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INDUSTRY INSIDE EDGE

Emerging New Models of Care: Growing the Ecosystem

INTRODUCTION Healthcare reform continues to roll as innovative health systems are no longer waiting on the sidelines to develop new models of care. They're not looking to CMS to convert reimbursement to value-based payments. The trigger has worked. The forces are in play. Healthcare is shifting to more distributed, consumer-engaged and less expensive models of care.

Is it too little, too late to stem the tide of outside disruptors? We talked to experts from Optum, Sentara Healthcare, Partners HealthCare and Intermountain Healthcare to describe the convergence of factors occurring, the internal disruption that've fostered and the new models of care that are emerging as a result. You be the judge.

Moment of convergence

"A number of factors are converging at this time, making some of the new care models plausible," says John Kontor, MD, senior vice president for provider technology services at Optum. "Most of these trends are being adopted by payors and patients, who are driving the new models—while provider organizations are the ones trying to figure out how to actually deliver sustainably on these models."

He cites three key factors in convergence:

1. **A progressive shift toward value-based payment models**
   "We're at an interesting crossroads. The slope has been steep, especially with Medicare Advantage. Now there's a little shallowing of that slope," says Kontor.
2. **The progress of patient-facing technologies and the shift of consumer-centered technology toward healthcare**
   "This trend is creating engagement in a way that we've not experienced before. For a long time we tried to engage patients through portals, but about the only thing they ever used EHR portals for was to print immunization records. PHRs [personal health records] failed in the 1980s. Now, with wearables, Google and Amazon, who have the eyes and trust of the populace," we're truly engaging consumers and patients, he says.
3. **ONC just announced a proposed new rule that could change everything**
   "It's been really difficult for diverse care teams to access data because it's been locked up in EHRs. EHR vendors have gotten better at unlocking data but not anywhere near what's necessary. However, the announcement https://searchhealthit.techtarget.com/news/252457399/ONC-CMS-drop-information-blocking-interoperability-rules-ahead-of-HIMSS last week by ONC

OPTUM™

John Kontor, MD, SVP, Provider Technology Services, Optum

"Most of these trends are being adopted by payors and patients, who are driving the new models—while provider organizations are the ones trying to figure out how to actually deliver sustainably on these models."

[The Office of the National Coordinator for Health Information Technology] means the healthcare industry has reason to be optimistic. The ONC published a new set of regs and rules to require every entity—EHR vendors, payors and providers—to make data accessible. The reason is to really accelerate the timeline and make data access affordable," says Kontor.

Driven by patients and payors

Some provider organizations are developing new models of care, he notes, but those are specific instances when it makes them more efficient at managing populations. Telehealth is a prime example of an effort by many health systems to reduce the total cost of care. However, Kontor says, "I really think we're going to see more and more patients and payors become the driving forces of new care models. Payors have the bottom line in the total cost of care and patients want ease of access—and potentially to have more diverse sets of options for care."

In the current model, he says, "if I've got A-fib, and I have a primary care doctor as orchestrator, theoretically once we free up the data and enabling technologies get more intelligent you can see how patients would be attracted to that more open ecosystem.

"With the eventual convergence of payors, providers and patients under value-based care, with better access to data and all with wearables, you can see how we can create an ecosystem that's a digital version of the Kaiser model. You can have a company that can monitor my Apple Watch, another that monitors your hospital stay in real time. It may be your insurance company, it could be a provider organization—likely in a merger—or it might be Google, Amazon or Apple," Kontor says. "This is a watershed moment; we've reached critical momentum. The ONC proposed reg is a stake in the ground, forcing the industry to get over the final hump."

Taking what he calls a different slant on new models of care, Kontor believes that new processes of care may be as important as new models. "It's a new wave with technology making the process of care more efficient. For example, prior authorization—the bugaboo of managed care in the 1990s in which a so-called clerk at an insurer could deny care prescribed by the patient's physician,

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and the number one complaint about insurance companies today—is on the verge of being automated by big payors like United Healthcare (which owns Optum).

