A Values Based Approach to Accountable Care

December 4, 2016
Orlando, FL

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Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<tbody>
<tr>
<td>1:00pm-1:10pm</td>
<td>Welcome</td>
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<tr>
<td>1:10pm-1:40pm</td>
<td>Surviving and Thriving in Value-Based Care</td>
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<tr>
<td>1:40pm-2:30pm</td>
<td>World Café</td>
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<td>2:30pm-2:45pm</td>
<td>Break</td>
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<td>2:45pm-4:00pm</td>
<td>Accountable Care in Action</td>
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<td>4:00pm-4:25pm</td>
<td>Insights, Reflections, and Questions</td>
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<tr>
<td>4:25pm-4:30pm</td>
<td>Wrap Up</td>
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Who We Are

Evan Benjamin, MD, FACP  
*Baystate Health*  
Senior Vice President for Quality & Population Health and  
Chief Quality Officer

George Kerwin, FACHE  
*Bellin Health*  
President and Chief Executive Officer

Saranya Loehr, MD, MPH  
*Institute for Healthcare Improvement*  
Head of North America Region

Surviving and Thriving in Value-Based Care
A Time of Transition and Predictions

• “Repeal and Replace” will take time and will likely not be as drastic as suggested
• MACRA was passed with broad Congressional support
• The consensus is that the move from volume to value will remain
• Most agree on the aim…better health, better care, lower cost
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

IHI High-Impact Leadership Framework

- Create Vision and Build Will
- Driven by Persons and Community
- Develop Capability
- Deliver Results
- Shape Culture
- Engage Across Boundaries
Key Drivers to Achieving Population Health Transformation

- Leading change during a time of transformation
- Using data to drive performance improvement
- Galvanizing physicians to support value-based care
- Partnering with patients in their care
- Effectively partnering with community organizations
- Redesigning care
- Leveraging payment models to achieve clinical and financial targets

Potential Paths to Value

- **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
Healthcare Delivery:
Goal: “Improvement in Value”

- **Reduce the costs** of care
  - Removing waste, unnecessary treatment
  - Improving efficiency through redesign of care model

- **Care Redesign** to achieve improvement in value
  - Outcomes that matter
  - Costs over time/an entire episode

- **Measures** that capture quality-outcomes and costs that make sense

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Healthcare *and* Health

- Challenging what true stewardship of a healthcare organization is

- Asking leadership and boards to assume responsibility for a populations’ health and the use of common resources

- Improving healthcare delivery and seeing the boundaries of healthcare delivery
Healthcare and Health (cont’d)

- Shift in accountability for overall health
- Understand social determinants of health
- Understand the health needs and assets of the community
- Reallocate strategic priorities and resources in the face of uncertainty

Strategies:
- Provider-hospital alignment, integrated network
- Quality and Patient Safety
- Efficiency through productivity management
- Integrated Information Systems
- Payor–provider partnerships
- Focus on community health

Competencies:
- Accountable governance and leadership
- Patient Centered care models
- Strategic Planning in unstable environment
- Use of electronic data for quality and population health mgmt
The Quality, Ethics, Value Linkage

- There is a linkage between quality, ethics, and value. When quality problems occur they generally create ethics conflicts. Similarly, when ethical conflicts occur, they often result in value and quality issues.

<table>
<thead>
<tr>
<th>Ethics Principles</th>
<th>Application to Value and Quality</th>
<th>IOMs Aims</th>
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<tbody>
<tr>
<td>Autonomy</td>
<td>Respect patient self-determination, promote shared decision making</td>
<td>Patient centered</td>
</tr>
<tr>
<td>Beneficence</td>
<td>Provide only effective care to meet patient's best interest</td>
<td>Effective, safe, timely, patient centered</td>
</tr>
<tr>
<td>Non-maleficence</td>
<td>Avoid and protect the patient from harm</td>
<td>Safe, effective, patient centered</td>
</tr>
<tr>
<td>Social &amp; Distributive Justice</td>
<td>Provide fair allocation and of resources and equitable access to services</td>
<td>Equitable, efficient</td>
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New Mental Models

Volume

- Patient Satisfaction
- Increase Top-Line Revenue
- Complex All-Purpose Hospitals and Facilities
- Quality Departments and Experts

Value

- Persons as Partners in Their Care
- Continuously Decrease Per Unit Cost and Waste
- Lower Cost, Focused Care Delivery Sites
- Quality Improvement in Daily Work for All Staff
# High-Impact Leadership Behaviors

1. **Person-centeredness**
   - Be consistently person-centered in word and deed

2. **Front Line Engagement**
   - Be a regular authentic presence at the front line and a visible champion of improvement

3. **Relentless Focus**
   - Remain focused on the vision and strategy

4. **Transparency**
   - Require transparency about results, progress, aims, and defects

