Ochsner® Health Network VALUE SUMMIT

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DIALOGUES TOWARDS AN ARCHITECTURE FOR VALUE-BASED CARE

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INTRODUCTION

OVERVIEW

In December 2017, the Ochsner® Health Network (OHN) Value Summit convened in New Orleans as a conversation among parties who approach health care from different vantages and perspectives. Participants explored the concepts of value, a fair return on the cost of goods and services, and value-based care in the context of the escalating challenges of the healthcare system in the United States (US).

The Summit opened with David Carmouche’s succinct description of how these challenges currently affect people seeking care within the US healthcare system:

- Premium costs are escalating
- One-third of the insured (the ‘under-insured’) have out-of-pocket costs which exceed 10% of their income (5% for those living in poverty) and so cannot afford to access covered services
- 50% of Americans cannot afford an acute health event, often costing from $400-$1000, and are likely to go into credit card debt if one arises
- Care ranks low for outcomes and high for cost

This unsustainable system also impacts the professionals working within health care, across industries and professional groups, as they try to address local challenges while called to account for widely publicized debacles within systems of care.

In seeking solutions commensurate with these problems, Michael Porter, in the December 23, 2010 issue of The New England Journal of Medicine, notes that different stakeholders in healthcare have “myriad, often conflicting goals…” In describing value, Porter suggests:

- Using value to define the framework for performance improvement
- Achieving high value for patients to increase economic sustainability for the healthcare system
- Meeting challenges in the measurement of provider and patient outcomes as a crucial component of value, of particular importance since value is differently defined for populations experiencing different levels of risk, potentially conferring different outcomes goals

The physicians and providers, payers, and suppliers who joined Summit conversations were challenged to consider these possibilities and others toward creating a new ‘healthcare ecosystem’. No single sector can create value, but by finding a way to come together in partnerships, it is possible to manage value in health care — and to contribute to creating, assessing, and refining value-based care across the healthcare continuum: patients, systems, populations, networks, industries and communities.
I. PAYER – PROVIDER RELATIONSHIPS
THE VALUE EQUATION & PRODUCTIVE PARTNERSHIP DESIGNS

We need to think about how to retool. We’d be happy to have people move from inefficient to efficient systems. Legacy and relationships are the hardest part of doing this, as well as marketing the partnership without letting cost, rather than quality, creep into the discussion.

- Steve Udvarhelyi, MD, MHA
  President and CEO, Blue Cross Blue Shield of Louisiana
I. PAYER – PROVIDER RELATIONSHIPS
THE VALUE EQUATION & PRODUCTIVE PARTNERSHIP DESIGNS

SECTION SUMMARY

• VALUE PROPOSITION FOR PAYER-PROVIDER COLLABORATION
• CURRENT LANDSCAPE OF VALUE-BASED PARTNERSHIPS
• INNOVATIVE MODELS FOR RISK-SHARING AND CARE IMPROVEMENT
• CHALLENGES WITH CULTURAL ALIGNMENT
• STRATEGIC OPPORTUNITIES

KEY INSIGHTS

VALUE PROPOSITION FOR PAYER-PROVIDER COLLABORATION

• Payers and providers must adopt a long-term view, as moving to risk and value takes a lot longer than one might think
• Across this transition, health care must be more partner-oriented – and more aware of the importance of relationships, which are not easy, rather than intentions
• Until now health care has been very ‘transaction-revenue’, but long-term that will not be a successful model, as it creates so much friction in the system
• Decisions in areas such as the most effective partnerships, economic incentives, and cost outcomes cannot be successfully determined and accomplished in transactional relationships
• It is important to proactively demonstrate with providers and in marketing that value-based care is indeed about affordability, but it is also about a better way of organizing to achieve better patient outcomes

After talking about reducing our rates, we said, “We are going to do this.” The benefit of being larger is that you can place a few bets. You have to experiment a little. We knew that if something didn’t go right, we could sit down again.

- Warner Thomas, MBA, CPA
  President & CEO, Ochsner Health System

CURRENT LANDSCAPE OF VALUE-BASED PARTNERSHIPS

• Partnerships are critical. The cost of care is not impacted solely from the provider side – the employer and insurer are also critical
• Value-based arrangements and relationships must be flexible: each one is unique and has its own culture, environment, and history
• Not everything must be owned to to be successful, but integrating and aligning the partnership to a common vision and culture is essential
CURRENT LANDSCAPE OF VALUE-BASED PARTNERSHIPS (continued)

- Key questions that support the success of value-based partnerships include: Is our culture patient-centered? Is this the right thing for the patient? Thinking in this way allows the system to move toward value.
- Members, constituents and communities are waiting for the transition into value-based care.
- Change management in a hospital is extremely difficult because there are so many more constituents. The systems are high grid, with many responsibilities, so that it can be tricky to ‘pop in’ value-based care. In such relationships the parties can feel more fragile, so it is imperative to make hospital margins safer.

The business model is more fragile in the medical world.
- Jerry Penso, MD, MBA
  President & CEO, American Medical Group Association

INNOVATIVE MODELS FOR RISK-SHARING AND CARE IMPROVEMENT

- Healthcare leaders must create economic models that are fair and incentivize, and that can intertwine with fee-for-service models where needed.
- The work is to share and use data, such as full risk claims data, in a timely and organized fashion.
- In data collection and analysis, a lot of chaos ensues if measures are not harmonized. It is important to identify measures that are relevant for the population and affordable, as well as metrics that can drive some of the necessary changes.
- Population/ACO models are still a work-in-progress.
- Pay attention to social determinants, as full engagement around them can be effective.

