PROMOTING RADICAL CHANGE

Carl Couch, M.D.
W. L. Roberts
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What Are We After?

In the fall of 1805, Napoleon had a problem...
What Are We After?

The English Channel

“Come into the Channel. Bring our united fleet and England is ours. If you are only here for 24 hours, all will be over, and six centuries of shame and insult will be avenged.”
What Are We After?

Napoleon’s combined fleet of 33 French and Spanish ships
30,000 men and 2,568 guns

Lord Nelson’s British Fleet of 27 smaller ships
17,000 men and 2,148 guns
Napoleon’s combined fleet of 33 French and Spanish ships

The VERY well-developed tactics of the day

...stay in parallel lines and fire broadsides

The British Fleet of 27 smaller ships
What Are We After?

Out gunned and out manned. Do things the conventional way & lose: **Break the rules**

Tired of playing defense: **Gain a decisive victory**

Leverage my strengths: **Gunners 2 to 3 x faster**

Take full advantage of the environment: **High swells, better trained sailors**

Highly confident, **determined** and able to make important decisions: **Sure & speedy process**

Willing to **do things differently** than they’ve ever been done before: **Committed to take the risk**
What Are We After?
What Are We After?

Napoleon’s combined fleet of 33 French and Spanish ships

The British Fleet of 27 smaller ships

Nelson’s Touch
What Are We After?

**French & Spanish Ships Lost**

22

to

**English Ships Lost**

0
What Are We After?

Britannia Triumphant

THE MOST DECISIVE and GLORIOUS
NAVAL VICTORY
that has ever been obtained

THE Victorious BRITISH FLEET
Commanded by the most RENOWNED, most GALLANT, and ever
to be LAMENTED HERO,
Admiral Lord Viscount
NELSON
Our Battle of Trafalgar
($2.5 Trillion Annual Spend)

**HARD**

- Identified Waste
  - $1.2 trillion

Behavioral
  - Obesity/overweight
    - $200 billion
  - Smoking
    - $567 million to $191 billion
  - Non-adherence
    - $100 billion
  - Alcohol abuse
    - $2 billion

Clinical
  - Defensive medicine
    - $210 billion
  - Preventable hospital readmissions
    - $25 billion
  - Poorly managed diabetes
    - $22 billion
  - Medical errors
    - $17 billion
  - Unnecessary ER visits
    - $14 billion
  - Treatment variations
    - $10 billion
  - Hospital acquired infections
    - $3 billion
  - Over-prescribing antibiotics
    - $1 billion

Operational
  - Claims processing
    - $21 billion to $210 billion
  - Ineffective use of IT
    - $81 billion to $88 billion
  - Staffing turnover
    - $21 billion
  - Paper prescriptions
    - $4 billion

**EASIER**

$82,975 v. $22,205 *
20.6 hours v. 2.5 hours

Observations and Opportunities from “Chasm”...known for >10 years

- Well documented, massive practice variation
- High rates of inappropriate care
- Unacceptable rates of preventable care-related injury and death
- Striking inability to “do what we know works”
- Huge waste, spiraling prices, limited access

- Brent James, MD
40+% of all resource expenditures in hospitals is quality-associated waste

- Simple inefficiency
- But particularly the 3 errors in care:
  - Too much care
  - Too Little Care
  - Wrong Care
- But... solutions require physician engagement

- Anderson, C. 1991
- James BC et al, 2006
Who Will Bring Solutions?
Take your pick....

The Regulators
The best way to slow increasing costs is to control the total resources going into the health care system.

The Marketeers
Competing health plans and information-empowered consumers would drive down costs, especially if insurance were restructured to give people the right incentives.

Systems Reformers
The best way to bend the cost curve is from the inside out, by creating a smarter health care system with the information base, new delivery models and payment incentives that will improve quality and lower costs.

- Mayo Clinic

How We Sail
Best in Class & Interlocking Capabilities

How would you arrange things differently if you had control over benefit structure and reimbursement?

Entry Point Redesign

How do you improve quality while lowering total cost?

