Redesigning Care Delivery for Success in Value-Based Payments: Steps from A to Z

National Value-Based Payment and Pay for Performance Summit

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GE Healthcare Partners

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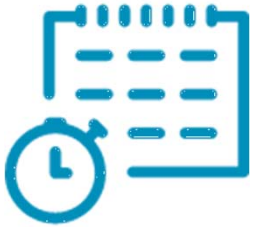
What You Can Expect From Today's Session

- Roles of coordinated care and primary care in today's healthcare environment.
- Preparing organizations for risk arrangements and key tenets of care model redesign.
- Role of leadership and cultural change within clinical transformation.
- What others have learned in their journey within population health management ("PHM") – The Jefferson New Jersey experience.
- Brainstorm and develop strategy and tactics to meet several healthcare challenges faced by a specific organization.
- Take-away tools, approaches, and strategies to succeed within PHM.
- An interactive session – sharing questions, answers, and observations.

What's on the Agenda



Topic	Timeline
Roles of Coordinated Care and Primary Care in Today's Healthcare Environment	1:00 p.m. to 1:30 p.m.
Care Model Execution and Clinical Transformation	1:30 p.m. to 1:50 p.m.
Case Study: Jefferson New Jersey	1:50 p.m. to 2:20 p.m.
Break	2:20 p.m. to 2:35 p.m.
Group Exercise: Strategy and Tactics to Meet Healthcare Challenges Faced by Jefferson New Jersey Several Years Ago	2:35 p.m. to 3:20 p.m.
Groups Report-out	3:20 p.m. to 4:00 p.m.
Break	4:00 p.m. to 4:15 p.m.
Jefferson New Jersey: The Real Story	4:15 p.m. to 4:50 p.m.
Wrap Up and What We Have Learned	4:50 p.m. to 5:00 p.m.

Section 1
Role of Coordinated Care in Primary Care and Today's Healthcare Environment

In healthcare, the past is not a prologue for the future.

"Change is the law of life. And those who look only to the past or present are certain to miss the future."
- John F. Kennedy


Consumerism
Telehealth
Diagnostics
Smart Devices
Clinical Innovation
Predictive Analytics
6 Disruptive Forces That Are
Reshaping
Healthcare

Disruptors.....

Form independent healthcare company for their employees in the United States.

Amazon, Berkshire Hathaway and JPMorgan Team Up to Try to Disrupt Health Care

By NICK WINGFIELD, KATIE THOMAS and REED ABELSON JAN. 30, 2018

Source: https://www.nytimes.com/2018/01/30/technology/amazon-berkshire-hathaway-jpmorgan-health-care.html

Other Industries Impact Patient Expectations

Consumer Trust

Percentage of consumers who would trust this kind of entity to manage their health:

40%	Walmart, Target, and other large retailers
39%	Healthcare provider
33%	Amazon, Google, and other digitally-enabled companies
37%	Insurance company

Source: www.hhmag.com, February 2015, The Birth of the Healthcare Consumer Survey, 2014

Burning Platform for Change

Accelerating costs and financial burden to individuals, companies, states, and federal government

Changing nature of competition; new entrants; changing scale

Clinical advances; innovations in science and technology

Societal behaviors, changes in expectation; demographics

Internet; data transparency; the democratization of health information

Dissatisfaction with “the healthcare system”: Uneven access/high rates of uninsured; sub-optimal quality, patient experience; significant variability in use rates and outcomes

Changing use rates; locations of care; structural changes to healthcare field

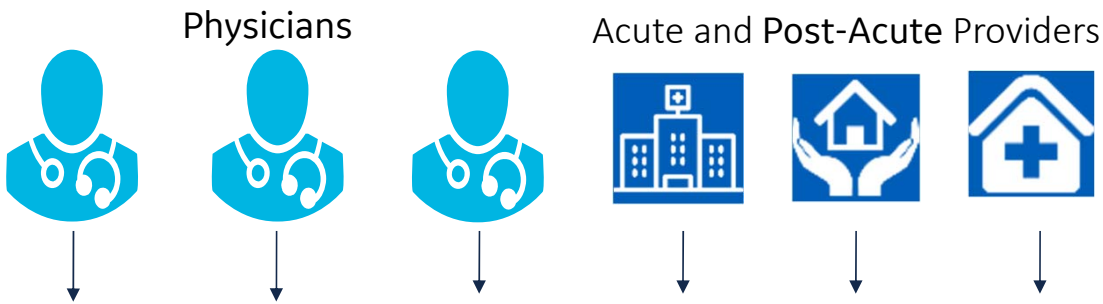
Indictments of healthcare quality, access, and cost

Politics

New Value-Based Contracts Require Clinical Input and Alignment

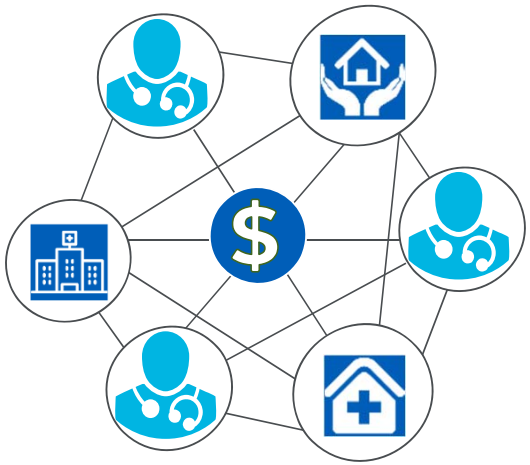
Effective compensation under value-based reimbursement requires a shift from individual performance to group and individual performance.

Fee-for-Service ("FFS")



Focus on individual productivity and incentives

Fee-for-Value



Requires alignment with group and system strategic goals (access, clinical quality, cost, utilization, patient engagement)

46% of physicians report signs of burnout > matched controls in other professions

Shanafelt TD, Boone S, Tan L, et al. Burnout and Satisfaction with Work-Life Balance Among U.S. Physicians Relative to the General U.S. Population. Arch Intern Med 2012;172:1377-85.

Stressed, burned out or dissatisfied physicians report a greater likelihood of making errors and more frequent instances of suboptimal patient care.

Williams ES, Manwell LB, Konrad TR, Linzer M. The Relationship of Organizational Culture, Stress, Satisfaction and Burnout with Physician Reported Error and Sub Optimal Patient Care: Results from the MEMO Study. Health Care Management Review 2007; 32 (3): 203-212

"I think the most important struggle clinicians have at the end of the day is with themselves when they feel ineffective providing appropriate care to their patients. One of my colleagues left medical practice… the final straw was when her patient had a heart attack while waiting to get in to see a cardiologist despite all she could do to try to arrange for the visit."

Source: UCSF Health Physician, Provider Experience Focus Group, 2014

Opportunity to Embrace Change

Become the Practice of the Future

Competition Proliferates

Source: TripleTree June 2015

Traditional Office Access

Patients expect and demand
immediate access to care

They will go wherever they can get it

We can improve traditional access with
more hours, efficiency, or both

Advanced Access

Gives patients the ability to schedule appointments when they want to be seen, regardless of their need

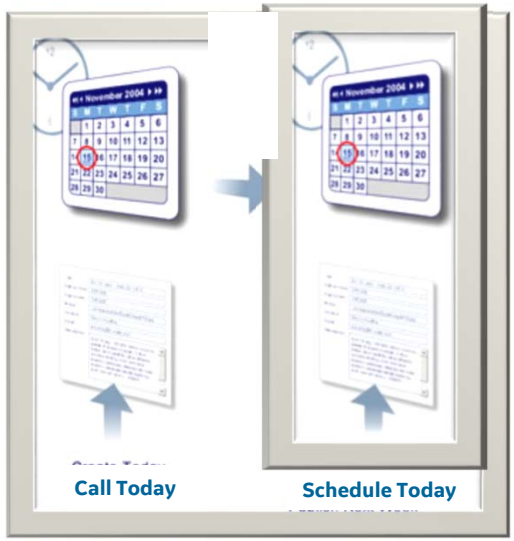
Measures and matches supply (capacity) with demand

Simplifies appointment types

“Do today’s work today”

Actively shapes demand

Increases capacity using existing resources



Practice Efficiency

Increased efficiency contributes to:

Lower costs

More capacity

Higher patient satisfaction

Greater patient access to care

Improves the quality of care

Higher physician and staff satisfaction

Telemedicine and Vitals Scanning

- Physician visits
- Home monitoring
- Smart phone apps
- Fit-Bit type devices
- Interface with electronic medical records

Team-based Care

Everyone to top of license

Physician as “quarterback”

Care Management

Focus resources on high-risk and rising-risk patients

Tailor resources to needs

Transportation assistance does not require a clinician

Promote a one-on-one care manager relationship

Share information across settings (hospital-skilled nursing facility [“SNF”]-home)

Transition protocols

Partnerships

- We often forget community resources
- Health happens where people live
- Many organizations promote health
- Create formal and informal partnerships
- Refer and connect

Church

School

Agency

Club

Patient Engagement and Activation

- In-office education
- Educational links
- Written materials
- Portals
- Care management
- Hospitality
- Medication reduction
- Group visits
- Self-monitoring tools
- Charging patients with responsibility to manage their condition

Physician Engagement

- Administrator - physician dyad structure
- Physician led governance
- Protected non-clinical time
- Focus on physician satisfaction to reduce burnout
- Physician leadership development

