SCOTTSDALE INSTITUTE

INSIDE EDGE

Volume 19, Number 2

New Models of Care and Financing

EXECUTIVE SUMMARY

Scottsdale Institute's Inside Edge report has always aimed at creating a "conversation" with the goal of sharing best practices among member organizations. Given the enormous learning curve health systems face in addressing this issue's topic, "New Models of Care and Financing," we may not deliver a ton of best practices. However, it sure makes for a stimulating conversation.

As healthcare moves from the proverbial volume to value, from fee-for-service to accountable care, we are not merely changing our accounting system—we are undergoing a revolution. We are both literally and figuratively "going at risk". Seemingly overnight familiar sign posts disappear, the terrain changes and old maps become obsolete. As new organizational structures, processes and metrics emerge, so must new executive roles and skill sets.

Our conversation about this new environment is with experts from CSC, Bellin Health System, Catholic Health Initiatives and Trinity Health. It does not stop here, however. We continue the conversation at SI's 20th Anniversary Spring Conference aptly themed "Moving from Volume to Value." Talk to you there!

Letting go of filling beds

Seismic change is occurring everywhere in the healthcare industry, yet we may not be aware of it beyond our local market.

"There is far more activity going on at both small and big healthcare organizations than is readily visible," says Jordan Battani, managing director of CSC's Global Institute for Emerging Healthcare Practices. "Everybody's trying lots of creative and innovative models out there. Hospital executives especially are letting go of their reflexive mantra: 'Got to fill my beds, got to fill my beds.'"

Most executives realize there's no future in fee-for-service, volume-based healthcare—despite the fact they're forced to generate revenue from the fee-for-service model even as it dies. "Everybody's operating in a mixed environment with cost-containment driven by Medicare, Medicaid and the private sector. Private health plans are reaching out to providers to develop creative network structures, care delivery models and reimbursement models," she says.

Among the many indicators of change: the dramatic shift in physician practice and ownership. While evident for several years, the trend is now so firmly entrenched there's no possibility of

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reversing it. Physician consolidation reflects the simultaneous acceleration of three factors: 1) The old model of small, entrepreneurial physician practices is not working because they can't develop the infrastructure required to effectively coordinate care and participate in accountable care arrangements; 2) Physician demographics are changing with an increasing expectation of work/life balance; 3) Hospitals and health systems cannot run with physicians to the altar fast enough.

Jordan Battani, Managing Director, Emerging Healthcare Practices, CSC

"This marriage is not just to fill beds, but to better manage, monitor and control the continuum of care, which is critical under new quality and performance models. The amount of change and how quickly it's happening is amazing," says Battani.

Analytics breakthrough coming

Hospitals' well-documented push for integration in the 1990s failed largely as a strategy for several reasons.

"The momentum was all from the private sector in the 1990s. This time it's coming from both the public and private sectors. They've never been as focused as now," says Battani. "In the 1990s it was all about squeezing costs out, but that approach triggered unexpected compromises in quality. Today as an industry we're much more able to identify quality and safety metrics. We have the analytical tools to ensure quality and safety and much better technology to enable it. We're at the beginning of a breakthrough in clinical analytics to drive quality and cost," she says.

In addition to expectations changing for both individuals (in people receiving care and how they participate in the care process) and physicians, employer-sponsored healthcare is changing rapidly. Large employers have become much more flexible in moving away from traditional health insurance. "Employer-sponsored healthcare coverage used to be a given like gravity, but many employers are exploring radical change in health plans, including a move to defined-contribution approaches to healthcare coverage," says Battani.

The trend is similar to what occurred with pensions 20 years ago with the innovation of the 401K, which replaced traditional defined-benefit plans guaranteed by employers. The 401K guarantees a contribution by the employer but not the outcome.

"The 401K insulated the employer from risk. The same thing is happening today in healthcare coverage. The employer will provide a defined contribution, but the employee has to make decisions about what healthcare coverage to purchase, and how to manage the contribution from the employer," she says. All the innovations—whether they are called accountable care, patient-centered medical home, bundled payments or capitation—are attempts by the healthcare industry to reduce healthcare-cost

inflation while simultaneously improving quality and outcomes.

