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HEALTHCARE

ADVENTHEALTH ON THE IMPACT OF PAYER-PROVIDER COLLABORATION ON CARE MANAGEMENT

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host, Alven Weil, and today we are joined by Jill Piazza, vice president of care integration and quality for AdventHealth's Population Health Services Organization, which exists to support AdventHealth's growing strategy for population health management.

A physical therapist by training, Piazza began working in progressive roles, focused on the growing population health management strategies for AdventHealth, beginning with community and employee wellness, then progressing into high risk care management programs. In her current role, she is responsible for the development and integration of longitudinal health management models, health transitions, medical and utilization management, quality, and member experience for the health system. Jill, welcome.

Jill: Thank you, Alven. My pleasure to be here.

Host: Today, we're going to discuss lessons learned from AdventHealth's Population Health Services Organization on ways payers and providers can more effectively collaborate to develop highly targeted, high-impact approaches to care management, or health management. Jill, for starters, please provide some background on AdventHealth's Population Health Services Organization.

Jill: Sure thing, and I probably should start with the fact that we actually just rebranded ourselves and we were formerly known as Adventist Health System. As of January 2nd, we are now known as AdventHealth. So it's a new name for the marketplace, which people may not be familiar with, but we are definitely not new to the marketplace. But three years ago, we did form a population health services organization in order to support our developing strategy for our clinically integrated networks. Back then, we were fairly early in our value-based journey, but have quickly advanced with capabilities that we've built around analytics, health management, network operations, and contract management...just to name a few areas. And in 2016, we began supporting services for our 58,000-member, self-funded employee health plan in Florida. We do cover nine states, but our work began in Florida. Today our PSHO provides services to support

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nearly 250,000 lives attributed to our clinically-integrated networks and our accountable care organization in Florida. And we do provide additional services supporting value-based contracts for the organizations we have outside of Florida. By the middle of this year, we're expecting to have around 270,000 member lives that we support.

Host: So, Jill, how do you and your organization define care, or health management, and what are some of the challenges and benefits it poses?

Jill: That's a great question. So, in our world, we actually last year started to transition away from using the term "care management" and began grouping our activities under a broader term that we call "health management." And that was a result of a kind of experience along the way. We started to find that whenever I used the term care management, people automatically went to chronic disease management and they thought that was the only service we were providing to manage members. And, what we do is actually a lot broader than that. We have a variety of programs that are risk-stratified and very highly targeted toward the members' specific needs based on their health risks. And our approach is very holistic. So, our term "health management," we feel really more accurately describes the totality of work that we're doing. And, as a health system, we are very focused on whole-person care.

Part of our new brand change, actually, brings a new brand promise to the work that we do called Feel Whole. And, as we got started in this work, we fundamentally felt that the care pathways and programs we were putting in place needed to address the whole person and not just the disease state. So, our desire is to continue that work focusing on whole-person healthcare and then, down the road, our vision is to progress this work beyond just the members we're managing under risk-based or value-based arrangements and get to the point where we really are able to provide these types of longitudinal health management programs to all the patients we serve. I think our biggest challenge right now is that we are still trying to survive in an era of fee-for-service, while still trying to advance competencies and capabilities in a value-based world. So, we're still very much in that two-canoe scenario. So, the struggle is learning how to pace the work while we continue to try and scale it, but still support our business model. So, that's probably the biggest long-term challenge I think we're faced with right now.

Host: Jill, how would you say the goals of health management typically vary between payers and providers?

Jill: Well, in my experience, payers have typically, or historically, been focused on reducing costs while still trying to achieve quality outcomes. Where providers, on the other hand, haven't really been as focused on cost, at least not outside of the acute care hospital setting, beyond length of stay and DRGs, for example. Instead, providers have focused more on quality, the experience of the patients that they're serving, and then the services that they're actually providing. At AdventHealth, our focus on pop health management, along with the creation of our clinically-integrated networks and accountable care organization is working to bridge that gap, not only between payers and providers, but also with employers, particularly self-funded employers. And working to align incentives across all of those entities, so that we're all working towards the same goal and have a common vision towards balance for cost, quality, and experience.

Host: Jill, if you would, please discuss some of the health management-related successes your organization has achieved.

Jill: Sure. So, in order to align priorities and make sure our efforts are focused on the right things, I think access to data and integrating actionable data and to physician workflows is essential to our success. The reality we've encountered, however, is that technology can often act as a barrier to this effort, or lack of technology can also act as a barrier. So, as an example, when we first got started in this work, we gave all of our physicians access to our business intelligence software, so that they could log in and view their member's care gaps and quality measure performance, and that sort of thing. But it was a separate system and the technology was not integrated with their EHR, or with their workflow in their practice. So, it required the doctors to remember a separate username and password, take separate time out of their day...it wasn't integrated into their schedule, or their visit schedule, and things like that.

And, we started to notice that it really wasn't being utilized. So, while it might seem like a step backward, we actually moved to providing printed paper reports to our providers. And we call that our member quality and utilization report. What we noticed, is that when those reports were hand-delivered to the practices and explained to the physicians, they started using that data to improve performance, really right away. And those reports itemized care

gaps and utilization statistics and it even shares with the provider, down to the member level, whether or not they're being managed in one of our health management programs.

So, the data's actionable and very specific. The physician knows whether their member's participating in our programs and even knows whether we've outreached to them and the patient declined participation. And, it also will highlight patients that haven't been identified, meaning that their health risks haven't risen to the point where they've been identified as needing health management.