Reducing friction

A number of third-party firms are working on technology-enabled techniques to automate prior authorization or eliminate it altogether. That takes away the pain and friction with the goal to reduce denials. Traditionally, prior authorization is a payor-driven process (that includes government) to help limit inappropriate spend. It's an inefficient process and automating it helps everybody. Many prior-authorization actions result in appeals that take time and money. Digitization of PA theoretically can tell a provider immediately if the procedure is authorized. Today it's a very human process marked by physicians or office staff being on the phone with clinical staff at insurance companies.

AI and machine learning now give us the promise of freeing PA up from a being a very cumbersome manual process. "We can really accelerate the process," he says. "For example, in the current world of the EHR you have to write a complex set of rules. If the patient has osteoporosis and a number of other comorbidities, it's ok for the doctor to order a scanning of vitamin D, but that's a very drawn out process. With AI and machine learning a machine can write some rules for that."

On the clinical level, recent research validates that any new care model will continue to incorporate clinical decision support (CDS). Dr. Kontor co-authored a study with Cedars Sinai on CDS's impact on the total cost of care. The research examined 26,000 admissions at Cedars Sinai and compared them to Choosing Wisely guidelines. The results were impressive. When physicians did not follow the computerized alerts then 29 percent increased the cost of care for an average of 6.2 percent higher total or $944 per admission. "It's the first evidence that computerized alerts redound to the total cost of care," he says.

'The dis-ease of life'

"Healthcare historically has been a very disease-based model," says Jordan Asher, MD, senior vice president and chief physician executive at Sentara Healthcare, a Norfolk, Va.,-based health system with 12 hospitals and a 500,000-member health plan serving Virginia and North Carolina. "Social determinants have been secondary. I'm focused on the dis-ease of life. We need to think of people within a humanistic context first. It may seem obvious but it's a huge nuance change. If I'm interacting with you I first have to know who you are and how activated and engaged you are in your own care."

Insignia Health licenses the Patient Activation Measure® (PAM®), a system to measure and improve patient activation. The Insignia Health website features nearly 500 independent research papers documenting how improved patient activation results in better clinical outcomes and lower costs.

SENTARA®

Jordan Asher, MD, SVP & Chief Physician Executive, Sentara Healthcare

"The basis of the new care model is: how do I simultaneously increase activation while treating the patient clinically? Because, if you're not activated, you're not going to participate in treatment and improve in the most meaningful way," he says.

Asher arrived at Sentara just six months ago from St. Louis-based Ascension where he led care management and its implementation of PAM.

"The basis of the new care model is: how do I simultaneously increase activation while treating the patient clinically? Because, if you're not activated, you're not going to participate in treatment and improve in the most meaningful way."

Nothing new under the sun

"I don't create anything new. I take a lot of what works in other spheres and try to put it together in new ways," he says. That includes a list of 15 determinants of health including disease-process needs, activation/engagement models, social and spiritual needs, financial mindset category and race, ethnicity and cultural context.

"Care models must be designed to fall into activation/engagement segments correlated to the patient's priority objectives," says Asher. "Your activation-health determination is so important to start with and then you work across the other health determinants, including your disease state. If I can increase your activation level I can have greater impact on your health. That's a more human-science approach versus physiological science. Effective care models should consider their first order to be human science and second order to be physiologic science."

Human science driven by activation will consider factors not only like a person's access to transportation to see her doctor or ability to pay for medications, but whether that person *cares* about going to the doctor or taking meds. "Let's talk about *why* you want to get well. The patient might answer, 'I want to make sure I can get to my son's graduation,'" he says.

If the activation—or motivation—level is so low, helping that person help themselves is much harder. If we can increase their activation level, they help solve their own problems and thus are more likely to be receptive to clinical interventions. "Measuring the patient's activation gives me a much better understanding of who you are and where I need to start with you," says Asher.

New way to stratify

Patient/consumer activation can turn a traditional population-health strategy on its head. "How this plays out," he says, "is that you don't begin to stratify people by high-cost. Instead, once you identify your population group you do an activation score, and focus on those with low activation. You can be a high-cost person who's highly activated. I'd argue your cost is likely appropriate."

Asher sees a person's activation level as ultimately becoming a dominant part of a health-risk assessment. "Your activation level is your greatest risk. Then I'd layer on the other risk factors."