5. **Boundarilessness**
   - Encourage and practice systems thinking and collaboration across boundaries

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**World Café**
World Café

• To share knowledge, stimulate creative thinking, and explore real-life issues and questions
• To get to know one another
• To foster small group dialogue in a large group

World Café: How it Works

• Break into smaller groups
• Each group will convene at a station
• Each group will spend 10 min discussing a topic
• When time is called, the group will rotate clockwise the next station to discuss a new topic
Participant Roles

- Introduce yourself (name and location)
- Contribute your thinking via conversation
- Listen to other participants
- Build on participant comments
- Link ideas from previous group

Key Drivers to Achieving Population Health Transformation

- Leading change during a time of transformation
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Leading Population Health Transformation
Let’s Get Started!

Key Drivers to Achieving Population Health Transformation

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Leading Population Health Transformation
Break
Baystate Health Is Committed to the Development of an Integrated Regional System of Care for All Residents of Western Massachusetts

Integrated Delivery System
- Baystate Medical Center – Tertiary Center
- Baystate Mary Lane, Baystate Wing, Baystate Franklin, & Baystate Noble Community Hospitals
- Baystate VNA and Hospice
- Baystate Medical Practices (650 MDs and advanced practitioners)
- Baycare Health Partners (3,100 MDs in our PHCs)

Integrated Health Plan
- Over 200,000 Members
- Only Provider Sponsored Health Plan offering Commercial, Medicare Advantage and Medicaid Managed Care Choices
- Medical Home for all lines of business, including MassHealth

Focused on Quality
- Nationally Recognized for Quality Care: Leapfrog Top Hospital - Truven Top 100 - Top 100 Integrated Systems - Magnet Designation - NCQA level 3 PCMH
- Health New England: Top 10 health plan in country #1 in customer service in the country

Committed to Academics
- Western Campus of Tufts University - 320 Residents
- Educated 1/3 of PCPs in Region
- Pioneer Valley Life Science Institute
- Center for Quality of Care Research
- Techspring - IT Innovation Center

Partner to the Community
- Volunteer Community Board
- $40M Hospital Community Benefit
- Partners for a Healthier Community Public/Private Partnership
- Baystate – Springfield Educational Partnership
- $2.6B Economic Impact

“To Improve the Health of the People in Our Communities Every Day, with Quality and Compassion”

Baystate Health 2020 Strategy

We prioritize safety by creating high reliability systems managed by highly functioning and engaged care teams.

We provide value to our community with smart growth and improved population health: high quality, affordable care.

We deliver high quality with best practices in clinical models of care for both individuals and populations.

We focus on the patient experience with access across the continuum of care that exceeds expectations.
Baystate Health Population Health

- **2006:** Massachusetts Healthcare Reform – Coverage
- **2010:** MA Reform: Healthcare Costs – state pressure on commercial payers and providers
- **2010:** BCBS MA began “Alternative Quality Contract” – Shared savings on global budget
- **2011:** HNE global contracting to mirror risk
- **2011:** Bundled Payment with HNE, owned health plan
- **2012:** CMS MSSP ACO ‘12-’15
- **2013:** CMMI Bundle Payments for Care Improvement (BPCI)
- **2016:** CMMI Next Generation ACO
- **2016:** Oncology Care Model Bundled Payment (OCM)
- **2016:** CMMI Transforming Care Practice Initiative (TCPI)
- **2016:** MA DSRIP Medicaid ACO

Next Generation ACO: Advantages

- **Benchmark:**
  - Prospective, predictable and stable
  - No rebasing
  - Rewards attainment and improvement
  - HCC risk scores may grow
  - No minimum savings rate
- **Beneficiary Attribution:**
  - Prospective with attestation
- **Beneficiary Benefit Enhancements:**
  - SNF 3-day rule waiver
  - Telehealth
  - Post-discharge home visits
  - Co-pay waivers
- **Payment Model:** getting “all in” not two canoes
Co-Evolution: Payment and Care Model

- Payment model and care model must support each other and evolve in parallel
- New opportunities to care differently;
- In-progress - develop future reimbursement model (capitation)

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**
Baystate Health Path to Population Health

1. Create High Value Network
2. Primary Care redesign: PCMH and care management
3. Knowledge of Costs and Spending, simple risk stratification
4. Partnerships – Integrated Behavioral Health, Narrow Post-Acute Care network
5. Care redesign: primary care, specialty care, care models
6. Data/Information Technology: HIE, Analytics, Risk Stratification, Care Management
Quality and Population Health:  
Multi-Year Strategy

- High Value Patient Care
  - Creation of High Value Network
  - Team Based Care
  - Top Quality

- Knowledge of Population
  - HIT Analytics
  - Scorecards
  - Registries
  - HIE

