Aligning value incentives in program design

IOM Roundtable on Value & Science-Driven Health Care

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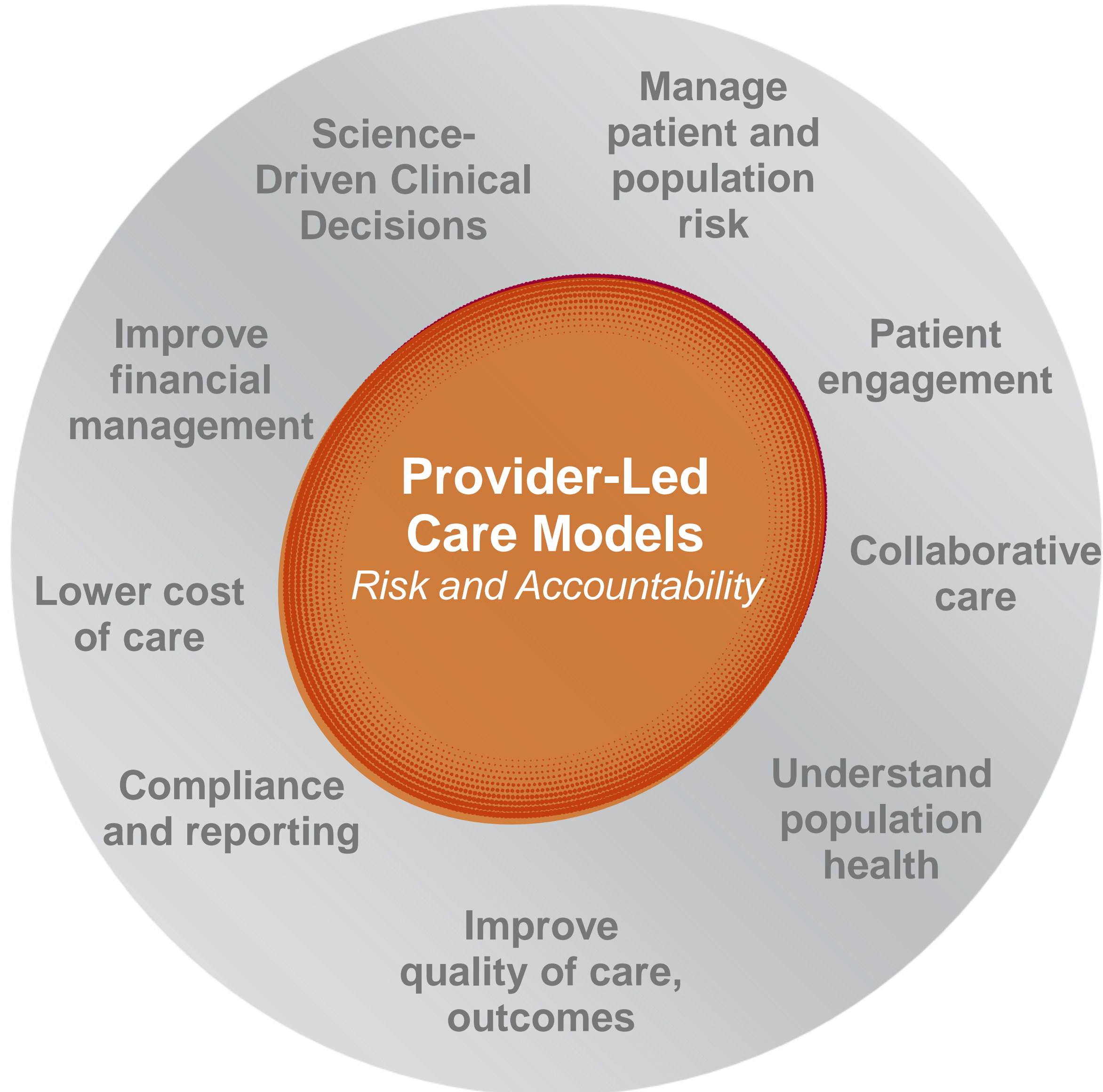
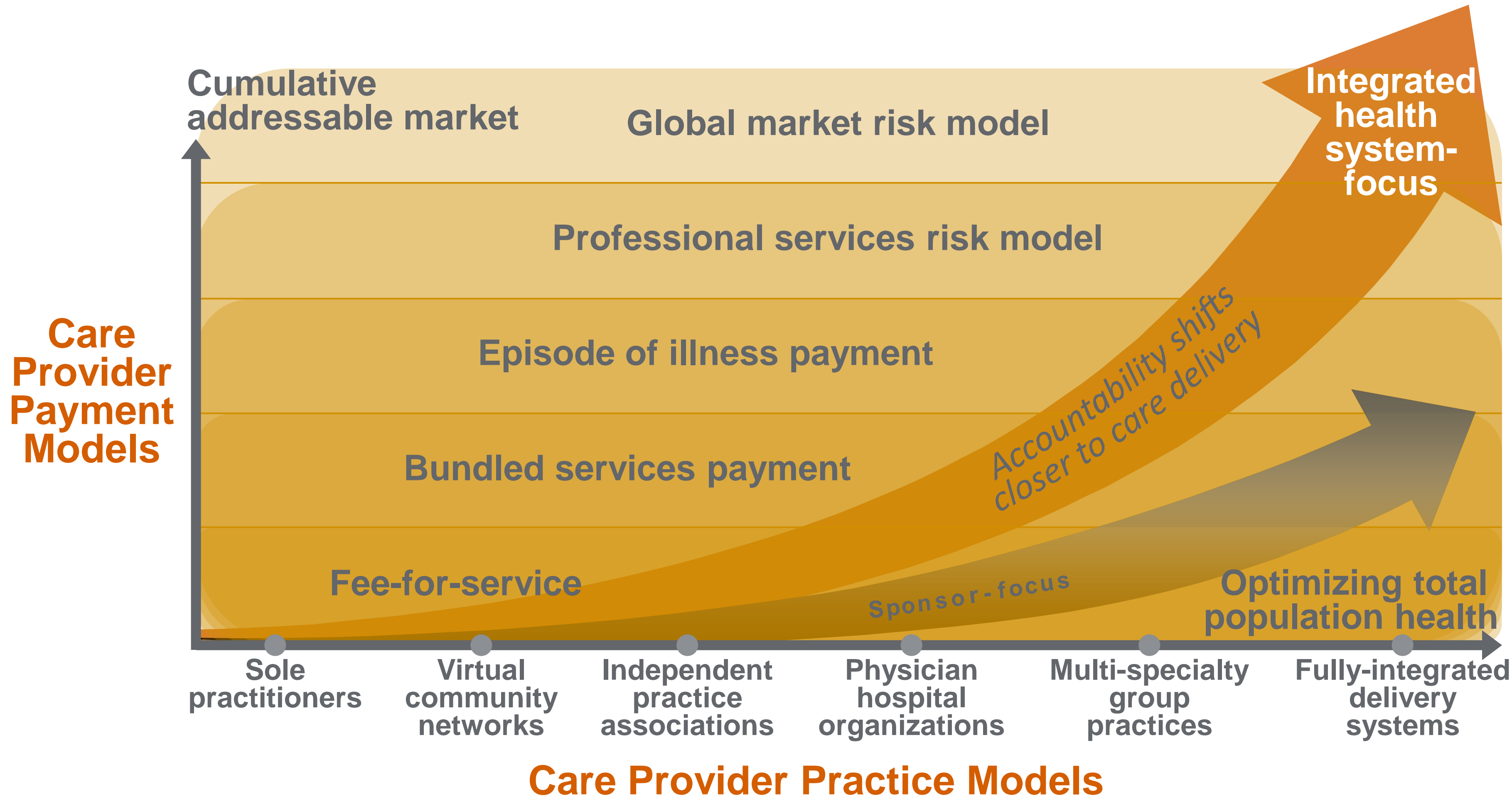
Providers are at the Epicenter of New Models of Care



