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Coordinated Care 101: A Primer

APG Colloquium

Laura Jacobs, David DiLoreto, M.D., and Peter Valenzuela, M.D.

What You Can Expect From Today's Session

- What does coordinated care mean, anyway?
- The range of risk arrangements and the approaches required to succeed
- What others have learned in their journey within population health management
- Take-away tools, approaches, and strategies to succeed within population health management
- Role of leadership and cultural change within clinical transformation
- An interactive session – sharing questions, answers, and observations

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What's on the Agenda

- Intro to Coordinated Care: Why, Where, What, How
- Care Coordination Principles and Operating Framework
- Break
- Leadership, Culture Change, and Reinforcing Incentives
- General Q&A

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Section 1

Intro to Coordinated Care: Why, Where, What, How

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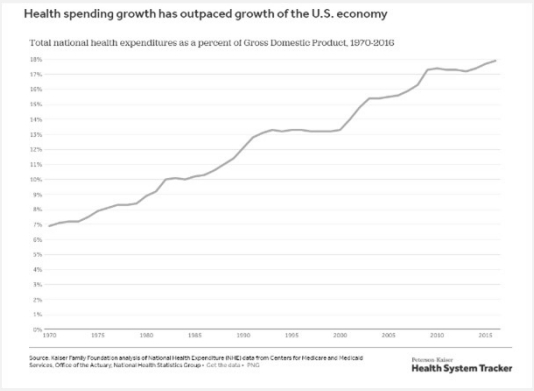
Why?

Follow the Money…

"The ballooning costs of healthcare act as a hungry tapeworm on the American economy."

- *Warren Buffet 2018*



A Tale of Two Cities:

Traditional Attempts at Lowering Costs only Exacerbate the Situation

Payers Use the Levers Available to Them

- Fee schedule reductions or modest increases
- Push services out of the hospital into outpatient settings (imaging, infusion)
- Site of service equality for clinic, ASC, other outpatient services
- Utilization management: Pre-authorization/Denials/Formularies
- Higher deductibles
- Tiered or narrow networks

Resulting in Provider and Consumer Frustration

- Pressures to increase productivity
- Rising administrative costs
- Higher bad debt
- Impact on patient access (maxed out provider schedules)
- Provider burn-out
- Service and care fragmentation
- Higher out of pocket costs for consumers

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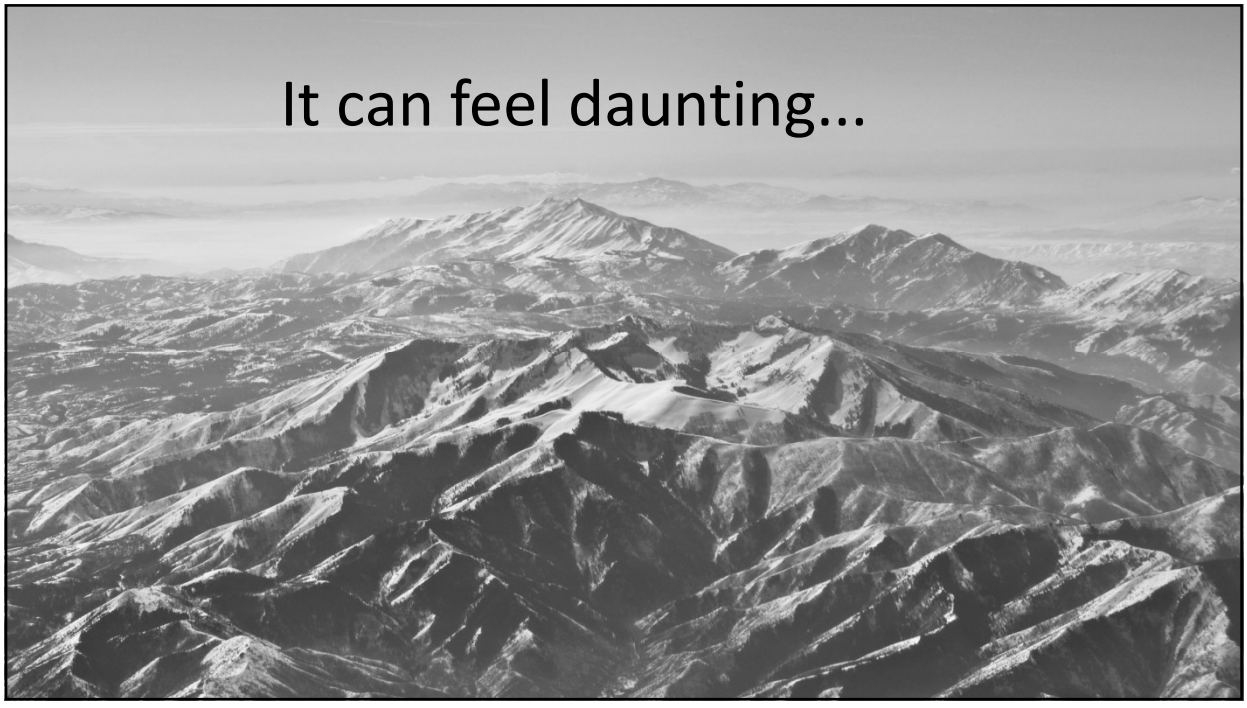
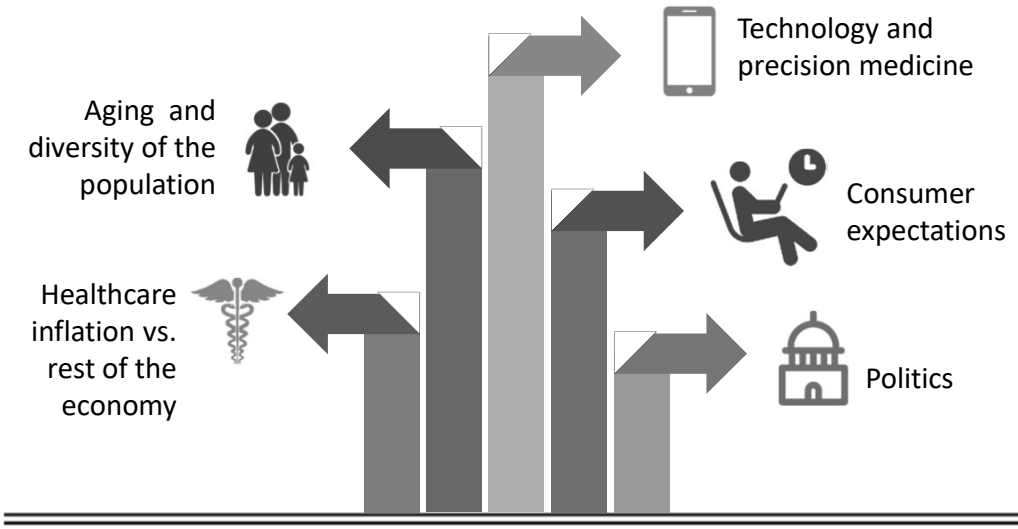
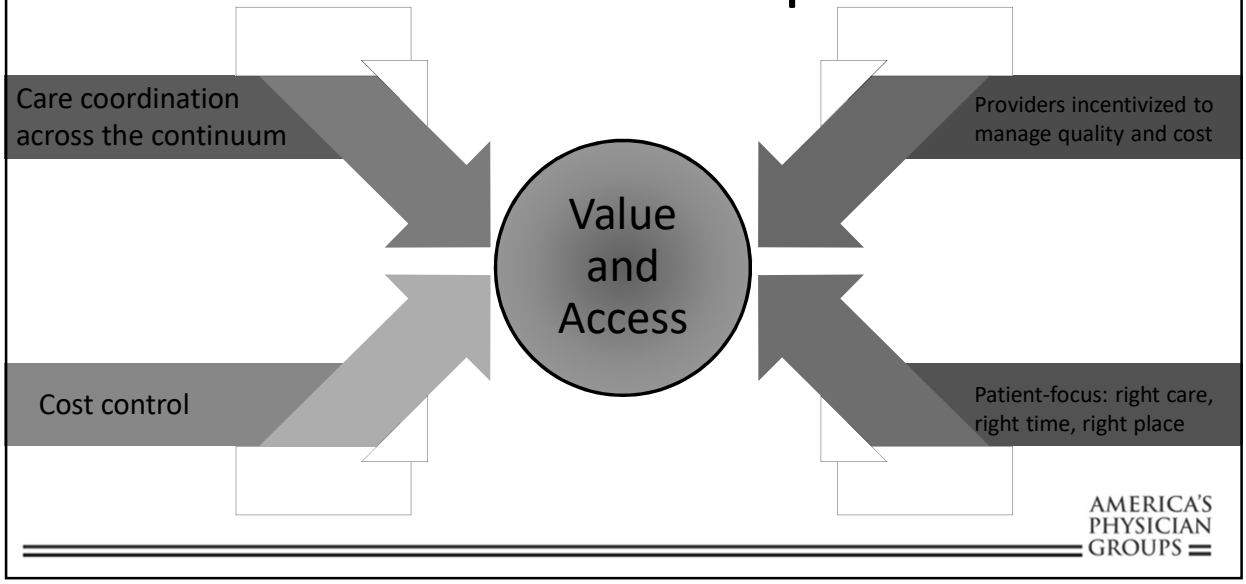


Macro Drivers of Change



What Does the Marketplace Want?



Consider the Facts…

33% of Medicare enrollees are in Medicare Advantage ("MA") plans

- 19.0 million MA enrollees; 45% increase between 2012-2017
- Nearly 1 in 5 MA enrollee is in a provider-sponsored plan

There are **1,011** active Accountable Care Organizations ("ACOs")

- 32.7 million individuals – 10% of US population; 6% annual growth
- 612 Medicare ACOs - 2018
- Commercial contracts represent more than half of all ACO covered lives

More planning to participate in **full risk**

- 47% of ACOs planning for shared savings/shared risk
- 38% planning for capitation
- MACRA incentivizes move to APMs
- CMS move to require two-sided risk

Source: Kaiser Family Foundation; Avalere; Leavitt Partners and the National Association of ACOs, Health Affairs 8/14/2018

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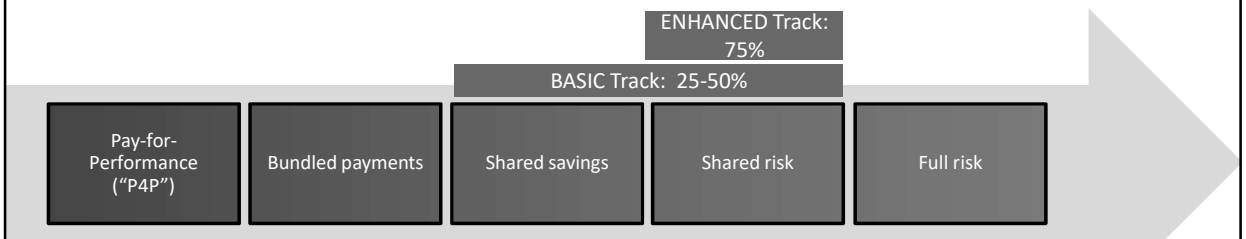
Medicare Models Continue to Focus on Greater Risk



Pay-for-Performance ("P4P")	Bundled payments	Shared savings	Shared risk	Full risk
• VBP • Readmit reduction • HAC • MIPS/APMs • CPC+	• CCJR • Cardiac Bundle • BPCI • Commercial Bundles	• MSSP: Track 1 (50%)	• MSSP: Track 1+ (50/30%) • MSSP: Track 2 (60%) • MSSP: Track 3 (75%) • Next-Gen (80-85%)	• Next-Gen ACO (full risk) • Provider-sponsored Medicare Advantage

