Healthcare Today: Rethinking Healthcare and Health: The New Health System

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Changing Healthcare Context

Fee for Service  Pay for Performance  Shared Savings  Shared Risk  Global Payment

Focus on Individuals  Individuals and Populations  Individuals, Populations and Communities

Care  Care and Cost  The Triple Aim

Do to  Do for  Do WITH
First Curve to Second Curve Markets

Volume Based First Curve
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital focus
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive
- Regulatory actions impede hospital-physician collaboration

Value-Based Second Curve
- Payment rewards population value, quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- Increased patient severity
- IT utilization essential for population health management
- Scale increases in importance
- Realigned incentives encouraged coordination

First Curve to Second Curve

- Netflix
- Blockbuster Video
### Strategies
- Provider-hospital alignment, integrated network
- Quality and Patient Safety
- Efficiency through productivity management
- Integrated Information Systems
- Payor–provider partnerships

### Competencies
- Accountable governance and leadership
- Patient Centered care models
- Strategic Planning in unstable environment
- Use of electronic data for quality and population health mgmt

### Potential Paths to the Second Curve
- **Redefine**: from a hospital based to a true delivery system
- **Integrate**: clinically integrate with providers and payors
- **Partner**: with larger system or health plan for at risk contracting
- **Experiment**: New payment models: ACO, Bundle Payments
The Key: Co-Evolution
Payment model and care model must support each other and evolve in parallel; New opportunities to care differently

The Transition to Population Health

Payment Continuum
Driving consistency in Quality care by changing the way we pay

Level of Financial Risk
Degree of Care Provider Integration and Accountability
The Massachusetts Experience

- Healthcare Reform 2006
  - Coverage
- Payment Reform 2010
  - BCBS AQC
- Creation of Networks
- Care Model Changes
- Data Analytics

The High Value Population Health Network
Improving Value Principles

- **Reduce Practice Variation:**
  - Sites of care, practice guidelines

- **Reduce Unnecessary Care:**
  - Choosing Wisely

- **Reliable Care: No defects**
  - Quality measures
  - Patient safety, harm events
  - Readmissions

- **Patient Centered Care and Measurement**
Patient Safety: Eliminating Harm

- Total Patient Harm is key to High Value Care
- Tracking Total Harm as a core improvement strategy
- Easy to understand; tracked by QI and Governance
- Transparency

Eliminating Total Patient Harm

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<td>8.48</td>
<td>6.7 († All by 2014)</td>
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Golden Valley Memorial Healthcare
Clinton, Missouri
Top Strategies for Eliminating Harm

- Transparency of Data: Total Harm Rate
- Governance of Improvement:
  - Leadership and accountability
- A Culture of Safety: Teamwork and Psychological Safety
- Improvement Capability
- Reduction in Practice Variation

PATIENT-CENTERED MEDICAL HOME (PCMH)
An Enhanced Primary-Care Model, Delivering

Access, Patient Engagement, Consistent Care Models, Patient Outreach
The Medical Neighborhood
“Right Care, Right Place, Right Time”

• Care Coordination
• Care Models/care agreements
• Population Management • Case Management

Decrease Inappropriate Utilization

- Imaging Use:
  - “in a study of 2000 MRI requisitions, more than half of the requests for lumbar spine were for indications considered inappropriate”

- Lab Tests

- Medication Management
Decrease Inappropriate Utilization

- Imaging Use
- Lab Tests:
  - 40% of patients are discharged with pending labs infrequently followed up


Appropriate Use of Resources: End of Life

- 90% of hospitalized patients with advanced end stage cancer receive antibiotics during the week prior to death
- 42% of nursing home residents with advanced dementia are prescribed antibiotics during last two weeks of life

Payor Partnerships: Payment and Integration

FFS Volume Based Care

P4P Quality and Efficiency

Alternative Payment Models Value Based Care

Bundled and Global Payments w/ Risk

Independent/Fragmented “A patient”

Interdependent/Coordinated “Population”
Episode-of-Care Based Bundled Payments

A single payment, per case, for all services associated with an acute inpatient care episode across silos of care and creating a bundle

The Joint Commission
Journal on Quality and Patient Safety

Care Processes

Experience with Designing and Implementing a Bundled Payment Program for Total Hip Replacement