Market Change Will Take Many Forms…

Community by Community



New value creation for existing solutions; **creation of new markets**

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Goals of the new model

- Macro-level
  - Improve the consumer experience
  - Improve the overall health of the population
  - Improve individual health outcomes
  - Decrease cost
- Micro-level
  - Seamless connectivity that delivers clinical information/value based options for the provider and patient at the point of care—optimizes science driven decisions
  - Transformational consumer & provider engagement
  - Sustainable solutions addressing health literacy

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What does improved quality & cost-effectiveness look like?

- Improved quality
  - Sustained & high performance as measured by quality of care and service outcomes, i.e., HEDIS, STAR ratings and other measures exceeding national benchmarks
  - Sustained & high consumer & provider satisfaction
  - Sustained populations health measures at or above 90th percentile
  - Mitigation of gaps in health literacy
  - Right care, right place, right time
- Cost-effectiveness
  - Zero-extremely low medical cost trend YOY that is sustainable
  - Extremely cost effective delivery systems that will result in competitive premiums for individual, private and public payers
  - Consistent throughout: provider payment aligned with performance/outcomes
  - Value based efficiency metrics

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Keys to success

- Interconnectivity/inoperability of a network of providers
- HIT infrastructure: eMR, data warehouse, point of care decision tools, shared flow of information across care settings and the ability to populate the measures that prove that value was achieved
- Consensus standards by which performance is measured with complete transparency
- Alignment of measures between CMS, States and Commercial purchasers given the fact that most physicians are multi-payer
- **Regardless of the clinical model: a physician-led culture is essential/critical**

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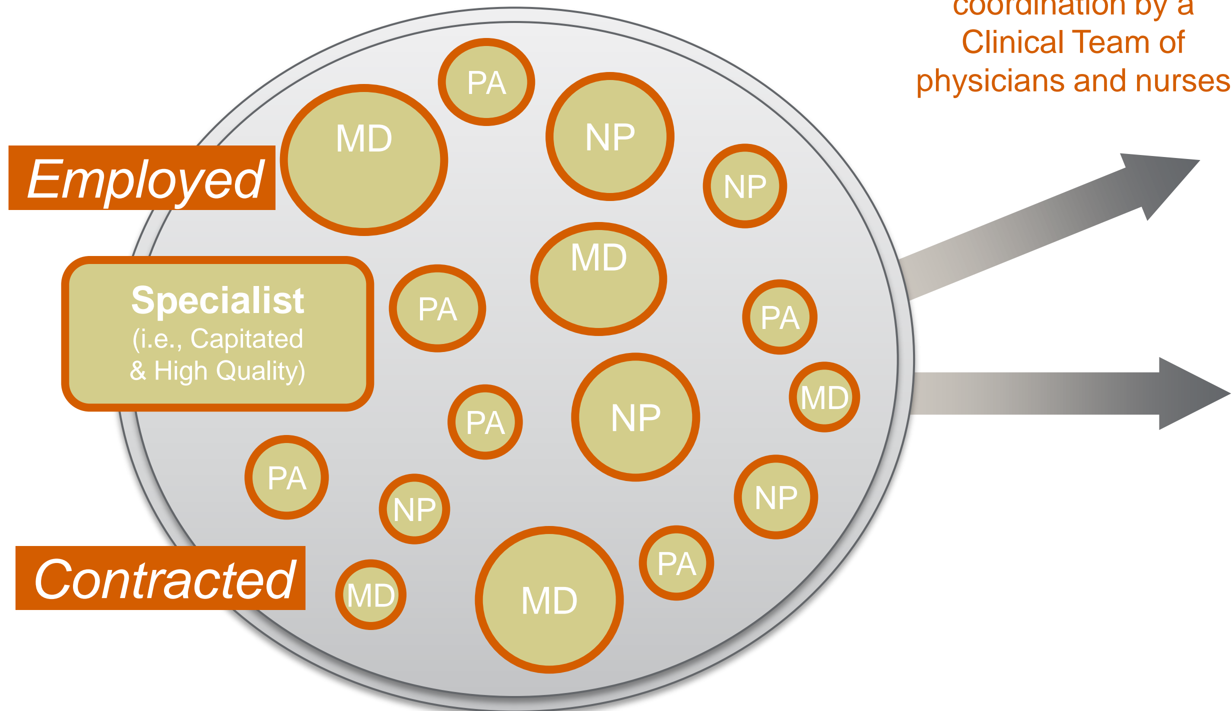
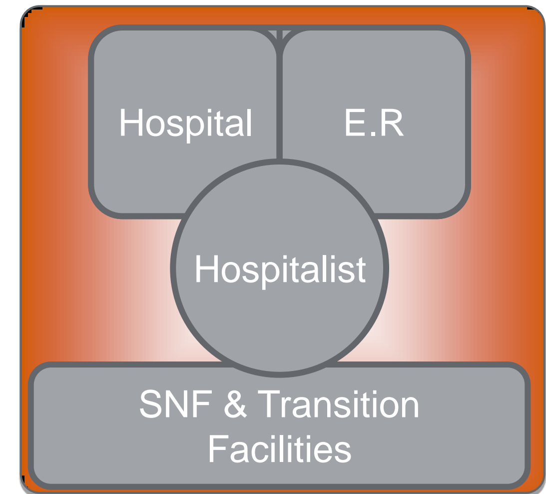
Delivery System Design (Practice Model)



