PARTNERS HEALTHCARE

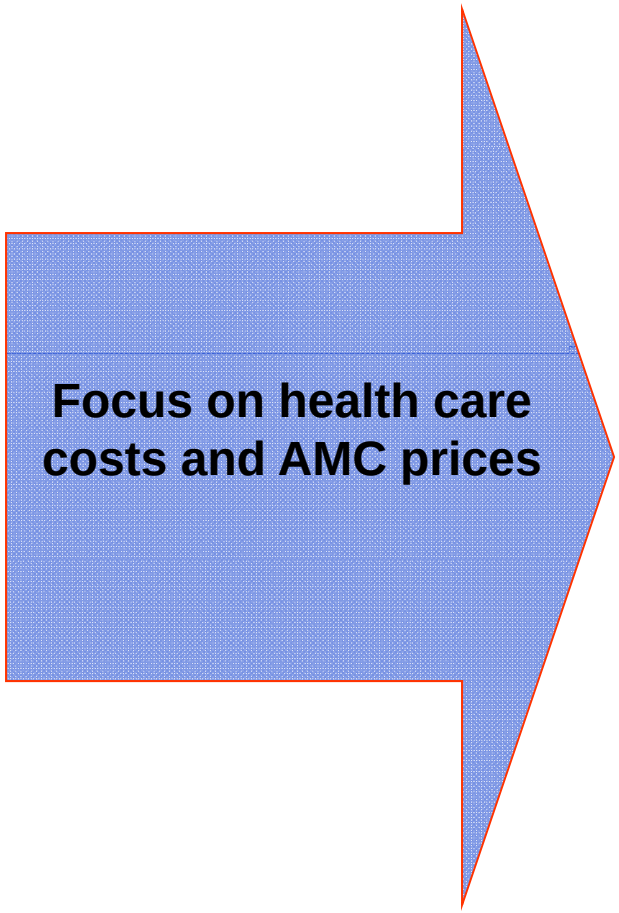
FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

# Healthcare Reform and Other Market Developments: Implications for AMCs

**Thomas H. Lee, MD, MSc.**
**Network President, Partners HealthCare System**
**Professor of Medicine, Harvard Medical School**
**Professor of Health Policy and Management, HSPH**
**Associate Editor, New England Journal of Medicine**

**October 24, 2011**

# Market Environment

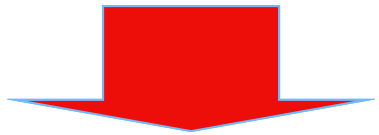



## Payment reform, Rate regulation, Patients as consumers

- Tiered, limited networks

## Risk Shift to Providers

- Global payments
- Shared Savings
- ACO/Population management
- Bundled payments
- Episodic management



## Changing Marketplace

- Focus on population management
- Reduced hospital use and other expensive resources

# Short- and Medium Term Implications and Challenges

- Commercial HMO shifting from fee-for-service to global budget
- Partners exploring Medicare Pioneer ACO agreement
- Partners remains under regulatory scrutiny from State and Federal offices
- Partners in due diligence for integrating with Neighborhood Health Plan
- Challenge of how should we be organized if we are to be successful in era ahead under active discussion

# Strategic Focus


Leading provider of population-based care

Premier episodic care/referral organization

- Take a greater role in managing patients' care in health and sickness
- Continue to be a world-class provider for referral and episodic care

Effective and efficient patient-family centered care

- Bring the right care at the right time and the right place

# We Understand the Work to Be Done

<table>
<tr><th></th><th colspan="2">Longitudinal Care</th><th colspan="2">Episodic Care</th></tr>
<tr><th></th><th colspan="2">Primary Care</th><th>Specialty Care</th><th>Hospital Care</th></tr>
<tr><td rowspan="3">Access to care</td><td colspan="3">Patient portal/physician portal</td><td>Optimize site of care</td></tr>
<tr><td colspan="3">Extended hours/same day appointments</td><td rowspan="2">Reduced low acuity admissions</td></tr>
<tr><td colspan="3">Expand virtual visit options</td></tr>
<tr><td rowspan="6">Design of care</td><td colspan="4">Defined process standards in priority conditions<br>(multidisciplinary teams, registries)</td></tr>
<tr><td colspan="2" rowspan="2">High risk care management</td><td rowspan="2">Required patient decision aids</td><td>Re-admissions</td></tr>
<tr><td>Hospital Acquired Conditions</td></tr>
<tr><td colspan="2" rowspan="2">100% preventive services</td><td rowspan="2">Appropriateness</td><td>Hand-off standards</td></tr>
<tr><td>Continuity visit</td></tr>
<tr><td colspan="4">EHR with decision support and order entry</td></tr>
<tr><td colspan="4">Incentive programs (recognition, financial)</td></tr>
<tr><td rowspan="3">Measurement</td><td colspan="4">Variance reporting/performance dashboards</td></tr>
<tr><td colspan="4">Quality metrics: clinical outcomes, satisfaction</td></tr>
<tr><td colspan="2">Costs/population</td><td colspan="2">Costs/episode</td></tr>
</table>

