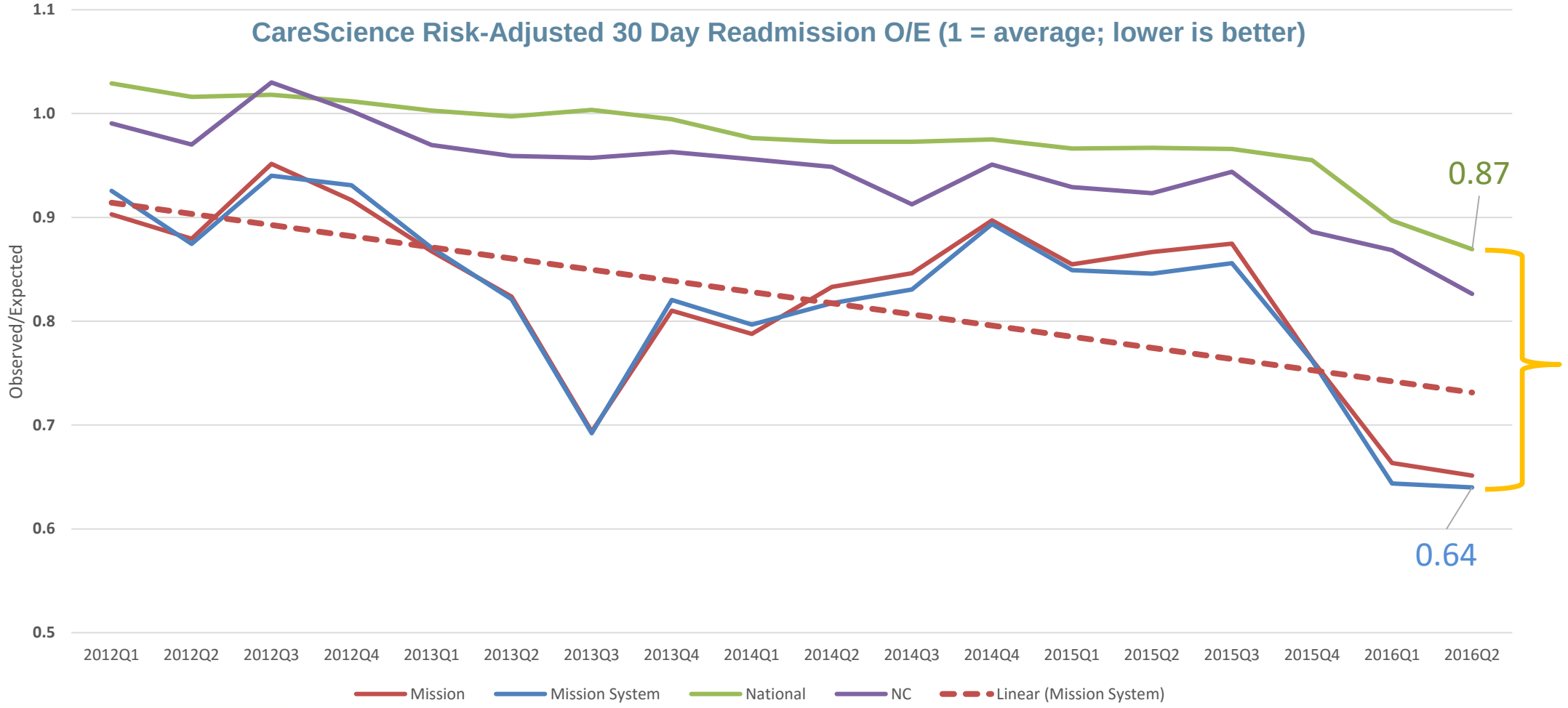
Mission Health Risk-adjusted Mortality (compared to State and Nation)



Mission Health Risk-adjusted Readmissions (compared to State and Nation)