Actively managed care coordination by a Clinical Team of physicians and nurses

Specialist
(FFS & High Quality)



Collaborative Practice Features

- **Primary Care Practice:** contracted with aligned payment | supported with data and clinical support network | close integration and coordination
- **Care Center:** clinic and infrastructure focused on chronic and complex patients and after hours support
- **Hospital and Hospitalist:** contracted and supported with embedded Transition Coach
- **Specialists:** right sized network, prioritized based on quality (performance + patient satisfaction) and economic criteria

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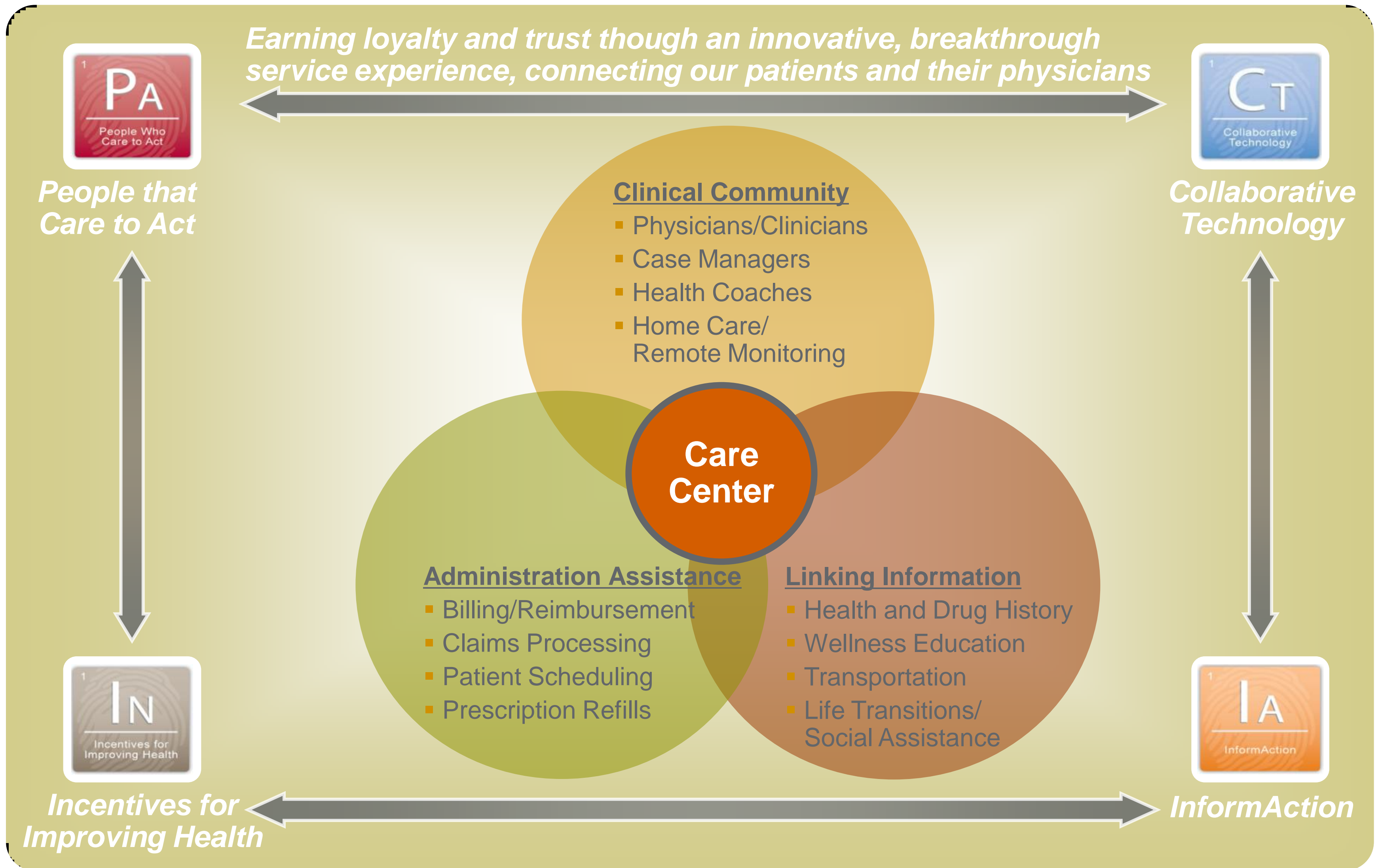
Delivery System Design (Service Model)