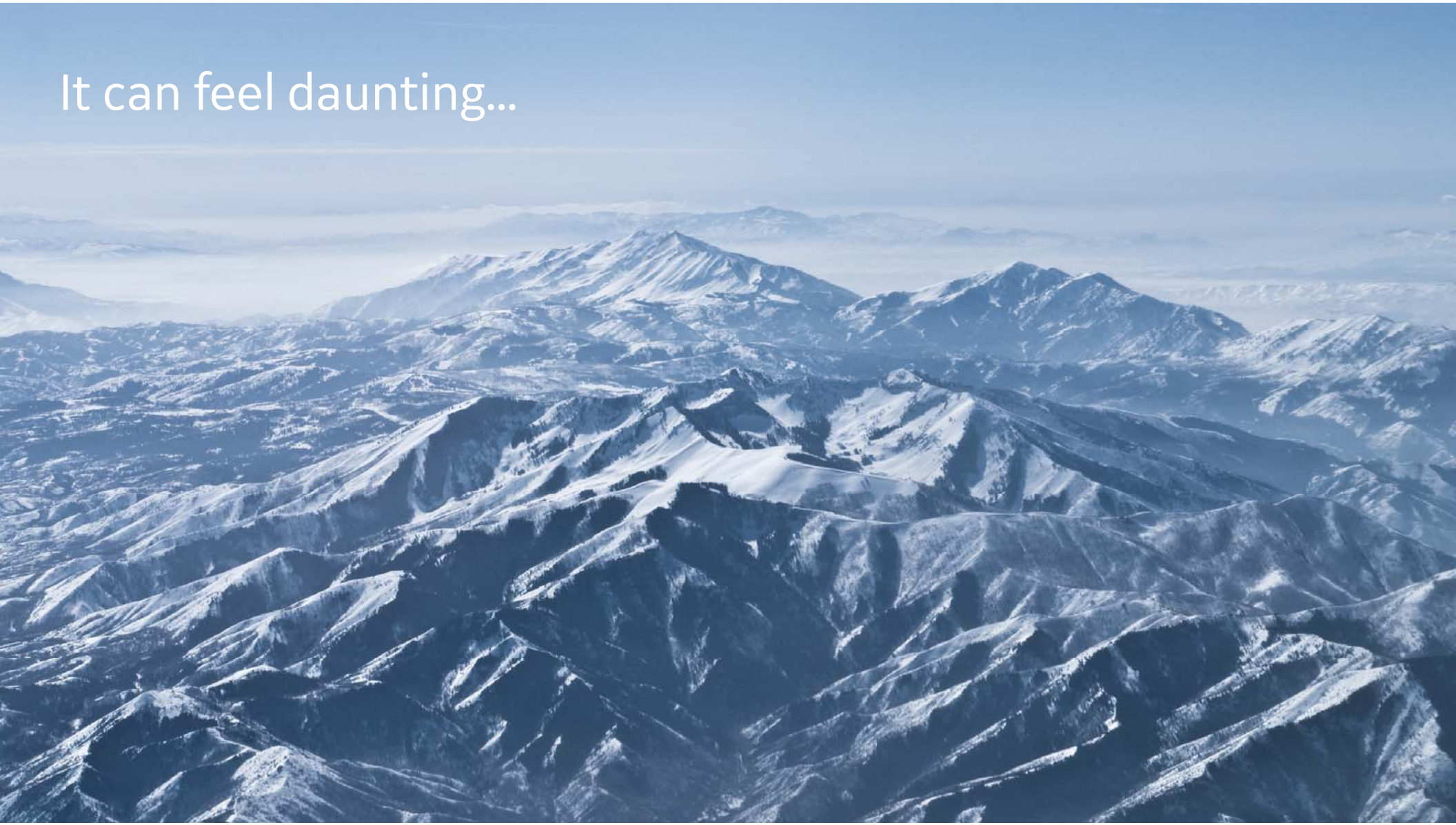
Compensation Trends

- Increasing need to be at or above market
- Quality and efficiency measures are becoming increasingly important; deemphasis on work relative value units ("wRVUs") and productive
- Pay for performance ("P4P") receiving increased attention
- Efficiency (cost of care) critical under a risk model of reimbursement
- Benefits and intangibles becoming more important
- Plans must address part-time physicians
- Plans are being redesigned more often to respond to changing market conditions

Change or Become Obsolete

Section 2
Preparing for Risk

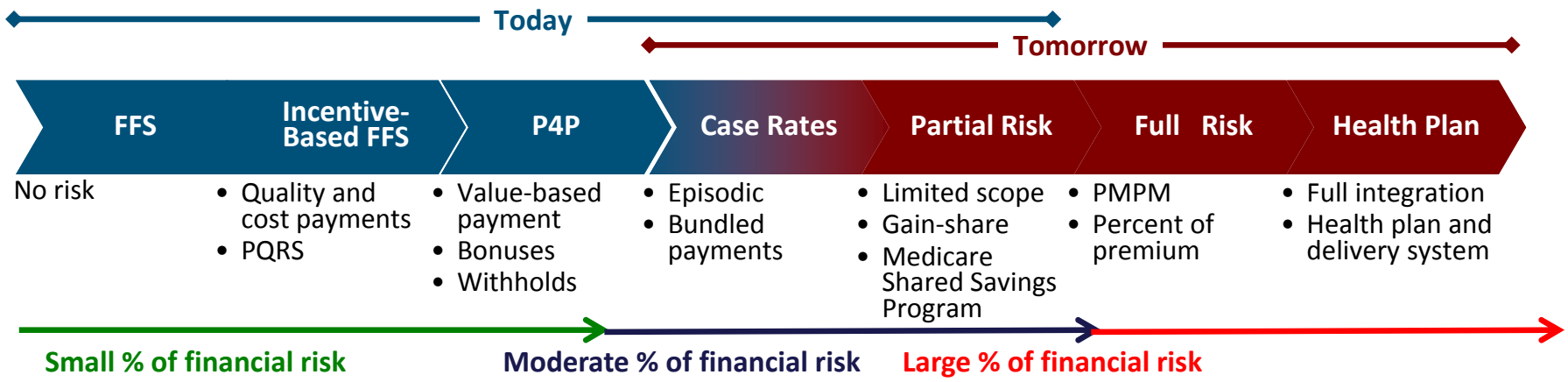
It can feel daunting...



The Journey: FFS Contracts to Value-Based Contracts

"When 30% of your business is in a non-FFS model, your structure starts to change."

Stephen M. Shortell, Ph.D., M.P.H.



Sources: (graphic) UnitedHealthcare: Value-based Contracting and Accountable Care Organizations. www.uhc.com/live/uhc_com/Assets/Documents/ViewpointACO.pdf. (quote) Dr. Shortell, as quoted in Thomas Lee, M.D.: Massachusetts Health Care Reform: An Academic Provider's Perspective. *Health Affairs Blog*, Aug. 13, 2012.

Why Take Risk?

Don’t leave money on the table

Participate in shared savings or share of premium, rather than leaving it with payers

Help with ways to improve patient care

Staff and information technology (“IT”) support for better care coordination and information to keep patients happy and healthier

Give voice to physicians and other clinicians

Models all require physician leadership and leading roles for nurses, pharmacists, and others

Building Blocks: Value-Based Critical Success Factors

Finance and Payer Contracting

Payer strategy and negotiation, risk-based methodologies, physician compensation and incentives, funds flow, and financial performance of organization

Health Information Technology ("HIT") and Data Analytics

Data aggregation and analytics for population health, tools for care plan, risk stratification, and integrated communication (health information exchange ["HIE"])

Leadership and Governance

Selection of physician and administrative leaders, governance design of organization, partnerships, and agreements

Patient Engagement

Monitoring of patient experience, access to care, ongoing performance improvement, patient engagement via portals, apps, and other outreach

Care Model Redesign

Patient-centered medical home ("PCMH"), care management, disease management, Lean/clinical process redesign

Quality and Outcomes

Quality metric selection and performance, cost-of-care analysis, transparency of quality, and financial information

Network and Access

Design and selection of an appropriate provider network, criteria for participation, recruitment and enrollment, gap analysis, and engagement

Transformational Strategy

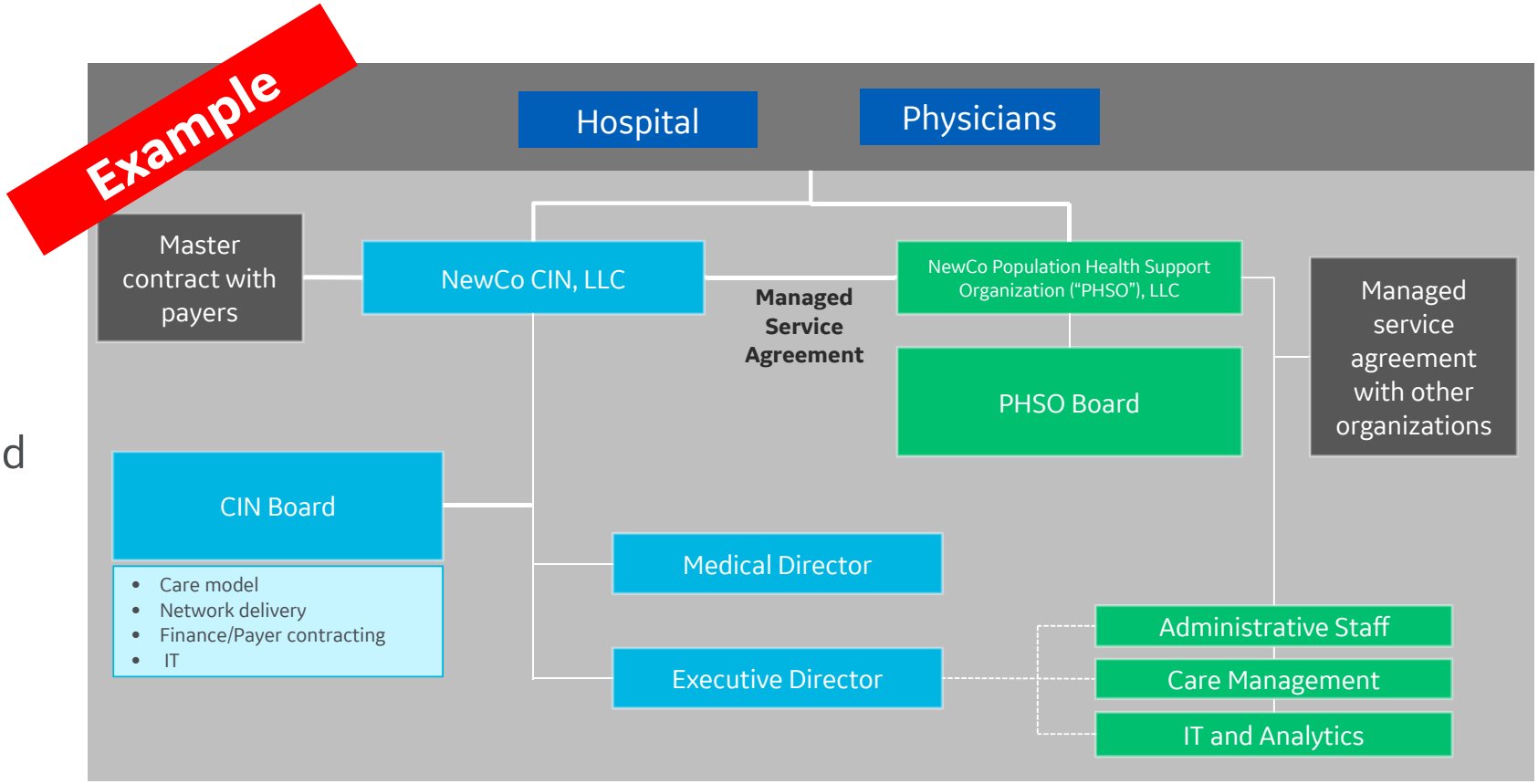
Organization-wide strategy and value proposition, continual transition to value-based system, and drivers of successful transformation

Shifting the Mindset

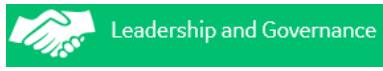
Philosophy/Expectations: Privilege	→	Right
Incentives: Do more	→	Appropriate care
Volume: Admit, readmit	→	Admit less
Patient: Little self responsibility	→	Accountability
Delivery Model: Lots of everything	→	Consolidation, hub and spoke
Patient Care: Face-to-face, physician focused	→	Remote monitoring, allied professionals
Pricing: Foggy, unclear	→	Transparent
Payment: FFS	→	Case rates, shared risk pools, bundled payments
Delivery of Care: Variable	→	Cost-effective care delivery, evidenced-based medicine

Creating the Organizational Structure in a World of Risk

Hospital, employed, and independent providers – creating a structure that promotes engagement and accountability



