Population Health Management and the Next Generation of Clinical Integration

Mega Conference
Wisconsin Dells, Wisconsin
January 20-22, 2016
GE Healthcare Camden Group

Dedicated to the Transformation of Healthcare

One of the nation's largest healthcare advisory firms. We work side by side with our clients to design strategy, formulate improvements, and achieve measureable outcomes - sustaining results well past engagement closure.

Our integrated and innovative solutions combine multidisciplinary expertise and thought leadership with complex modeling and financial analytics.
Our Practice Areas and Services

**Population Health Management**
- Clinically Integrated Networks, ACOs, Population Health Alliances
- Bundled Payments
- Continuum of Care Network Development
- Care Model and Care Management Programs
- Population Health Analytics
- Health Plan Advisory and Payer Contracting

**Strategy and Leadership**
- Strategy Advisory, Development, and Activation
- Strategic Resource and Cost Management
- Outcomes-Based Process Improvement
- Management System
- Leadership System
- Leadership Development
- Change Management

**Financial and Transaction Advisory**
- Transaction Advisory and Process Management
- Pre- and Post-Merger Efficiency Studies
- Feasibility Studies
- Business Valuations
- FMV Compensation Opinions
- Payer Strategies and Contract Review

**Physician Services**
- Practice Transformation
- Performance Improvement
- Physician Compensation Plan Redesign
- Patient Access and Throughput
- IPA/Medical Group Formation and Consolidation
- Governance and Management Structure Redesign
- Revenue Cycle Improvement

**Care Redesign and Delivery**
- Care Access
- Care Design
- Care Management
- Capacity Optimization and Patient Flow
- Regulatory Compliance and Accreditation Preparation
- Workforce Management
- Hospital-Wide Turnarounds
- Facility Design
- Analytics for Hospital Operations and Clinical Transformation
The Changing Healthcare Paradigm

- Hospitals are no longer at the pinnacle of care; they are a provider on the continuum
- Continued pressure to reduce overall cost of care
- Shifts in reimbursement structures based on value, not just volume
- Increase focus on consumerism in healthcare services
- Greater need to collaborate vs. compete in order for providers to remain viable
Cost Management – America’s Healthcare Transformation

- Government spending on healthcare continues to rise due to an aging population
- Rising costs per enrollee has contributed to growth of spending in programs
- According to the CDC, about two-thirds of Medicare beneficiaries had 2 or more chronic conditions
Trends in Inpatient Utilization in Community Hospitals

An upturn in profitability in the face of declining admissions

Source: Avalere Health analysis of American Hospital Association Survey data, 2012
Goal: Increase Alternative Payment Models

By 2018, 50 Percent of Payments will be through Alternative Payment Models

### Historical Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Alternative payment models (Categories 3 to 4)</th>
<th>Fee-for-service (“FFS”) linked to quality (Categories 2 to 4)</th>
<th>All Medicare FFS (Categories 1 to 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0%</td>
<td>~70%</td>
<td>~70%</td>
</tr>
<tr>
<td>2014</td>
<td>~20%</td>
<td>&gt;80%</td>
<td>&gt;80%</td>
</tr>
</tbody>
</table>

### Goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Alternative payment models (Categories 3 to 4)</th>
<th>Fee-for-service (“FFS”) linked to quality (Categories 2 to 4)</th>
<th>All Medicare FFS (Categories 1 to 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>30%</td>
<td>85%</td>
<td>85%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
<td>90%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Source: CMMI, Bundled Payment Summit, June 2015
Traditional Model of Care Based on Fee-for-Service

- Patients were directed through physicians into the hospitals for services
- Hospitals promoted their breadth of services to attract physician referrals
- Patients traditionally saw themselves aligned with their physician and hospital
- Duplication of services and redundancies in care drove the revenue model
The Result…

A strong and growing sense among organizational leaders of a need to recalibrate strategy.

- Nothing is off the table
- Underlying business models up for reconsideration
- Shift to greater collaboration
- Innovation as the basis for organizational change management
Emergence of Clinically Integrated Networks

CINs are the new value-based organization designed to produce “value” in care delivery

- CINs promote systems to organize and integrate care to create “value”
- “Value” is produced through reducing the cost of care AND proven quality performance
- Demonstrating “value” yields economic opportunities for providers in the CIN
- Keys to success is using “value” to drive more patients into the network, decrease cost-of-care, and create new value-based revenue streams

Question: Where do you fit within the new value-based organization?
Overview of Clinical Integration

Emerging as the predominant approach to managing populations, engaging in value-based contracts and in coordinating care among providers.

