Beth Israel Lahey Health Performance Network

Provider Orientation

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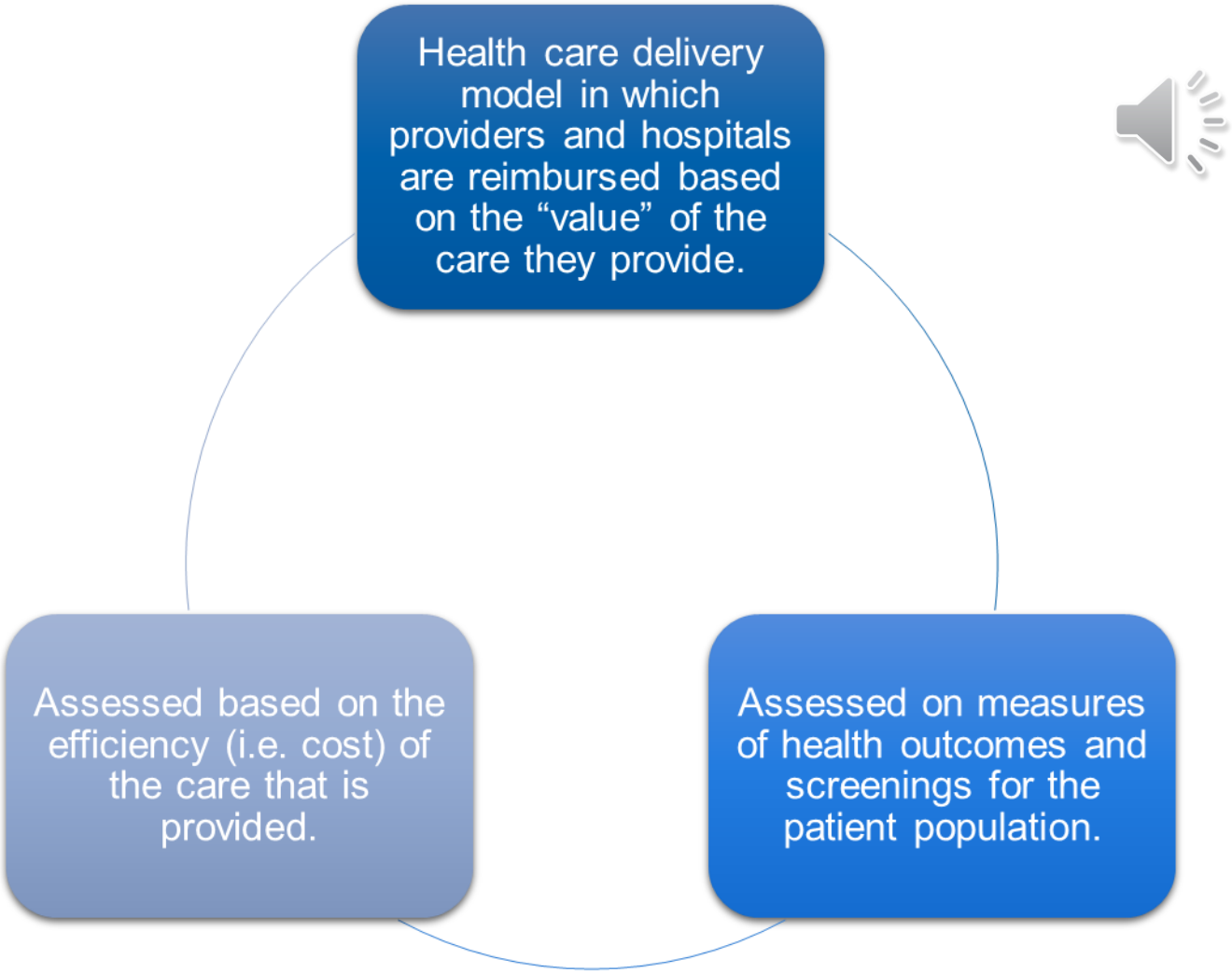
Value Based Care
What is it?

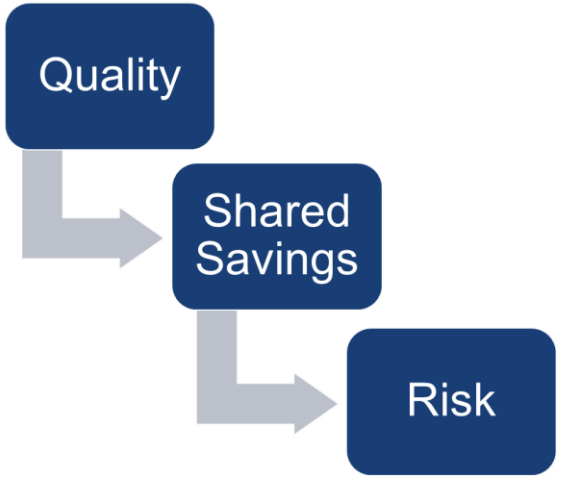


Quality Measure Examples:
-these are the metrics that are monitored and scored

Patient Experience	Care Coordination	Chronic Disease	Screenings
• Inpatient • Outpatient	• Readmission • Med rec post discharge	• Diabetes • Hypertension • Depression	• Falls Risk • BMI • Tobacco Use • Vaccines • Cancer Screenings