So, don't bet on Asher developing a new diabetics program. "I'd start with an activation program. That's the key point. We're conditioned to come at it from a disease-state perspective. How do we begin to think of you as a consumer and what makes you tick. It's a different frame of reference. How you educate becomes very different now. How you learn and engage depends on who you are and the problems you are trying to solve. We need to design care models that address your level of activation in ways that are much different than what we do today."

'The whole thing'

Sree Chaguturu, MD, has been chief population health officer and vice president at Partners HealthCare for only 18 months, but helped launch Partners' Population Health in 2012. Today Partners Population Health has become a launch pad itself for a slew of population-health initiatives designed as an integrated, holistic fabric.

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Sree Chaguturu, MD, chief population health officer and VP, Partners HealthCare

"We're doing the whole thing," he says. "We've designed and implemented a broad range of care models and supporting infrastructure for patients and populations. If a program is a vertical we build a horizontal component. That's all been combined together. [Visit https://populationhealth.partners.org/ for a rich trove of resources on Partners' population-health strategy and click the "Care Redesign" tab for a particular take on new models of care.]

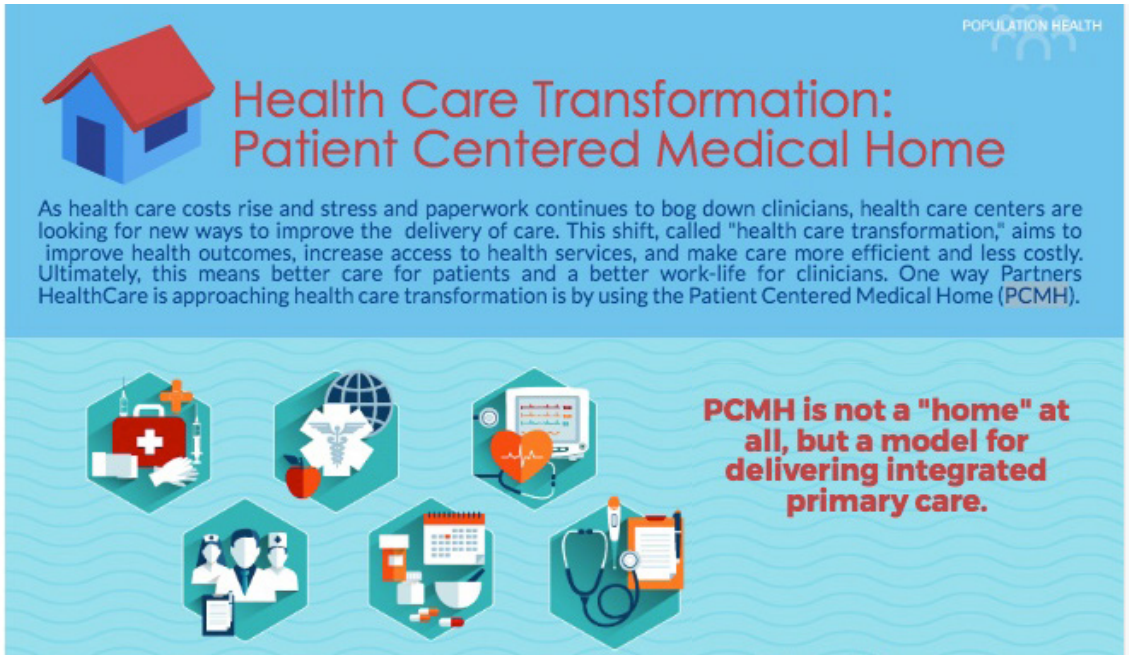
Of course, population health doesn't happen in a vacuum. Massachusetts passed healthcare reform in 2006 and again in 2012, the latter aimed at restraining cost growth to 3.6 percent or lower. "Ultimately we'd be facing price controls," Chaguturu says. As a result, Partners signed new cost-limiting contracts with commercial payors and Medicare that created the country's largest ACO.

Those initial contracts have evolved into more sophisticated commercial, Medicare and Medicaid risk contracts covering 700,000 lives, about two thirds of the lives Partners manages under primary care.

Pacing is important

"We needed to think about the clinical risk. There's a pacing to this transformation, a necessary order. We started with primary care as central to managing populations, but before that we needed to ensure primary care was organized around a new, patient-centered, data-driven, team-based model. That led us to the patient-centered medical home," he says.

