Consolidation and Change Are Inevitable: Payment Will Demand It

LeadingAge New York
Saratoga Springs, NY
May 20, 2015

Overview

- Introduction
- The Big Picture Update
  - Hospitals in Flux
  - ACOs
  - Payment Models
  - Managed Care and Insurance
  - Patient-Centered Medical Home
  - Post-Acute Care
  - Disruption & Innovation
  - Population Health & Clinical Integration
- The Imperatives Around Change and Collaboration
- What Should We Do?
- Stepping into Change
An Opening Question…

What worries you most about the next three years?

Here Now the News…

Feds claim HCR ManorCare bilked Medicare

By Lisa Schencker  | April 21, 2015

The U.S. Justice Department has jumped into several lawsuits alleging that HCR ManorCare, one of the largest nursing home chains in the U.S., provided medically unreasonable and unnecessary services to patients to collect more from Medicare and Tricare.

HCR ManorCare said in a statement Tuesday that the allegations are "unjust, and we will vigorously defend ourselves in court."
Here Now the News...

**Future of dual eligible demonstrations questioned due to low enrollment**

By Virgil Dickson | April 21, 2015

There are growing worries about the future of an ambitious federal demonstration aimed at improving coordination of care for millions of low-income and disabled Americans who are dually eligible for Medicaid and Medicare.

Health plan leaders and state officials expressed concern during a webinar event on April 16 that current federal-state demonstrations in 11 states may not yield the cost savings the Obama administration and the states hoped for – at least in the projected time frame.

Here Now the News...

**Humana invests further in home health visits**

By Bob Herman | April 21, 2015

Health insurer Humana has acquired Your Home Advantage, a Deerfield Beach, Fla.-based company that sends nurse practitioners and other providers to assess and care for patients in their homes.

Humana is one of the largest Medicare Advantage insurers in the country, covering more than 3 million people. In-home care has become a rising business priority for Humana and other insurers that treat large numbers of seniors because managing chronic conditions and coordinating care at home is cheaper and potentially safer than having patients stay in acute-care hospitals.
This is not a time to stand still

The Big Trends Impacting Healthcare Providers

- Consolidation/ Collaboration/ Networks and Mergers
- Focus on Transitions Between Care Settings
- Evaluation of the Cost of Care Across Continuum
- Increasing Access to Obtain Market Share
- New Payment Models
- Demonstration of Quality
- Population Health Management And Value-Based Care

Transitions Between Care Settings

Consolidation/ Collaboration/ Networks and Mergers

Focus on Transitions Between Care Settings

Evaluation of the Cost of Care Across Continuum

Increasing Access to Obtain Market Share

New Payment Models

Demonstration of Quality

Population Health Management And Value-Based Care
The Big Picture Update

Healthcare Today

Complex, Confounding, Challenging …. Changing
Evolving Healthcare Economics

**Reality**
- Health Services 2.5% Margin

**Choice**
- Integration

**Strategy**
- Bigger
- Reduce Cost Profile (Units and Price)

**Goal**

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**Trends in Inpatient Utilization in Community Hospitals**

Source: Avalere Health analysis of American Hospital Association Survey data, 2012

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Inpatient admissions

An upturn in profitability in the face of declining admissions

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Total inpatient days in community hospitals

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Days (millions)

Admissions (per 1,000)
Hospital and Health System Major Pressures

- Credit Rating Requirements
- Employed Physician Losses
- SGR (Reimbursement Reduction)
- Throughput Volume Declines
- Sequestration
- Health Insurance Exchange
- Operating Costs
- Capital Requirements
- RAC Audits
- ICD-10
- Price Transparency
- Payer Mix Change

Pyramid of Success

- Quaternary
- Tertiary
- Community Hospital
- Surgical Specialists
- Medical Specialists
- Primary Care
- Access Points
  - (UCC, FQHCs, ED, Health Plans, Physician Offices, Retail Clinics, etc.)

Defined Population

<table>
<thead>
<tr>
<th>Commercial</th>
<th>CMS</th>
<th>Dual Eligibles</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>ACO-MSSP</td>
<td>HMO</td>
<td>HMO</td>
</tr>
<tr>
<td>PPO</td>
<td>Pioneer ACO</td>
<td>Medicare Advantage</td>
<td>Fee-for-service</td>
</tr>
<tr>
<td>Direct to Employers</td>
<td>Insurance Exchange</td>
<td>Bundled Payment</td>
<td></td>
</tr>
</tbody>
</table>
Institute for Healthcare Improvement: The Triple Aim™

The Triple Aim™ set forth by the Institute for Healthcare Improvement:

- Optimal care delivery within and across the continuum
- Focused on improving the health of the population and cost of care
- Right care, Right place, Right time

RIGHT PRICE!

Source: http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm

Paradigm Shift

<table>
<thead>
<tr>
<th>Philosophy/Expectations: Privilege</th>
<th>Right</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentives: Do more</td>
<td>Appropriate care</td>
</tr>
<tr>
<td>Volume: Admit, readmit</td>
<td>Admit less</td>
</tr>
<tr>
<td>Patient: Little self responsibility</td>
<td>Accountability</td>
</tr>
<tr>
<td>Delivery Model: Lots of everything</td>
<td>Consolidation, hub and spoke</td>
</tr>
<tr>
<td>Patient Care: Face-to-face, physician focused</td>
<td>Remote monitoring, allied professionals</td>
</tr>
<tr>
<td>Pricing: Foggy, unclear</td>
<td>Transparent</td>
</tr>
<tr>
<td>Payment: Fee-for-service</td>
<td>Case rates, shared risk pools, bundled payments</td>
</tr>
<tr>
<td>Delivery of Care: Variable</td>
<td>Cost effective care delivery, evidenced based</td>
</tr>
</tbody>
</table>
1. H. Eugene Lindsey, M.D., CEO of Atrius Health stated his goal is to become the largest ACO in Massachusetts. In the future their physician group will evaluate hospitals for contracts based on quality, reliability, and prices.

