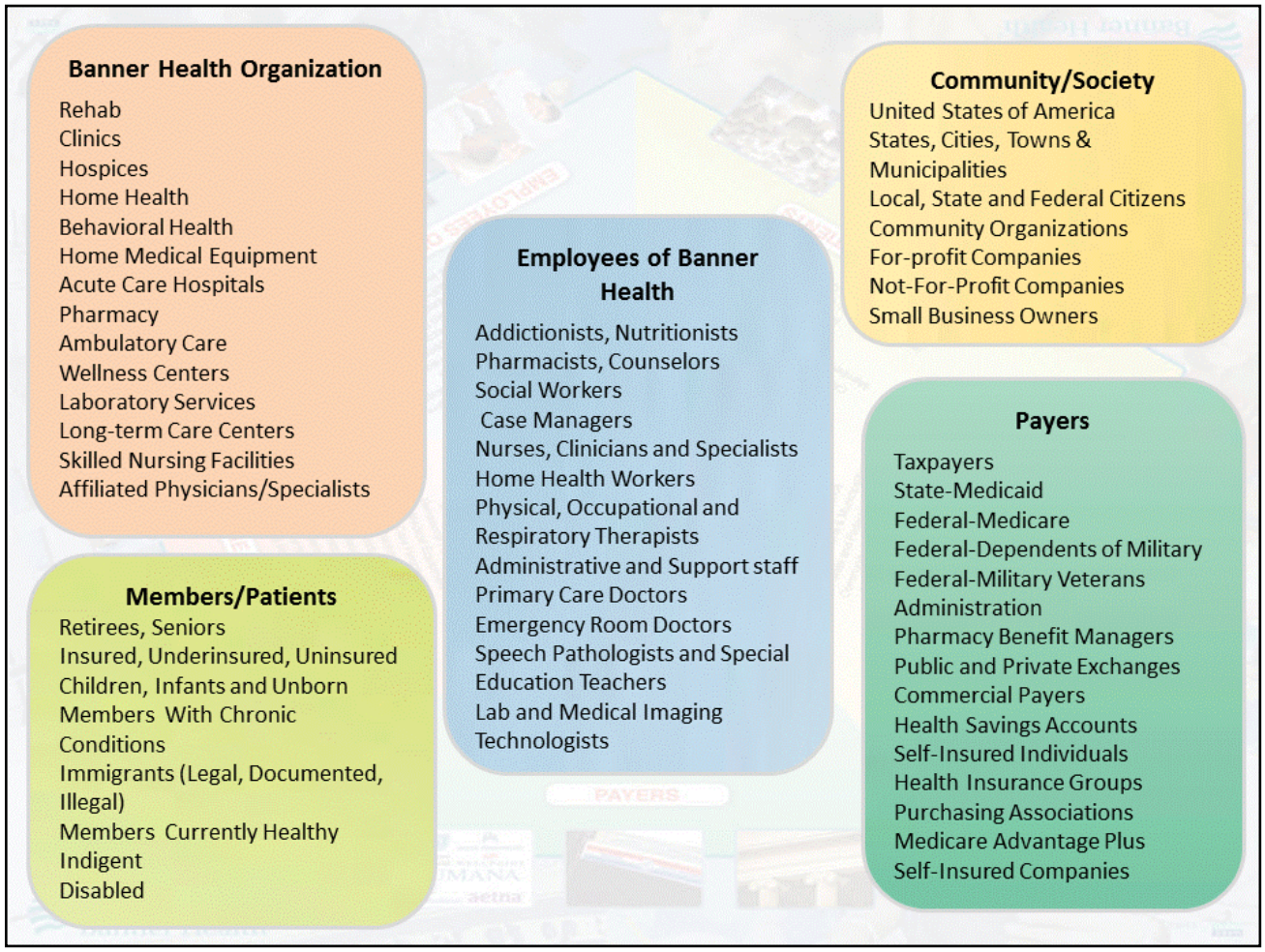
Transforming the Future of Healthcare

Learning Journal

Transforming the Future: Learning Map

Where did you find yourself on the map?

- Members/Patients
- Employees of Banner Health
- Banner Health Organization
- Payers
- Community/Society



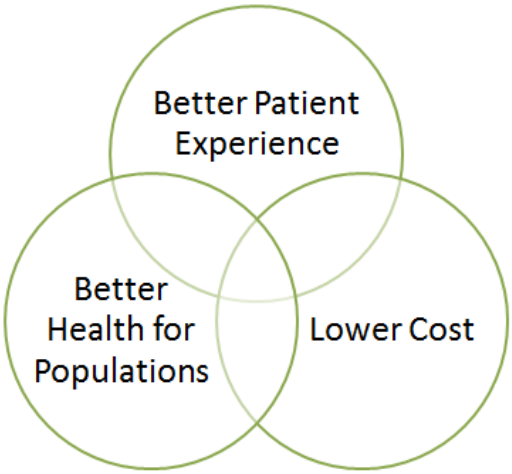
Sally's Story 2009: Pre Healthcare Transformation

What is not working well?

