

CLINICAL INTEGRATION

HFMA PRESENTATION SEPTEMBER 2010

David S. Weil, MHA

*You've got to be very careful if you don't know
where you are going...*

because you may not get there.

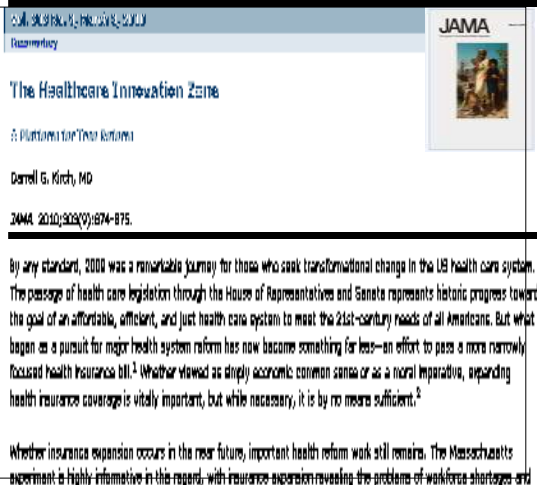
Y.B. (circa 1975)

Purpose: Review These Concepts

- Change will occur: Driven by economics
 - Cost
 - Utilization
- New health care models will emerge:
Accountable care type organizations likely
- How this impacts Health System XYZ is uncertain
- Clinical integration needed whatever the model

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Health Innovation Zone



JAMA
Recommendation

The Healthcare Innovation Zone

A Platform for The Future

Darrell G. Kirch, MD

JAMA. 2010;303(9):874-875.

By any standard, 2010 was a remarkable journey for those who seek transformational change in the US health care system. The passage of health care legislation through the House of Representatives and Senate represents historic progress toward the goal of an affordable, efficient, and just health care system to meet the 21st-century needs of all Americans. But what began as a pursuit for major health system reform has now become something far less—an effort to pass a more narrowly focused health insurance bill.¹ Whether viewed as simply economic common sense or as a moral imperative, expanding health insurance coverage is vitally important, but while necessary, it is by no means sufficient.²

Whether insurance expansion occurs in the near future, important health reform work still remains. The Massachusetts experiment is highly informative in this regard, with insurance expansion revealing the problems of workforce shortages and

Likely to occur even now.

Proposal includes:

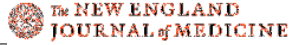
1. Bundling payments
2. Medical homes
3. Accountable care organizations
4. Physician/hospital integration

Goal is to demonstrate that coordination of the full spectrum of care for a defined population under multiple payment systems would improve quality while controlling costs.

Congress as H.R.3664

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Integrated Delivery Systems



PERSPECTIVE

21ST-CENTURY HEALTH CARE

21st-Century Health Care — The Case for Integrated Delivery Systems

Francis J. Crosson, M.D.

It was 1933. The United States was in the midst of a severe economic downturn that was to become the Great Depression. Data from 1929 showed that U.S. health care expenditures had reached 4% of the U.S. gross domestic product, a sum that was believed to threaten the country's financial recovery. After nearly a year of work, the Committee on the Costs of Medical Care, chaired by Dr. Ray Lyman Wilbur, the president of Stanford University, published its findings and recommendations.¹ The first bold-face recommendation read, "Med-

tained but that waste re from unnecessary and uns must be eliminated if the is to be financially susta The primary cause of unne care is the costly brew of sive technology and fee-for- payment of physicians.² M sicians want to do the rig for their patients. It is eas them to do so when the sions about what services vide are guided, as much sible, by science and p needs rather than by pers nancial considerations. Th can be accomplished rea:

Key points:

- Payment reform will occur.
- Multi-specialty integration of physicians combined with hospitals to form new "accountable" systems of care will occur.
- Advances in clinical information technology will provide a practical integration tool.

This is why change will occur

Health care reform advocates recognize the need to reduce the cost of health care from its forecasted 6.2 percent compounded annual growth rate to contribute to economic recovery. A major focus area has been the high incidence of Medicare enrollee readmissions after hospital discharge: A recent *New England Journal of Medicine* article concluded these avoidable costs were more than \$17 billion annually.

Whatever the payment reform, Health Systems will need to be prepared.