“Clinical Integration...is an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality”

Drivers of Clinically Integrated Care

**Key Drivers**

- Cost Management
- Data Aggregation
- Coordinated Care Management
- Minimize Leakage
- Coordinated Network of Providers
- Aligned Incentives
- Patient Access/Outreach

Value-based care drivers depend on a variety of organizational capabilities.

**Market Pace of Change**

- Fast
- Fast/Moderate
- Moderate
- Moderate/Slow
- Slow

Source: The Camden Group
The Evolution of Clinically Integrated Care

**Phase 1**
*Develop the CI Network*
- Build the CI network infrastructure
- Establish quality programs, incentive models, and outcome tracking
- Develop care management infrastructure
- Enter into limited risk-based contracts

*Revenue opportunities through savings: 5 to 10 percent*

**Phase 2**
*Create CI Collaborative*
- Leverage infrastructure with providers in new markets
- Develop products
  - Partner with payer(s) (carrier as the middle-man)
  - Larger provider network
  - Access to membership
  - Direct to employer contracts

*Revenue opportunities through savings and new revenue streams: 10 to 20 percent*

**Phase 3**
*Provider-Sponsored Health Plan*
- Full service provider of ACO services
- Offer insurance products direct to the market
- Commoditize products and services
- Direct full-risk contracting with employers
- New reimbursement models
- Advanced benefits designs

*Revenue opportunities through risk arrangements, service offerings: 10 to 15 percent*

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Source: The Camden Group

GEHC Camden Group | 1/20–22/2016
Risk vs. Capabilities

The immediate strategic imperative is to build a baseline infrastructure and transitional capabilities that will aid the development of value-based care.

**Capabilities**
- Enterprise care/utilization management
- Total cost of care management
- Cost management
- Risk-contracting evaluation
- Analytics, reporting, and monitoring
- Provider network development
- Referral management
- Quality programs
- Care management

**Strategy**
- Transition to full-risk contracts directed to employers with the focus on further reductions of “cost of care”
- Expand CIN to a regional collaborative with the addition of provider organizations to drive membership
- Develop CIN with focus on provider network development and value-based contracts

Source: The Camden Group
Trends in Wisconsin Health System Consolidation

- Shawano merges with Thedacare
- Ministry joins Ascension Health Alliance (Parent of Columbia St. Mary’s)
- Ministry buys Wheaton Franciscan’s Stake in Affinity Health System
- Meriter Health Systems joins UnityPoint
- Aurora buys 49 percent in Bay Area Medical Center
- Watertown Regional sell majority stake to LifePoint Hospitals Inc.
- Wild Rose Community Memorial Hospital merges with ThedaCare
- SSM Health Care buys Dean Health Systems
- Community Memorial joins Hospital Sisters Health System
- North Star Health System joins Aspirus
- Mercy and Rockford Health System merge
- SwedishAmerican and UW Health merge
- Aspirus buys Riverview Hospital Association

Source: The Camden Group
The Integrated Health Network

- 5,700+ physicians and participating providers
- 555 clinics
- 45 hospitals
- 85 continuum of care partners
AboutHealth

- 7,000+ providers
- 7 health systems
- 47 hospitals
- 90 percent of Wisconsin has accessible care offered through AboutHealth
Cannot Forget the Payers: Alignment of Needs

- Provider capabilities
  - Clinical expertise
  - Proficient in managing the patient’s care
  - Clinical technology and resources
- Provider needs
  - Access to membership
  - Assistance with population health infrastructure (analytics, care management, technology)
  - Advance risk-based contracting support

Value-based Care focused on increasing access, reducing costs, and improving quality of care

- Payer capabilities
  - Business and insurance management expertise
  - Proficient in understanding encounter drivers of cost
  - Access to employers
- Payer needs
  - Access to an aligned clinical network
  - Assistance in clinically managing the patient across the continuum
  - Support with care management and coordination

Source: The Camden Group
What Types of Affiliation(s) Best Positions Your Organization?

