CREATING HIGH VALUE PARTNERSHIPS ACROSS THE CONTINUUM

The Hospital + Healthsystem Association of Pennsylvania
Payment Reform Summit
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Gordon Phillips, MPS has nothing to disclose. Laura Kohler, RN, BSN has nothing to disclose.
OBJECTIVES

Outline **key forces** driving the need for stronger partnerships with post-acute providers (internal and external!)

Discuss **key challenges** organizations face as they move to new business models

Identify **key strategies** for vetting potential partners, achieving alignment, and establishing successful partnerships
ROADMAP FOR TODAY’S DISCUSSION

Driving Forces – An Industry in Transition

Implications for Healthcare Delivery

Building Successful Value-Based Partnerships

Partnership in Action
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WE FIND OURSELVES IN “INTERESTING” TIMES...

"The picture's pretty bleak, gentlemen. ... The world's climates are changing, the mammals are taking over, and we all have a brain about the size of a walnut."
The U.S. healthcare industry is currently undergoing what will ultimately be a radical transformation, driven by unsustainable cost increases, increased regulation, and shifting power relationships among payers, providers, physicians, and patients.
MAJOR DRIVERS OF TRANSITION

- Changes in the Competitive Landscape
- Regulatory Shifts
- Technological Changes
- Changing Market Expectations
HOW DID WE GET HERE?

• Spiraling Healthcare Cost Inflation

Growth in national health expenditures (NHE) and gross domestic product (GDP), and NHE as a share of GDP, 1989-2015

Source: Health Affairs, December 2016
• Consumer/Employer Pushback on Rising Insurance Premiums
• Lagging Quality Indicators

Average life expectancy at birth (years)
CMS IS DEMANDING MORE VALUE FROM PROVIDERS

- BPCI
- MSSP
- HAC Reduction Program
- CJR
- OCM
- Cardiac Rehabilitation Incentive Payment Model
- IMPACT Act
- ACOs (Pioneer, Next-Gen)
- Hospital Value-based Purchasing (HVBP) Program
- Hospital Readmissions Reduction Program

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MOVEMENT TO NEW PAYMENT MODELS IS ACCELERATING
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Massive consolidation in delivery

- 94 hospital mergers/acquisitions in 2012 (highest in past decade)
- ½ of ASCs closed since 2009 were purchased by hospitals
  (Ambulatory Surgery Center Association)

Rush to employ doctors

- >½ of physicians employed by hospitals; up 32% since 2000
  (American Hospital Association)
- Trend fueled by the creation of accountable care organizations
  (New England Journal of Medicine)
CONSOLIDATION AND CONVERGENCE

Movement away from traditional bricks and mortar

Traditional Healthcare Delivery

Insurers

Employers

Unique partnerships

Accelerates pricing pressure and demand for value

Competition from new sources

Medical tourism
Market-based solutions are characterized by:

- **Transparency**

- **Accountability for health outcomes and cost... across the continuum of care**

- **Consumer choice based on real competition**
WHAT IT WILL TAKE TO DELIVER VALUE *TOMORROW*

A defined set of services with a specified quality outcome delivered at a predictable, transparent price...

...across the continuum of care.

...the basis for going at risk...

*the foundation for population health and bundled pricing.*
WHAT IT WILL TAKE TO DELIVER VALUE TOMORROW

Defined Services + Fixed Price + Quality Commitments/Guarantees

Providers/Payers Aligned to Deliver Value

Economic and Clinical Value
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BUILDING HIGH VALUE PARTNERSHIPS

P³ Management System™
FOUNDATIONAL QUESTIONS

• What goals and requirements does the partnership need to address?
• How well do providers meet our needs?
• What is the best option for addressing post-acute needs (build/buy/partner)?
• How do we select our partners and structure solid partnership agreements?
• How do we maintain a healthy, high performing partnership?
What goals and requirements does the partnership need to address?

- Patient demographics
- Performance/capability gaps
- Coverage and capacity requirements
- Competitor/market forces
- APM/ACO/bundle requirements
- Strategic goals & therapeutic priorities
- Threshold credential requirements
- Partner evaluation criteria
- Partnership agreements and performance dashboards
CURRENT PROVIDER PERFORMANCE

Accessibility & Capacity

Geographic coverage

Service and resource alignment

How well do providers (including our own) meet our needs?

Quality and outcomes

Operational efficiency

Grow

Watch

Reduce
BUILD/BUY/PARTNER OPTIONS

What is the best option for addressing post-acute needs?

**Build**
- Capital-intensive
- Higher risk
- Culture/infrastructure challenges
- Cost and revenue at the same time

**Buy**
- Capital-intensive
- Higher risk
- Cost and revenue at the same time

**Partner**
- Lower entry costs
- Quicker to operationalize
- Premium on selecting the “right” partners and having strong value-based partnership agreements
PARTNER SELECTION AND AGREEMENTS

How do we select our partners and structure solid partnership agreements?