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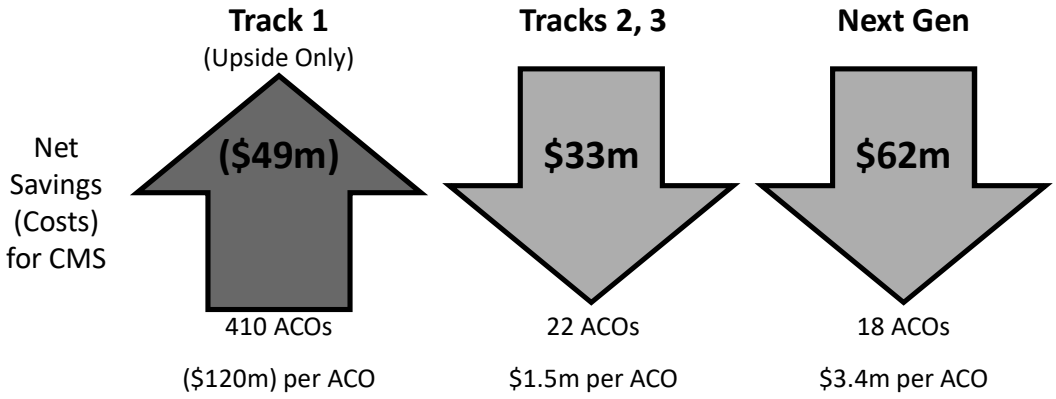
Medicare ACO 2016 Performance

Downside Risk = Medicare Savings



Source: CMS Analysis, Health Affairs Blog 8/9/18; NORC, University of Chicago, "Next Generation Accountable Care Organization Evaluation" 8/27/18

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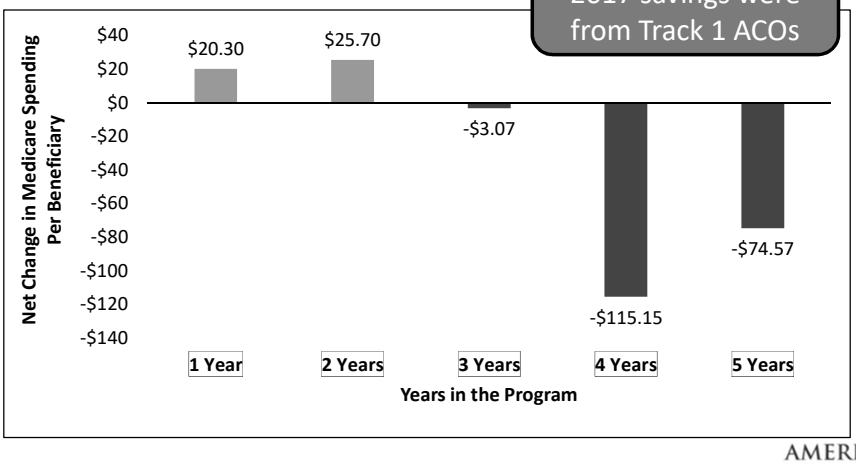
ACOs of All Types Perform Better Over Time*

$291/$314M 2017 savings were from Track 1 ACOs

Net Reduction in Medicare Spending per Beneficiary by ACO's Number of Years in the program based on analysis of 2017 CMS data



*Source: Avalere, 2018

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Disruptors: Accelerating the Change

UnitedHealthcare

amazon

Google

BERKSHIRE HATHAWAY INC.
J.P.Morgan

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Employers Are Increasingly Taking Action...

Walmart
Save money. Live better.

intel

GM

Qualcomm

LOWE'S

BOEING

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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 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

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But they call it "risk" for a reason...

Major health systems announce losses in provider-owned health plans

- Sutter Health Plan lost $12.2M during the first half of 2017 on an enrollment of 48,284.
- Northwell announced closure of its health plan, CareConnect, after losing $157.8M in 2016.
- Memorial Hermann Health Insurance lost $15M in 2016.

Yet...

- Kaiser Permanente generated $2.2B in operating income in 2017.

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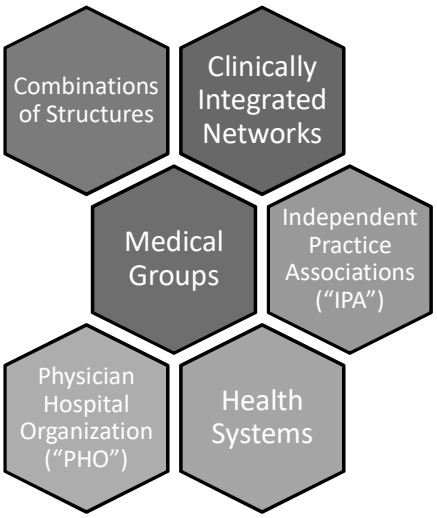
Where?

Types of Organizations Taking Risk



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Market Factors to Consider

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Trigger Events that Accelerate Activation of Market Change

Employer direct contracting (e.g., Boeing, Intel)

Change in CMS rules

Competition moves first – white-label product with health plan

Kaiser or other out of state system enters the market

New outpatient models accelerate spread (e.g., Oak Street, Iora, One Medical)

Retail companies broaden scope of service (e.g., CVS, Walmart, Amazon)

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What Strategy Makes Sense for You?

- Creating the "glue" for clinical integration – sharing risk without merging
  - Separate healthcare systems
  - Separate medical groups
  - Other joint ventures
- Plan-to-plan private label products
  - Self-insured employers (including provider employees!)
  - Evolution of ACOs into capitation
- Provider-owned health plan
  - Commercial products
  - Medicare Advantage, Medicaid managed care
  - Regional product for Exchange

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What?

Value-based Critical Success Factors

- Vision and Leadership Commitment
- Strong Care Management Capabilities
- Effective and Engaged Care Teams
- Larger Patient Population
- Efficient Clinical Operations
- Contracting Models Support Population Health
- Compensation Models that Align Incentives
- Proactive Patient Engagement
- Enabling Information Technology

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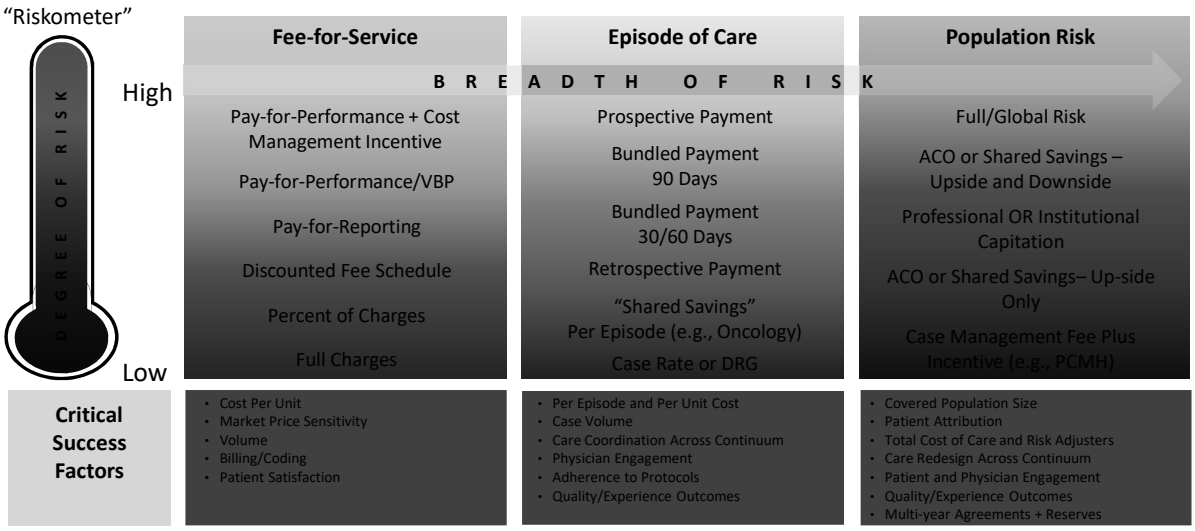
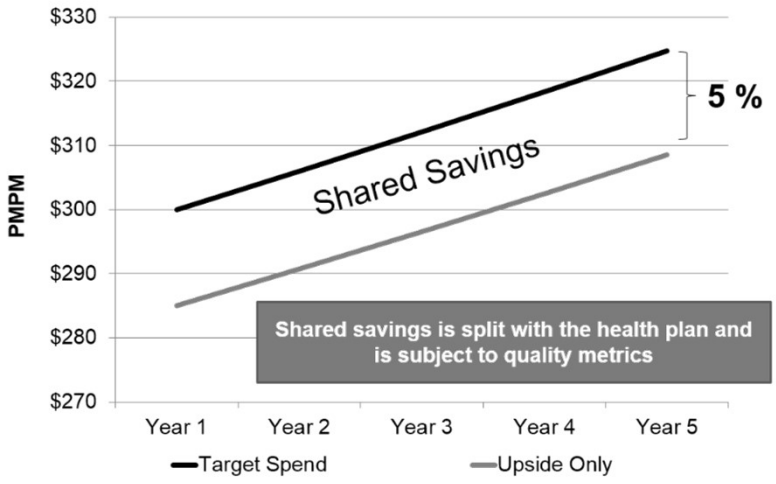
"Risk" Models Come in Many Flavors



Shared Savings: Upside Only



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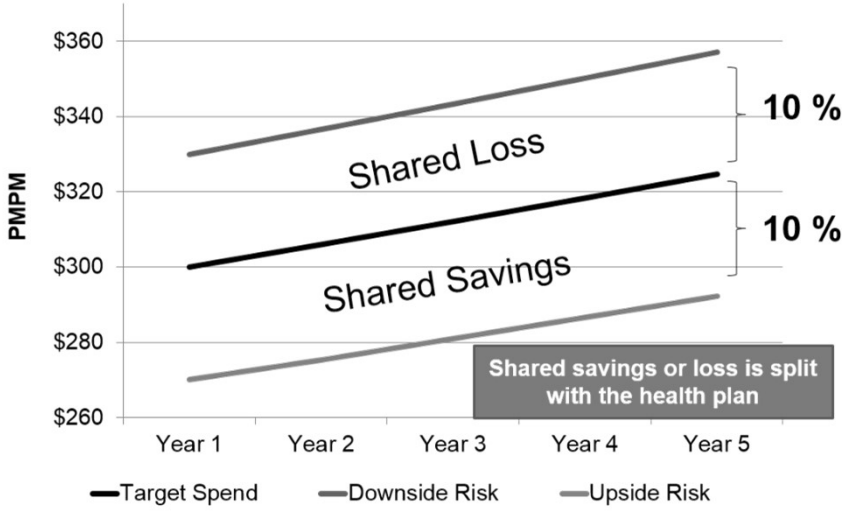
Shared Savings: Upside and Downside



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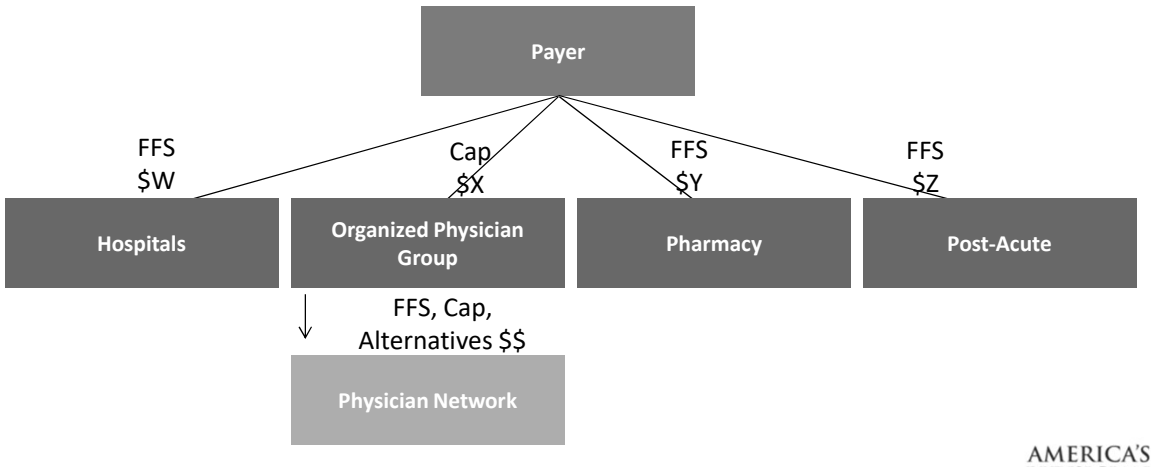
Professional Risk



Note: Only top 4 categories of health spending displayed.

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Full and Global Risk Contracts

Full Risk

- Capitation for institutional and professional services.
- Medical group and hospital often share surplus and deficit in risk pool.

Global Risk

- Single entity receives all funding and pays all claims.

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Regulatory Issues

States Regulate Risk Bearing Entities

- Know your state requirements - they vary widely.
  - Knox-Keene Health Care Service Plan Act of 1975 (California).
  - New York required the Department of Health to establish a program governing the approval of ACOs.
  - Massachusetts requires all Risk Bearing Provider Organizations ("RBPO") to register with state agencies.
    - Provider organizations that take on significant risk must fall under the DOI oversight even under alternative payment models.