<table>
<thead>
<tr>
<th></th>
<th>Option 1: “Go it Alone”</th>
<th>Option 2: Collaborative CIN</th>
<th>Option 3: Contract/Affiliate with 1 or Both of the “Super CINs”</th>
<th>Option 4: Join 1 of the Super CINs</th>
<th>Option 5: Merge with a Health System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention of local control</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Access to population health tools and resources, and big data</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Participation in broader network, shared savings, new payer agreements</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
<td>Medium</td>
</tr>
<tr>
<td>Additional capital requirements</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
</tr>
<tr>
<td>Risk of not clinically integrating and not delivering high quality at low cost</td>
<td>High</td>
<td>Low/Medium</td>
<td>Low/Medium</td>
<td>Low</td>
<td>Low/Medium</td>
</tr>
</tbody>
</table>
Economics of Value-Based Care Arrangements
External Drivers of Change

- Pressures to reduce the cost of care for employers and patients
  - Reducing the “avoidable costs”
- Continued pressure to reduce fee schedule and shift into value-based contracting
- Many acquisitions, collaboration, and mergers across healthcare
- Greater focus on data and analytics to drive performance, contracts, and reimbursement
- Expanded need for electronic health technology to improve performance and efficiencies
- Independent physicians are feeling increasingly isolated
Leading the Reimbursement Changes
Centers for Medicare & Medicaid Services Payments to Providers

<table>
<thead>
<tr>
<th>Category 1: FFS with No Link to Quality</th>
<th>Category 2: FFS with Link to Quality</th>
<th>Category 3: Alternative Payment Models Build on FFS Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments based on volume with no link to quality or efficiency</td>
<td>Payments vary based on the quality/efficiency of healthcare delivery</td>
<td>Payments linked to effective episode care management</td>
<td>Payment not triggered by service delivery and volume not linked to payment</td>
</tr>
<tr>
<td>Limited in Medicare FFS</td>
<td>Hospital value-based purchasing</td>
<td>Payments triggered by service delivery; opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are responsible for the care of a beneficiary for a period ≥ 1 year</td>
</tr>
<tr>
<td>Majority of Medicare payments linked to quality</td>
<td>Physician value-based modifier</td>
<td>ACOs</td>
<td>Eligible Pioneer ACOs in Years 3 to 5</td>
</tr>
<tr>
<td>Readmissions/Hospital acquired condition reduction program</td>
<td>Readmissions/Hospital acquired condition reduction program</td>
<td>Medical homes</td>
<td></td>
</tr>
<tr>
<td>Bundled payments</td>
<td>Readmissions/Hospital acquired condition reduction program</td>
<td>Bundled payments</td>
<td></td>
</tr>
<tr>
<td>Comprehensive primary care initiative</td>
<td>Readmissions/Hospital acquired condition reduction program</td>
<td>Comprehensive primary care initiative</td>
<td></td>
</tr>
<tr>
<td>Comprehensive end stage renal disease (&quot;ESRD&quot;)</td>
<td>Readmissions/Hospital acquired condition reduction program</td>
<td>Comprehensive end stage renal disease (&quot;ESRD&quot;)</td>
<td></td>
</tr>
<tr>
<td>Medicare-Medicaid financial alignment initiative FFS model</td>
<td>Readmissions/Hospital acquired condition reduction program</td>
<td>Medicare-Medicaid financial alignment initiative FFS model</td>
<td></td>
</tr>
</tbody>
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GEHC Camden Group | 1/20–22/2016
Transition to Risk Timing

Risks with Moving too Fast

- Reduced reimbursement rates
- Lower utilization driven by own organization
- Limited gains in market share for being low-cost/high-quality relative to market
- Unnecessary infrastructure investment

Risks with Moving too Slow

- Lost market share through tiered/narrow networks
- Reduced utilization driven by other organizations
- Inability to capture dollars for reduced utilization
- Limited leverage for aligning other providers
- Allows others to dictate your future
Financial Opportunity for Clinically Integrated Care

**Financial Impact Drivers**

- **Infrastructure Cost Savings**
  - Reduce costs through PI, shared management services, and care management infrastructure
  - Lower IT infrastructure and support costs
  - Move toward a lower PMPM cost of care model removing 10 percent to 30 percent over 5 to 10 years

