Medical Leadership

Eight Steps for “Moving the Colony”

Kyle Allen DO, AGSF
VP Clinical Integration
Medial Director Geriatric Medicine
Riverside Health System
Kyle.allen@rivhs.com

Are You Fred?
If I were to transform my health system/practice to be best in class to care for older adults and those with complex illness......

How Could I help Lead this Change?
Leadership

- Heroic Passion
- Vision
- “Level 5” Leadership
- Accountability
- Emotional Intelligence
- Negotiating
- Servant Leadership
Key Characters

Can you name these folks in your institution?

✓ Fred
✓ Alice
✓ Dr NoNo
✓ Buddy
✓ Professor
✓ Louis
✓ Scout

http://www.kotterinternational.com/our-principles/our-iceberg-is-melting/understandingiceberg
The Four Camps of Healthcare Organizations

- Paralyzed by Confusion
- Embracing the Opportunities
- Happily Existing in Denial
- Resigned to Acceptance

Resiliency

Greater

Lower

Understanding

Lower

Greater
The 8 “Physics Laws” of Change

1. Create a sense of urgency
2. Create the guiding coalition.
3. Developing a vision and strategy.
4. Communicating the change vision.
5. Empowering broad-based action.
7. Consolidating gains and producing more change.
8. Anchoring new approaches in the culture.
The Eight–Stage Process of Creating Major Change:

1. Establishing a sense of urgency.
   - Examining the market and competitive realities.
   - Identifying and discussing crises, potential crises, or major opportunities.
The Goals of Transformation: Accountable Care Act and Accountable Care Organizations

Current Fee For Service System

Value Based Health Care System

Most Healthcare Systems do not recognize the community

- Integrating Care Across the Continuum
- Aligning Incentives for Value and Quality
- Reducing the Cost Curve

The Community Based Organizations
Eyes on the Top Users

Medicare FFS:

10% of Beneficiaries

57% of Costs
The Eight–Stage Process of Creating Major Change:

2. Create the guiding coalition.
   – Putting together a group with enough power to lead the change.
   – Getting the group to work together as a team.

So enough with the talk. Let’s do something!
The Eight–Stage Process of Creating Major Change:

3. Developing a vision and strategy.
   - Creating a vision to help direct the change effort.
   - Developing strategies for achieving that vision.

"The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it."

Michelangelo
The North Star:

- Aim for “community ACO model” and arrangements to ensure that:
  - When any older person in your area must live with serious chronic illnesses in the last phase of life,
  - That frail older adult can count on living as meaningfully and comfortably as possible,
  - At a sustainable cost to our families and to the society.

Reynolds Conference
The Eight–Stage Process of Creating Major Change:

4. Communicating the change vision.
   – Using every vehicle possible to constantly communicate the new vision and strategies.
   – Having the guiding coalition role model the behavior expected of employees.
The Eight–Stage Process of Creating Major Change:

5. Empowering broad-based action.
   - Getting rid of obstacles.
   - Changing systems or structures that undermine the change vision.
   - Encouraging risk taking and nontraditional ideas, activities, and actions.

Never, ever think outside of the box.
Hospital stay may speed decline among elderly

Study is first to gauge risks to cognitive function

By Janice Lloyd
USA TODAY

Hospitalization of older people might place them at higher risk for accelerated cognitive decline, a study suggested Wednesday.

Stick to proper dosages

Marie Bernard, deputy director of the National Institute on Aging, says following these steps can help older people avoid problems stemming from hospital stays:

- Take medications as prescribed and try to prevent medical problems.
- Contact a health care provider when a concern occurs to see if you can be treated as an outpatient.
- When staying in a hospital, whether a family member or patient, do not

“The focus of acute care is taking care of the medical problem and not the care of the elderly down the road.”