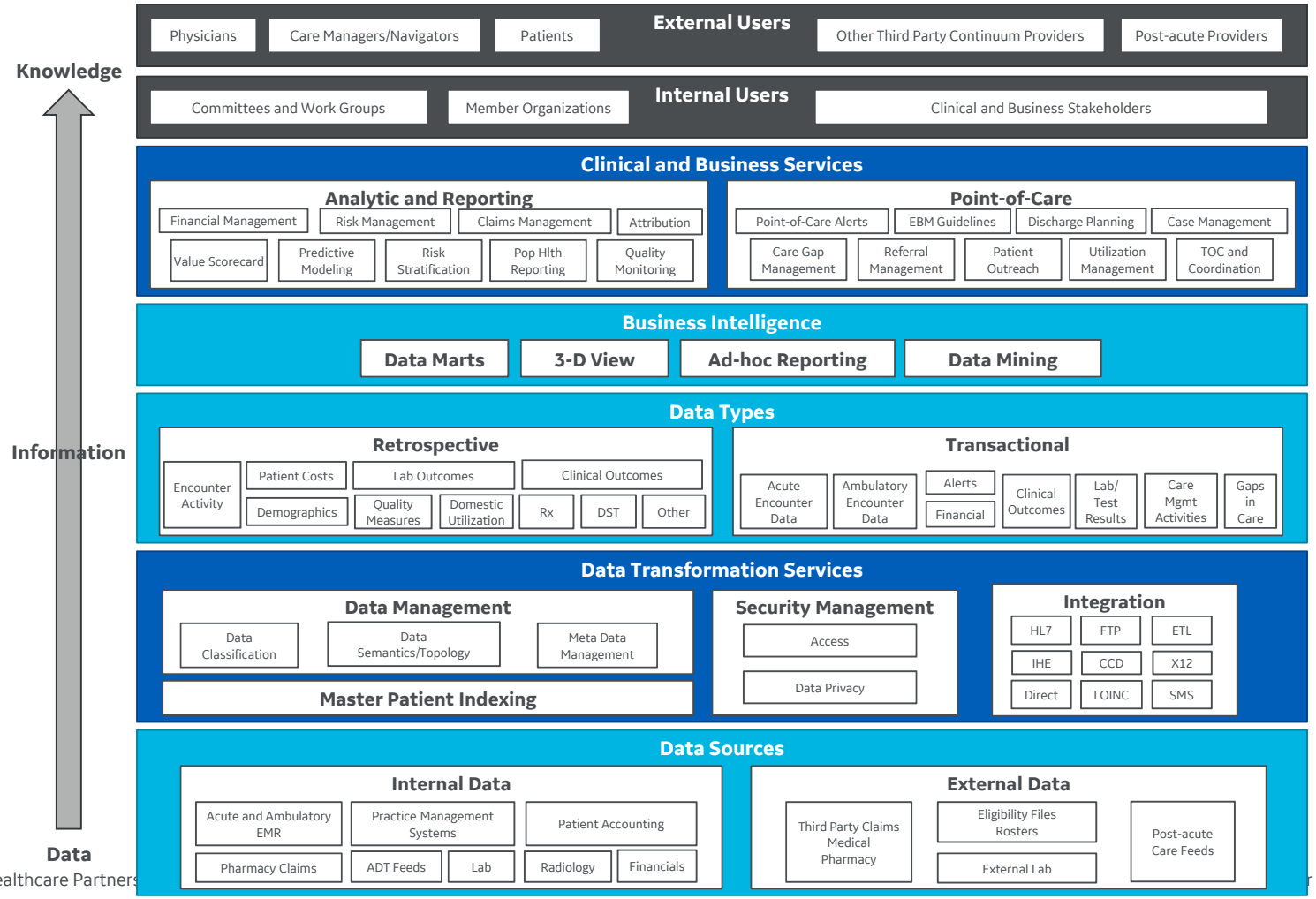
Developing Meaningful Clinician Engagement



Understand physician perspective	Embrace physician-led, governance leadership committees
Acknowledge the past	Reframe the challenge to align physician, hospital, and patient interests
Ensure physicians have some control	Dismantle cultural barriers
Keep physicians informed	Communicate frequently, openly, and clearly
Involve physicians and ask for their guidance and support in some decision-making	Actively listen and create forums for conversation, shared learning, and decision-making
Identify and mentor physician-leaders	Celebrate quality and success
Incentives tied to value-based care	Identify physician champions; enlist and nurture allies
Ensure support staff and streamlined clinical care	Organize for performance and reduce administrative hassles
Give physicians a reason to get and stay engaged	Demonstrate value proposition
Validate data before presenting to physicians…and then validate again…	Optimize technology and manage expectations
Stay ahead of the competition in designing innovative compensation models	Make initiatives easy to try and easy to do
Make care model change a partnership, not a mandate	Emphasize fairness and transparency
Use peer pressure	Position conversation as collaboration and consider the process an interest-based negotiation

Genuinely focus on improving clinical care and ethical centering (instead of just costs)

Making data useful information



Analytics Identifies Where to Begin

Risk Stratification

Project Charters

Process Mapping

Change Acceleration Process ("CAP")

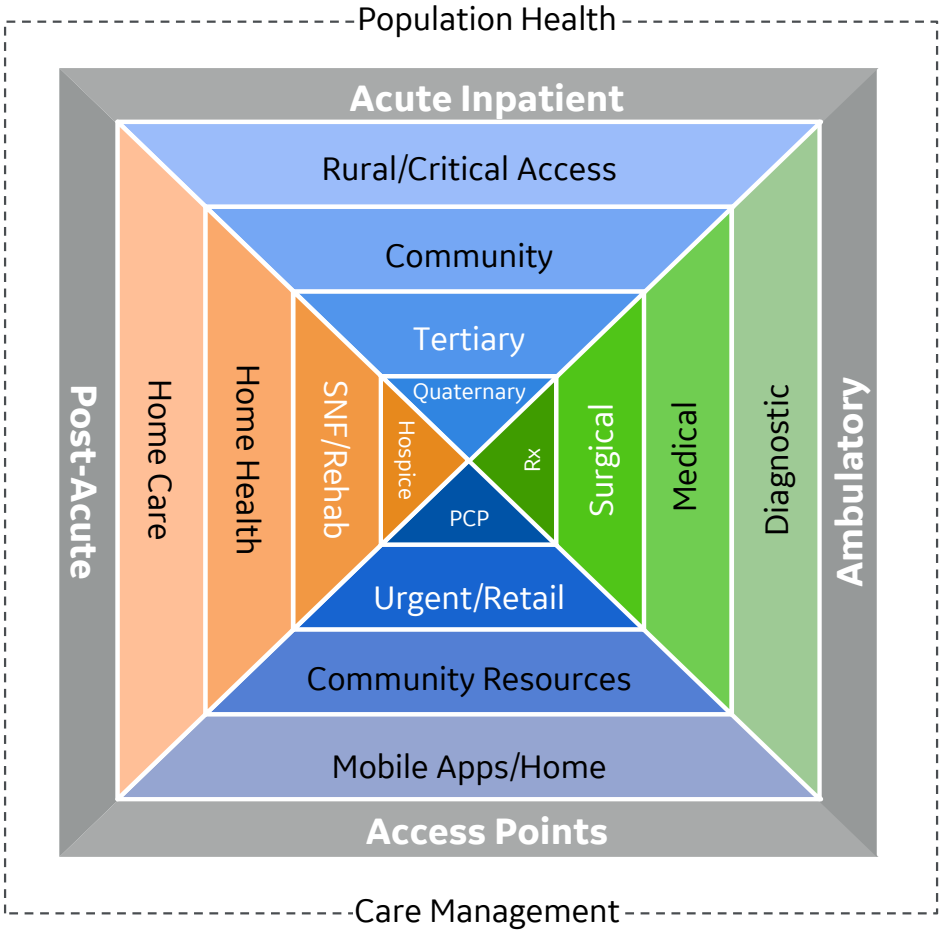
Benchmark Analysis

Key Performance Indicators ("KPIs")

- Traditional
- Next generation (population health management)

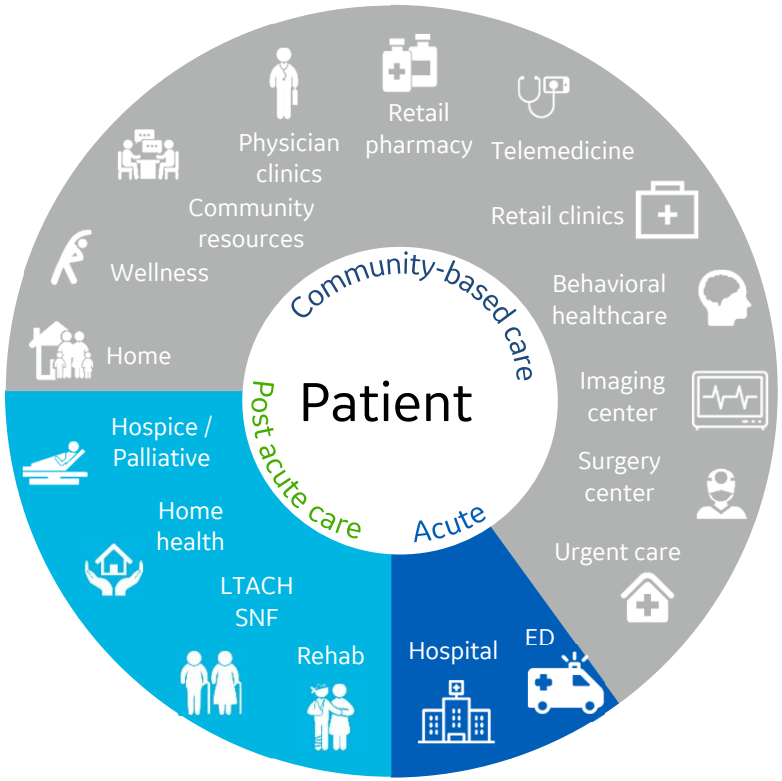
Dashboards and Reports

What is Your Network Strategy?