Public health crisis of the 21st century

The expectations have taken us back to Don Berwick's Triple Aim of enhancing the patient experience, improving population health and reducing cost.

"We're facing the public health crisis of the 21st century, which is the morbidity and mortality of the chronically ill," says Battani. "It's as big a crisis for us as infectious disease was in the 20th century, but we can't fix it with antibiotics and indoor plumbing. Our big challenge is to achieve improvements in public health status—and it's global. The culprits are the usual suspects of chronic disease, such as obesity, diabetes, heart failure, and you can't fix them with surgery or a miracle drug."

Solving those issues is far more complicated than those we've faced in the past—and will require a multiplicity of solutions, at least partly because of the diverse psychosocial nature of the challenge. Different individuals respond to different prods to improve or maintain their health status.

Merely educating people as to what works drives some people and not others, for example. Medication compliance is a case in point: the biggest factor in people not taking their medication is the level of seriousness of the condition. Patients who have been told they have a life-threating illness, for example, tend to go into denial and not follow up on therapy.

"It's not just about financials, education or responsibility," she says. It's a complex issue whose costs, financial and personal, permeate all of society, which is why every aspect of society is becoming galvanized around the issue. Cities and counties are designing neighborhoods that promote walking and other types of exercise, for example. Mobile apps are appearing that guide you grocery shopping so that you avoid unhealthy foods.

"Part of the new care delivery model has to change the way we live. All this innovation we're seeing is just the tip of the iceberg," says Battani.

Betting on Green Bay

The winds of healthcare reform have swept even the frozen tundra of Lambeau Field.

"We're definitely in exciting times," says Jacquelyn Hunt, CIO and CQO for Bellin Health System, an integrated delivery system in Green Bay, Wisc. "The connection between quality and IT has never been closer."

With just a 167-bed hospital, Bellin is a small delivery system serving a population of about 600,000 in northeast Wisconsin and northwest Michigan. But small size hasn't kept it from a bold organizational vision, which reads: "The people in our region will be the healthiest in the nation."

That vision and innovation in the marketplace has guided Bellin to focus on managing the health and affordability of care for populations in their region. Bellin was awarded a Pioneer ACO contract by CMS under its Center for Medicare and Medicaid Innovation

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MAY
Patient Engagement: Beyond the Portal

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Contact Chuck Appleby, cappleby@scottsdaleinstitute.org with expert sources, case studies or ideas.

TELECONFERENCES

March 18
SI-Cerner Users Collaborative No. 52: Care Value System
- Barbara Caspers, MS, RN, VP, National Nursing Services, Catholic Health Initiatives

March 21
Can the CDS Collaborative for Performance Improvement Advance Your Quality Improvement Efforts?
- Jerome A. Osheroff, MD, FACP, FACMI, TMIT Consulting, LLC

March 27
Trends in Clinical Quality Measurement
- Ferdinand Velasco, MD, CMIO, Texas Health Resources
- Maggie Lohnes, HIMSS

March 28
Capturing and Reporting Pricing and Outcomes Data
- Louis Diamond, president, Quality Health Care Advisory Group
- Melinda Ashton, MD, FAAP, VP, Patient Safety and Quality Services, Hawaii Pacific Health

April 2
Evolving View of MU: Lessons from the Field
- Eric Finocchiaro, director, Deloitte Consulting
- Ryan Haggerty, senior manager Deloitte & Touche LLC

April 9
Moving from Clinical Documentation to Clinical Insight
- Alan Stein, MD, PhD, VP, Healthcare Technology, Autonomy, an HP company

continued on next page

(CMMI), for which Hunt serves as a mentor to innovation advisors with health IT-related projects.

bellinhealth

Jacquelyn Hunt, CIO/ CQO, Bellin Health System

The health system is also focused on managing the health of its own 3,200 employees and some of their dependents. "With our own costs increasing, we first looked internally to test concepts to improve health and lower employer costs. When we successfully test a new product internally we can then confidently offer it to local employers facing similar challenges. As we get better at managing populations, we share our story with employers and consider new lines of business. There is no place to walk-the-talk like in your own place of business," she says.

