Creating a Value-Driven Health Care Delivery System: Quality and Outcomes Do and Will Matter
Agenda

• **Level-setting**: Key Concepts from Healthcare’s Current State

• **Working Example**: Transportation, the New York State Delivery System Reform Incentive Payment (DSRIP) program and the Finger Lakes Performing Provider System (FLPPS)

• **Q&A**
Level-setting

Key concepts from healthcare’s current state:

- Social Determinants of Health
- The Triple AIM
- Value-based reimbursement
- Rapid implementation of Health Information Technology (HIT)
- Integrated Delivery Systems
Social Determinants of Health
Social Factors Contributing to Health Outcomes

Proportional Contributions of Contributing Factors to Premature Death

- Genetic predisposition: 30%
- Behavioral patterns: 40%
- Social circumstances: 15%
- Environmental exposure: 5%
- Health care: 10%


“Health Policy Brief: Community Development and Health,” Health Affairs, November 10, 2011
http://www.healthaffairs.org/healthpolicybriefs/
Social Determinants of Health

- Illness
- Injury
- Risk taking behaviour
- Unhealthy lifestyles

- Unemployment or unhealthy work
- Stigma and discrimination
- Lack of affordable healthy options
- Limited opportunities for education
- Poor access to services, transport and good housing
- Unhealthy and unsafe physical environments
- Poverty and deprivation
Why it matters

• **Transportation is a Social Determinant of Health**
  - Transport to health care services
  - Transport to social support

• **Mobility is a Social Determinant of Health**
  - Understanding a person’s patterns of mobility can help inform all patient interactions
    • Better Referrals and Care Management
    • Restricted Mobility Due to Social Environment, such as Neighborhood Violence
The Triple Aim
The Triple Aim

Source: Institute for Healthcare Improvement
Why it matters

The Triple Aim offers a the common principals for collective focus and impact:

– Is your intervention leading to improved health?
– Is your intervention ALSO cost-effective?
– Would a patient ALSO confirm that your intervention provided a positive experience?
Value-Based Reimbursement
From Volume to Value

Fee-for Service Reimbursement:
- Reimbursement tied to **volume** (per individual)
- Quality not rewarded
- Collaboration/integration not valued
- No shared financial risk

Value-Based Reimbursement:
- Reimbursement tied to **value, quality and efficiency**
- Payment to manage a **population**
- Shared **accountability**
- IT core to strategy
Medicare’s Move to Value Based Payment

Source: Center for Medicare and Medicaid Services, 2015
Why it matters

• Transportation is a potentially high-value asset
• Transportation Providers must look beyond volume to the value of transportation services provided

The ability to define the value of transportation services, in terms of both cost and benefit, will determine how successful transportation providers are in navigating value-based payment.
# Example

## Traditional Fee for Service: Volume of Services Provided

- Cost of Ride
- Number of Rides

## Value Based Payment: Cost

### Potential Cost Associated with Limited Access to Transportation Services

- Cost of missed appointments
- Cost of poor outcome due to missed appointment
- Cost of inappropriate utilization due to poor outcomes

## Value-Based Payment: Benefit

### Potential Benefit Associated with the Provision of Transportation Services

- Improved access to primary care, prevention and chronic disease management services
- Improved clinical outcomes due to appropriate use of primary care
- Reduction in high-cost service utilization (e.g. Emergency Department/Inpatient Admissions)
Health Information Technology
The Promise of HIT

Investments in Health Information Technology will ensure:

• The RIGHT INFORMATION
• Gets to the RIGHT PERSON
• In the RIGHT PLACE
• At the RIGHT TIME
• In the RIGHT WAY
• At the RIGHT COST
Hospital Adoption of Electronic Health Records

May 2011

December 2013

Dashboard.healthit.gov, 2013
Physician e-RX through an EHR

Dashboard.healthit.gov, 2013
Key Result: DATA

• **Big Data**: Big Data is defined as the sophisticated and rapid analysis of massive amounts of diverse information.
  - Patterns and Trends in data to identify services with the highest cost-benefit
  - Population Based
  - Predictive Analytics

• **Long Data**: Long Data is data that tracks individual health over time and allows patients and their providers to see patterns and trends.
  - Longitudinal Health Record
  - Person(s) based
  - Tie provision of service to outcomes
Why it matters

• Transportation data needs to be included in healthcare’s Big Data revolution to be analyzed appropriately.
  – Claims (Today)
  – Individual **access** to transportation services
  – Closed-loop **referral and use** of transportation services (including public transport)
  – Transport to **non-medical services** Use of transportation needs to be documented in longitudinal health record and tied to outcomes.