Value Based Reimbursement-

Healthcare Organizations can be reimbursed in a number of ways

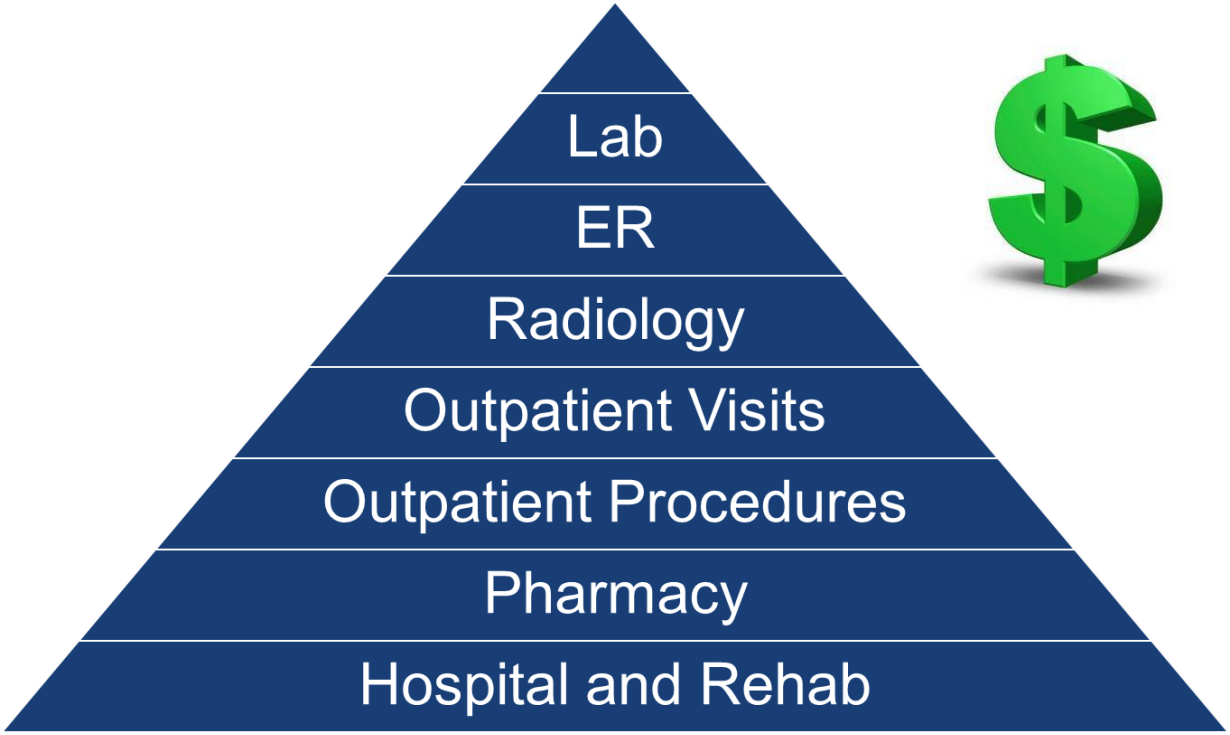


In certain contracts we are reimbursed directly for achieving success on quality measures.

- Quality performance can also influence our percent of shared savings or risk.
- In shared savings contract the organization is given a budget to care for the patient population. If the organization is able to care for that population more efficiently and spend less than the budget then they will share in the savings with the payer.
- In a full risk contract, the organization may share in a surplus but also has financial downside risk if cost of care exceeds the budget.

The ability for quality performance to influence your percent of shared savings or risk sets the current environment apart from the managed care approach that we experienced decades ago.

Total Medical Expense (TME)…



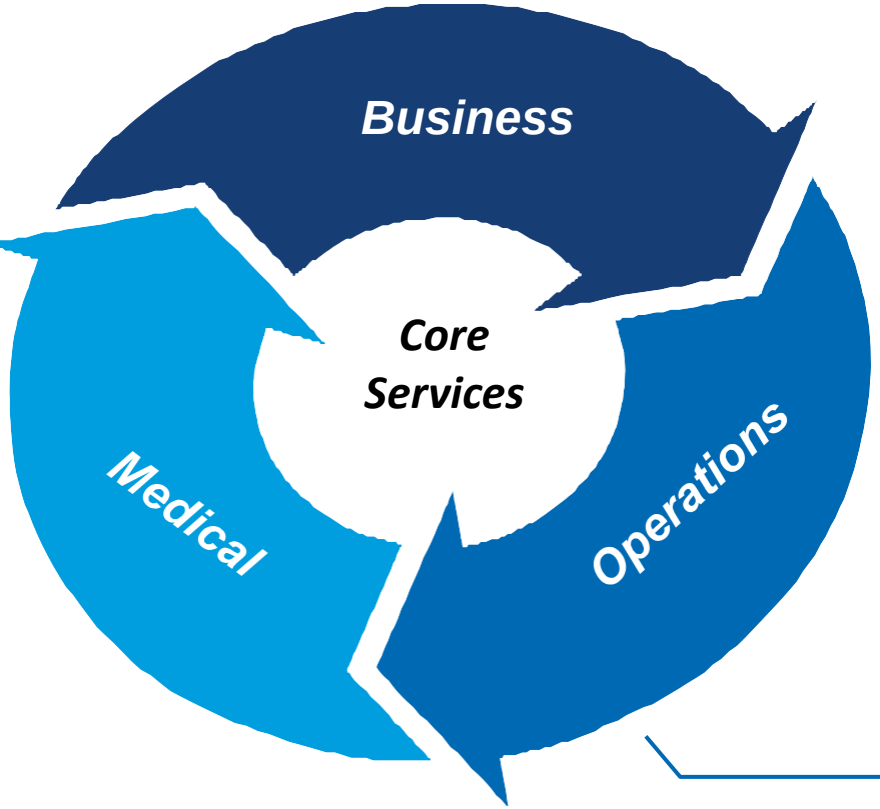
These are the biggest buckets of cost.

