Carl Philipp Gottfried von Clausewitz

Prussian Cavalry Officer 1792 to 1831

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“The fog of war”

-Carl Philipp Gottfried von Clausewitz

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WE GAIN PERSPECTIVE BY GETTING HIGHER

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WE ARE 25 YEARS
INTO A 40-YEAR
HEALTH CARE TRANSFORMATION

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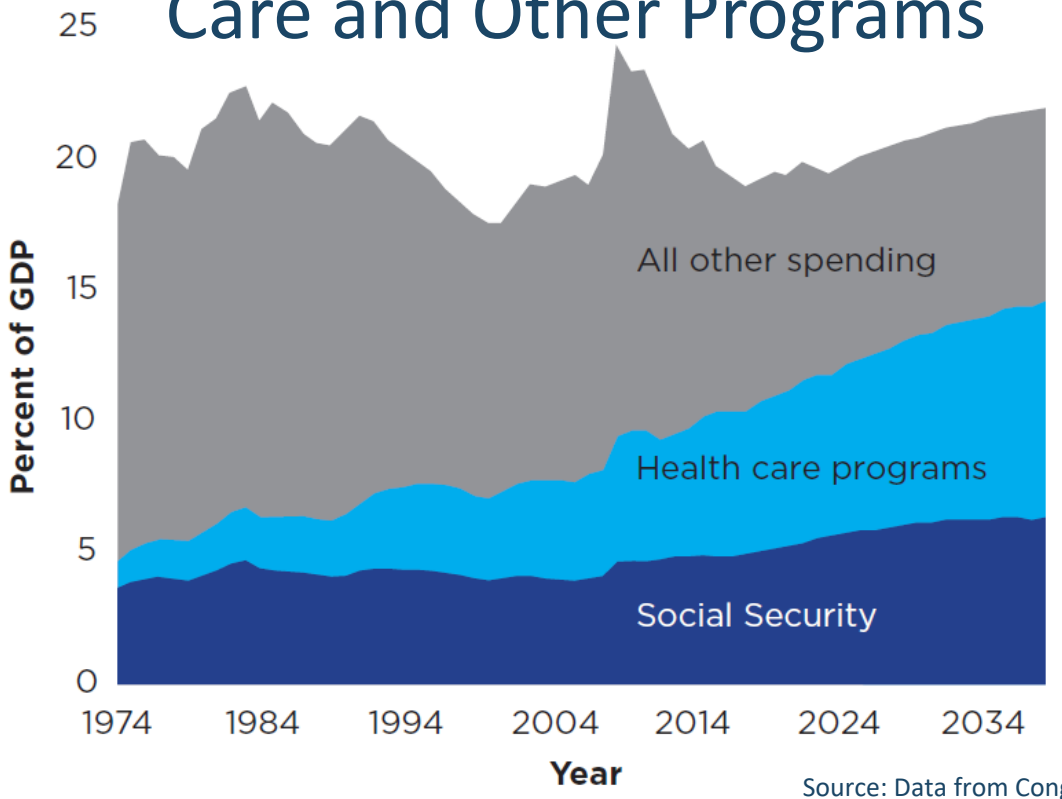
Historical and Projected Federal Spending: Health Care and Other Programs



Source: Data from Congressional Budget Office

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LOSING COMPASSION IS UNACCEPTABLE
BUT, SO IS
LOSING U.S. ECONOMIC LEADERSHIP

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UNIQUELY AMERICAN HEALTH CARE SYSTEM

