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Collaborating to transform the patient care continuum

NELC Population Health and Value Management Symposium Executive Summary:

Date: ***September 27, 2018***

Background:

Exciting news! NELC held its first **Population Health and Value Management Symposium** on September 14, 2018 at the Portsmouth Harbor Events &Conference Center in Portsmouth, NH. At the Symposium, NELC brought together clinical and administrative leadership from 29 of our 53 member hospitals who lead the population health and value management efforts within their respective institutions and markets.

The agenda included a broad overview of the current healthcare market, providing insights into the market forces causing rapid and profound changes to our healthcare system. Speakers representing Brigham & Women's Hospital, Massachusetts General Hospital, Central Maine Healthcare, MaineHealth and Beth Israel Deaconess Care Organization delivered powerful presentations. Feedback from the audience was enthusiastic to both the quality of speakers and content of their messages. Our goal is to understand your needs and how we can positively impact your population health, site of care management or length of stay management initiatives.

Michael Souza, NELC President and CEO said: "We are all working towards the same goal: develop patient centric models of care to provide the right care, at the right time in the optimal location for the patient. These must be in alignment with the changes in the reimbursement structure to be able to reduce overall Total Medical Expenses (TME). The Population Health Symposium is our attempt to share information with and between our member hospitals to foster working more closely together to respond to the challenges we all face in healthcare today. Bringing to mind our vision statement, New England Life Care will be an indispensable care partner collaborating with members to transform the patient care continuum."

Please see the Link to the symposium slides: http://pophealth.nelifecare.org

Summary:

Jessica Dudley, MD Chief Medical Officer and VP of Care Innovation BWPO served as Emcee for the day introducing key note speaker **Sree Chaguturu, MD, Chief Population Health Officer Partners HealthCare**. Speaking on **The Past, Present and Future of American Healthcare**, Dr. Chaguturu focused on the history of costs, the transition from fee for service to value based care and cost containment.

- Health care should predictably increase as a percentage of GDP
- Historically we have had four eras of health care costs – hospital, physician, prescription and low cost eras

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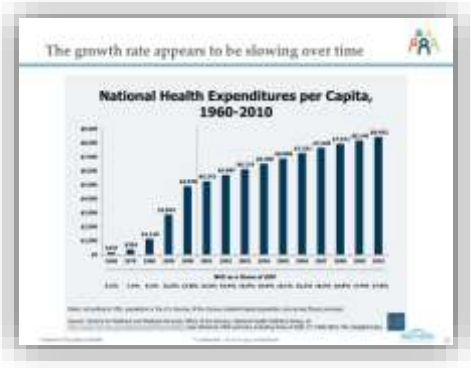
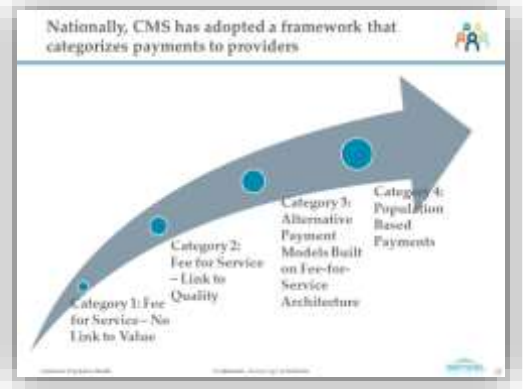
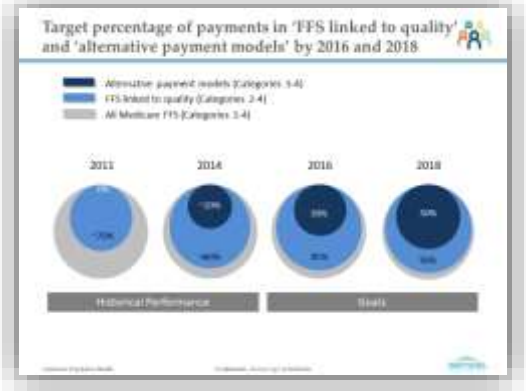
- Health care spending has exceeded economic growth in every recent decade. Since 1970, spending/capita has grown an avg. of 8.2% or 2.4 percentage points faster the GDP.
- Regulation and technology have been a major factors in determining spend within each era
- The U.S. spent $8,402 /person on health care in 2010 vs. $4,878 /person in 1960. Health care spending has consumed an increasing share of economic activity over time.



