Innovation Challenge: A Deeper Dive

We are funding and awarding applicants that propose an entirely new model of care or an "adapted" model that has been previously implemented. Adapted solutions should build upon a successful model previously tested while piloting an approach that is a new and/or unique service by improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care at SCL Health.

The Patient Journey

Medical and public health experts generally agree that socioeconomic and environmental factors have an overwhelming influence on health disparity and patient outcomes. If health systems aim to thrive under outcomes- and value-based reimbursement, they must also assume greater responsibility for the health of the communities they serve — both inside and outside of the hospital walls.

What does this mean to the patient? Sometimes when we think about the journey of a patient, the pathway may seem simple when viewed as a series of touch points with SCL Health. Let use a surgical patient as an example.

Yet, in reality, the actual patient journey includes many steps.
Moreover, that journey starts **before they reach-out** to our ministry and **continues after** they arrive home, many of which are outside of the existing care pathway touchpoints (picture 1). So where can we improve this journey and make it the best-in-class experience?
Innovations are often created in the gaps and negative experiences, such as handoffs.

Healthcare background

Healthcare is going under tremendous transformation – not seen since the last 60 years.

Around the nation, every healthcare system is struggling with rising costs and uneven quality despite the hard work of well-intentioned, well-trained clinicians. Healthcare leaders and policymakers have tried countless incremental fixes—attacking fraud, reducing errors, enforcing practice guidelines, making patients better “consumers,” implementing electronic medical records—but none have had much impact.

Consequently, the U.S. healthcare system is the most costly in the world, accounting for 17 percent of the gross domestic product. That’s a number that could rise as high as 20 percent by 2020 [Source: National Healthcare Expenditure Projections, 2010-2020, Centers for Medicare and Medicaid Services, Office of the Actuary]. At the same time, countries with health systems that outperform the U.S. are also under pressure to derive greater value for the resources
devoted to their health care systems when factoring in dynamics such as aging populations, longer life spans, chronic health problems, and the associated costs of these issues.

When we talk about basing health care on value, not volume, what does that really mean?

**Moving from Volume to Value**

In the current fee-for-service model of reimbursing providers for health care services provided, those providing care get paid to “do more.” The more tests you order, the more patients you see, and the procedures you do determines how much more money you will make.

By basing performance on volume (i.e., the number of patients or procedures), we are left with enormous variation in rates of procedures and tests such as imaging and screening. As documented by The Dartmouth Atlas of Health Care, there is a 2.5-fold variation in Medicare spending nationally, even after adjusting for differences in local prices, age, race and underlying health of the population. This geographic variation in spending is unwarranted; patients who live in areas where Medicare spends more per capita are neither sicker than those who live in regions where Medicare spends less, nor do they prefer more care. Perhaps most surprising, they show no evidence of better health outcomes.

One way of addressing this variation – and giving patients the care they want and need – is to move to a reimbursement system that is value-based, in which payment is determined by an equation that values quality, cost and time. The better the quality, the lower the cost, and the better the outcomes over time determines how much money is made.

For patients, this means safe, appropriate, and effective care with enduring results and at reasonable cost. For us, it means employing evidence-based medicine and proven treatments and techniques that take into account the patients’ wishes and preferences.

**Not if, but when**

In January 2015, the Department of Health and Human Services (HHS) announced a goal to have 30 percent of Medicare payments tied to alternative payment models by the end of 2016. In March, [HHS estimated it reached that goal](https://www.healthcare.gov/medicare-facts/)—nine months ahead of schedule. HHS isn’t stopping at 30 percent, though. By 2018, they aim to have 50 percent of payments tied to these models and they have put several plans in place to meet their goal.

There is no longer any doubt about how to increase the value of care. The question is, which organizations will lead the way and how quickly can others follow? The challenge of becoming a value-based organization should not be underestimated, given the entrenched interests and practices of many decades. This transformation must come from within. Only physicians and provider organizations can put in place the set of interdependent steps needed to improve
value, because ultimately value is determined by how medicine is practiced. Yet every other stakeholder in the health care system has a role to play. Patients, health plans, employers, and suppliers can hasten the transformation—and all will benefit greatly from doing so.

Additionally, as reimbursement systems for providers move from fee-for-service to risk-based models, the incentives will move to keeping defined populations healthy as a way of controlling costs. Defined populations under new payment models are those “attributed” to us because we are the entity responsible for their health and health care costs.