We didn’t stop at an economic relationship. What was very different was that we went, sat down, and brought our team in to meet all the division leaders to ask how we could change the patient experience, asking, “What can we do differently?” These discussions created more interest in innovation, along with backing, as you can’t create change without creating an infrastructure in a way that is viable.
- Steve Udvarhelyi, MD, MHA
  President & CEO, Blue Cross Blue Shield of Louisiana

CHALLENGES WITH CULTURAL ALIGNMENT

- The solution for health care now requires bringing silos together, as each has strengths and experiences needed for success.
- Business and clinical leaders must work together to bring about needed changes. Administrative leaders must have physician partners to help get physicians on board – or it won’t be successful.
CHALLENGES WITH CULTURAL ALIGNMENT (continued)

- Both sides will have to give something up, and some of that will require a leap of faith. Without knowing exactly how the change to value-based care will work, both sides must be committed to making it work.
- Making the transition to value-based care begins with reducing physicians’ panel sizes so that they have time to have conversations.
- On the community side, bringing together community leaders can lead to full engagement.

You must create a patient-centric culture: You have to ask, “Is this the right thing for the patient?”

- Jerry Penso, MD, MBA
  President & CEO, American Medical Group Association

STRATEGIC OPPORTUNITIES

- It is crucial to work together to account to goals and objectives, as these are what partnerships are designed to help achieve.
- Alignment can yield a 20-25% reduction in costs.
- Information on a range of variables from outside the network, from technicians to populations, is needed: Identify who has that information and get it back to the providers and the hospital.
- The hospital side of the house has both community responsibilities and teaching responsibilities, making it difficult to move from volume to value and so requiring a much more gradual path.
- The key in working together is real-time feedback.

IMPLICATIONS

- In a partnership, each party must be prepared to give up something from its prior legacy to go forward, so that partnership members can let go of the long legacy of a specific business model.
- The partnership should be focused on creating a system which supports a great healthcare product, one that is less expensive and provides better care.
- Healthcare partnerships should keep working together on: market enrollment and creating sufficient products for their region.
- Value-based care will not work if only people who have high healthcare needs are paying for it.

Our mission is to take a step down and learn, to engage discussion, to do something that will fundamentally improve health care in the state, and at the end of the day, to bring all these to the grass roots level.

- Steve Udvarhelyi, MD, MHA
  President and CEO, Blue Cross Blue Shield of Louisiana
II. RISK

BECOMING A RISK-BEARING ORGANIZATION & MANAGING RISK-BASED POPULATIONS

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II. RISK

BECOMING A RISK-BEARING ORGANIZATION & MANAGING RISK-BASED POPULATIONS

SECTION SUMMARY

• NETWORK CONFIGURATION
• CONTRACTING
• DECISION SUPPORT & ENGAGEMENT STRATEGIES
• FINANCIAL MODELS

KEY INSIGHTS

NETWORK CONFIGURATION

• Change takes a long time; it requires modifying specialist fee schedules, attracting more business, developing a position around an attributed versus a product-based model, and accomplishing alignment in a manner that demonstrates the network’s ability to take control over the utilization of some services

• Networks need to think about what they are trying to do with risk. If it is undertaken to improve health, the network is on the right path; if it is just trying to make money, it won’t work

• To advance a successful health care alignment strategy, every action taken as an organization must lead to better care as defined by the physicians, with quality an absolute must. Providers are not focused on payers, but patients

• Insisting on efficiency to reduce waste is crucial, but distribution has to occur ‘across the deck’

• In addition, everything must lead to more satisfied patients, a better patient and physician experience, and patient willingness to recommend the network. Although they may or may not know differences in provider expertise, patients now have access to technology, want ready access to specialists, and are willing to shop and find someone for an ‘appointment tomorrow’


The biggest problem? Most hospitals don’t see a physician as a partner, but as a part of the system they can make more efficient.

- Michael James, JD
President & CEO, Genesys Physician Health Organization

CONTRACTING

• The solution for health care is to bring the silos together, with network partners and contractors contributing their strengths toward:
  - Gathering and sharing data
  - Revising approaches to market pressures
  - Working with Medicaid
II. RISK

BECOMING A RISK-BEARING ORGANIZATION & MANAGING RISK-BASED POPULATIONS

CONTRACTING (continued)

- Evaluating demand for different types of products
- Managing prescription and device use, adherence issues, effectiveness, and costs
- Monitoring employee, contractor, and patient experiences
- Investing in the push to ‘get the word out’ about value-based care through dialogue

- Currently many organizations are attempting to achieve value-based goals by using a fee-for-service schedule. It might be more helpful to sit down with payers and ask, “What do you need to be successful?”

- An economic problem cannot be solved through technology; nonetheless, a group of technology vendors are now tasked with trying to help their clients solve problems of incentives, productivity, and burnout. Network leadership should instead develop creative approaches, grounded in trust and collaboratively determined, to address this problem

- With the move into population health has come the effort to ‘get the right information to the right individuals at the right time’ so as to improve healthcare decision-making, adherence, and potentially outcomes. Network engagement of this effort can help in establishing trust between governance and hospital physicians by demonstrating that providers are choosing to be in an organization that is putting everything together to make them successful

In this competitive environment, if we move away from a complete sharing of data, with transparency and accuracy, there will be problems. Thus, foundational to a recalibration of relationships is the trust that you won’t be using shared information as a competitive weapon, but that we instead design programs that assist in the sharing all kinds of data.