Bellin's innovative work with employers has garnered it a chapter in the book "Pursuing the Triple Aim: Seven Innovators Show the Way to Better Care, Better Health, and Lower Costs," (http://www.amazon.com/Pursuing-Triple-Aim-Innovators-Better/dp/1118205723).

Like the Green Bay Packers for whom it is official care provider, Bellin is community owned—a factor that has shaped its strategic vision.

Small but agile

"We are the smaller and only locally owned healthcare system in Green Bay, which has made us absolutely competitive. We are also blessed with a very innovative CEO and leadership team," she says. Actively participating in the Institute for Healthcare Improvement (IHI) Triple Aim initiative has helped to inform Bellin's strategies for the following:

- *Improving the experience of care—providing care that is effective, safe and reliable—to every patient, every time*
- *Improving the health of a population, reaching out to communities and organizations focusing on prevention and wellness, and managing chronic disease*
- *Decreasing per capita costs*

In first deploying the Triple Aim concepts within its employee population, Bellin's Business Health and Human Resources teams work closely with an insurance broker to embed incentives, encourage healthy behavior and increase the connection between an employee and their primary care team.

"A key component of the employee engagement strategy is providing each employee with knowledge of their health risk assessment (HRA) score. That single score is well correlated with better health and lower cost. An innovation is to integrate that information into the electronic medical record so it is also broadly available. Ideally, each employee will have their own online shared care plan that is supported by their primary care team," she says.

Keeping shipshape

"We are also looking far outside our own walls. In order to improve health across our region, we need to bring care where people spend their time. That means schools and employers, where people spend eight hours a day as compared to the 15 minutes they spend at a doctor's visit. We're thinking more holistically regarding what, where and how healthcare services are delivered," she says.

Bellin has eschewed building hospitals and instead operates more than 50 onsite clinics, including pods in parking lots at local businesses and shipyards. Bellin is willing to engage employers with as few as 100 employees or as many as 50,000. It scales services appropriate to the employer's size. A video on Bellin's Triple Aim work with employers is accessible on YouTube: http://www.youtube.com/watch?v=1hoW-xZw4wk.

The health system has also launched FastCare, a walk-in clinic offering, located in retail locations. Unlike other similar competitors, Bellin's FastCare differentiates itself by requiring clinics to be tied to and staffed by a local health system.

"We probably could have expanded our FastCare model to other areas, but we believe people should always be connected back to primary care, to avoid further care disintegration. There are plenty of other organizations selling the retail clinic concept. The difference is that we emphasize continuity of care," says Hunt. Bellin has found a niche offering their turnkey retail-clinic solution, which provides facility construction, marketing, policies and other start-up needs. FastCare has been attractive to health systems focused on coordinating care, reducing unnecessary emergency room volumes or offering care in underserved areas.

"Bellin is adapting to a spectrum of business arrangements based on the philosophy and readiness of the employer and/or payer. Some employers don't see employee health as their domain and will shift that expense elsewhere. Some employers are interested but not that committed. More progressive companies see the connection between workplace productivity, health and safety and see the influence they can have. We look to create at-risk partnerships with those progressive companies, regardless of where they get their primary care services. It's being very customer focused. We're seeing all kinds of interesting market arrangements," she says.

IT to Achieve the Triple Aim

IT is integral to supporting new models of care and financing. Bellin's size and innovative market strategies require that every IT dollar spent is laser focused and will deliver on promises of improved health and greater efficiency. Hunt summarizes the Bellin IT strategy:

- "Work from our long-range 'iVision' which connects to organizational vision and the needs of patients, customers and providers.
- Prioritize our IT resources and capital through six business-led teams. The chairs of these teams meet regularly to continue to

continued

April 10
Using Analytics to Improve Physician Engagement
- Kristen M. Farmer, MA, BSN, RN, manager, Professional Practice, Spectrum Health
- James Schweigert, MD, associate medical director, Quality and Medical Director Emergency Medicine, Spectrum Health

April 22
SI-Cerner Users Collaborative No. 53: Role and Impact of CDS at Memorial Hermann
- Thomas Nguyen, MS, clinical information analyst, Clinical Decision Support, Memorial Hermann Healthcare System