2. Kevin Tabb, M.D., CEO, Beth Israel Deaconess Medical Center has indicated a strategy shift away from heads-in-beds to the hospital becoming part of a larger ecosystem.\(^{(1)}\)

3. Steven Goldstein, CEO, Strong Memorial Hospital University of Rochester Medical Center – the issue is not how do we maintain our hospital, the right question is “how do we provide care to the community?”\(^{(2)}\)

Hospitals will become smaller, more focused on emergent trauma, exotic diagnostic technologies, and will be one part of an integrated network.
Volume is Moving Away From the Inpatient Category
Outpatient Healthcare Spending Tops All Categories

Total Healthcare Spending by Category

- Hospital: 38%
- Physician and Clinical Services: 11%
- Other Professional Services: 6%
- Dental Services: 6%
- Other Health, Residential, and Personal Care Services: 5%
- Home Health Care: 6%
- Nursing Care Facilities and Continuing Care Retirement Communities: 3%
- Prescription Drugs: 2%
- DME: 2%
- Other: 2%

Source: Centers for Medicare & Medicaid Service 2013

The Changing Role of the Acute Care Hospital
Current State (2014)

- Broad array medical/surgical services
- Obstetrics (“OB”)
- ED/Trauma
- Radiation therapy
- Rehabilitation
- Other therapies
The Changing Role of the Acute Care Hospital

Five Years

- ↑ Minimally-invasive surgery reduces ALOS and average daily census (“ADC”)
- ↑ Use of pharmacologic treatment reduces surgical volume
- Medical treatment further shifts to outpatient
- Diagnostic imaging shifts to ambulatory centers
- Increased remote monitoring of chronically ill
- Rapid transition from acute to post-acute

The Changing Role of the Acute Care Hospital

Six to Ten Years

- ↑ Use of micro, endoscopic, and laser surgery further reduces ALOS and ADC
- Continued expansion of non-surgical medical treatments further reduces surgery
- Expanded role of genomics increases personalized medicine
The Changing Role of the Acute Care Hospital

15+ Years

- Many tertiary services consolidated, regionalized:
  - Cardiac surgery
  - Cranial surgery
  - Rehabilitation

- Most surgery is outpatient

Hospitals are increasingly offering non-hospital services

Source: Avalere Health Analysis of American Hospital Association Annual Survey Data, 2012
20/05/2015

ACOs

ACOs Growth and Dispersion

- There are over 600 ACOs in the United States
  - ACOs are estimated to cover 20.5 million Americans
  - The majority of covered lives are under commercial ACO contracts, followed by the Medicare Shared Savings Program, the Pioneer ACO program and Medicaid ACOs
- With the 89 new Medicare Shared Savings Program (MSSP) ACO organization which started January 2015, 23,000 healthcare providers will be added to accountable care initiatives
- In 2014, MSSP and the Pioneer ACOs generated $417M in cost savings
  - Medicare spending per beneficiary remained the same from the year prior – in the past 4 years spending has increased

Source: Becker Hospital Review
Accountable Care: How Do You Generate Savings

- Integrated Delivery Network
- Population management
- Well care
- Chronic disease management
- Effective use of appropriate clinicians
- Medical home
- Bundled payment

50% Care Management

15-20% Lower Cost Site

15-20% Throughput (Volume)

Post-acute, outpatient, emergency department use

Extended hours, higher occupancy, narrower network

Generic use, GPO, standardization

Appropriate Economic Indicators

Motivation for ACO’s

- Medicare volume growth unsustainable
- Check the rapid adoption of costly technology against efficacy
  - Give comparative effectiveness a chance to work
- Duplication of services due to defensive medicine or poor communication between providers
- Inconsistent care approaches result in uneven quality
- Lack of care coordination
- Need a mechanism to:
  - Counteract the incentive for volume growth in the Fee-for-Service ("FFS") system
  - Reward improved quality

Source: MEDPAC, Report to the Congress: Improving Incentives in the Medicare Program, June 2009
Why have some ACOs been unsuccessful

- Organization have failed to reduce costs enough qualify for shared savings. This is a result of:
  - Limited of physician engagement or buy-in
  - IT infrastructure is not robust enough to support data gathering requirements
  - Incentives are not aligned with new delivery/payment models
  - Inability to manage patients across the continuum
    - Failing to manage transitions of care effectively
    - Leakage of patients seeing out-of-ACO providers

Next Generation ACO Model Highlights

- Announced March 10, 2015
- Builds upon experience of Pioneer ACO and MSSP
- Minimum of 10,000 beneficiaries must be attributed to participate
  - 7,500 for rural ACOs
- Compared to Pioneer and MSSP ACOs, the program offers:
  - A stable and predictable benchmarking methodology
  - Innovative payment mechanisms, including a pathway to capitation
  - Increased risk and reward percentages
  - Tactics for increased beneficiary alignment and engagement
  - More opportunities for affiliation and partnership with providers
  - Requirement for outcome-based contracts with other payers beyond Medicare
- Designed for organizations with **demonstrated success** in:
  - Population health management and patient-centered care models
  - Managing the total cost of care and/or risk-bearing arrangements
- Rapid application timeline:
  - Notice of intent **due May 1, 2015**
  - Application **due June 1, 2015**
Next Generation ACO: Beneficiary Engagement

The new model promotes increased beneficiary engagement - largely through waivers - providing unprecedented opportunities for ACO program development.