- David Hanekom, MD, FACP, CMPE
  CEO, Arizona Care Network

DECISION SUPPORT & ENGAGEMENT STRATEGIES

- We all want to grow: part of change is who gets and who gives to balance the system. This requires a recalibration of relationships

- Ways for evaluating the appetite for change within an organization exist. Some of these include accounting for the organization’s culture, assessing whether or not governance is prepared to understand the proposed change’s implications, and determining whether or not governance is prepared to engage in dialogue

- In a healthcare network, expectations concerning the physician governance structure can make a huge difference

- Change leadership must increase transparency between physicians and decision makers, provide necessary infrastructure and virtual support, and focus 80-90% of its effort on implementation

- The network’s partnerships must work for everybody. Physicians cannot be told, “You have to take a decrease in quality of life”
II. RISK

BECOMING A RISK-BEARING ORGANIZATION & MANAGING RISK-BASED POPULATIONS

DECISION SUPPORT & ENGAGEMENT STRATEGIES (continued)

- Focusing on the mission-driven aspects of changes toward value-based care is the right thing to do, and will help focus providers on their interest in patients and core values

The decisions that physicians and patients choose to make or not to make drive health care.

- David Hanekom, MD, FACP, CMPE
  CEO, Arizona Care Network

FINANCIAL MODELS

- Historically the same provider has been asked to make decisions with competing incentives; now the move is towards a product-based network to take control of over- and underutilization
- In a risk contract, with 8-10% admin cost, if you develop the right contract, you don’t underwrite it. In that kind of contract, providers are much more in control of technology. In a value-based contract, it is the reverse. However, neither of those pure models is likely to exist in the future
- Payers, who are now designing the value systems, are thus also currently controlling the technology
- When the focus is on what’s in the best interest of the patient there is little disagreement; when talking about finances there is more division
- Population health, although required from the top down, rarely generates a quick ROI and is very much missing. However, many healthcare activities address, “Can we manage the Medicaid and Medicare populations?”
- Examine the network’s system – highest cost to lowest cost – while doing the transformation work and modifying the fee schedule. Insist on more efficient delivery to help achieve lower cost. The system’s commercial business is critical for financial sustainability
- However, these changes must lead to more satisfied patients, and providers also must be satisfied with their role
- Change takes a very long time and it is very expensive

If you are going to take on risk, you need to make sure you are getting paid in a meaningful way.

- Josh Rosenthal, PhD
  Co-Founder & Chief Scientific Officer, RowdMap Analytics, Inc.

We have healthy children and grandchildren, and we need systems to sustain that.

- Michael James, JD
  President & CEO, Genesys Physician Health Organization
• To move toward sustainability in providing value-based care and meeting population health priorities, healthcare networks should develop, implement, and collect and analyze data to help:
  - Reduce low-value care for patients and communities
  - Expand primary care
  - Develop and implement changes toward value-based health care on the primary care side, including innovative uses of staff, resources and community to:
    ◦ Help patients gain access to providers and other help they may need
    ◦ Preserve necessary pipelines to care
    ◦ Control costs of care
  - Ensure top-of-license use for our primary care providers
  - Track and review physician referral patterns
  - Use care management for population health and other health initiatives to improve quality and potentially patient outcomes
  - Understand the role of behavioral health and the social determinants of health: the care people need may not necessarily be with the provider
As you build out your team, you need to think about what kinds of experience and skill sets you need. Seek enough difference in who you bring on board to contribute differences in viewpoints – You can’t teach experience.

- David Carmouche, MD
  Senior VP & President, Ochsner Health Network
III. COLLABORATION & LEADERSHIP

TOOLS FOR SUCCESS

SECTION SUMMARY

• 3-WAY ALIGNMENT IN RISK-BASED CONTRACTING
• INNOVATIVE COLLABORATION MODELS
• LEADERSHIP SKILLS FOR PARTNERING ACROSS THE HEALTHCARE SYSTEM

KEY INSIGHTS

3-WAY ALIGNMENT IN RISK-BASED CONTRACTING

• A payer-provider-industry alignment requires thinking out of the box. It cannot be what the model has been, ‘us versus them’, for aligned stakeholders

• Given that everyone leads from their comfort zone, it is highly uncomfortable to ‘get out of one’s own box’. Nevertheless, it is critical to step back and away from each side’s core business and ask, “What are we trying to do?”

• An effective starting point is to focus on care, setting aside each parties’ own interests

• A lot of acrimonious discussion can transpire, so start by determining a clear, shared vision of what success and achievement will look like. Otherwise the partnership can begin something, only to realize a couple years down the line that its ‘alignment’ was toward divergent goals

• It may take considerable time to find a payer willing to provide a value-based contract, with some saying, “Here’s your data; good luck.” However, putting the burden on one or another side to find value-based care solutions will not work

• The challenges of value-based care must be jointly solved. Networks and payers need to be transparent with their data, show clinicians what the things they do cost, seek physician input for care redelivery, and allow physicians to make the end decisions on patient care

When most successful, you can’t tell in a meeting who the payers are and who are the providers. Collectively we solve problems.