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Implementing Capitation-based Contracts

- Tracking and gathering encounter data and sharing with providers to change behavior.
- Termination clause to deal with: continuing care obligations, communication to members, medical record transfer, not to compete.
- Bonus pools for quality of care, patient satisfaction, and administrative compliance.
- Policies for use of other specialists and ancillary providers.
- Do you have a seat at the table for benefit design?

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Risk Adjustment

Hierarchical Condition Category ("HCC") Coding Becomes Increasingly Important With Increasing Degrees of Risk

Hypothetical example of individual patient risk score (numbers are examples).

Risk Adjustment Coefficients	$
Male Age 77	5,100
CHF	3,900
Diabetes w/complications	3,300
COPD	3,700
Beneficiary's predicted exp	16,000
Average exp for all beneficiaries	10,000
Risk Score	1.60

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Risk Adjustment

As degree of risk increases, risk adjustment becomes increasingly important. In Medicare Shared Savings, it impacts the provider's benchmark; and in advanced risk (capitation) for MA, it impacts the payment to the Plan and subsequent capitation to the provider organization.

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Commercial Risk

Full or Partial Risk

- Provider's Own Self-Funded Employees
- Direct to Employer Contracting
- ACO
- Professional Capitation
- Full Risk or Global Risk

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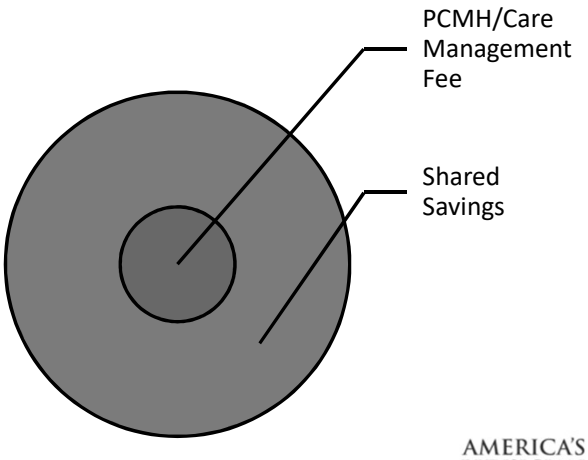
Commercial Carrier Programs

Often a Combination of Methodologies

- Some level of formal PCMH accreditation may be required.
- Care management fees paid on a PMPM basis are negotiable and often deducted from any savings.
- Number of attributed lives requirement may be lower (e.g., 1,500)
- Quality metric performance and STAR rating (MA) are important components.



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Commercial/Private Contracting

Additional Considerations

- Which products are included? Individual, exchange, employer group risk, self-funded, etc.
- Is this a private plan with a MA or Managed Medicaid product?
- 3 R's

Risk adjustment • **R**e-insurance • **R**isk corridors

- If pursuing partial capitation, what are carveouts (e.g., pharmacy, mental health, transplants, etc.)
- If shared savings, how are benchmarks established?
  - What is the attribution process?

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Attribution

Non-HMO attribution can be handled in several ways:

Prospective	Organizations are provided with a list of attributed members at the beginning of a performance year; attribution is based on data from the patients' use of services in the previous year.
Performance Year	Patients are attributed to organizations at the end of the year based on patients' use of care during the actual performance year.
Hybrid	Preliminary prospective assignment methodology with final retrospective reconciliation where there is prospective attribution initially; followed by retrospective reconciliation.

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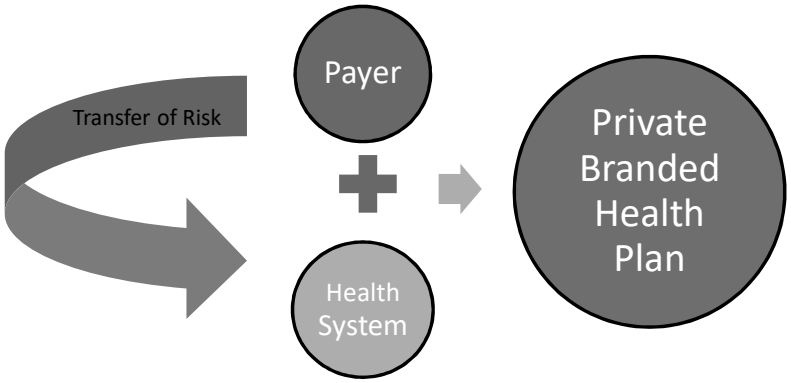
Medicare Advantage

- Enrollment growth, attractive option for health systems to:
  - Partner with payers - private branded plan



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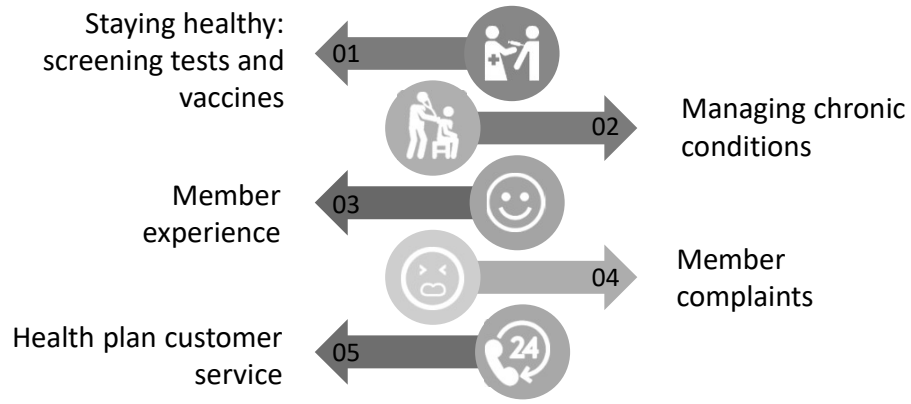
Medicare STAR Ratings

Five domains impact payment and enrollment growth potential.



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Managed Medicaid

- Managed Medicaid plans often willing to share risk and/or capitate providers.
- Shared savings/ACO, partial and full capitation alternatives.
- Need to understand the differences in populations and sub-populations, e.g., pediatric population, low-income adults, disabled individuals, dual eligibles, etc.
- Many organizations taking risk for Medicaid often have a high volume of Medicaid enrollees and experience caring for this population.

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How?

Where Do You Start?

- ✓ **Establish the vision**
  - Is this a strategy or a new way of life?
  - Where is the opportunity?
- ✓ **Identify the leadership**
  - Clinical and administrative leadership must be aligned
- ✓ **What is the strategy**
  - Objective assessment of capabilities
  - Clear view of risk tolerance
  - Experience and potential for culture, behavior, and clinical change
- ✓ **Determine the population focus**
- ✓ **Establish the plan**

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Strategies for Adapting to Risk

Must Be Responsive to Market Conditions

Stage of Development	Entry	Proficient	"All-in"
	• Upside only • "No regret" populations	• Defined risk corridors • Aligned payers	• Organizational commitment
Products/ Populations	MSSP MSSP - Basic Self-insured employees P4P/PPO ACO – Upside only	Medicare Advantage capitation/risk Commercial capitation/risk MSSP/Next Gen risk Direct to employer	Medicaid/Dual Global Risk "Private Label" health plan Health plan joint ventures Provider-owned health plan
Critical Capabilities	• Network development • Integrated care management • Analytics • Governance – physician engagement	• Hospitalist/Care management team across the continuum • New care models • Predictive analytics • Aligned provider compensation	• Reserves • Full scope population health management services • Re-shape provider network/portfolio

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Consider the Population Characteristics

Medicare	Medicaid	Duals	Commercial
Chronic disease(s)	Moms, babies	Behavioral health	Prevention
End of life care	Behavioral health	Socio-economic challenges	Chronic disease
Physician loyalty	Patient dis-engagement	Patient dis-engagement	Physician "disloyalty"

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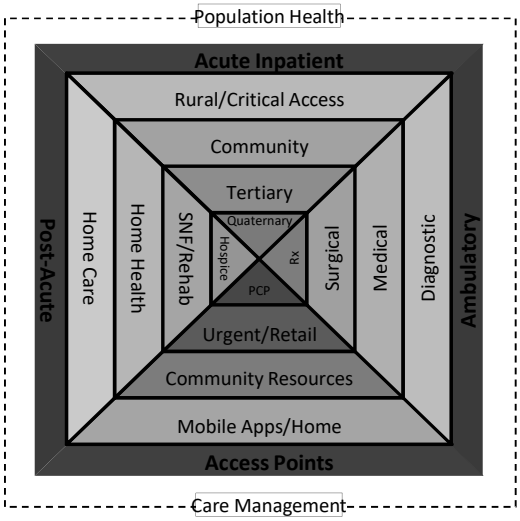
What is Your Network Strategy?



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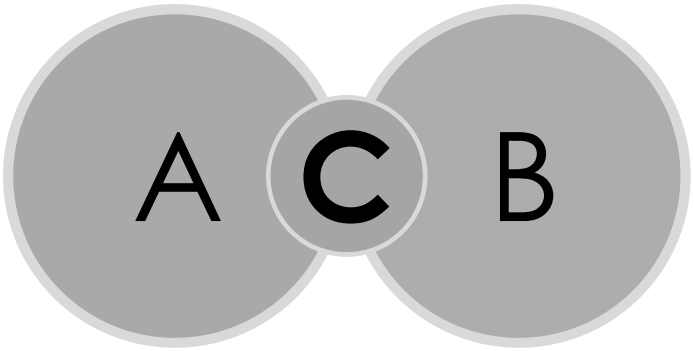
Dual Transformation



TRANSFORMATION **A**
Reposition Today

TRANSFORMATION **B**
Create Tomorrow

CAPABILITIES LINK
Catalyze Core Assets

Source: Anthony, Gilbert, Johnson, Dual Transformation: How to Reposition Today's Business While Creating the Future

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Surviving in World A While Shifting to World B

Activate Key Elements that Support Success in Both Worlds

- ☑ Actively manage "no regret" populations: employees, Medicare
- ☑ Develop bundled payment vehicles for certain procedures – expand market reach
- ☑ Create a more unified approach to care management: reduce redundancies, inefficiencies
- ☑ Relentless focus on patient access: anywhere, everywhere
- ☑ Optimize existing facilities through creative capacity management strategies
- ☑ Strengthen analytics to provide transparency on true costs and outliers
- ☑ Use payer $$ to evolve care models

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Implications of Transitioning to the "New" World

Confronting Our Sacred Cows

- Shifting capital away from bricks and mortar
- Making difficult decisions to reduce traditional "towers of power" (acute care beds)
- Aligning clinical resources with true population health needs: clinical network; physician mix
- Management resources and talent management

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Critical Success Factors – Population Risk

Financial

- Cash reserves
- Stable history
- Pricing
- Tolerance for risk
- Population risk profile
- Contract language

Functional

- Experience
- Population size
- Geographic coverage
- Analytics and data capture
- Actionable reports
- Care management and patient activation

Cultural

- Population focus (vs. provider-centric)
- Constructive collaboration among providers
- Accountability
- Stamina to respond to competitive forces (internal and external)

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Section 2

Care Coordination Principles and Operating Framework

Where Do You Start?