But it allows the providers to have some additional information. So, if they see a patient in their practice that we did identify for health management that chose not to participate with us, they can then engage with that member and really encourage them to join this program and help make the behavior changes that they need to make to improve their health. So, I think the lesson there is that the more actionable member level data we can put in the provider's hands that fits in their workflow, the better. And the more we can get back to the point of integrating that into their workflow electronically, the better off we'll be. And that's the journey I think we're still on. So, that's been one big piece is that we can't do this work without the providers having the right data and the right actionable data to improve performance.

But, with the work that we started back in 2016 with our own employees, we've already started to see some great outcomes, and just from 2016 to 2017, we saw an 8.1 percent reduction in admissions per thousand for our member population, which we were excited to see. And then, from 2017 to 2018, we saw another 2.9 percent reduction in admits per thousand. And, what we realized when we start looking at our data is a lot of these admissions are preventable. If we had better access to primary care and better management of the patients in primary care, as well as better management of the patients in our longitudinal health management programs, that really began to influence admission utilization in the hospital.

Another item that we saw a reduction in with our per member, per month costs, and as a self-funded organization, that's something that's really paramount because all the work that we're doing to try and improve quality and care for the patients. Our hope is that as we reduce unnecessary utilization, it will translate into lower costs to the organization. And, we did see a 3.1 percent decrease in per member, per month cost for our employee population from 2016 to 2017, and then another 1.2 percent reduction from 17 to 18. So, we're hoping that we'll continue to see downward trends there, as we continue to get closer to benchmark goals that we're working towards. Our year-over-year improvement won't be quite as dramatic, but if we can stabilize that and then we'll have capacity to do other work with this population, as well as the other populations that we're managing.

So, one thing that I think kind of differentiates us as well is how we built out our program. So, I mentioned our brand promise and our Feel Whole promise and our focus on holistic care. We actually started incorporating that thinking into the build of our program three years ago.

And really, to me, it tied back to our health system's mission back then. We're a faith-based organization and we are focused on the whole person. So, when we began to build out our programs, even just for our employee population, we looked at the data, what the data was telling us, and to figure out where do we get started. And, we looked at what the biggest cost drivers were for chronic illnesses. But, when we built out our pathways and protocols for how we were going to manage those chronic conditions, we established a set of guiding principles to guide that work to ensure we were promoting whole-person care, that it was aligned with our mission, and we weren't just focused on a single disease state. And that, to me, made a big difference in the actual experience of participating in health management. Unlike the traditional disease management programs that you typically see under a health plan where they might only manage diabetes, but not any of their other comorbid conditions or none of the social issues that are really driving their continued hospital utilization.

Our approach really aims to target all of the barriers that that member's facing. So, the other thing that we do also try to do with our team members is remind them of their work and how it ties back to our mission. And I feel like that's very important just to build organizational health within our team, because to work as a nurse health advisor, which is what we call our team members, they're helping patients to manage conditions that they may not have been managing for decades.

And it's really hard work. You're working with human behavior and all sorts of barriers come into play with that. But, when we remind our team members of their connection back to our larger mission, or our bigger why, it really does help to inspire them and keep them motivated with this work. And with that, we try to make sure we're constantly sharing the stories of the impact they're having on the members we work with.

So, those stories of change and true life change and the impact that it's having on the individual members is definitely motivating and inspiring. So, we do try to make sure that we're constantly sharing the impact of the work with the team.

So, some of the lessons I think we've learned along the way is that we really can't do this by ourselves. We can aim to produce great holistic health management programs and have very robust risk stratification tools and identification methodology to get the right patients, our members, engaged with this work. But, if we don't do work within our network to improve access to primary care and working collaboratively with our physicians to close gaps in care, or work with our HR departments or our employer partners to change benefit plan design, then there's only so much impact we can have. One thing we're noticing now within our own employee population is we have opportunity to relook at our copays and what are we doing to make sure we're incentivizing our members to access care in the most appropriate setting, at the most appropriate costs.

We're continuing to struggle with ED utilization and we're seeing that access to primary care is a driver of that. And then the differential and copay between the ED versus urgent care, for example. We're asking ourselves, is that a big enough difference to really incentivize people to go to urgent care when they should be going to urgent care and the ED when they are experiencing a true emergency.

So, those are some of the questions that we're working with our other stakeholders on right now. And, then, again, back to that data piece, that the data we're sharing with our physicians has to be actionable and it has to be down to the member level. And, then I think once all those types of things are aligned, then you start to really have a robust impact on performance.

Host: Outstanding insights, Jill. Any final thoughts or takeaways?

Jill: Yeah, I think one of my biggest realizations over the past three years since I've been involved in this work, is that everybody is still on this journey. We're all still maturing really across the country in this work and value-based care and there's some best practices that are emerging, but I don't think anybody truly has this all figured out. And, as we do continue in this work, we will continue to evolve and mature. I think access to data, system integration, enabling IT technology, improving the capabilities and expertise of our provider network and continuing to align both the incentives and the reimbursement models. We'll all need to progress forward in order for us to collectively succeed in this work. But, I feel in my heart of hearts that this is truly the direction we need to continue moving in as an industry. I think it's the right way to be providing healthcare to our communities and I look back over the past three years of work that we've done at AdventHealth and I'm excited about what we've accomplished and I'm even more excited really about what our future holds and excited to see what we continue to accomplish as we mature on this journey.

Host: Jill, very well done. Thank you so much for joining us today.

Jill: It was my pleasure, Alven. Thanks for giving us the opportunity to share a little bit of our story.

Announcer: That concludes today's episode. Be sure to check in with us for future installments on the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share it with friends and colleagues on social media. Learn more at navigant.com.

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