Other Causes of Why Change Are Likely to Occur

- High variability of care regionally
- Most care is not evidence based
- Efficient care does not appear to be the primary goal in most places
- High variability of cost regionally
- The high variability in outcomes seems independent of costs

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[Illustration by Chris Gash / www.chrisgash.com]

Will bundling include doctors? Medicare looking for alternative payment plans

CMS is testing bundled payments to hospital-physician groups for inpatient episodes of care. Expanding to post-acute care may be the next step.

amednews.com

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Advisory Board Company Report

Even without reform these changes are likely to occur.

– Chas Rodes

- Fundamental payment changes
- Transparency
- Transitions of care
- Emphasis on chronic diseases
- Population medicine
- Increased importance of Information Systems
- Improved end of life care
- Advent of a new healthcare model

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Baucus Plan – Senate Committee Recommendations include:

- Delivery system reforms: Hospital readmissions
- Care transition programs
- Pilot program on payment bundling
- Value-based purchasing
- Accountable care organizations
- Workforce: Graduate medical education
- Comparative effectiveness/quality

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Concept of Disruptive Innovation

- Based on a book entitled
 - THE INNOVATOR'S PRESCRIPTION
- Authors: Clayton Christensen
Jerome Grossman
Jason Hwang
- Subtitled: A Disruptive Solution for Health Care

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Daily Disruptors

- Mobile Phone
- Internet Access/Information Exchange
- Green Technology

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Message of The Innovation Prescription

Be ready for change – even if you are at the top of your game

- Example 1: Computer Technology - EMR
- Example 2: Cardiac Surgery/Angioplasty
- Example 3: Current Hospital Care – Home Monitoring

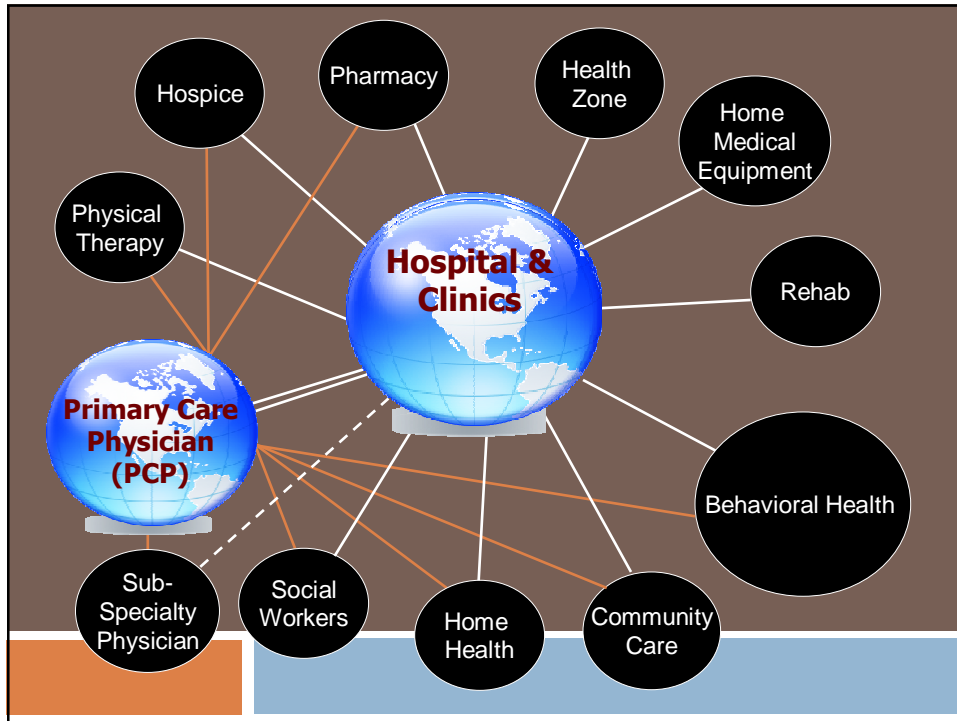
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The Innovation Prescription

What Is Needed?