- John Walker, MD, CPE
  Chief Transformation Officer, CHESS

INNOVATIVE COLLABORATION MODELS

• Massive changes in health care were triggered by many factors, including the Affordable Care and Patient Protection Act of 2010 (ACA). Everyone in the industry was dealing with challenging uncertainties; no one had the answers. Payers were renegotiating; providers were seeking access. However, the uncertainty led to willingness to think about new approaches

• Social determinants of health play a prominent role, particularly in the context of chronic illness and transitions in care
III. COLLABORATION & LEADERSHIP

TOOLS FOR SUCCESS

INNOVATIVE COLLABORATION MODELS (continued)

- Big data, population health and the social determinants of health now figure more prominently, but also controversially, in efforts to create new approaches to care delivery, outcomes, and payment. Effective collaborations that can help advance and implement value-based care will:
  - Listen to each other to create alignment, rather than advocate for a previously held point of view
  - Come in without a solution already in mind
- Leadership must be prepared to help people who come in from the outside to be successful
- It is important to educate collaborators about each other’s business market and challenges. In developing, reviewing, or modifying approaches to value-based care with providers:
  - Come with at least a model, if not real data, on medical cost offsets
  - Be ready to have discussions and to ‘put your money where your mouth is’
  - Be prepared to supply support services
- It is imperative to accelerate recruiting new talent. In particular, recruit people who have different experiences and divergent opinions onto your teams. They bring:
  - Skills sets that would otherwise take many years to develop
  - New experiences and perspectives that can help expedite the work
- Four reasons that leadership and partnerships can run into difficulties when aiming for value:
  - There is no playbook
  - There is a lot of uncertainty
  - Leaders are often put in the position of leading things in which they have no direct experience
  - When you start to get into the practicalities, rather than the high-level concept, the delivery of high-quality, value-based care is very difficult

*The social determinants of health are among the things now that have become popular and a buzzword, but they truly are critical; it is the things that don’t contribute directly to the care that contribute to its cost.*

- Philip Oravetz, MD, MPH, MBA
  Medical Director, Accountable Care, Ochsner Health System

LEADERSHIP SKILLS FOR PARTNERING ACROSS THE HEALTHCARE SYSTEM

- Leaders always try to do the job, but soon realize that specific skills make for success. However, leadership requirements today are very different from past. We are now looking to develop leaders who demonstrate the ability to collaborate with diverse stakeholders, across sectors
- In building out a team, it is important to remember that leaders cannot coach experiences. Collaborations can help in this, but it is difficult
III. COLLABORATION & LEADERSHIP

TOOLS FOR SUCCESS

LEADERSHIP SKILLS FOR PARTNERING ACROSS THE HEALTHCARE SYSTEM (continued)

- Communication remains the key to:
  - Building connections
  - Aligning shared vision
  - Making sure things are advancing properly
- Email communication may be efficient, but it is not very effective
- Aligning one's own organization can be challenging, but you cannot lead others if you can't lead your own group
- For leaders, the most important thing to remember is that the key to change is:
  - Go back to your organization and do something different
  - Don’t get inspired only to go back to the usual at our institutions
  - Go back and take action
- Value is all about the right thing for patients

You have to be willing to have those tough conversations in order to get back to your original goals.
- Jeff Huff
  Principal, Jewish General Hospital LLC
  Senior Advisor, The Exequor Group

IMPLICATIONS

- We are in the era of big data, new conceptual frameworks, inundation with emailed communications, and the imperative to rein in healthcare costs while improving health outcomes
- Direct communication and the relationships it yields remain among the most powerful available tools for effectively addressing the challenges of value-based care
- Listening to and understanding clinician needs are important to building a culture of trust
- We are about to see a renaissance in population health by better incorporation of the social determinants of care in the predictive model of health care as a whole
- Be willing to hold each other accountable – it is human nature to get back to business as usual, so challenge each other to come or get back to the goals established at the beginning of the collaboration
IV. SPECIALTY CARE
A NEW REALITY & EVIDENCE-BASED SUCCESS MECHANISMS

We can talk all day about plans for specialty care, but they won’t work if the physician leaders do not understand the why and trust you. They must trust that you have their interest at heart.

- Christopher White, MD
  System Chairman of Cardiovascular Diseases, Ochsner Health System
IV. SPECIALTY CARE

A NEW REALITY & EVIDENCE-BASED SUCCESS MECHANISMS

SECTION SUMMARY

• THE QUALITY PAYMENT PROGRAM’S IMPACT ON SYSTEMS, SPECIALTY PROVIDERS, AND OTHER HEALTHCARE STAKEHOLDERS
• MEASURES AND REPORTING REQUIREMENTS
• ADVANCED ALTERNATIVE PAYMENT MODELS (APMS) AND BUNDLED PAYMENTS
• RISK IN SPECIALTY CARE DELIVERY
• TRANSFORMATION MODELS FOR SPECIALTY CARE
• SUCCESS FACTORS AND TOOLS FOR DRIVING STANDARDIZATION

KEY INSIGHTS

THE QUALITY PAYMENT PROGRAM’S IMPACT ON SYSTEMS, SPECIALTY PROVIDERS, AND OTHER HEALTHCARE STAKEHOLDERS

• Technology is critical; we are going to see a lot of build on technology
  - It is not just signing up for technology and a payment program
  - You must know how to use your data
  - Business needs to be very diligent, however, that the compensation plans are in place even before the risk plans are in place
• Focus on complex case management to keep patients out of the hospital; pay special attention to transition management
• Make full use of existing assets, such as administrative data and registries, to avoid reinventing the wheel while working to meet Centers for Medicare and Medicaid Services (CMS) and value-based care goals
• The Oncology Care Model (CMS Innovation Center), another one of those leading-edge models, does have a few threats. Care and oncology payments depend heavily on the administration of medication, so keep an eye on provider differences in different settings
• For these efforts to improve quality care while reducing cost to be effective, they must also work economically with the provider
• A payer’s model works with contracted providers at a discount to cover a geography and sell their products as ‘high performer networks’ that cut out high cost/low efficiency providers. The next evolution is where they put together networks of providers who are actually implementing alternative payment
• It is not too soon to start thinking about the next phase of the Quality Payment Program

As to the patient-centered medical home – when people thought that would be all – the part that everyone missed was that primary care is only 3% of the spend; most is with specialty care spend.