[See Partners' Patient-Centered Medical Home (PCMH) at https://populationhealth.partners.org/care-redesign-programs/primary-care-programs/patient-centered-medical-home/]



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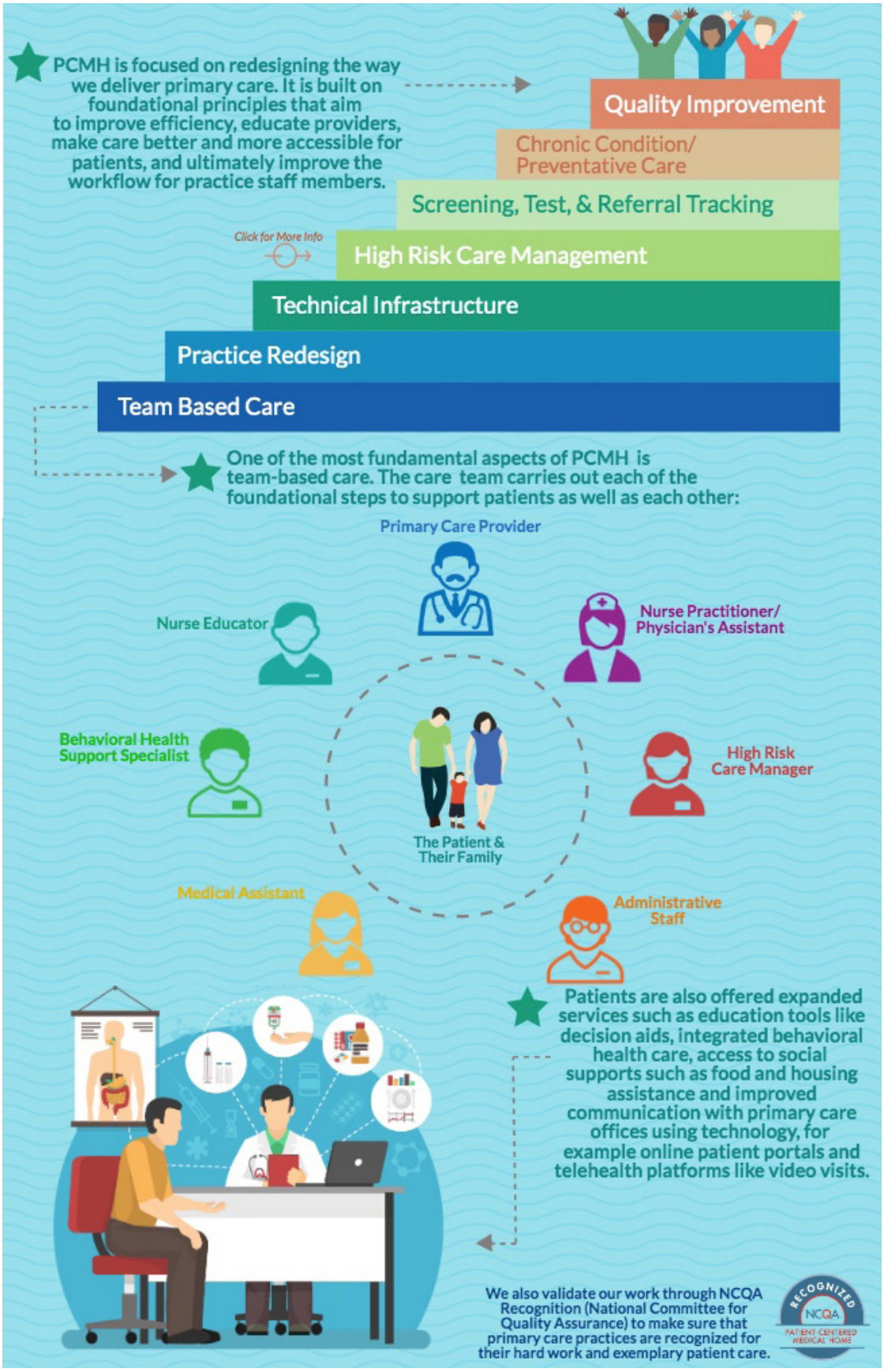
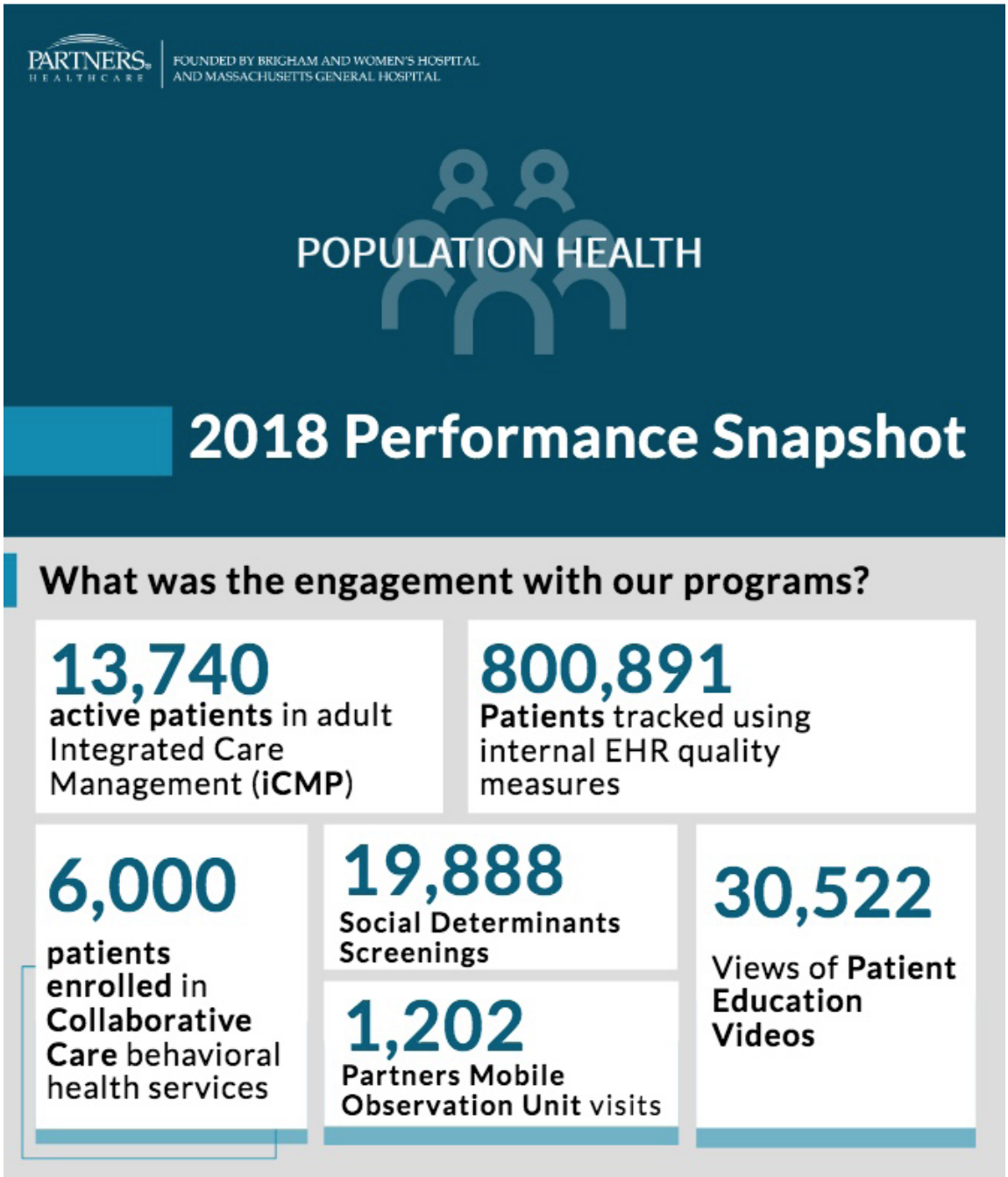


