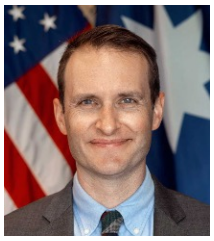
Evolution of Value-Based Care:

Trends, Challenges, and Opportunities



Moderator
Galen Benshoof, MPA
Enterprise Director, Employee Insurance, Minnesota Management and Budget

Panelist
Clint MacKinney, MD, MS
Chief Medical Officer, Cibolo Health

Panelist
Sean Wherry, MD
Physician, Section Medical Director Population Health Section, CentraCare

Panelist
Hannah Wieshalla, MBA
Executive Director, Population Health and Central MN ACO

MN Community MEASUREMENT

1

Rural Engines for Value-Based Care

CELEBRATING 20 YEARS | 2005-2025
MN Community MEASUREMENT

MN Community Measurement
September 25, 2024

Rural HEALTH VALUE

Clint MacKinney, MD, MS
University of Iowa and Cibolo Health

rupri RURAL POLICY RESEARCH INSTITUTE

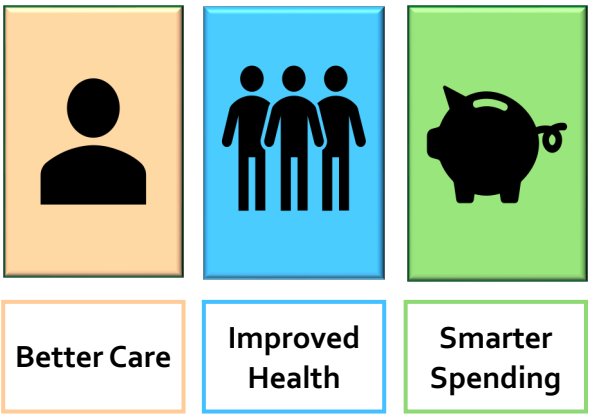
IOWA PUBLIC HEALTH

StratisHealth

2

Triple Aim and Why It's Important

- What most people expect of the healthcare system!
- Shouldn't we be paid for what our patients and communities deserve?
- Let's also consider the *Quadruple* Aim.



Rural HEALTH VALUE

3

3

From Now Until When

- **Today**: fee-for-service predominates
  - Pays for each unit of service
  - Rewards industriousness and efficiency
  - Contributes to high-cost health care
  - Worsens professional satisfaction
- **Future**: **value-based care**
  - Requires team-based care
  - Rewards better care and efficiency
  - Increases healthcare quality
  - Reduces healthcare costs
  - Improves professional satisfaction

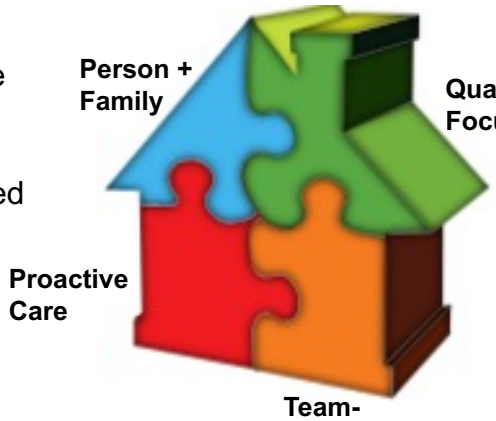
Rural HEALTH VALUE

4

4

Value-Based *Care*

- Value-based care prioritizes high-quality, person-centered, and efficient care.
- Value-based care does NOT prioritize the volume of services provided.
- **Robust primary care** practices are an essential ingredient (as in person-centered health homes).
- But we have a problem…



Rural HEALTH VALUE

5

5

The Value Conundrum

You can always count on Americans to do the right thing – after they've tried everything else.

- Fee-for-service
- Full capitation
- Market-based
- Single payer

- What about paying for **healthcare value**?

Rural HEALTH VALUE

6

6

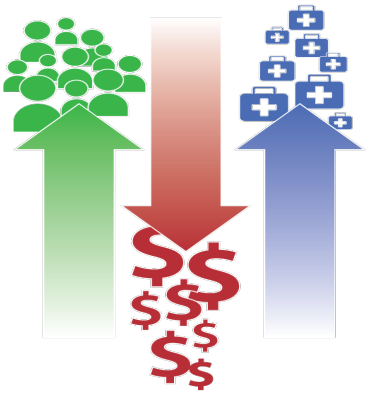
Form Follows Finance

- How we *deliver* care depends in part on how we are *paid* for care.
- Thus, new value-based payment systems are changing <u>both</u> payment and healthcare delivery.
- Payment supplies fuel for the Volume → **Value** transition.