- Terry McGeeney, MD
  President, Care Accountability, Inc.
IV. SPECIALTY CARE

A NEW REALITY & EVIDENCE-BASED SUCCESS MECHANISMS

MEASURES AND REPORTING REQUIREMENTS

- The call within value-based care to adhere to more consistent, standardized practices at the specialty level has led to increasing concerns, such as, “How do we determine ‘final say’ in standardization?”

- Data analytics are critical at all levels of assessment; however, EHRs were designed and built to document episodes of care; they were not built to capture or to analyze data

- The challenges of interoperability and clean data have become critically important given the use of data EHRs in measuring, reporting, and developing standards
  - Getting a massive amount of data from an EHR may not be helpful if much of it has been entered “by brute force”
  - Sometimes where and how things are being documented is the bigger problem (entered at a wrong site in the record, etc.)

- Integrating data from claims may be more useful

- Where the EHR fails to provide needed functionality, as is frequent in specialty care, providers must build their own “really cool tools” to capture meaningful information about patients, such as patient-reported data, that they are able to access and use in real time

- These tools confer many clinical advantages in value-based care, including opportunities to get to know the patient’s plans and to solve the patient’s agenda, not the provider’s

- In reporting, competing priorities and tensions exist that no one wants to discuss: CEOs talk candidly about problems with interoperability that serve their business model quite well. The data and knowledge from reporting may be forthcoming, but the critical issue is trust

- Challenges encountered in stand-alone practices will not be solved by EHRs

People with chronic diseases probably see their specialist as their de facto primary care doctor.

- Charles Saunders, MD
CEO, Integra Connect

ADVANCED ALTERNATIVE PAYMENT MODELS (APMS) AND BUNDLED PAYMENTS

- Practices should learn everything they can from their experience in preparing for the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). This will be the same preparation needed for commercial payers

- Focus on care coordination and case management – and at the center of that is good analytics

- Transparency must exist within offices and groups as to who had best outcomes, with shared information assisting improvements across the board

- Poor communication between stakeholders will result in bitter feelings, as well as lead to disappointment and many unmet expectations

- The best way to survive economically is to be effective in a 2-sided risk model. However, many practices are a long way off
IV. SPECIALTY CARE

A NEW REALITY & EVIDENCE-BASED SUCCESS MECHANISMS

ADVANCED ALTERNATIVE PAYMENT MODELS (APMS) AND BUNDLED PAYMENTS (continued)

*Do what is best for patients; ask the system to address efficiency.*
- Christopher White, MD
  System Chairman of Cardiovascular Diseases, Ochsner Health System

RISK IN SPECIALTY CARE DELIVERY

- The change to value-based care is inevitable; those who are ready will be the most likely to succeed
- To move forward as a specialty practice, it’s all about knowing your data
  - You must know your data
  - Know the population you care for
  - Know those who come to the office
- Specialists must have options for where they deliver they care, but one catch-22 now exists in the form of the guaranteed volume assumed from hospitals. In the long run, hospital use may mitigate against including the specialist within a network
- It is worth the work to try to make sure that you are in those networks, and not excluded from those networks
- The current effort is to increase the margins, so our hospitals can survive. For this, it is imperative to focus on cost and savings and to take out whatever does not need to be done
- Health care has arrived at the point where a gain on productivity does not actually pay for itself
  - This costs us terribly in terms of engagement
  - Leaders need to look for areas of potential savings
- Predictions said that “60% value will be the tipping point” – but we are at 60% value, and it is not the tipping point
  - We are at a tipping point where it is a mistake to ask physicians to do ‘one more thing’
  - Networks must be mindful of the physician and other healthcare team members and their lives: If you add something new, then either add a significant amount of efficiency for them, or take 2 things away
- Systems and providers should hedge their bets as best as possible: “Do what you have to do”
- They should not go too far down a path until they are relatively sure, because things are going to change

*The people who are comfortable taking risks – you want to hold on to them if you possibly can.*
- Kathleen Blake, MD, MPH
  VP of Healthcare Quality, American Medical Association
IV. SPECIALTY CARE

A NEW REALITY & EVIDENCE-BASED SUCCESS MECHANISMS

TRANSFORMATION MODELS FOR SPECIALTY CARE

• Thinking that one can talk to primary care and fix everything in specialty care is incredibly naïve. Specialists must be engaged; they need to be brought in and rewarded in some way for changes.

• Personalization will help drive a more patient-centered care, in which patients can be seen in the context of ‘today’, as compared with ‘before’. In this context, specialists can start with patients by saying ‘Oh I see that …” and then go on to problem solve.

• Systems should modify their compensation practices and agreements they have with physicians based on performance; also, they should look at how they recruit and retain physicians.