- **Drive New Membership**
  - Collaborative product offerings with payers
  - Narrow network contracts with payers, employers
  - Discount pricing of clinical services or programs to other CI provider members

- **Increase Domestic Utilization**
  - Minimize member out-of-network utilization
  - Steer members to a hospital (Tier 1) or collaborative network (Tier 2)

- **Expand Service Offerings**
  - Offer “clinical excellence” service programs (i.e., Advanced Pediatric Services) to collaborative
  - Expand organized system of care opportunities
Financial Opportunity for Clinically Integrated Care

Building an attractive value proposition is critical to meeting value-based care and clinical integration goals

Objectives:
- Establish value-based care as the alignment vehicle
- Develop sufficient benefits to encourage value-based contracts

Value Proposition Components

<table>
<thead>
<tr>
<th>Economic</th>
<th>Clinical</th>
<th>Value-Added Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrated opportunities to reduce the “cost of care” and increase quality through clinical performance and patient access</td>
<td>Incorporate tools, data, and resources to enhance current patient care delivery models and improve quality outcomes</td>
<td>Create infrastructure benefits to ease challenges facing physicians focusing on the greatest need of the population</td>
</tr>
</tbody>
</table>
Value-Based Contracting

- Value-based contracting = accountability for cost and quality
- Value-based contract goals
  - Assume accountability for patients (members) within the contract
  - Manage patients around the total cost of care
  - Use quality metrics to drive outcome improvement
  - Deliver a CIN of providers
Value-Based Payment Models

- **FFS with Quality Incentives**
- **Shared Savings**
- **Narrow Networks**
- **Bundled Payments/Partial Capitation**
- **Full/Global Capitation**

Level of Risk:
- Low
- High
Key Drivers of a Value-Based Contract

<table>
<thead>
<tr>
<th>Key Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement (FFS vs. Capitation)</td>
</tr>
<tr>
<td>Cost-of-care (PMPM)</td>
</tr>
<tr>
<td>Provider/Member Attribution</td>
</tr>
<tr>
<td>Care Management and Quality Indicators</td>
</tr>
<tr>
<td>Reconciliation Period</td>
</tr>
<tr>
<td>Patient Access</td>
</tr>
</tbody>
</table>

Value-Based Contract Products

Patients

Employers
Assess the Payer Market

- Payer concentration and competition in the market affect opportunities
- Existing quality programs
- Earning incentives in existing contracts
- Potential partnership opportunities
- Narrow networks and commercial HMO
Out of Pocket Pain

Deductibles for employer-sponsored plans are on the rise.

Average Deductible for Single Coverage

<table>
<thead>
<tr>
<th>Year</th>
<th>Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$584</td>
</tr>
<tr>
<td>2008</td>
<td>$735</td>
</tr>
<tr>
<td>2010</td>
<td>$917</td>
</tr>
<tr>
<td>2012</td>
<td>$1,097</td>
</tr>
<tr>
<td>2014</td>
<td>$1,217</td>
</tr>
</tbody>
</table>

Note: Data are for covered workers with a general annual health plan deductible for single coverage.
Source: Kaiser Family Foundation
“Risk” Models Come in Many Flavors

<table>
<thead>
<tr>
<th>“Riskometer”</th>
<th>Fee-for-Service</th>
<th>Episode of Care</th>
<th>Population Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Pay-for-Performance</td>
<td>Bundled Payment 90-Days</td>
<td>Full/Global Risk</td>
</tr>
<tr>
<td></td>
<td>Discounted Fee Schedule</td>
<td>Bundled Payment 30/60 Days</td>
<td>ACO or Shared Savings – Up-/Down-Side</td>
</tr>
<tr>
<td></td>
<td>Percent of Charges</td>
<td>“Shared Savings” Per Episode</td>
<td>ACO or Shared Savings – Up-Side Only</td>
</tr>
<tr>
<td></td>
<td>Full Charges</td>
<td>(e.g., Oncology)</td>
<td>Professional OR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Case Rate or DRG</td>
<td>Institutional Capitation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Case Management Fee</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Plus Incentive (e.g., PCMH)</td>
</tr>
</tbody>
</table>