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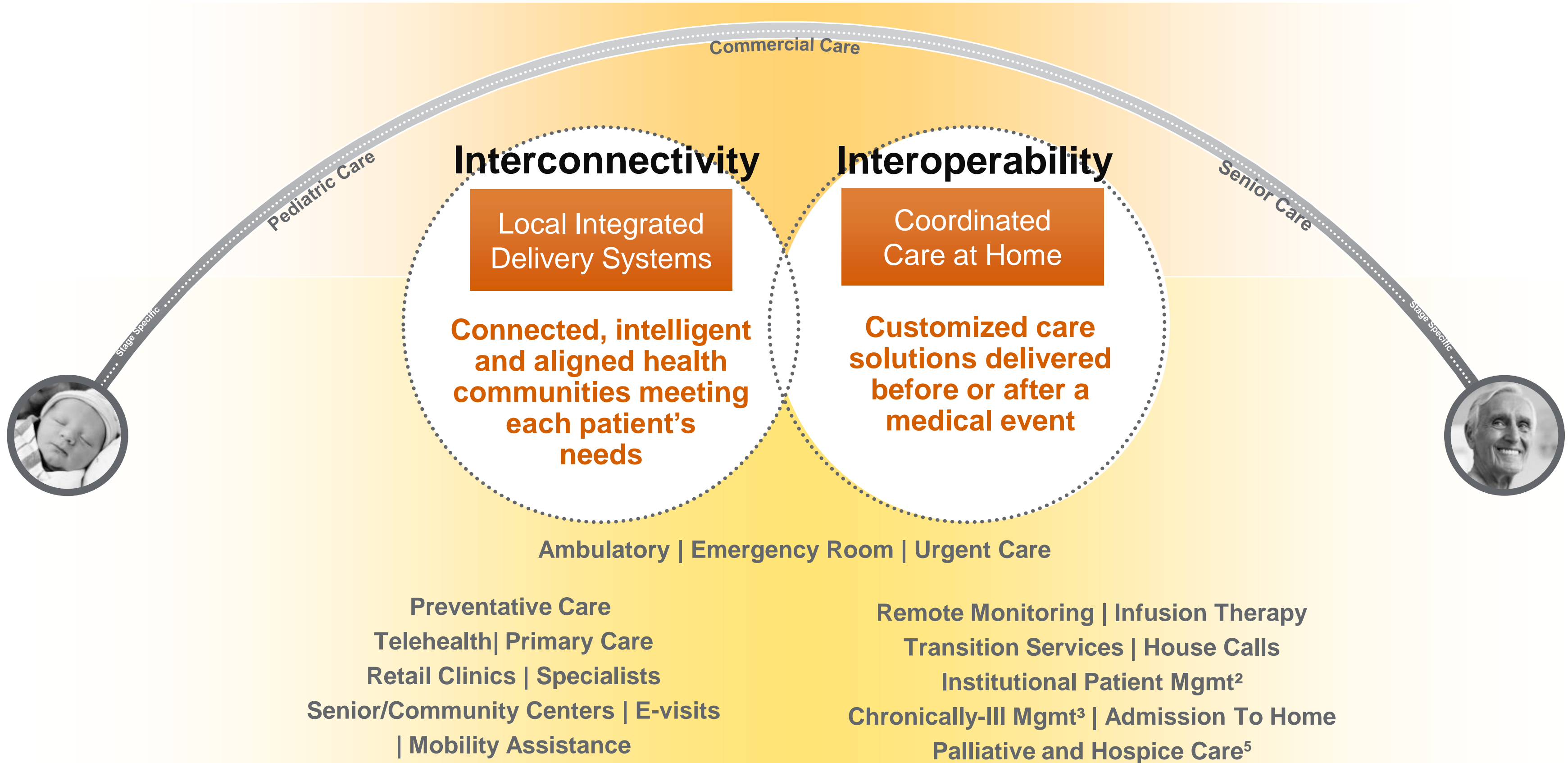
Delivering Care and Services to Patients



2. Skilled Nursing; 3. Nurse Practitioner Home Visits; 4. 12-18 Months to Live; 5. <6 Months to Live

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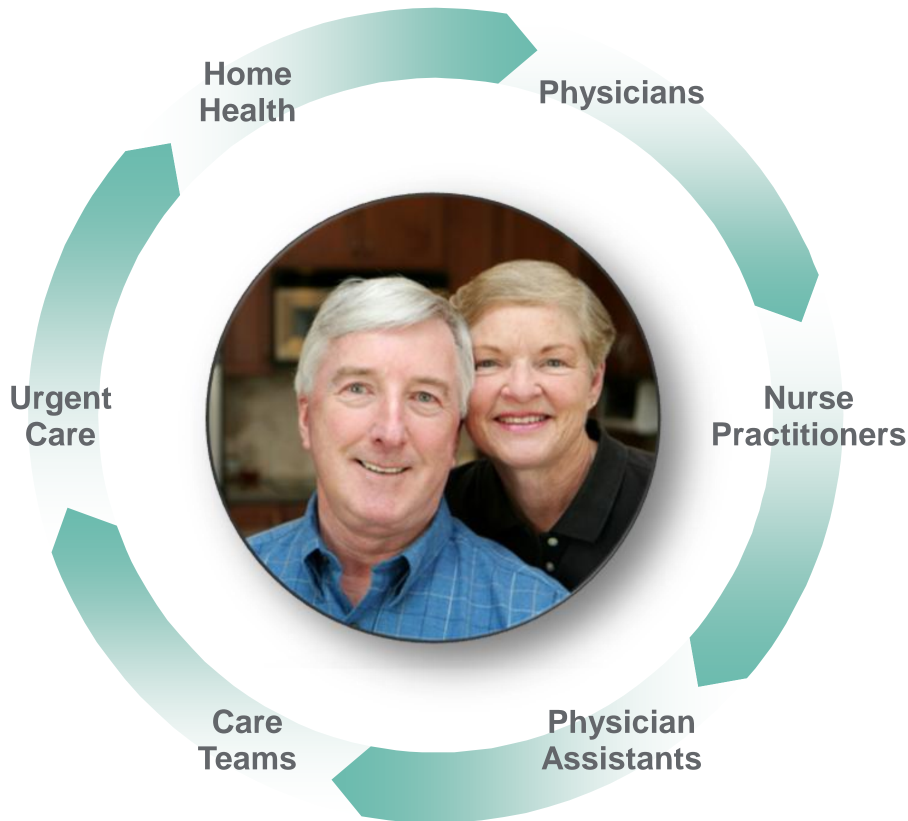
Practical Application of Coordinated IPAs