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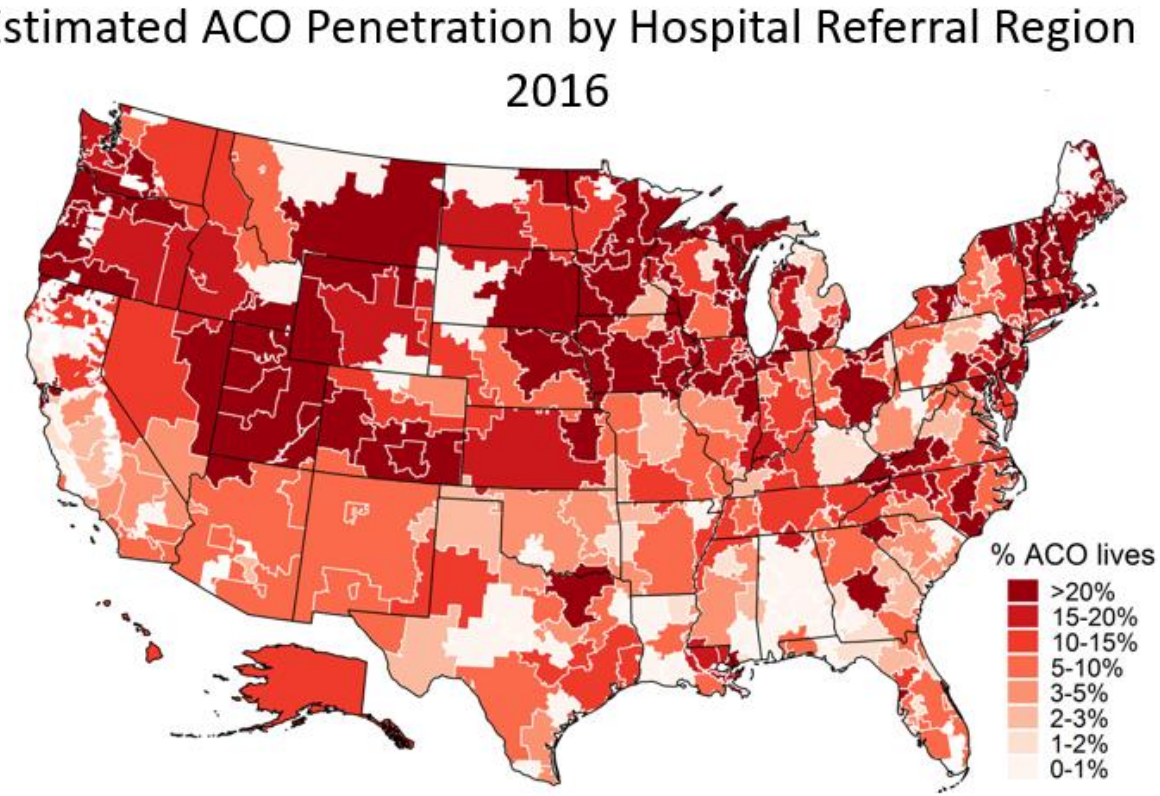
ACO Penetration of lives over time



Source: *Leavitt Partners Center for Accountable Care Intelligence*

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ECONOMIC IMPERATIVE

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

"This administration and this President are **not interested in incremental steps**. We are unafraid of **disrupting** existing arrangements..."

- Secretary Azar

ECONOMIC IMPERATIVE

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

"It will require some degree of **federal intervention** — perhaps even an **uncomfortable** degree. That may sound surprising coming from an administration that deeply believes in the power of markets and competition."

- Secretary Azar

ECONOMIC IMPERATIVE

"There is **no turning back** to an unsustainable system that pays for procedures rather than value. In fact, the **only option is to charge forward** — for HHS to take bolder action, and for providers and payers to join with us."

