Building the Competencies for Value-Based Care in an Academic Health System

Health Forum and the American Hospital Association Leadership Summit
Agenda

About YNHHS

Background

Cost Value Positioning

YNHHS - Tenet Strategic Alliance

Population Management

Summary
Yale New Haven Health System

- Founded in 1995
- Corporate Members
  - Yale New Haven Hospital
  - Bridgeport Hospital
  - Greenwich Hospital
  - Northeast Medical Group
- Clinical Affiliates
  - Bristol Hospital
  - Charlotte Hungerford
  - Lawrence & Memorial
  - The Westerly Hospital, RI
  - Sharon Hospital
  - Griffin Hospital
  - St. Mary’s Hospital
- Affiliated with the Yale School of Medicine

FY 2013 Critical Indicators

<table>
<thead>
<tr>
<th>Critical Indicator</th>
<th>System Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Licensed Beds</td>
<td>2,130</td>
</tr>
<tr>
<td>Inpatient Discharges</td>
<td>111,396</td>
</tr>
<tr>
<td>Outpatient Encounters</td>
<td>1,625,152</td>
</tr>
<tr>
<td>Net Revenue</td>
<td>$3.2 B</td>
</tr>
<tr>
<td>Medical Staff</td>
<td>6,060</td>
</tr>
<tr>
<td>Employees</td>
<td>18,388</td>
</tr>
</tbody>
</table>
Vision/Mission/Values

Yale New Haven Health enhances the lives of those we serve by providing access to integrated, high value, patient-centered care in collaboration with others who share our values.

Yale New Haven Health is committed to innovation and excellence in patient care, teaching, research, and service to our communities.

Values

INTEGRITY
Putting patients and families first
Doing the right thing

PATIENT-CENTERED
ACCOUNTABILITY
Being responsible and taking action

RESPECT
Valuing all people

COMPASSION
Being empathetic
Market Forces

Cost Rising > Inflation

Challenges to Value Proposition

Constrained Resources

Aging Population

Connecticut Medicaid Reductions

Consumerism
Transitioning from Volume to Value

**TODAY**

**Performance Based on Volume**
- Revenue driven; margin impacted more by volume and reimbursement per admission and units of work than cost
- Limited incentives to prevent admissions and coordinate care; quality and safety initiatives are process driven
- Organizational focus is on advancing the position of specific providers/points of care delivery; little or moderate integration across the network and across the continuum
- Focus is on managing episodes of illness and disease

**FUTURE**

**Performance Based on Value**
- Cost driven; margin impacted more by managing costs - both variable and fixed
- Positioned to optimize quality, safety and patient satisfaction
- Organizational focus is on advancing the network or system of provider partners; high degree of integration across the network/system and coordination across the continuum
- Focus is on prevention and population health

Maximizing value is required, but transitioning too quickly may compromise current financial performance.

Elements of value can improve performance now by maximizing margins; controlling costs; and enhancing quality, safety and satisfaction.
YNHHS FY 2013 – 2015 Strategy

Scale/Portfolio Strategy
- Access and Geographic Reach
- Clinical Breadth & Depth
- Payer and Payment Strategy

Physician Alignment & Integration Strategy
- Access to Capital

Value Strategy
- Cost/Unit
- Quality, Safety and Service
- Population Health

Efficient and Effective Organization and Governance Structure
Cost Value Positioning
Cost Value Positioning

Entities assessed

- Bridgeport Hospital
- Greenwich Hospital
- Health Services Corporation
- Northeast Medical Group
- Yale-New Haven Hospital

Focus areas

- Clinical Redesign
- Comprehensive Performance Improvement
- Non-Labor
- Labor
- Human Resources
YNHHS Realized Implementation Summary

As of 5/31/14
YNHHS Annualized Implementation Summary

As of 5/31/14
CVP: Clinical Redesign

<table>
<thead>
<tr>
<th>FY 2014</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>Achieved TD</td>
<td>Gap</td>
</tr>
<tr>
<td>$38,000,000</td>
<td>$8,905,123</td>
<td>($29,094,877)</td>
</tr>
</tbody>
</table>