The total medical expense is determined by the **total claims each payer reimburses for care received** by their population.

The biggest costs are often driven by **inpatient hospitalization** and a fair amount of the work we do focuses on keeping patients healthy in an effort to keep them out of the Emergency Room and out of the hospital.

Beth Israel Lahey Health Performance Network

BIHPLN will provide services to the clinically integrated network to maximize success in value-based payment models



Business:

Contracting
Finance
Accounting*
Contracting Analytics
Financial Operations*
Financial Reporting
Financial Settlements
Performance Analytics & Reporting
Information Technology
Data Integration
Data Warehouse
Legal*
Network Strategy

Medical:

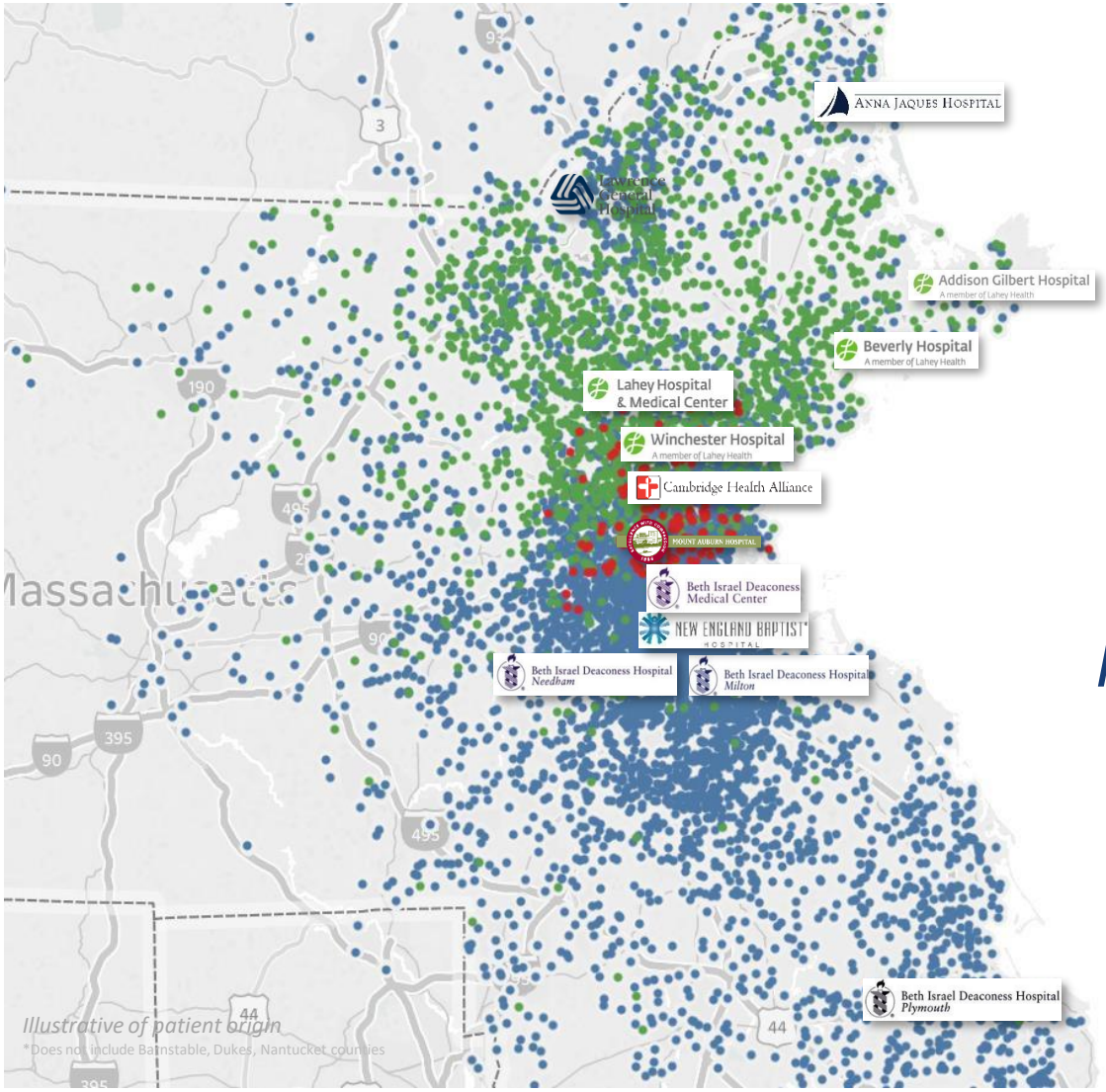
Care Management
Clinical & Quality Performance Informatics
Medical Management
Pharmacy Utilization
Quality
Risk Unit Management
Standardization of Best Clinical Practices