- ✓ Establish the vision
  - Is this a strategy or a new way of life?
  - Where is the opportunity?
- ✓ Identify the leadership
  - Clinical and administrative leadership must be aligned
- ✓ What is the strategy
  - Objective assessment of capabilities
  - Clear view of risk tolerance
  - Experience and potential for culture, behavior, and clinical change
- ✓ Determine the population focus
- ✓ Establish the plan

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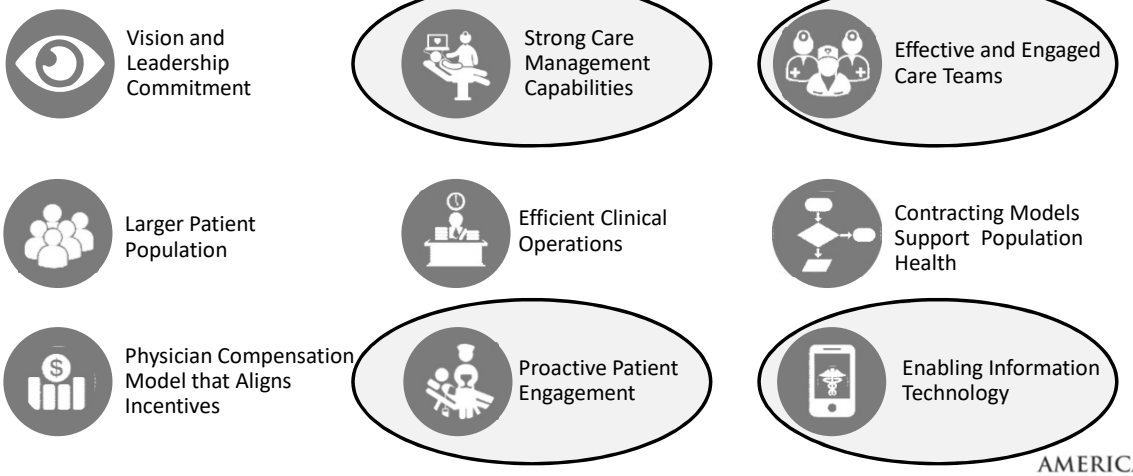
Value-based Critical Success Factors



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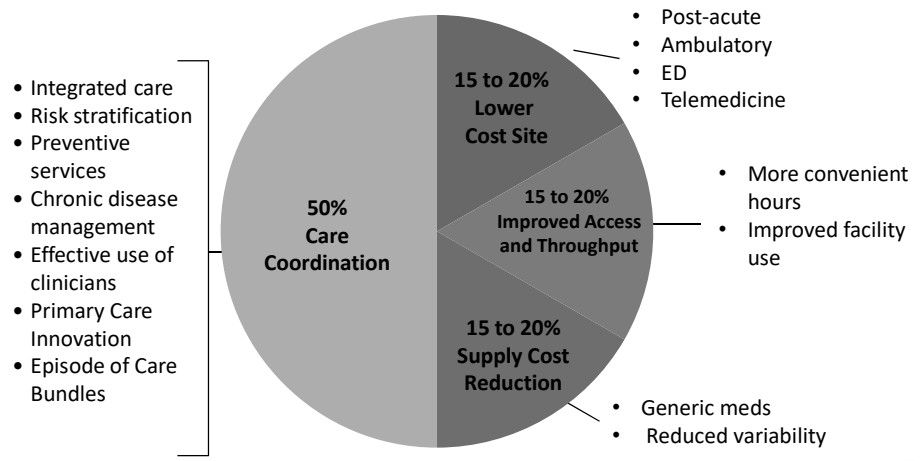
Strong Care Management Capabilities

Care Coordination is the "GPS" for Patients and the Most Effective Cost Intervention in Achieving Benefits from Care Model Redesign



Source: Bending The Spending Curve By Altering Care Delivery Patterns: Health Affairs 2017: 36(5)

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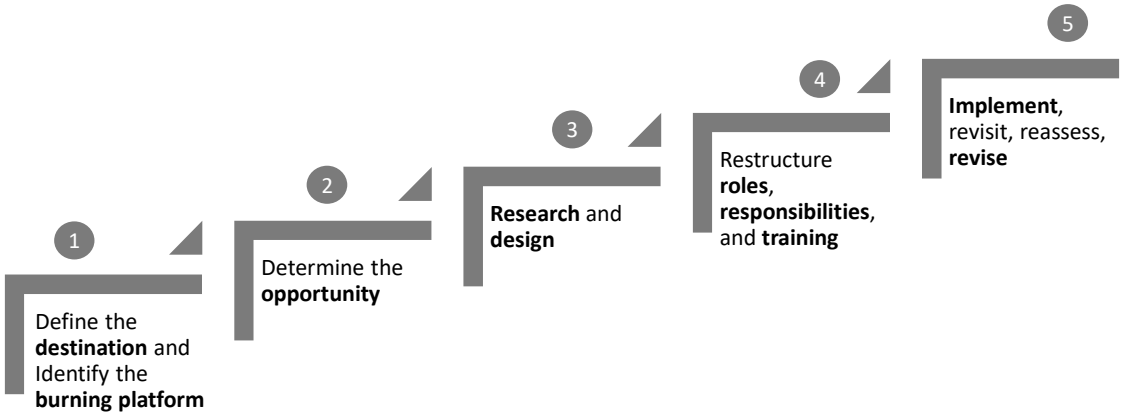
Care Coordination Starter Kit: Where to Begin?



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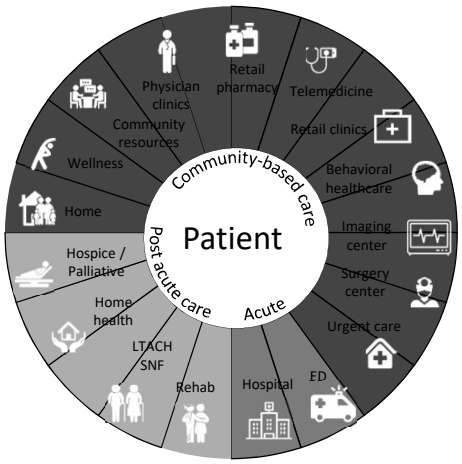
Leverage and Repurpose Existing Resources While Creating and Maintaining New Partnerships: Organized System of Care



Desired Attributes

- 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
- Information technology infrastructure to support data driven interventions

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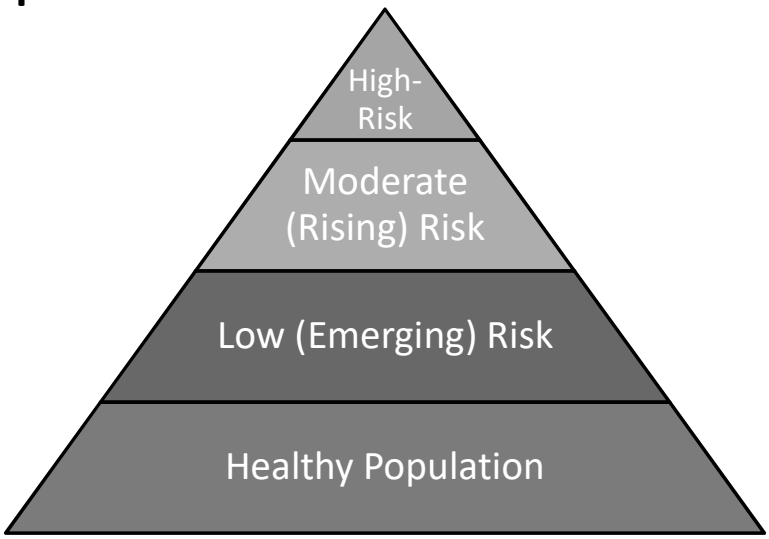
Population Risk Stratification



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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
- Increasing need for providers to risk stratify
- Risk stratification helps care managers organize their workflow and task activities

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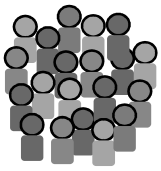
Apply Risk Stratification to the Care Model



Risk Stratification Tool

- Consolidate data from Claims, EMR,
- Analyze claims and clinical data
- Stratify patients by risk levels
- Refer to appropriate level of care

High Risk CM | Complex CM | Disease Management | Preventive Health

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Typical Risk Stratification Criteria and Triggers

Inpatient Triggers

- Patients with extended LOS (> 5 days)
- Patients with more than 1 unplanned admission within the past 90 days
- Patients with high intensity of service: ventilators, dialysis
- Age > 75 years
- Admission to a long-term care facility
- Certain high-risk diagnoses (both primary and secondary) including: heart failure, COPD, renal failure, stroke, complex cancers, dementia, or severe mental health issues
- High risk units (ICU, step down, transplant)
- Any admission or ED visit for a patient on CM

Outpatient Triggers

- Chronic diseases with potential down the road complications: diabetes, asthma, hypertension, coronary heart disease
- Triggers to indicate poor self-maintenance such as HbA1c > 10
- Patients with more than 3 chronic conditions
- Patients with more than 7 medications
- Patients with history of frequent ED visits and admissions
- Mild to moderate mental health issues

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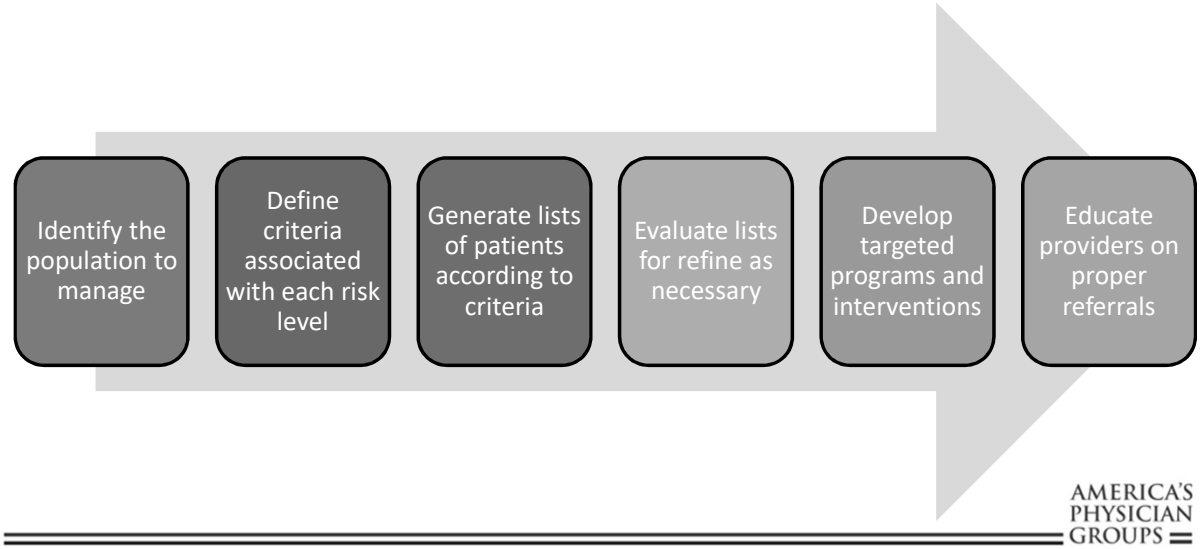
Redesigned Risk-based Care Model



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Typical Interventions for Different Risk Levels

High Risk CM	• Care Manager calls 3 times per week • In-person, in-clinic visit with patient • Work in partnership with practices and providers • Early intervention for urgent symptoms – refer to urgent care or hospitalists
Complex CM	• Care Manager calls 2 times per week • Early identification of patients requiring medical intervention • Symptom and disease education
Disease Management	• Interactive Voice Response ("IVR") outreach • Care Manager calls when triggered by IVR • Care Coordinator calls 1 time a month, can refer to Care Manager
Preventive Health	• Automated clinical workflow and patient reminders • Patient education materials

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Typical Care Manager Workflows

Push/Pull Referrals

- Educate referral sources which may include data, providers, and case managers
- Establish a process via telephone, fax, technology

Assess Needs

- Assess patients' needs (ADLs, IADLs, PHQ-9)
- Consider scoring and tracking progress
- Identify frequency of assessments
- Develop protocols for interventions based on assessment results

Care Plan

- Set goals with the patient and caregivers
- Develop action items and interventions
- Identify barriers
- Track progress

Follow-Up

- Track progress
- Adjust care plan as needed
- Continually assess patient for right level of care and clinical program

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Case Study and Group Discussion:

An Efficient and Effective Care Coordination Staffing Model

Episode of Care Bundles at an Academic Health Center

Care coordination staffing depends on population, ability to leverage existing resources and specific bundle(s).

1. Annual case volume for three bundles: 450 major lower extremity joint replacement cases, 460 lumbar spinal fusion cases, 225 cardiac valves
2. Pluralistic medical staff : 50% of physicians employed
3. Care coordination staffing ratio: 1 RN Clinical Care Coordinator: 240 patients
4. Average care coordination daily case mix: 20-25 pre-ops, 4-6 inpatients, 50-60 90 day post-ops
5. Total investment of $750K, $3.5M in new annual performance revenue

What criteria do you use in staffing care coordination to support your value-based contracts?