Thinking Differently About the Continuum of Care

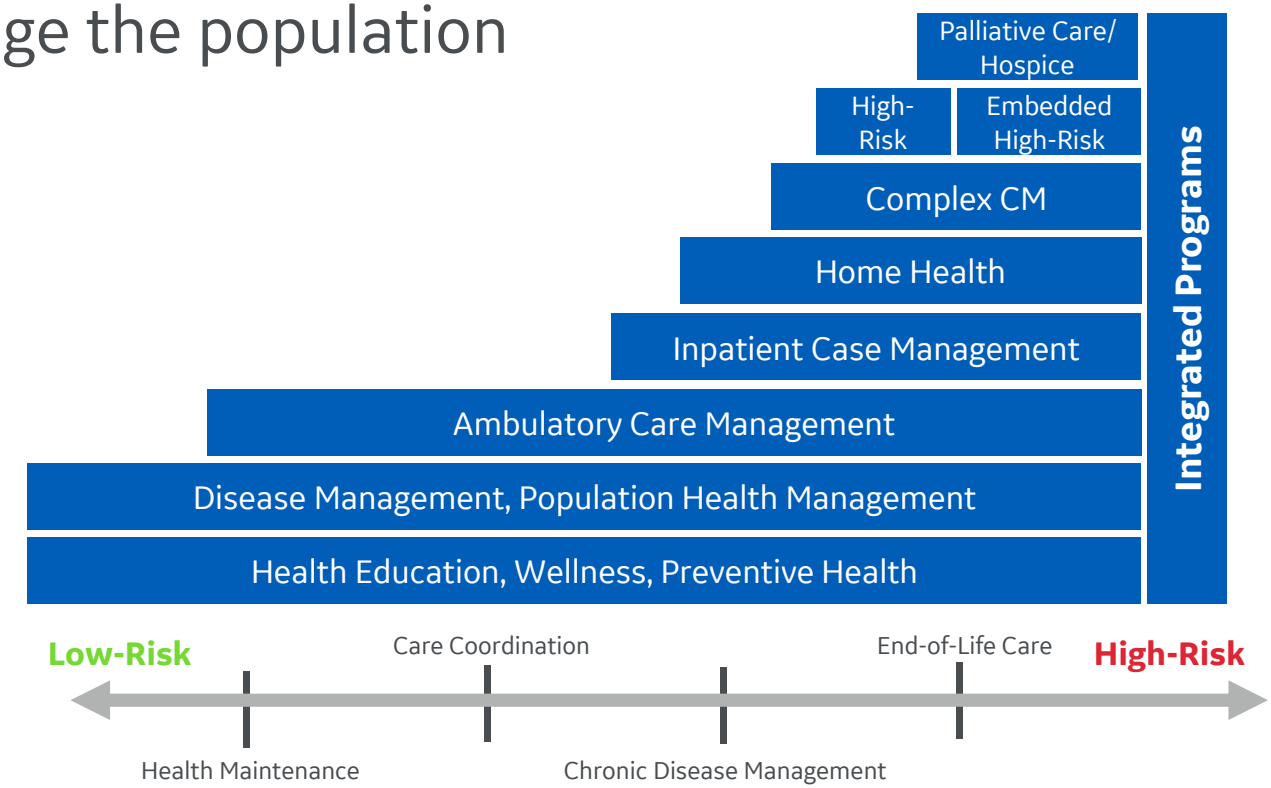
Organized System of Care



- High-performing integrated model
- High-quality, efficient care across the continuum and community
- Standardized process for care coordination
- Evidence-based practice and programs
- Engagement and empowerment of patients and providers
- IT infrastructure for data driven care

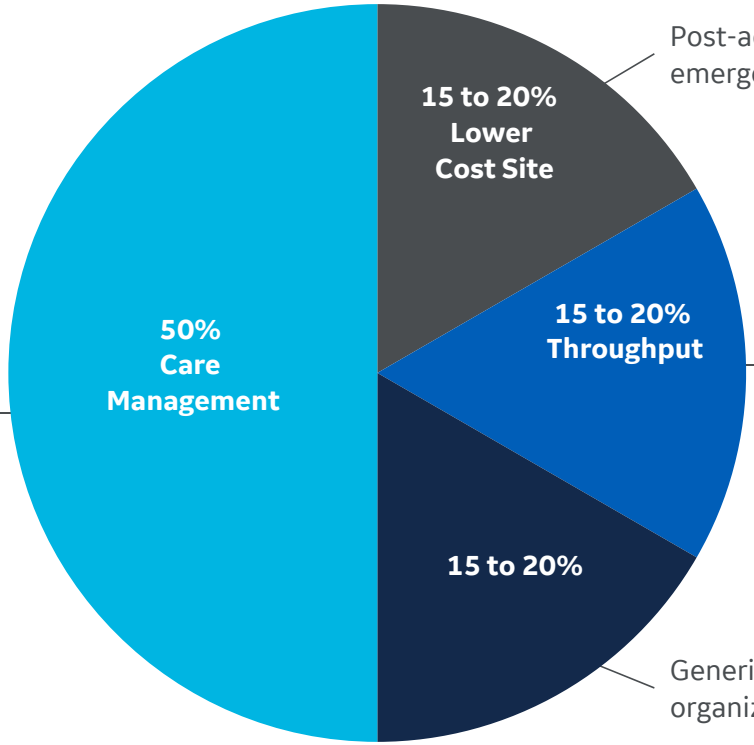
Model of Care

Programs to manage the population



Foundation: Care Management is at the Heart of Care Model Redesign

- Integrated delivery network
- Population management
- Well care
- Chronic disease management
- Effective use of appropriate clinicians
- Medical home
- Bundled payments



Post-acute, ambulatory, UCC, emergency department use

Hours convenient to patients, higher occupancy, providers practicing at the top of their license

Generic use, group purchasing organization, reduction in variability

Appropriate economic indicators

Why is it Important?

Organizations assuming risk for populations based on overall performance

Focus high intensity services on high risk populations

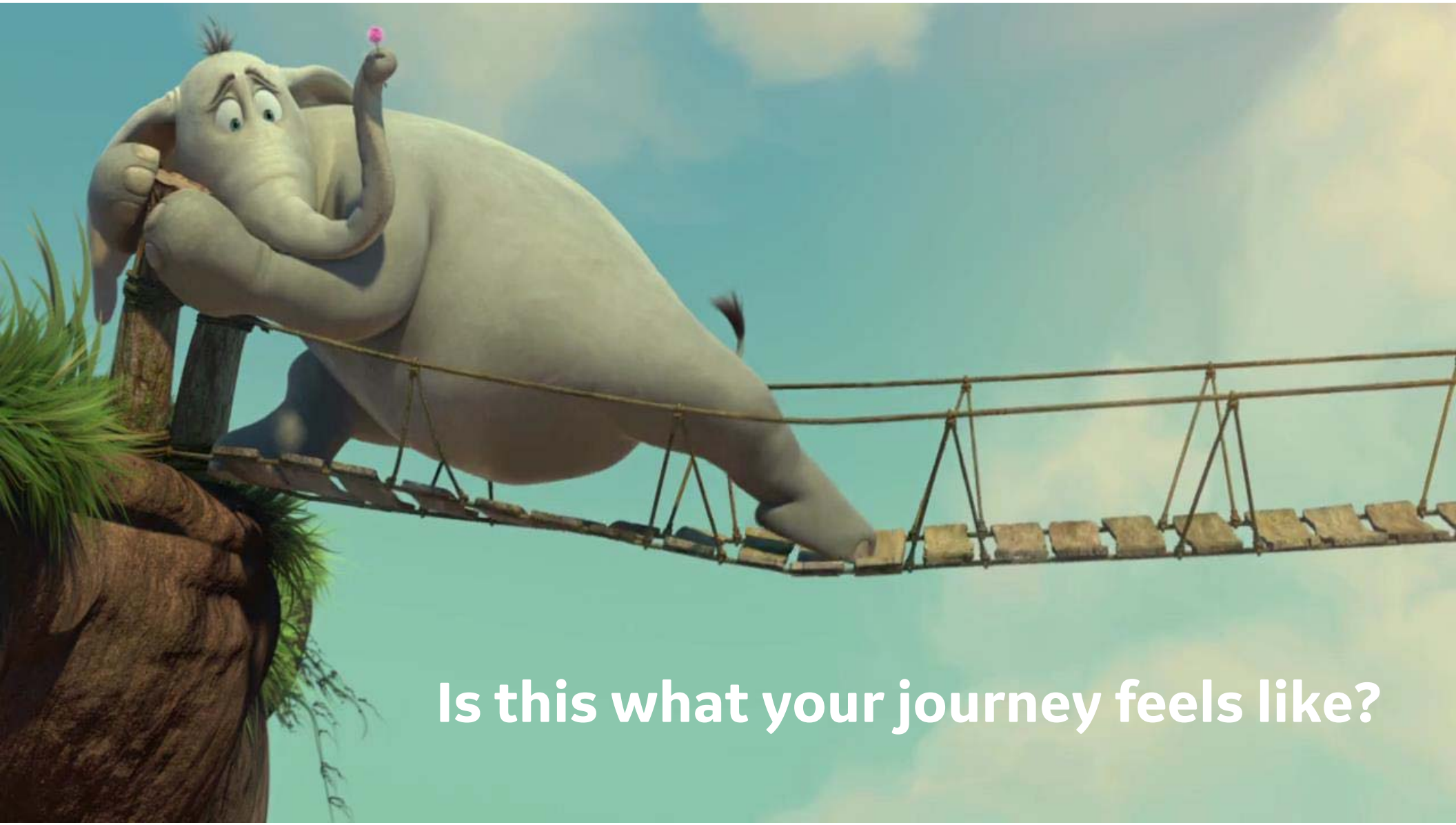
Majority of healthcare dollars are spent by a small percentage of population

- 80/20 rule

Rapid increase in the need to risk stratify

- Healthcare reform
- Rising costs
- Prevalence of chronic diseases

Risk stratification helps care managers organize their workflow and task activities

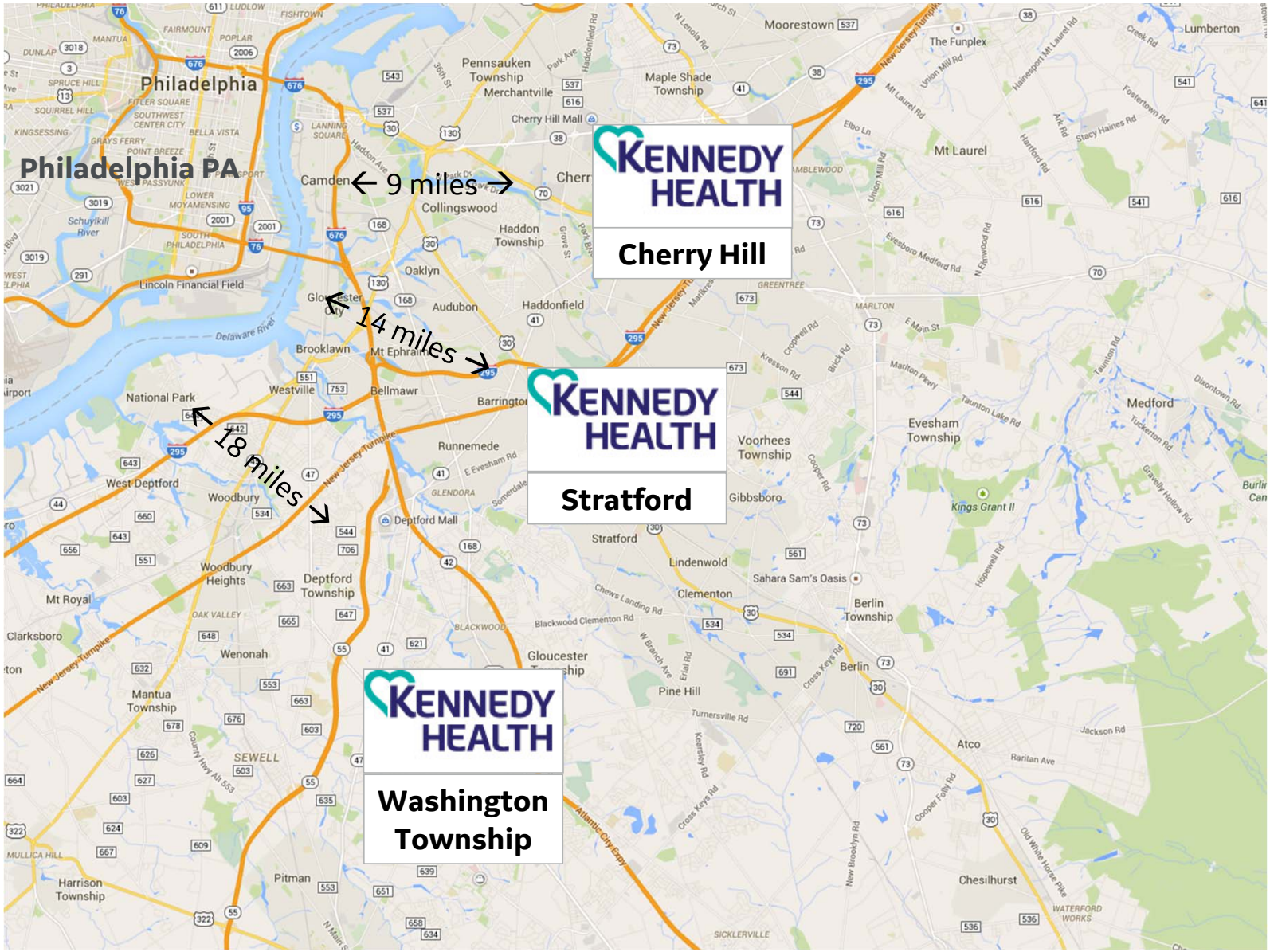

Is this what your journey feels like?