Operations:

Administration
Communications
Human Resources*
Medicaid ACO Operations
Network Payor Programs, Development and Deployment
Network Relations
Provider Enrollment

* - Shared Service

A Comprehensive, High-Value Network



*Over **4,300 physicians, including 836 PCPs** – within 5 miles of 74% of Eastern MA residents*

*A managed **patient population of ~1.3 million***

*Including **450,000 under risk** contracts*

Current State: BIDCO, LCPN, and MACIPA
Network Size

				Total
Total Physicians	2,547	1,301	499	**4,347**
PCPs	528	209	99	**836**
Specialists	2,019	1,092	400	**3,511**
Hospitals	8	6	1	**15**

Hospital network: 87% member / 13% non-member

Primary care network: 43% employed / 57% independent

BILHPN collaborates with risk units…

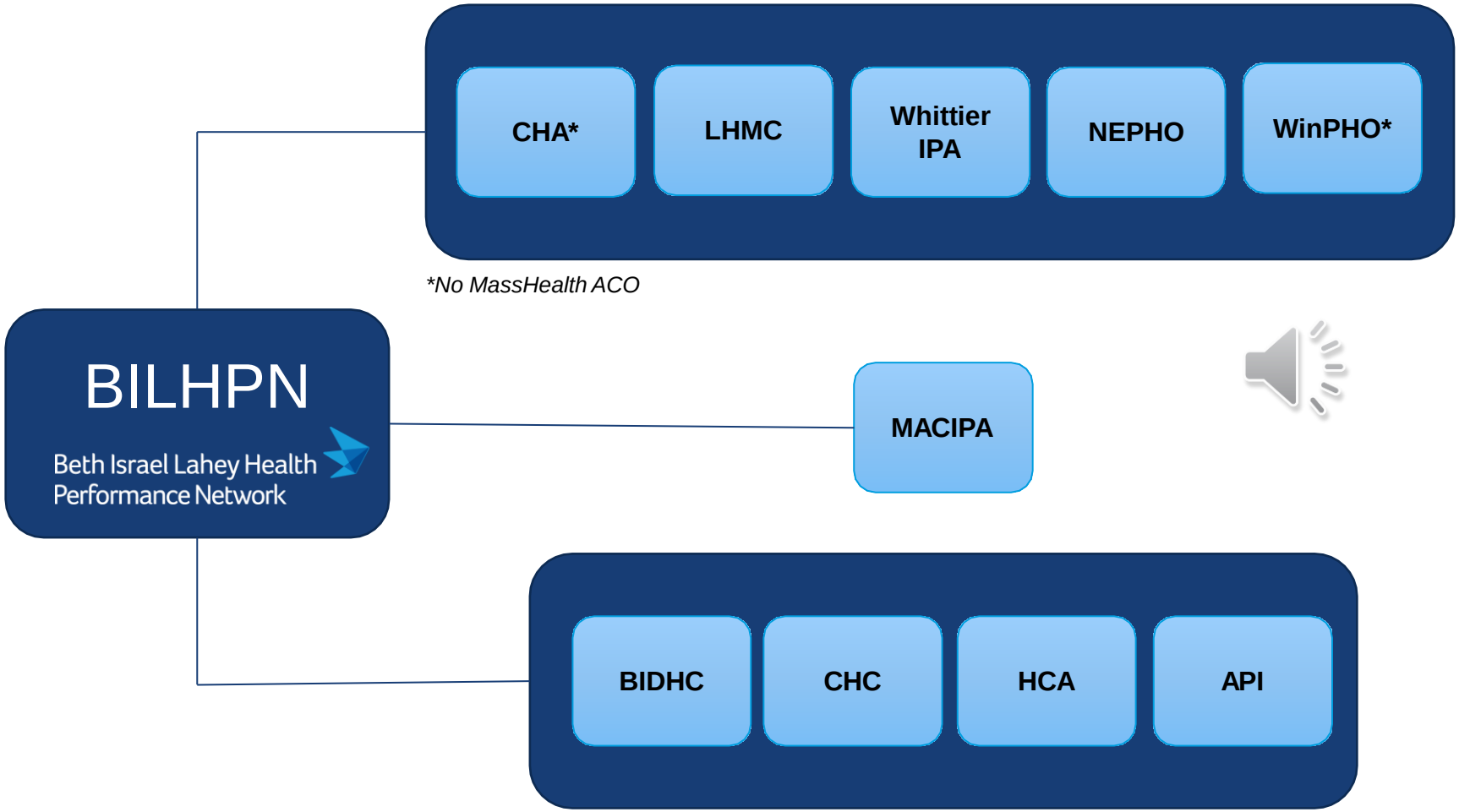
Each of these risk units within our larger organization is **comprised of physician groups and their affiliated hospital.**

Each group is tracked on performance as it relates to **quality and efficiency**.