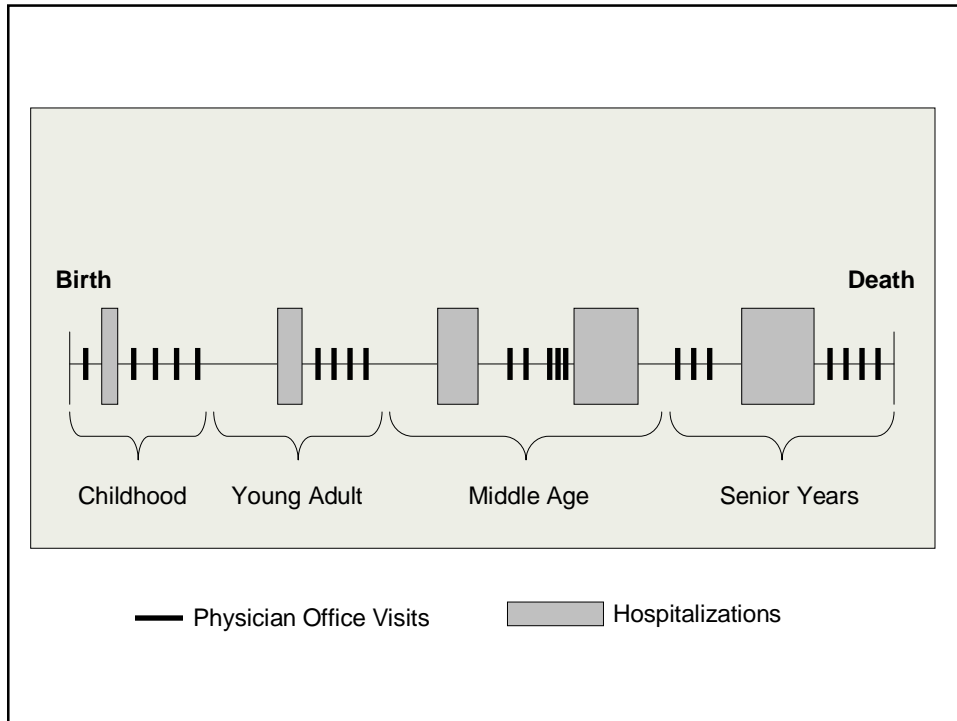
- A model that can combine acute care with chronic care.
- One with seamless transitions of care.
- One that “cares for patients” even when they are not ill.

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What Should The ACO Model Include?

- Care for people/families throughout their entire lives
- Ability to provide various types of care besides hospital and clinic care:
 - Patient-centered medical home
 - Network of specialty and subspecialty care
 - Mental health capabilities
 - Rehabilitation facilities
 - Physical therapy/speech therapy
 - Patient education
 - Wellness programs
 - Home health
 - Hospice



“It’s about the System of Care”

Bottom line of analysis of Ian Morrison

- Not about individual quality of the doctors
- Not about the individual quality of the nurses
- Not about the buildings