April 25
PMO Collaborative No. 3: PMO Organizational Structure and Scope Within Large Health Systems
- John Kocon, VP, Enterprise Program Management Office, Catholic Health Initiatives (moderator)
- Melissa Dill, VP, Shared System Services, Ascension Health
- Johnathan Nielsen, senior director, Programs & Projects Management Office, Dignity Health

May 2
St. Vincent Health: Readmissions Reduction Results
- Alan D. Snell, MD, MMM, CMIO, St. Vincent Health

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improve our processes, flow and performance.

- Invite patients to participate on IT projects that involve patient flow/care to ensure we deliver what our customers ultimately want and need.
- Incorporate quality improvement methodologies within IT and across the organization to support users and system redesign.
- Focus our investment and development on disease management, utilization management, case management, care coordination, patient engagement in support of our Triple Aim work."

"Moving from volume to value sounds relatively straightforward, but it's an absolutely whole new world. You're really talking about risk management and insurance."

Answering questions for 40 markets

In contrast, Catholic Health Initiatives (CHI) is standardizing new models of care and financing on a nearly national scale.

"We are in 40 markets and are doing different things in clearing this evolutionary path for our facilities," says Michael Rowan, COO of CHI, an Englewood, Colo.-based health system with 78 hospitals in 17 states and nearly $10 billion in annual revenues. Each market solution is different depending on local providers and payers.

"Some payers are trying to get ahead of the game and others are enjoying the status quo," he says.

CHI is building out the operational capabilities for each of its markets in terms of payer negotiation and care model in order to get to a value-based model. The goal is to combine those two factors in a way that achieves clinical outcomes with a supporting financial mechanism.

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Michael Rowan, COO, Catholic Health Initiatives

"In some locations we're pushing the market and in others we're following," added Rowan. As an organization the biggest priority is to build the skill sets. We're historically a hospital company intent on keeping our hospitals full. That's a very different world than one focused on delivering value. The concept of value is evolving from a current simplistic one of delivering top clinical quality to a future one of population health management. How do you keep people as well as possible?" asks Rowan.

'A whole new world'

Certainly part of the solution involves identifying populations, coming to conclusions regarding their healthcare costs and determining how to keep people from getting sick to begin with. "How do we create local leadership teams who can work across the continuum of both prevention and treatment. That's a complicated process," he says.

"Moving from volume to value sounds relatively straightforward, but it's an absolutely whole new world. You're really talking about risk management

and insurance. So, in other words, what's the probability of something occurring and how do we actually plan for it," asks Rowan.

Today's attempts at cost control are much more informed than HMOs 30 years ago when the answer was to minimize access to treatment.

"We want to keep people from needing treatment, not keep them from treatment when they need it," he says. "It's about changing the care model and the kinds of activities that physicians are engaged in on a day-to-day basis. We want to evolve most of our physicians into work that prevents illness rather than reactively attempting to treat illness. Given the current reimbursement models in the industry we have to think about how do we change the financial incentives. So, how do you incentivize staff? What is the mix of healthcare providers that is required to take care of a population of patients? How many gastrointestinal surgeons do you need in that scenario? What are the implications under population health management for a cardiology practice which is currently highly focused on doing interventional procedures versus primary care cardiology?"

For CHI, answering those questions means developing a system where administrative and clinical leaders work to develop a network of providers to support the new model.

"There will be a shakeout. Hospital utilization is already dropping. In the future, there will be fewer hospital beds and fewer hospitals. The need for as many executives whose primary skill set is running a hospital will drop. The key is can those individuals translate their skills into creating and managing a system focused on the continuum of care, which goes way beyond the hospital," says Rowan.

Being a good shepherd

While CHI does not have a formal educational track, it has developed a series of educational opportunities for its market leaders. CHI recently presented the template to about 200 of its executives at a three-day session. "We explained the path to evolve our health systems from volume-focused to value-focused, the required activities and the distribution of work between national and local to accomplish this. We're not focused so much on individuals as on the development of local health systems that meet the needs of the market and the changing healthcare industry," he says.

