"THE TIMES THEY ARE A-CHANGIN' – HOW ARE YOU LEADING?"

Breckenridge Forum; February 24 – 25, 2015

BACKGROUND

In 1964, Bob Dylan released his now legendary song *The Times They Are A-Changin'*. Some of the lyrics from this timeless classic are especially pertinent in healthcare today and became the inspiration for this forum:

Come gather 'round people
Wherever you roam
And admit that the waters
Around you have grown
Then you better start swimmin'
Or you'll sink like a stone
For the times they are a-changin'.

The healthcare landscape in the United States is undergoing a systematic transition from which no organization is immune. As the industry moves towards value-based healthcare, healthcare leaders must strategically steer their organizations through changes that could fundamentally transform the way care is delivered. "The times they are a-changin – how are you leading?" forum held in Breckenridge, Colorado gathered ten organizations, with demonstrated success in improving quality and access to care while also lowering healthcare costs, for a two-day discussion on their approaches towards delivering higher value healthcare.

PARTICIPATING ORGANIZATIONS AND PRESENTATION TOPICS

1. Arizona State University (Host)
2. Ascension Health: "Health City Cayman Islands – An Experiment Worth Noting"
3. Banner Health: "Banner's Intensive Ambulatory Care via Telehealth"
4. Denver Health: "Population Health – Informed Care at Denver Health"
5. Everett Clinic: "Working with Employers – The Boeing Experience"
6. Grand Junction, Colorado: "Grand Junction – Challenged to Change"
7. Intermountain Healthcare: "Intermountain's Shared Accountability Commitment"
8. Mayo Clinic: "Nontraditional Patient Base Strategies"
9. Medical Group Management Association (MGMA): "Views Seen by a Broader MGMA Membership"
10. North Texas Specialty Physicians (NTSP): "How Can a Small IPA Compete with the Big Boys"
11. Via Christi: "Via Christi Response to Value Based Purchasing"

COMMON TERMS HEARD AT THE FORUM (IN ALPHABETICAL ORDER)

- Care coordinators
- Collaboration
- Cost reduction/ containment
- Downside risk
- Expanding/ owning health plans
- Financial incentives/ alternative physician reimbursement
- Home-based healthcare
- Patient centeredness
- Physician leaders
- Population health/ individualized medicine
- Providers working at top of scope
- Reducing readmissions
- Risk stratification/ defined populations
- Shared vision
- Teamwork/ team-based models
- Technology
- Telehealth

COMMON THEMES DISCUSSED:

Vision: Organizational Leadership

Each organization represented at the forum demonstrated a shared vision and direction in which they are moving. As would be expected, the specific vision statements and the manner in which each organization actualized their vision varied among the groups. However, all organizations were aligned in terms of seeking a solution to one simple question: What is the right thing to do for our patients?

Two common visionary themes appeared among the forum organizations as priority goals:

1. *High value health:* A shared responsibility between patients and providers to maximize the behaviors, resources, and knowledge necessary to achieve optimal health.
2. *High value healthcare:* Defined as producing optimal outcomes by delivering the right treatment, to the right patient, at the right time, in a safe and effective environment that meets the needs of the patient and doing so in a cost effective manner.

The organizations at this forum could be described as early adopters within the realm of finding solutions to achieve both of these goals. They have already taken initial steps to culturally and systematically align their organizations in a way to embrace the necessary changes. For these 10 organizations, it is not a question of whether or not they need to accomplish these goals, but rather how to do so at an appropriate pace. With an industry that continues to move through immense political and systematic reform, organizational timing with key quality and/or cost containing improvements becomes fundamental for success.

What is currently happening?

Opportunities

Each of the organizations discussed current methods in which they are approaching the transition to value-based health and healthcare. Some are getting involved in more nationally recognized reform approaches such as the CMS Accountable Care Organization pilot program, while others are taking a more localized and internal restructuring approach. All are having success with increasing access, improving quality, and containing costs. It is interesting to note however, that much of the change seemed related to the pressures placed on the organizations by either consumers, employers or CMS. There was limited mention of changes stemming from requests by specific insurance companies.

Threats

Although each organization demonstrated successful progress towards their goals, none did so without overcoming barriers along the way. Furthermore, none were so naïve to ignore additional barriers they will likely face moving forward. For example, it is well known that many organizations involved with the CMS ACO pilot program have faced extensive challenges meeting the ever-changing program requirements, especially those organizations that already produce high quality at a lower cost. Additionally, there could be challenges ahead for those hospital-based organizations that fail to adapt to the overall changing landscape, specifically those organizations that continue forward with the traditional 'keep the hospital full' approach. David Gans from the ***Medical Group Management Association*** (MGMA) presented a quote that summed this up quite well:

"It is not necessary to change. Survival is not necessary." – W. Edwards Deming

What are the strategic and tactical responses to opportunities?