View entire infographic to see how 'PCMH Aligns with the 4 Goals of Health Care Transformation.'
PUBLICATION CREDIT: Partners Population Health
AUTHOR CREDIT: Emma Sconyers
PHOTO CREDIT: Piktochart

Also, Chaguturu's team had to segment the population to understand who was at-risk for higher costs. [see "Data at Work" https://populationhealth.partners.org/data-analytics/]

Partners uses the Epic EHR and hired Health Catalyst to build its data warehouse and predictive algorithms. "We've had more than a decade of identifying high-risk patients and developing care for them. We have 100-plus care managers who work with primary care physicians. As a result we've reduced ED visits and hospitalizations by 6 percent and 8 percent, respectively, for Medicare patients."



View entire infographic to see the impact of Partners' population health programs.

Analytics and evolution

"The PCMH, data and analytics are foundational on our journey to value-based care," and the process continually unfolds, Chaguturu says. "We began to see factors like mental health as a big burden without any caregiver. So we integrated behavioral health into protocols, methods and work types. We added an initial assessment of depression."

Behavioral health elements include:

- Team-based Care—support for the care team including embedded specialists;
- Substance Use Screening—built-out tools for screening;
- Virtual Cognitive Behavioral Therapy—digital cognitive health;
- Resource Finding—assets to refer people to community-based agencies;
- Care Management for Medicaid Patients;
- Recovery Coaching—patients who've been through the experience; and an
- Integrated Substance Use Disorder Team.

[To explore how each element is further defined, check out Partner's behavioral health strategy for population health at https://populationhealth.partners.org/care-redesign-programs/primary-care-programs/behavioral-health-program/]

"For example, I had a patient who came in with severe depression," he says. "She and I recognized she wanted to start meds, but she didn't want a med that caused weight gain. I was able to do an e-consultation that got an answer within six minutes of a medication that wouldn't cause weight gain. "

Building on telehealth, Chaguturu says, "We recognize there's lots of opportunity around virtual care, including doctor-to-doctor asynchronous communication and patient-to-doctor synchronous communication, both of which can be done on either over the telehealth or website platform."

e-consults, virtual care and remote monitoring

Cost studies revealed surprises. "e-consults with inpatient specialists had more impact than virtual care, in large part because it helps avoid unnecessary tests downstream," he says. Remote monitoring shows value for blood pressure, CHF and diabetes. Partners is exploring use of Mobile Messenger and Virtual Health coaching for outpatients.

"We believe in a comprehensive approach to population-health management. We realize that it takes a journey," says Chaguturu, who practices post-acute and transitional care. Those specialties are riddled with practice variation, especially in skilled nursing facilities [SNFs] and long-term care [LTC] facilities. "As we explore homecare solutions for lower-acuity patients, we've implemented an algorithm that helps determine whether a patient should go to an LTC or rehab facility, so we can track when they enter and leave."

Partners has built a "high-value" network of independent SNFs, working with them to improve quality and efficiency. It has also expanded into hospice. "At end of life patients are never asked what they want. We ensure we identify their preferences through our serious illness care program. And for patients choosing hospice we've built out a home-based palliative care program," he says.

Partners has also launched a new model of hospital care called the Home Hospital Program, which has admitted 250 patients in the past two years.

And yes, patient engagement is still a viable term at Partners. It has developed patient decision-making and education tools to optimize the patient and consumer experience.

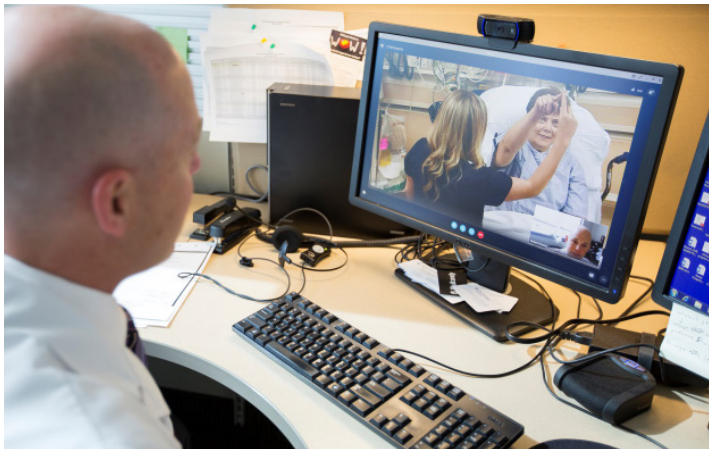
"We've had more than a decade of identifying high-risk patients and developing care for them. We have 100-plus care managers who work with primary care physicians. As a result we've reduced ED visits and hospitalizations by 6 percent and 8 percent, respectively, for Medicare patients."