- Care system where doctors, medical information, care plans and medication history all connect together.
- Providing quality medical care that is safe, effective, efficient, timely, personalized, and equitable for its members.
- Ability to have a multi-payer platform

IPA Technology Integration



Electronic Medical Record
- Tasking
- E-Rx
- Referral integration

Digital Imaging
- Radiology
- Cardiology
- Integrated into EMR

External Connections
- Quest Lab
- Pharmacies
- Referrals – specialists

Web-based Self-Service
- Appointment scheduling
- Problems
- Rx renewal
- Vitals
- E-visits
- Portable medical record
- Results
- Advanced directive

Custom Clinic Tools
- Kiosk check-in
- Skype- like customer service Kiosk
- Patient education
- Patient medical profile (wrapper) for triage

Patient Notifications

Automated phone calls and email
- Appointment reminders
- Rx notifications
- Orders/results notifications

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Practical Application of Coordinated Post Acute Care

- Providing innovative, provider-driven, patient centric healthcare solutions designed for high risk, medically complex populations
- Delivering the right care, to the right patients, at the right time, resulting in improved quality and lower health care costs
- Proven success and cost savings
  - Impact on Acute Admits
  - ER Readmission Rates
  - Cost of End of Life Care

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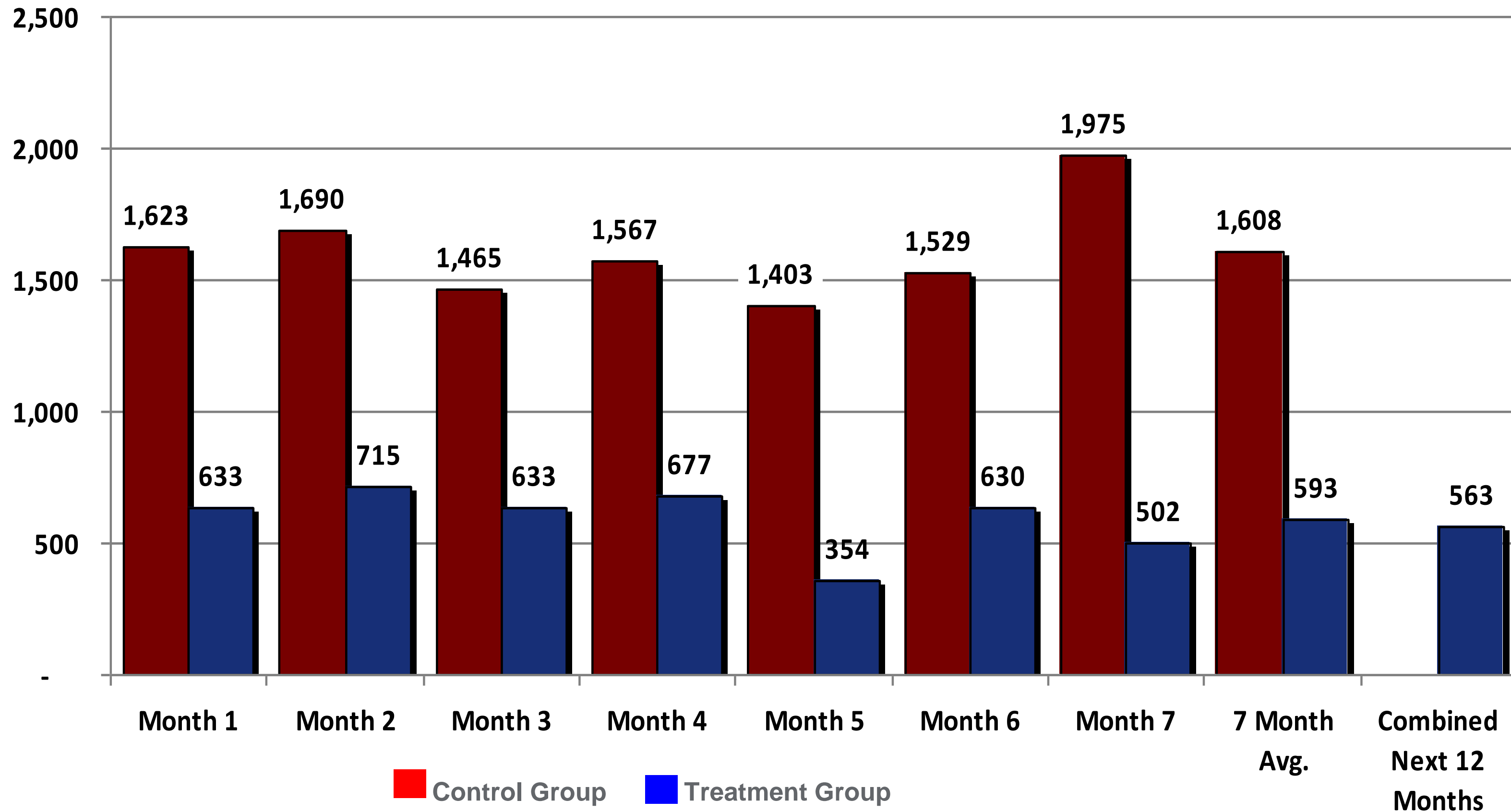
High Risk Dual SNP Members – Acute Admits/1,000 Comparison