1. Focusing on population health: While this entails improving the health of an entire population, one key to effectively accomplish population health is through the efficient, individualized delivery of care.

2. Defining populations: It is important to accurately stratify members of the population into the appropriate level of care management that best suits their health needs. As one forum participant stated, "one size doesn't fit all." ***Denver Health*** has developed a proprietary risk stratification tool that allows them to accurately triage patients into one of four 'clinical risk groups' (CRGs):
    a. *Tier One: e-Touch/ Panel Management*: Lowest risk population, mainly contacted through text messages, emails, etc. with reminders about preventative care services and/or vaccinations.
    b. *Tier Two: Chronic Disease Management*: Patients with one or more chronic diseases are given the tools to effectively manage their disease and remain active in their everyday lives.
    c. *Tier Three: Complex Case Management*: Higher risk patients who present with complex levels of disease(s) are provided higher intensity case management.
    d. *Tier Four: High-Intensity Treatment Teams*: Highest risk patients, receive complex case management.

3. More high-touch patient management: This is especially critical for those patients that fall into the highest risk and highest cost categories. Once identified, care is delivered to these specific patient populations through specially developed care teams led by a physician. The physician leads could either be primary care physicians or specialists, as determined by the level of specialized knowledge needed to effectively treat a given patient. Based in Wichita, KS, ***Via Christi Health*** (VCH) HOPE is participating in the Program for All-Inclusive Care for the Elderly (PACE) to identify best practices for high-touch patient management. The results of this program show that better health outcomes while using fewer health resources can be achieved when care focus shifts from reactionary to preventative, interdisciplinary teams are utilized to coordinate care, and bundled financing models are used instead of fee-for-service.

4. Coordinating Care: Applying a team-based model to care delivery demands collaboration among all care providers involved. The ***Banner Health*** iCare Primary Care model leverages highly collaborative care delivery teams supported by technology and telehealth services to provide patients with the care they need while allowing them to remain in their homes. This care delivery model is comprised of five main components:
    a. *Patients home:* The main site of care delivery
    b. *Primary care physician (PCP) office:* The members' existing PCP and team
    c. *Telehealth team:* This team consists of physicians, social workers, registered nurses, pharmacists, care coordinators/care quarterbacks, and a health unit secretary. Through coordinated efforts, they respond directly to member requests for help and utilize software that looks for adverse trends in patient vitals, enabling the team to intervene before these adverse trends become adverse outcomes.
    d. *Mobile health team:* A health coach travels to the patient's home to engage the member in their own care. Other services such as home health, can be brought into the home to deliver needed medical care.
    e. *In home tools*: Bluetooth enabled measurement tools, provided to patients, allow the telehealth team to monitor vital signs such as weight, blood pressure, heart rate, and glucose levels. Patients are also provided a tablet which allows two-way audio and video conversation with the telehealth team, monitoring for early signs of depression and changes in pain levels, and communication of educational resources.

5. Aligning Incentives: An integral element of successful care coordination is aligned incentives. There are various manners in which to achieve this, but a highly successful approach links provider reimbursement to quality. For example, ***North Texas Specialty Physicians*** (NTSP), an independent physician association (IPA) consisting of both primary care and specialty physicians, capitates physician services based on specialty. Throughout the year, the physicians receive a predetermined percentage of their fee-for-service (FFS) payments for the care they deliver. At the end of that year, the physician may receive a bonus or payback based on meeting the division's capitation, quality metrics, and patient satisfaction requirements. By linking at least a portion of the physician's payment to both quality and cost metrics, NTSP physicians have an incentive to avoid over-utilization, yet ensure that patients receive the necessary care.

6. Extending Care Through Transitions: Through care transition services, patients are better monitored for adherence to discharge instructions including medication, rehabilitation, follow-up appointments, etc. significantly reducing their likelihood of a readmission.

7. Importance of RN and Allied Health: The incorporation of RN and other allied health staff into patient management provides opportunities for every provider to work at their highest scope of practice. It also allows for the right programs to be delivered by the most impactful care provider. ***Intermountain Healthcare*** (based in Salt Lake City, Utah), sought to significantly improve their patient medication adherence by having physicians review medication instructions with patients prior to discharge. At the time, approximately 64% of patients were receiving these instructions. After physicians were given specific instructions to review medications with every patient prior to discharge, this number increased to 68%. Not exactly the profound impact Intermountain was looking for. Upon further review, Intermountain Healthcare decided to shift this responsibility from the physician over to the discharge nurse. After giving nurses the exact same instructions, the number of patients receiving medication reviews prior to discharge went from 68% to 92% literally overnight, and currently stands at 98%.