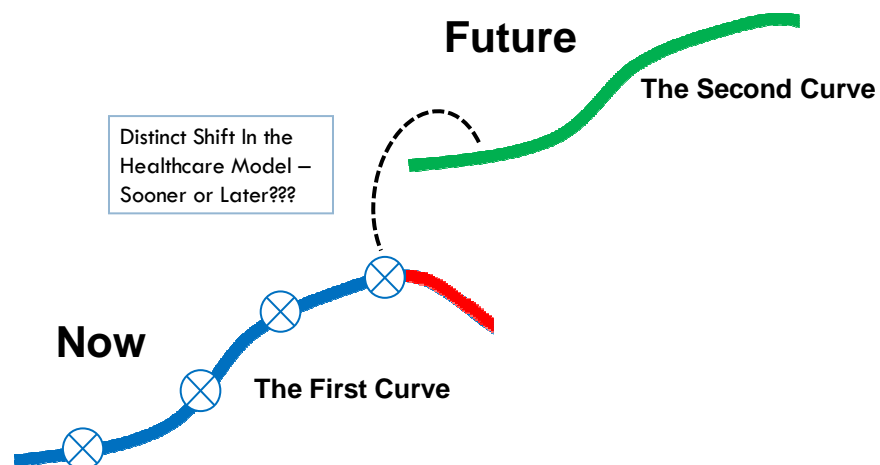
November 4, 2009

Two Curves Concept

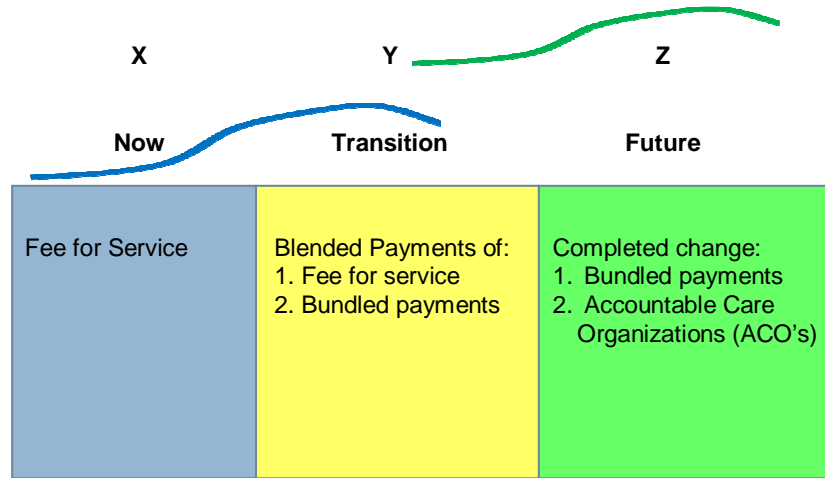
- Ian Morrison book “The Second Curve- Managing the Velocity of Change”
- Describes 2 time frames or “curves”
 - Timeframe – present, core business
 - Timeframe – future, where growth is likely
- Challenge = when to move your business plan to the 2nd curve?

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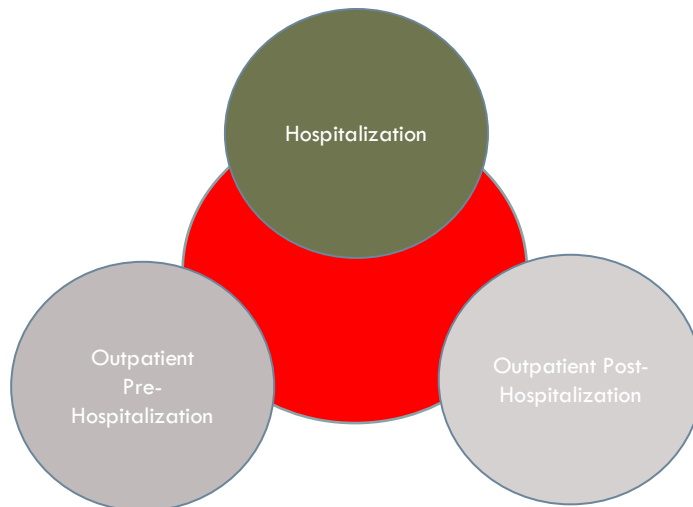
Poised to Make the Jump



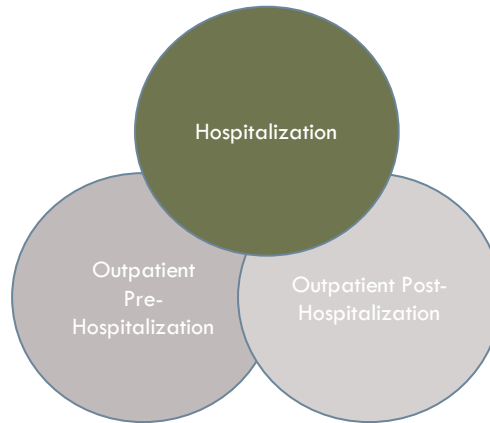
Payments and Moving to the 2nd Curve



Outmigration: Where Healthcare is Now



Integration

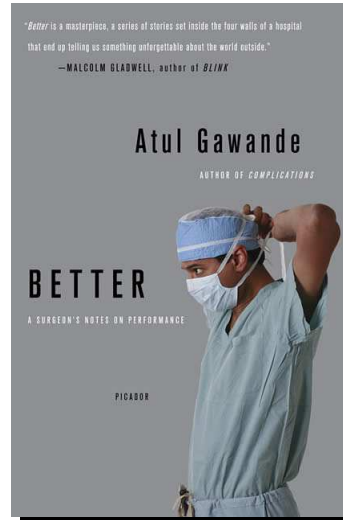


Medical Home

- Importance of primary care doctor
- Quarterback/point guard/mother hen/father rooster
- Proactive Care – Not reactive care like present
- Continuous Care: Firefighters/police
- Information/communication vital
 - ▣ Human to human
 - ▣ Power of information technology
 - ▣ PCP led care team: Behavioral health, nutrition, wellness programs - Health Zone (80/20 rule)
 - ▣ Goal to eliminate gap failures as patient is cared for in the multiple components of the health system