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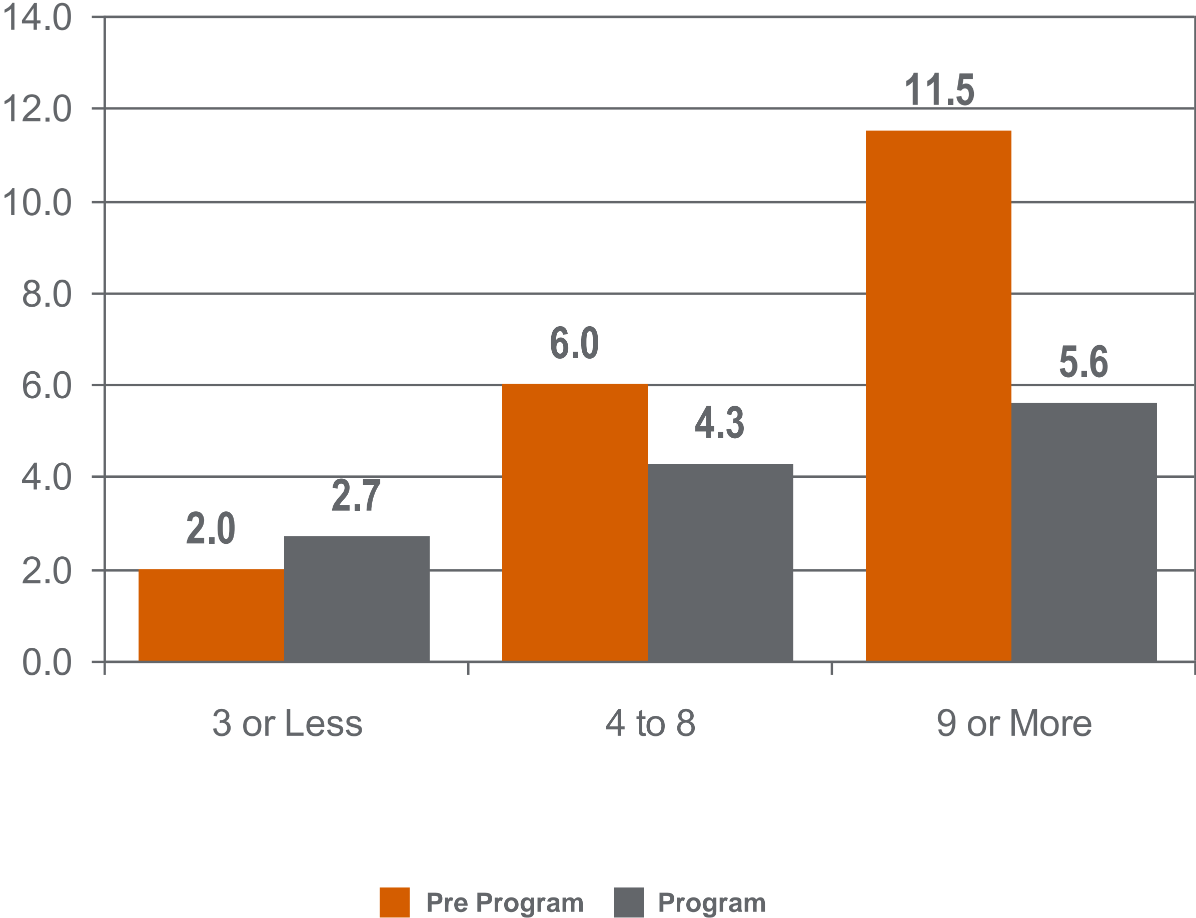
High Risk Medicare Advantage Members Medication Management