- Integration of Care
  - Integrated Behavioral Health
  - Care Management
  - End of Life Care

- Patient / Member Engagement
  - Alternate & E-visits
  - Proactive Outreach
  - Direct Primary Care

- Partnerships
  - Alternate Care Sites
  - Post-Acute care
  - Urgent Care
  - Community Health

- Medical Management
  - Care Models and Agreements/Specialist Engagement
  - High End Radiology
  - Bundled Payments

The Intersection of the Aligned Provider Network

Combining Payment Models to Control Costs

Higher Quality Care

Lower Total Cost of Care
Engaging Specialists

Costly Care
Appropriate use & less expensive sites

Quality Care and Patient Satisfaction

Enhanced Access
unnecessary ED visits Hospital admissions & readmissions; leakage

Coding
Benchmark & Identify complex patients in need of more care

Bundles In & Out Patient

Governance Active Participant

Specialists

NGACO -MACRA -Funds flow -P4P Projects

PCP Collaboration
Care models, co management, re-visits & HIE

Risk Adjusted Member Months
factored by
- Efficiency
- Quality
- Citizenship

Unique Patients x Intensity
factored by
- Efficiency (HCC coding)
- Quality (patient satisfaction)
- Citizenship

NG-ACO Funds Flow Model

<table>
<thead>
<tr>
<th>Inter-Provider Split</th>
<th>Intra-Provider Split</th>
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<tr>
<td><strong>Surplus/Deficit</strong></td>
<td><strong>Risk Adjusted Member Months</strong></td>
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<tr>
<td><strong>Participant s</strong></td>
<td>Factored by</td>
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<tr>
<td>Primary Care</td>
<td>Efficiency</td>
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<tr>
<td>Specialty Care</td>
<td>Quality</td>
</tr>
<tr>
<td>Hospital</td>
<td>Citizenship</td>
</tr>
<tr>
<td>NGACO (2016-18)</td>
<td><strong>Unique Patients x Intensity</strong></td>
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<tr>
<td>55%</td>
<td>Factored by</td>
</tr>
<tr>
<td>20%</td>
<td>Efficiency (HCC coding)</td>
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<tr>
<td>25%</td>
<td>Quality (patient satisfaction)</td>
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<tr>
<td></td>
<td>Citizenship</td>
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Healthcare Delivery Model

- Primary Care redesign
  - Prevention, Coordination, Navigation, Behavioral
  - Patient Outreach and coaching
- Preventable ED and Admission avoidance
- Improved transitions of care
- Specialty- Primary Care agreements
- Access and Communication
- End of life care
- Decrease ineffective care/utilization
- Bundled Payment Models

OVERKILL

An avalanche of unnecessary medical care is harming patients physically and financially. What can we do about it?

BY ATUL GAWANDE

H. Gilbert Welch, a Dartmouth Medical School professor, is an expert on over diagnosis, and in his excellent new book, "Less Medicine, More Health," he explains the phenomenon this way: we’ve assumed, he says, that cancers are all like rabbits that you want to catch before they escape the barnyard pen. But some are more like birds—the most aggressive cancers have already taken flight before you can discover them, which is why some people still die from cancer, despite early detection. And lots are more like turtles. They aren’t going anywhere. Removing them won’t make any difference.

We’ve learned these lessons the hard way. Over the past two decades, we’ve triped the number of thyroid cancers we detect and remove in the United States, but we haven’t reduced the death rate at all. In South Korea, widespread ultrasound screening has led to a fifteen-fold increase in detection of small thyroid cancers. Thyroid cancer is now the No. 1 cancer diagnosed and treated in that country. But, as Welch points out, the death rate hasn’t dropped one iota there, either. (Meanwhile, the number of people with permanent complications from thyroid surgery has skyrocketed.) It’s all over-diagnosis. We’re just catching turtles.
Knowledge of the Population

- Registries
- Risk Stratification
- Patient Reported Outcomes
- Predictive analytics
- Geographic information systems

Core Competencies of IT Infrastructure

- 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
Community Health

- Partnerships with agencies
- Community Health Needs Assessment
- Link to Core population health strategy of system
- Understand social determinants of health
- Plan to mitigate risk of poor health

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
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.