Financing

Care Integration

Population Health Infrastructure

All 4 functions woven together by our “Clinical Transformation” efforts.
How We Sail
Best in Class & Interlocking Capabilities

Entry Point Redesign
HealthTexas

Financing
TCA & Payer Alliances

Care Integration
BQA

Population Health Infrastructure
BIS, TCA, BQA
Patient Centeredness
The “Provider-Designed” Health Management Company
Best in Class & Interlocking Capabilities

Entry Point Redesign

- Real-Time Predictive Modeling Software
  - alerts

- Appointing, Intake, Referral Management
  - call center

- Beneficiary Profile Management (i.e. HRA, Biometrics, Segmentation)
  - wellness

- PCP, PCMH or Super PCMH
  - supported physician manager

- Medical Home Alternative
  - DM assignment, i.e. center of excellence, community clinic, or surveillance list
The “Provider-Designed” Health Management Company
Best in Class & Interlocking Capabilities

Care Integration

- Clinical/Stakeholder Governance Authority
  - ACO-eligible board

- Access, Quality & Value Design & Discipline
  - “Best Care” organization & local level committees

- Close Provider Alignment, CQI Feedback Loop, Delivery Design (i.e. Bundling)
  - network development

- Strategic Clinical Capability Placement, Resource Application
  - delivery design input
Baylor Quality Alliance’s mission is to achieve the highest quality, cost effective care possible for the patients that we serve through clinical integration.

BQA Board of Managers
August 12, 2011
Baylor Quality Alliance

- **Governance**: 19-member Board of Managers, 14 practicing physicians; *physician*-driven.

- **Membership**: physician members will include independent physicians as well as employed physicians and other care delivery entities.

- **Participation Agreements**: agreement will hold all participants accountable for care coordination, clinical integration, data sharing, and quality and cost performance.

- Able to participate in new healthcare *funding* methods such as bundling, shared savings, and forms of capitation.

- Strong foundation of NCQA-certified Patient Centered *Medical Homes*. 
Standards of Participation

- **Communication Standards**
  Agreeing to communicate on all facets of care and performance

- **Quality Standards**
  EBM; Standardized Protocols and care paths

- **Cost-effective Standards**
  Avoidance of waste and inefficiency at all points

- **Automation Standards**
  Agreeing to use EHR, HIE, Registry function; capture of cost and quality data

- **Citizenship Standards**
  Agreement to uphold the mission/ vision of BQA
Key BQA Committees Launched

- Membership and Standards Committee
- Best Care and Clinical Integration Committee
- Population Management Committee
- Compliance Committee
- Finance and Contracting Committee
- IT Committee

- Approved BQA Board 7/11
What’s BQA doing?

- **Recognize crisis**: Build the case that we must plan to change
- **Create Culture**: Agree to become accountable for value.
- **Organize Ourselves**: to deliver highest quality at lowest cost, integrated across the entire continuum of care.
- Start gradually and accelerate as we become competent
The “Provider-Designed” Health Management Company
Best in Class & Interlocking Capabilities

Population Health Infrastructure

Collection of Data at Point of Care
EMR/HIE selection, implementation and support

Collection of Data at Point of Contact
call center, care coordination & navigation

Collection of Customer Support Data
Claims, SES, DM, segmentation & predictive modeling

Quality Assurance & Reporting
informaticists, biostatisticians, quality & safety researchers

Value Assurance
utilization management (esp. pharmacy), risk prediction & stratification
**Population Health Resource Relationship**

*2010 Data from Mayo Clinic HSER*

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<th>% of total COST</th>
<th>% Population</th>
<th># Chronic Diseases</th>
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**Services Needed**

- NP Home Intensive Care; Case worker; Social Svc; 24/7 Access
- Multi-disciplinary Care Teams, Home Monitoring Protocol-Driven; No “Gaps”
- “Medical Home”; Education
- Community Support; Treatment to goal
- Wellness, Risk Screening
- Shared Decision Making
- Health Education

Grawande, Atul: “Hot Spots”
New Yorker, January 2011
The “Provider-Designed” Health Management Company
Best in Class & Interlocking Capabilities

Financing

- Patient Activation & Compliance Design Varies by Risk Segment
  - Provider-designed benefits structure

- Co-Pays, Co-Insurance & Deductibles Vary by Risk Segment
  - Domestic steerage, stronger behavior incentives

- One Size Does Not Fit All
  - Site of service designed for need, resources applied disproportionately

- Ease of Use
  - One standard for financial interactions, quality & utilization standards, no claims

- Reward Manager
  - Medical home enrollment, PQRS, contact cap, direct compensation
The Texas Care Alliance: Baylor, Memorial, Scott & White, Trinity Mother Francis

TCASS
“The Enabler” Shared Services Co.

PDHMC
“The Objective” Provider Designed Health Management Company

TCA
“The Value Driver”: A Catalyst Forged from the Best Thinking in 4 Best Systems
Break with convention: Baylor is not a place

Leverage our strengths: Mission, brand, education & research, Physician alignment

Be determined and able to make important decisions: Speed and improve our processes

Be willing to do things differently than they’ve ever been done before: Innovate with what “we” trust to be true

Commit to the strategy: “England expects all men will do their duty”