MISSION HEALTH

KEY STRATEGIES

BECOME A TRULY GREAT PLACE TO WORK AND PRACTICE

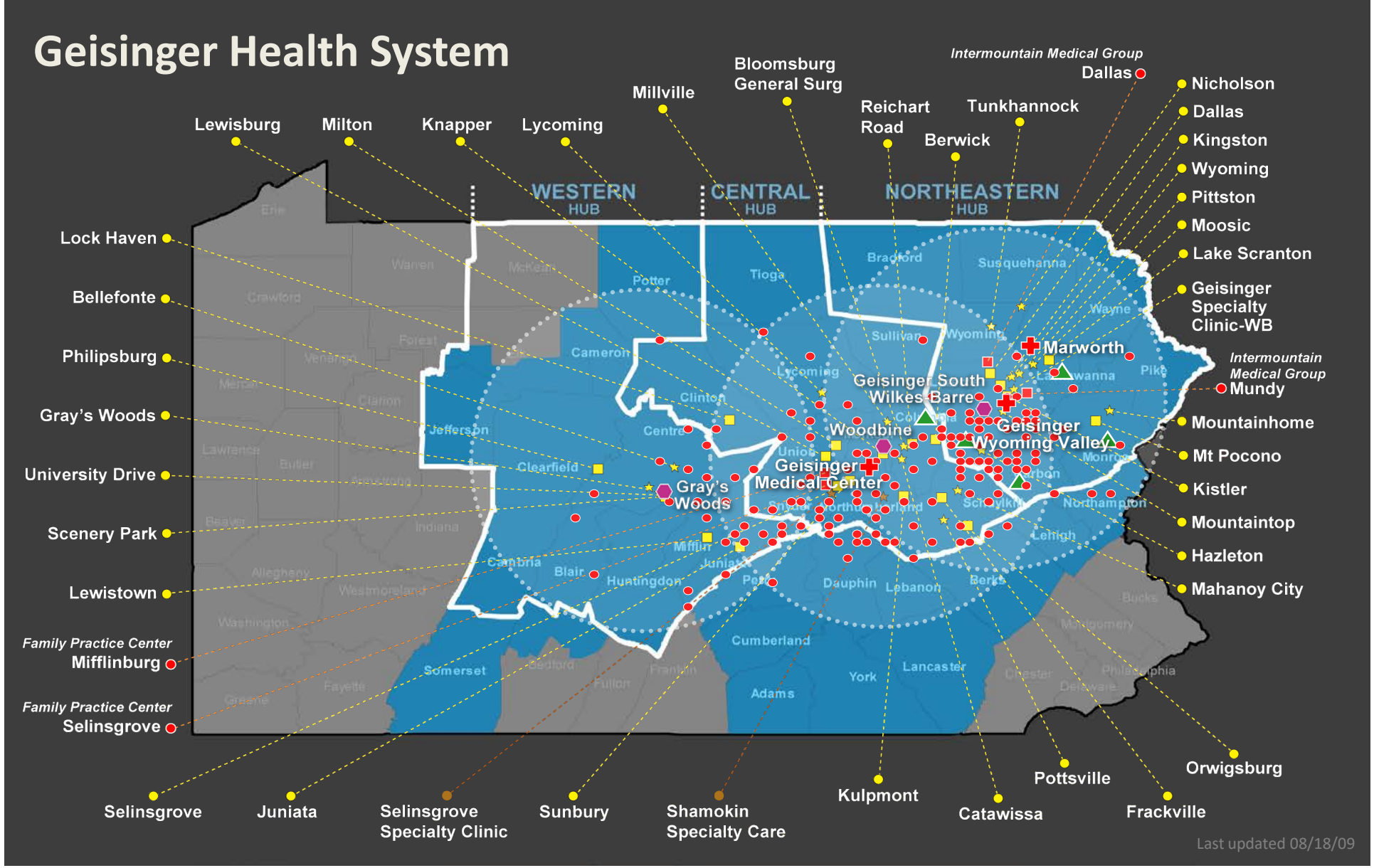
PROVIDE THE SAFEST, HIGHEST-QUALITY CARE IN THE NATION WHEN, WHERE AND HOW DESIRED BY CONSUMERS

ACHIEVE LONG-TERM FINANCIAL STABILITY

ACHIEVE TARGETED GROWTH

EFFECTIVELY GROW, AND MANAGE, OUR AT-RISK POPULATION

Geisinger Health System



- Geisinger ProvenHealth Navigator Sites
- Contracted ProvenHealth Navigator Sites
- Geisinger Medical Groups
- Geisinger Specialty Clinics
- Geisinger Inpatient Facilities
- Ambulatory Care Facility
- Geisinger Health System Hub and Spoke Market Area
- Geisinger Health Plan Service Area
- Careworks Convenient Healthcare
- Non-Geisinger Physicians With EHR