Barbara Resnick, American Geriatrics Society
The Eight–Stage Process of Creating Major Change:

   – Planning for visible improvements in performance or “wins”.
   – Creating those wins.
   – Visibly recognizing and rewarding people who made the wins possible.
Synergy deemed ‘unprecedented’

Warner impressed by plan to reduce readmissions of Medicare patients

BY PRUE SALASKY
psalasky@dailypress.com

NEWPORT NEWS — More than half of hospital readmissions of Medicare patients within 30 days result from socio-economic factors and the physical environment, compared to just 10 percent for medical reasons, Kathy Vesley-Massey, CEO of Bay Aging, said at a forum hosted by the Eastern Virginia Care Transitions program.

Bay Aging is the lead agency in the program, which is a collaboration of five agencies on aging, four health systems, 11 hospitals and multiple other health providers. The group is two years into a five-year Medicare pilot project to bring down patient costs and reduce 30-day re-

Vesley-Massey said at the roundtable presentation with two dozen stakeholders and U.S. Sen. Mark Warner, D-Va., at Riverside Re-

which also provided the impetus by instituting penalties on hospitals for readmissions. Most who qualify for coaching are ‘dual-

that the eastern Virginia program still leaves gaps, particularly in addressing mental health read-

missions. These form a high per-
The Eight–Stage Process of Creating Major Change:

7. Consolidating gains and producing more change.
   – Using increased credibility to change all systems, structures, and policies that don’t impeded the transformation vision.
   – Hiring, promoting, and developing people who can implement the change vision.
   – Reinvigorating the process with new projects, themes, and change agents.
Evidence-Based Geriatric Care Models Serve as Cost “Stabilization Wedges”

- ACE/Geri Consults
- ACE Units
- ACE Tracker
- Care Transitions
- INTERACT
- CTI with EVCTP
- NICHE
- Delirium Prevention Protocols
- HELP Program
- PACE Program
- Medical Home
- House Calls
- Continuum of Compassionate Care
- Palliative Care Programs

Costs with care as usual

Continuing Health Care Expenditures

Slide from Dr. M Malone, Medical Director of Senior Services, Aurora Health Care presented at 2013 NICHE Annual Scientific Meeting

Pacala, Socolow. Science 2004;305:968-72
The Eight–Stage Process of Creating Major Change:

8. Anchoring new approaches in the culture.
   – Creating better performance through customer- and productivity-oriented behavior, more and better leadership, and more effective management.
   – Articulating the connections between new behaviors and organizational success.
   – Developing means to ensure leadership development and succession.
RHS NICHE STRUCTURE
NURSES IMPROVING CARE FOR HEALTHSYSTEM ELDERS

RHS NEC NICHE STEERING COMMITTEE

NICHE AFFILIATE STEERING COMMITTEE

NICHE CONCEPT INTEGRATED AT SITES

RRI
HRSH
RBHC
HOME HEALTH HOSPICE
RMG
… The Question is not “If?”…
It is “How?” and “When?”
Sustaining Geriatrics: View from the Dark Side

2015 Reynolds Grantee Annual Meeting

John B. Murphy, MD
Professor of Medicine and Family Medicine
Warren Alpert School of Medicine of Brown University,
Executive Vice President Physician Affairs, Lifespan
Conflicts of Interest

• None
Goals

• Acculturate you to the perspective of those living in the C-Suite
• Delineate some opportunities for win-win arrangements between a health system and geriatrics
• Provide tips on working with the C-Suite
Lifespan

- $1.8 billion operating budget
- 4 hospitals; 15,000 employees
- EVP Physician Affairs System-wide Responsibilities
  - Quality and Safety (EVP Nursing Affairs)
  - Medical Staff (2500)
  - Hospital CMOs
  - Research ($80 million)
  - GME (600 housestaff)
  - Physician Contracting & 500 Provider practice plan
  - Lab (hospitals and lab outreach)
  - Service Lines- Cardiovascular, Cancer, DI
  - Risk (PL including Captive and Clinical Risk Management, GL (property, auto, cyber, etc.), D&O)
  - Facilities, Property Management, Design and Home Medical (DME)
The typical Academic Medical Center makes its margin on 15% of the discharges: the remaining 85% have no margin or a negative margin.