- After years of increases, the rate of increase in national health spending has been declining since 2002. Since 2002 when the rate of increase in national spending was 9.5% over the prior year, annual spending declined to nearly half or 3.9% by 2010. CMS attributes the slower growth to the onset of the recession in 2007 thru 2009 with people reluctant to spend money on medical care.
- There are some near term threats to the fourth era
    - technology/new drugs
    - market dynamics/provider consolidation
    - increasing cost burden on the middle class

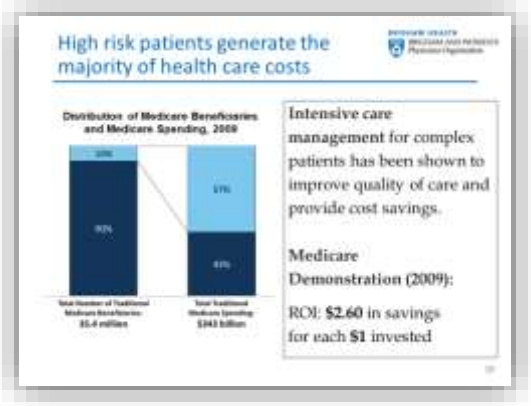
- Value based care continues to grow, which may help us prepare for an inevitable fifth era in which pre/post-acute care management and right site of care will play an ever increasing roll.





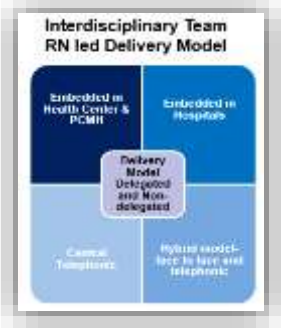
Emergency Department and inpatient beds are expensive fixed costs reserved for acutely ill people. With a goal of improving care of patients, complex care management aims to keep complicated patients "healthy" and out of the hospital while alternative pathways diverts "sick" patients to the most appropriate, convenient and efficient resource.

Rebecca Cunningham, MD and Karl Laskowski, MD, MBA BWPO presented **Pre-acute Programs and Services: ED Avoidance and Patient Care Strategies**. Intensive care management for complex patients has shown to improve quality of care and provide cost savings.



As many as 59% of 4M readmissions were deemed preventable costing Medicare $17.8B in 2013. Heart failure and pneumonia account for half of all costs with CHF forecasted to increase to $53B by 2030.

Stephen Baybutt, MS RN, MaineHealth Care at Home and Brooke Shankland, RN, MaineHealth Cardiology presented: MH Home Diuretic Protocol (HDP): Safe, Patient Centered Care to Keep patients with Advanced HF at Home. Using a telehealth program model to enhance capacity for complex patient care, a dedicated specialized nursing and tech team targeted the CHF population to reduce readmission.



Committed to creating innovative industry leading best practices, BIDCO is a value based physician and hospital network and Accountable Care Organization. **Roger Schutt, DO, Post-acute Medical Director, SNF/Home network presented an overview of the BIDCO population health programs focusing on complex care and transitions of care management.**

Goal: Build an aligned network of SNFs through a preferred provider network leveraging shared skills of diverse physician practices, community, and tertiary hospitals and SNFs.

BIDCO Preferred SNF network:

- RN led care management program to facilitate care coordination and medical management for medically complicated patients
- Strict inclusion criteria and re-evaluation for preferred facilities
- Improves quality of care and reduces length of stay and hospital admissions

- Allows for admission to SNF without 3 day qualifying stay
- Allows for direct admission to SNF from ED, home or physician

With the Healthcare system moving from fee for service to value based care**, Jordan Cohen, Esq. Mintz Levin presented Alternative Payment Models and Value Based Care Arrangements.** Post-Acute care as proven crucial to the success of this new paradigm. ACO's under the Medicare Shared Savings Program (MSSP) is an example of a value based care model that has specifically made an impact her in New England. Cohen shares some keys to success in responding the new reimbursement models.

Keys to success:

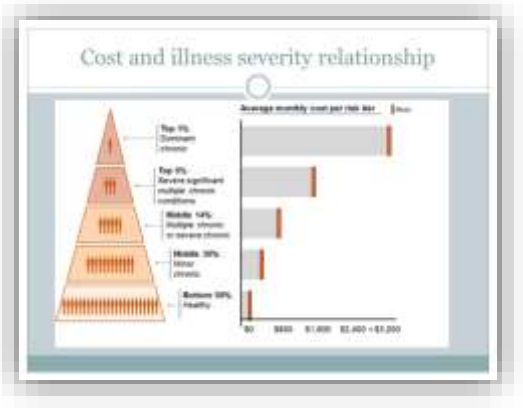
- Performance Measurement
- Technology
- Planning for Regulatory Uncertainty / QPP
- Involvement of Counsel

Ryan Thompson, MD; Medical Director Care Continuum & Complex Care, Massachusetts General Hospital presented, MGH Home Hospital: Reaching Backwards to Move Forwards. In 1930, over 40% of doctor-patient interactions took place in the home, but by 1980 this number had dropped to < 1%. For the past 2 decades, care has been delivered in the doctor's office, ambulatory clinic, and on the units of acute care hospitals.