- **Resourced Redesign Projects**
  - System Projects
  - Service Line and Delivery Network Projects

- **Clinical Performance Improvement**
  - Medicare Payment Retention
  - Ongoing QVI Reduction
YNHHS - Tenet Strategic Alliance

Regional Provider Network

Clinically Integrated Regional Network (CIN)
YNHHS/Tenet: Strategic Alliance

- Regional Provider Organization, LLC
  - An integrated provider network of Tenet’s Connecticut, Rhode Island, New York and Western Massachusetts providers (including physician organizations) and potentially all of New England

- Clinically Integrated Network that Takes Risk
  - An organization to provide clinical integration, risk contracting and risk management infrastructure for physicians, hospitals and other providers
Potential Regional Provider Network

Each circle represents an IDN – ambulatory/physician/acute/home health/sub-acute
Regional Provider Network

- Joint venture: YNHHS - 20%; Tenet - 80%
- Tenet operates providers
- YNHHS provides clinical support, quality, clinical service lines and brand
  - Criteria for brand use
- Regulatory approval process
Clinically Integrated Network: Clinical Benefits

- Improves access to quality care
- Handles health of populations across state
- Manages patients across continuum of care
- Achieves collaborative scale
- Drives common usage of:
  » Data platform
  » Metrics and measurement
  » Evidence-based best practices
Clinically Integrated Network that Takes Risk

- Regional Clinically Integrated Network drives common
  - Data platform
  - Metrics and measurement
  - Evidence based best practices
  - Deployment of care management to support improvement
  - Contracting to achieve benefit of integration

- “Local” Clinically Integrated Provider Groups
  - Can be employed physician groups, large independent physician groups, PHOs, IPAs, etc. – may be a collaborative of several of these
  - Clinical process transformation and performance improvement efforts occur at this level
Clinically Integrated Network: Risk Contracting

- Providers = Initial risk contract beneficiaries
- Initial equity owners responsible for infrastructure investment and future required capital
  - Repaid over time with modest return
- Evolves into greater risk over five years consistent with evolution of risk in the market and ability of payers to administer
Clinically Integrated Network: Conifer VBC Product Portfolio & Solution
Enterprise Care Management
Enterprise Care Management

Population Health Initiatives

- Patient Centered Medical Home (PCMH)
- Our Employees
- CMS Bundled Payments

Maximizing System Effectiveness
Care Management Current State
Patient Centered Medical Home

Comprehensive, evidence-based care
Patient Engagement and Centeredness
Increased Access to Care
Across the Continuum Care Coordination

Team-based Care: Provides additional services, improves flow, fosters patient-centeredness, improves experience and quality of care

Data: Use of patient/disease registries and tracking of performance and quality metrics
PCMH: Impact

Diabetes Outcome Example

- Embedded care coordinator
- Implementation of registry
- Care coordinator identifies patients with gaps in care
- Does direct outreach to those patients to
  - Schedule visits
  - Obtain up to date lab values
  - Provide education
  - Connect with additional resources
livingwellCARES

- Confidential, free service offered to all employees & their families on our health plan living with chronic conditions
- Utilization Outcomes:

<table>
<thead>
<tr>
<th>Group</th>
<th>Total</th>
<th>PMPM</th>
<th>EBM Compliance</th>
<th>Admits / 1K</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invited but not Participating</td>
<td>742</td>
<td>$1.4K</td>
<td>78%</td>
<td>210</td>
</tr>
<tr>
<td>Participating Telephonically (disease management vendor)</td>
<td>49</td>
<td>$1.9K</td>
<td>82%</td>
<td>333</td>
</tr>
<tr>
<td>livingwellCARES</td>
<td>280</td>
<td>$1.1K</td>
<td>84%</td>
<td>108</td>
</tr>
</tbody>
</table>
High Levels of Patient Satisfaction:

Questions 1-6

<table>
<thead>
<tr>
<th>Agree or Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>My care coordinator explains things to me in a way that is easy to understand</td>
</tr>
<tr>
<td>The information provided to me by my care coordinator has helped me manage my health problems</td>
</tr>
<tr>
<td>I have made changes in the way I take care of myself as a result of working with my care coordinator</td>
</tr>
<tr>
<td>When I have questions, I am able to reach my care coordinator</td>
</tr>
<tr>
<td>Participating in this program has made a positive difference in my health</td>
</tr>
<tr>
<td>I would recommend this program to other YNHHS employees or their families</td>
</tr>
</tbody>
</table>

“I am grateful for this opportunity. The timing could not have been more perfect as I was just diagnosed with diabetes and looking for more education and support. My care coordinator is great! She has educated me, made referrals, tracks my care, assists with interpreting results (labs) for me, and recommends stress reduction techniques and more. I now feel more in control of managing my illness. And when unexpected things pop up I know she is available to assists with this revolving circle of changing needs. Thank you!”
Bundle Criteria

- YNHHS worked with an awardee convener, Remedy Partners, to assess opportunity for each episode bundle based on the following criteria:
  - Alignment with cost and value positioning.
  - Post-acute facility cost reduction opportunity
  - Readmission reduction opportunity
  - Implant device cost reduction opportunity
  - Physician partnership opportunity

**Selected Bundles**
- Congestive Heart Failure
- Major Cardiac Procedures
- Acute Myocardial Infarction
- Chest Pain
- Atherosclerosis
- Medical Vascular Procedures
- Major Lower Joint Procedures
- Hip and Knee Procedures
- Hip and Knee Revisions
- Cervical Fusion
- Major Upper Joint Procedures
Bundled Payments

BPCI Executive Committee

Care Redesign

Gainsharing

Data / Reporting

Clinical Redesign

Cardiovascular

Orthopedics

Primary Care / ED

Care Management

SNF

HHC/VNA

PCMH
Care Management for BPCI

Transition Management
- Ensure patient is “tagged and flagged”
- Optimize use of working DRG
- Transition Coordinators
- Remedy Call Center
- Evaluation of BPCI patients that do re-present

SNF / HHA Partnerships
- Assessment on
  - LOS
  - Readmission rates
  - CMS STAR ratings
  - Compliance with performance improvement processes
  - Patient and CM satisfaction
  - Capabilities survey

Connect with Physician Offices
- Warm hand-off to primary care offices – optimal for those with PCMH care coordinators
- Identification of patients without PCP and referral
Maximizing System Effectiveness

**FOUNDATIONAL CAPABILITIES**

“No regrets” capabilities to support today’s objectives and provide flexibility and degrees of freedom in meeting future value-based requirements

**TARGETED ADVANCED CAPABILITIES**

Focused capabilities to ready the organization for current and near-term value-based arrangement

**PHM ADVANCED CAPABILITIES**

Advanced capabilities to support managing a population’s health with enhanced focus on prevention and wellness

The roadmap will help the organization successfully realize meaningful benefits to patients and the health system, while maintaining the financial strength required to remain successful.

Source: The Chartis Group
ECM: Future Vision

**Acute Care Management Leader**
- Budget development
- Standard practice
- Selection and oversight of delivery network care management directors
- Performance improvement
- Management of system resources

**Shared Accountability**
- Enterprise care management strategy
- Post-acute care management development
- Performance expectations and monitoring
- System relationship management

**Ambulatory Care Management Leader**
- Budget development
- Standard practice
- Selection and oversight of delivery network care management directors
- Performance improvement
- Management of system resources

For Local Care Management Activities
- Daily operations
- Budget management
- Staff performance management
- Local relationship management

Delivery Networks & Clinically Integrated Physician Network

Source: The Chartis Group