<table>
<thead>
<tr>
<th>Voluntary Alignment</th>
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<tbody>
<tr>
<td>■ Beneficiaries may voluntarily elect to become aligned with Next Generation ACOs, simplifying attribution</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coordinated Care Reward</th>
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<tbody>
<tr>
<td>■ CMS will make direct payments to beneficiaries who receive a certain percentage of services from Next Generation ACO network participants</td>
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<table>
<thead>
<tr>
<th>3-Day SNF Rule Waiver</th>
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<tbody>
<tr>
<td>■ Waiver will allow beneficiaries to be admitted to qualified SNF affiliates either directly or with an inpatient stay less than 3 days</td>
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<thead>
<tr>
<th>Telehealth Expansion</th>
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<tbody>
<tr>
<td>■ Waiver will allow telehealth services for beneficiaries even if they are not located in rural areas</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Post-Discharge Home Visit</th>
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</thead>
<tbody>
<tr>
<td>■ Waiver will allow “incident to” claims for home visits to non-homebound beneficiaries by licensed clinicians under the general supervision of Next Generation ACO network participants (allowable after discharge from an applicable inpatient setting)</td>
</tr>
</tbody>
</table>

Payment Models
### Payment Models

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>P4P</th>
<th>Bundled Payment</th>
<th>Medical Home</th>
<th>Accountable Care/CI</th>
<th>Global Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Drivers of Reimbursement</td>
<td>Volume</td>
<td>Negotiated rate increases</td>
<td>Quality performance targets</td>
<td>Episodic Care coordination</td>
<td>Quality performance</td>
<td>Accept risk</td>
</tr>
<tr>
<td>Elements for Success</td>
<td>Productivity Group size</td>
<td>Ability to collect and measure results Reporting Clinical guidelines</td>
<td>Coordination of services within a given timeframe for specific diagnosis related group Reporting Clinical guidelines</td>
<td>Care model redesign Care teams Access Reporting capabilities Referral tracking Patient self-management support</td>
<td>Care model redesign Clinical leadership Clinical guidelines Preferred specialists and hospitals Care coordination Customer service Strategic partnerships</td>
<td>Disease management Utilization management Clinical oversight</td>
</tr>
</tbody>
</table>

#### Degree of Population Risk Transferred to Provider by Payment System

- **Low**
- **High**

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### Unprecedented Adoption of Bundled Payment

**Where Are Bundled Payments Happening?**

[Map showing the adoption of bundled payments across the United States and Mexico.]

Source: CMS
Bundled Payments

Executive Summary

- Under a bundled payments model, a payer issues one sum, or a “bundled” payment, to the physicians, hospitals, and post-acute care providers involved in delivering an episode of care during a specific time period.
- Because a bundled payment is smaller than the sum of individual payments to providers, providers can only succeed by reducing input costs and delivering a more efficient episode of care.
- Medicare’s BPCI initiative, which aims to increase coordination among Medicare beneficiary providers, is the most prominent bundled payment program. Providers have also partnered with commercial payers in similar bundled payment programs.

Source: http://www.advisory.com/research/health-care-industry-committee/members/resources/cheat-sheets/bundled-payments

Over One-Half of Nation Now Testing Bundled Payment, P4P, Shared Savings, CI, ACO, Payer, and Provider Collaboratives

Sources: Advisory Board Company, Commonwealth Fund
Managed Care & Insurance

What Does Managed Care Manage?

*The Uncertain Cost of Tomorrow’s Health Care A Set Price Today (aka RISK)*

When payors hold the risk, they use three levers to manage it:

**Medical Cost**
- Covertages
- Limits
- Cost sharing
- Incentives to shape consumption

**Price**
- Unit cost of a service
- Negotiated rate
- Payment terms

**Volume**
- Authorizations
- Guidelines
- Medical necessity
- Severity of illness, intensity of service

**WANT LESS**
- Pay Less
- Use Less
Nationally, 50 to 80 million lives are expected to be “on the move” due to reform.

**Change in Insurance Status**

Principal shifts nationally among major coverage categories

<table>
<thead>
<tr>
<th>Primary Origins</th>
<th>Primary Destinations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uninsured</td>
<td>Individual</td>
</tr>
<tr>
<td>Employer</td>
<td>Medicaid</td>
</tr>
</tbody>
</table>

(1) Flows do not include population growth

Source: MPACT Release 4.9.4.1; Scenario B: medium employer opt-out; high salience; Medicaid Reversion to Federal

In the scenario shown, 65 million individuals will change coverage

Other scenarios show a range of 50 to 80 million individuals who will change coverage

The cost of employer-sponsored health benefits has doubled in the last decade, offsetting much of the rise in workers’ compensation. Average worker and employer contributions to the family health plan in 2011 dollars.
Navigating Health Insurance Exchanges
Key Questions and Implications for Providers

- The ACA’s healthcare exchanges - the largest expansion of health insurance availability since the advent of Medicare and Medicaid in 1965 - are expected to cover 24 million Americans by 2016.