Value and the Medical Home: Effects of Transformed Primary Care

Richard J. Gilfillan, MD; Janet Tomcavage, RN, MSN; Meredith B. Rosenthal, PhD; Duane E. Davis, MD; Jove Graham, PhD; Jason A. Roy, PhD; Steven B. Pierdon, MD; Frederick J. Bloom Jr, MD, MMM; Thomas R. Graf, MD; Roy Goldman, PhD, FSA; Karena M. Weikel, BA; Bruce H. Hamory, MD; Ronald A. Paulus, MD, MBA; and Glenn D. Steele Jr, MD, PhD

Both policy makers and private payers in the United States have begun to recognize that improving care coordination across the fragmented healthcare delivery system is essential to improve the quality and affordability of care. Related efforts include recent Medicare demonstrations examining the impact of external disease management programs and payment reforms that reward integrated care organizations.[1,2] An alternative approach—the patient-centered medical home—involves enhanced primary care practices as the locus of integration and coordination of care. A version of the medical home model was originally described by the American Academy of Pediatrics

Background: The primary care medical home has been promoted to integrate and improve patient care while reducing healthcare spending, but with little formal study of the model or evidence of its efficacy. ProvenHealth Navigator (PHN), an intensive multidimensional medical home model that addresses care delivery and financing, was introduced into 11 different primary care practices. The goals were to improve the quality, efficiency, and patient experience of care.

O *(Am J Manag Care. 2010;16(8):607-614)* lical home model to improve the efficiency of care for Medicare beneficiaries.

By Glenn D. Steele, Jean A. Haynes, Duane E. Davis, Janet Tomcavage, Walter F. Stewart, Tom R. Graf, Ronald A. Paulus, Karena Weikel, and Janet Shikles

DOI: 10.1377/hlthaff.2010.0840
HEALTH AFFAIRS 29,
NO. 11 (2010): 2047–2053

ANALYSIS & COMMENTARY

How Geisinger's Advanced Medical Home Model Argues The Case For Rapid-Cycle Innovation

ABSTRACT The Patient Protection and Affordable Care Act of 2010 provides for a number of major payment and delivery system initiatives. These potential changes need to be tested, scaled, and adapted with an urgency not evident in previous demonstration projects of the Centers for Medicare and Medicaid Services. We discuss lessons learned from our iterative tests of care reengineering at Geisinger—specifically, through our advanced medical home model, ProvenHealth Navigator℠, and the way we continuously modified the model to improve quality and value. We hypothesize that the most important ingredient in our model has been the embedding of nurse case managers into our community practices and the real-time feedback of data on the use of health services by the most complex patients.

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Duane E. Davis is vice president and chief medical officer of Geisinger Health Plan.

Janet Tomcavage is vice president of health services for Geisinger Health Plan.

PRESS ENTERPRISE

SERVING DANVILLE, BLOOMSBURG, BERWICK, ELYSBURG, MAINVILLE, BEACH HAVEN

MONDAY, JULY 6, 2009 75¢

Central teachers gain $7G average

Super: Health-care savings balance raises in contract

By GARY PANG
Press Enterprise Writer

SOUTH CENTRE TWP. — Central Columbia teachers will see their average salary of $53,417 jump up by $7,000 under a new three-year contract, newspaper calculations show.

School directors recently gave 4.54 percent raises to their teachers, the largest in the area for the coming year.

But Superintendent Harry Mathias said the district can afford the pay increases because the teachers agreed to changes that will slash health insurance costs.

Teachers also agreed to pay more toward their health insurance.

The changes will let Central keep the lowest insurance costs among area school districts, he said.

The new contract costs $8.3 million in the coming year, Mathias estimated. However, retirements would reduce expenses, he added.

Higher starting salary

Pay raises were set at 4.54 percent for the coming year; 3.62 percent in the contract's second year, 2010-11, and 4.36 percent in 2011-12.

These raises would push the average teacher salary up to $55,842 in the coming year, $57,864 in the second year and $60,387 in the third year, calculations show.

Central also raised the starting salary for teachers. The $33,638 figure would jump up in three years by $4,774, calculations show.

The starting salary will be $35,656 in the coming year, $37,054 in the second year and $38,412 in the final year, Mathias said.

But the contract isn't just about pay raises, he said.

New insurance

Back in April, Central was predicting a big rise in insurance premiums. To lower costs, the district switched from Capital Blue Cross to Geisinger Health Plan for all employees.

The switch will reduce costs by $130,000 to $140,000, Mathias estimated.

The union accepted the change as part of the new contract, Mathias said.