Getting better

- Most of the improvements in health care are not produced by the discovery of new drugs or technologies, but rather, the everyday simple things being done better.
- Nursing councils, peer review, quality projects, guidelines and best practices all work, but they are not reliant on new technology.
- Recovery, not discovery makes things better. Continuous quality improvement through customization for your patients and your workforce.



Importance of Documentation

- Clinical snapshot patient's condition
- Needed for team care
- Possible marker of quality care / disease severity / Case Mix Index

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Time Spent on Clinical Documentation

A Survey of Internal Medicine Residents and Program Directors

Amel M. Ghannouchi, MD; Collin P. Wood, MD; Ph.D.; Carol Fogleson, MD; Jason E. Washburn, MD; Joseph C. Kessler, MD

Arch Intern Med. 2019;179(4):377-386.

Background: Clinical documentation and clerical duties are substantial activities for internal medicine residents. Therefore, we sought to understand the perceptions of internal medicine residents regarding the time devoted to documentation and direct patient care, as well as the perceived frequency and importance of feedback on patient-related documentation.

Methods: As part of the 2018 National Medical Residency Examination, residents voluntarily completed a survey that included questions on the average daily hours spent in direct patient contact and clinical documentation during hospital rotations. Feedback and program structure were asked to report on the frequency and importance of feedback provided to residents by faculty on patient-related documentation.

Results: A total of 16 482 residents (85.9%) and 207 PIs (51.7%) completed the survey. There were 87.4% of residents who reported spending an average of 4 hours daily on documentation and 92.4% reported spending this amount of time in direct patient contact. The majority of residents (86.8%) and program directors (85.6%) believed that feedback on documentation occurred less than 50% of the time. Program directors were more likely than residents to believe feedback on documentation is highly important (75.2% vs 60.4%; $P < .001$).

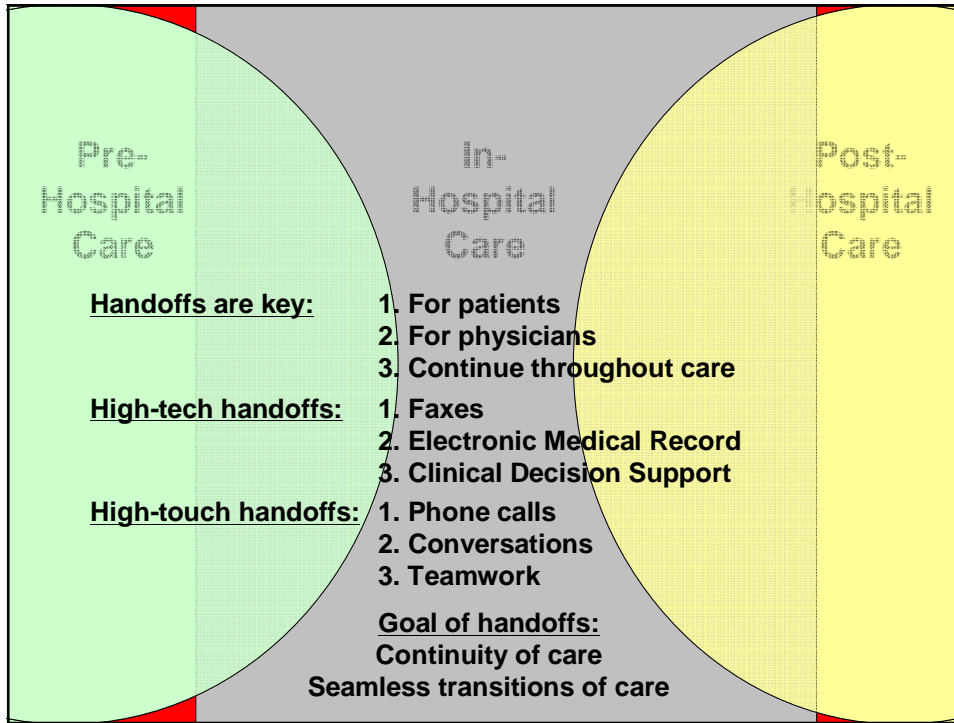
Winning The Race



- Medicine is not an individual endeavor any more
- Teamwork is how we win
- Network trumps the stars

