THE STRATEGIC CASE FOR PROMOTING VALUE BASED MEDICAL CARE

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Learning Objectives

- Review Current and Future Trends Shaping the Healthcare Delivery System
- Shaping the Healthcare Delivery System
- Assess the Transformation to Value-based Health Care
- Examine the Role of Population Health Value-based Care
- Examine Approaches to Create A Value-based Health Care Delivery System
- Align Organizational Healthcare Model With A Value-based Care Model
- Case Study
- Lessons Learned

Review Current and Future Trends Shaping the Healthcare Delivery System
6 Remarkable Facts About the Future of Health Care

01 Preventive Medicine & Population Health Will Soar
02 Aging Population and Proliferation of Chronic Diseases
03 Transition to Value Based-care, Analytics & Predictive Medicine Will Transform Healthcare
04 Medical Providers Will Have Access to More Data
05 Innovation, Consolidation, and Collaboration Will Destroy Silos
06 U.S. Healthcare Spending to Reach Nearly 20% of GDP by 2025

Healthcare Spending Continues to Grow

UNSUSTAINABLE SPENDING GROWTH

Source: CMS, (2017)

Recent Moderation in Trend Is Promising, But Not Clear Yet Whether Structural...
A Population More Predisposed to Comorbidity

Worsening Case Mix Not Just Due to Aging

Obesity Rate Among U.S. Adults¹

1988

2016


¹) Body Mass Index ≥ 30, or 30 pounds overweight for 5’ 4” person.

Chronic Disease Growth Outpacing Population Growth

Projected Increase in Chronic Disease Cases

2003-2023

29.0%

31.0%

39.0%

41.0%

53.0%

54.0%

62.0%

Stroke Pulmonary Conditions

Hypertension Heart Disease Diabetes Mental Disorders

Cancer

Political Implications for 2018 - 2020

There is no new money in healthcare

Increased influence of large health systems and physician groups

Continued growth of value-based payment models/MACRA implementation

Increased market competition for device and pharmaceuticals

Increased state flexibility and control of Medicaid

Continued push toward consumer-driven healthcare

Growth in, and increased competition for, Medicare Advantage and private health plans
### The New Competitive Environment

The Nature of Collaborative and Competition Is Fundamentally Changing

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
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<tbody>
<tr>
<td>Single community markets</td>
<td>Large regional markets</td>
</tr>
<tr>
<td>Provider competition</td>
<td>High value network competition</td>
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<tr>
<td>Competition / Integration among providers</td>
<td>Greater competition among regional players</td>
</tr>
<tr>
<td>Prolific payer strategies</td>
<td>Narrow networks with preferred payers</td>
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<td>Greater market change and confusion</td>
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ASSESS THE TRANSFORMATION TO VALUE-BASED HEALTH

FROM

- Single community markets
- Provider competition
- Competition / Integration among local providers
- Prolific payer strategies
- Uncontrolled growth of networks

TO

- Large regional markets
- High value network competition
- Greater competition among regional players
- Narrow networks with preferred payers
- Greater market change and confusion
The Transformation To Value-based Health

- The transformation to value-based health care is well under way. Some organizations are still at the stage of pilots and initiatives in individual practice areas. Other organizations, such as the Cleveland Clinic and Germany’s Schön Klinik, have undertaken large-scale changes involving multiple components of the value agenda. The result has been striking improvements in outcomes and efficiency, and growth in market share (Michael E. Porter & Thomas H. Lee, MD, 2013, HBR).

Transition To Value-based Payment

<table>
<thead>
<tr>
<th>PAY FOR VOLUME</th>
<th>PAY FOR VALUE</th>
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<tbody>
<tr>
<td>Fragmented care</td>
<td>Accountable care across the continuum</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>Global payment</td>
</tr>
<tr>
<td>Adversarial payers and no transparency</td>
<td>Right care, right setting, right time</td>
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<tr>
<td>Limited HIT role</td>
<td>Triple Aim metrics</td>
</tr>
<tr>
<td>Lack of outcome-based metrics</td>
<td>Fostering wellness</td>
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<tr>
<td>Duplication and waste</td>
<td>Payer and provider partners using transparency</td>
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<tr>
<td>Data analytics is the name of the game</td>
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What Are the Benefits of Value-Based Healthcare Delivery?