This is particularly critical as the rates of chronic disease increase in the U.S. By 2020, it is estimated that 167 million Americans will have at least one chronic condition; 88 million will have multiple chronic conditions. Treatment of chronic disease currently accounts for 78 percent of all healthcare spending in the United States.

Under the current fee-for-service reimbursement system, healthcare organizations and providers are paid based on individual visits, tests, treatments, and procedures. In this system, a person with diabetes receives medication, treatment, and hopefully, ongoing management. But there is no incentive and no structure in place to deal with the underlying causes of the diabetes, nor to address other health conditions that might co-exist, or life challenges that may impede the process of effective management.

In a population-based approach, we take a far broader view of health and the factors that influence the health of a community – often called "the social determinants of health." Education, economics, availability of transportation, access to exercise and healthy foods – these are some of the things that influence the health of a given population. Telling an obese person with diabetes to eat more nutritious foods is of little use if the family’s ability to travel is limited and there is no source of healthy, affordable food within close distance.

This shift to population health and value-based care also means reaching out in different ways and developing new models of care. To effectively deliver health – rather than just health care – we need to be in the communities, working in new kinds of partnerships, to reach people in their homes, schools, and community centers. Telehealth and care navigators who help to coordinate resources and guide individuals through the process will become more common and valuable in this new paradigm.

Finding solutions

This challenge seeks new and “adapted” designs that must be developed to simultaneously pursue three dimensions, which we call the “Triple Aim” and value-based care:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.
The fundamental difference between population health and health care as we have come to know it is that population health is centered on caring for groups of people rather than individual patients, and it is more about "health" than it is "care." That may sound like pure semantics, but this is a critical distinction. Hospitals and physicians today are principally concerned with the patient in front of them—how the patient presents in the moment and what services he or she has come to receive. By contrast, a population health and value-based care practitioner is concerned with achieving healthy outcomes for an entire patient population over a period of time inside or outside our four walls.

The situation

As SCL Health moves into value-based care, our ability to deliver coordinated services within and outside our four walls is critical.

Implementing the value agenda is not a one-shot effort. It is a journey that providers embark on, starting with the adoption of the goal of value, a culture of patients first, and the expectation of constant, measurable improvement.

We need your efforts, energy, and ideas to move us towards the transforming landscape of healthcare so we can continue to live out our mission and vision to the communities and people we serve.

For instance, patients often have multiple agencies and care coordinators providing services without a shared plan of care. Often, care provided to the patient is fragmented based on the agency or the role of the care coordinators. The social determinants of health are not consistently collected, recorded and addressed in the plan of care. Additionally, there is not an easy way to communicate a shared plan of care and care updates to agencies and care coordinators across the community. Lastly, the patient may not understand their shared plan of care and cannot easily communicate their needs to care providers.

As part of health reform and confronting a health care system with costs that are unsustainable, policymakers and others have been looking at – and testing – new payment models. These would move away from fee-for-service and payment based on volume to systems that encourage more coordinated care, focusing on the overall health of the population.

The graph below shows the incentives under the current payment model and the evolution of the incentives as we shift from fee for service to population health.
Is it worth it?

There’s no shortage of benefits to patients and providers who embrace this model.

For the patient, it:

- Creates a plan of care that is transparent to the patient and is perceived as having value by the patient
- Incorporates two-way communication with providers and care teams
- Helps patients to access resources available in the community and how to access them
- Coordinates care across multiple providers, including medication management
- Receives care closer to the patient's location (e.g. community or home-based services)
- Empowers the patient and caregivers to actively participate in their care

For the provider, it:

- Links providers in a community to a coordinated plan of care
- Eliminates duplicative and conflicting work between providers
- Shares information with the patient based on the patient’s preference
- Encourages staff to function at the top of their license
- Broadens the type and role of staff providing the care

Scope

Solutions that improve patient care, patient flow and provider workflow in appropriate settings (inside and outside our four walls) are in scope. The ideal solution is patient-centric and helps
patients, family members and care providers implement a coordinated plan of care across multiple disciplines, settings and organizations. The solution must simplify the current care process and eliminate fragmentation of care. In addition, patient information and warm handoffs must be accessible to the patient as well as multiple care providers and organizations. Finally, the solution must achieve cost savings during the testing period, while maintaining or improving quality of care and/or access to health care services within and outside our four walls.

The solutions submitted should take the learnings and successes from previous solutions and enhance them to meet the needs of patients with elements that are unique to SCL Health.

Applicants may "adapt" previously implemented models or propose an entirely new model of care. Adapted solutions should build upon a successful model previously tested while piloting an approach that is a new and/or unique service for dual eligible patients at SCL Health.