Section 3
Case Study: The Jefferson New Jersey Story...Part 1

Case Study: Kennedy Hospitals

The View From 2011

3 Kennedy Hospitals in New Jersey



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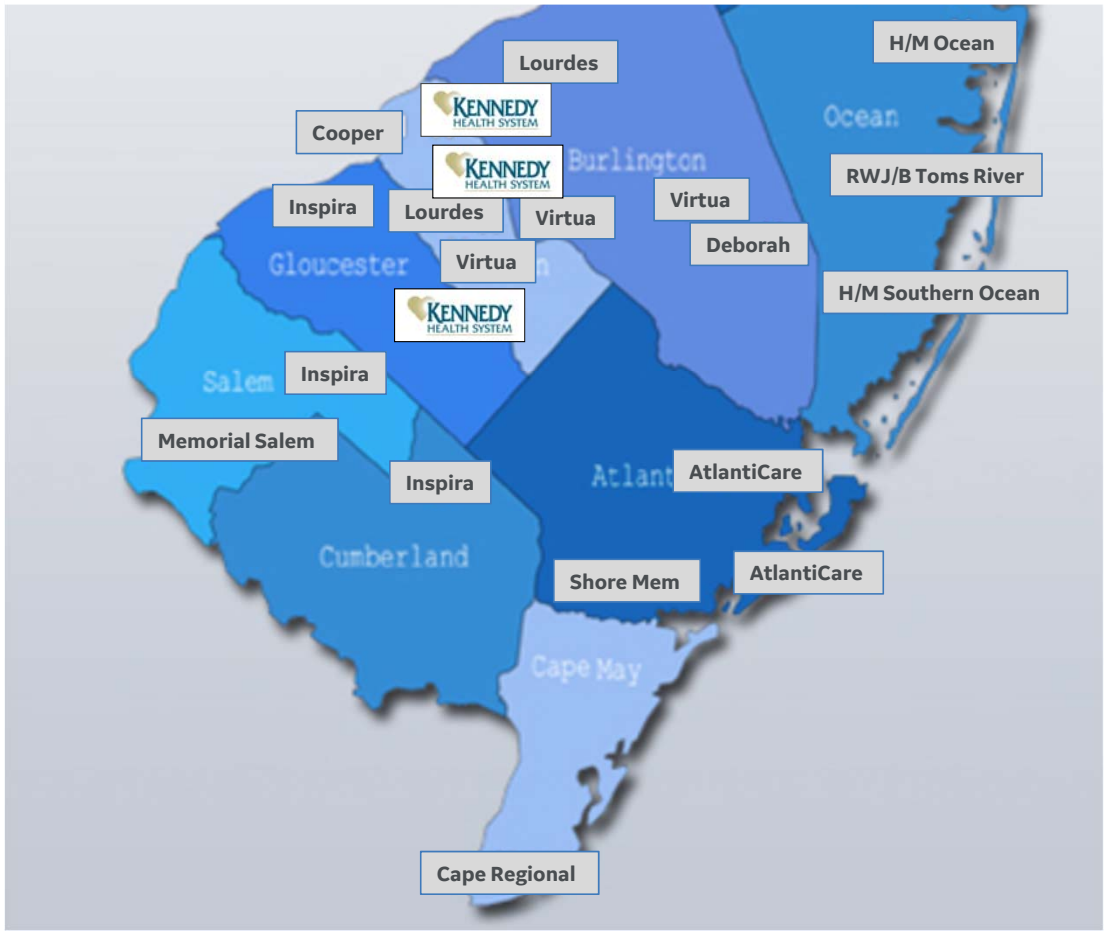
South Jersey Hospitals

21 hospitals

2.4 million residents



Business Model Review Identified from Competitors

Competing community hospitals

- Buying physician practices/employing more physicians
- Raising the bar for *top provider* image

More ambulatory centers and alternative service providers

Physicians reconsidering alignment options

Tertiary hospitals capturing referrals

National healthcare reform uncertainties

Market Forces

Consolidation of primary care physicians ("PCPs") in Kennedy Hospital service area

Employer	Employed Physicians 2015
Virtua Health System	72
Cooper Health System	55
Our Lady of Lourdes	28
Kennedy Health ("KH")*	27
Inspira Health System	20
Rowan University School of Medicine	22
Total	**224**

+/-120 PCPs remain in independent practice

We expect 95% of PCPs in South Jersey to be employed by 2020

* Includes 2 Family Health Center physicians

State of the Facilities 2011: Investments Required

Cherry Hill

Distance from Philadelphia: *9 miles*

Stratford

14 miles

Washington Township

18 miles

Kennedy Health 2012

Medical Staff

Pluralistic model

- Mostly private
- UMDNJ SOM (currently Rowan SOM)

Few employed physicians

Non-employment physician engagement models

Very strong and loyal primary care base

Source: KHS Medical Staff Development Plan – June 2011

The State of the Kennedy Health System in 2011

Medical Staff

1. Very strong and loyal primary care base, but many may want employment
2. Our aligned PCPs referring to other health systems
3. Under-resourced in endocrinology, neurology, and vascular surgery
4. Gaps in specialty coverage for 3 emergency departments (“EDs”) and inpatient services
5. Growth potential to the south and west
6. Non-employment physician engagement models needed development
7. In need of stronger medical staff/physician leadership

Source: KHS Medical Staff Development Plan – June 2011

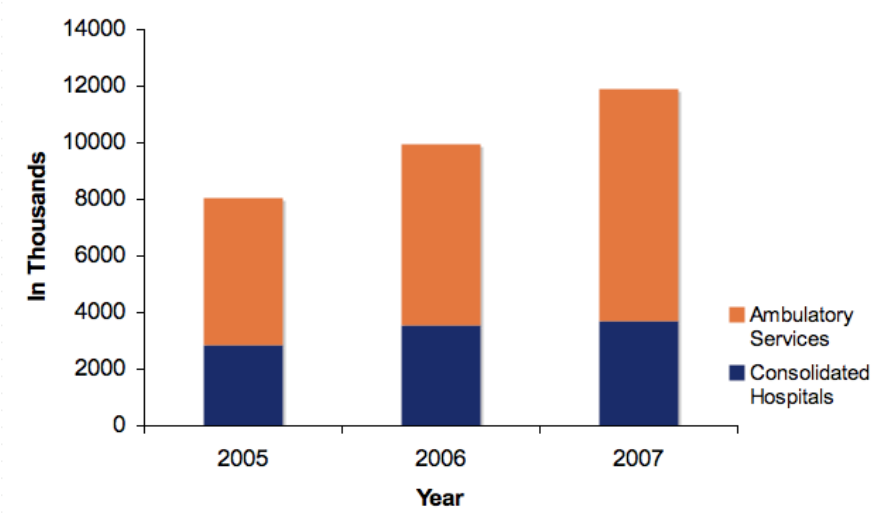
The 2011 Business Model Ignored Significant Risks

1. Unnecessary ED visits
   - 30% to 35% can be treated by family practitioners
2. No reimbursement for
   - Re-admissions within 30 days
   - Inpatient services not related to the admitting diagnosis
   - Care for hospital-acquired conditions
3. New reporting demands for quality measures
   - With reimbursement consequences!
4. Decrease in government subsidies

What We Discovered

Our economics were driven by:

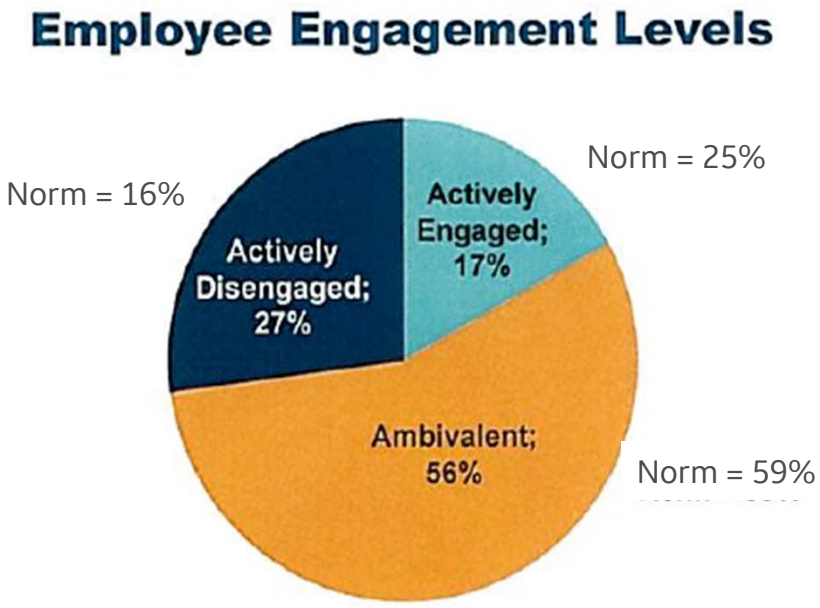
- A large emergency room (“ER”) volume
- Governmental payers and subsidies
- 75% of the bottom line was driven by downstream business



	Total Cases	% from ED
Cardiology	5,795	97%
Gastroenterology	2,543	97%
General Medicine	1,125	96%
General Surgery	1,705	71%
Neurology	1,414	99%
Dermatology	849	96%
Endocrinology	747	97%
Nephrology	1,085	94%
Urology	657	63%
Vascular Surgery	343	59%
Total	25,649	78%

78% of hospital cases originated in the ED

Kennedy Health System 2011



"There is no culture of accountability here, there never has been."

"Medical staff does not have a meaningful role."