Winthrop E. Whitcomb, MD; Tara Lagu, MD, MPH; Robert J. Krushell, MD; Andrew P. Lehman, MD; Jordan Greenbaum, MD; Joan McGirr, BSN, RN; Penelope S. Pekow, PhD; Stephanie Calcasola, MSN, RN; Evan Benjamin, MD; Janice Mayforth; Peter K. Lindenauer, MD, MSC

Bundled payments, also known as episode-based payments, represent the reimbursement of health care providers for projected costs over a distinct episode of care. They are an alternative to the current fee-for-service payment system, in which hospitals and physicians are paid for each service provided. A number of health systems have begun to report their experience with bundled payments, with mixed results. Background: Bundled payments also known as episode-based payments, are intended to contain health care costs and promote quality. In 2011 a bundled payment pilot program for total hip replacement was implemented by an integrated health care delivery system in conjunction with a commercial health plan subsidiary. In July 2015 the Centers for Medicare & Medicaid Services (CMS) proposed the Comprehensive Care for Joint Replacement Model to test bundled payment for
Core Competencies of IT Infrastructure for Clinical Integration

- **Network Connectivity**: Establish an integrated network, with seamless patient data exchange across the continuum of care; MD to MD communication.
- **Clinical Knowledge Management**: Create mechanisms for instilling evidence-based medicine, decision support, cost and quality analytics, real time tracking.
- **Patient Activation**: Activate patients in their own care to improve outcomes, health.
- **Financial Operations**: Adapt financial systems for flexibility under a variety of new payment methodologies.
- **Population Risk Management**: Leverage analytics to assess, manage population health risk and total cost of care; care management.

**Improving Clinical Care**

**Adapting Administrative Infrastructure**

**Data Management & Population IT**

What is Population Health Management

- **DATA AGGREGATION**: Various Data Sources (EMR, Claim, HIE, Etc).
- **RISK STRATIFICATION**: CHF, Diabetes, Etc.
- **CARE COORDINATION**: Disease Registries (condition-specific external view of data).
- **PATIENT OUTREACH**: Clinical Outcomes.

**Single Source Data File**: Aggregated, normalized and dropped into data warehouses such as HPI.
Transitions in Care

- **Hospital:**
  - Risk Screen patients
  - Communication to PCP
  - “teach back”
  - Interdisciplinary rounds
  - End of life discussions
  - Medication reconciliation program!

- **At Discharge:**
  - Follow up appointment
  - Detailed d/c instructions
  - Teach back at d/c
  - Selection of narrow PAC network, VNA and SNF

- **Post Discharge:**
  - Follow up phone calls
  - Medication rec
  - Community network
  - Case Management

Post Acute Care

- **Narrow Network of Partners**
- **Quality and Citizenship Ratings**
- **Embedded Providers**
- **Seamless Communication**
Clinical Integration: The Path to Population Health

THE UNDERPINNING BUILDING BLOCKS

- Access
- Team-based Care
- Top Quality
- Patient Safety

- HIT Analytics
- registries
- Scorecards
- PI Reported Outcomes

- Electronic Medical Record
- Care Coordination
- Shared Patient Info (HIE)
- Communication
- End-of-Life Care

- Bundled Payments
- Decrease Utilization/Practice Variation
- Transitions of Care
- Care Models and Agreements

- Community Providers
- Alternative Care Sites (Post Acute Care, UC, home care))
- Payors
- Employers

- Patient Engagement
- Culture of Health
- Alternative Visits (telehealth)
- Patient Portal
- Pro-Active Outreach

Measurement

- Accountable Quality Volume System
- Current Quantity Volume System

- Patient Centered Medical Home
- Patient Engagement (Enrollment)
- High Value Network
- Care Management and Care Navigation
- Population IT and Data Management
- Bundled Payments / Episodes of Care
- I PAIN: Cost Efficiency
- Payment Models
Examples: Strategic Plan

Nationwide Children’s Hospital (OH)

Strategic Plan:
1. Do not harm me
2. Cure me
3. Treat me with respect
4. Navigate my care
5. Keep me well
Examples: Bellin Health:

- From Healthcare to Health
Table Discussion

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