• Leverage data to create Value Statement
Integrated Delivery Systems
Key Pillars of an Integrated Delivery System

Integrated Delivery System

Provider Network  Patient Outreach  Information Technology  Value Based Payment  Population Health  Care Management  Community Service Providers
Integrated Delivery Systems (IDS) are a potential cure for systematic fragmentation that adversely impacts quality, costs and outcomes. (Enthoven, 2009)
Examples of Integrated Delivery Systems

• Accountable Care Organizations (ACOs)
• Accountable Health Communities (AHCs)
• Performing Provider Systems (PPSs)
• Some Independent (Individual) Practice Associations (IPA)
• Some Large Health Systems that span the Continuum of Care
Growth in Accountable Care Organizations

Accountable Care Organization Sponsoring Entity

Accountable Care Organizations by State

Medicaid Accountable Care Organizations

As of October 2014, Medicaid Programs in 12 States Are Sponsoring 59 ACOs with More Planned

ACO: Accountable Care Organization
*ACOs only include pediatric Medicaid populations
**These models include programs that reward providers for high-quality and low-cost care (e.g., patient-centered medical home).
Note: This map was created using publicly available information. The actual number of Medicaid ACOs may vary depending on criteria used to define an ACO contract.
Our future success will be defined by our ability to collaborate, anticipate, plan, design and integrate systems, in new and innovative ways.
Why it matters

• There is a place for transportation within integrated networks.

• Potential Path to Integration:
  – Collaborate on common goals and objectives
  – Digitize and collect data
  – Develop a common ground and common language
  – Draft value-statement
  – Become embedded in system redesign
  – Be prepared for ongoing evaluation and improvement
Example:
Transportation, NYS Delivery System Reform Incentive Payment Program, and the Finger Lakes Performing Provider System
2011: NYS Creates the Medicaid Redesign Team

Governor’s Vision for Reform

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure." - Governor Andrew M. Cuomo, January 5, 2011
2014: NYS Received as 1115 Waiver from CMS

Delivery System Reform Incentive Payment Program

• $8 Billion in Medicaid Funds, over 5 years, to Implement Projects aimed at Radical Transformation of the NYS Medicaid Delivery System

• Opportunity to Prepare for System-Wide Transformation via Regional Collaboration between Health Systems and Community-Based Providers and Agencies

• Overarching Objectives of DSRIP in NYS:
  • Improve Clinical Outcomes
  • Reduce Avoidable Hospital Use by 25% over 5 Years
  • **Achieve Triple Aim: Reduce Costs, Improve Patient Experience and Improve Patient Outcomes**
DSRIP Nationwide

Seven States are Implementing DSRIP Programs

- Washington: Plans to implement in 2016, pending waiver approval
- Kansas: Approved in 2013 for $100m, implemented in 2015
- New York: Approved in 2014 for $6.42b
- New Hampshire: Approved in 2016 for $150m
- Illinois: Waiver pending
- Massachusetts (DSTI): Approved in 2011 for $630m; extended for 2015-2017 for $690m
- New Jersey: Approved in 2012 for $666m
- Alabama: Waiver pending


FLPPS FINGER LAKES PERFORMING PROVIDER SYSTEM
Integrated Delivery Systems in NYS DSRIP

Performing Provider Systems (PPS)

- 25 across NYS
- Not-for profit entities
- Largely hospital-owned
- Network of Medical and Behavioral Healthcare Providers, Social Service Providers and Community-Based Organizations
- Implement DSRIP-specific projects
- Collectively accountable for significant, measurable improvements in clinical outcomes, system utilization, population health and patient experience
Finger Lakes Performing Provider System

- **13 Counties** - Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Steuben, Wayne, Wyoming, and Yates
- **1.5M Population**
- **413,289 Lives** (incl. 100K uninsured)
- **5 Naturally Occurring Care Networks (NOCNs)**
- **600 Partner Organizations**
- **28 Hospitals**
- **3,000 Providers**
  Primary Care, SNF, Hospice, Specialists, Pharmacies, etc.
Finger Lakes Performing Provider System’s Transportation Committee

Goal:
Support Project-Level Transportation Mitigation Strategies and Individual Partners Struggling with Transportation-Related Issues

Strategies
• Define Challenges by County and Identify Solutions with Input and Endorsement by Regional NOCN Workgroups
• Share and Initiate Best Practices
• Patient Education Regarding Transportation
The FLPPS Integrated Delivery System

- DSRIP Project 2.a.i: Creating an Integrated Delivery System Focused on Evidence Based Medicine and Population Health Management

- Cornerstone of FLPPS DSRIP Implementation

- Creates foundation for
  - Collective performance
  - Shared accountability
  - Value-based reimbursement
• Transportation solution A costs less than transportation solution B
• Transportation solution A will better impact an outcome or individual X

Transportation solution A is the highest value solution for Individual X based on their diagnosis, socioeconomic status and patterns of mobility.
Lessons Learned to Date

• Challenge to maintain focus on transportation in the midst of widespread delivery system redesign

• Mobility is not well documented or recognized as a cultural preference

• Existing data systems underdeveloped or hidden behind layers of red tape.
Key Takeaways

• Transportation as a recognized asset within Integrated Delivery Systems (IDSs)
  – Participate in system redesign projects
• Connect to IDS Data Environment
  – Regional Health Information Organization
  – Receive and track referrals in digital environments
• Create a value-proposition
  – Monitor health outcomes tied to programs and interventions
  – Identify high-value programs
• Inclusion in value-based payment design and implementation
Q and A
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Thank you!