– Secretary Azar

A Journey to Competency

SOCCER ACADEMIES

OVER 100 SOCCER COMPETENCIES

13. Always keep yourself between your opponent and your own goal.

32. The goalkeeper must command his/her area.

89. Deceiving an opponent (the concept of the feint) through dribbling.

104. Defense starts as soon as the ball is lost.

QUANTIFYING COMPETENCIES

13. Run the 30-meter dash in under 4.5 seconds

32. Maintain the ball for 10 consecutive passes in 4 v. 1 game of keep-away

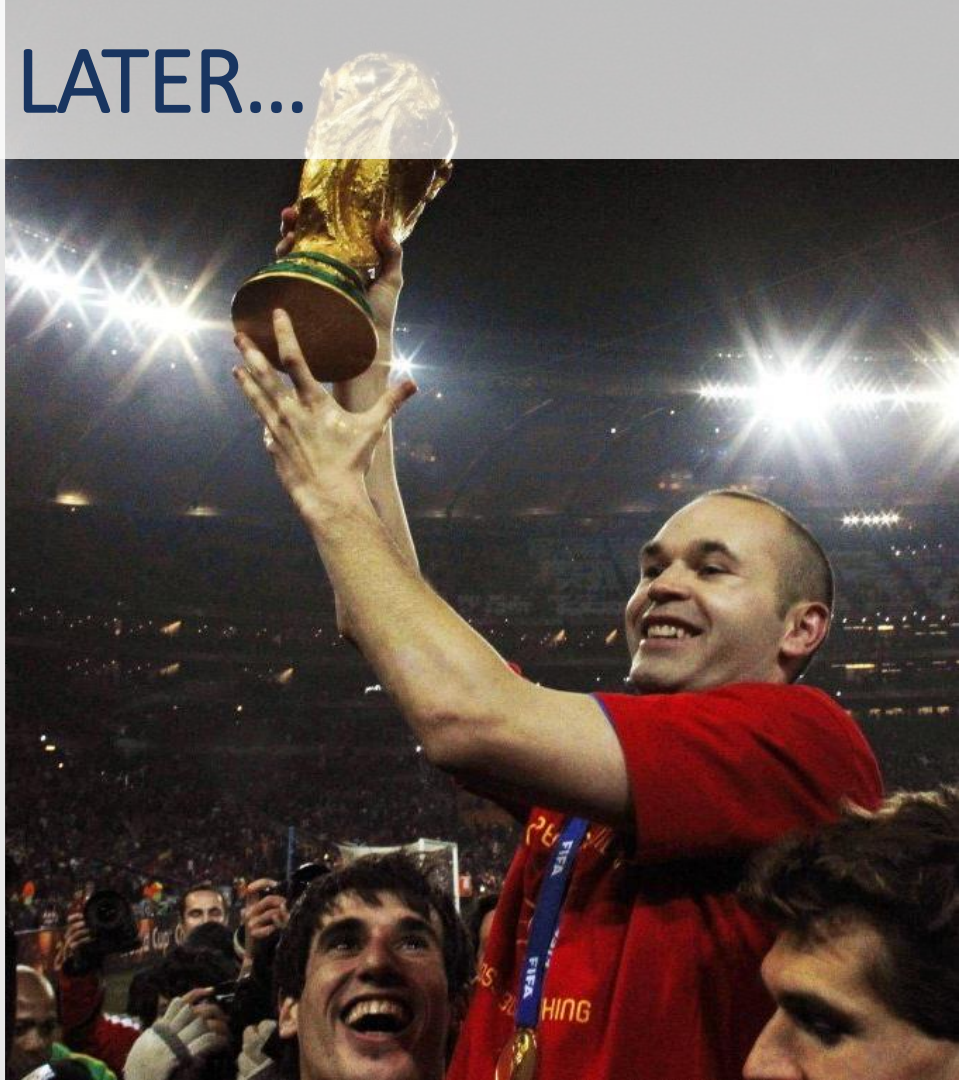
104. Jump 12 inches vertically

89. Juggle the ball 30 touches alternating feet without it touching the ground

LA MASIA

adidas
GETTY IMAGES

14 YEARS LATER…



A Journey to Success in a Value Based Payment World

BIGGEST RATE LIMITER – PROVIDER READINESS

OVER 150 IDENTIFIED COMPETENCIES

16. Designate a primary coordinator of care to assure continuity throughout the continuum of care

31. Develop ability to distribute shared savings and performance-based payments to providers

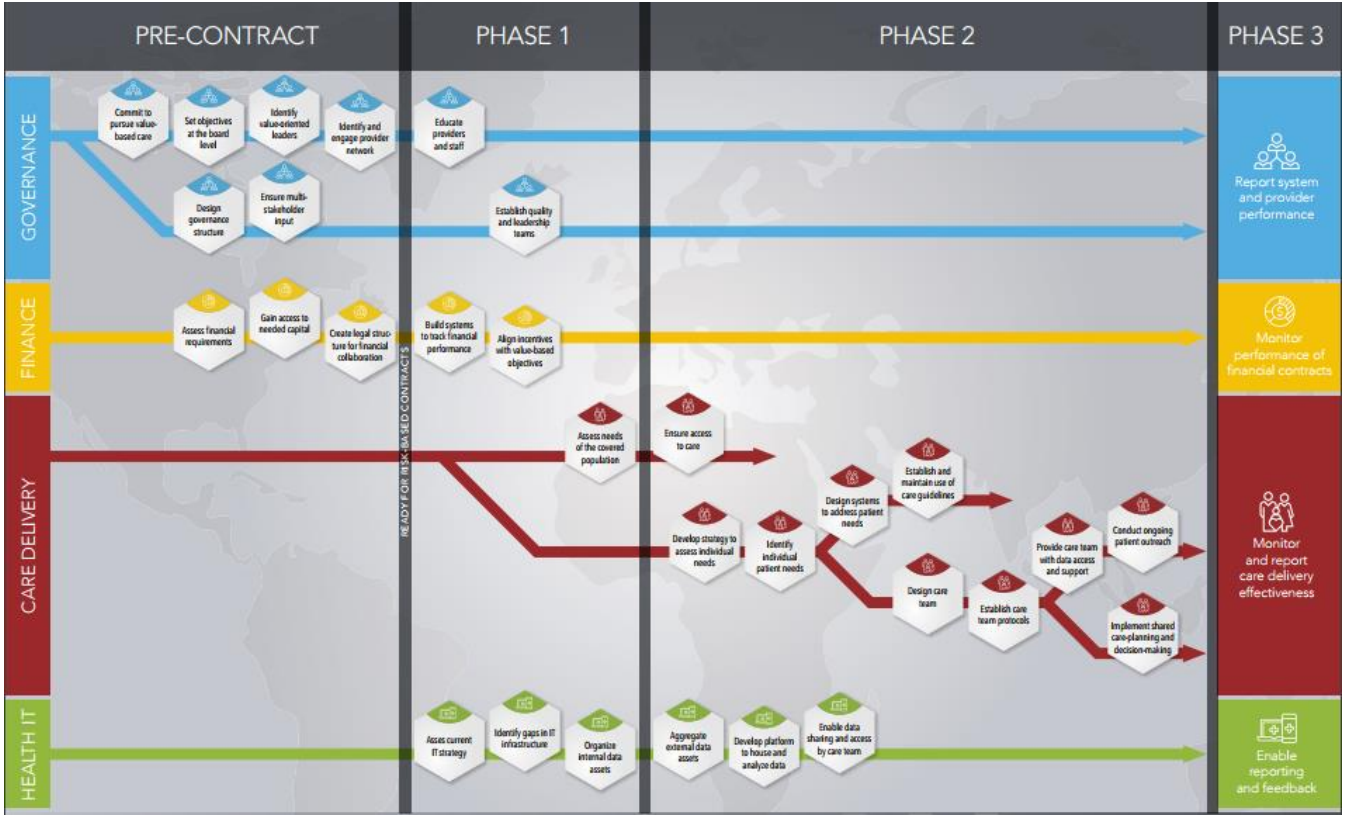
56. Align your organization's mission, vision, and strategy with value-based care and patient-centeredness objectives