Handoffs are Critical





Making An Impact On Readmissions

ADVISORY.COM MEMBERSHIPS H-WORKS ACADE

MARKETING & PLANNING LEADERSHIP COUNCIL

MY ADVISORS
 Access our Expertise
 Relationship Manager
 Leah Brown

Daily Briefing

Hospitals target discharge process to reduce readmissions

02/17/2010

More hospitals are re-evaluating their patient readmission rates and implementing new initiatives ahead of likely payment reforms intended to penalize facilities for preventable readmissions and reward providers that keep patients out of the hospital.

Rehospitalizations are a "red flag" within health care, the *Jacksonville Business Journal* notes, as they cost Medicare \$17.4 billion annually and threaten care quality. Although studies show that a more efficient discharge process, greater follow-up and better patient monitoring can prevent adverse events and readmissions, this seamless "community approach" is difficult to create and maintain. A 2007 *JAMA* study, for example, found that direct communication between hospital physicians and primary care physicians (PCPs) is "infrequent" and that PCPs rarely see discharge summaries at a patient's first visit after leaving the hospital.

RESEARCH INITIATIVES

- Centers of Excellence
- Consumer Strategy
- Internet Strategy
- Outpatient Strategy
- Planning Process
- Recruiting Marketing
- Revenue Strategy

MEMBERSHIP RESOURCES

- On-Demand National Meeting Webcasts
- On-Demand Webconferences
- Flash Report Archive
- Document Warehouse
- Publications Archive
- Best Practice

- Rehospitalizations are a "red flag".
- Mayo initiative: "something was missed at time of discharge".
- Brooks Home Care initiative: uses technology to monitor patients at home, sends providers to patients' homes every day for 2 weeks, uses transitional care manager for highest risk patients.

The company we're keeping. . .



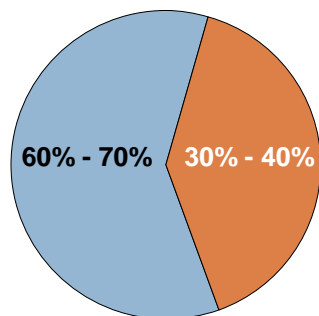
Johns Hopkins Bayview Medical Center



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Unwanted Outcomes

Sometimes, no matter what we do, awful things happen... but if we improve our care, we can help some patients.



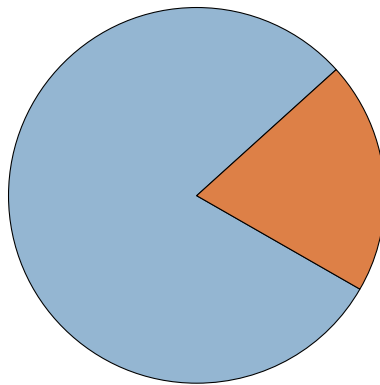
End of Life Care



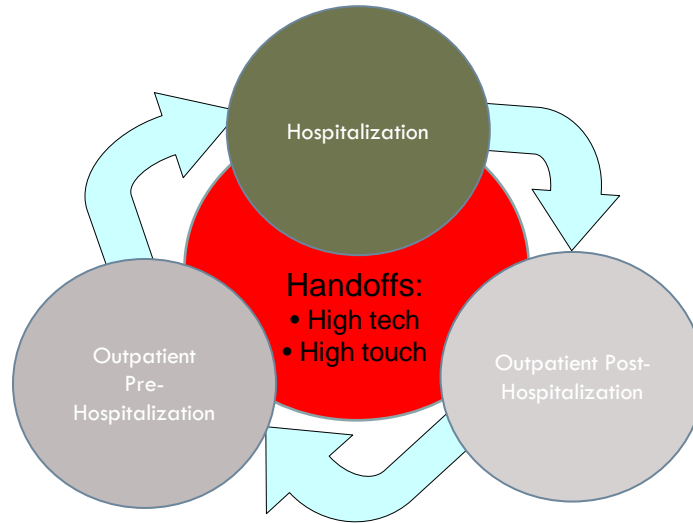
1. Right care, right time, right place.
2. Who can do it better?
3. Hospital, Hospice, Home...