While other school districts are facing 7 to 8 percent increases in insurance costs, Central is dealing with just a 2.5 percent increase, the superintendent said.

Central's average health insurance cost is $8,400 per teacher, Mathias estimated. He said other school districts are paying thousands of dollars more.

That's because many school districts get health insurance through the Northeast Pennsylvania School Health Trust, he said. Central, however, finds insurance and bargains on its own. That reduces district costs by $500,000.

Teachers' concession

Teachers made another concession that might save Central an additional $20,000, Mathias said.

Before, teachers could choose between an ordinary plan and a more expensive one. If they chose the pricier plan, they paid more money toward the upgrade, but the district picked up some of the additional cost.

Now if they choose a pricier insurance plan, they'll swallow all the extra expenses.

The pricier plan costs $250 more for single employees and $650 more for employees with families.

What they'll pay

Teachers had been paying 10 percent of their insurance premiums. That will increase to 11 percent in the first year of the new contract, then 12 percent the second year and 13 percent the third year.

Mathias gave examples of what they might pay in the coming year. These figures do not include the "buy-up" option.

- The premium for a single employee is $4,500, with the employee paying $500.
- The premium for a family plan is $10,500, so the employee pays $1,150.

The rate is different for non-teacher employees, Mathias noted. Support staff members pay 5 percent of their premiums, while administrators pay 6 percent of their premiums, plus .6 percent of their salaries.

Expense breakdown

The contract's cost of $8.3 million for the coming year includes insurance expenses: $1 million for teachers and $800,000 to $900,000 for everyone else, Mathias estimated.

In 2008-09, Central paid about $7.17 million in teacher salaries and $1 million in benefits, Mathias said.

Despite the recent raises, the Central board is not increasing taxes in the coming year under its recently passed budget.

Primary Care Council – December 2011

Thanks for your nice note and the invitation to become a member of the Primary Care Advisory Group. I would be glad to participate in that group based on your assurance that we will have a seat at the adult table, and not be an ancillary group, there for show.