- Patients spend less money to achieve better health.
- Providers achieve efficiencies and greater patient satisfaction.
- Payers control costs and reduce risk.
- Suppliers align prices with patient outcomes.
- Societal/Population becomes healthier while reducing overall healthcare spending.
What are CMS' original Value-based Programs?

There are four original value-based programs, their goal is to link provider performance of quality measures to provider payment:

- Hospital Value-Based Purchasing (HVBP) Program
- Hospital Readmission Reduction (HRR) Program
- Value Modifier (VM) Program (also called the Physician Value-Based Modifier or PVBM)
- Hospital Acquired Conditions (HAC) Program

There are several other value-based programs:

- End-Stage Renal Disease (ESRD) Quality Initiative Program
- Skilled Nursing Facility Value-Based Program
- Home Health Value-Based Program (HHVBP)
What is Population Health Value-based Care

Population health is about improving outcomes for communities by improving outcomes for individuals. Health care is fundamentally shifting from managing encounters and venues to people across networks, and providers need solutions to know, manage and engage with their populations.

A simple definition is "the health outcomes of a group of individuals, including the distribution of the outcomes within the group."

The Triple Aim defines 3 interdependent aspects:

• Improving the health of a population
• Improving the patients experience of care
• Reducing the per capita costs of care

Engaged Communities:
- Proactive care processes
- Identified patients
- Focused on wellness
- Community resource navigator

Engaged Patients:
- Identified and incorporated patient goals
- Focused on continuity and coordination
- Facilitated communication channels

Identified Opportunities to Reduce Waste:
- 4 Rights
- Duplication avoided
- Improved coordination/transitions
- Used automation to reduce resource needs
- Improved screening and prevention
- Aligned incentives to show value

Achieving Success Making the “Triple Aim” Possible

Better Health for the Population
Population Health Management (PHM)
The Future of Healthcare Paradigm Shift

**Today:**
- Reactive and Volume-based

**The Future:**
- Proactive and Value-based

**Drivers**
- Health Reform
- Affordability Gap
- Triple Aim
- Weight of the Nation
- Reimbursement

**Encourage**
- me!

**Educate**
- me!

**Treat**
- me holistically!!

**I will pay**
- you!

Individuals are accountable for their health with the health system as their health advocate.

PHM provides comprehensive authoritative strategies for improving the systems and policies that affect health care quality, access, and outcomes, ultimately improving the health of an entire population.

**Key Pillars of Population Health Management**
- Workflows, role changes, people, care coaches, wellness program development, health risk assessment, population engagement
- Business vision, population definition, policies, modeling, financials, contracts, procedures, market analysis, and value proposition
- Integration and interoperability including HIE, patient portal, analytics, coaching tools and health risk assessment
- Risk, incentives, payment management, shared savings

**Contracting Structures By Complexity And Provider Risk**

- Fee-for-service
- Inpatient case rates (DRGs)
- Pay for performance
- Bundled payment for acute care (inpatient only)
- Bundled payment for episodes of care
- Primary care management fees
- Shared savings with upside only
- Shared savings with downside risk
- Global capitation
The Most Common Contracting Structures By Complexity And Provider Risk

- Fee-for-service
- Inpatient case rates (DRGs)
- Pay for performance
- Bundled payment
- Global capitation

Getting Paid Less to Do Less

New Payment Models Calling Old Imperatives Into Question

<table>
<thead>
<tr>
<th>Accountable Payment Models</th>
<th>PERFORMANCE RISK</th>
<th>UTILIZATION RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td></td>
<td>Volume of Care</td>
<td></td>
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</table>