Patient Communications

The 80/20 Rule



Handoff Communication



Most Agree On:

COMMENTARY

Replicating High-Quality Medical Care Organizations

David Mechanic, PhD

MOST AGREE ON THE NEED FOR RESTRUCTURING the US health care delivery system and increasing the capacity to provide coordinated care across the illness continuum in a patient-centered fashion. There is strong interest in developing accountable care organizations that have the capacities to (1) monitor meaningfully patient needs and outcomes, (2) use performance indicators for assessment of physicians and other professionals, and (3) implement new forms of reimbursement that result in improved quality while constraining increases in cost. A range of exemplary models are commonly used as examples including the Mayo Clinic, the Cleveland Clinic, Kaiser-Permanente, and Geisinger Health System but these examples are poorly matched to the existing distribution of medical practices and their small sizes.

In 2005-2006, almost half of all physicians practiced by themselves or in partnerships and only 9% were in groups of 11 or more.¹ Group organization in primary care was much the same. The notion that the organizational structures and cultures of the exemplary models can be replicated in even a decade seems unlikely. Major changes in reimbursement can

care program for their construction, shipyard, and industrial workers.

Expenditures can be reduced by payment constraints on health care organizations and clinicians and by increasing patient cost sharing. But such crude constraints do not distinguish between appropriate and wasteful care seeking among patients. Nor do they prevent manipulation of reimbursement by health organizations and physicians such as risk avoidance, shifting responsibility to others, increasing volume, or up coding. The changes needed to realistically reorganize the provision of care requires reconstituting the norms and culture of the work of physicians and other professionals through their buy-in and centrality in change efforts.

The importance of culture

Physicians are dissatisfied with what they experience in chaotic care environments.⁴ There is ample indication that workflow is more harmonious when physicians and other health care professionals participate in establishing care processes, when professional autonomy is valued and preserved within the context of organizational accountability, and the norms and culture support professionalism. An organizational practice particularly disturbing to physicians

Need to restructure healthcare in the U.S.

- Need to provide coordinated care across a continuum.
- Strong interest in developing accountable care type organizations.

What's Needed?/Core Focus:

COMMENTARY

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➤ **Change to culture of integration and collaboration.**

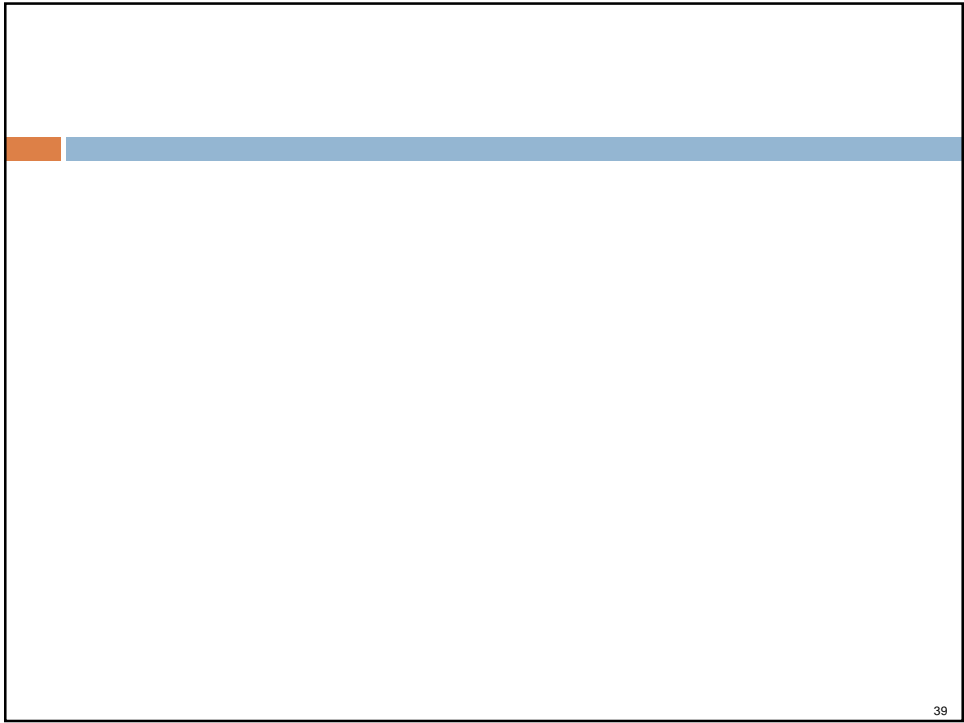
- Mission
- Leadership
- Measurement
- Transparency
- Care coordination
- Information systems
- Operational support