Primary Care Summit – November 2012

PLEASE JOIN US FOR THE INAUGURAL
WESTERN NORTH CAROLINA

PRIMARY CARE
SUMMIT

DR. PAULUS INTRODUCES
THE FIRST ANNUAL
WESTERN NORTH CAROLINA
PRIMARY CARE SUMMIT

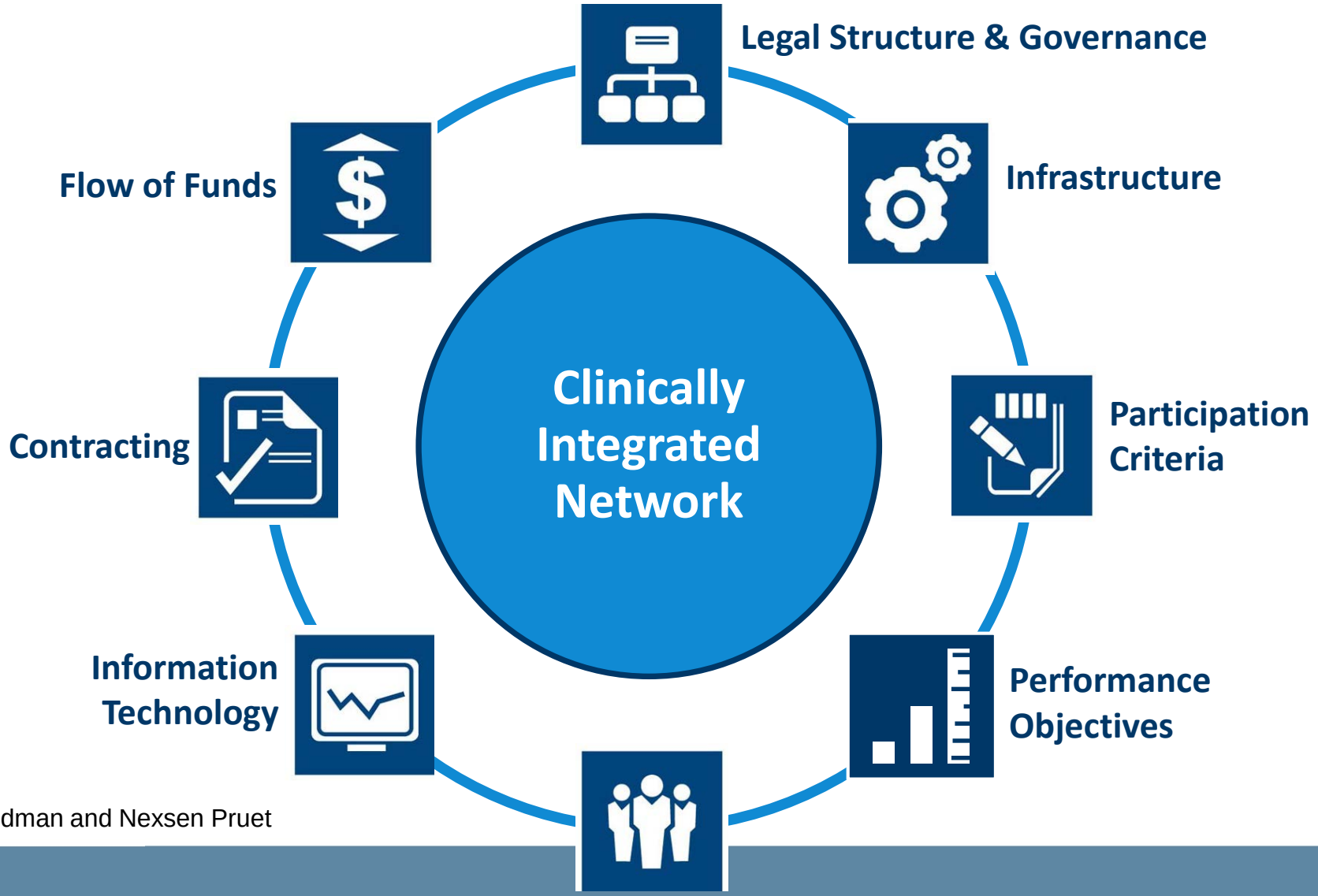
- > 100 attendees
- High satisfaction

Primary Care Service Line November 2013

Medical Administrative Committee
November 15, 2013
Page 2

Old Business		