• Given the swirl of new roles – coordinators, navigators, and others - one solution has been the primary care medical home; a potential solution is also a specialty care medical home, which could help avoid providers seeing only ‘one part of the elephant’

• Effective communication is critical. A study of high volume communications between specialists and primary care examined 250K ‘fyi’ forms of information sent between specialist and primary care. With that kind of noise, you can’t find the signal.
  - These communications were of low value, with 25-30% of questions not answered and procedures not followed through on; the failure to respond went both ways.
  - The study showed that $30 of each specialty visit went for communication inefficiencies.

  If we want to engage with physician specialists, make their lives easier to allow them to do the right thing.
  - Eric Newman, MD
  Director of Quality and Innovation, Medical Institute, Geisinger Health Care System

SUCCESS FACTORS AND TOOLS FOR DRIVING STANDARDIZATION

• The fundamental challenges in health care are that we don’t know how much it costs to take care of our patients across specialties and primary care; it is thus of crucial importance to engage clinicians every step of the way toward value-based care and standardization.

• Variation can be considered the enemy of quality; however, a role for variation as a positive intervention during an unfolding event exists, particularly in such acute events as are encountered in the surgical theater.

• Everyone must come to the table to contribute to the development of appropriate tools toward quality, value-based standardization of care. Approximately 60/70/80% of the time concurrence with an established, agreed-upon, evidence-based or best-practices pathway is likely to be reasonable, with documentation expected for variation.

• In a study of heart failure outcomes, patients seen at large centers were expected to have better outcomes than those treated at smaller centers, with fewer resources, etc.
  - Patients at the smaller centers did better, as their staff and providers knew their patients.

• It is important to find a way to maintain that deep knowledge of patients as individuals while still taking care of populations.
IV. SPECIALTY CARE
A NEW REALITY & EVIDENCE-BASED SUCCESS MECHANISMS

SUCCESS FACTORS AND TOOLS FOR DRIVING STANDARDIZATION (continued)

• Part of the challenge for variation is that in such areas as the operating room variation may follow a ‘sin curve’, with needless variation on one side, but important variation on the other. As of yet, systems and networks have no data by which to distinguish one from the other, aside from the surgeon’s brief operating reports

• It is important to train the young generation of physicians in business concepts, such as the supply chain, so they can better contribute in developing and implementing value-based care

• Unfortunately, productivity is all too often called out, when what is needed is quality, and that can only be achieved by collaboration, communication, shared data, and shared vision

Where there are deficiencies, there are opportunities. We need to take the time to understand why we are doing what we are doing. If you align with the staff and people in the trenches, you can really make some beneficial changes.

- Vinod Dasa, MD
  Associate Professor, Vice Chair of Academic Affairs, Irvin Cohen Chair of Research, Orthopedics, LSU School of Medicine, New Orleans

IMPLICATIONS

• It is very important for systems to position themselves in the mind of the payer, as well as the provider

• The primary issue is how to move physician specialists to change their practice towards standardization

• It takes a lot of energy to convince a one-over-one leader to take the risks required by value-based changes in the delivery of specialty care, but that leader’s participation is essential

• After gaining this leader’s trust and participation, however, you must be very careful that you have set reasonable standards and goals for the changes to be implemented: they have to be achievable
V. INNOVATION
CREATING CONTINUITY AND COLLABORATION THROUGH INNOVATION

_Sometimes the simplest things – small, low cost things, combined with technology – have achieved significant results._

- Gordon Moore, MD
  Senior Medical Director, Population and Payment Solutions, 3M Health Informations Systems
V. INNOVATION
CREATING CONTINUITY AND COLLABORATION THROUGH INNOVATION

SECTION SUMMARY

• PITFALLS OF DELIVERY ENVIRONMENT SILOS
• CORE COMPONENTS FOR CARE INTEGRATION: CARE COORDINATION, TRANSITIONS OF CARE, SPECIALTY CARE, TECHNOLOGY, AND COMMUNICATION
• BEST PRACTICES AND INNOVATIVE MODELS

KEY INSIGHTS

PITFALLS OF DELIVERY ENVIRONMENT SILOS

• Miscommunication and cultural difficulties can arise in understanding the need to have change to overcome challenges facing contemporary health care

• These obstacles are important because health care is currently broken and fragmented, and this fragmentation impacts everyone. There is:
  - Fragmentation between providers
  - Lack of communication between patient and hospital
  - Fragmentation between patients and family
  - Fragmentation between providers and payers

• Fragmentation is also furthered by fragmentation in data, as well as not making better use of emerging knowledge from the data and knowledge. Better quality, value-based care and health outcomes could be achieved by using these data and knowledge, particularly for:
  - Health impacts of the social determinants of health
  - Biological basis of health/illness (by extrapolation)
  - What we already know about different treatment approaches, etc.
  - Including these could lead to better outcomes and reduce deaths

• There is no one individual solution. You need to be thinking about partnerships

*We need to learn how to think at a local, regional, and national level about all this. Question every process or procedure in assessing, “Why do we have to do it this way?” (For example, “Why have a waiting room?”). Change small things to make a big difference.*

- Richard Milani, MD
Chief Clinical Transformation Officer, Ochsner Health System
V. INNOVATION
CREATING CONTINUITY AND COLLABORATION THROUGH INNOVATION

CORE COMPONENTS FOR CARE INTEGRATION: CARE COORDINATION, TRANSITIONS OF CARE, SPECIALTY CARE, TECHNOLOGY, AND COMMUNICATION

• Pricing pressure is the greatest strategic challenge facing health care today, including
  - Pricing levels in innovation models
  - Amount of money in health care
  - Amounts in healthcare innovation (e.g., devices/usability)
  - Less than 1% of the money in the system goes to consumers to educate them in how to make good healthcare decisions

• Crucial markers to consider in determining strategies for integrating care:
  - Health of the population served by a group or system
  - Costs of care
  - Quality of care
  - Is the life of the caregiver improving too?