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2013, for community hospitals.
(1) Includes Medicare Disproportionate Share payments.
(2) Includes Medicaid Disproportionate Share payments.
Distribution of Hospital Cost by Payer Type, 1980, 2000 and 2013

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2013, for community hospitals.

(1) Non-patient represents costs for cafeterias, parking lots, gift shops and other non-patient care operating services and are not attributed to any one payer.

(2) Uncompensated care represents bad debt expense and charity care, at cost.

(3) Private payer formulas were updated in 2014 to account for the change in bad debt calculations, which is now reported as a deduction from revenue rather than an expense.

(4) Percentages were rounded, so they do not add to 100 percent in all years.
Percentage of Hospitals with Negative Total and Operating Margins: 1995 – 2013

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2013, for community hospitals.
Annual Percent Change in Hospital Prices, 2002 - 2013

Percent of Hospital Costs\(^{(1)}\) by Type of Expense, 2013

- **Wages and Benefits**, 59.2%
- **Other Services**\(^{(3)}\), 20.0%
- **Prescription Drugs**, 6.3%
- **Other Products (e.g., Food, Medical Instruments)**, 14.4%

- **Professional Fees**, 9.1%
- **Utilities**, 2.3%
- **Professional Liability Insurance**, 1.2%
- **All Other: Labor Intensive**, 3.7%
- **All Other: Non-labor Intensive**, 3.7\(^{(2)}\)

Source: AHA analysis of Centers for Medicare and Medicaid Services data, using base year 2010 weights.

\(^{(1)}\) Does not include capital.

\(^{(2)}\) Includes postage and telephone expenses.

\(^{(3)}\) Percentages were rounded, so they do not add to 20 percent.
Percent of Hospitals Incurring a HRRP Penalty, FYs 2013-2015

- FY 2013: 37% No Penalty, 63% Penalized
- FY 2014: 36% No Penalty, 64% Penalized
- FY 2015: 24% No Penalty, 76% Penalized

Two conditions added to the HRRP

CMS: Centers for Medicare & Medicaid Services; HRRP = Hospital Readmissions Reduction Program; FY = Fiscal Year
Note: FY 2013 n = 3,500, FY 2014 n = 3,483, FY 2015 n = 3,476
30-Day, All-Condition Medicare Readmission Rates

Scale of Difficulty in Resource Acquisition

- Operating expenses: Difficult
- Capital expenditures: Very difficult
- Space: Extremely difficult
Academic Medical Centers/Health Systems

• Once you have seen one AMC, you have seen one AMC
• You need to know your health system
  – Budget Cycle
  – Fiscal status/pressures (e.g., margin, other major initiatives)
  – Market issues (e.g., stage on the FFS to full risk continuum market share/local competition)
  – Opportunities/Challenges (e.g., penalty status for HRRP, VBP etc.)
The Range of Value-Based Arrangements on the Risk Continuum

Increasing Risk (Financial and Operational)

- FFS
- Incentive-Based FFS
- P4P
- Case Rates
- Partial Risk
- Full Risk
- Health Plan

Physician Quality Reporting System

Bonuses (Quality and Cost Target Payments)

- Withholds
  - Episodic Payments
  - Bundled Payments
  - PMPM and/or Percent of Premium

Gainsharing/Shared Savings

At Risk for All Medical Services and Administrative Expenses
Opportunities: Cost Reduction, Quality & Market Share Enhancement

- Geriatric Fracture Program
- Geriatric Trauma Program
- Geriatric Total Joint Replacement Program
- Geriatric General Surgery
- Palliative Care Program
- Others (Ace, Grace, GEM, HELP)
Opportunities:
Revenue Incentives/Penalty Avoidance

• Readmissions (Disproportionally hits AMCs)
  – Naylor, Coleman, Jack, ED diversion, others

• Bundled Payments: Medicare and Advantage
  – Readmissions, SNF utilization and LOS (Sound - a risk or an opportunity)