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

Quality and Population Health: Multi-Year Strategy

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- Population Health
  - Alternate & E-visits
  - Proactive Outreach
  - Direct Primary Care
Why and How Bellin Health has Taken Accountability for the Health of its Population

George Kerwin, FACHE
Bellin Health

Driven by Persons and Community
Driven by Persons and Community Segmentation is a Critical Skill

A Shift in the Corridor

<table>
<thead>
<tr>
<th>Low Risk</th>
<th>High Risk</th>
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<tr>
<td>Low Coordination</td>
<td>High Coordination</td>
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<tr>
<td>Insure Health</td>
<td>Manage Health</td>
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<tr>
<td>Anthem Commercial</td>
<td>Medicare FFS</td>
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<td>Humana Medicare Advantage</td>
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<tr>
<td>UHC Commercial ACO</td>
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<td>UHC Medicare Advantage ACP Program</td>
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<td>WPS / Arise</td>
<td>Other Fee for Service Contracts</td>
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<td>BCBS of Michigan Commercial &amp; Medicare Advantage</td>
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<td>Network Health Plan</td>
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<tr>
<td>UHC Commercial FFS (Future Increases tied to Quality Metrics)</td>
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<td>TODAY</td>
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Build Will

Bellin Health Mission:
Bellin Health is a community-owned not-for-profit organization responsible for improving the health and wellbeing of people living in Northeast Wisconsin and the Upper Peninsula of Michigan, and all others we serve.

We carry out this responsibility through individualized care excellence, community health improvement, and equitable healthcare financing plans—all designed to positively impact health and wellbeing. We are steadfast in our commitment to providing compassionate, safe, and coordinated care that is accessible and affordable for everyone.

We build trusted relationships and advance true collaboration, fueling our desire to constantly improve and innovate.

Build Will

Bellin Health Vision:
The people in our region will be the healthiest in the nation, resulting in improved economic vitality in the communities we serve.
Develop Capability: The New Integrated System

Developing Capability: Scaling the System
Develop Capability: Look for the Right Tools

9 Steps to Population Health

Step 1: Understand the Population
- Risk Stratify (includes Psychosocial & Social Economic considerations)

Step 2: Define Goals
- For the Patient
- For the Care Team
- For the System
Develop Capability

9 Steps to Population Health

Step 3: High Level Design
- Extended care team members based upon data...how much/how many
- Specialty physician alignment
- Resource assessment
- Develop overall strategies

Step 4: Activate the Care Team
- Workflows
- Training
- Team building
- Visit
- Between visit

Develop Capability

9 Steps to Population Health

Step 5: Engage the Individual
- Goals Setting
- Activation at appropriate level

Step 6: Measure Outcomes
- How are we doing compared to goals

Step 7: Provide Feedback
- Team feedback on performance

Step 8: 30 Day Performance (action) Plan

Step 9: Recalibrate Goals
- Celebrate
Deliver Results

Bellin Health

- **Covered Employee Health Plan Lives:**
  - 2,272 with health plan
  - 5,050 total employees and dependents covered

- **Health Costs:**
  - 1.25% average increase last 4 years
  - 15% below average employer spend

- **Health Risk Appraisal Scores:**
  - 4.2 points above national average

- **Savings per year from average employer spend:**
  - $3,941,820 per year
Deliver Results

Employer Products

1. Corporate Challenge
   - Make it fun
     - Peer-based
     - Competition
     - Energize employees
     - Focus on improving overall health

2. Individual Programs
   - Maximum flexibility
     - HRA's
     - Nutrition/Fitness
     - Occupational Health
     - Rehabilitation, Ergonomics
     - Weight Management
     - Tobacco Cessation

3. Onsite Clinics
   - Onsite convenience
     - RN
     - Therapist
     - Nurse Practitioner
     - Physicians’ Assistant
     - Physician

4. Strategic Partner
   - Guaranteed lower cost
     - Shared savings
     - Pay for Performance
     - HRA improvement
     - Peer group roundtable

Deliver Results

Strategic Partner Employers

- **Employers:** 16
- **Covered lives:**
  - 26,432 employees and dependents
- **Health Costs:**
  - 2.8% average increase last 4 years
- **Health Risk Appraisal Scores:**
  - 7.1 points above national average

“Win” for Employers
Deliver Results

Brown County Municipality

- Covered Employee Health Plan Lives:
  - 1,341 employees with health plan
  - 3,462 total employees and dependents covered
- Health Costs:
  - 3.3% average decrease last 4 years
  - 2015 Brown County spend at $10,834/EE/plan
  - 2015 Av. WI County spend at $14,446/EE/p
- Health Risk Appraisal Scores:
  - 5.7 points above national average
- Savings per year from average WI County spend:
  - $4,843,692 per year

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Deliver Results

PIONEER
Medicare Accountable Care Organization

- Medicare Recipients:
  - 20,000
- Health Costs:
  - $8,521 per person
  - Lowest of all Pioneer ACOs
- Quality Scores:
  - 94.5% overall score
  - Highest of all Pioneer ACOs
- Total Savings Below National Trend for 3 Years
  - $13,693,000
- Our Share of the Savings
  - $9,585,000
A Shift in the Corridor

Insights, Reflections, and Questions
Wrap-up