Critical Success Factors
- Cost per unit
- Market price sensitivity
- Volume
- Billing/Coding
- Patient satisfaction

- Per episode cost
- Case volume
- Care coordination across continuum
- Physician engagement
- Adherence to protocols

- Patient attribution: Test and monitor
- Covered population size
- Total cost of care and risk adjusters
- Patient and physician engagement
- Care redesign across continuum
- Quality/Experience outcomes
- Compliance: Build it in
- Multi-year agreements and reserves
Progression of Payer Opportunity

Phase 1: Start with system beneficiaries
- Savings offset start-up costs
- Providers proof of concept

Phase 2: Then local employers
- Make the value proposition
- Larger infrastructure creates economies of scale

Phase 3: Lastly payers
- Shared savings-upside only
- Downside risk with proven competency
Categories of CIN Savings

- **Leakage Reduction** (Bring In-Network)
  - Primary Care Access
  - Referral HIT Support
  - Benefits Design
  - Call Center Support
  - Medical Director Calls
  - Network Awareness
  - Provider Mixers
  - Special Access
  - Marketing Centers of Excellence

- **High Claims Reduction** (Already Sick)
  - Decrease LOS
  - Decrease Hospital Variable Utilization
  - Protocol Adoption
  - Reduce Readmission
  - Transitional Clinic
  - Step Down to SNF
  - Managed Discharges
  - Reduce NCE Testing
  - Lower Complications

- **Disease Mgmt. Prevention** (Reduce Illness)
  - Decrease Admit Rate
  - Manage CHF, DM
  - Manage BEH Health
  - Manage High-Risk Patients
  - Quality Incentives
  - Gap Management
  - Improve Screening
  - Improve Immunization
  - Care Guidelines
  - Complete Handoffs
Key Areas Where Organizations Struggle

- Creating connected care across acute, ambulatory, post-acute, and ancillary solutions satisfying 2 requirements:
  - Interoperability: Exchange of clinical and encounter content
  - Transactional Information: Exchange of data

- Building data governance and managing cultural paradigm shifts in support of the organization’s analytic needs

- Translating data to information that integrates efficiently into the clinical workflow

- Supporting care management through aggregated clinical information from multiple sources allowing for:
  - Building a dynamic person risk indicator to drive care
  - Managing information workflow
  - Greater focus on clinical management and less on workflow management
Building an Analytics Strategy

Design Process

Define the Objectives

- Strategic
- Clinical and Operational
- Financial
- Contractual

Prioritize the Requirements

- Core data needs within each area
- Technology to create meaningful information

Build the Strategy

- Data governance
- Organizational structure
- Information management

Key Strategic Objective: Analytics capabilities must translate well to the business and clinical stakeholder needs.
Clinical interoperability and transactional information are what ties the system together.
Building an Analytics Strategy/Focused Actionable Results

Approach

Strategic Development

- Provider network expansion through enhanced connectivity, integrated care management, analytics, and value-based performance
- Solution platform to support value-based and risk-based contracting
- Integrated care systems via interoperability and information management
- Referral management and domestic utilization

Operational Optimization

- Real-time performance data that supports operational output for clinical, financial, and contracting objectives
- Patient-relevant decision support at the point-of-care to improve provider effectiveness in delivering appropriate and necessary interventions
- Longitudinal patient record and advanced analytics to support population health management

Financial Effectiveness

- Cost-of-care modeling to support value-based contracting
- Quantify the impact and outcomes of care interventions and care management models/approaches
- Outcome tracking and clinical program effectiveness measures
Analytics Strategic Objectives

- Value-based contracting
- Care management
- Point-of-care interoperability
- Patient outreach and engagement
- Financial effectiveness
Analytics Future State Vision

Begin with the End in Mind

Data Sources

- Clinical
- Operational
- Financial

Business Intelligence

- Population Health
- Predictive Modeling
- Risk Stratification
- Integrated Care Coordination
- Evidence-Based Decision Support
- Consistency of Care

Future State Goals

- Improve Patient Wellness
- Improve Patient Satisfaction
- Reduce Fraud and Abuse
- Reduce Administrative Costs
- Provide Better Clinical Decision Support
- Increased Quality

2015 Goals

- Improve Patient Wellness
- Reduce Fraud and Abuse
- Provide Better Clinical Decision Support
- Increased Quality

Data Analytics Process

- Understand Source Data
- Normalize and Aggregate Data
- Store Data
- Apply Analytics
- Fact-Based Decisions
- Action Oriented Outcomes
Business Intelligence Data Management Framework

Source: The Camden Group
GEHC Camden Group | 1/20–22/2016
Analytics Strategy Components

There are 3 main components of a data analytics strategy including data governance, organizational structure, and core data. Each of these components will be addressed in the multi-phase strategy.