The BILH Performance Network medical management team works closely with risk unit leadership to **track and improve performance** on specified goals.

BILHPN Risk Unit Structure

- Risk Units pair PCPs with a BILHPN hospital and may include specialists
  - PCP is paired with one hospital, Risk Unit may go across multiple hospitals



Population Health Programs

- Quality
- Care management
- Clinical Pharmacy

Quality

Measures

- In-depth knowledge of risk contract quality measures

Strategy

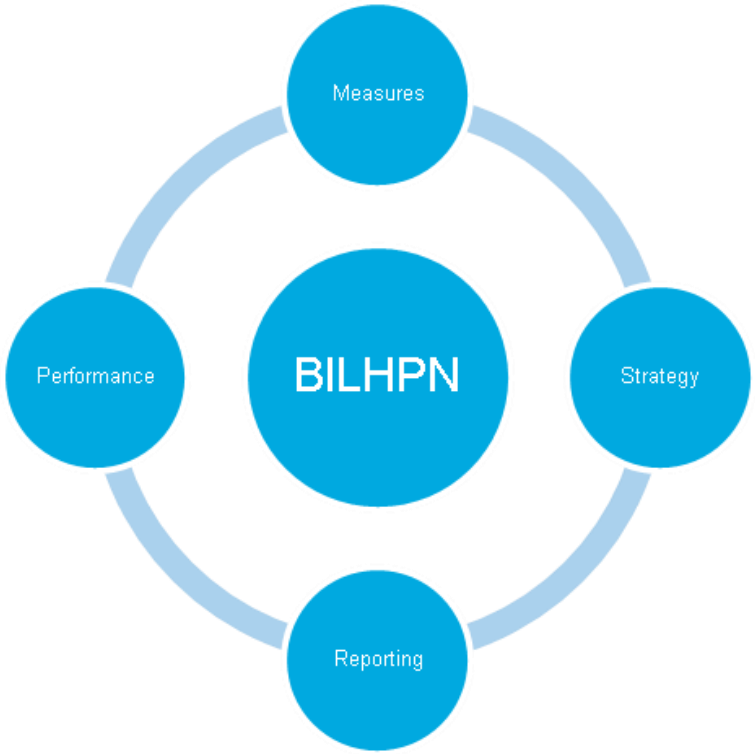
- Work with key stakeholders to develop recommendations/best practice initiatives per evidence-based guidelines
- Develop initiatives to improve performance and reduce practice burden through use of technology
- Identify common opportunities across units to standardize approach and communication

Reporting

- Produce and provide trend, gaps in care, performance report regularly
- Perform “deep dive” analytics on areas of focus

