Jefferson Health: Clinical Integration: Focus on Value

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Learning Objectives

1. Explain the forces driving healthcare reform
2. Discuss the notion of patients as consumers and game changers
3. Describe ways in which we can provide value to our customers
Price and Performance Concerns

- The U.S. spends more on health care per capita than other OECD* countries

- U.S. ranks in the bottom 25% of those countries on life expectancy

*Organization for Economic Co-Operation and Development
U.S. Healthcare Expenses are Not Sustainable

Projected Total Health Care Expenses for U.S. Families: 2002-2021

- Health Reform expands coverage
- Payment rates and coverage levels less rich per capita basis
- Huge pressure on the delivery system to improve value
  - From households;
  - From government;
  - From business

Who can't afford it

Source: 2011 Milliman Medical Index

Source: 2012 AHRQ data analysis, Henry Miller, Ph.D.
Affordable Care Act

• Signed into law on March 23, 2010
• Coverage Expansion
  – Adult children through age 26
  – Prohibits lifetime limits on dollar value of coverage
  – Individual and Employer Mandates
  – Health Insurance Exchange
  – Medicaid Expansion to 133% FPL
• Delivery System Reform
  – Patient Centered Outcomes Research
  – Center for Medicare and Medicaid Intervention
  – Medicare Shared Savings Program (ACO’s)
  – Hospital-based programs: Value-Based Purchasing, Readmission Reduction, Hospital Acquired Conditions
• Financing
  – Tanning salon tax
  – Medicare Advantage Payments restructured
  – Individual and Employer penalties (tax)
  – Annual Health Insurance Provider Fees
  – New Medicare Tax on High Income Taxpayers
  – Pharmaceutical company Fees
National Marketplace - Insurers

• Contract with Employers, Individuals and Federal and State Governments (Customers) to provide health care coverage for individuals or groups

• Are under increasing pressure from their “Customers” -
  ❖ Responsible for financial risk and the quality of the network and health care services that are provided for their members.
  ❖ CMS and State Medicaid plans require payers to achieve quality and cost metrics.
  ❖ Payers who do not hit quality and efficiency targets will suffer financial losses.
  ❖ Medicare Advantage plans with <3.4 stars in a market are at risk of losing ability to sell in that market

• Are looking for provider partners to work with to improve the health of the populations they serve including the following:
  ❖ Sharing of data and information
  ❖ Aligned financial incentives
  ❖ Development of co-branded local market products
  ❖ Narrow Networks
  ❖ Joint Ventures
National Marketplace - patients

The “new customers” are game changers

- Experiencing the high cost of health care for first time
- Purchasing on Health Insurance Exchange exposes cost of premiums and co-payments for standard product designs
- Price sensitive in choosing insurance products. Cost conscious in seeking healthcare services

Insurers craft new offerings for Consumer Health Insurance Exchanges - including narrow, segmented, and tiered networks that limit or exclude high cost providers
Approximately 70% of the plans on the health insurance marketplaces/Exchanges feature restricted provider networks.
Consumers shop for standard benefit packages - the “metals”. Silver Plan pays 70% of consumer healthcare costs.

Rates vary by benefit package selected, tobacco use, age and geography.
- Sliding scale subsidies for those up to 400% of Federal Poverty level (2015: $11,670 for individual; $23,850 for family of four)
Consumer Decisions

Call US Now for a FREE quote at 818.705.9200

Sale Vehicle: New 2015 LEXUS IS 250 Lease special at 239/month
National: The “Purchaser” of Health Insurance Coverage rapidly shifting

 Already 61% govt, soon to be 73%

Source: Advisory Board, 2013.
National Marketplace: CMS Drives Quality Agenda

CMS limiting profitability for hospitals that do not hit performance thresholds—with more than 7% of payment at risk. Other payers adopt similar strategies.
Medicare Advantage: CMS Quality Measures

Payers monitor Provider network performance to achieve Star ratings

Data Sources: % of Overall Star Rating

- HEDIS: 33%
- CAHPS: 16%
- RX - PDE: 20%
- HOS Survey: 12%
- PDE (Rx Metrics): 2%
- Appeals: 2%
- Language/TTY/TDD: 1%
- CTM: 1%
- Disenrollment: 1%
- Beneficiary Access: 1%
- Hold Time: 1%
- Timely Part D Enroll: 2%

Data Sources: % of Overall Star Rating
Medicare Advantage: CMS Stars Program HOS: 
Patient-Reported Outcomes
Jefferson Strategy: Triple Aim