Source: GE Healthcare Partners internal data

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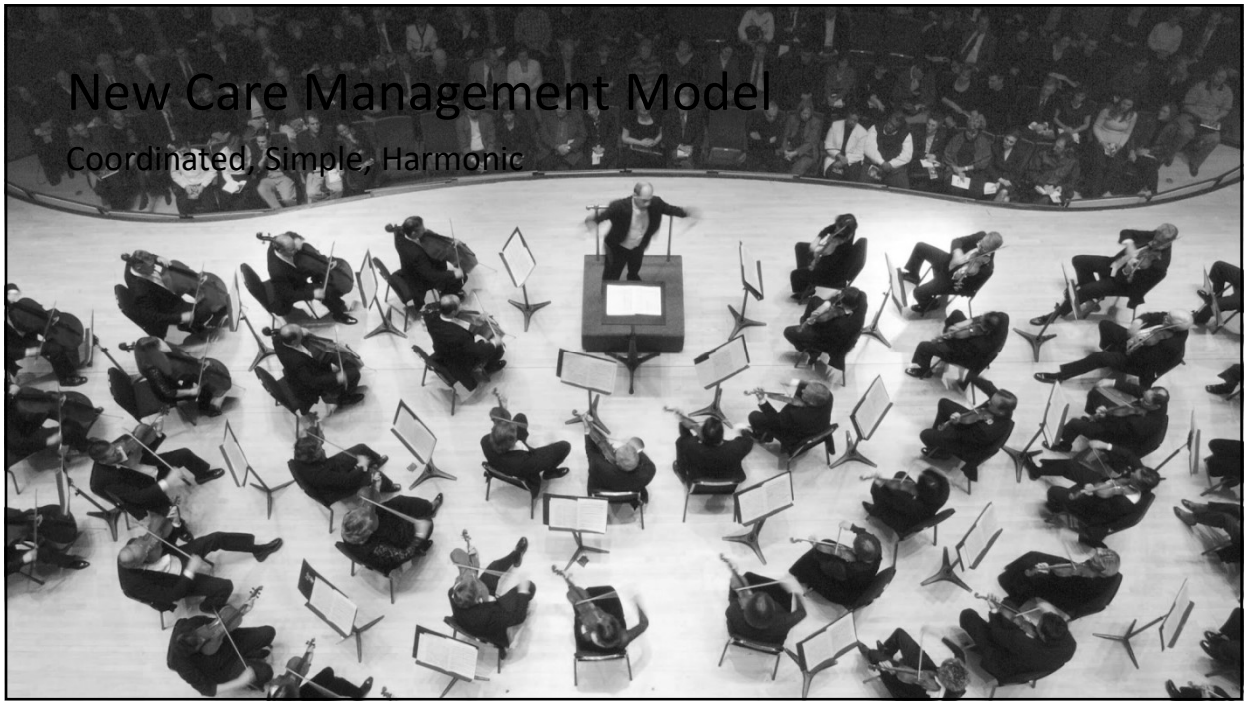
Effective and Engaged Care Teams



Redesigned Care Team

Desired Attributes

- Accessible-"Always on"
- Longitudinal Care Plan
- Adjusts for Care Intensity
- Many Staff Roles Upshifted
- Use Shared Decision-Making with Patients
- Responsible in-sourcing
- Good Partnerships
- Meet Quality Guidelines
- Invest in upgrading people skills

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Care Management: What Is It and What Are Its Guiding Principles

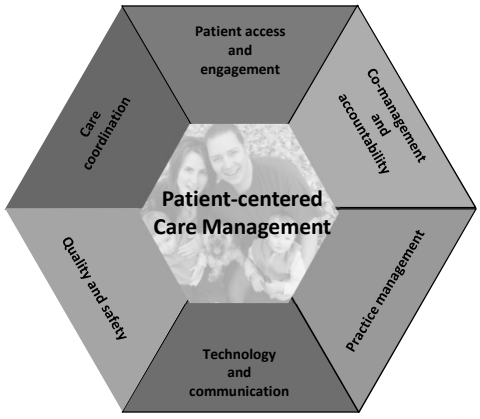
> *A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.*
>
> The Case Management Society of America

Care management infrastructure:

- Care management organization
- Hospital-based clinicians
- Inpatient care management
- Ambulatory case management
- Post-acute care settings
- High-risk clinics
- Disease management
- Pharmacy management
- Transitions management
- Referral and centers
- Utilization management
- Health education/promotion
- IT

Care management functions:

- Care plan development and management
- Education/Self-management
- Care coordination across networks
- Support to patient and caregivers
- Referral to community-based resources
- End-of-life support (advanced directives, palliative care and hospice referrals)



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Integrated Care Management

Foundational Principles	Care Management							
Care Settings	Hospital		Post-Acute Care				Ambulatory and Community	
Practice Areas	ED	Inpatient	SNF	Long-term care	Home Health	End of Life Care	Remote Care Managers	MD Office Care Managers
Roles and Responsibilities	• Readmission reduction • Appropriateness of admission/ gatekeeping • Connection to social services • Follow-up care • ED diversion	• Care progression • ALOS reduction • Post-discharge planning • UM (continued stay status) • Psychosocial services • Patient Class/ Observations	• ALOS reduction • Connection to the ambulatory care manager • Managing transitions of care • BP and other disease-specific programs	• End-of-life ("EOL") discussions • Connection to the ambulatory care manager if newly admitted	• Assist patients with self-management • Home assessment (falls, safety, etc.)	• EOL discussions • Palliative care • Hospice	• Telephonic assessment and counseling • ED visit prevention • Risk stratification • BP and other disease-specific programs	• Co-visits • PCMH integration • Management of complex chronic patients • Quality metrics and UM review • Managing transitions of care

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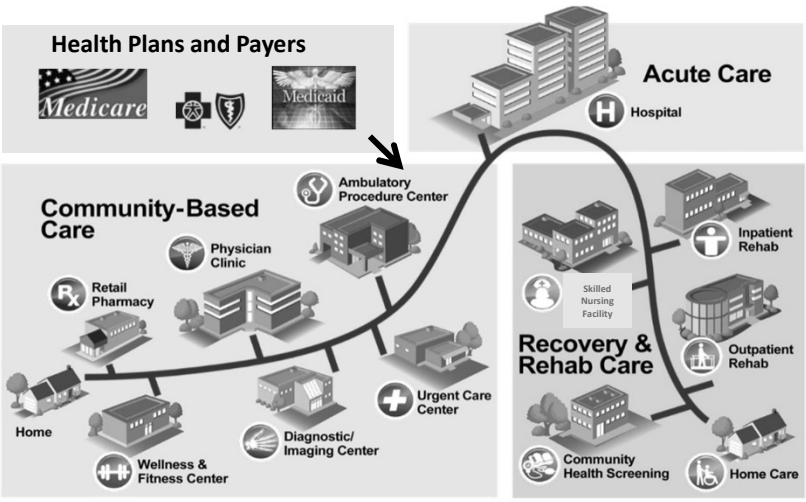
Care Management is the Common Thread: Linking the Patient Through Every Setting



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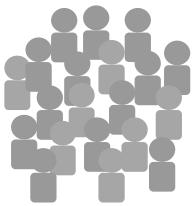
Care Management Program Design



Right patient

Patient identification through:

- Population stratification
- Clinical qualifiers
- Disease states
- Frailty
- Coordination needs

Right place

Patient engagement at:

- Home
- Hospital, SNF
- Care transitions
- Telephonic

Right time

Patient outreach when:

- New patient
- After primary care physician visit
- 30 days post-acute
- New diagnosis
- New prescription

Right role

Patient care delivery by:

- Appropriate individual, based on training
- Care team member with expertise who fulfills patient needs

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Basic Elements of a Patient Care Plan

Patient Goals

- Align essential health goals with patient and family/caregiver preferences and personal goals
- Goals need to be measurable – tie them with an outcome

Delegation/Timeline

- Interventions and action items can be assigned to any member of the care team and/or the patient/family along with a target completion date; progress should be tracked

Problems/Issues

- These do not need to be (and often are not) ICD diagnosis codes
- May include chronic conditions like diabetes or COPD, but also issues like nutrition or falls

Barriers

- Any actual or potential obstacles or challenges that arise that could impede the completion of an intervention or fulfillment of a goal; all barriers need to be overcome with an action

Interventions/Achievable Action Items

- To-dos" or next steps that need to be taken in order to meet the goal(s)

Living Document

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Types of Care Plans

Episodic	Routine	Complex	Advanced
Condition-based	Focused on annual wellness exam	Patients with Poly-Chronic Conditions	End-of-Life Issues
Prior to an anticipated episode of care	Discussion of patients goals for the year and options available	Includes patient and family/caregiver and multi-disciplinary team	Clarify patient perception of their health and treatment options
Surgical procedure with post-surgical needs	Planned	Patient Defined Goals	Medical and non-medical interventions
Anticipated		Unified Care Plan	

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Sample Care Plan

Goal	• "I want to be able to get back to my gardening." • General strengthening, improve and stabilize quad strength and ambulation.
Problems	• Currently walker-dependent s/p right knee replacement. • Pain management: Currently on PCA pump.
Actions	• Exercises to progress knee strength and range of motion to 80° flexion by D/C. Practice walker stability, stairs. • Progress from PCA to oral meds within next 24 hours with pain controlled at 3.
Delegation	• PT, OT • M.D., nursing
Barriers	• 3 steps to reach home front door: PT and OT working on walker safety on steps.

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Case Study and Group Discussion:

USAA On-site Workplace Clinic

USAA Health Services

Location: San Antonio, TX corporate campus, 14,000 employees

Staffing: 6 RNs, 1 FTE Advanced Practice RN, 1 Physician Assistant 6RNs, 3 Medical Assistants, 4 administrative assistants and 0.3 part-time physician supervision.

Annual Clinic and Telemedicine Visits: 31,819, Total on-site provider visits 6,108

Reimbursement Model: Cost-plus payment to Premise Health

Extended Week–day hours, 60% of visits open-access, average weight time is 6 minutes

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USAA Health Services

Risk Stratification Tool: looks at clinical measures, sick time used and workers' comp costs. High-risk patients referred to 5 FTE intensive outpatient care management team

Evidence-Based Protocols: Over 90 protocols in use. Developed by multi-disciplinary team of MDs and RNs and embedded in EHR

- Allows nurses to manage wide-range of conditions including low back pain, sore throats, UTIs
- PA performs routine routine office based procedures
- On-site part-time allergist and psychologist. Contract with specialists who provide rapid access for USAA employees

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USAA Health Services

Standing Orders Incorporated into most protocols and guidelines.

Example: Patient with sinus symptoms and sore throat. May be due to allergies but meets criteria for strep testing. Standing order in place. RN perform rapid stress test. If (+) sees provider immediately. If (-) nurse provides education on symptom management.

Logistics Model Allows providers to see telemedicine consults in-between patient on-site visits.

Staff Selection Criteria Emphasizes listening and communication skills.

Source: Stanford University Clinical Excellence Research Center

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Proactive Patient Engagement

Framework for Successful Patient Activation

Motivation

- Customer-dependent factors (i.e., what makes one want to engage and stay activated)

Ability

- How easy is it for the consumer to be engaged and for the system to deliver easy-to-use methods for engagement/activation
- This is dependent on healthcare provider/system (i.e., goal is to make it easy for patients to do the right thing and hard to do the wrong thing)

Triggers

- These are conditions, life events, illnesses or other events that induces one to get motivated to get engaged

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Patient Engagement

"Actions individuals must take to obtain the greatest benefit from health care services available to them."

The Center for Advancing Health

- Focus on behaviors of individuals that are critical to health outcomes
- Individualize information and professional advice according to needs, preferences, and abilities

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How is Patient Engagement Different from Patient Activation?