**Core Data Requirements**
- Defined roles and named resources
- Process of governance to ensure integrity of data
- Specific tools in place such as:
  - Data architecture maps
  - Data dictionaries
  - Data vocabularies
  - Standardized reports
  - Common formats
  - Consistent, reliable reporting

**Organization**
- Organizational structure
- Type of resources
- Number of resources

**Data Governance**
- Need a solid, reliable base of data
- Understand all data sources
- What data do I need?
- What data do I have?
- What mechanism do I use to analyze data for:
  - Population health
  - Risk stratification
  - Predictive modeling
  - Quality
  - Evidence-based decisions
  - Consistency of care
Analytics Strategy Must Support the Value Proposition

- Readmissions
- Referral management
- Transitions in care
- Cost management ("cost-of-care")
- Patient engagement and activation
- Consumerism
Steps in Building Operationally Driven Analytics

1. Define the Future State
2. Prioritize the Technology Requirements
3. Identify the Capabilities and Requirements Around the Strategic Objectives
4. Build Out the Solutions Framework
5. Establish the Analytics Strategic Plan
Effective Care Created Economic Value

Only half of being an effective care provider is the intelligence to make a correct diagnosis and treatment plan. An effective care provider must also have skills of **communication** and **persuasion** adequate to translate that theoretical benefit into **patient acceptance**, **motivation**, **action**, and **results**.

The **Right Care** at the **Right Time** and the **Right Place**.
Patient Access with Drive Opportunities

Access Points
(UCC, FQHCs, ED, Health Plans, Physician Offices, Retail Clinics, etc.)

- Quaternary
- Tertiary
- Community Hospital
- Surgical Specialists
- Medical Specialists
- Primary Care

Defined Population

<table>
<thead>
<tr>
<th>Commercial</th>
<th>CMS</th>
<th>Dual Eligibles</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>ACO-Medicare Shared Savings Program</td>
<td>HMO</td>
<td>HMO</td>
</tr>
<tr>
<td>PPO</td>
<td>Pioneer ACO</td>
<td></td>
<td>Fee-for-service</td>
</tr>
<tr>
<td>Direct to Employers</td>
<td>Medicare Advantage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance Exchange</td>
<td>Bundled Payment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bundled Payment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: The Camden Group
Closing the Communications Gap

Patients need to play a more active role in their care, but providers increased access modalities and education in order to engage patients in these new accountability expectations.

- Unscheduled Referrals: 60%
- Missed Appointments: 23%
- Do Not Receive Follow-Up Care: 36%

Source: Beryl Health
Access is the New Driver of Value

- Patients want convenient access
- Patients value their time
  - Convenient, easy access
  - Weekends and evening hours matter
  - Minimal wait times and efficient patient cycle times
- New provider entrants are going after low intensity market share (and some are moving into specialty care) because they can meet patient requirements for access
How Do People Rate Access?

- Ease of Access
- Process Transparency
- Mobility
- Customer Service
- Process Efficiency
- Process Consistency
- Clinical Outcomes
- Continuity of Care
Prioritizing Convenience and Affordability

Average Utilities for Top Ten Preferred Primary Care Clinic Attributes

n=3,873

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Utility</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can walk in without an appointment, and I’m guaranteed to be seen within 30 minutes</td>
<td>4.11</td>
</tr>
<tr>
<td>If I need lab tests or x-rays, I can get them done at the clinic instead of going to another location</td>
<td>3.98</td>
</tr>
<tr>
<td>The provider is in-network for my insurer</td>
<td>3.95</td>
</tr>
<tr>
<td>The visit will be free</td>
<td>3.94</td>
</tr>
<tr>
<td>Access to a clinic or provider 24 hours a day, 7 days a week</td>
<td>3.91</td>
</tr>
<tr>
<td>I can get an appointment for later today</td>
<td>3.70</td>
</tr>
<tr>
<td>The provider explains possible causes of my illness and helps me plan ways to stay healthy in the future</td>
<td>3.04</td>
</tr>
<tr>
<td>Each time I visit the clinic, the same provider will treat me</td>
<td>3.01</td>
</tr>
<tr>
<td>If I need a prescription, I can get it filled quickly and a convenient location</td>
<td>3.00</td>
</tr>
<tr>
<td>The clinic is located near my home</td>
<td>3.00</td>
</tr>
</tbody>
</table>