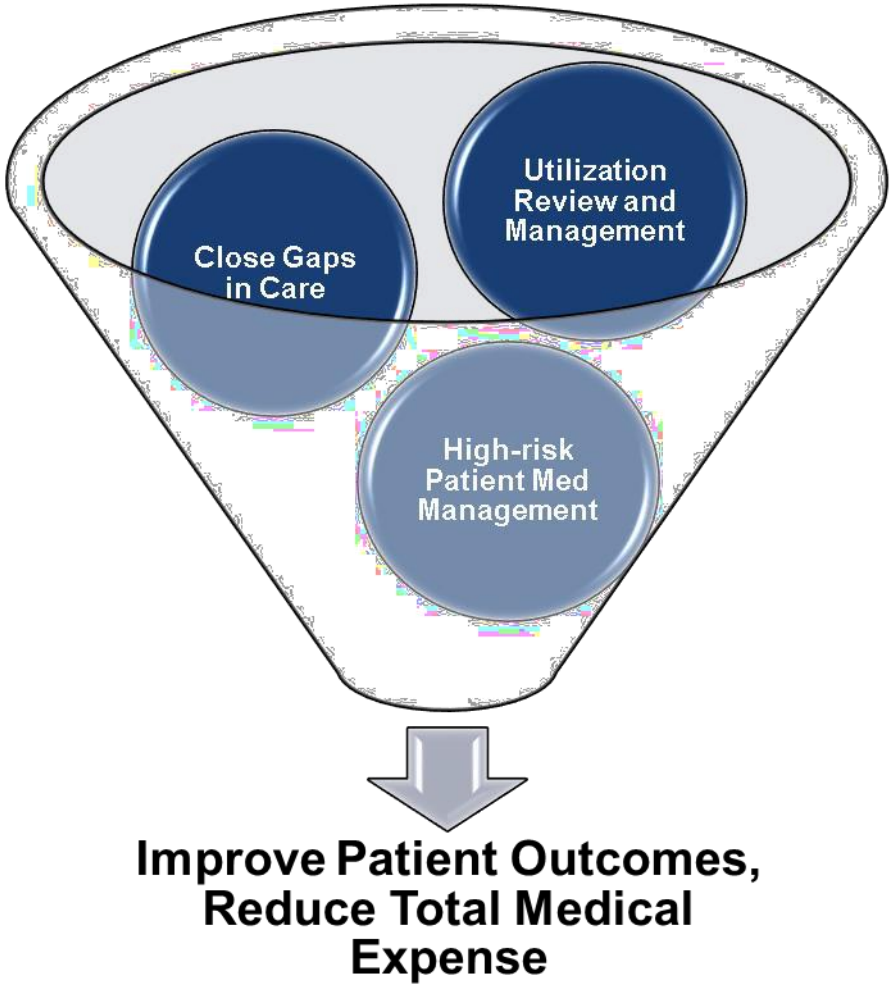
Performance

- Produce and provide performance against contract and other benchmarks
- Identify areas of focus based on performance at a network and risk unit level

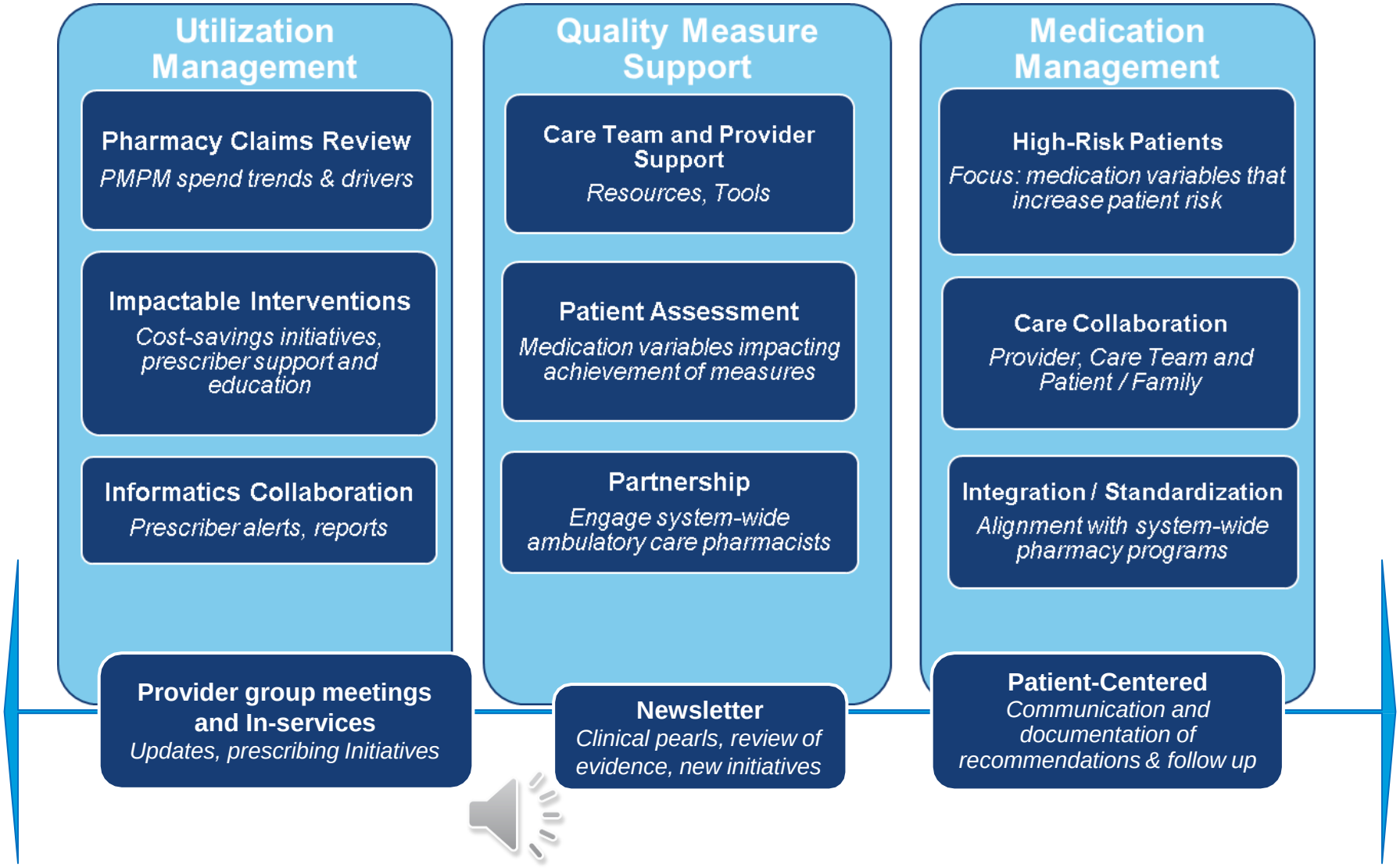


Pharmacy

Support clinical and financial performance through coordinated pharmacy programs aimed at improving cost-effective medication use and quality of care.