• Systematizing practices, capturing data, and performing assessments across the healthcare system continuum are imperative to effectively address fragmentation and integrate care. This type of problem solving should be approached as a skill set
  - Address the intersection of the ‘oceans of people’ working in health care
  - Try to understand documentation, its potential impact in patient care and its limits within data collection/analysis paradigms
  - Improve tools and approaches that can help avoid the need to hunt through documentation
  - Identify documentation problems that can impede effective, timely communication and fix them

• New strategies for coordinating care must be embraced by everyone in the healthcare partnership. Effective change particularly requires the ability of leadership to say, “We will establish this.” Change may start with the top of the organization, but it must be embraced at the bottom

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*We need to remove the barriers, and then support people in achieving their health goals. This requires that we ask questions, listen to people, and then get out of the way and remove the barriers that we’ve put in their way.*

- Gordon Moore, MD
  Senior Medical Director, Population and Payment Solutions, 3M Health Informations Systems

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BEST PRACTICES AND INNOVATIVE MODELS

• 300 healthcare executives, when asked what is needed to address current challenges in health care, responded, “value-based care”

• The cultural aspect of change is one of the most significant barriers
BEST PRACTICES AND INNOVATIVE MODELS (continued)

- Innovation efforts must begin to consider value-based initiatives aimed at consumers. Collaboration across the health care of populations; this in itself constitutes innovation.
- How healthcare systems and groups engage the public is now particularly critical.
  - State governments and employers must be helped to understand both paths to success and potential value.
  - Value must be demonstrated to payers.
  - These efforts could help improve overall wellness.
- The biggest health issue across the globe is chronic disease, but systems are not yet designed to provide care or gather data to better address chronic disease management.
  - Chronic disease states often change more frequently in patients than we measure.
  - Meeting the challenges of value-based care for chronic illness will require new workflows and methodologies.

Vast opportunities exist for technology to step up and provide data integration so that the right actors can work with less friction.

- Gordon Moore, MD
  Senior Medical Director, Population and Payment Solutions, 3M Health Informations Systems

IMPLICATIONS

- Healthcare systems and partnerships should communicate off a single source of truth.
- New approaches to innovation itself are needed. It is crucial to measure, listen, and co-create goals with patients; patient innovation is needed to achieve improved measures.
- Conversations are now occurring, with more interest from employers about their investment.
VI. MANUFACTURERS
THE ROLE OF THE PHARMACEUTICAL AND DEVICE INDUSTRY IN VALUE-BASED CARE

Our products are sometimes seen as interventions and sometimes seen as costs. Another way to looking at them is as a form of long-term investment.

- Peter Juhn, MD, MPH
  VP & Global Head of Value-based Partnerships, Amgen
VI. MANUFACTURERS
THE ROLE OF THE PHARMACEUTICAL AND DEVICE INDUSTRY IN VALUE-BASED CARE

SECTION SUMMARY

• INDUSTRY AND SYSTEM PERSPECTIVES ON PARTNERSHIPS
• SHARED PRIORITIES IN CARE MANAGEMENT
• COLLABORATIONS IN MANAGING QUALITY AND COST

KEY INSIGHTS

INDUSTRY AND SYSTEM PERSPECTIVES ON PARTNERSHIPS
• Compared to other industries, such as manufacturing and services, health care offers very few guarantees
• It’s complicated:
  - Historically device companies have rationalized added costs by better outcomes that ultimately reduce cost
  - However, reduced cost usually goes to whoever has longitudinal care (Medicare)
  - Companies have no way to charge Medicare, so they charge health systems
  - Suppliers launch new technologies at a high price now justify with “We’ll help you get high reimbursement from CMS or a pass-through or what have you”
• Parties are now trying to change the nature of the conversation; there is a larger set of issues that have an impact. To move people from the legacy approach toward acknowledging the new approach it is essential to work collaboratively with the system and the physicians
• The new approach from suppliers is to engage health systems directly; see what the problems is and try to help with the outcomes part of the equation
• Device makers want health plans to be able to say: “If we look at outcomes, let’s throw our business to those folks who help us get better outcomes
• Supplier hesitancy on addressing cost persists, but there are successes. Supply companies now want to be ‘solutions’ companies. These teams do nothing but try to solve healthcare issues to address the lack of partnerships
• True risk sharing would allow us to reduce our cost while suppliers increase revenue
• The question would become, “Where can we throw market share to you, and you lower costs for us?”