Health Systems moving into the Insurance Arena

20 percent of Health Systems will become Payers by 2018

- As of August 2013, 34 percent of the 100 hospitals and health systems surveyed indicated that owned health plans
  - 21 percent of hospital and health systems indicated that they plan to launch health plans.

Source: HealthLeaders Media
Employers Poised to Exit Health Insurance Market

- S&P Capital IQ predicts that by 2020, about 90% of American workers who now receive employee-sponsored health insurance will be shifted to government exchanges
- Largest companies could save 4% of the total value of their companies
- Total savings for companies with more than 50 employees would equal $3.25 trillion
- Remaining question: Will the federal government or individuals pay the difference?

Source: S&P Capital IQ, New York Times

Affordable Care Act’s Medicaid Expansion

States outlook on Medicaid Expansion as of 2015

- 29 states (including DC) are expanding Medicaid
- 19 states have not yet expanded Medicaid
- 3 states have not made a decision

Source: Families USA: The Voice for Health Care Consumers.
Medicaid to See Continued Growth

Economic policy and conditions affect Medicaid spending and enrollment

![Graph showing Medicaid spending growth and enrollment growth](image)

Note: Enrollment percentage changes are June to June and spending growth is measured in states fiscal year.

Source: Kaiser Family Foundation

Medicare Beneficiaries Projected to Double by 2030

![Graph showing number of Medicare beneficiaries from 1966 to 2030](image)

Medicare Trustees See Growing Cash Flow Deficit

Cash Flow Deficits in the Medicare HI Trust Fund
Based on Medicare Trustees' Intermediate and High Cost Assumptions, Billions of Dollars

Workers Contributing to Medicare Declining

Source: www.justfacts.com
Patient-Centered Medical Home

PCMH’s Role in Delivery System Reform

- Better, stronger primary care is necessary for any health system redesign solution
- Medical homes are at the core of successful population health and ACOs that are currently being developed by public and private payers
  - Aligned strategies: care coordination, team-based care, increased/innovative access, and chronic disease management
- PCMH encourages collaboration with community-based “medical-neighbors” to encourage partnerships and the flow of information
  - PCMH practices will be a hub for the medical neighborhood, as non-medical factors have been shown to have a greater impact on health status than medical care

PCMH Activity

- There are nearly 500 programs dedicated to improving primary care*
- 37 States have public and private PCMH Initiatives using the National Committee for Quality Assurance Recognition**


Cost and Quality Results

- Decreases in the cost of care
  - Per member per month, return on investment, and total cost of care
- Reductions in unnecessary or avoidable services
  - Includes emergency department (“ED”) or urgent care, inpatient admissions, and readmissions
- Improvements in population health indicators
  - Better controlled HbA1c, blood pressures and LDL levels
- Improvements in access to care
  - Improved overall access to primary care physicians
- Improvements in patient satisfaction
  - Overall satisfaction, recommending the practice, and provider communication

Post-Acute Care

Post Acute Care Spending Is Significant

Source: MedPAC, June 2014 Data Book
Medicare Patients Highest Volume Users of PAC

Currently there are 47.6 million Medicare beneficiaries with an estimated 9,100 individuals added to the program each day.\(^1\)

Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care” \(^2\)

43% of Medicare Beneficiaries are Discharged from Acute Hospitals to Post-Acute Care

Higher

Intensity of Service

Lower

- SHORT-TERM ACUTE CARE HOSPITALS
- LONG-TERM ACUTE CARE HOSPITALS
- INPATIENT REHAB
- SKILLED NURSING FACILITIES
- OUTPATIENT REHAB
- HOME HEALTH CARE

Patients’ first site of discharge after acute care hospital stay

2% 10% 41% 9% 37%

Patients’ use of site during a 90 day episode

2% 11% 52% 21% 61%

\(^1\) Source: U.S. Census Projections

Post-Acute Care Spending Variation Demands Control

Total Spend

- Baseline

- Acute

- RX

- OP

- Post Acute

+$450

+$150

+$50

+$50

+$350

-$68

-$40

-$28

-$90

Source: Medicare Spend Variation PBPM, NEJM – 368;16 – 18 April 2013
Post-Acute Accounts for a Big Chunk of Episodic Costs

<table>
<thead>
<tr>
<th>Stroke</th>
<th>Hospital</th>
<th>MD</th>
<th>PAC</th>
<th>R</th>
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</thead>
<tbody>
<tr>
<td>Hip &amp; Femur Procedures</td>
<td>Hospital</td>
<td>MD</td>
<td>PAC</td>
<td></td>
</tr>
<tr>
<td>Cardiac Bypass</td>
<td>Hospital</td>
<td>MD</td>
<td>PAC</td>
<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Hospital</td>
<td>MD</td>
<td>PAC</td>
<td>Readmit</td>
</tr>
</tbody>
</table>

And what is the typical hospital or MD relationship with PAC?

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5% Medicare claims files

Looking Towards Networks...
The History of Acute & Post-Acute Relationships

- Historically challenged and tangled relationships – “kick the can down the road”
- Collective misunderstandings about payment, process and the definition of “success”
- Isolated points of pain
- Revolving door fundamental to a FFS business model
- No incentives (or punishments) to work together
Looking Towards Networks…
The Narrow, Preferred Provider, or “Premier” Network

- The idea of networks is hardly new but has recently exploded for post acute services and SNFs in particular
- ACOs, IDNs, and regional health systems have taken several approaches in constructing and creating networks – some better than others
- Forward-looking organizations are emphasizing partnerships with post-acute providers, rather than just a credentialed or vetted list of facilities
- Integration and care redesign are fundamental

Value-Based, Clinically Integrated Organizations Must Address Advanced Illness on Four Fronts

1. **Population Risk Stratification**: sorting out which patients require intensive management and monitoring
2. **Care Management Implementation**: deploying the model by which advanced/chronic illness patients will be managed
3. **Post-Acute Network Development**: evolving narrow, preferred networks to achieve quality and lower costs
4. **Palliative Care Expansion**: improving integration of palliative care services in both acute and post-acute settings
Integrated Delivery Network Thinking…
Next-Generation Partnership Strategy

Why prioritize acute care partnerships now?