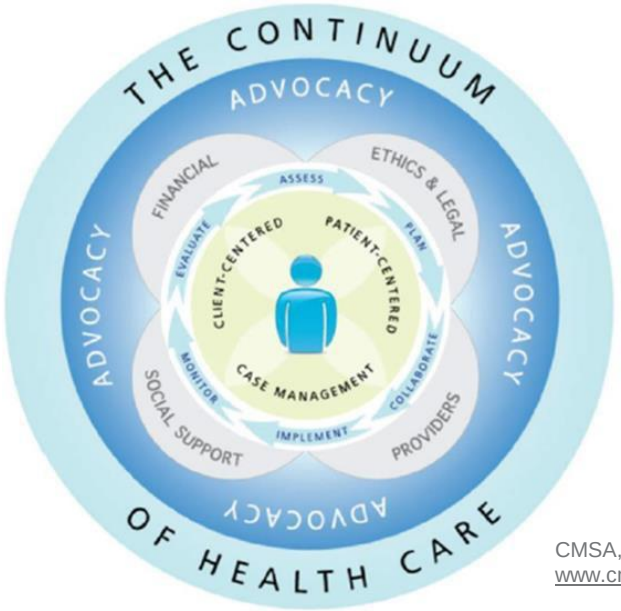


Pharmacy Team -support using a multi-prong approach



Care Management

- Support the achievement of optimal health outcomes with a patient-centered model
- Use data to focus on impactable conditions to assure patients receive high value care in the right setting at the right time
- Utilize proven processes and tools to measure a patient's understanding and ability to self-manage their health
- Measure outcomes to identify best practice



CMSA, Standards of Practice for Case Management, 2016. www.cmsa.org

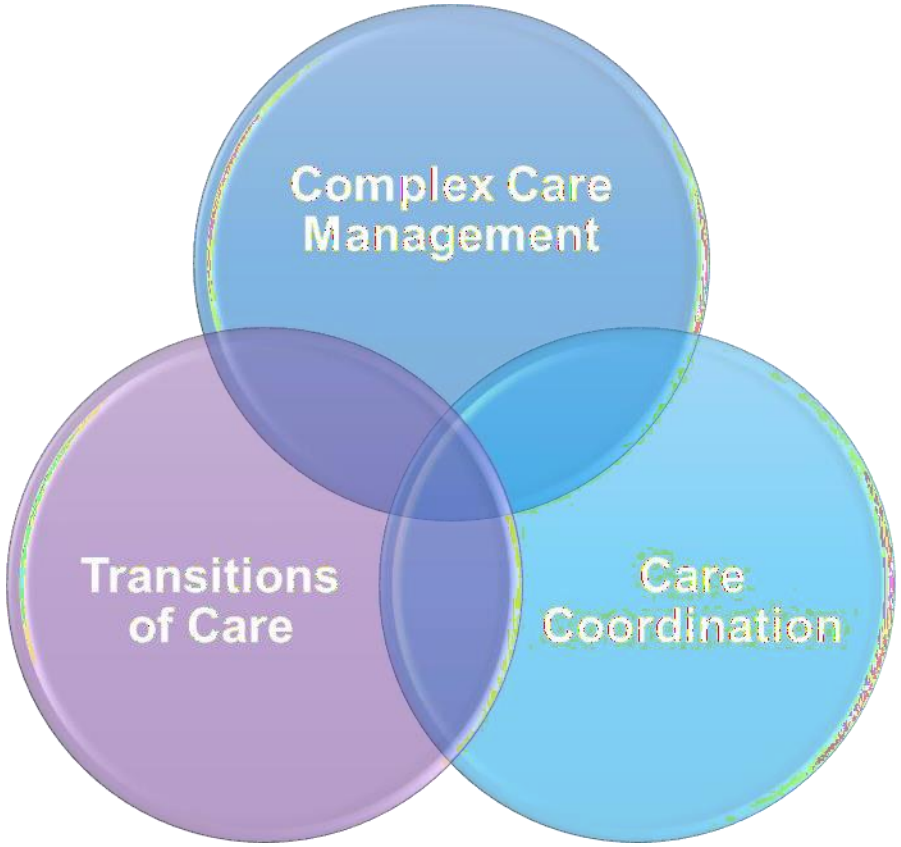
Care Management

A collaborative process of assessment, planning, facilitation, coordination, education and advocacy

Complex Care Management: Provided to patients with complex medical or psychosocial issues requiring extensive resources and navigation support

Transitions of Care: An intensive but short-term engagement with a patient following a hospital or skilled facility discharge

Care Coordination: Coordination of resources and care plan elements by licensed or non-licenses staff, often to address social determinants of health



Care Retention

- Retaining care within the system can lead to improved quality and lower cost.

- Closer communication between primary care providers, specialists, and other members of the care team can lead to better outcomes and better patient experience.

- The Performance Network has created referral guidelines to advise providers, staff and referral management teams of the appropriate criteria for approving referrals in or out of network.

- Our goal is to care for all of our patients needs with the exception being the rare times when there is particular required clinical expertise outside of our system.

What does success look like?