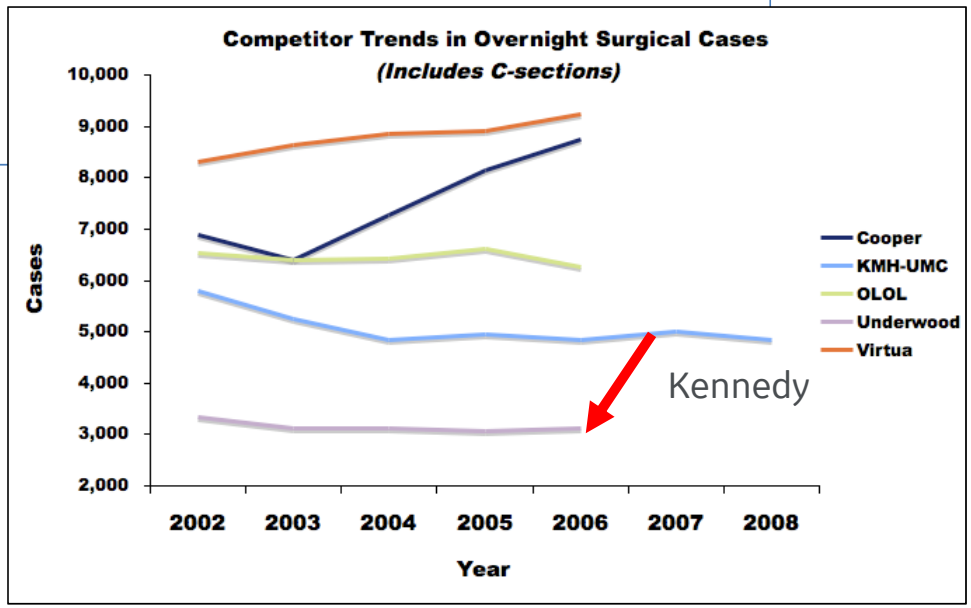
"Kennedy thinks that their medical staff is much stronger than it is, that's a problem."

A wake-up call for a new leadership!

Source: KHS Strategic Plan 2010

Kennedy Hospitals in 2011

- We needed to improve the depth and quality of our specialty care services
- Significant elective volume was going to our competition



Break

Section 4
Group Exercises: Design your Proposed Tactical Approaches to Primary Care Transformation

Case Study Discussion Question:

What tactics would you implement in Kennedy's market position?

Instructions for Break-out

We will divide you into 4 groups

Each group will be given a topic: **Network**, **Care Model**, **Leadership/Governance, or Technology/Analytics**

Put yourself in Kennedy's shoes: In preparing for risk, what actions would you take to transition the organization?

Please, focus on 1 of the 4 topics above

Use easels and markers to capture your groups idea

Each group will report-out on their teams ideas

Food for Thought

Network	Care Model	Leadership/Governance	Technology /Analytics
• Developing the network to support the market • Engaging employed and independent physician • Service gaps • Geographic footprint • Addressing access	• Initiatives supporting population health • Value-based care • Meaningful physician engagement to activate new models	• Physician engagement • Physician groups • Governance structure/formation of committees • Compensation/Incentive design • Instilling accountability • Creating the culture	• IT infrastructure to support population health initiatives and care model redesign • Benefits of transparently reporting data/outcomes to providers • Innovative applications that can help providers communicate more effectively

Break

Section 5
Case Study: The Jefferson New Jersey Story... Part 2

Opportunity to Manage the Risks

3 acute-care hospitals in good locations with 150,000 ER visits

A large out-migration of patients we are capable of caring for locally

Over 200 aligned and valued PCPs

A set of inpatient and ambulatory clinicians across multiple sites poised to integrate care delivery to meet defined objectives

What Became Apparent to Kennedy Leadership

We needed to change the relationship between the hospital leaders and the medical staff

We needed to listen more

We needed to be more responsive to physician needs

Kennedy Hospitals in 2011

Strategic planning process

- All key stakeholders in the organization participated

We examined:

- The drivers of our economics
- The quality of our clinical programs
- The basis of driving patient flow in the market
- The intent of healthcare reform
- The competitive marketplace

The Components Necessary to Achieve Success

A clinical/practice environment in which primary care physicians drive the practice of medicine for their patients

An acute-care system in which evidenced-based practice is managed by physicians

A mechanism to promote physician management of patient care

The Kennedy Strategy for Partnering with PCPs

Accommodation for physician preferences

- Engage School of Osteopathic Medicine full-time faculty
- Consider creating a Physician Hospital Organization (“PHO”)
- Offer employment KH Alliance

Physician Alignment Strategy

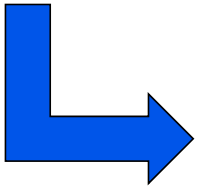
Kennedy Health Market Share

Our Target Patient Population in 2020	
Residents in KH market communities	686,000
Projected market share % in 2020	29%
Required KH patient population at projected market share	**200,000**

Creating the Medical Group

KENNEDY HEALTH SYSTEM

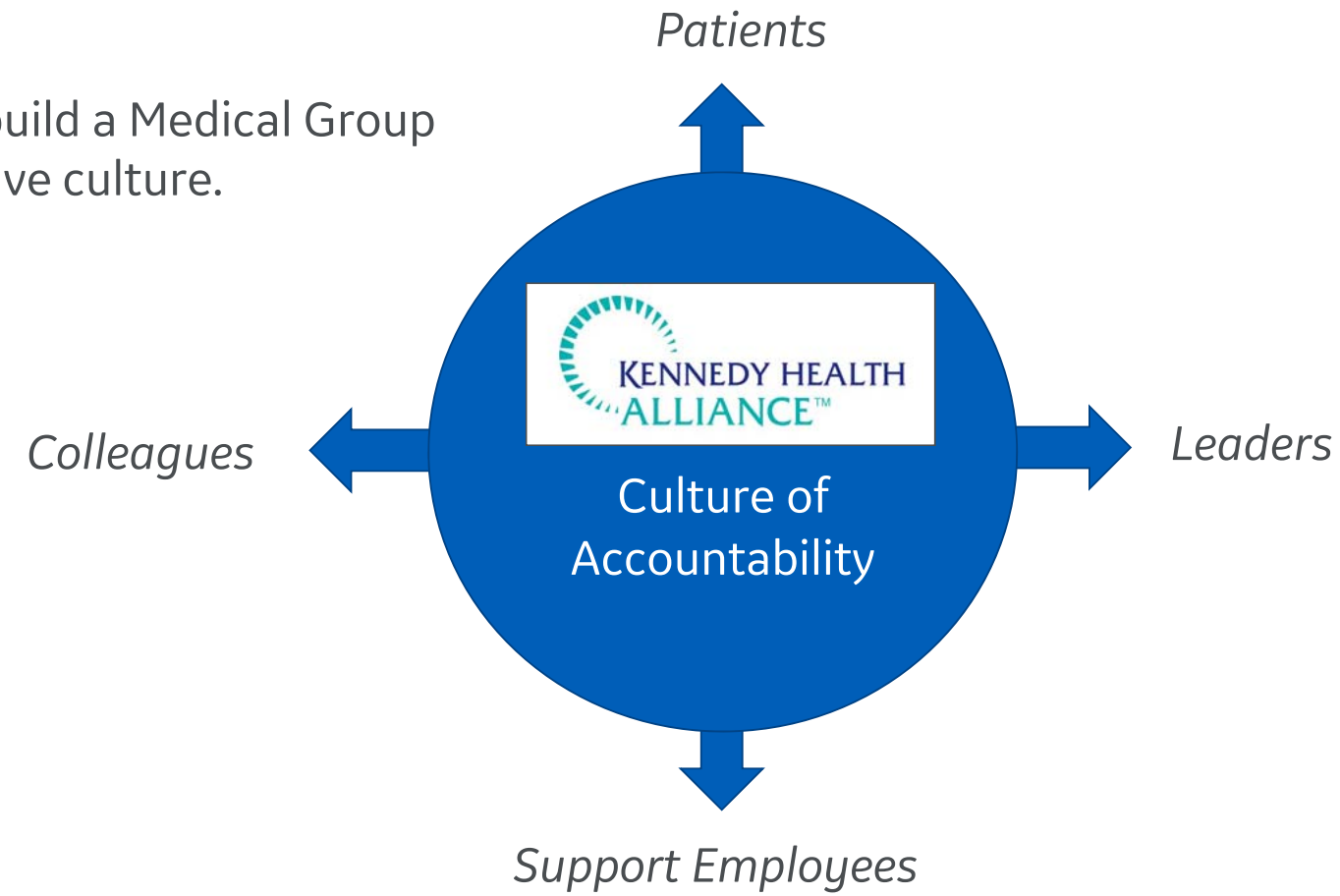
An easel, a marker and trail mix . .