127. Identify diagnoses and patients' health care and social support needs that both drive spending and are modifiable

ACCOUNTABLE CARE ATLAS

ACCOUNTABLE CARE ATLAS

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY



LEADERSHIP COHORT

1. What leadership and structural competencies are common among successful providers?
2. How executive decisions are made in prioritizing advancements?
3. How market contexts may influence these competencies and decisions?

Hackensack University Medical Group

ASCENSION

FAIRVIEW

accenture

3M Science. Applied to Life.

CONIFER HEALTH SOLUTIONS

VALUE-BASED READINESS ASSESSMENT

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

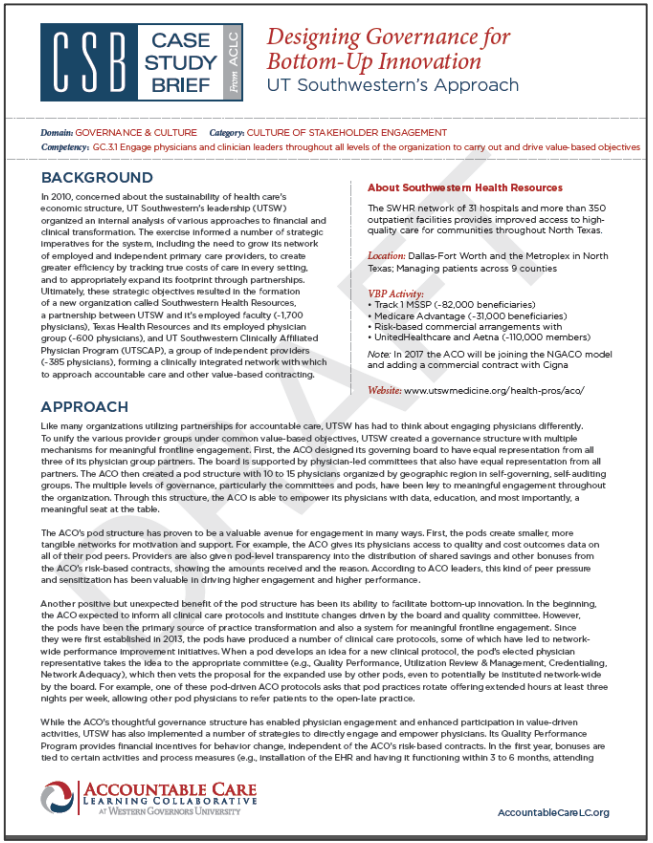
THE Dartmouth INSTITUTE FOR HEALTH POLICY & CLINICAL PRACTICE

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

CASE STUDY BRIEFS (CSBS)

