VALUE IN TEAM BASED CARE
PHASE I: CARE MANAGEMENT

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OBJECTIVES

Upon completion of the CME, the learner will:

- Verbalize how healthcare cost containment measures nationwide have driven changes in practice
- Identify how Clinical Integration strives to add value
- Determine care management value in the eyes of the customer

HIGHLIGHTS

- Kettering Health Network Statistics
- Challenged with Value Based Care
- Internal Evaluation of Readiness
- Clinically Integrated Network and Value
- Care Management Infrastructure
  - Policy
  - Care Manager training
  - Physician Engagement
- Metrics for Success and Value
- Next steps on Our KHN Journey

DAYTON OHIO POPULATION ASSESSMENT

- Kettering Health Network is located in SW Ohio
- 7 Hospitals in Dayton Ohio
- Market Area Assessment:
  - 1 major competitor in the region
  - Close proximity to Columbus and Cincinnati
  - Payer Mix locally: 30% commercial, 30% Medicare and products, 30% Medicaid/Self Pay

A small part of the city extends into Greene County. In the 2010 census, the **population** was 141,759, and the **Dayton** metropolitan area had 799,232 residents, making it **Ohio's** fourth-largest metropolitan area, after Cleveland, Cincinnati, and Columbus, and the 63rd-largest in the United States.

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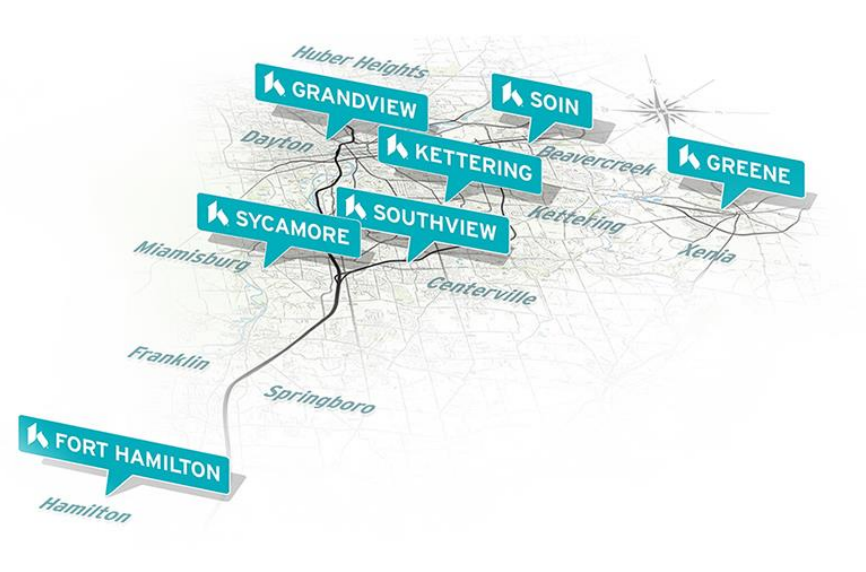
Top employers in the Dayton area

25 top employers

1. Wright-Patterson Air Force Base, 27,400 employees
2. Premier Health Partners, 14,135 employees
3. Kettering Health Network, 5,029 employees
4. Montgomery County, 4,559 employees
5. The Kroger Company, 4,100 employees
6. LexisNexis, 3,100 employees
7. Sinclair Community College, 2,726 employees
8. Dayton Public Schools, 2,574 employees
9. Wright State University, 2,948 employees
10. AK Steel Corporation, 2,400 employees
11. Honda of America Manufacturing, 2,400 employees
12. Community Mercy Health Partners, 2,297 employees
13. University of Dayton, 2,191 employees
14. VA Medical Center, 1,914 employees
15. City of Dayton, 1,913 employees
16. Emerson Climate Technologies, 1,533 employees
17. Meijer, Inc., 1,367 employees
18. Children's Medical Center of Dayton, 1,335 employees

Name	Location	Opened
Fort Hamilton Hospital	Hamilton, Ohio	1929
Grandview Medical Center	Dayton, Ohio	1926
Greene Memorial Hospital	Xenia, Ohio	1950
Indu and Raj Soin Medical Center	Beavercreek, Ohio	2012
Kettering Medical Center	Kettering, Ohio	1964
Southview Medical Center	Centerville, Ohio	1978
Sycamore Medical Center	Miamisburg, Ohio	1978