Rural HEALTH VALUE

Value-Based *Payment*

- **Payment** for one or more parts of the Triple Aim.
  - Better patient care
  - Improved community health
  - Smarter spending
- Not payment for an individual service; that is, NOT fee-for-service.
- To *receive* value-based payment, we must *deliver* value-based care.



Rural HEALTH VALUE

Why Discussing Payment, Not Care?

- Career as a rural family doc, yet…
- Money is a medium of exchange.
- Incentives drive behavior.
- Not all incentives are financial, but finance remains important.
- Let's incentivize the Triple Aim.
- Make it easy to do the *right* thing.

Rural HEALTH VALUE

9

RURAL CLINICALLY INTEGRATED NETWORKS

CIBOLO

10

A CIN is a *Cooperative*

- A **cooperative** is a membership organization, whose members work together to achieve ***common goals***.
- Members have
  - Mutual authority
  - Collective accountability
  - Shared savings/profits
- Goal is VBC contracts with all payers.
- The rural healthcare clinically integrated network is <u>not</u> anti-payer and <u>not</u> anti-system. **It is pro-rural!**

 | 11

11

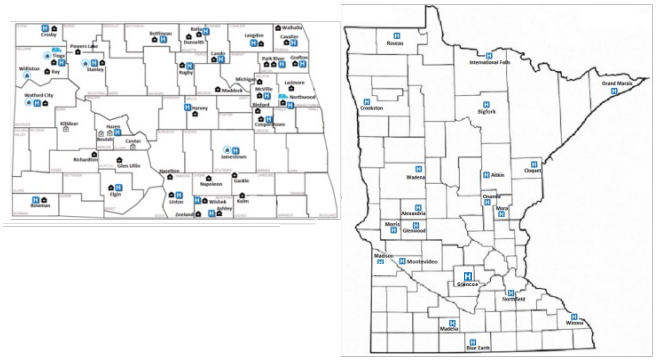
Rural Challenges

Loss of operational control through distant health system affiliations.	→	Maintain control through *interdependence* with peers.
Patient and service volumes too low for value-based care contracts.	→	Combine patients to gain scale for value-based care contracts.
Payer-designed programs do not recognize rural healthcare realities.	→	Design health plans to recognize and reward rural strengths.
Under-resourced performance improvement systems.	→	Share performance improvement and data analysis resources.
Inaccurate or incomplete performance data held by payers.	→	Control your own data with a shared population health platform.

 | 12

12

Rough Rider & Headwaters Combined Stats



- 42 hospital members plus many clinics and *growing!*
- ~ 775,000 persons
- ~ $2.0 billion in net revenue
- ~ 13,000 member employees
- ~ 50,000 MSSP lives
- Like a farmers' cooperative, we are stronger ***together***.

13

CIN Governance

- Non-profit incorporation – in the state where the CIN operates.
- Governing Board of Directors – elected by the CIN CEOs.
- Cibolo staff – supports strategic, administrative, operational, financial, and clinical operations.
- Working committees – representatives from each CIN member that make recommendations to the Board.

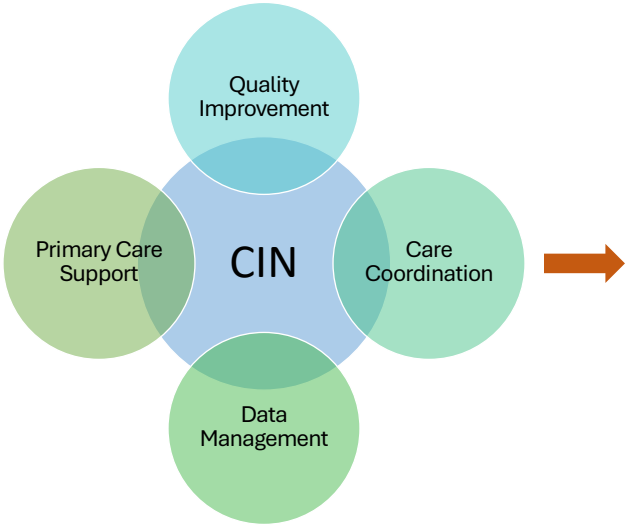
14

CIN Committees

- Clinical Integration Committee
  - Physician, PA, or NP from each CIN member
  - All **clinical** issues (e.g., quality improvement and data analysis)
- Care Coordination Committee
  - Care coordinators, quality directors, and/or clinic managers from each CIN member
  - All **workflow** issues (e.g., team-based care and care coordination)
- Business Integration Committee
  - CFO or COO from each CIN member
  - All **business** issues (e.g., shared services identification and payer negotiations)