Definitions

- Patient Engagement – acquisition of knowledge, skills and confidence to manage one's health that leads to self-reinforcing repeated interactions across multitude of healthcare channels
  - Education oriented
- Patient Activation – the activities and interventions that are used to support increased participation and personal accountability in their own health by patients and consumers
  - Action oriented

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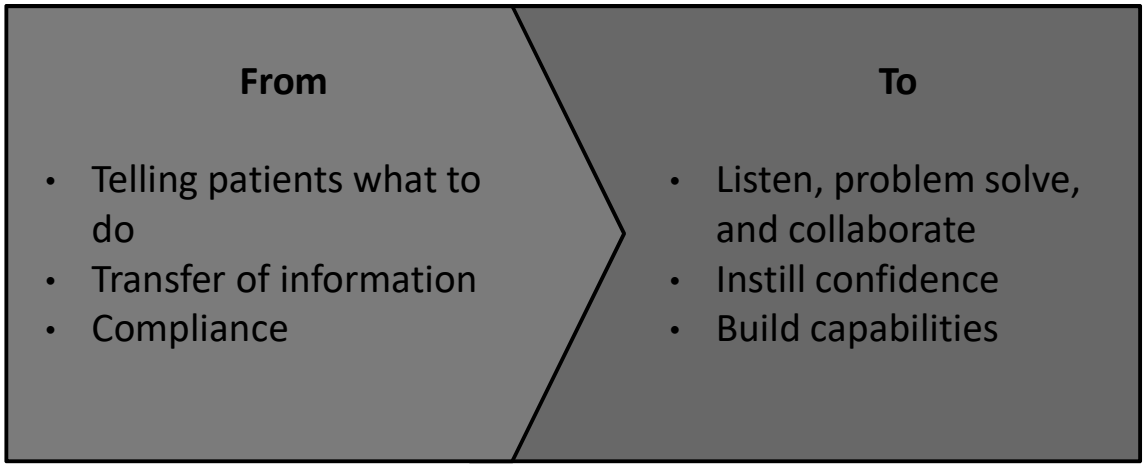
Patient Engagement Paradigm Shift



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Validated Patient Activation Measures

Survey items assess the following:

Self Management

- Ability to self-manage problems
- Ability to engage in activities to maintain health
- Ability to be involved in treatment choices
- Ability to collaborate with providers
- Ability to select providers based on performance
- Ability to navigate the health care system

Levels of Activation

- Belief that the patient role in activation is important
- Having the confidence and knowledge to take action
- Proactively taking action to improve health status
- Staying the course even under stress

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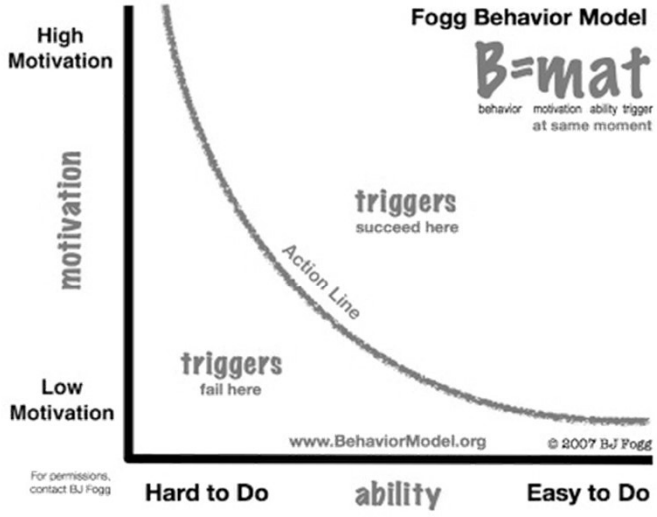
Solution Design and Development

Fogg method of Behavior Design (Motivation, Ability, Triggers)



Source: http://www.foggmethod.com/.

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Improving Activation Scores Improves Outcomes

↑ satisfaction
Patient activation scores = ↑ Clinical outcomes and patient
↓ Cost of care

Growing body of research indicates that validated patient activation scores can be a significant predictor of outcomes including improved service utilization of emergency department use and hospitalizations.

Increases in patient activation scores over 4 years were correlated with improvement in medication adherence, self-management knowledge functional health and reduced number of emergency department visits. When activation levels change, many health-related outcomes change in the same direction.

Hibbard, JH and Greene, J; What the Evidence Shows About Patient Activation. Health Affairs: 32 (2): 2012

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Case Study and Group Discussion:

Design-Thinking Improves Patient-Caregiver Conversations

Rotterdam Eye Hospital

Design-Thinking Principles: were used in planning the renovation of an aging facility. Primary goal was to reduce patients' fears of blindness. Developed a series of small-scale, low-cost experiments to test and iterate on ideas gained across many industries.

Example: Pediatric section sent beautiful T-shirts with an a specific animal print in advance of admission. The consulting ophthalmologist wears a button with same animal during appointments which gives them an immediate connection.

Example: 'Eye Care Air" Staff safety and teamwork training includes how to speak frankly with patients without triggering panic.

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Rotterdam Eye Hospital

Design Thinking and Patient Conversations: Design team observed physicians and patients discussing treatment options. Post-conversation interviews and surveys enabled team to identify four categories of patients:

- "Google" Patients - obsessive about information
- "Dominant" Patients - want to be firmly in charge
- "Quiet" Patients - will say everything is fine even when it isn't
- "Emotional" Patients-want reassurance that their caregivers are looking after them.

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Rotterdam Eye Hospital

	Google Patient	Dominant Patient	Quiet Patient	Emotional Patient
Biggest Fear	Uncertainty, irrational behaviors of others	Coming across as weak	Change	Feeling alone and left out
Symptoms	Believe they know the cause of their medical issue. They speak softly and are reflective. Upset when presented with vague information.	Get angry if they have to come back multiple times. Hate sitting in waiting room. Shake hands vigorously. Try to get to the point immediately	Dislike giving negative feedback. Tend to wrap suggestions in stories or with examples. Shake hands softly. Speak slowly and melodiously.	Move around a lot and make dramatic gestures. Shake hands for a long time and may pat you on the shoulder. Small talk is important to them.
Prescription	Provide clarity and order. Give detailed information. Be transparent about outcomes and risks	Use an efficient appointment process. Be direct with them and skip social talk.	Don't take "yes" or "good" as an answer. Keep asking questions. Find one-on-one conversation opportunities.	Spend time engaged in small talk and build a personal relationship. Reassure them during treatment.

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Rotterdam Eye Hospital

People Behave Differently Depending on Context: It's important to recognize the change and respond appropriately.

Training: Two days of initial training with annual one day update. Principles of patient types are reviewed at staff meetings with a Trivial Pursuit like game that also include questions on issues like infection prevention, medication safety and checklist management.

Employee Responses: Ten years in existence. 99% recommend the program to colleagues and 96% wish to continue annual follow-up sessions.

Patient Responses: Net promoter scores >70.6%. Average for all hospitals in the Netherlands is 42.2%.

Source: Deichman, R, van der Heijde, R. Harvard Business Review. 2017

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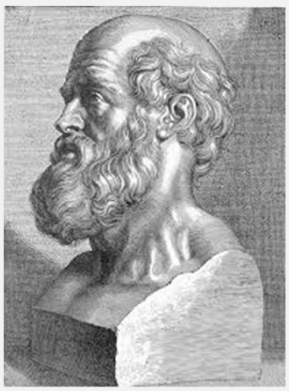

"It is more important to know what sort of person has a disease than it is to know what sort of disease a person has."

- Hippocrates

(460-370BC); Physician, Father of Western Medicine)

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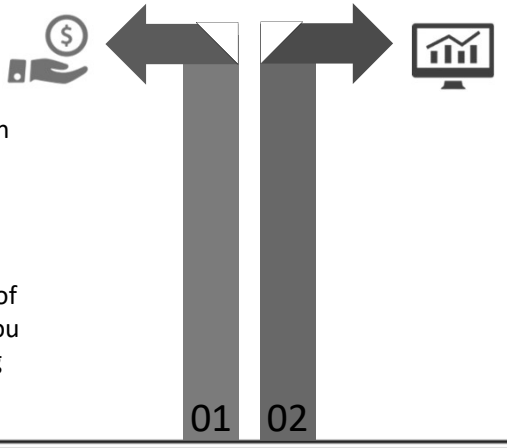
Information Technology and Data Analytics

IT Support for Care Coordination Depended on Two Core Sources



Paid Claims Data

- Tells you who your patients are and much of what happened to them
- Cannot tell you how they are doing
- Not a good indicator of whether the things you are doing are working

EHR Data

- Provides more detailed information on clinical quality and care pathway compliance
- Data models are complex and often customized
- Few specific data standards across EHR software platforms

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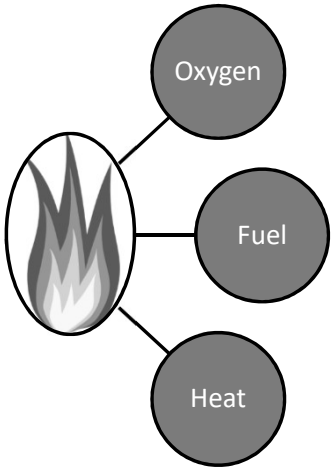
Giant Leap Forward for Humans



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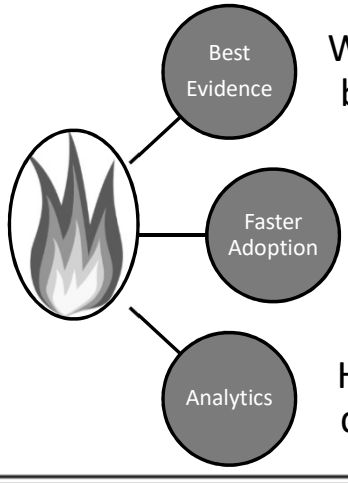
Giant Leap Forward for Care Coordination



What should be done?

How do we transform?

How are we doing?

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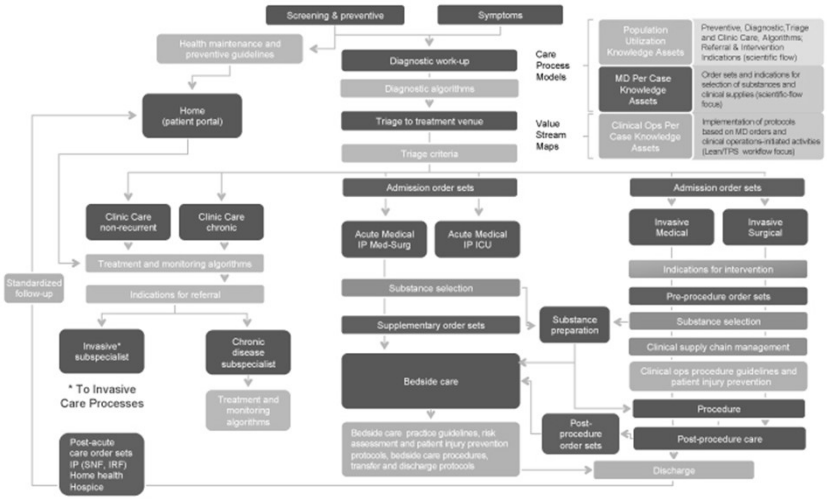
Other Key Enablers Were Electronic Data Warehouses Patient Registries and Care Improvement Maps



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But What About Patient Generated Data ?