• Value Based Purchasing (four domains)
  – Clinical Processes of Care (catheter removal)
  – Outcomes
    • PSI 90 – Pressure Ulcers
    • Palliative Care and Mortality (PNA, CHF)
  – Patient Experience
  – Efficiency (3 days prior to and 30 days post discharge costs)

Modest potential
Opportunities:
Leadership Roles

• Quality
• DIO
• CMO
• Medical Director Ambulatory Care, SNF, HHA
• Payer leadership
• Consulting
• Development (Grateful Patients)
Dealing with the C-Suite

• Know your AMC and if you do not, ask for help.
• Be confident about what you have to offer, you can deliver great value.
• There is no one named “Administration”.
• Start with introducing the concept, not the fully baked program.
• Be patient, a program may not get approved with the first ask.
• Deliver on the first program and more will come, credibility is earned or lost.
• The answer to every obstacle is not more resources, it is often working smarter.
Dealing with the C-Suite, con’t.

• Do not over promise or overstate.
• Do not under or over estimate expenses:
  • Space, FTE’s & fringe, communications, IT (e.g., EMR custom build), data collection/analysis and capital equipment.
• Learn to use an Excel spreadsheet.
• Do not try to pass off a research effort as a clinical program.
• If you are not passionate about a project/program, do not proceed. Even with adequate funding/support this is hard work.
Brief Market Overview & Key Population Health Terms

Population Health vs. Value Based Care

ACO vs. CIN Definition

MSSP

MLR
A view from the marketplace…

• What are external parties looking for (*consumers, employers, payers*)?
  – Access
  – Value = quality / cost (bundles, low cost)
  – Partnership to reduce cost, improve wellness and engage workforce
  – Excellence in care delivery and customer service
  – Clinical innovations / programs for value
  – Collaborative medical staff
  – Population data – IT Infrastructure, PHS, etc.
  – Assistance with Risk contracting
  – Trust

Meeting the triple aim of quality, cost reduction, and patient satisfaction means VALUE to the marketplace.
CMS Value Based Goals

CMS is Driving Value-Based Payment

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018:

- All Medicare FFS (Categories 1-4): 30% in 2016, 50% in 2018
- FFS linked to quality (Categories 2-4): 85% in 2016, 90% in 2018
- Alternative payment models (Categories 3-4)

Commercial payers will follow suit.

Source: CMS Press Release, January 26, 2015, Computerworld

The number of covered lives associated with new risk contracts is growing rapidly:

Covered Lives Under Risk-Bearing Contracts

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>14</td>
<td>18</td>
<td>24</td>
<td>34</td>
<td>57</td>
<td>80</td>
<td>96</td>
</tr>
</tbody>
</table>

Growth Drivers:
- Higher density of medium and large hospitals
- Higher concentration of physician practices
- Higher per capita spend

1. Estimates based on data from Lazard Partners
2. Projections from States

Source: CMS Press Release, January 26, 2015, Computerworld
Value Based Model Transition Over Time - All Payers

Projected Ambulatory Provider Model Evolution
% of physicians in value-based operating model

- Medicare programs are only the tip of the iceberg; the commercial market is moving to value as well

<table>
<thead>
<tr>
<th>Year</th>
<th>Docs (%)</th>
<th>Docs (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>~10%</td>
<td>~45k</td>
</tr>
<tr>
<td>2015</td>
<td>~40%</td>
<td>~230k</td>
</tr>
<tr>
<td>2020</td>
<td>~65%</td>
<td>~360k</td>
</tr>
</tbody>
</table>

Value based models (e.g., episode based care, population care)

Fee for service

Sources: AHD Acute Data; SK&A, NEJM; RWJ Foundation; HIMMS; Commonwealth Fund; Oliver Wyman Analysis
CMS’s Path to Meeting Goals

• Bundled Payment Programs
  – BPCI- Model 1 (inpatient-hospital), 2 (inpatient+ post acute- hospital+ facility costs), 3 (post acute), 4 (hospital+ physician) – by application
  – Comprehensive Joint Replacement for Hospitals- mandatory
  – Oncology Care Management- Chemo bundle- by application

• Million Hearts
• Part D Enhanced Medication Therapy
• Merit Based Incentive Payment System (MIPS)
• MSSP- Track 1, 2, 3, Next Generation
• Pioneer ACO
What Is Population Health?