Become Market Leader in Creating Value

Patient experience of care
Access & Service

Health of a Population

Improving the health of populations
Quality & Safety are essential patient expectations

Experience of Care

Per Capita Cost

At the Lowest Cost:
Streamline “best practice” care delivery

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Jefferson Strategy: Triple Aim

Patient Experience

Patient Experience: ACCESS and Service

- Investment in infrastructure to support same day scheduling, simplified registration, care navigation and coordination.
  - JUP increasing percent of patients seen within goal of 7 days for primary care, 14 days specialists.
  - Increase availability of same day/next day appointments
  - Urgent Care: Smylie Times in Northeast-March 2015
    Washington Square in Center City - May 2015

*Develop patient-centric care model – throughout Jefferson.*

*Outstanding service + Efficient care = Patient and Provider Satisfaction.*

*Patients and providers will seek the “must have” Jefferson Brand.*
JeffSTAT: Increase Transfers!
Access and Service for Referring Providers

- **800-JEFF-121**
- Take advantage of outstanding call center and transfer service to increase access to Jefferson physicians and care 24/7/365.
- Access for physicians requesting emergent transfer or urgent referrals.
- Streamlining patient flow in hospital required in order to ensure timely bed assignment for incoming transfers.
- Timely communication back to referring physicians is key to successful program.
Jefferson Strategy: Triple Aim

Lower the Total Cost of Care

• Lowest Cost: Streamline “best practice” care delivery
  – Key is to provide value - High quality, efficient, cost effective care.

• Hospital Initiatives underway:
  – Care Management to ensure right “level of care” for all patients.
  – New Hospitalist model.
  – Decrease variation in care.
  – Metrics to include process, clinical and financial outcomes.

• Ongoing Performance Measurement:
  – Success in risk contracting will require close oversight of clinical and financial performance.
  – Care delivery must be streamlined to remain profitable.
Payers join Providers to Focus on Value

- Jefferson: Opportunity to be leading academic provider.
- Marketplace now mandating focus on value.
  - Providers must collaborate with payers on shared goals to increase (or maintain) market share.
  - Market share will no longer the number of hospital days or procedures....but the number of “lives” who choose to have access to Jefferson and then select Jefferson for care.
- Jefferson must work to become the “must-have provider” in the marketplace.
Accountable Care

Performance Accountability Expanding Across the Care Continuum

Degree of Shared Risk

Care Continuum

Capitation/Shared Savings Models

Episodic Bundling

Hospital-Physician Bundling

Pay-for-Performance
The New Marketplace

• Health Care Reform creates new consumer marketplace
  – Cost will be major driver for plans on Health Insurance Exchange
  – Consumers with higher out-of-pocket spend
  – Service, clinical outcomes and will be key as consumers look for value

• Accountable Care Goal: Deliver Value
  – P4P, Bundle, Tiered Network; Shared Savings, Capitation
  – “At risk” providers will make decisions based on outcomes and cost
  – More critical evaluation of new products re: added value
  – Ongoing monitoring of metrics reports
    • Patient Experience
    • Clinical outcomes
    • Total cost of care
Patients as Informed Consumers

News, DTC Advertising, Internet Searches

- Screening
- Genetic Testing
- Treatments
- Facilities
Population Management:
Requires Actionable Information

• Wellness and Clinical programs:
  – Collect data on entire population - by condition, etc.
  – Risk stratify by severity of illness, resource utilization, etc.
  – Set goals and deliver value - Triple Aim
  – “Evidence-based” care pathways / guidelines

• Metrics must be timely, accurate and actionable,
  – Resource utilization
    • Medications
    • Hospitalizations
    • Imaging, diagnostics, consultations
  – Total cost of care - Quality metrics
  – Patient experience

• Physicians must “believe” the data. It must be valid, clinically relevant and actionable

• Collaboration with payers to get complete data set.
Challenges of Accountable Care:

Complexity of Defining Value: Effectiveness and Efficiency Metrics.

Cost?

Clinical Outcome

Patient Satisfaction
Upcoming Bestseller

- Stephen Klasko is writing another book:
  - “How ______* screwed up Healthcare”
    *Insert Your Name Here.

His point: All of us contribute to the complex, inefficient, expensive and occasionally unsafe healthcare delivery system:

Patients    Pharma    Caregivers    Payers
Clinicians  Policy makers  Academic leaders  Manufacturers
Administrators  IT Vendors....

» We are all responsible for the problem;
Everybody has a story to tell about how the healthcare delivery system failed....
Everyone of us has a role to play in changing that story...

How will you do it? Own your story.