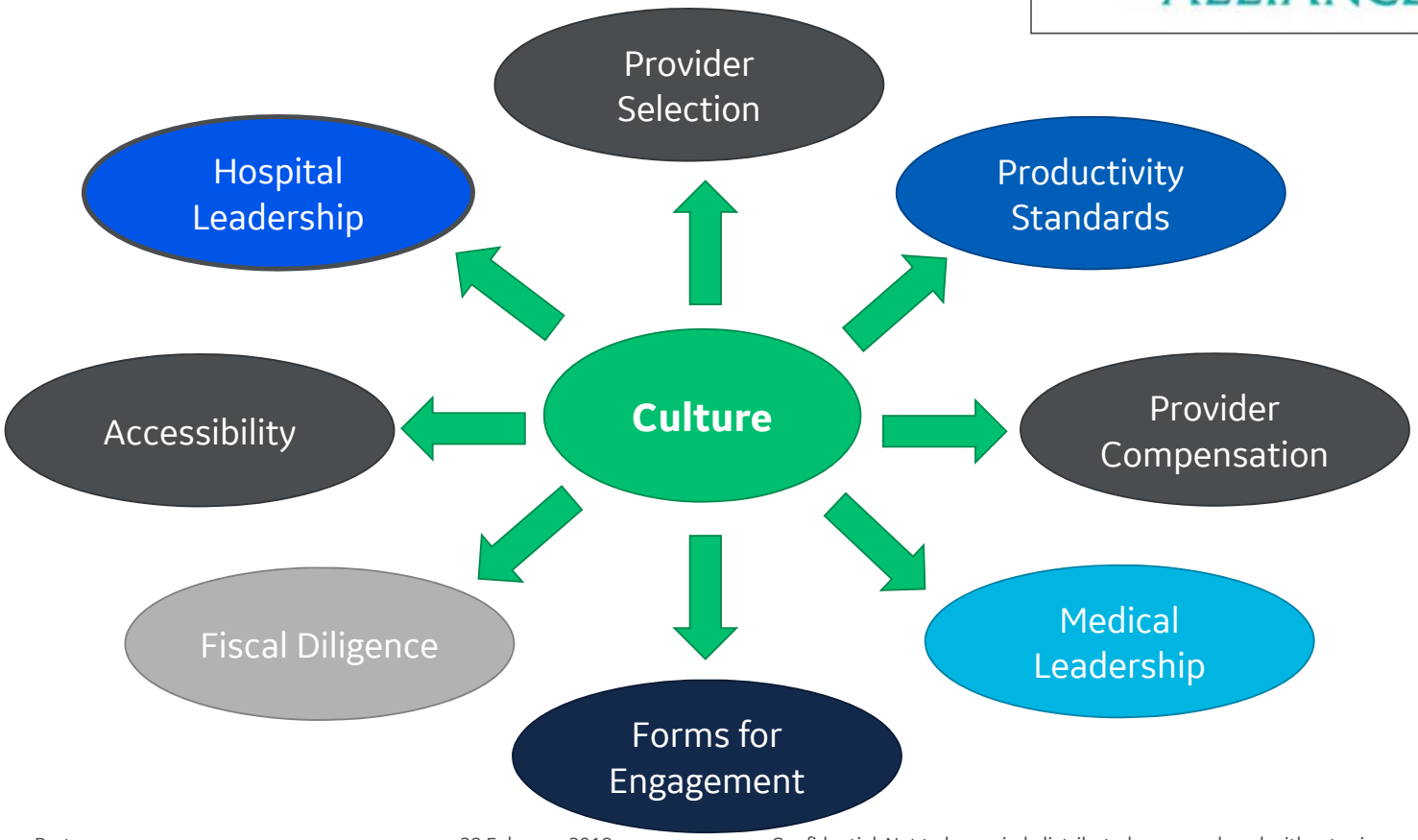
KENNEDY HEALTH ALLIANCE™

Medical Group

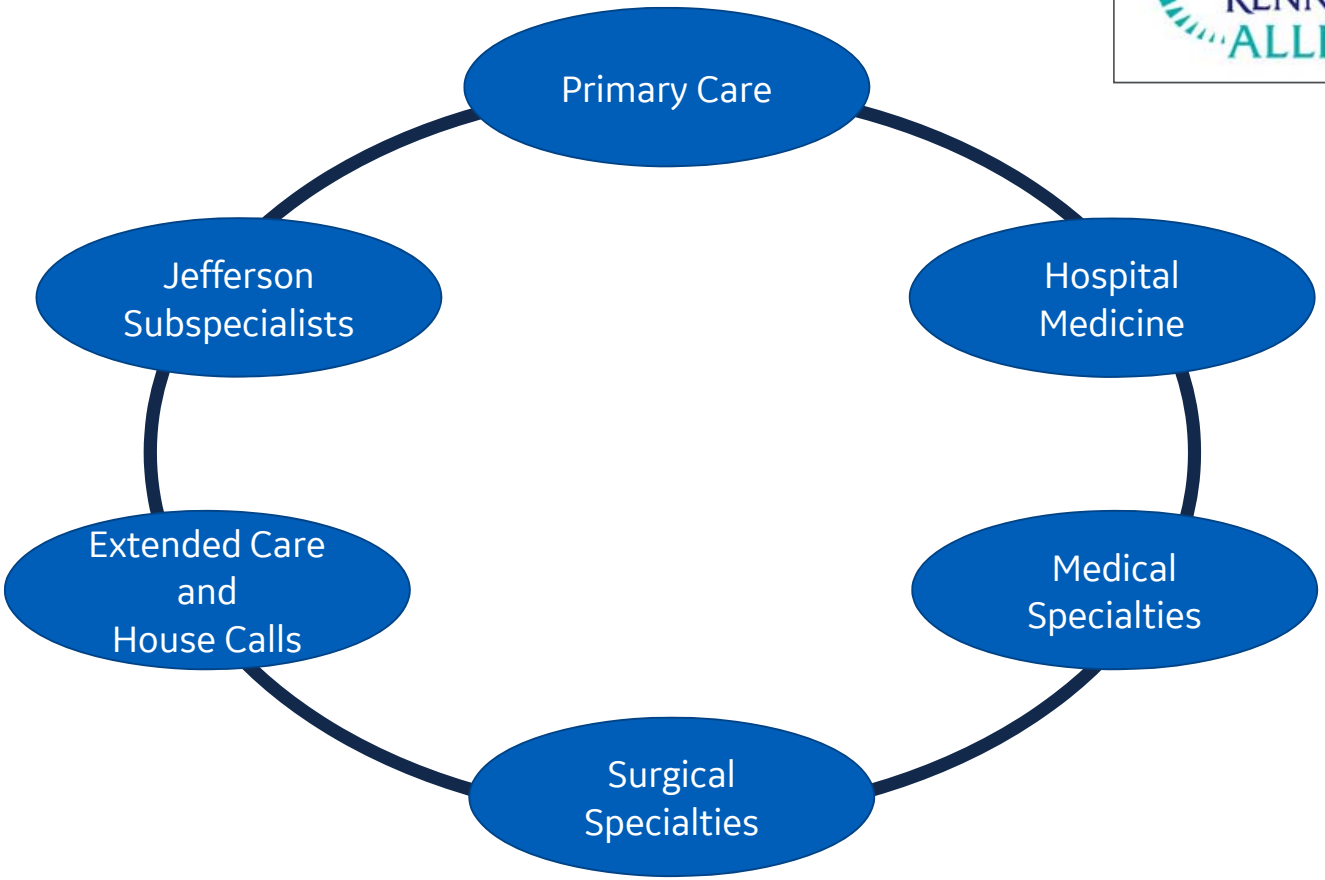
We sought to build a Medical Group with a responsive culture.



Creating the Medical Group

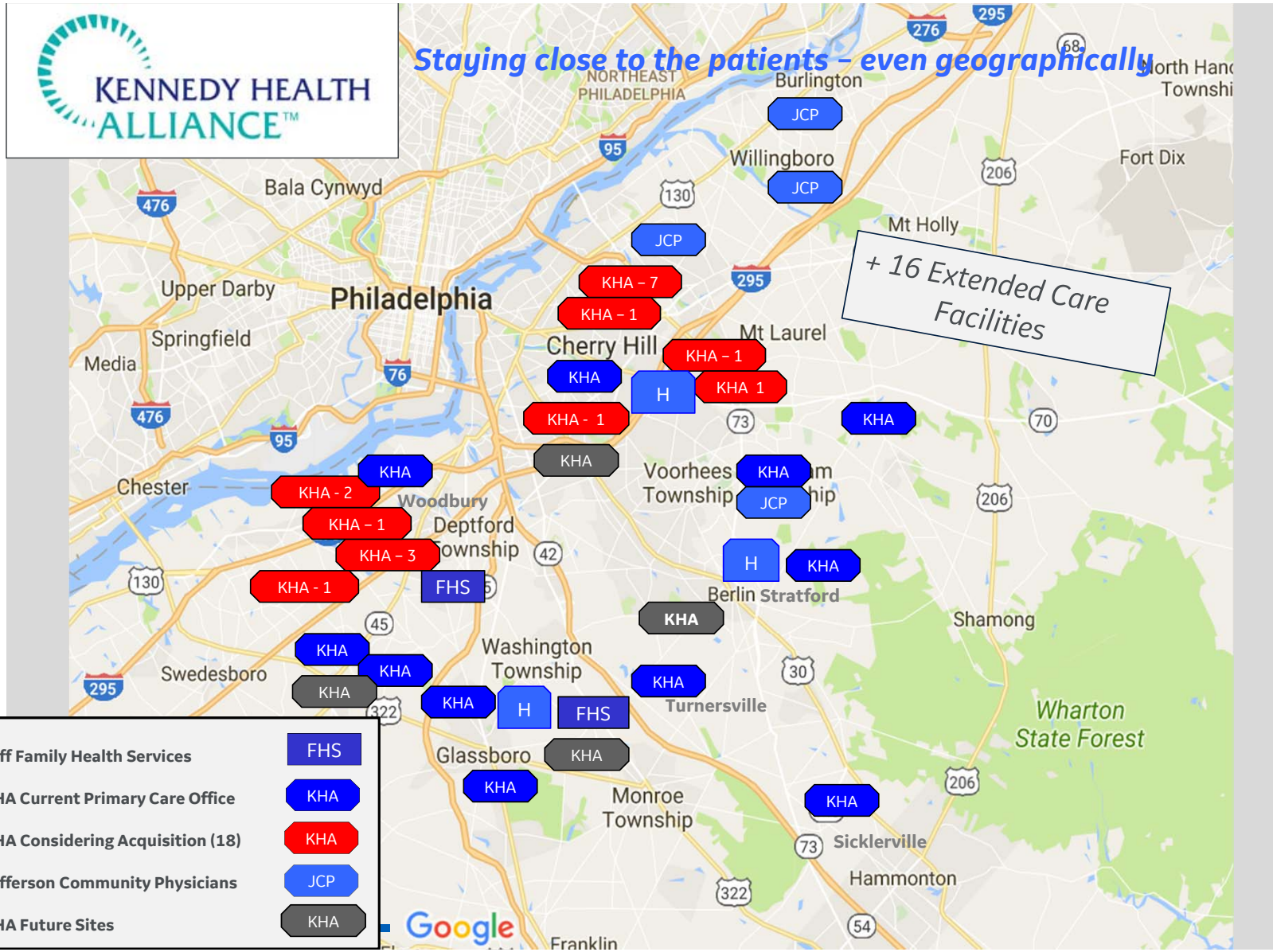


Growing the Medical Group



KENNEDY HEALTH ALLIANCE™

Staying close to the patients – even geographically



Jeff Family Health Services	FHS
KHA Current Primary Care Office	KHA
KHA Considering Acquisition (18)	KHA
Jefferson Community Physicians	JCP
KHA Future Sites	KHA