As you listen to Sally's story, use the space below to make a note when you hear the process break down. Be ready to share your thoughts.

The Accountable Healthcare Organization (ACO)

Focus



Knowledge Check

Which of the following statements is NOT true?

A. Financial health depends on keeping patients and members as healthy as possible for a pre-determined amount per patient/member.

B. A percentage of income is tied to quality and patient satisfaction measures.

C. Providers are paid piecemeal for procedures and tests so there is an incentive to perform high margin procedures.

D. Banner is one of 32 entities in the U.S enrolled with Medicare/Medicaid as a pioneer ACO.

E. Attempts to keep its network members healthy as possible and deliver care as efficiently as possible.

F. If care can be delivered for less than the pre-determined amount per member, the ACO comes out ahead. If not, it loses money.

Reading

(1) While 'Accountable Care' certainly refers to the ACO being accountable for the care of its patients and members, it also refers to patients and members becoming more accountable for staying as healthy as possible. In other words, it becomes more of a partnership between the organization and the person to stay healthy.

(2) To make this work in our Banner Health ACO, we truly have to work as a team. This means constantly sharing and updating the information we have on our patients and members, seeing them more often, getting to know them as people and not just "reacting" to their immediate care needs.

The Accountable Healthcare Organization (ACO), continued

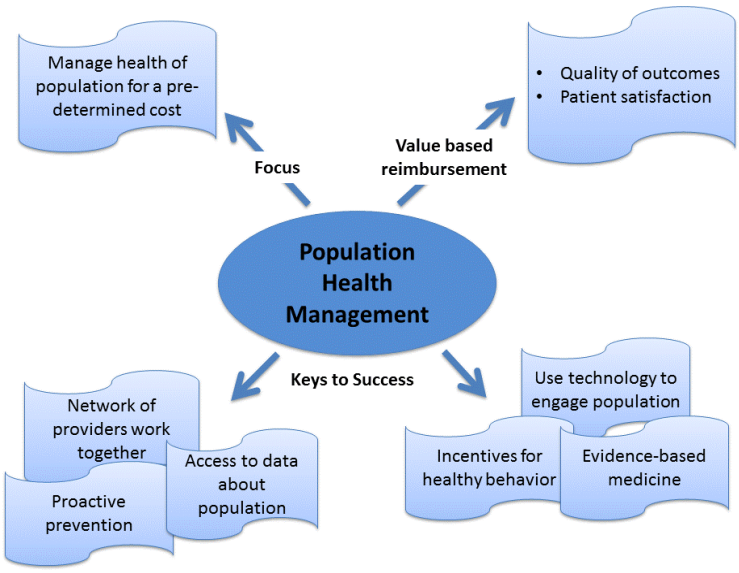
(3) This inevitably means asking a lot more questions. It means engaging with individuals on an authentic human level as we work with them to take better care of themselves. It means better understanding their habits at home, as well as their risk factors and support mechanisms.

(**4)** And it also means proactively checking in with them before seeing them, actively following up on care plans, letting them know that we are in this game together…in short, that we are all focused on the same goal.

Population Health Management (PHM)

Focus

Managing and improving health of a specific population for a pre-determined cost.



Keys to Success

1. A network of providers that work together to improve health while reducing cost to provide care (hospitals, PCP, specialists, city health departments).
2. Access to lots of data about the population so all providers must collect and share data.
3. Networks must proactively engage population to take better care of themselves (example diabetic's education: meds, exercise, weight reduction).
4. Proactively take steps to reduce likelihood of sickness/injury. For example, senior fall prevention in home.
5. Use of technology to engage population.
6. Innovative incentives for healthy behaviors.
7. Apply Evidence-based medicine to reduce variation with consistent predictable, high quality patient outcomes for the population.

Continued on next page

Population Health Management (PHM), continued

How is Banner Implementing PHM?

How many of these initiatives/programs do you recognize?

- MyBanner Patient Portal
- Biometric Screening
- Alzheimer's Prevention
- Patient Centered Medical Home
  - Active Health
  - Depression Screening
- Incentives to quit smoking (higher insurance premiums
- Stroke Education

Want to learn more?

The following resources can be found on the Banner Intranet:

Patient-Centered Medical Home Resource Page

Implementation of MyBanner Patient Portal

Banner Alzheimer's Prevention Initiative

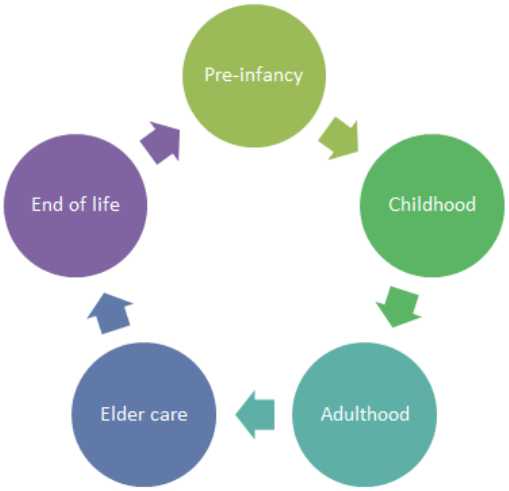
Sally's Story 2015: Post Healthcare Transformation

What has improved?