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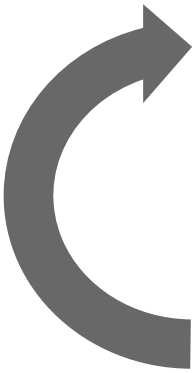
Potential Roadmap for Patient Generated Health Data ("PGHD")

2018-2023
Growth
- Provider and Patient Interest increases
- Apple opens Health Kit to App Developers
- Open Application Standards for data (FIHR)
- Liability Concerns Addressed

2024-2028
Maturity
- PGHD flows seamlessly as part of routine care and research
- Machine-learning assisted
- Fewer face-to-face provider visits needed for optimal care
- Remote access available for many health services



2016-2017
Early Adoption
- Cutting edge organizations see value and begin incorporating PGHD into EDW
- Interest in Precision Health begins

2012-2015
Exploration
- Explosion in consumer devices
- Federal government explores PGHD opportunities
- Patient collection of PGDH begins

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Putting It All Together….. Incrementally

Accelerate Transformation

Refine the Program
- Assess care transitions
- Improve patient access
- Optimize IT
- Expand capabilities
- Further integrate initiatives across the continuum

Address Short-term Opportunities

Establish Quick Wins
- Identify targeted population
- Prioritize care management initiatives
- Provide team training and education
- Create an implementation plan
- Engage patients
- Align incentives

Position the Organization for Success

Align the Vision
- Build strategic vision for alignment
- Catalogue current initiatives by location
- Identify staffing – current and projected

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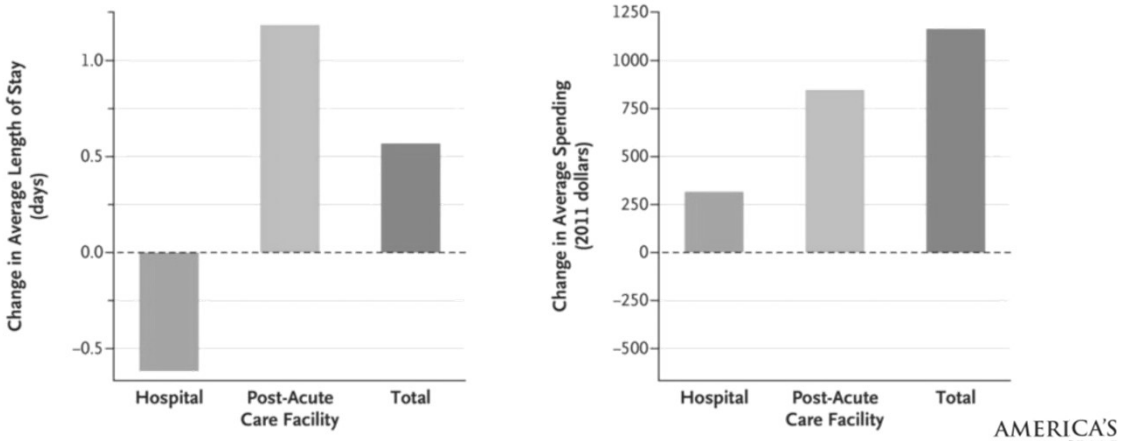
Case Studies and Group Discussion:

Home-to-Home Time Measuring What Matters to Patients

Changes in Medicare ALOS and Spending 2004-2011



Source: Barnett, ML, Grabowski, DC, Mehorta, A, et al. NEJM Catalyst. July 24, 2017

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Home-to-Home Time

- Would a responsible focus on Home-to-Home, rather than acute care ALOS, be a better measure in episode of care and global risk contracts?
- Would it facilitate better care coordination between acute care and post acute care providers?
- What would patients want?

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Personalized Perfect Care Bundle: Measuring Quality from the Patient's Perspective

Personalized Perfect Care ("PPC") Bundles combine multiple distinct measures that are scored "all-or-none" with a patient's care counted as complete if all eligible measures are met.

In the example on the right, only 17.6% of patients were up to date on all measures.

Measure	Score
Current "Clinical Excellence Index"	
Preventive	
Colorectal cancer screening	59.8%
Breast cancer screening	71.0%
Cervical cancer screening	70.7%
Pediatric immunization	78.0%
Depression assessment	18.8%
Chronic	
A1c <9 in patients with diabetes	76.1%
Blood pressure <140/90 in patients with hypertension	69.1%
Statin prescribed in patients with atherosclerotic cardiovascular disease	75.1%
Personalized Perfect Care Bundle	17.6%

Source: Swedish Medical Group

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PPC Bundle

- Does the PPC Bundle more accurately reflect whether each patient treated by an organization receives evidence based, effective care at the right time for his/her conditions?
- Would it lead to better health outcomes and fewer quality measures?
- Would it identify clusters of individuals who need more attention and support?
- Could using it lead to better health equity?

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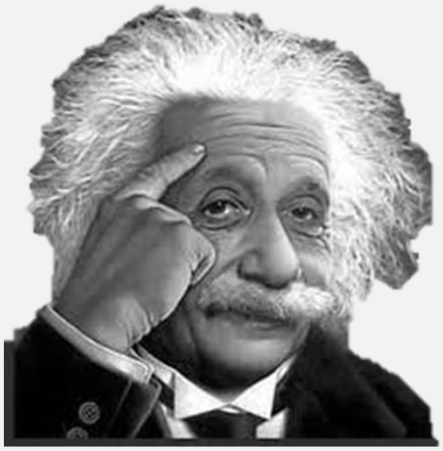

"The significant problems we face cannot be solved by the same level of thinking that created them."

- Albert Einstein

(1879-1955) Theoretical Physicist, Father of Modern Physics

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Section 3

Physician Leadership, Culture Change & Reinforcing Incentives

How do we get Docs on board?

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It will **NOT** be easy…

Over 70% of change efforts **FAIL**

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Key Ingredients for Success

- Strong leadership
- Effective, value-based infrastructure
- Incentives to hit goals

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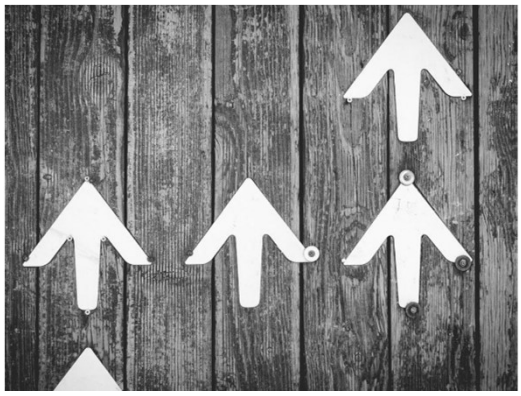
Strong Leadership



- Shapes culture of the group
- Drives engagement
- Promotes value-based strategies

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Characteristics of Strong Physician Leaders

Emotional Intelligence	Vision	Personal Commitment
Professional Credibility	Quality Improvement	Organizational Altruism

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The right leaders will guide the **changes** you need to make

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Kotter's 8 Steps for Change

Create a climate for change
- Establish a sense of urgency
- Create the guiding coalition
- Develop a change vision

Engage and enable the whole organization
- Communicate the vision for buy-in
- Empower broad-based action
- Generate short-term wins

Implement and sustain change
- Never let up
- Incorporate change into the culture

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Based on books and articles by John P. Kotter. Harvard Business Review

Step 1: Establish our sense of urgency

- Most important step
- Complacency kills change
- Don't just focus on building a "rational" business case with lengthy, expensive analysis

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Based on books and articles by John P. Kotter. Harvard Business Review

Step 1 (continued)

Tactics for building *true* urgency:

- Bring outside reality in
- Behave with urgency every day
- Find opportunity in crisis
- **Communicate**

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Based on books and articles by John P. Kotter. Harvard Business Review

Step 2: Create our guiding coalition

- Must contain:
  - A shared objective
  - Trust
  - The right people-power, expertise, credibility

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Based on books and articles by John P. Kotter. Harvard Business Review

Step 3: Develop our change vision

- Bold but achievable
- Paints a vivid picture of the future
- Appeals to hearts (and minds)
- Is easy to communicate quickly—in 60 seconds

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Step 4: Communicate our vision for buy-in

Must be:

- Constant
- Heartfelt
- Consistent

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Step 5 Empower broad-based action

- Common barriers that prevent change
  - Mindset
  - Systems
  - Bosses

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Step 6: Generate short-term wins

Wins must be:

- Visible
- Unambiguous
- Relevant
- Celebrated

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Step 7: Never let up

- Eliminate unnecessary, demoralizing work
- Continue learning from experience
- Keep urgency up

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Step 8: Incorporate change into our culture

To embed change into our culture:

- It's OK if resisters leave
- It's imperative that we promote the right people

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Based on books and articles by John P. Kotter. Harvard Business Review

What **infrastructure** should you consider in a value-based world?

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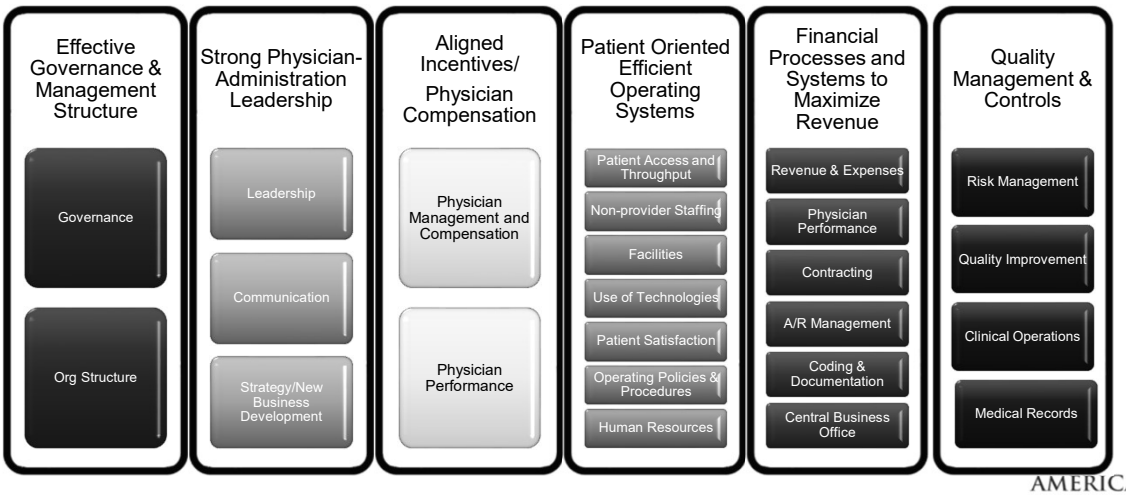
Components of High-Performing Medical Groups



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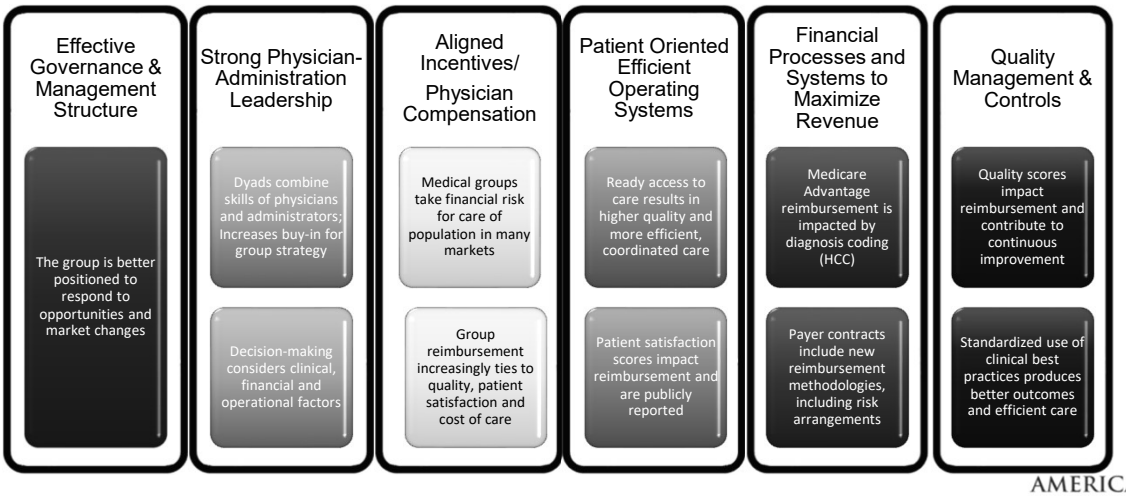
From Survive to Thrive: Leading the Transition to Value. Marc Mertz and Dr. Peter Valenzuela. Group Practice Journal. April 2015

Value-Based Implications



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From Survive to Thrive: Leading the Transition to Value. Marc Mertz and Dr. Peter Valenzuela. Group Practice Journal. April 2015

Once you have your leadership and infrastructure, how do you reinforce **incentives**?

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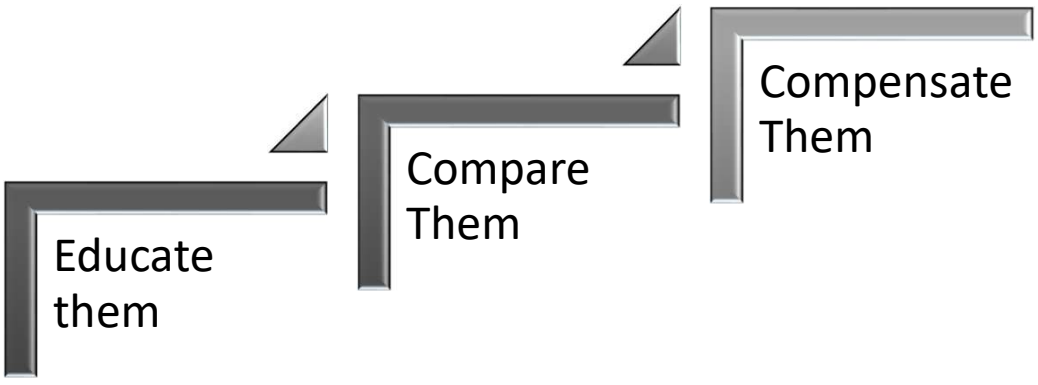
Ways to affect physician behavior



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Educate Them:
How does moving to value help Primary Care?