- Today’s hospital leaders, facing delivery system and payment reform, are scrutinizing their relationships with post-acute care entities and are ready to strengthen partnerships with high performers - and scale back relationships with partners falling short.

- With reimbursement for their services decreasing, post-acute care providers must build a joint infrastructure with acute care organizations that supports smooth care transitions, clinical quality, and financial accountability.

Disruption and Innovation:
Technologies and Clinical Advances

Future Therapies: Cardiovascular

- Third-generation ventricular assist devices (“VAD”) (near-term)
  - Smaller, fully implantable, eliminating driveline, reduced wear/tear, longer device life
- Leadless implantable (near-term)
  - Pacemakers and cardiac rhythm management devices
  - Detect cardiac arrhythmias without electrodes, fewer complications
Future Therapies: Cardiovascular

- Fenestrated stent grafts
  (current/near term)
  - Grafts with holes can be aligned with intended branch vessels, permitting incorporation of the visceral and renal arteries into endovascular repair, enabling optimal sealing
  - Advancements allow patients with short or angulated necks to have endovascular therapy
- Increased ability to repair structural heart defects in the cath lab; potential future clinical innovations include:
  - Bioabsorbable stents
  - Left atrial appendage occlusion devices
  - Stem cell transplants
  - Therapeutic angiogenesis
  - Renal nerve ablation

Future Therapies: Oncology Services

- Advancements in molecular genetic testing will transform management and prevention of cancer
- 5-year horizon:
  - Medical oncology
    - Tumor-site specific radiotracers and therapeutics (nanotechnology)
    - Molecular imaging
    - Oral chemotherapy
  - Radiation therapy
    - Proton beam, carbon ion, real-time adaptive therapy, stereotactic body radiotherapy, etc.
  - Interventional/Surgical oncology
    - Drug eluding beads, microwave ablation, multi-modality interventional therapies

Source: Nasal spray – Getty Images; Proton-Beam Therapy – The Children’s Hospital of Philadelphia
Future Therapies: Neurosciences

- Use of stem cell treatment for stroke and spinal cord injury
- Immunological treatment for some neurologic disorders
- Increasing application of genomics
- Insulin nasal spray for Alzheimer’s disease (in trials):
  - May help cognitive functioning by preventing formation of tau
- Expanded use of medical therapies will replace a portion of surgical cases
- Increase in the use of stereotactic radiosurgery (“SRS”)
- Begin to see robotics and NOTES applied in neurosurgery, shortening ALOS and shifting more cases to outpatient settings

Source: Carbon-Ion particle therapy – Siemens

Apple Healthkit

- [Images of Apple Healthkit app interfaces showing health data and features]
Exploding Array of Remote Diagnostics and Monitoring

- Nike Fuel Band
- CellScope
- Otoscope
- Scanadu Scout

Exploding Array of Remote Diagnostics and Monitoring

- MC10 Biostamp
- Google Smart Contact Lens
  Monitors Blood Glucose Level
- Bio Devices’ Vital Jacket
The Future of Clinical Decision-Making?

Watson

Currently, Watson being tested at/with:

- Sloan-Kettering Cancer Center
  - Researchers are currently training Watson to assist in complex decision making, typically found in the oncology diagnosis process

- The Cleveland Clinic
  - Helping develop Watson as a tool for training young physicians, and possibly as a bedside tool itself

Disruption and Innovation: New Entrants
Retailer Innovation

Walmart Healthcare Retail Strategy

- Target primary care services
  - Identify physician shortage areas
  - Target geography to start: South Carolina and Texas - mostly rural areas
  - Initial volumes: 15 to 20 per day
  - Partnered with QuadMed to staff and run the clinics
- Cost:
  - $40 per visit
  - Employees and dependents: $4 per visit
  - Drive business to their pharmacies
Walmart: Healthcare Begins Here

- DirectHealth.com
  - Online health insurance comparison
    - Medicare (1,700 plans, 12 carriers)
    - Commercial (1,000s, 300+ carriers)
    - Insurance exchanges
    - Available in 2,700 of 4,000 stores

- Testing 11 healthcare clinics
  - Primary care vs. over 100 leased healthcare clinics

- Insurance/Health plan next?

Future Challenges
One More Wild Card – The Patient
Health Illiteracy

- Health literacy includes the ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex healthcare systems.

- Health literacy refers to a complex group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations.


Health Illiteracy

- 14 percent of U.S. adults are estimated to have below basic “document literacy,” the ability to read and understand documents.

- Only 12 percent of the population has proficient health literacy.