The concept of population health first came about in 2003 when David Kindig and Greg Stoddart defined it as “the health outcome of a group of individuals, including the distribution of such outcomes within the group.

Interpretation and understanding of the phrase “population health” differs greatly – in a survey of 100 health care leaders conducted by George Washington University, many executives view it as an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve.
What Is Value Based Care?

In the value based delivery model, care is organized around the patient and meeting a defined set of patient needs over the full care cycle. The aim is improve health outcomes, and to do so with increased efficiency.

5 Essential Elements for Transforming Into a Value Based Practice

1. Basing primary care on patients’ needs
2. Integrating delivery models by subgroup
3. Measuring value for each subgroup
4. Aligning payment with value, control the premium dollar
5. Integrating subgroup teams and specialty care

Fee for Service to Value Based Care

The Old System

- Fee for service model
- Patients “discharged”
- Disease Management focus
- Addressing Sickness
- Measuring Mortality/Harm

The New System

- Value based reimbursement model
- Patients “transitioned”
- Care Coordination and navigation
- Addressing Health
- Measuring Risk of Harm
Clinical Integration (CIN) Definition

*Definition*: the purposeful “fostering of collaboration among independent doctors and hospitals in a way that increases both the quality and efficiency of patient care.”

Key Components of Clinical Integration

1. Collaboration between hospitals and physicians (both independent and hospital-employed); generally multi-specialty

2. Purposeful agreement to improve quality and efficiency of care, including enhanced patient health status, care outcomes, utilization, and other defined factors

3. Use of evidence-based practices and data-driven performance improvement, informed by IT tools to accomplish #2

4. Often serves as the physician network of an ACO
ACO Definition

Definition: an entity made up of health care providers that agree to work together to improve the health of their patients while also lowering the cost of care.

Key Components of an ACO:
1. Legally structured arrangement between hospitals, primary care and/or specialty physicians, and perhaps other providers (such as post-acute care facilities, inpatient rehab facilities, skilled nursing facility care, home health care, and more) to coordinate and deliver efficient and effective care for a defined patient population for a specified period of time.

2. Assumes accountability for improving healthcare quality and slowing the growth of healthcare costs through contracts such as Medicare Shared Savings (MSSP).

3. Provides the organizational capacity to establish an administrative body to manage patient care, ensure high-quality care, receive and distribute payments to the entity, and manage financial risks incurred by the entity.
The Medicare Shared Savings Program (MSSP) is an approach to the delivery of health care aimed at reducing fragmentation, improving population health, and lowering overall growth in expenditures by:

1. Promoting accountability for the care of Medicare fee-for-service beneficiaries
2. Improving coordination of care for services provided under Medicare Parts A and B
3. Encouraging investment in infrastructure and redesigned care processes

**ACO Payment Cycle**

1. **Assignment:** Patients assigned to ACO based on terms of contract.
2. **Billing:** Providers bill normally, payers pay standard fee-for-service payment.
3. **Comparison:** Total cost of care for assigned patients compared to target.
4. **Shared Savings:** Payer levies payment or penalty based on expenditure comparison to target, adjusted for quality measures.
MLR – Reducing the Cost of Care

- Success under ACO or value is achieved by working together to deliver high quality and coordinated care in order to reduce costs.

- A medical loss ratio (MLR) measures the fraction of the total insurance premiums that health plans use on clinical services as opposed to administration and profit.
MLR – Old v. New

- Under existing payer contracts providers do not get to keep any savings generated by reducing the MLR.

- Under new types of payment models providers get to keep a portion of the savings generated by reducing the MLR.