# The Good and Bad News About Progress

- Flood of progress and knowledge imposed on fragmented delivery system leads to:
  - Individual clinicians feel *less* knowledgeable
  - Super-specialization, which means more people involved in care
- Too many people, too much to do, no one with all the responsibility or all the information

*A path forward based upon teachings from three colleagues:*

1. *Porter Strategy*
2. *Gawande Tactics*
3. *Bohmer Operations*

# Performance Dashboard 1.0 for End of Life Care

| **Diagnosis:** | Patients receiving end-of-life care. | | | | | | |
|---|---|---|---|---|---|---|---|
| **Measures** | **Data Source** | **BWHPO** | **MGHPO** | **NW PHO** | **NSHS/ NSPO** | **DFCI** | **Benchmark** |
| **VOLUME** | | | | | | | |
| Cases FYxx | RPDR | | | | | | |
| **OUTCOMES** | | | | | | | |
| Documentation of HCP | QDW | | | | | | |
| Documentation of resuscitation preferences and EOL care goals | | | | | | | |
| ACP dicussion with family and patient | | | | | | | |
| Completion of advance directive or durable power of attorney forms | | | | | | | |
| Presence of DNR/DNI orders | | | | | | | |
| Referral to hospice | | | | | | | |
| Time from DNR orders to death | | | | | | | |
| Time from referral to hospice to death | | | | | | | |
| **RESOURCE USE** | | | | | | | |
| Hospital days | UHC | | | | | | |
| ICU days | | | | | | | |
| Length of stay | | | | | | | |
| ED visits | | | | | | | |
| Readmissions | | | | | | | |
| Chemotherapy in last 2 weeks of life | RPDR/ UHC/ TSI | | | | | | |
| Number of doctors seen, excl. Palliative Care | | | | | | | |
| Inpatient hospice days | TSI | | | | | | |
| Costs of care | | | | | | | |
| **RESTRICTIONS** | | | | | | | |

*Inclusions:*

Adult Patients (age >18) who died during fiscal year 20xx with qualifying diagnoses and who were managed as an outpatient by a Partners physician.

Resource use counted for 6 months prior to death.

*Exclusions:*

Age <18

# Value Dashboard 2.0 Preliminary Recommendations
## (Stroke Example)

- Days spent at home 90 days post-stroke
- Patients with NIH Stroke severity level populated
- Modified Rankin scale at day 90 (discrete values)
  - 0: No symptoms
  - 1: Symptoms but no disability
  - 2-4: Decreased mobility
  - 5: Bed-ridden
  - 6: Death
- Functional Independence Measures (FIMs) upon admission and discharge from post-acute rehabilitation:
  - Self-care
  - Sphincter control
  - Transfers
  - Locomotion
  - Communication
  - Social cognition
- Barthel Index of performance in basic Activities of Daily Living upon admission and discharge from post-acute rehabilitation
- Outcome and Assessment Information Set (OASIS) for home care

# Elephants in the Room - 1

1

The pace and pressures are not going to disappear any time soon.

- Changes in payment models – for both Medicare and commercial populations – are going to make care redesign more than just a theoretical effort in value creation.
  - Care redesign will  be critical to efforts to manage trend.
- Changes in reimbursement will put even more pressure on hospitals to reduce costs and become more efficient.
  - Patient affordability efforts will be critical to maintaining our margins and preserving the mission.

Implication for Partners

We will not have the luxury of designing perfect solutions. The pressure to act will be profound and the consequences of inaction will be great.

# Elephants in the Room - 2

2

Thought leadership does not automatically translate into effectiveness.

- Our clinicians include national and international experts on almost any topic.
  - No shortage of good ideas for improvement of value of care
  - Difficulty prioritizing among them
  - Difficulty getting commitment to implement

Implication for Partners

We have to be able to prioritize, to focus, and to execute – across the System and as a system. And we need to commit to improvement over the long term.

# Elephants in the Room - 3

3

## We are not engineered for effective population management.

- Our size, complexity, culture makes it difficult to achieve consensus, so the pace of decision-making is slow.
  - 20 committees can say no, but not clear who can say yes.
- Challenges in rationalizing System strategic priorities with Entity priorities and Practice priorities create conflict and barriers at implementation:
  - "Unfunded mandate" vs. "failure to prioritize."
  - Sense of an unmanageable number of things to do.

**Implication for Partners**

We must be willing to confront – and resolve – the "third rail" issues that keep us from executing on a coherent strategy.