Rewards and Recognition
for prevention and management

Better Quality
outcomes for their patients

Connectedness
in an otherwise isolated world

Influence and Access
with payers to better contracts

Care management
services for which they are not paid

Efficient Data
transfer between themselves and specialists and facilities

Feedback
on performance and supports to improve

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Educate Them:
How does moving to value help Specialists?

The network promotes awareness of specialists by primary care providers

Reporting back to referring physician is enhanced

The system can make it easier to refer to an in-network specialist than an outside one

Can demonstrate superior quality in the market

The specialist will have better access to the referring physician's clinical data

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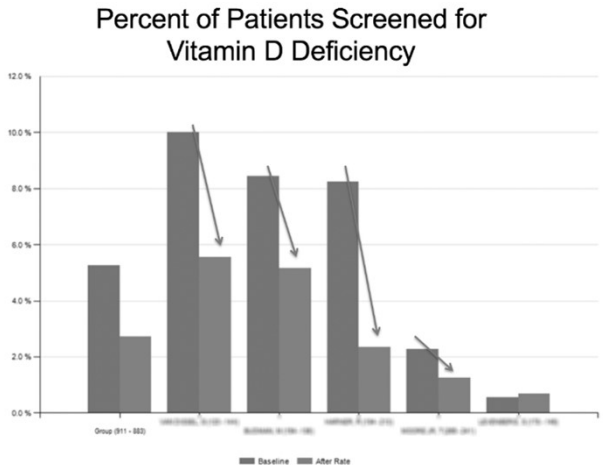
Compare Them: What are your partners doing?



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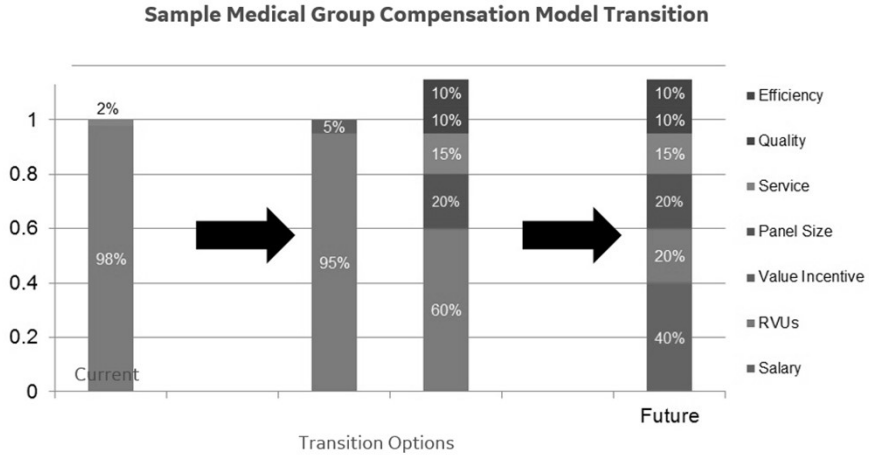
Compensate Them: What are you prioritizing?



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Case Study

Sutter Medical Group of the Redwoods Path to Coordinated, Value-based Care

Background

- Comprised of 120 multi-specialty providers practicing throughout Sonoma County
- Affiliated with Sutter Pacific Medical Foundation
- Statistics
  - Approximately 120,000 active lives
  - 240,000 patient encounters annually
  - 200,000 ancillary encounters annually

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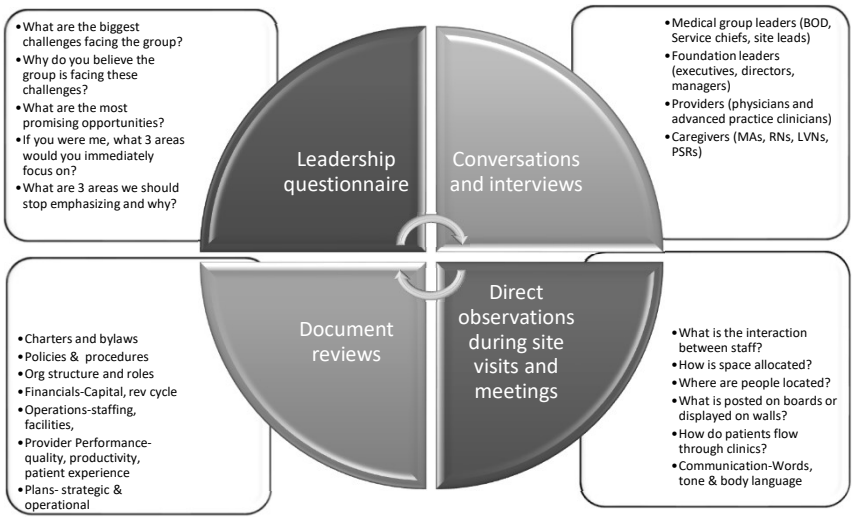
Group Assessment



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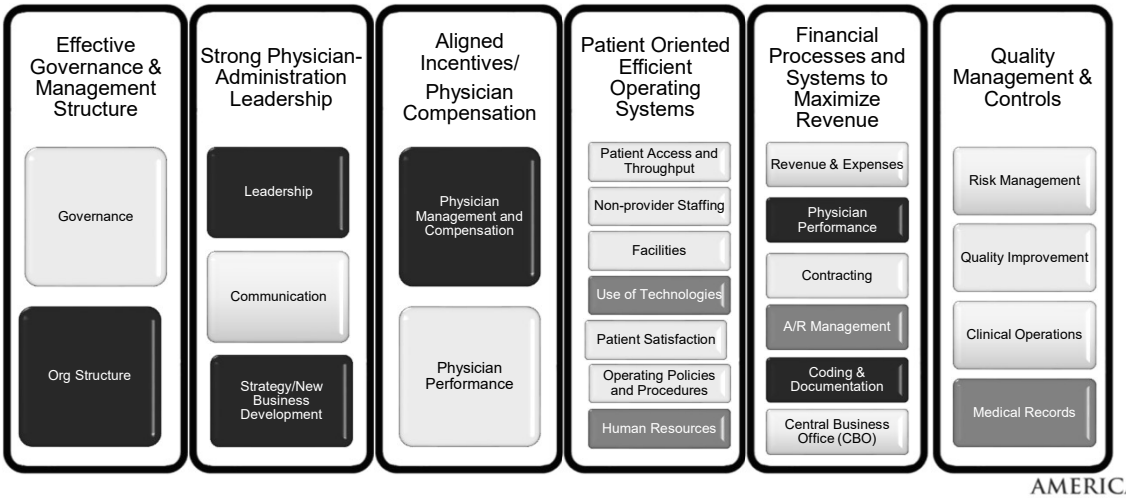
How we compared to high-performing groups



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How we'd know we were getting better

↑Provider Satisfaction
As measured by the AMGA Provider Satisfaction Survey and group engagement

↑ Patient Experience
As measured by Patient Assessment Surveys

↑ Quality
As measured by state and national benchmarks

↑ Provider Performance
As measured by chart closure, patient messaging TAT and internal referrals

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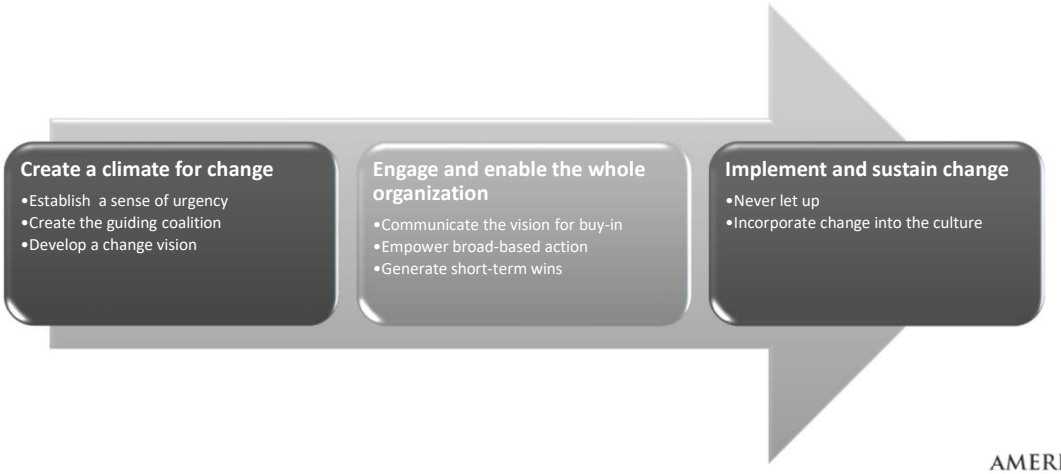
How we planned to change?



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What we did

Create a climate for change

- Replaced group president with medical director for quality
- Formalized dyad leadership structure
- Instituted governance and dyad education

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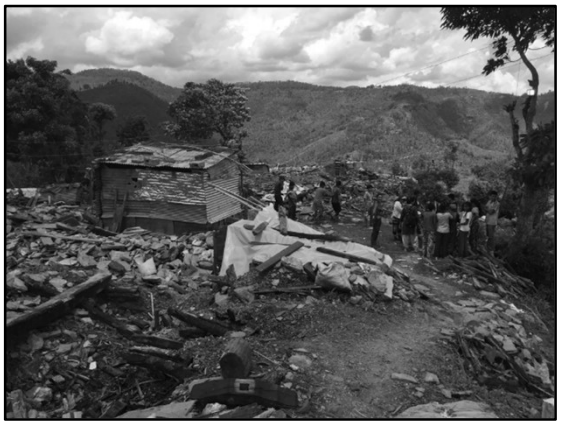
What we did



Engage and enable the whole organization

- Formed new committees
  - Strategy
  - Compensation
  - Advanced Practice Clinicians
  - Well-being

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What we did

Engage and enable the whole organization

- Our well-being plan targeting personal, professional and social pillars

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What we did

Implement and sustain change

- End of year bonus
- Shareholder criteria
- Require art of communicating with patients course
- Target fun!

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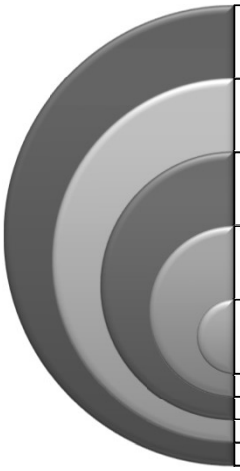
Incentivizing Change



Patient Experience	• Patient assessment surveys
Citizenship	• Committee participation • Community involvement
Service	• My health online enrollment (MHO) • MHO turnaround times
Quality	• Pay for performance (P4P)
Value	• Payment for capitation • Share of ACO savings

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So, How are we doing 5 years into our journey…

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Provider Satisfaction

Leadership & Communication

17th %tile → 90th %tile On AMGA Survey

Acceptance by Colleagues

24th %tile → 76th %tile On AMGA Survey

Overall Satisfaction

34th %tile → 68th %tile On AMGA Survey

Provider Engagement

All-Group meeting attendance increased by 22%

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Patient Satisfaction

"90th %tile Nationally"

By Integrated Healthcare Association

Top 10 in State

Among 170 medical groups in "Overall rating of doctor"

Top 10 in State

Among 170 medical groups in "Overall rating of healthcare"

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Quality

Ronald P. Bangasser Award

Based on P4P measures of clinical quality, patient experience and meaningful use of IT

Top Performing Physician Group

Highest designation awarded by the Integrated Healthcare Association

Elite Status

Highest possible standard recognized by America's Physician Groups (previously CAPG)

Right Care Initiative Award

Recognized by the California Department of Managed Care

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Provider Performance

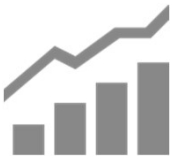
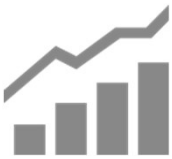


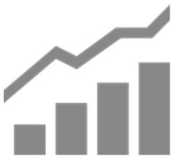
Chart Closure <30 days

Improved from 1,200 charts monthly to less than 20 charts monthly



Patient Messaging TAT<24 hours

Improved from 78% to 92%



Internal Referrals

Increased 4-fold

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Summary

- Strong leadership drives change and establishes culture
- A value-based infrastructure promotes coordinated care
- Incentives motivate the behavior you need

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