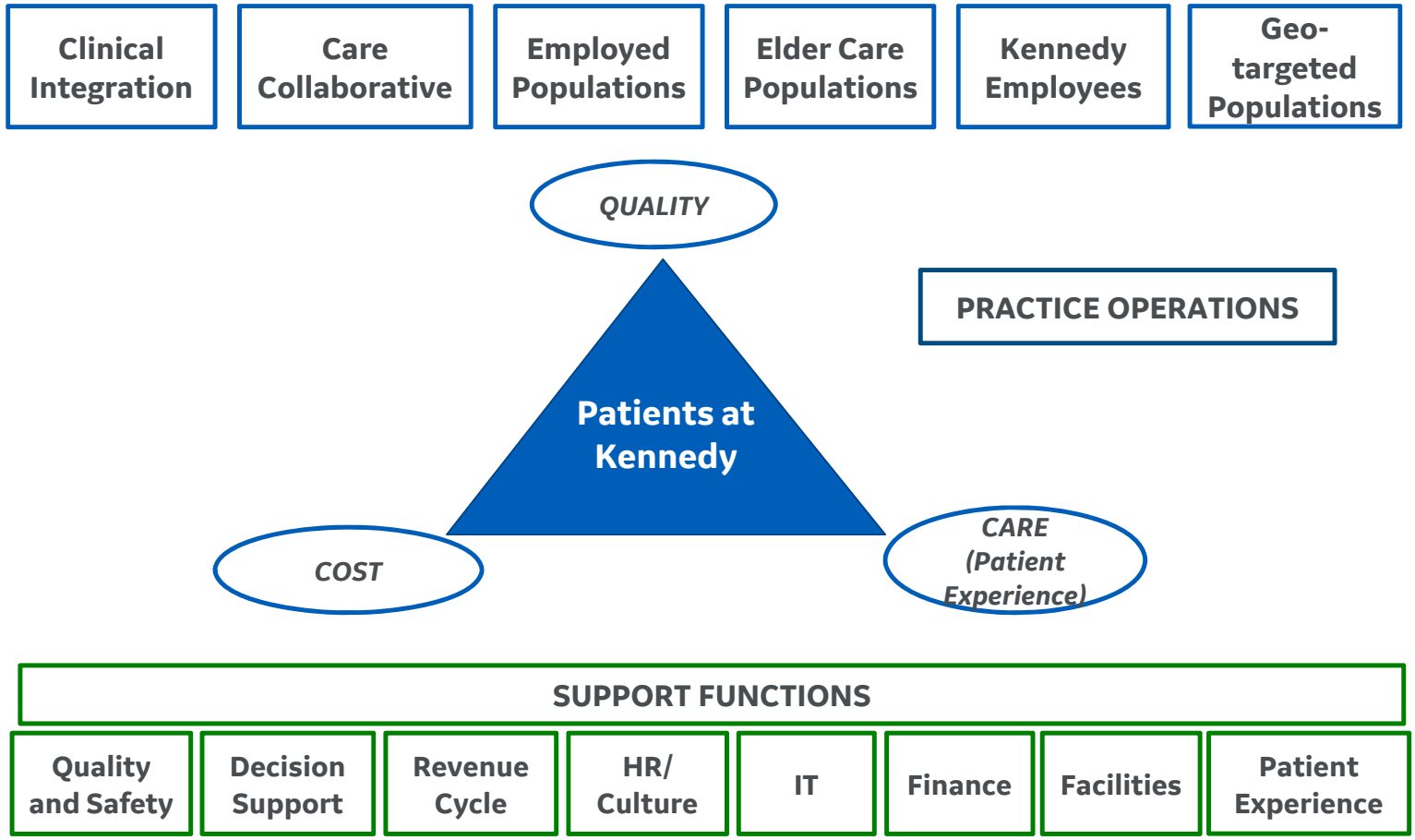
In November 2010

KENNEDY HEALTH ALLIANCE™

Specialty	Physicians	Advanced Practice	Total
Primary Care	79	31	110
Surgical Specialties	15	0	15
Medical Specialties	40	7	47
Total	134	38	172

2017
KENNEDY HEALTH ALLIANCE™

Population Health at Kennedy



Transitioning How We Provide Care

From: CPT-based Provider Behavior		To: Neighborly Provider Behavior
Driven by billable events	→	Integrated, member of a team
Competence in diagnosis and treatment	→	Longitudinal focus
Playing your role	→	Cross-provider communicating
With your patient information	→	Integrated EHR

Migration Into Population Health

Attention to the right population

Under the right contract

Providing the right individual care

At the right time

By the right professionals

In the right locations

With the right data

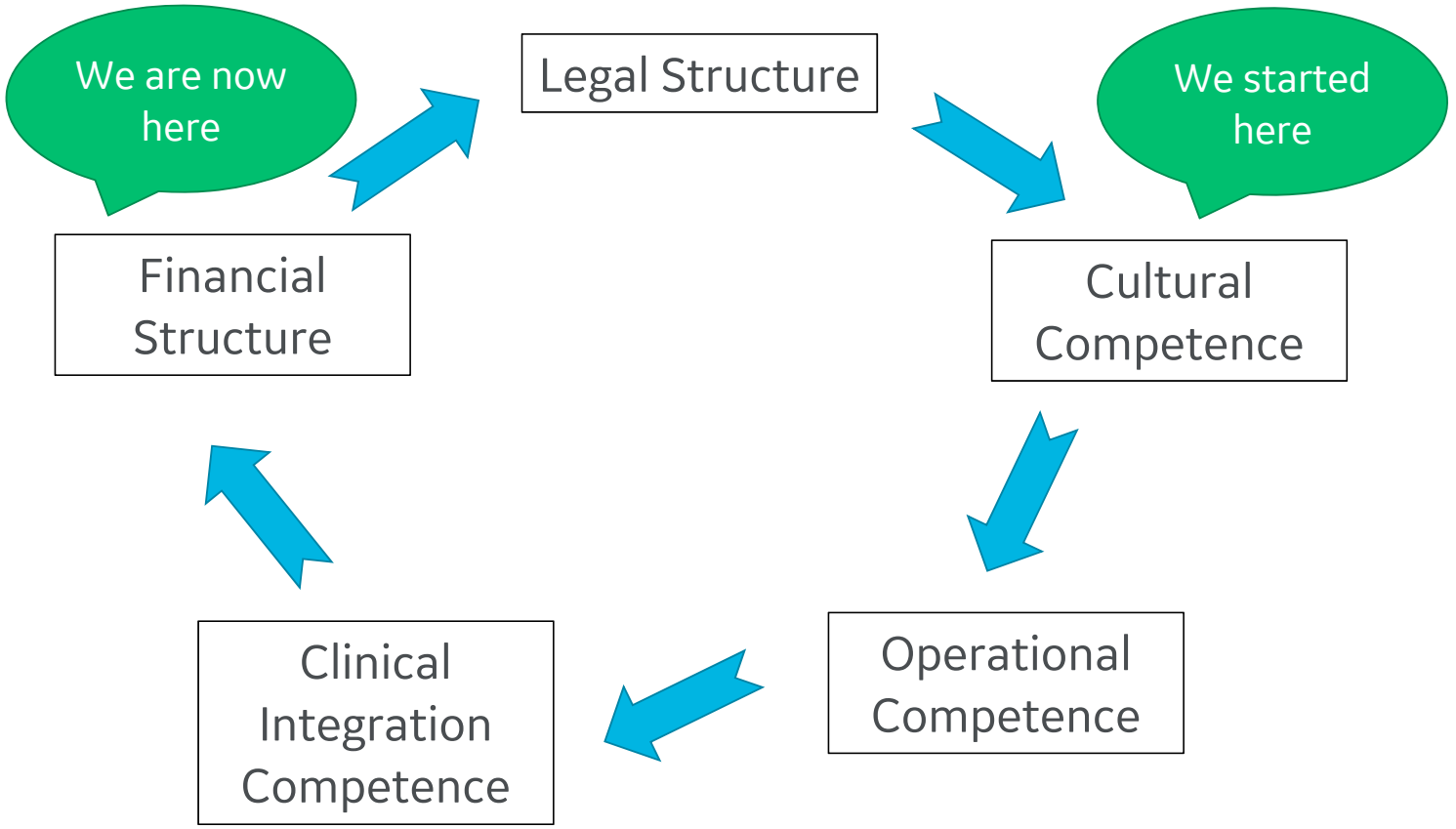
And within the right organizational structure/accountability!

It’s Been a Long Journey

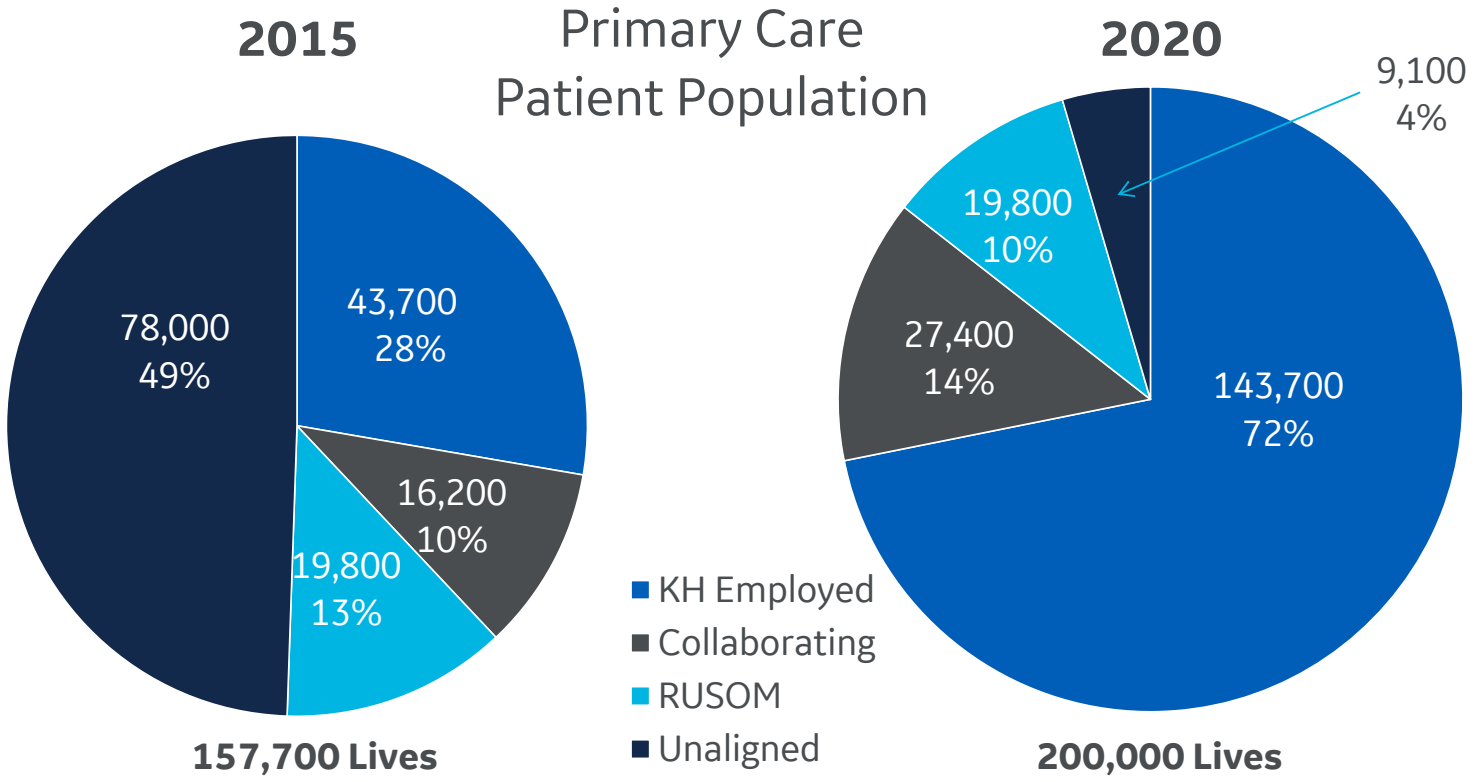
An IT foundation in an EHR	2013
Patient-centered medical home competencies	2013
Nurse navigators	2013
Metric-based, upside-only, supplemental payments	2014
DSRIP – New Jersey *	
Value-based purchasing	2013
Behavioral Health Population Program	2018
Medicare Shared Savings Program … why so late?	2018

* Delivery System Reform Incentive Payment

Accountable Care



Physician Alignment Strategy



Success in Value Based Payment: From A to Z

A. Accessible, accountable
B. Ballsy
C. Crazy (a little), courageous, culture
D. Directive
E. Equitable
F. Funded $$
G. Guts
H. Helpful
I. Indefatigable (persisting tirelessly)
J. Judicious
K. Kind
L. Learning at every step
M. Mindful
N. Not a naysayer
O. Optimistic
P. Productive
Q. Quality pursuing
R. Relationship building
S. Stealing ideas shamelessly
T. Team-based
U. Unified
V. Visible leadership
W. Welcoming for patients
X. Xenophiliac (embracing diversity)
Y. YOLO!
Z. Zealous