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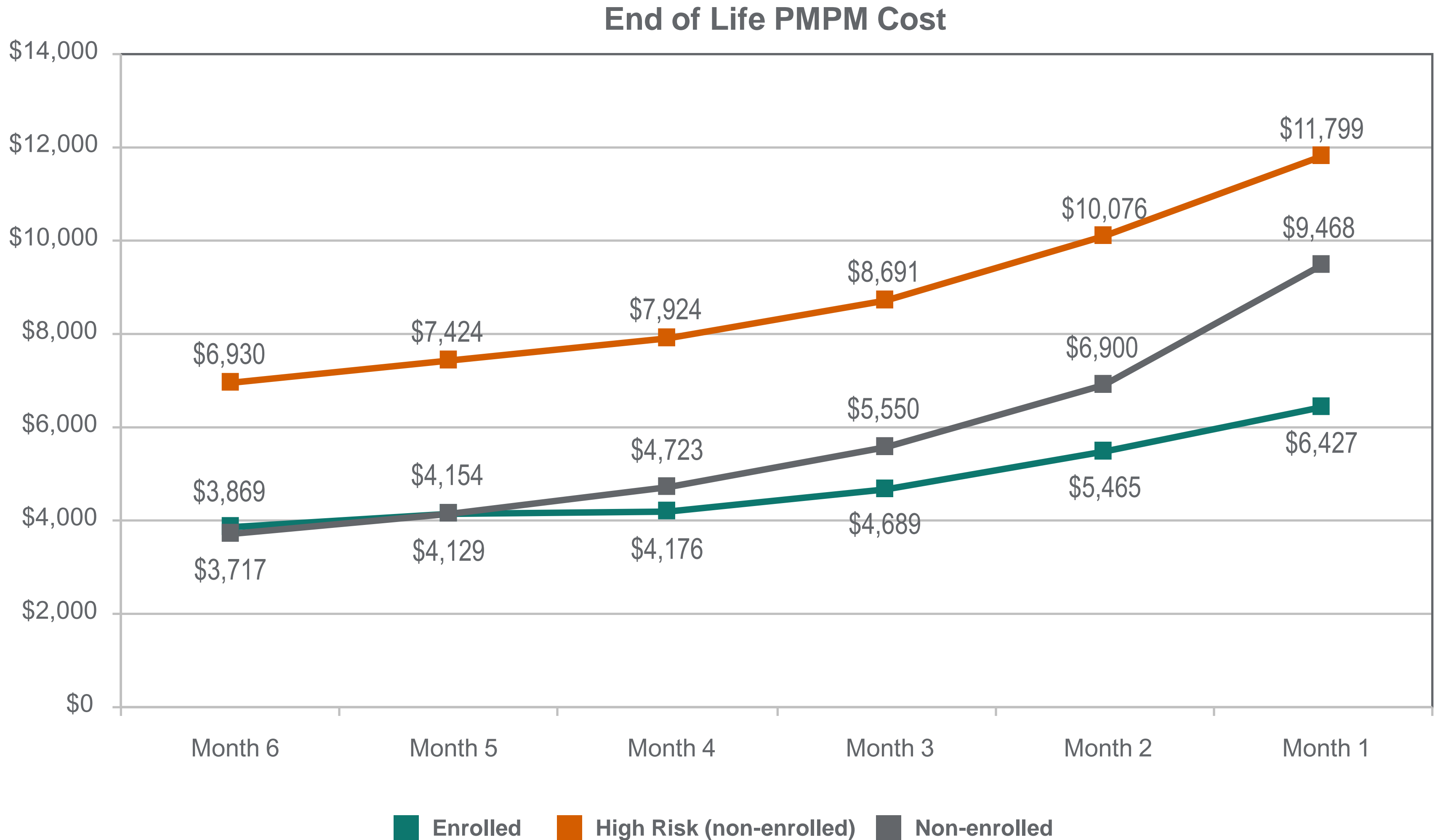
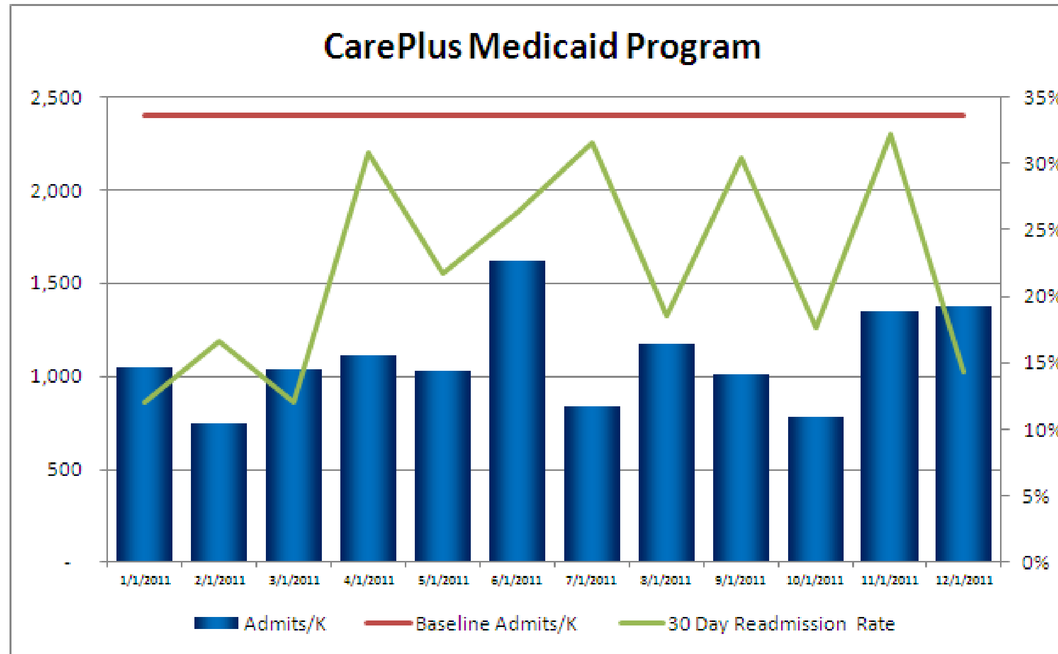
High Risk Medicare Advantage Members
End of Life Care



High Risk Age, Blind & Disabled Medicaid Members



- Strong reduction in acute admissions/K compared to baseline
- Reducing from 2,400 Admits/K to an average of 1,090/K
- Average 30 day readmission rate dropped to 23% from 32.7%