KETTERING HEALTH NETWORK

7 Hospital system across Dayton Ohio and northern Cincinnati Ohio

Serves approximately 60,000 discharges annually network wide

Network Hospitals:

- 1 large hospital
  - (Kettering Medical Center)
- 4 mid-size facilities
  - (Fort Hamilton, Grandview, Soin, Sycamore)
- 2 small facilities
  - (Greene, Southview)

KETTERING HEALTH NETWORK MISSION AND VISION

Mission

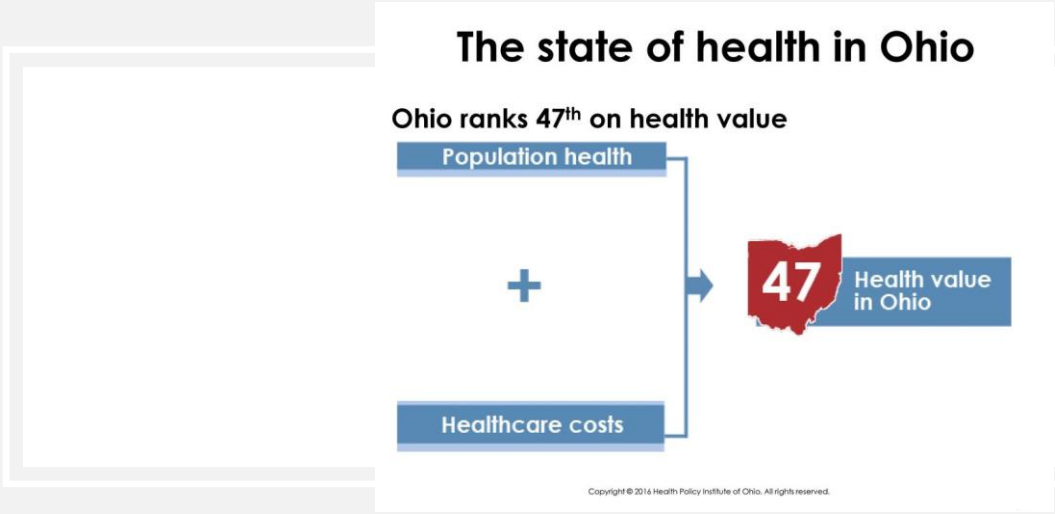
- Improve the quality of life of the people in the communities we serve through healthcare and education.
- We are dedicated to excellence and to providing each individual the most appropriate care in the most appropriate setting. In the spirit of Seventh-Day Adventist health care ministry, we strive to be innovative an convey Gods love in a caring environment.

Vision

Kettering Health Network will be recognized as the leader in transforming the healthcare experience.

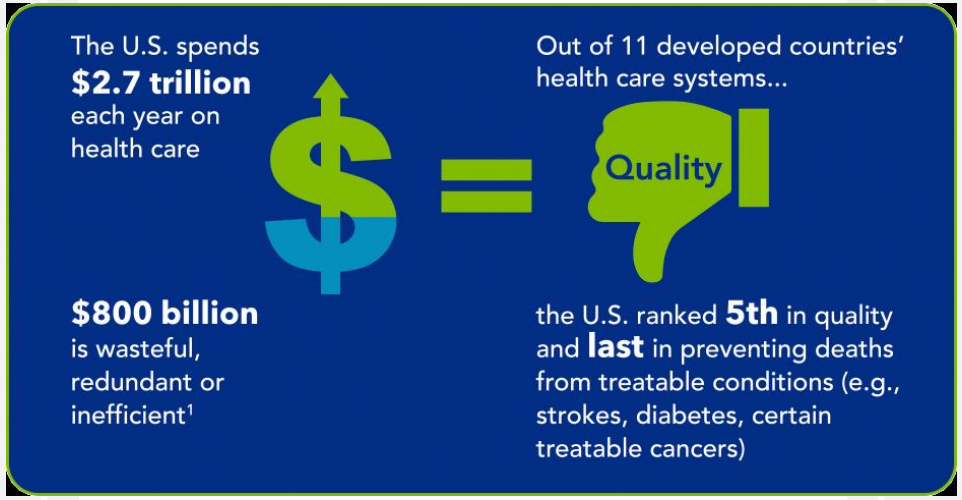
WERE WE MEETING OUR MISSION?