### What Consumers Want

**Digital Age**

<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single choice</td>
<td>Many choices with structure</td>
</tr>
<tr>
<td>Telephone/In-person</td>
<td>Digitally enabled</td>
</tr>
<tr>
<td>No cost/price information</td>
<td>Options with price</td>
</tr>
<tr>
<td>Limited visibility to care</td>
<td>Visibility through delivery of care</td>
</tr>
<tr>
<td>Service is provider convenient</td>
<td>Service on demand</td>
</tr>
<tr>
<td>Limited access to your medical records</td>
<td>24/7 access to your medical records</td>
</tr>
<tr>
<td>Face-to-face visit</td>
<td>Digital, telemedicine</td>
</tr>
<tr>
<td>Limited hours of access</td>
<td>Extended hours of access</td>
</tr>
</tbody>
</table>

Source: [www.hhmag.com](http://www.hhmag.com), February 2015, and The Camden Group
Meeting All Expectations Requires Redesign

**Patient Expectations**
- Affordability
- Ease of access (24/7)
- Portal
- Self-scheduling
- Immediate results
- Care coordination
- Good outcomes

**Payer Expectations**
- Cost management
- Disease management
- Care management
- Data exchange/reporting
- EMR use
- Quality outcomes

**Health System Desires**
- Patient-centric scheduling
- Aligned provider incentives
- Reduced losses
- Ability to focus on patient retention and care redesign
- Efficient/Effective practice management

**Access Redesign**
Consumerism Driving Person-Centric Health Access

5 Steps to Becoming More Consumer-Friendly

1. Get a view of the consumers that your health system can serve
   - Market segments
   - Disease state
   - Health needs
   - Generation?

2. Determine your consumer experience strategy and execute it
   - Best care
   - Best value
   - Lifetime partner for health
   - Fast, convenient

3. Identify how to track your progress
   - Meaningful metrics
   - Clear dashboards

4. Appoint a consumer champion
   - Consumer profile
   - Consumer needs

5. Allocate resources to support your consumer experience strategy
   - ROI

Source: www.hhmag.com, February 2015, Jaime Estupiñán, and The Camden Group
Increasing Consumer Loyalty

- The health system’s goal is to provide a remarkable experience for any consumer, at any time, on any device.
- The culture should shift from patient satisfaction to patient loyalty.

Single **Voice**
- Patient Care Centers
- Call Center

Single **Brand**
- Patient Portal
- Mobile App

Single **Experience**
- Social Media

Source: The Camden Group
Objectives of “Best in Class” Patient Access

**Increase in Patient Loyalty**
- Patient capture and loyalty
- Patient retention
- Promotes growth and revenue opportunity

**Improve Patient Quality**
- Patient engagement
- Effective touch points and access to care

**Improve Patient Satisfaction**
- Patient experience
- “Right” staff
- Value and transparency

**Reduce Cost**
- Operational efficiency and effectiveness
- Engaged providers and staff

“Best in Class” Patient Access
How Patients View Access

- Multiple calls to call center

- Routing requests through multiple calls and faxes through several people over several days

- No value to completing a patient’s request, but they do add handling time cost and wait time

Source: Paul Rhino Consulting
Creating Loyal Patients for Life

Patient Expectation Management
Self-Service

- Patient Portal
- Text Messaging
- E-Mail

Multi-Channel Contact Center
Patient Access Management
Integrates Self-service with High-touch Access Points to Meet Individualized Patient Needs

- Telephone
- In Person
- Social Media
  - Live Chat/Assist

High-Touch

Patient Experience Management

- Culture of Customer Service Excellence
- Workforce Management and Optimization
- User Friendly Platform
- Customer Segmentation and Proactive Contact