- Bundled Pricing
  - Bundled Payments for Care improvement programs
  - Bundled bundled contracts
- Pay-for-Performance
  - Value-Based Purchasing
  - Readmissions penalties
  - Quality-based commercial contracts
- Shared Savings
  - Medicare Shared Savings Program
  - Pioneer ACO Program
  - Commercial ACO contracts

EXAMINE APPROACHES TO CREATE A VALUE-BASED HEALTH CARE DELIVERY SYSTEM
Organize "Integrated Practice Units" or "IPUs" around patient conditions

Organize primary and preventative care to serve distinct patient segments

Measure outcomes & cost

Offer bundled pricing arrangements

Integrate delivery across separate facilities

Expand geographic coverage by excellent providers

Build and enable information technology

Creating a Value-Based Health Care Delivery System

The Strategic Vision

Michael Porter, Harvard University, 2013

Population Health Accountable Care Organizations

Executing Strategy in the Accountable Care Era

Tactics for Evolving Primary Care to Support Accountable Care Strategy
Physicians the Key Player

Physicians Essential to Generating Value from System

Physicians

Hospitals Integrating Physicians

Population Integrating Physicians

Care Planning

Care Coordination

Value-Added Processes

Three Fundamental Principles

Recalling the Tenets of True Population Health Value Based Care

An End to Factionalism

Physician-Oriented Leadership

Patients at the Center

Hospital leaders, physicians must move beyond "us vs. them" mentality to one of system unity, shared purpose

System leaders need not be physicians, but must have collegial, productive relationships with physician partners

All stakeholders must understand that system value derives from serving patient needs through high-quality, cost-effective care

The New Hospital-Physician Compact

Collaborating to Deliver Value to Patients

Patient Demands

System Responsibilities

Timely Access

• Physicians build schedules around patient needs, connect to other providers to expedite care

• System invests in alternative access points and necessary capacity

Cost-Effective Care

• Physicians proactively work to reduce costs, streamline care

• System encourages use of lower cost care pathways

Principled Referrals

• Referral decisions based on quality and cost, not habit

• Providers proactively engage patients in care management

Top-Quality Care

• Physicians build and utilize evidence-based care standards

• Clinical decision support optimized for quality and efficiency

Open Communication

• Providers view teams and required shared practice

• Providers proactively engage patients in care management

Unified Care Experience

• Care transitions appear seamless, care coordinated

• Information is a system asset, utilized by all to streamline care experience

• Physicians actively work to reduce cost, unnecessary utilization

• System encourages use of low-cost care pathways
Case Study: Diabetes Management

Lifetime Medical Costs for Treating Type 2 Diabetes

<table>
<thead>
<tr>
<th>Age at Time of Diagnosis</th>
<th>Lifetime Medical Costs for Men</th>
<th>Lifetime Medical Costs for Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-44 years old</td>
<td>$110,400</td>
<td>$130,800</td>
</tr>
<tr>
<td>45-54 years old</td>
<td>$85,500</td>
<td>$56,600</td>
</tr>
<tr>
<td>55-64 years old</td>
<td>$106,200</td>
<td>$124,700</td>
</tr>
<tr>
<td>65 or older</td>
<td>$84,000</td>
<td>$54,700</td>
</tr>
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</table>

- **28.75 million**
- **-1.75 million**

Number of people in United States with Type 2 Diabetes

New Cases of Type 2 Diabetes

Source: American Diabetes Association, American Journal of Preventive Medicine, September 2016

Goal Is to Eliminate System Waste, Improve Care and Reduce Cost

Case Study: Diabetes Performance Measure Set

<table>
<thead>
<tr>
<th>Measures</th>
<th>Quality Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>HgbA1C - patient specific goal</td>
<td>Meets patient goal on problem list</td>
</tr>
<tr>
<td>LDL - patient specific goal</td>
<td>Meets goal or on high-intensity statin</td>
</tr>
<tr>
<td>Blood pressure goal</td>
<td>Meets patient goal on problem list</td>
</tr>
<tr>
<td>Urine protein testing</td>
<td>Yearly</td>
</tr>
<tr>
<td>Pneumococcal Immunization</td>
<td>Once ~65, Once ~65 (at least 5 yrs. after 1st test)</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>Patients who achieve ALL of the above standards</td>
<td>Diabetes Management Bundle Percentage</td>
</tr>
</tbody>
</table>
An Evidence-based Approach for Value-based Care Transformation to Deliver Outcomes