The session described a pathway to the development of clinically integrated networks in each of CHI's local markets by the end of the calendar year.

"These clinically integrated networks are legal organizations with facilities and physician practices capable of contracting to provide healthcare services with a health insurer, employer or government entity. It doesn't mean we'll have a contract, but we'll have stood up an entity that is capable of developing this template," says Rowan.

Senior leadership will meet monthly with each market to ensure they're meeting milestones and to identify additional resources they may need.

"In the future, there will be fewer hospital beds and fewer hospitals. The need for as many executives whose primary skill set is running a hospital will drop."

"Clinical integration implies so much more than an EMR. It's the entire continuum of care, which involves multiple systems and the ability to leverage analytics broadly."

"We spent a great deal of time at this retreat helping people understand the IT infrastructure required, especially the business intelligence component to do population health management, wellness and managing the premium dollar," he says. "Healthcare is a data-driven process. It's one thing to have a medical record for one patient, it's another thing to track a population of diabetics. The whole information management piece for populations is by orders of magnitude more sophisticated."

A post-EMR Trinity

Livonia, Mich.-based Trinity Health has been in the news a lot lately. Just this month Trinity CEO Joe Swedish was named the new CEO of Wellpoint Inc., the nation's second-largest health insurer. As much as any recent event, the move underscores the blurring line between providers and payers as we enter a new era of risk and payment in healthcare.

In October Trinity and Catholic Health East announced their intent to consolidate into what would become a coast-to-coast health system with 82 hospitals in 21 states with nearly 90,000 employees and 4,100 employed physicians. The move reflects the accelerated industry consolidation occurring to better leverage the emerging new models of care and financing.

The collaboration between the provider and payer worlds is also continuing at Trinity on a less visible level. "You're starting to see more people coming into Trinity with experience in both provider and payer arenas," says Marcus Shipley, senior VP and CIO, who came to the health system last year from health insurer CIGNA, where he was VP of IT. "This new world is upon us. It's the post-EMR era."

TRINITY HEALTH
Livonia, Michigan

Marcus Shipley, SVP/ CIO, Trinity Health

For the past 12 years Trinity has focused on its systemwide Genesis platform, a standardized EMR implementation. Genesis provides the core IT foundation upon which Trinity will build the next-generation platform for accountable care. "It is a great foundation and does what it's supposed to do. During the recent fungal meningitis outbreak we were able to roll out real-time alerts, rules and reporting quickly to providers. It was impressive," he says.

The post-EMR era, however, requires new IT functionality and a broader vision. "We're in the process of developing analytics capabilities for clinical integration and the continuum of care—improving quality, consumer experience, and risk management. Risk management is an important competency of this era including the actuarial risk of a population, financial risk in contracts and the clinical risk associated with quality of care. For IT that means unlocking the data from proprietary applications and helping our business partners leverage it to manage this continuum of risk," says Shipley.

'IT in transition'

This new era also means retooling the IT organization to focus on the new competencies required for clinical integration including analytics, integration, interoperability and consumer engagement.

"Our IT is in transition. We're reorienting the organization to focus on these competencies. IT associates who helped implement the EMR are people who appreciate standardization; this is essential to the data that will drive future analytics. Recruiting and developing talent will be even more critical to our future. Medical informatics continues to be important, and increasingly we will look to other industries like insurance and retail," says Shipley.

The heart of this transformation is a significant change-management challenge. There must be a sense of urgency, a shared vision and direction. "Our associates must appreciate the significance of the change. It's not one thing. It's establishing a clear vision, making the case and ensuring IS enables it. That's when you start to build momentum and the organization comes with you," says Shipley.

The goal is much broader than an EMR implementation. "Clinical integration implies so much more than an EMR. It's the entire continuum of care, which involves multiple systems and the ability to leverage analytics broadly. It's a challenging technical problem, but the payoff is huge."

Conclusion

Despite its academic-sounding tone, the issue of "New Models of Care and Financing" is anything but dry. We're witnessing innovation and creativity on a massive scale as the healthcare "industry" undergoes a revolution, triggered from the top but carried out from the grass roots upward. How American.

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