William Hathaway, MD	Dr. Hathaway provided follow up to the discussion held at the last meeting of the committee regarding Service line organizational structure. A motion was made, seconded and passed by voting members to approve the formation of a Primary Care Service Line.	

Clinically Integrated Network: Key Components



Source: Dixon Hughes Goodman and Nexsen Pruet

MISSION HEALTH

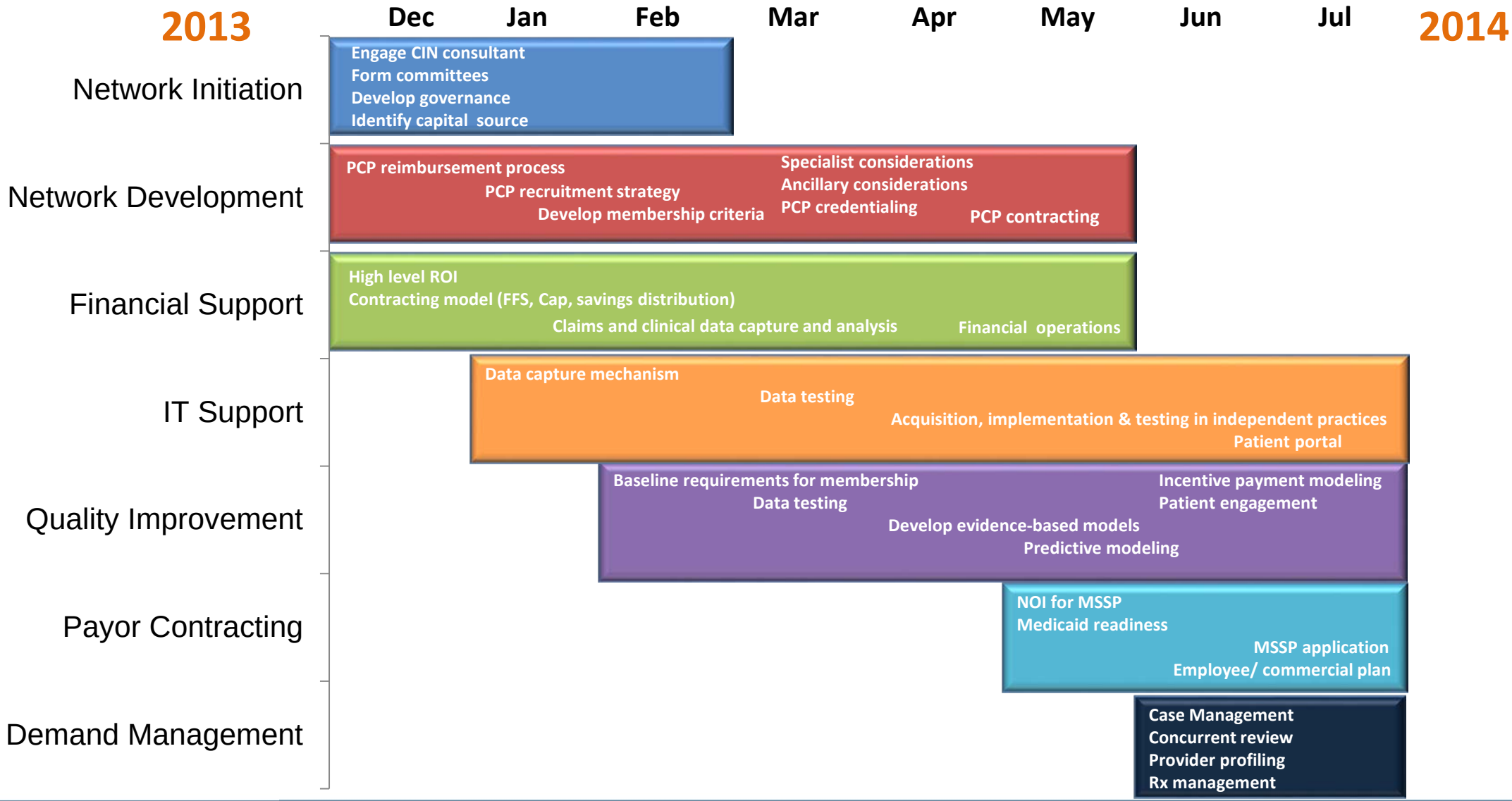
SWOT Summary
(Mission Health/Physician Community)