1. EVALUATE population health and develop a value-based care strategy
2. ANALYZE clinical and financial data to prioritize opportunities for improvement
3. ENGAGE the care continuum—provider network, physicians, and patients—to drive behavior change
4. OPERATIONALIZE the care model and incentive structure to manage population health effectively
5. SUPPORT transformation into a value-based population health model through advisory, operational, and technology services

Improving the Customer Experience of Care

Improving the Health of Population

Reducing per Capital Costs of Care

Applying the Principles of Workflow Redesign

Provide clinical decision support—health and evidence-based alerts
Expand patient-specific strategies using registry report data
Identify care gaps
Refine care plans—customer centered—patient report cards
Restructure physician compensation/payment packages

Notable Process Improvements

Case Study: System of Care for Diabetes

Workflow Redesign

Diabetes Management Results

105 MI's prevented
NNT to prevent 1 MI
82 patients

140 strokes prevented
NNT to prevent 1 stroke
170 patients

166 cases of retinopathy prevented
NNT to prevent 1 retinopathy
152 patients

Source: Primary Care Diabetes Bundle Management: Three-Year Outcomes for Microvascular and Macrovascular Events (FBloom; TGraf; WStewart; GSteele, et. al., June 2016 (20(6); 175-182)
**Impact of Geisinger Care Model on Quality and Cost**

- **Acute care admissions**: 27.5%
- **All cause 30-day readmissions**: 34%
- **Patients say quality of care improved when they worked with a case manager**: 72%

Note: Outcomes represent the period 2007–2016 and more than 80,000 Geisinger Health Plan members in Geisinger Health System practices.

**The Time is Right for Value-based Care**

Healthcare Organizations Can Achieve the Greatest Benefit of Value-based Care Programs

-**VALUE-BASED PAYMENT ROADMAP**

**Lessons Learned Along The Way**

- It is not the tool created in the EHR, but the tool's implementation into a system of care that makes it successful.
- Compensation helps focus attention, but is not sufficient to drive change.
- Reliability improves when practice is redesigned to spread the work out over a team and gives each team member clearly defined roles.
- Measures are never perfect, but they improve with time and are vital for:
  - Measuring quality, accuracy, and costs.
  - Monitoring the change process.

NOT JUST REENGINEERING - THIS IS FOR THE "LONG HAUL"
Lessons Learned: Determining the Speed of Transformation to Value-based Care Models

- The readiness of payers for a value-based payment model
- Alignment of compensation models with VBP arrangements
- Readiness of competitors to implement value-based arrangements
- Level of transparency that exists

Lessons Learned: Common Barriers to Value-based Care Success

- Leadership commitment and vision
- Cultural change
- Size / market presence
- Financial resources
- Lack of aligned primary care network
- Population health information technology
- Lack of physician engagement
  - Behavioral economics
  - Physician leadership
  - dyad leadership
  - Population leadership education / training

Lessons Learned: Determining the Speed of Transformation to Value-based Models

- Organization of medical practice
- Integration of the delivery system into organized vehicles
- Supply, distribution and model for primary care services
- Hospital and physician EMR's and connectivity
- Culture based on concepts such as the partnership relationship / trust
Lessons Learned: Overcoming the Challenges of Transparency in Value-based Care

Transparency from a Consumer Perspective
Transparency from a Physician Perspective
Transparency Within a Healthcare Organization
Transparency Between Payers and Providers

What Is the Future of Value-Based Healthcare?

Moving from a fee-for-service to a fee-for-value system will take time, and the transition has proved more difficult than expected as the healthcare landscape continues to evolve and providers increase their adoption of value-based care models. However, the transition from fee-for-service to fee-for-value has been embraced as the best method for lowering healthcare costs while increasing quality care and helping people lead healthier lives.

References