MGH is turning this paradigm upside down! The MGH Home Hospital Program identifies patients in their ED, eligible for an inpatient admission, with applicable ambulatory care-sensitive conditions; then admits them to MGH Home Hospital – where hospital level acute care is received by the patient from the comfort of their own bed. Sound crazy? It is happening every day at MGH, want to learn more?

Rami Karjian, President and COO; presented Medically Home (MH): This state of the art, technology enabled healthcare company is making it possible for Providers to care for acutely ill patients at home. MH's proprietary "mission control center" actually links the at home, acutely ill patient to all clinical, medical, equipment, and supply resources needed to deliver hospital level care at home. Medically Home predicts that 20% of current hospital admissions will qualify for care under their model. Sound exciting? Want to learn more how this innovative technology model of care works?

Data is everywhere digitalizing the medical world. "The new doctor patient relationship includes an abundance of technology." states, **Dervilla McCann, MD, MPH Chief of Population Health, CMO CMHC**. There are many data challenges for the healthcare industry from storage, reporting, security and sharing to the most important standardization, de-duplication and normalization to remove ambiguity and correct the scale resulting in clean, complete accurate data. Keys to success in using data to drive clinical outcomes include using data to support, not lead allowing clinical need to drive initiatives. Know the sources of your data and recognize the importance of your data mining steps. Always put patients in the center and find aligned clinical and data partners for a multidisciplinary approach to reducing readmissions.



Key Takeaways:

- Healthcare Direction:
  - Value based care continues to grow, which may help us prepare for an inevitable fifth era in which pre/post-acute care management and right site of care will play an ever increasing roll.
  - Importance of developing alternative care pathways to refer patients to most appropriate site of care avoiding expensive unnecessary acute care settings
  - Developing alternative sites of care to ED and Hospital settings
  - Development of Home Based Programs
  - Shared Cost Savings
- New technologies bridging patients and healthcare systems are essential for many programs communication:
  - Telehealth (e.g. home diuretic protocol)
  - HIPAA compliant tools for virtual visits (MGH Home Hospital)
  - Virtual transfer of patient monitoring (Medically Home)
- Pre & Post-Acute Care programs implemented by Outpatient and ED Care Managers hold a key role for high risk patients/preventing admission
- ED avoidance & referral programs: Opportunity for "robust ambulatory care" vs. ED/Hospital admission:
  - Partners Mobile Observation Unit
  - SNF Waivers
  - Home (NELC)
- Importance of expanding clinical partnerships to find aligned clinical and data partners for a multidisciplinary approach to reducing readmissions.
- Networking between members to share best practices
- Data collection is paramount to measuring the true cost savings of programs that improve quality of care and reduces length of stay and hospital admissions

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Key Questions for NELC member hospitals:

1. How does your hospital, PHO, ACO and Population Health team members integrate clinically, administratively, technically and financially with alternate site of care partners?
    - (Ex: Home infusion, SNFs, VNA, community support groups, mental health advocates)
2. Are your member hospital initiatives aligned with the emerging value based healthcare model?
3. Are you looking to decant beds or reduce hospital readmissions?
4. Are you looking for new models of care to address modern patient and system needs?
5. How does your hospital integrate new technology into your Population Health Programs?
6. Are you sharing data with your Population health departments and your alternate site of care partners?
7. What other community partners are necessary to make alternative site of care and value management programs successful?
    - (Ex: SNFs, VNA, Home infusion, Elderly advocacy organizations, meals-on-wheels, etc.)
8. How do you collaborate with payors to "fund" Population Health and Value Management programs along the continuum of care?

Recommendations/Next Steps:

1. Schedule follow-up meetings with your Population Health Teams and NELC to understand each member hospital's healthcare initiatives and see where NELC can integrate to extend the continuum of care into the community?
2. Engage necessary community partners into the conversation (i.e. SNFs, VNA, outpatient clinics, community advocacy and support services). How do you do this now?
3. Partner with NELC to achieve your population health and value management goals and collaborate in the negotiation of better contracts with payers, enabling NELC to deliver more care in the home?
4. Identify key member hospital leaders in your health systems, who did not attend and would benefit from the NELC Population Health Symposium information.
5. Partner with NELC to drive better outcomes by scheduling meetings with NELC to review the relevant opportunities for your member hospital to decant beds and reduce hospital admissions/readmissions.