Improving patient outcomes has got to be the cornerstone of what we do.
- Rob Lerman, MD
  VP, Supply Chain Clinical Services, Dignity Health

SHARED PRIORITIES IN SPECIALTY MANAGEMENT
• All stakeholders have to acknowledge that there is an affordability and quality challenge that we have to address
VI. MANUFACTURERS

THE ROLE OF THE PHARMACEUTICAL AND DEVICE INDUSTRY IN VALUE-BASED CARE

SHARED PRIORITIES IN SPECIALTY MANAGEMENT (continued)

- The pharma business has been too laser-focused on its own product mix and business model
  - The challenge now is to break out of that and ask, “What does value actually mean?”
    - Value, outcomes divided by cost, is ‘what you get for what you pay for’
- Across health care in general, the focus is too often on cost and not enough on outcomes
- We need to think about how we relate to our stakeholders
- Supply/manufacturing companies want to do the right thing, but are caught owing to their own financial pressure and boards. They are trying to work around the cost issue by adopting add-on services for a quick solution
- Cost is a joint responsibility, as industry won’t have a place to sell in the event of institutional bankruptcies. Thus the question has to be, “What can we do to lower your costs so that you can lower mine?” This kind of team can only work within partnerships

By looking at specific chronic disease states and together figuring out how to improve those patients to ensure that we can deliver products wherever they are, hospital, clinic, or home, we have really reduced chronic care and made life better for patients.

- Michael Louviere
  VP Supply Chain, Ochsner Health System

COLLABORATIONS IN MANAGING QUALITY AND COST

- We are going to have to move from transaction relationships to collaborative relationships. We don’t do that very well – we speak different languages
- We really must think ahead of the game and prevent things before they happen, not just tack on technology. We also have to eliminate wasteful technology (the ‘graveyard of devices bought and not used’). Let’s figure out proactively how to do it right the first time
- Interest in developing relationships with a health system is not necessarily related to the product, but to the therapeutic area
- Three principles:
  - There must be a mutual value in any contract
  - Clarity in creating a decision-making structure that really incorporates all parties involved
  - Mutual contribution – all partners should contribute resources (i.e., money, people, data) to ensure that everyone is getting the benefits of the partnership
- We should sit down and, instead of separate negotiations, look at the broad portfolio of products in the pipeline, plus our capability, plus what you need to determine where health systems can throw market share to industry and industry can lower health system costs for a financial win-win
VI. MANUFACTURERS

THE ROLE OF THE PHARMACEUTICAL AND DEVICE INDUSTRY IN VALUE-BASED CARE

• This becomes particularly challenging in a commercial mix in which there is turnover among policies. An intervention requires money upfront, but can be an investment for which payout occurs in 5-10 years. However, once a patient turns 65, they enter Medicare. Here is an opportunity to really think: these people are going to be on Medicare for the rest of their lives, and a lot of things will be addressed that should have been addressed before.

• Might Medicare be interested in paying for things that will give it reimbursement/cost effectiveness 10 years down the line? An opportunity exists for Medicare to provide help — especially preventive care — for patients who are 55, where earlier preventative care may lower later risk.

At the end of the day, this is really all about the patients. Can we work with the docs to help patients get access to the products they need?

- Peter Juhn, MD, MPH
  VP & Global Head of Value-based Partnerships, Amgen

IMPLICATIONS

• Ask questions and work on opportunities and tools that can help better identify who uses products and then make it possible for them to stay adherent to those products.

• You won’t have collaboration:
  - If you don’t have mutual consent
  - If you’re not transparent
  - If you don’t trust each other
  - If you are not motivated by a real desire to collaborate

• Lightening round
  - Give it a try
  - Open communication, build trust, transparency
  - Look for win-wins
CONCLUSION

Perhaps one comment suffices to capture the experience, professionalism and commitment that characterized the 2017 Ochsner® Health Network Value Summit: From what I heard today, uncertain times are not for the faint of heart.

Indeed these are uncertain times for US health care. However, the opportunities for forging new tools, new measures, new languages, and new visions — and to create them within innovative, collaborative partnerships — were embraced by Summit participants. Across the two days of the Value Summit, panelists and participants rose to the invitation to contribute their views and to deeply consider the views of others.

No satisfying answers exist by which to contain and manage the present, future, and vastly changing healthcare landscape. The Value Summit nevertheless showed that we are eager to step back and assess, to apply fine-grained inquiry to address overarching concerns, and to share the data obtained with those similarly willing to put in the hours, year after year, toward better value in the care of our populations, communities, and patients.

The Value Summit showed that US health care has not lost its way across this change. Dialogue and communication toward action on complex issues are underway. Trust and strategy, the backbone of all successful enterprise, are alive and well, acknowledging the difficulty of commitment, ready to take the leaps of faith required.

The OHN Value Summit’s conversations brought together the colleagues and communities who must travel in tandem, in partnerships and collaborations, to re-envision health care as a system characterized by value, quality, and better outcomes. The conversations were neither a beginning nor an end. However, they mattered in inspiring courage to meet the day-to-day challenges that must be faced, the renewed effort that must be shouldered, and the thoughtfulness that must animate moment-by-moment decision-making. They mattered in underscoring that we must succeed together in changing health care, and the worlds it exists to serve.
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**Christopher White, MD** – System Chairman of Cardiovascular Diseases, Ochsner Health System
**David Zook** – Chair, Faegre Baker Daniels Consulting
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ABOUT OCHSNER
Ochsner Health System is Louisiana’s largest non-profit, academic, healthcare system. Driven by a mission to Serve, Heal, Lead, Educate and Innovate, coordinated clinical and hospital patient care is provided across the region by Ochsner’s 29 owned, managed and affiliated hospitals and more than 80 health centers and urgent care centers. Ochsner is the only Louisiana hospital recognized by U.S. News & World Report as a “Best Hospital” across four specialty categories caring for patients from all 50 states and more than 80 countries worldwide each year. Ochsner employs more than 18,000 employees and over 1,100 physicians in over 90 medical specialties and subspecialties, and conducts more than 600 clinical research studies. For more information, please visit ochsnerhealthnetwork.org.

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