8. Expanding/Owning Insurance Companies: Moving to full capitation and mini-capitation models allows for a more 'closed loop' business model that enables healthcare organizations to financially benefit from cost-saving innovations and models of care delivery. Many of the healthcare organizations represented at the forum have their own health plans or have established a closely integrated relationship with a private insurer. For example, the Mesa County IPA, located in ***Grand Junction, CO***, has partnered with Rocky Mountain Health Plans (Rocky), the area's largest health insurer to create a virtually integrated health system. Although both entities remain separate in terms of organizational structure, their collaborations and incentives are so closely aligned they function much like a fully integrated system. Through this partnership, physicians agree to have 20% of their income be contingent on quality performance and cost containment indicators. Therefore, the higher the quality of care delivered, the greater the financial reward given to the physician. Furthermore, this reward could be even greater if overall resource use is prudent. Additionally, Rocky agreed to pay physicians similar rates regardless of whether the patients are publicly or privately insured. This allows for unfettered access for all residents, especially Medicaid and Medicare beneficiaries. At the end of the day, it becomes a win for everyone involved. Rocky is able to contain costs, physicians are able to provide high-quality care and be financially rewarded for doing so, and patients from all demographics experience equal access to this care. All of the attending organizations expressed plans to take on greater financial risk through new payment models.

9. Increasing Use of Technology/Telehealth: Nearly every one of these new care delivery models includes the use of novel IT platforms and/or telehealth services. Denver Health is utilizing a system that not only stratifies their patients into four categories of risk to allow for a customized treatment approach, but also has the capability to communicate the patients risk category to all providers via their health records and hospital wrist bands. Grand Junction and NTSP both created their own Health Information Exchange (HIE), with features that allow physicians to see and read the notes that other providers recorded for a given patient. Banner Health has a 24-hour telehealth ICU specialist available, with a press of a button, to every one of its ICU beds. This allows ICU nurses to access additional support with administering medication, professional advice, and/or patient engagement. Additionally, this telehealth ICU specialist has the capability to monitor trends in the patient's vital signs, allowing for early detection of potentially devastating events.

10. Contracting with Employers: It is becoming more common to see major employers take proactive steps to collaborate and negotiate their health plans directly with providers. The Boeing Company recently approached the ***Everett Clinic*** and two other healthcare organizations to formulate a plan to provide care to its high cost, complex patients. Subsequently, a three-year pilot program developed that resulted in 20% lower per capita spending by these patients and Boeing. Encouraged by these results, Everett Clinic decided to transition this program over to a subset of high-risk Medicare Advantage (MA) patients. Launched in January 2015, this new pilot will again seek to use the same team-based model to lower costs and improve the health of high-risk patients.

11. Expanding Geographic Reach of Providers: As organizations transition their services towards value-based care, some are also simultaneously expanding these services to reach beyond their local population. ***Ascension Health***, headquartered in Missouri, has developed a strategic partnership with Narayana Health of India to build a 104-bed tertiary surgical hospital in the Cayman Islands. This hospital is specially designed to provide high-quality, low cost services for a limited set of specialty procedures. Through a number of incentives provided by the government of the Cayman Islands coupled with an adapted version of the Narayana 'minimalist' operating model, Ascension has been able to offer care at less than half the cost typically seen in the United States. ***Mayo Clinic*** is also seeking to expand the reach of its providers but through a virtual approach. Through its affiliated care network and use of technology such as telehealth services and mobile application development, Mayo Clinic seeks to build 200 million meaningful relationships by 2020.

Other discussion points worth noting:

1. Employing Physicians is Not Mandatory: Although most organizations would like to expand their employed group practices, they also recognize they will have to work collaboratively with independent physicians.

2. Hospital Admissions: It is interesting to note that there was no mention, by any organization, of the importance of keeping hospital beds full. The group uniformly accepted that for an efficient delivery system to evolve, the number of admissions per population must decrease. This is important since the use of hospital care is the biggest factor driving the difference between high cost and low-cost areas.

Operational challenges for the immediate future

1. Need for new payment models
2. Need for internal provider payment models encouraging and financially incentivizing efficiency, integration, and quality
3. Contracting with employers to deliver high value healthcare
4. Need to get the government to focus on payment models that keep the high-value providers in business rather than insisting on shared savings payment approaches which actually punish the high value providers and disproportionally benefit the high cost medical centers