Source: *National Network of Libraries of Medicine; Pie Chart: Health Literacy Innovation*
### Consumer and Patient Engagement

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<thead>
<tr>
<th>America’s Health</th>
<th>Adult Population</th>
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<tbody>
<tr>
<td>Obesity</td>
<td>34%</td>
</tr>
<tr>
<td>Lack of regular exercise</td>
<td>70%</td>
</tr>
<tr>
<td>Smoking</td>
<td>28%</td>
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<tr>
<td>Alcohol abuse</td>
<td>8%</td>
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<tr>
<td>Drug abuse</td>
<td>7%</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>25%</td>
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<tr>
<td>Lack of immunization</td>
<td>22%</td>
</tr>
<tr>
<td>Poor nutrition</td>
<td>33%</td>
</tr>
<tr>
<td>Occupational exposure</td>
<td>5%</td>
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<tr>
<td>Poor safety habits</td>
<td>20%</td>
</tr>
<tr>
<td>Intentional risk-taking</td>
<td>3%</td>
</tr>
<tr>
<td>Care avoidance/postponement</td>
<td>17%</td>
</tr>
<tr>
<td>Patient non-compliance</td>
<td>50-75% +</td>
</tr>
</tbody>
</table>

Non-compliance not only threatens the patient’s health but also costs the healthcare system an estimated $290B a year*

Source: Adapted from – Susan Dentzer, Editor-In-Chief, Health Affairs, “Health Care, Health Policy and the 2012 Elections” Illinois Hospital Association, 2011 IHA Leadership Summit, September 20, 2011

*“Thinking Outside The Pillbox: A System-wide Approach to Improving Patient Adherence for Chronic Disease.” NEHI. 2009

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**The Future Ain’t So Pretty…**

As compared to their parents:

**Boomers are more likely to suffer from hypertension, high cholesterol, and diabetes.**

They are more likely to be obese and less likely to exercise.

*According to the CDC, Americans spend roughly $147 billion on obesity and $177 billion on diabetes.*

Source: JAMA Internal Medicine, Volume 173, No. 2 – January 2013
Patient Engagement...of Lack Thereof

- The National Report Card on Adherence is based on patients' responses to the following:
- In the past 12 months, patients:
  - Failed to fill or refill a prescription
  - Missed a dose
  - Took a lower or higher dose than prescribed
  - Stopped a prescription early
  - Took an old medication for a new problem without consulting a doctor
  - Took someone else’s medicine
  - Forgot whether they’d taken a medication

Average score = 79
Zero (non-adherent on 9 behaviors) to 100 (perfect adherence)

Source: Medication Adherence in America: A National Report 2013

Population Health & Clinical Integration:
A Brief Primer
Population Health Management
A Coordinated Pathway of Care

Create the Right Culture for Change
- Interviews
- Committee meetings
- Vision

Engage and Enable Across the System
- Gap assessment
- Integrated model design
- Rationale
- Empowerment and accountability

Communicate and Collaborate
- Plan for implementation
- Resources and budget
- Technology
- Metrics for success

Implement and Sustain Change
- Short-term wins, long-term sustainability
- Reassess, revise, revisit

Cultural Transformation To Achieve Population Health Management
Start With A Vision
Population Health Management Model

Key Components

- Network of providers that spans the continuum
- Strategic partnerships
- Community linkages
- Clinical leadership
- Care model redesign
- Clinical guidelines and protocols
- Care coordination
- Patient engagement
- Risk stratification capabilities
- Data, analysis, and reporting

Population Health Management

Wellness/Preventive Care
Primary Care/PCMH
Specialty Care
Community-Based Services
Pharmacies
Behavioral Health
Urgent Care
Emergency Services
Hospital Care
Post-Acute Care/Home Care
End-of-Life Care

Patient Data
Provider Data
Payer Data

Risk Stratification
Predictive Modeling
Clinical Guidelines

Care Management Model

Integrated, standardized workflow management and monitoring

Seamless Patient Experience Across the Continuum

Patient Identified
Patient Needs Assessed
Care Plan Developed
Care Plan Implemented
Care Plan Monitored

Source: The Camden Group
Population Health Management: Success Factors

- Clinician experience to manage cost of care: culture, philosophy
- Correct mix of clinicians: Primary care physicians, specialists, allied professionals, and use of technology eVisits and telehealth
- Do we have access to a full continuum of services?
- Do we have an IT system that includes: CPOE, EMR, ambulatory EMR ("aEMR"), enterprise data warehouse ("EDW"), analytics, telehealth?
- Geographically dispersed delivery sites (hub and spoke relationship)
- Are we accessible to the patient? If so, in what time period?
- Do we have an appropriate payment methodology with incentives to reward changing behavior of clinicians and the continuum of care providers?

Definitions of Clinical Integration

- "Clinical Integration is defined as the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units so as to maximize the value of services delivered. Clinical integration includes both horizontal integration (the coordination of activities at the same stage of delivery of care) as well as vertical integration (the coordination of services at different stages)."


- “An active and ongoing program to evaluate and modify the clinical practice patterns of the physician participants so as to create a high degree of interdependence and collaboration among the physicians to control costs and ensure quality.”