- Listen carefully to Sally's 2015 story and be prepared to discuss some specific ways things have improved.
- Can you identify Accountable Care and Population Health Management in action?

Continuum of Care

Focus



Managing health across the lifespan at the right time, in the right place.

Reading

(1) The Continuum of Care model includes: Providing different types of care in different settings. Better coordinating that care across the different settings. Providing a progression of care intensity that varies according to need. Providing the right care in the right place at the right time. In other words, better matching the care provided to the healthcare need.

(**2)** For example, the *Continuum of Care* for reproductive, maternal, newborn and child health includes integrated services for mothers and children from pre-pregnancy to delivery, and then from the immediate postnatal period through early childhood. These services might be provided by a variety of outpatient services, clinics and other health facilities.

(3) In the Continuum of Care model, as care providers, we become much more active in helping a patient move between different care settings. We become much more effective in providing seamless coordination between these care settings. We are more proactive in checking in before and after seeing the patient. We are more diligent in following up on care plans. And for you as a patient, it feels much more like one integrated delivery system with you at the center.

Think about it

What were some examples of different care settings from Sally's 2015 story?

Integration of Delivery

Goal

Improving the quality and coordiantion of multiple hand-offs in the very complex process of delivering healh care

Consequences: Lack of Integration

- Doctors sometimes don't know what drugs other physicians have prescribed.
- Hospitals sometimes don't know what other tests and procedures have been done.
- Pharmacists may not know if a patient has multiple prescriptions from multiple physicians for multiple controlled substances.
- Insurers may not know what specific needs a patient may have.
- Not only does this create potential risks for the patient. It also creates a system that is frustrating and extremely difficult to navigate.

Knowledge Check

All of these *except one* will be required for Integration of Delivery:

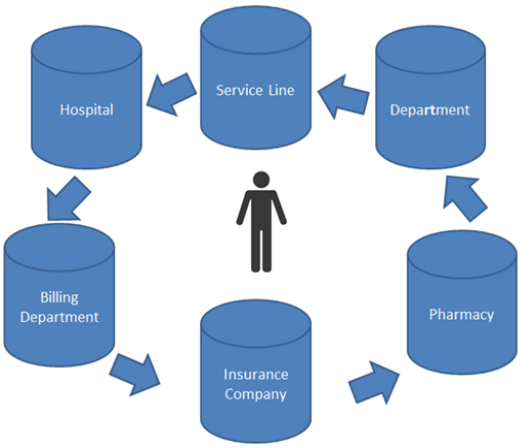
A. Information Technology-information about treatment must go with patient as they move between caregivers.

B. Development of standard protocols using best available evidence

C. Physicians and staff must form collaborative teams

D. Caring for one case, one disease and one procedure at a time.

E. Use of Patient Centered Medical homes focused on coordinating care.



Integration of Delivery is a critical building block in the process of comprehensive care coordination that will ultimately lead to better health, longer life, higher patient satisfaction and less expensive care.

Connecting the Dots

Concept Review

Match the following concepts to their definitions below:

A. Integration of Delivery
B. Accountable Healthcare Organization
C. Continuum of Care
D. Population Health Management

Definition	Concept
A group of coordinated care providers who collectively agree to be accountable for the care and health of a specific population	
Managing a specific population for a predetermined cost. The goal is to keep the population as healthy as possible, thus reducing healthcare costs.	
Improving the quality and coordination of multiple hand-offs in the very complex process of delivering health care.	
A shift away from a mostly acute care focus to a focus on providing multiple health-care services (hospital care, home care, hospice, preventive care, etc.) and managing health all the way across the lifespan.	

3 Key Levers

One way to understand the relationship between the four concepts is to understand what is central to all of them

Lever #1: **Information**

The right information in the right way at the right time will be required for each of these concepts to be successful. Doctors, hospitals and home care workers will need to actively share information in order to coordinate care. Electronic health records (EHRs), health information exchanges (HIEs), data sharing and analytics will be used to identify financial and clinical risk in a member/patient population and measure how targeted approaches may help them.

Continued on next page

Connecting the Dots, continued

3 Levers, continued

Lever #2: Care Coordination

At the heart of these four concepts is the ability to coordinate and manage all of a member/patient's needs across multiple providers and settings. Primary Care Physicians and other care coordinators rise in importance in this new world. They become key conduits to care with other practitioners in other settings, have more responsibility for preventative care, document information that drives care models for certain patient populations, and they become a key resource in gaining patient engagement in their own health.

Lever #3 You

Success with all of these concepts requires that each of us become active participants in keeping ourselves healthy and out of hospitals. Entire populations must become engaged in their own health in ways that they haven't in the last few decades. This will be one of the most difficult and interesting challenges we face. How do we incent people to be healthy? How do we change behavior in positive and productive ways? How do we each become active participants in transforming the future of healthcare?

Reflection

- How could the successful implementation of these concepts impact your own work as a Banner employee?
- What about other areas of the learning map (Member/Patient, Society, Payers and Banner as a whole)?