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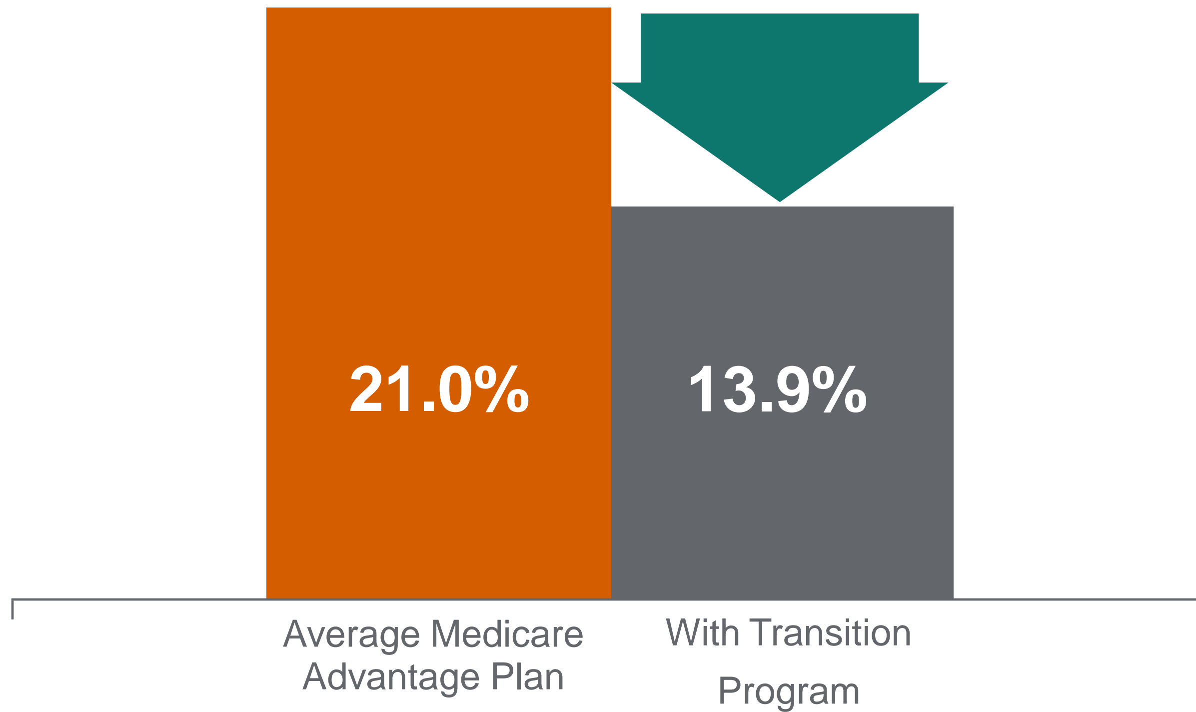
Reduction in Readmissions
Medicare Advantage Members



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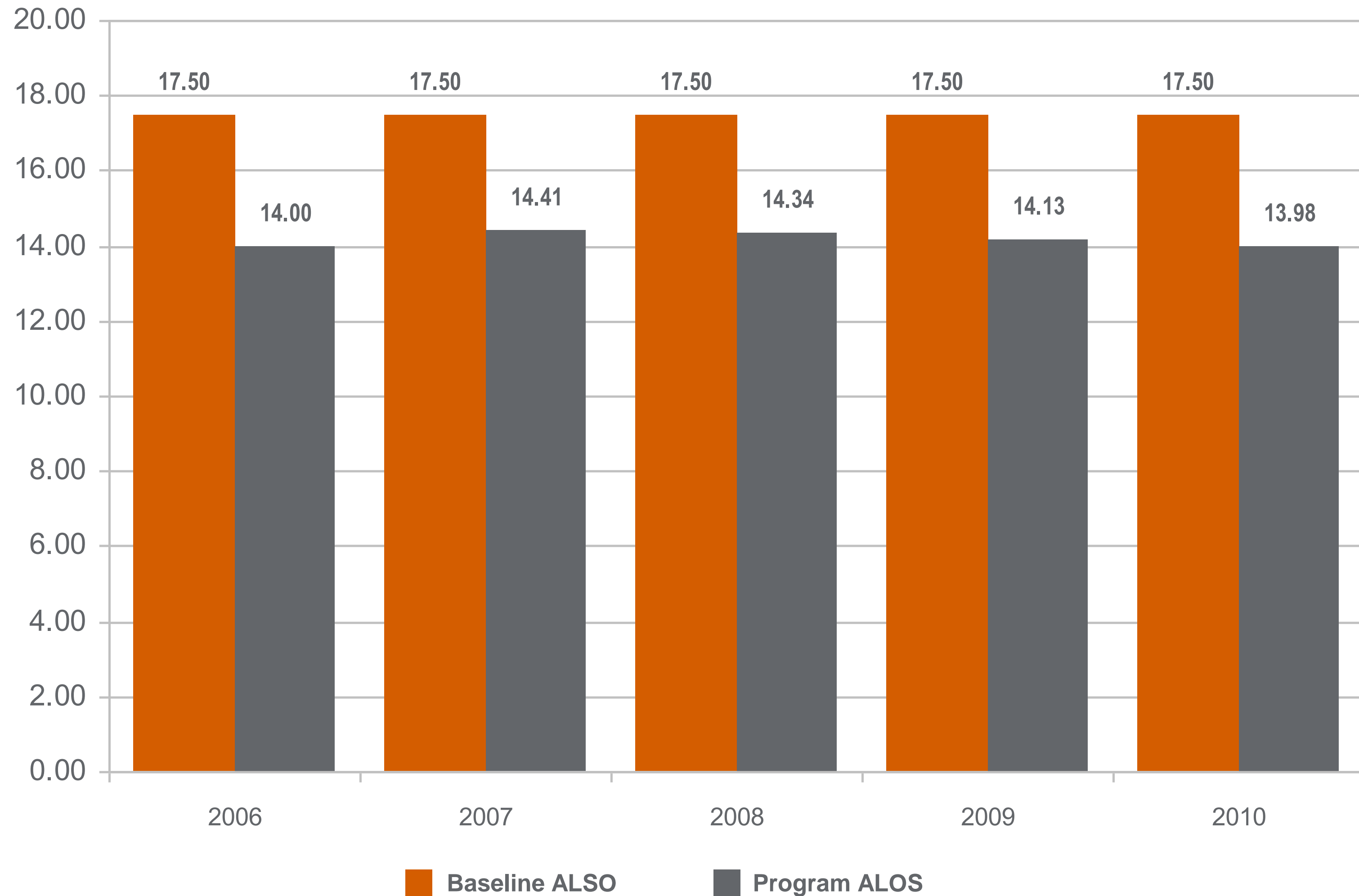
Sub-Acute SNF Transitions – Medicare Advantage Members Skilled Length of Stay Improvement



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Barriers to future success

- Reconciling the confusing landscape of competing performance measures across the system
- Sub-optimal HIT inter-connectivity and inter-operability
- Adequate capital needed for practice transformation
- Gap between fee-for-service and value base contracting that is needed to fully drive change

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