- **Strengths**
  - Strong position of high quality
  - Relatively low cost producer of care across a very broad spectrum of services
  - Excellent physician community committed to excellence
- **Weaknesses**
  - Payer mix
  - Somewhat late start on population health
  - “Hero culture” vs. systematic management
  - Some “mistrust” between health system and physicians

SWOT Summary
(Mission Health/Physician Community)

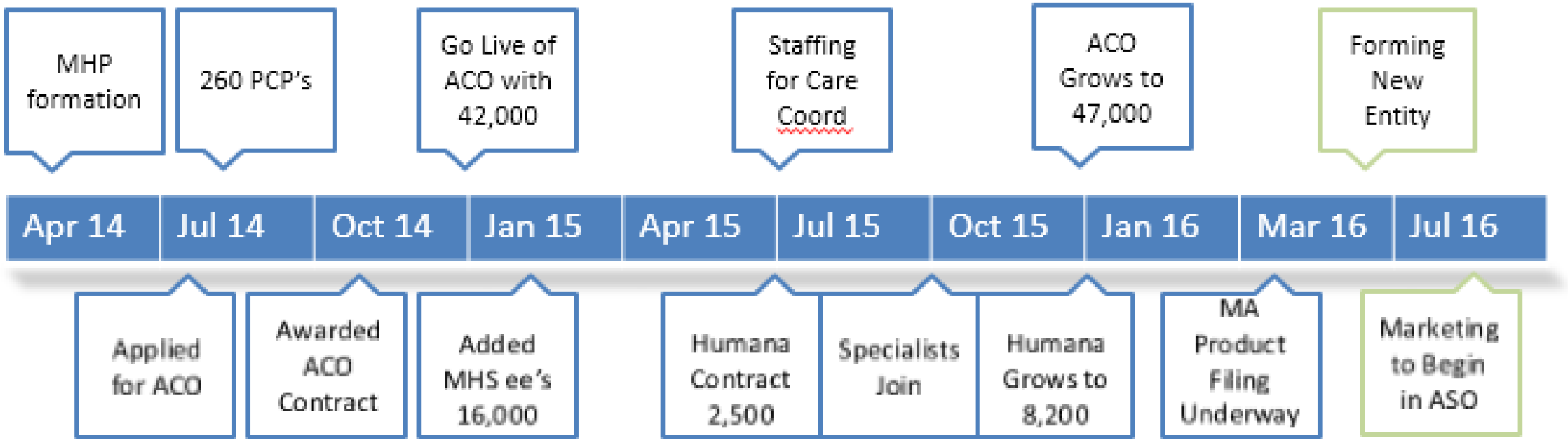
- **Opportunities**
  - Improve fee-for-service performance via care model redesign
  - Create Population Health model to secure future and benefit community
- **Threats**
  - Declining reimbursement
  - “Hospital” vs. “Physician” vs. **COMMUNITY** optimization
  - Major shift in competitive landscape
  - Someone else seizing the “Population Health Dividend”