Telehealth with returns

Mike Phillips, MD, is a partner with Intermountain Ventures, an $80-million evergreen venture fund that invests in direct-to-consumer technology-based models like telehealth and the virtual hospital.

"We invest in products we can use to achieve higher quality and lower cost of care," he says. "We're a not-for-profit so anything we do is designed around improving care."

Several of these new models are working today. A tele-ICU covering 330 beds across 30 hospitals has resulted in decreased mortality and length of stay (LOS). It's has also improved quality by standardizing care across its application area. Tele-stroke and tele-hospitalist programs cover 31 hospitals.



Intermountain's telestroke program at work: the provider side.

Transcending mountains

"We're in the Intermountain West where the service areas are crazy in their expanse, sometimes 500 miles. That's a wide space to care for patients, so you need technology," he says.

"We're trying to keep care local, do it at lower cost and improve it for patients, whose support structure is at home. Someone having to visit a sick relative 250 miles away faces an enormous burden. And physicians are limited in what they can do in such a wide geography. With just a little bit of help from telehealth technology patients can visit with master clinicians," says Phillips, adding that small rural hospitals—often the biggest employer in town—can be important nodes in a telehealth care model. "Telehealth reinforces the concept that care is delivered locally and not on a helicopter."

INTERMOUNTAIN VENTURES

Mike Phillips, MD, Partner, Intermountain Ventures

Direct-to-consumer (D2C) telehealth can save money. "We charge $49 for a virtual visit which translates to $130-per-visit value to Intermountain as a result of fewer visits to the ED and urgent care clinics. We've had a good conversion rate of patients. It's also created a new volume of patients and is a huge patient satisfier," he says.

Intermountain's telestroke program at work: the patient side.

Launched two-and-a-half years ago, Intermountain's telehealth program, called Connect Care Pro, has grown to 35,000 patients, scoring 4.9 out of 5.0 in patient recommendations. "Patient satisfaction is high because we address patients' problems." It uses the American Well technology platform, while Intermountain's inpatient telehealth uses an in-house system that sets up cameras and other equipment at the hospital bedside.

Connecting with master clinicians

Provider to provider (P2P) telehealth relies on the concept of master clinicians, including physicians, advanced practice clinicians and nurses working as a team. The team brings extensive experience, best practices, and established care pathways to the bedside working hand-in-hand with local providers.

Currently residing in Intermountain's supply chain center, Connect Care Pro is moving to a 20,000-square-foot space co-locating with the ICU, hospitalists and telehealth administration. The hub allows economies of scale, redundant internet and secure places for people to deliver care remotely with an always-on system.

"The question almost never asked is 'What are you not going to do as a result of using telehealth?' We call it asset-light growth, which means less spending on local infrastructure. It's a change in how we deliver care and what we invest in. This is a different kind of investment which leverages community resources like homes and cellphones—all kinds of things that as a health system we previously overlooked even though we use Uber and Airbnb in our personal lives," says Phillips.

"It's the new way to deliver care. There is little added value to sitting in a waiting room or in some cases getting on a helicopter. Our focus remains on helping our patients lead the healthiest lives possible. We're just using new technology," he says.

INTERMOUNTAIN'S LAUNCHES AT-HOME PRIMARY CARE

Intermountain Healthcare is expanding its home-based services this year to include primary care, some traditional hospital-level services and palliative care for patients with chronic or serious medical conditions.

The new service, called Intermountain at Home, is a comprehensive program that will expand established Intermountain Homecare & Hospice services to prevent or shorten hospital admissions, and enable patients to receive care where they prefer to receive it—in their homes.

"Intermountain at Home is a thoughtful, proactive and preventive healthcare approach that extends complex medical treatment and technologies beyond clinics and hospitals to help us care for patients in their own homes," said Seth Glickman, MD, Intermountain chief medical officer of community-based care, in a press release.

Home-based nursing services were introduced at Intermountain in 1982 to transition patients safely home after hospital discharges. Since then, Intermountain Homecare & Hospice has continued to grow and now supports patients with home-based post-hospital, palliative and end-of-life care as well as medical equipment maintenance.

Intermountain at Home will incorporate these services, and add other functions, over the next several months. These include ongoing home check-ups with a primary care physician or advanced practice clinician. These providers can address their patients' medical needs and symptoms of chronic or serious medical conditions, without requiring patients to travel to a hospital or clinic.