Patient Engagement Management

- Effective Business Process Execution
The Next Generation of Patient Access Offering

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Offerings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enterprise-Wide Access/Experience</td>
<td>- Enterprise-wide touch point inventory</td>
</tr>
<tr>
<td>Experience Strategy</td>
<td>- Customer profiles and journey mapping</td>
</tr>
<tr>
<td></td>
<td>- Touch point scorecard</td>
</tr>
<tr>
<td></td>
<td>- Experience gap analysis and recommendations</td>
</tr>
<tr>
<td></td>
<td>- Enterprise-wide strategy</td>
</tr>
<tr>
<td></td>
<td>- Solutions road map</td>
</tr>
<tr>
<td>Interactive Digital Access</td>
<td>- Design and build customer portal</td>
</tr>
<tr>
<td></td>
<td>- Design and implement mobile strategy</td>
</tr>
<tr>
<td></td>
<td>- Design and implement social media experience program</td>
</tr>
<tr>
<td>Voice Access</td>
<td>- Design access and experience strategy call center</td>
</tr>
<tr>
<td></td>
<td>- Define requirements and create customer relation manager system (“CRM”)</td>
</tr>
<tr>
<td></td>
<td>- Select and implement CRM</td>
</tr>
<tr>
<td>Process Elimination/Automation</td>
<td>- Optimize use of existing technology to eliminate duplication and automate paper processes</td>
</tr>
<tr>
<td>Advanced Access</td>
<td>- Create systems that give patients the ability to schedule an appointment with their physician when they want or need to be seen, regardless of the patients complaint or need</td>
</tr>
<tr>
<td></td>
<td>- Measure and match supply, demand, and capacity</td>
</tr>
<tr>
<td></td>
<td>- Increase capacity using existing resources</td>
</tr>
<tr>
<td>Process Redesign</td>
<td>- Identify current state workflows</td>
</tr>
<tr>
<td></td>
<td>- Develop future state “ideal” workflows</td>
</tr>
<tr>
<td></td>
<td>- Design and implement new workflows</td>
</tr>
<tr>
<td></td>
<td>- Implement change management initiatives</td>
</tr>
</tbody>
</table>

Goal: To provide a remarkable experience for any consumer, at any time, on any device.
Area of Focus

The basic principle that the patient should be at the center of every decision made.

- **Omni-channel contact centers**
  - Scheduling, registration, insurance verification, revenue cycle, physician referral, and nurse triage

- **EMR and patient portals**
  - Optimizing patient portals, improving physician workflows, and roll-out planning

- **Interactive marketing, branding, and traditional media**
  - Integrating content across communication mediums

- **New business ventures**
  - Market readiness, business strategy, and investment analysis

Source: Singola Consulting and The Camden Group
Metrics and Measurements

**Implementation**
- Enhancing contact center performance
- Reporting as the “truth” for the contact center
- Aligning contact centers and enterprise goals
- Reducing manual efforts
- Defining qualitative metrics

**Evaluation**
- Agent performance
- Voice of the customer
- Staffing levels
- Scheduling efficiencies
- Marketing effectiveness
- Downstream revenue
- Online payments/Self-service

**Goal:** Shift patient satisfaction into person-centric loyalty
Critical Success Factors

- Established guiding principles to assist in building vision, consensus, and decision-making
- Senior hospital leadership styles that are in alignment under a collaborative environment
- A separate legal entity with independent business and clinical leadership groups
  - Allows the collaborative to have its own brand identity
- Building the right services to quickly promote in the market
- Strong focus on data aggregation, population health analytics, and performance reporting
- A transparent flow of funds between collaborative and provider members
Key Challenges

- Creating interoperability across the network (many EMRs)
- The cost of HIT infrastructure
- Managing cultural paradigm shifts
- Conflicted motives in mixed reimbursement world
- Reluctance of payers to reward value directly
Key Challenges

- Healthcare is going through major transformations
- Changes in healthcare delivery and aligning incentives will make all of us more accountable
- Adoption and integration of information technology is a big driver of change
- New financial models with actionable data will lead to results
- Continue to manage the cultural change
- In the end, it is the right thing to do for our patients and community
Contact Information

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