- How do we provide quality healthcare?
- How do we add value?
- Is our current system successful?
- Where could we be more innovative?
- Are we providing the best healthcare for our community?
- What steps must be taken to help us be recognized as the leader in health delivery?



DRIVING FORCES FOR COLLABORATIVE CARE

- **CMS Value Based Purchasing**
  - CHF and COPD readmission penalties year over year
  - 22-25% readmission rate from home care and SNF's
- **Employee Health Costs Rising**
  - Large inflationary spend to care for the Kettering Health Network Employees and Beneficiaries
- **Medicare Spend per Beneficiary**
  - Zero points attained in the last 4 years
- **Comprehensive Joint Replacement (CJR) mandatory bundle**
  - Year 1 without downside did NOT look favorable
- **32 KHN Employed practices in the CPC + program**
  - Without baseline infrastructure in place to provide care management activities



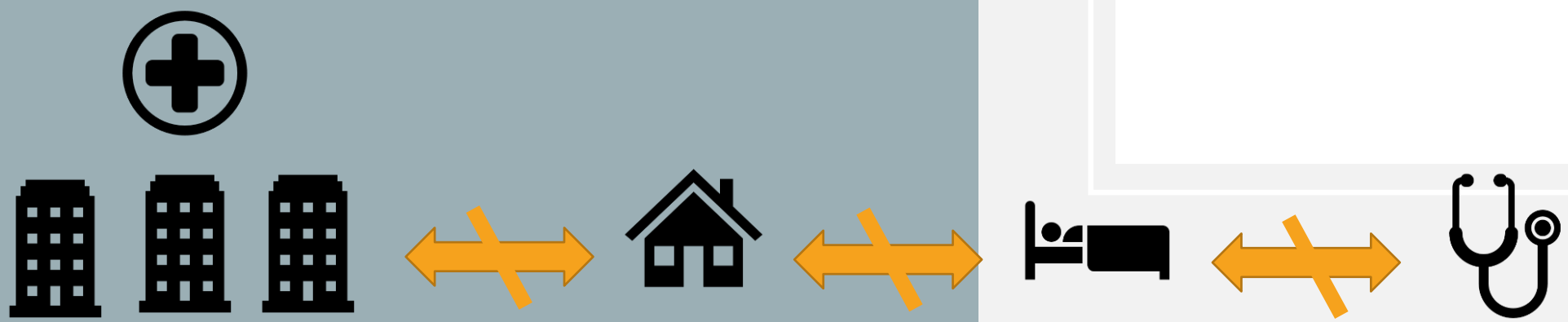
CHALLENGES WITH CURRENT STATE

Silos within the hospital systems

Silos between hospitals and outpatient environment

Silos between service entities

Lack of definitive process to handoff between care delivery sites



OUR CARE DELIVERY PROGRAM

Hospitals

7 Delivery Sites across the area

3 Free-standing ED

Hospitalist Care Predominant

50% of PCP Independent vs 50% Employed Physicians

Many engaging in CPC+ initiative

Joint Venture Home Care

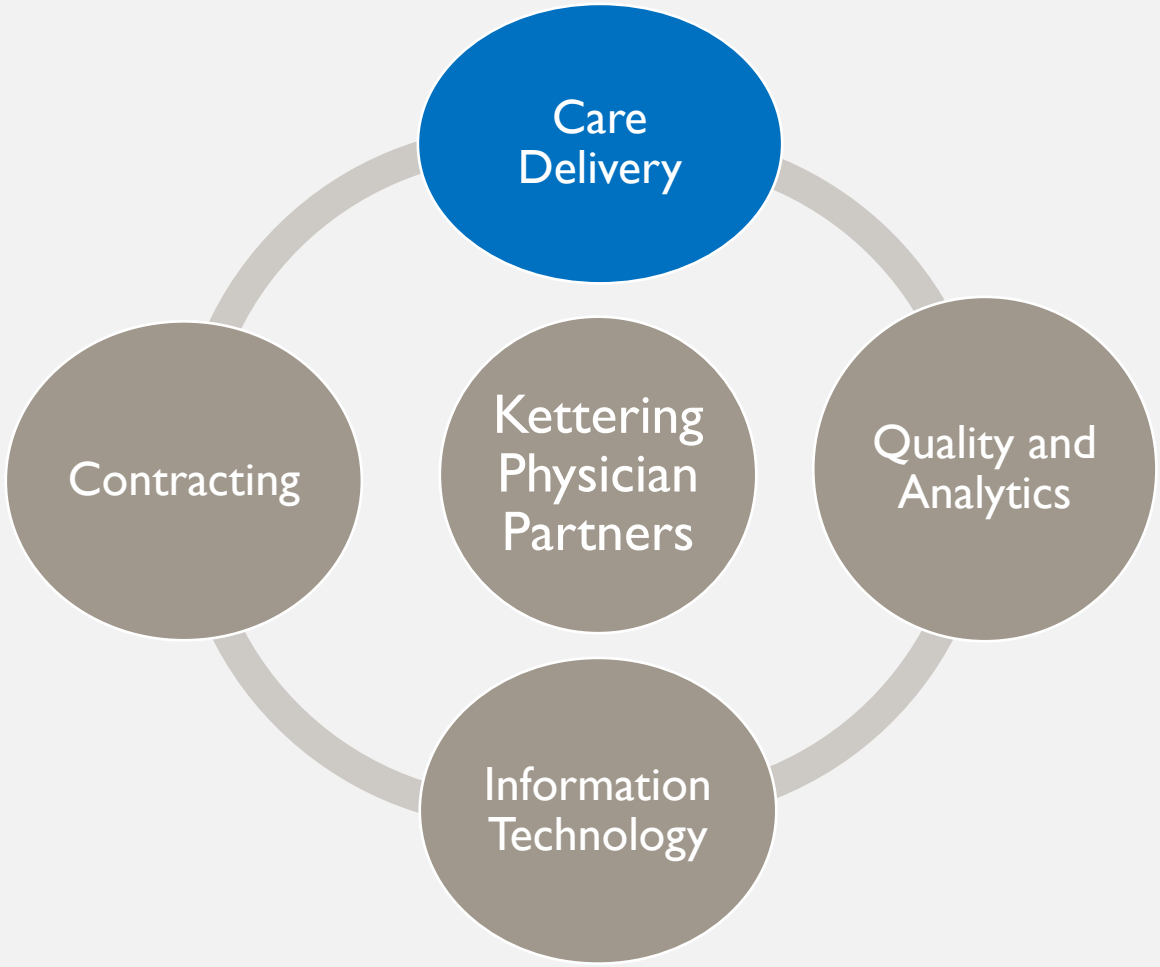
Engaged with building collaborative process

Skilled Nursing Facility Relationships

Engaged with building collaborative process

No Link Between Entities

ESTABLISHING A CLINICALLY INTEGRATED NETWORK



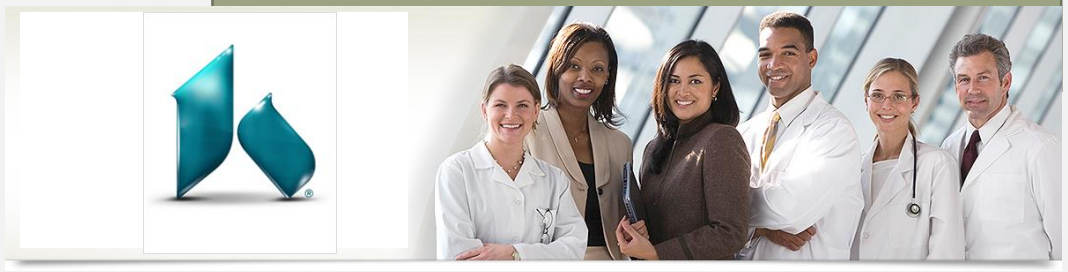
2017Year 1 CIN
Kettering Physician Partners