Traditional medical staff-hospital relationship
Physicians are “customers” of the hospital
Competition over outpatient services and revenue streams
Fee-for-service payment mechanisms predominate

Organizational models created to achieve physician-hospital integration (e.g., joint ventures, employment)
Physician-only models may include entering into managed care risk (e.g., IPA)
Focus is on creating structures that align strategic and financial goals – typically of one aspect (or segment) of the healthcare delivery system (e.g., a service line, an outpatient service, physician recruitment, payer type)

All characteristics of CI, with a greater degree of financial integration and interdependence
Ability to approach the market and payers with an integrated system (i.e., hospitals, physicians, and other providers of care)
Culture is totally focused on the success of the “system” vs. the individual components (e.g., hospital vs. physician group)

1990’s Era Insurance Driven | ACA-Era Provider Driven
---|---
**Economics**
Discounts | Contracts at Current Price
Withholds | Incentives

**Management**
Lower Utilization | Appropriate Utilization
Prevention | Management of Chronic Disease
Patients Enroll and then Gatekeeper | Attribution/Relationships and then Coordination

**Market**
Booming Economy | Recession
Limited Informatics | Robust Informatics
Rethinking The “Care Team”

Physicians – Primary Care and Specialists
Outpatient Clinic Staff
Hospitalists/ SNFists
Case/Care Managers, Social Workers
Behavioral Health
Home Health and Ambulatory Services
Community-Based Resources
Nursing

Integrated PAC Model Depends on Care Management Bridging Across the Silos…

“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
Why Now?

- Why disrupt a business model that is working for us now?
  - It may be working for you, but it is likely that local employers and other payers are seeking a solution to their rising healthcare costs – if you are not a willing participant, they will find someone who will be.
- Can’t we just wait until we see the market change?
  - It has already changed...Medicare, Medicaid, competitors (both health system and provider groups), BCBS, employers have already implemented new models.
  - Transitioning to the “new world” takes time – a new culture must be created, and new capabilities must be developed.
- We are the market leader; why can’t we control the pace of change?
  - You may not even see the change agent coming: competitor(s) outside your market, employer, payer, retail, technology.

“If past history was all there was to the game, the richest people would be librarians.”

Warren Buffett
The Imperatives Around Change & Collaboration
Consolidation is Occurring Throughout Healthcare

Primary Care  Vertical Integration
Urgent Care
Ambulatory Procedure Center  Horizontal Integration
Acute Care/Hospitals
Rehabilitation
Skilled Nursing Facility (“SNF”)
Home Care

Rate of Hospital Consolidation is Accelerating

Hospital Mergers and Acquisitions 1998-2013

Number of Hospitals in Systems

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2011, for community hospitals.
Note: Hospitals include all nonfederal, short-term general and specialty hospitals whose facilities and services are available to the public.

Partnering Models

It is Always About...
- Ownership
- Governance
- Decision-making
- Culture/Strategic Vision
- Name/Brand
The $4 Billion Threshold
If you’re not big enough on your own, you’re going to need someone else to survive.

Industry pundits say $4-6 billion for a health system.
How much for an aging services organization?

Why is This Happening?
Increasingly Strategic, Not Financial Decision

- **Acquirer perspective**
  - Scale can provide strength (economies of scale)
  - Geographic diversification is beneficial for access to capital
  - For-profit and private equity money is chasing hospitals

- **Acquiree perspective**
  - Service development, differentiation, and rationalization
  - Increased visibility from a regional or national brand
  - Support for integrated physician engagement
  - Infrastructure to support quality initiatives
  - Expertise to support migration to quality-/efficiency-based payment contracts
  - IT investment requirements
  - Mitigated risk
Observable Forces and Trends in Healthcare

- Margins deteriorating
  - ↑ Debt burdens/Covenants
  - ↓ Volumes
  - ↑ Operating and payroll expense

- Payments under stress
  - → Medicare reimbursement flat
  - ↑ Penalties and risk
  - ↑ Medicaid expansion (it depends)
    - Impact on payer mix
  - ? Commercial health plans
    - Shifting to “at-risk” models
      - Degree of payment at-risk, expected capture
  - ↑ Bundling
    - Greater need for care coordination/continuum
  - ↑ Accountable care organizations (“ACO”)

Observable Forces and Trends in Healthcare

- Quality
  - ↑ Scope of metrics
    - Core measures
    - Readmissions
    - Patient experience
    - Utilization rates (tests, procedures, etc.)
  - ↑ Performance connected to payment
    - Incentives penalties

- Care model redesign
  - Patient-centered medical home (“PCMH”)
  - Bundled payments (“BP”)
  - Accountable Care (commercial and Medicare Shared Savings Program)
  - Clinical integration (“CI”)
Observable Forces and Trends in Healthcare

- Demographics
  - Flat in many regions
  - Aging
  - Birth rates
  - Limited “organic” growth
- Inpatient volumes flat or decline
  - In most regions
  - Long-term trend
- Outpatient volume increasing
  - Hospitals capture a portion
  - More players

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Observable Forces and Trends in Healthcare

- Competition
  - Competition for share of healthcare spend (hospitals and physicians are biggest target)
  - New “category” players
- Locations of care
  - Expanding
  - Outpatient deployments by systems
  - Role of hospital “evolving”
- Physicians – need for:
  - Clinical Integration
  - Physician-to-physician alignment
  - Physician-to-hospital alignment
  - Quality and economics
Observable Forces and Trends in Healthcare

- Continuum – increasingly important
  - Challenges of care coordination

- Consolidation of field
  - Both horizontal and vertical
    - Hospitals:
      - Mergers and acquisitions
      - Closures
      - Pursuit of “scale”
      - Efficiencies

- Physicians
  - Larger groups
  - Fewer independents
  - Employment grows
  - Shortages and uneven distribution

What Should We Do?
Our Thoughts
The Winners Will Be:
- Large integrated providers with:
  - Large/Growing employed medical groups and/or closely aligned medical staffs
  - Systems with experience managing risk across the continuum of care
  - Partnership or ownership of the continuum of care (home care, skilled nursing, etc.)
- Effective at clinically-integrated population management
- Expanded access points
- Cost efficient across all payers, especially Medicare
- High quality and highly unique market positions or services