Network Development Timeline



Mission Health

Phase I Milestones



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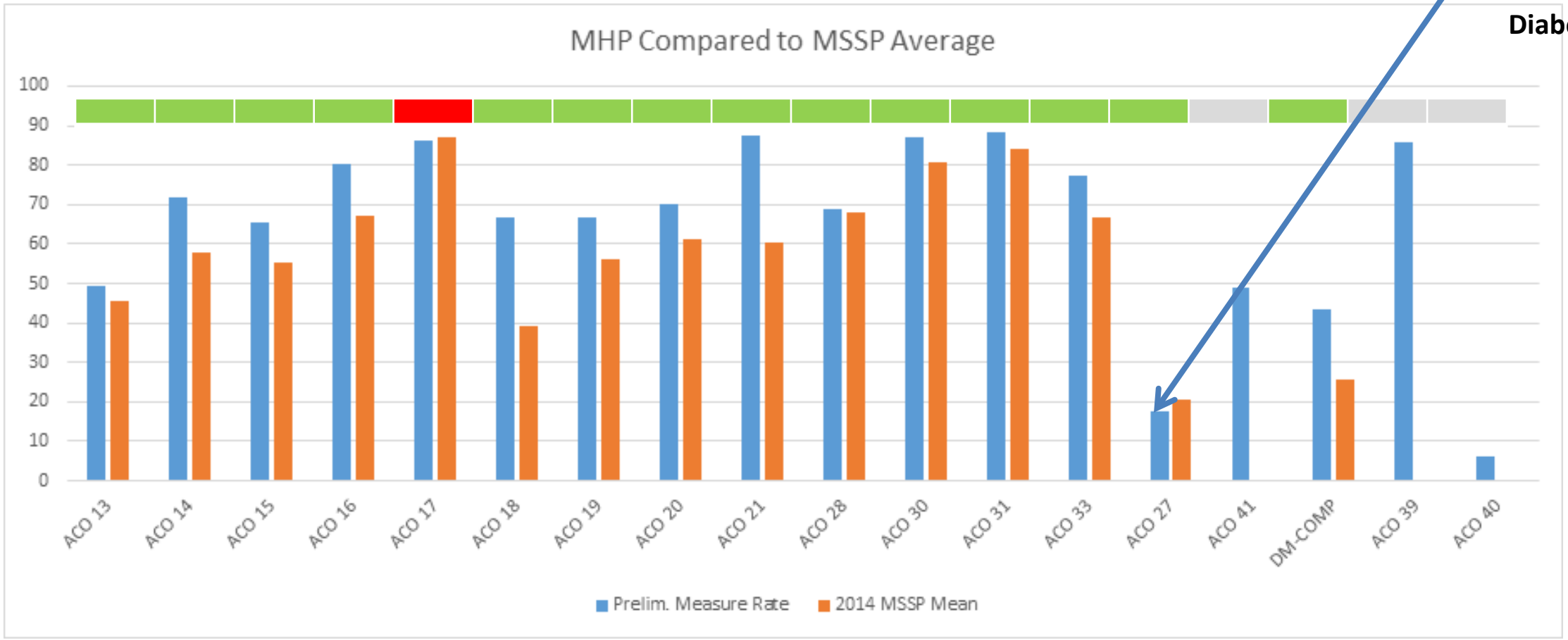
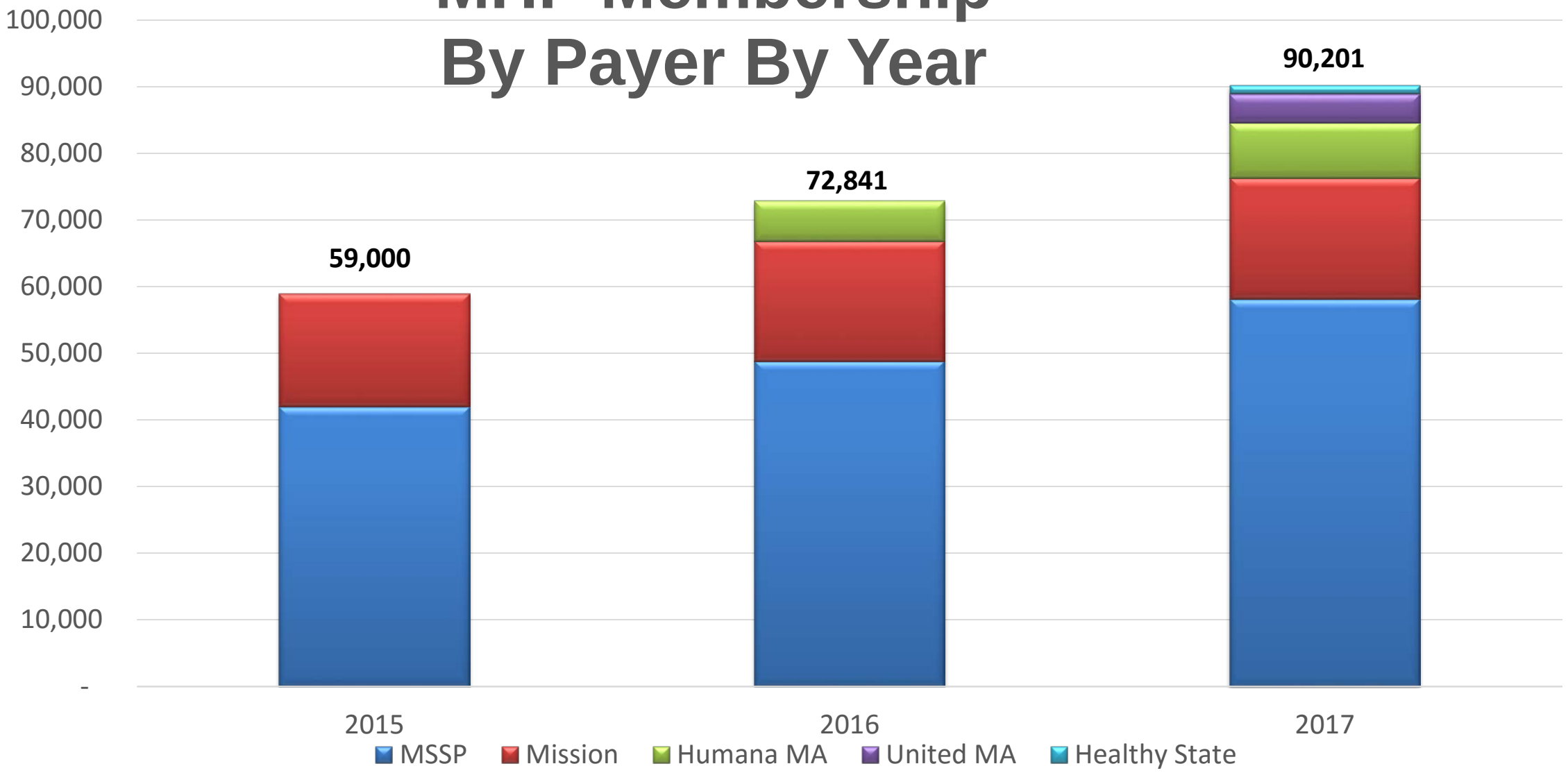
Year 1 MSSP Quality Performance



Only measure where lower is better – Poorly Controlled Diabetics

MHP Membership By Payer By Year



One of the Lowest Total Spends Nationally

Asheville, N.C.

33rd lowest-spending for Medicare out of 306 places

← Lower-spending places Higher-spending →

Asheville, N.C.

32nd lowest-spending for private insurance

← Lower-spending places Higher-spending →

MSSP: Very Low Spending Benchmark…

- Of 362 ACOs (2015), only 27 (7.5%) had lower targets than MHP; 334 were higher (or 92%)
  - Benchmark spend/beneficiary: $22,777 (max) $10,400 (min)
  - **MHP Benchmark spend/beneficiary: $8,047**
  - Difference: $14,730/$2,353
- In 2015 ACOs that achieved shared savings had an average benchmark of $11,393; those that didn't had an average benchmark of $9,986.

Results

- Managed Mission Health's self-insured medical trend:
- +2.6% vs. +6.5% national trend (3.9% trend shift)
- Mission Health Partners:
  - Reduced Readmissions 6.2%
  - Decreased ED Utilization 5.8%/1,000/year among Medicare beneficiaries