Subcommittee of the Board:
CARE DELIVERY

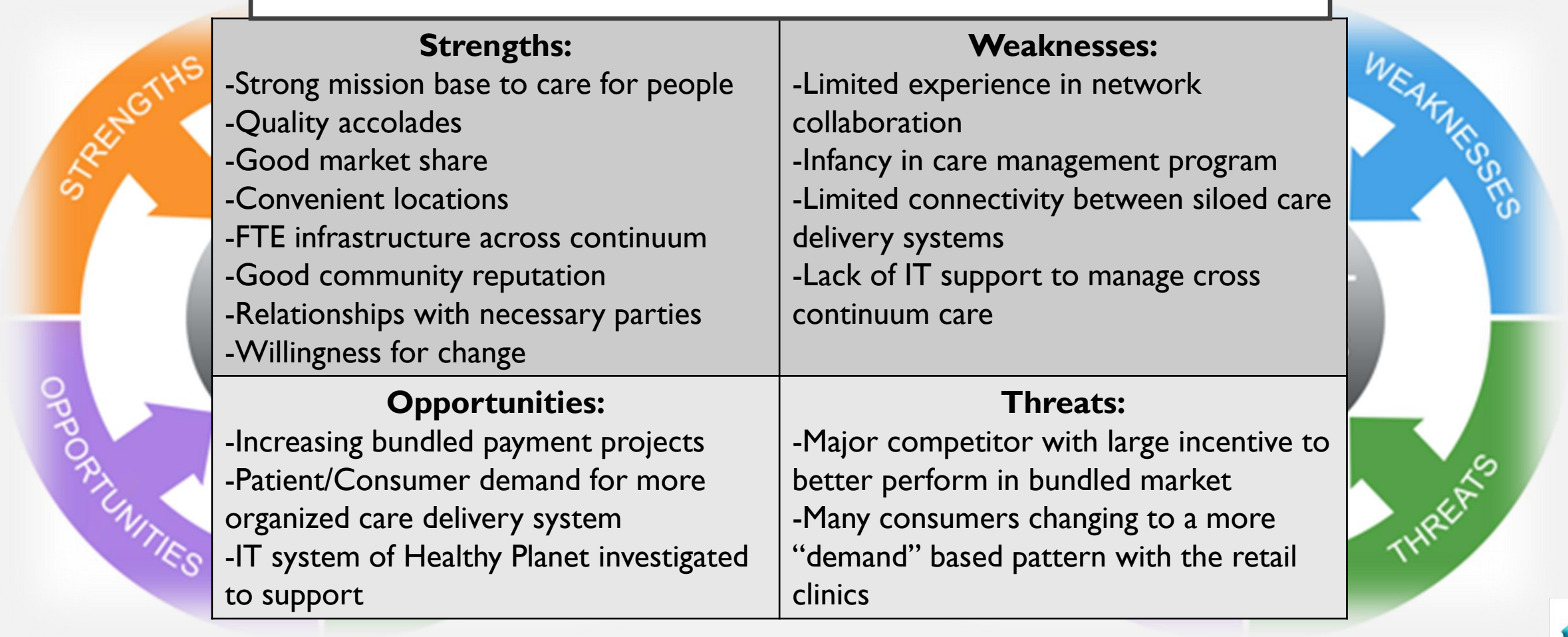
Develops strategy for value
Identify the ultimate customer(s)
Create implementation plan
Monitor the programs for success

WHERE IS THE VALUE?

- Benefit / Cost = Value in the eyes of the customer
- Providing coordinated care across continuum sites
- Providing appropriate care at the appropriate delivery site
- Giving timely care
- Avoiding unnecessary costs or utilization



WHERE WE BEGAN



Strengths:	**Weaknesses:**
-Strong mission base to care for people -Quality accolades -Good market share -Convenient locations -FTE infrastructure across continuum -Good community reputation -Relationships with necessary parties -Willingness for change	-Limited experience in network collaboration -Infancy in care management program -Limited connectivity between siloed care delivery systems -Lack of IT support to manage cross continuum care
Opportunities:	**Threats:**
-Increasing bundled payment projects -Patient/Consumer demand for more organized care delivery system -IT system of Healthy Planet investigated to support	-Major competitor with large incentive to better perform in bundled market -Many consumers changing to a more "demand" based pattern with the retail clinics

STEPS TO DEVELOPING A VALUE-ADDED PRODUCT

Invest in Care Management Infrastructure

Reinforce Relationships with Physicians

Performance Improvement and Narrowed Network

Engagement with Large System with years of experience:

HEALTH SOLUTIONS® powered by Geisinger®

SILOS AND FRAGMENTS

Our Care Management Delivery Silos	Our At Risk Contracts	Our Current Rate of Success and Opportunity for Improvement
Kettering Medical Center	UHC ACO Contract	Elevated Readmissions Rate
Sycamore Medical Center	Employee Health Plan	High ED Utilization Patterns
Soin Medical Center and Greene Memorial	Primary Care CPC measures	Increasing cost accountability
Fort Hamilton Hospital	BPCI Advanced Application	MSPB point option
Grandview and Southview Medical Centers		
Kettering Physician Network		
Employee Health Plan		
Care Transitions Team		
Independent CPC + practices		

STEPWISE APPROACH TO BRINGING ALIGNMENT

Care Management Training

- Bring the teams to a baseline knowledge level of concepts and application

Policy and Process Development

- Create infrastructure for each portion of the care management team to rely upon at various levels

Physician and Senior Leader Engagement

- Capture the physician and senior leaders with team based care learning to support initiative

Photo: BlessingWhite

Embedded Link…

OUR MESSAGE TO OUR ENTIRE NETWORK

WHERE TO START AND WHY?

Policy Development

- Creates the guardrails and structure to what the teams will be doing daily
- Gives clarity to the teams on what portions of work will be performed at each level of care
- Provides reassurance to the care manager that patient care management will have specific activities completed at each level of care
- Develops accountability to the patient and other team members as they are a position within the greater continuum of care

IDENTIFICATION OF A HIGH RISK PATIENT

- High Risk Diagnoses:
  - CHF
  - COPD
  - Sepsis
  - Pneumonia
  - Uncontrolled Diabetes
  - Stroke
- Cognition difficulties
- 10 or more medications
- Multiple Barriers to care or safety concerns

- Utilization History
  - 2 or more hospitalizations in the last 90 days
  - Readmission within the last 30 days
  - 3 Emergency Department visits within the last 180 das
  - New skilled nursing facility admission or recent exacerbation of long term patient

Photo: Healthcare Informatics Magazine

AT RISK?

With fixed resources within our care management enterprise, we decided to focus our employee energy on those patients where our network holds greatest risk.

Identification of these contracts can be difficult for the care management end-user to recognize within the daily workflow

Flagging system must be in place to reduce the time necessary screening patients for appropriate services

CARE MANAGER EXAMPLE
PATIENT LISTS
HIGH RISK=≥ 30

Name	DOB	Risk Score	Readmission?	At Risk Contract?	PCP
Patient A	01/01/2018	50	Yes	Yes	Employed
Patient B	02/01/2018	40	No	No	Employed
Patient C	03/01/2018	30	Yes	Yes	Independent
Patient D	04/01/2018	50	Yes	No	Independent
Patient E	05/01/2018	20	No	Yes	Employed
Patient F	06/01/2018	20	No	No	Independent

High Risk Score + At Risk Contract = CARE MANAGEMENT ACROSS CONTINUUM

Foundation of KHN Care Management: Step 1

Care Management Program Guide

- Overarching awareness of the network infrastructure
- Defines key concepts and application
- Outlines training needs of the team

Transitions Admission Care Path

- Who is seen?
- What activities are performed?
- How will they transition to next level?

Non Admission Care Path

- Who is seen
- What activities are performed?
- How will they transition to the next level?

ADDITIONAL CRITICAL POLICIES

Care Plan Policy

Enrollment

Follow up

Care Coordination

Referral Between Care Managers

Referral to Members of the Health Team

Medication Reconciliation

Case Closure

HOW CAN WE APPLY THE CONCEPTS?

Patient High Risk

At Risk

Non-Employed KPP

Employed KPN

KHN Care Management

CPC+ Care Management

Care Transitions

Care Transitions

KPN Care Management

<u>Team of At Risk Contract Support Care Management</u>
-Current: 3.0 FTE
-Supports Non employed practices manage high risk cases

<u>Team of Transitional Support Care Management For Unattached Patients after Hospitalization</u>
-Current FTE 6.0
-Supports all High Risk/At Risk cases
-Primary focused on sickest risk with SNF use
-Will expand to Home Based Care

<u>Team of Primary Care Based Care Management</u>
-Current FTE 13.0
-Supports PCMH and CPC+ initiatives
-Will care manage high risk cases within PCP practice