- Cultural and value alignment
- Financial stability
- Clinical alignment
- Performance transparency and reporting
- Shared commitment to perf. improvement
- Openness to risk and gain sharing
- Cost and quality variation management

Request for Information

Leadership and staff interviews

On-site facility reviews

Case mgr. and MD perspectives
PARTNERSHIP MANAGEMENT

How do we maintain a healthy, high performing partnership?

- Performance dashboards/reporting
- Clearly defined roles/responsibilities
- Best practice ID and sharing
- Regular performance reviews
- Variance management process
- RCAs for “sentinel events”
- Timely issue resolution
- Collaborative decisions
- Bi-directional information flow
- Learning-based culture
- Cross-continuum performance improvement

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ST. LUKE’S UNIVERSITY HEALTH NETWORK

• Located in Eastern PA / Western NJ
  o 6 hospitals in PA; 1 in NJ
  o More than 185 service sites in 8 counties

• Revenues = $1.5B

• Employ 534 Physicians and 283 AP’s

• 67 Level III NCQA PCMH’s

“The statements contained in this presentation are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document.”
SLUHN BPCI MODEL 2 HISTORY

- SLUHN started as the largest Model 2 in the nation in October 2013.
  - Allentown, Bethlehem and Warren first to start
  - Anderson started in October 2014
  - Goal = learn and improve care for all patients as opposed to a specific bundle

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SNF DEVELOPMENT FIRST STEPS

2013: Assessed Landscape

- History of strong SNF relationships
- Assessed baseline CMS claims data and Nursing Home Compare
  - Cost, LOS, Readmission, Quality, Staffing, Safety
- Evaluated referral patterns both in and out of the system
  - >90 SNF’S in and out of the network in baseline
- Determined outreach to higher volume SNFS for RFIs

2013: Meeting with SNFs

- Discussed BPCI with 16 SNFs
- Preferred versus aligned
- 6 chose preferred status; remaining skeptical
SNF DEVELOPMENT SECOND STEPS

2014: Initiated Quarterly Meetings

- **SNF Members**: Corporate leadership, NHA, DON, rehab leads, social work leads

  Challenges:
  - SNFs with large market share
  - Contracted Rehab companies
  - Social worker practice
  - Skill to benefit mindset
  - Patient perceived Medicare FFS benefits

- **SLUHN Members**: BPCI program director, VP Quality, Senior Care Administrator, Chief of Geriatrics, field RN, Network Director of Case Management

  Goals:
  - Assess for barriers
  - Share data
  - Development mutual goals
SNF DEVELOPMENT SECOND STEPS

2014: SNF Support

- Embedded Field RN into weekly utilization management meetings
- Embedded SLUHN physicians as medical directors +/- attending's
- Assisted with educational opportunities: CHF, COPD
SNF DEVELOPMENT THIRD STEPS

2014: Hospital Interventions

• BPCI Goals/Education sessions
  o Hospitalist/specialists
  o Case managers, Nursing, Therapy

• Scripting to case managers preferred vs aligned status

• Patient education materials
  o CMS 5 star ratings
  o Expectations of preferred SNF care
  o SLUHN Physicians within the SNF’S

• Barriers: patient choice
SNF DEVELOPMENT FOURTH STEP

2015-2016: Focused Approach Toward Quality

- Clinical pathways: AMI, CHF, COPD, DM, PNA, Sepsis, MLJ
  - Pre SNF admission through discharge
- Risk assessments utilizing BOOST tool at the SNF level
- SNF score cards
  - Quarterly self reported metrics
  - Quarterly clinical pathway audits
- Physician hand-offs
- Transition of care documents
- PCP appointments prior to SNF discharge
- Multi-disciplinary approach
  - Pharmacy, Respiratory therapy, Nutrition, Activities, cognitive assessments
  - Palliative Care, Hospice
SNF DEVELOPMENT FIFTH STEP

2015-2016: Home Health Integration

• Provided SNFS and patients with home health education
  o Services available to transition patients safely

• Participated in discharge planning meetings
  o Assess current clinical and therapy status
  o Established patient goals for continuation of care
SNF DEVELOPMENT SIXTH STEP

Drive Competition

• 2Q16 Narrowed the network from 16 to 9
• Healthy Competition
• Re-evaluate every 6 months
• 4Q16
  o Removed a lower performing SNF
  o Replaced with higher performing SNF
• 1Q16
  o No changes
  o Warnings to SNF with high readmissions
RESULTS

Sustained improvement over 12 quarters

Source: CMS - BPCI Claims Data
RESULTS

Noted variability in readmissions, but well below baseline

Source: CMS - BPCI Claims Data
RESULTS

Sustained improvement over 12 quarters

Source: CMS - BPCI Claims Data
THE POWER OF PARTNERSHIP – KEY TAKEAWAYS

Performance transparency and continuous improvement

Standardized care paths and transitions

Value differentiation

Disciplined partner selection and management

Cross-continuum care coordination & efficiencies

Preferred provider networks

Value and culture alignment

A defined set of services with a specified quality outcome delivered at a predictable, transparent price...across the continuum of care.
AN EMBLEMATIC EXAMPLE – THE GREEN BEAN STORY....

“At the end of the day, all parties need to be committed to a mutually beneficial, value-creating relationship”
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