Intermountain at Home will also help patients transition directly to new home-based, hospital-level services that will include remote monitoring, expanded telemedicine capabilities and virtual urgent care visits.

For more details check out: https://www.globenewswire.com/news-release/2019/03/11/1751331/0/en/Intermountain-Healthcare-Launches-New-Intermountain-at-Home-Service-to-Enable-Patients-to-Receive-Clinical-Care-at-Home.html

"We invest in products we can use to achieve higher quality and lower cost of care. We're a not-for-profit so anything we do is designed around improving care."

COUNTIES AND COMMUNITIES

Lisa Nichols, assistant VP for community health, Intermountain Healthcare, and co-leader, The Utah Alliance for the Determinants of Health

Lisa Nichols, assistant vice president for community health at Intermountain Healthcare, is co-leading "The Utah Alliance for the Determinants of Health," a demonstration project in two counties—Weber and Washington—in roughly opposite corners of the state. Intermountain is contributing $12 million in the three-year demonstration project. This charitable contribution will be invested in community-based organizations to address gaps in the resources available to meet community needs.

"Our mission is to achieve healthier communities, lower healthcare costs and be a model that can be replicated in other areas of the country," she says. "We know health systems account for only 10 percent of a person's health. It's really about social and environmental conditions where people live."

Convened by Intermountain, the Alliance includes city, county and state agencies as well as community-based organizations collaborating to address social needs—housing instability, utility needs, food insecurity, interpersonal violence and transportation—living in the two counties. It will focus on members of SelectHealth, Intermountain Healthcare's 35-year-old health plan covering more than 850,000 lives in Utah and Idaho. The goal is to identify best practices focused on social determinants of health and rural healthcare in the same conversation, use CMMI principles as guidance in building models and to scale those models across the system to make healthcare more affordable.

Designed within the Accountable Health Communities model of CMS, the Alliance's guiding principles will be *assessment, assistance* and *alignment*. "Assessment applies both proactively and at the point of care. We use an analytics-based risk-predictive model to identify individuals with the highest total cost of care. Assistance means helping people navigate healthcare—and non-health resources like foodbanks and other community organizations—with the help of community health workers. Alignment means making sure we're addressing the gaps between needs and community resources," notes Nichols.

continued >

Small, commonsense things can stand in the way

For example, "When you talk to the food bank they say we have plenty of food and we have a lot of people who come to us. But they need carts for people using public transportation to get their food from the food bank to home. We are coordinating a resource inventory and improving coordination between health and social service providers. The Alliance includes a digital tool so a referral can be made from a health provider to a foodbank," she says.

The tool allows coordination between social service agencies. "It's like an EMR for social determinants of health," says Nichols. Most tools have a consumer-facing app but the priority is communication between the health system and community agencies. "We spent all of 2018 planning. We've started testing with just 48 participants. We've selected a vendor for the digital tool and rolling it out in third quarter."

The alliance's scope is 1,200 participants. "The goal is to understand and scale it, but it starts with individuals. We worked with a homeless woman last week to get her a housing voucher and know homelessness correlates to poor health outcomes. She had 69 cents and needed $15 to get a criminal background check. That same $15 was standing between her and housing. Alignment is meeting those resources. Another example is a person needing a pair of steel-toed boots. Small common-sense things."

Conclusion

We're at the proverbial inflection point. New models of care are emerging—and have already emerged—as the factors of value-based payment, digital technology and consumerism converge. They have put the "pop" back into population health for health systems. While driven by consumers and payors, trailblazing health systems have "woke" to the fact that healthcare is both no different than other industries and yet very different. The difference does lie in the complexity. That's why the health systems of the future are moving quickly while not hurrying.

"The journey we've taken is one of incremental expansion as care management evolves," says Partners' Chaguturu. "We're building a tapestry of medical management programs. There's no silver bullet in controlling healthcare costs. It requires a variety of programs and initiatives. The challenge is to determine what the right order and pacing of implementation is in these medical management programs. You have to build political and financial will. While you don't need risk management to build into fee for service, if your hospital is at capacity, you need medical management programs to become more efficient. Depending on your marketplace, you might choose a different kind of medical management and pace. But there's no question medical management is needed in both worlds."

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