So, This All Means What for Aging Services?
The Nitty Gritty Reality…
- Inpatient hospital use will continue to decline; outpatient use will grow
- Single source providers will be very challenged to survive without some degree of affiliation, partnership or collaboration.
- Coordination of service across all levels will be crucial and continuum-oriented efforts will achieve the greatest value
- Cost efficiency and quality will grow evermore critical
- Acuity will keep pushing downward along the continuum
- Commercial payers and managed care will rule the universe
Aging Services Thinking Ahead…

1. Gear up for population health – we can play a big role
2. Get your risk game together
3. Grow more access points – capture more population
4. Garner more primary care service and relationships – think pyramid!
5. Get serious about quality, measurement and outcomes
6. Go for a more competitive cost structure – both expenses and revenues across the board!

At the End of it All…

There is a strong and growing sense among acute, physician and health care leaders about the need to completely recalibrate their strategy.

Nothing is off the table

All underlying business models up for reconsideration
Stepping into Change…

As our industry changes, so must our business and culture.

These are the good old days.
1. Create Consensus of the Change
2. Develop a Clear Plan and Strategy
3. Build the Right Change Team
4. Tear Down Barriers
5. Communicate Constantly
6. Foster Competency and Learning
7. Anchor and Celebrate
Create Consensus of the Change

- Driving consensus demand two things – an understanding of the future state, and the reason or rationale for why the organization must change
  - Demands establishing a common understanding among your organization – leadership, board, staff, residents and other stakeholders
  - Both the future state and reasons for change must grab attention and be easily understood – key thoughts captured story!
  - SWOT or SPOT analyses can be helpful in organizing thinking and identifying key elements

Where Are You in the Journey?

Everyone is at a different place...

*If just starting, your emphasis should be primarily strategic.*

*But if you’re down the road and already shifting, the imperatives are largely tactical.*
Starting the Journey…
Strategic Considerations

If you’re late to the game, strategic considerations should take precedence over tactical moves:

1. Have a crystal clear understanding of who and where you are and craft a clearly defined vision for where you want to be.
2. Get out into your market, be informed about changes and the implications of payment and delivery reform – LEARN!
3. Seek out collaborations and partnerships with other like-minded providers or organizations.
4. Craft and understand your value proposition – it will inform and oftentimes define the tactical steps to follow.

Crafting a Value Proposition
In Three Broad Parts:

1. Understanding the environment, challenges, and issues – “the value gap”
   - At-risk payment environments/penalties
   - Quality challenges / cost management

2. Demonstration/evidence of solution – “that which fills the gap”
   - Measurable outcomes – quality, process, cost
   - Service/continuum offerings – settings and skills, niche/distinctions
   - Future planning/intentions – how preparing for the next gap and future change

3. Working Together - matching solutions to problems
   - Transactional and strategic suggestions – programmatic specifics or improved transfers to joint operating committees or workgroups
   - Network participation – being a premier provider or engaging as such
   - Connecting emerging services to customer needs, pilots, demonstrations
Build the Right Change Team

- The right team may not be your leadership team – it might need to look broader than that.
  - Involve members across the organization, both horizontally and vertically – different viewpoints are critical
  - Look for people with good communication skills and those are inspirational to others
  - Resident services staff are essential – they will be your advocates among other staff

- Ideal team members include people who:
  - Challenge the status quo
  - Are generally optimistic
  - Not adverse to hard work
  - Build relationships well

You need thinkers and doers!

Tear Down Barriers

- Knocking down the barriers to change is a key step – avoid figuring out “how to work around something”

- If you create strong consensus and have a good plan, sticking to it is key in taking out barriers.
  - It’s hard to people to oppose something they helped create or felt they had input

- Be prepared to address:
  - Fear that the staff base is unprepared to achieve the vision
  - Necessary resources, planning and support to accomplish the change
  - Real fear and lack of experience with change
Communicate Clearly

- Continuous and ongoing communication is absolutely critical to maintain momentum – communication engenders trust and trust overcomes fear
  - Must address both internal audiences and external audiences
  - They will likely require different messages and at different times
- Utilize existing channels, but if necessary, create and use new ones – newsletters, bulletin boards, social media
- Communication topics include:
  - Re-statements of vision and plan
  - Accomplishments to date
  - Celebrations of success
  - Acknowledgment of actions or achievements
  - Work yet to be done

Foster Competency and Learning

- Any change involves a learning curve – you’ll need new skills and abilities across the organization
- Plan for it from beginning – likely to be a key pillar in any change or strategic plan, especially given expanding technology use, changing clinical needs and different customers
- In-situ and role-based training are often the best approaches, either mentored or guided by experts
- Informal training networks or skill teams are another means to create reinforced training for continuous learning
Anchor and Celebrate

- Celebrating accomplishment around change is essential in making it stick – but it’s more than just a big party at the end.
  - Every step along the journey offers an opportunity for evaluation, reflection and congratulation.
  - Performance rewards are but one tool and should encompass a range of options – some monetary (ideally small) but many non-monetary.
  - Change team members should be empowered to highlight and recognize positive movement on the spot.
  - Leaders must champion accomplishments daily and make them ongoing part of every staff, board and stakeholder interaction.

Fifty Reasons Not to Change

[Diagram showing fifty reasons not to change, including reasons like it's too ambitious, it's too complicated, it's too political, we don't have the staff, it needs committee study, etc.]
Embrace it.

Questions?
Thank You!

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