- Chronic Disease Management
- Teaming and top of license work
- Evidence based practice
- Transitions of Care
- Advanced care planning
- Case Management/SDOH
- Coding
- Growth and Care Retention

Initiatives and Programs at Lahey Burlington

- Readmission Reduction Task Force
  - work to evaluate reasons for re-admissions across disease states and partner to help prevent in the future

- CHF clinic
  - Robust inpatient-outpatient collaborative team that sees patients in both settings, and connects with home VNA services as well

- COPD-Pneumonia Pulmonary based team
  - Work ongoing to see our sickest and chronic patients to help keep them as healthy as possible and cared for at home as much as possible

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Initiatives and Programs at Lahey Burlington
continued...

- Palliative Care Program
  - Inpatient and Outpatient program that sees many of our sickest patients
  - Collaborates with Home Health and Hospice as well as our local SNF's

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Finally… the ‘ask’ for Providers ….to think about:

-In the world of value based care, how we work together to help our patients and the organization achieve mutual success

- Help patients improve **control of their chronic disease**, particularly diabetes and high blood pressure – which when not well controlled can lead to adverse outcomes.

- Deliver care that is based on the most recent and accurate evidence. **Evidenced based practice** is not only better care but frequently aligns with lower cost. Example: in primary care we looked at the evidence for screening lab testing and have shared practice variation data to encourage providers and staff to have internal conversations around which labs should be ordered for routine physicals.

- Take great **care when transitioning** out of an acute or subacute care facility they are at risk for clinical deterioration, medication errors or other problems leading to gaps in care. Our care managers are particularly diligent in watching out for our patients during this critical time and we encourage our practices to do the same.

- Often when we think about **advanced care planning** we think about a discussion of code status. This is only one small component of advanced care planning. We encourage our providers to have open and honest conversations with their patient to elicit overall goals of care and to put a plan in place to assist the patient with achieving those goals. Our patients who are facing serious illness or end of life deserve the opportunity to have this discussion with their providers.

The 'ask' for Providers: -continued….

- Wewould like all providers and staff to be **practicing at the top of their license**. Focusing on the job you trained for and utilizing your unique skills will improve the care we deliver and increase efficiency.

- We have already discussed **care management** and the efforts that our nurses and social workers make to improve patient care.
- We seek to elicit from our patients their **social determinants of health**, many of which we understand can negatively impact a patient's health care status. A couple of the big examples are insecurity of food or housing. Once we know their challenges, we can do our best to assist our patients with those challenges.

- **Coding… always fun- CDI work is always ongoing**
- Coding is an important factor when it comes to the ability to be successful in the world of risk contracts. Payers base our budgets partially on the burden of disease in our population. This is data that they receive only by our ability to **accurately and thoroughly** code our patients' disease states and diagnoses. Many of our EHR's have reminder systems in place to prompt our providers to address diagnoses that may not have been addressed and coded in that year.

- Finally, **growing our patient population** is helpful in being able to manage financial risk. As previously mentioned, part of this effort involves encouraging our patients to receive all clinically appropriate care within our trusted network.

BILHPN Importance of Acuity/Risk Documentation

What is Clinical Documentation Improvement (CDI)/Acuity?

Risk Adjustment: Diagnosis code driven methodologies used to predict the cost of health care for patients based on **clinical condition groups/disease burden** scales

- RAF or Risk Adjustment Factor is the score to evaluate the prediction of factors that apply to the individual disease burden
- RAF is determined based on demographics, diagnoses, and disease interactions

To reflect acuity accurately (e.g. how sick are our patients), diagnoses must be captured **annually**

- Diagnoses require specific documentation
- Higher level of specificity within diagnoses can potentially lead to higher weight (specificity)

-continued….

Why Clinical Documentation Improvement (CDI)

- Value of Acuity Documentation & Coding Improved data for clinical management
- Care coordination, informed medical decision making, and data capture/application experience
- Improve health status to align with current acuity of our patients
- Impacts budget for financial management
- Appropriate reimbursement for patient population

Moderate Level of Specificity			*High Level of Specificity*		
Age 76 female (Base)	0.437	$4,370	Age 76 female (Base)	0.437	$4,370
Type 2 Diabetes unspecified- E11.9	0.105	$1,050	**Type 2 Diabetes with CKD- E11.22**	0.302	$3,020
CKD unspecified- N18.9	0.00	$0.00	**CKD Stage 3a - N18.31**	0.069	$690
Obesity- E66.9	0.00	$0.00	**Severe Obesity- E66.01**	0.250	$2,500
Major Depressive Disorder, Single- F32.9	0.00	$0.00	**Major Depressive Disorder, Single, Mild- F32.0**	0.309	$3,090
Total Risk Factor Score	**.542**		**Total Risk Factor Score**	**1.367**	
Estimated Average/ Month		**$452**	**Estimated Average/ Month**		**$1,139**
Estimated Dollars/ Year for this patient		**$5,420**	**Estimated Dollars/ Year for this patient**		**$13,670**

* An estimated Average Country Rate of $10,000 per year is used

Welcome to BILH! and Welcome to Lahey!

THANK YOU for taking the time to make it through this presentation.

PLEASE don't hesitate to reach out by phone or email anytime.

We will look forward to working with you and supporting you.

We are very excited that you have decided to join the BILH team! Again, WELCOME!