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Achievable Improvements

- **Pre-admission: Medical Home**
- **Hospital:**
 - Improved care
 - Team medicine
 - Improved handoffs
 - Improved care plans/documentation
 - Improved end of life care
- **Post Hospital:**
 - Readmissions
 - Communication
 - Patient education

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Bringing It Home

Case For Reform

Variation of Regional Cost

- Harvard Professor 2009 Article
- Average Medicare Spending in McAllen was twice as high as El Paso despite similar population demographics
- Required reading at the White House
- Current incentives drive costs to = that of McAllen

Provider supply drives utilization. Ie. ECG, EEG, Imaging studies...

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Stronger Coordination Needed

“The health care Medicare beneficiaries receive is often fragmented as patients move among different physicians and across different care settings (e.g., hospital to home care). As a result, patients do not always receive timely care best suited to their needs. Fragmentation is reinforced by the failure of the current payment system to recognize and pay for care coordination.”

Institute of Medicare

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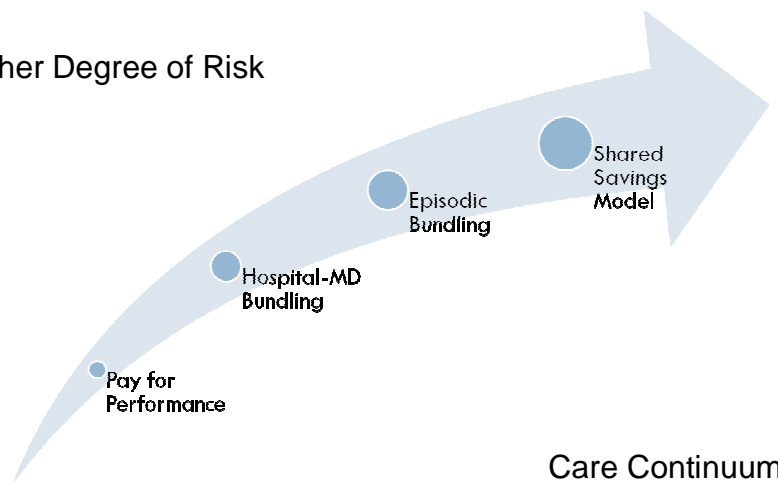
Health Systems Are Held Accountable, Yet Largely Not In Control

- CMS is requiring measures to be met in order to prevent being penalized for subpar performance.
- Fundamentally, the Hospital has limited impact on many of the measures.
- Measures are often tied to readmission rates and mortality rates within 30-days.
 - ▣ AMI
 - ▣ Heart Failure
 - ▣ Pneumonia

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Shifting Risk

Higher Degree of Risk



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MedPac View of the World

- ACO's would change practice patterns driving savings
- Spending targets would be set based on national growth targets
- Critical mass is key to ACO success

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Why Medicare Wants ACO's

- Current Medicare spending is unsustainable
- ***“By definition something unsustainable cannot continue.”***
- Medicare is focused on changing the spending trajectory
- ACO's will create a system of incentives that tie provider payments to quality and resource use
- Objectives:
 - Reduce regional variation
 - Lower unnecessary services
 - Create a system of incentives and coordination

MedPac Report 2009

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Alignment Potential

Readmissions

ACO incentives complement the incentive in the Commission's readmission policy recommended in June 2008 (MedPAC 2008). The readmission recommendation creates a penalty for hospitals (but not physicians) with high readmission rates. Under the ACO model, physicians as well as hospitals are rewarded if a reduction in readmission rates leads to lower annual spending per beneficiary. By aligning physician and hospital incentives to reduce readmissions, the ACO policy coupled with a readmission policy could have a larger effect than either policy on its own.

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Reality of Reform

*It's better to embrace change than have
it forced upon you...
Success will be driven by the ability to
evolve and adapt...*

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