ACCOUNTABLE CARE LEARNING COLLABORATIVE AT WESTERN GOVERNORS UNIVERSITY

- Organization overview
- Background
- Approach
- Results
- Challenges with implementation
- Key Learnings
- Contact information



CSB CASE STUDY BRIEF from ACLC

Designing Governance for Bottom-Up Innovation

UT Southwestern's Approach

Domain: GOVERNANCE & CULTURE *Category:* CULTURE OF STAKEHOLDER ENGAGEMENT

Competency: GC.3.1 Engage physicians and clinician leaders throughout all levels of the organization to carry out and drive value-based objectives

BACKGROUND

In 2010, concerned about the sustainability of health care's economic structure, UT Southwestern's leadership (UTSW) organized an internal analysis of various approaches to financial and clinical transformation. The exercise informed a number of strategic imperatives for the system, including the need to grow its network of employed and independent primary care providers, to create greater efficiency by tracking true costs of care in every setting, and to appropriately expand its footprint through partnerships. Ultimately, these strategic objectives resulted in the formation of a new organization called Southwestern Health Resources, a partnership between UTSW and it's employed faculty (~1,700 physicians), Texas Health Resources and its employed physician group (~600 physicians), and UT Southwestern Clinically Affiliated Physician Program (UTSCAP), a group of independent providers (~385 physicians), forming a clinically integrated network with which to approach accountable care and other value-based contracting.

About Southwestern Health Resources

The SWHR network of 31 hospitals and more than 350 outpatient facilities provides improved access to high-quality care for communities throughout North Texas.

Location: Dallas-Fort Worth and the Metroplex in North Texas; Managing patients across 9 counties

VBP Activity:
- Track 1 MSSP (~82,000 beneficiaries)
- Medicare Advantage (~31,000 beneficiaries)
- Risk-based commercial arrangements with
- UnitedHealthcare and Aetna (~110,000 members)

Note: In 2017 the ACO will be joining the NGACO model and adding a commercial contract with Cigna

Website: www.utswmedicine.org/health-pros/aco/

APPROACH

Like many organizations utilizing partnerships for accountable care, UTSW has had to think about engaging physicians differently. To unify the various provider groups under common value-based objectives, UTSW created a governance structure with multiple mechanisms for meaningful frontline engagement. First, the ACO designed its governing board to have equal representation from all three of its physician group partners. The board is supported by physician-led committees that also have equal representation from all partners. The ACO then created a pod structure with 10 to 15 physicians organized by geographic region in self-governing, self-auditing groups. The multiple levels of governance, particularly the committees and pods, have been key to meaningful engagement throughout the organization. Through this structure, the ACO is able to empower its physicians with data, education, and most importantly, a meaningful seat at the table.

The ACO's pod structure has proven to be a valuable avenue for engagement in many ways. First, the pods create smaller, more tangible networks for motivation and support. For example, the ACO gives its physicians access to quality and cost outcomes data on all of their pod peers. Providers are also given pod-level transparency into the distribution of shared savings and other bonuses from the ACO's risk-based contracts, showing the amounts received and the reason. According to ACO leaders, this kind of peer pressure and sensitization has been valuable in driving higher engagement and higher performance.

Another positive but unexpected benefit of the pod structure has been its ability to facilitate bottom-up innovation. In the beginning, the ACO expected to inform all clinical care protocols and institute changes driven by the board and quality committee. However, the pods have been the primary source of practice transformation and also a system for meaningful frontline engagement. Since they were first established in 2013, the pods have produced a number of clinical care protocols, some of which have led to network-wide performance improvement initiatives. When a pod develops an idea for a new clinical protocol, the pod's elected physician representative takes the idea to the appropriate committee (e.g., Quality Performance, Utilization Review & Management, Credentialing, Network Adequacy), which then vets the proposal for the expanded use by other pods, even to potentially be instituted network-wide by the board. For example, one of these pod-driven ACO protocols asks that pod practices rotate offering extended hours at least three nights per week, allowing other pod physicians to refer patients to the open-late practice.

While the ACO's thoughtful governance structure has enabled physician engagement and enhanced participation in value-driven activities, UTSW has also implemented a number of strategies to directly engage and empower physicians. Its Quality Performance Program provides financial incentives for behavior change, independent of the ACO's risk-based contracts. In the first year, bonuses are tied to certain activities and process measures (e.g., installation of the EHR and having it functioning within 3 to 6 months, attending

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AccountableCareLC.org

DRAFT

HOW YOU CAN HELP

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WE HAVE MORE TO DO

HOW YOU CAN HELP

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TEXT
YOUR NAME
YOUR EMAIL
TO: 201.783.3255

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THANK YOU!