TRAINING THE TEAM

XG Learn:

42 hours of baseline Care Management Knowledge

On-site reinforcement of learning through staff meetings

Network-wide meeting on Enterprise Change

Disease specific CEU

Onboarding changes

Epic Education on Healthy Planet Deployment

TERMINOLOGY

PHYSICIAN AND SENIOR LEADER ENGAGEMENT

- Monthly Learning Sessions
- Communication Plan
- Work Groups

TEAM BASED CARE

Governance by Physician Leaders

Implemented by Senior Leaders

- Critical component of successful enterprise-wide care management
- Understand the value of the other members of the team
- Buy-in on most complex, time-consuming cases
- Role designation and clarity of work

COMMUNICATION

- Monthly email notification on large changes in practice
- Monthly President Meeting and Executive Leader Meeting on status report
- Monthly Care Delivery (KPP Board) Updates on KHN Enterprise Care Management
- Team education plan transparent and cross-continuum
- Manager-level workgroup to disseminate information

DEFINING SUCCESS

Must first understand the audience…

OVERARCHING METRICS FOR SUCCESS

Productivity

- Enrollment and Case Closure
- Maintain case volume: Transitions: 50/month, Disease Management: 100/month
- Attain case closure within timeframe: Transitions: 30 days, Disease Mgmt: 6-12 months

Timeliness

- Contact with Patient/Family
- Connect with patient in timely manner: Transitions: 2-5 days, Disease Management: 5-14 days
- Perform medication reconciliation at first or second session
- Discuss advanced care planning at first or second session

Care Needs

- Resource Allocation
- Provide patient/family with the necessary resources for success prior to closure
- Reach % patient-specific goals prior to closure

OVERARCHING METRICS FOR SUCCESS

Utilization

- Post Engagement

- Reduce At Risk case readmission rates by 5% in year 1
- Reduce At Risk ED utilization by 10% in year 1
- Increase PCP appts in At Risk patients by 10% in year 1

Capture

- % Engaged in care management

- Care managers will be engaged with 75% of all "High Risk" patients in At Risk arrangements
- Handoffs from inpatient service will be complete on 75% of all High Risk/At Risk Patients

Communication

- At Risk Contracts

- Each care management enterprise will communicate with the "At Risk" care team at regular intervals
- Each care manager will log 100% of activities within Healthy Planet on day of service

PROGRAM GOALS

Ultimate Wildly Important Goal (WIG)

Add Value in the Eyes of the Customer

Value = Outcome/Cost

The 4 Disciplines of Execution

Lead Measures

- Operational
- Care Manager or Physician Level

Lag Measures

- At Risk Contract Level
- Enterprise Care Management Impact

Physician Time Saved, Patient Health, and Outcomes Attained

Care Management Activity Cost

CUSTOMER: PHYSICIAN

Provider Time

- Care manager will educate patient on disease specific items
- Care manager will coordinate services needed
- Care manager will summarize care delivered in EHR

Patient Health

- Care manager will partner to identify goals and work with patient to meet goals
- Care manager will assist in closing care gaps
- Care manager will support patient in healthy lifestyle factors

Outcomes

- Care manager will support the patient in keeping physician appointments and other key drivers for success
- Care manager will work to break down barriers to care

Patient Time Preserved, Patient Health and Satisfaction

Care Management Activity Cost

CUSTOMER: PATIENT/FAMILY

Patient Time

- Care manager will support the patient in reducing time spent accessing the health system through a more coordinated care delivery

Patient Health

- Care manager will partner to identify goals and work with patient to meet goals
- Care manager will perform medication reconciliation to create clarity and avoid errors
- Care manager will support patient in healthy lifestyle factors

Satisfaction

- Care manager will support the patient in keeping physician appointments and other key drivers for success
- Care manager will work to break down barriers to care

NEXT STEPS FOR KETTERING HEALTH NETWORK

- Finish Training Deployment across 2018-2019
- Finalize Policies with Internal Oversight Committee
- Kickoff Meeting June 2018
- Healthy Planet Build and Training Summer 2018
- Publicize the Dashboards at each Care Management Delivery Site
- Continue through the PDCA cycle…

QUESTIONS