15

CIN Functions and Solutions

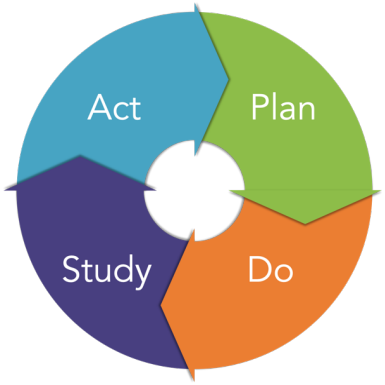


Quadruple Aim
- Better patient care
- Improved community health
- Smarter spending
- Care team well-being

16

CIN Solution – Quality Improvement

- Too many measures! Focusing on all means focusing on none.
- Clinical Integration Committee selects 10 quality measures each year for the CIN.
- Each member then selects 1-2 for a 6-month *focused* improvement project.
- Share project results among all members. Learn from each other!



17

CIN Solutions – Care Coordination

- Primary care team
  - Physicians, APPs, nurses, managers, coders, care coordinators, registration, and more
- Local team
  - Primary care team, Public Health, pharmacists, community health workers, community-based organizations, and more
- Virtual team
  - Supports, not supplants, local team
  - Services that are not available locally

Requires a consistent care coordination *system* to assure health care occurs at the right place and at the right time without duplication or waste.

18

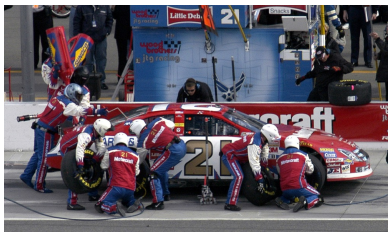
CIN Solution – Data Management

- Population health IT platform
- Quality and cost data management
- Data collection, analysis, and reporting
- *Actionable* quality and cost reports
- Payer-agnostic and EHR-agnostic
- CIN "owns" its data in perpetuity
- Very expensive to purchase and operate – requires a collaborative

19

CIN Solution – Primary Care Support

- Practicing Primary Care *Wisely* Initiative
- Initiative goals
  - Continuous clinical quality improvement
  - Increased primary care practice efficiency
  - Improved primary care team satisfaction
  - A culture of belonging as RRHVN members
- Team-based care focus
- Designed to return time in the workday to busy professionals
- Consultant team led by Stratis Health (with AMA, QHA, and Blue Agilis)



20

Clinically Integrated Network Summary

- Provides solutions to many rural healthcare organization challenges.
- Encourages independence through interdependence.
- Allows payer negotiations and single-signature contracting.
- Requires strong organization capacity and leadership skill.
- Offers an opportunity to advance the Quadruple Aim – serving rural people, places, and providers.

 |

21

THANK YOU

Contact

clint.mackinney@cibolohealth.com

22

Evolution of Value-Based Care:

Trends, Challenges, and Opportunities

Panelist
Sean Wherry, MD
Physician, Section Medical Director Population Health Section, CentraCare

Panelist
Hannah Wieshalla, MBA
Executive Director, Population Health and Central MN ACO

MN Community MEASUREMENT

23

2024 CENTRACARE Facts & Figures

Data as of June 30, 2023

AT A GLANCE

10 HOSPITALS[1]

30+ CLINICS

160+ OUTREACH LOCATIONS

ONE MEDICAL SCHOOL

REGIONS & HOSPITALS

EASTERN & WESTERN
Long Prairie
Melrose
Monticello
Sauk Centre

CENTRAL
St. Cloud

SOUTHWEST
Benson
Litchfield[1]
Paynesville
Redwood Falls
Willmar

[1]CentraCare operates 10 hospitals including management oversight for Meeker Memorial Hospital & Clinics. Other data points do not include Meeker Memorial Hospital.

[2]CentraCare Hospital Admissions: Inpatient = 32,663 and Outpatient = 412,534

PATIENT CARE

346K UNIQUE PATIENTS

445K HOSPITAL ADMISSIONS[2]

54K SURGERIES PERFORMED

120K ER VISITS

CAREGIVERS

11.6K Employees

900+ PHYSICIANS & APPS

990+ VOLUNTEERS

FINANCIALS

$1.9B Total Revenue

0.31% OPERATING MARGIN

$328M COMMUNITY BENEFIT

24

24

CentraCare's VBC Landscape

- Over 10 years experience
- 150,000 covered lives
- Many different payer partner arrangements
- Central MN ACO
- 44% tipping threshold
- System commitment to Population Health

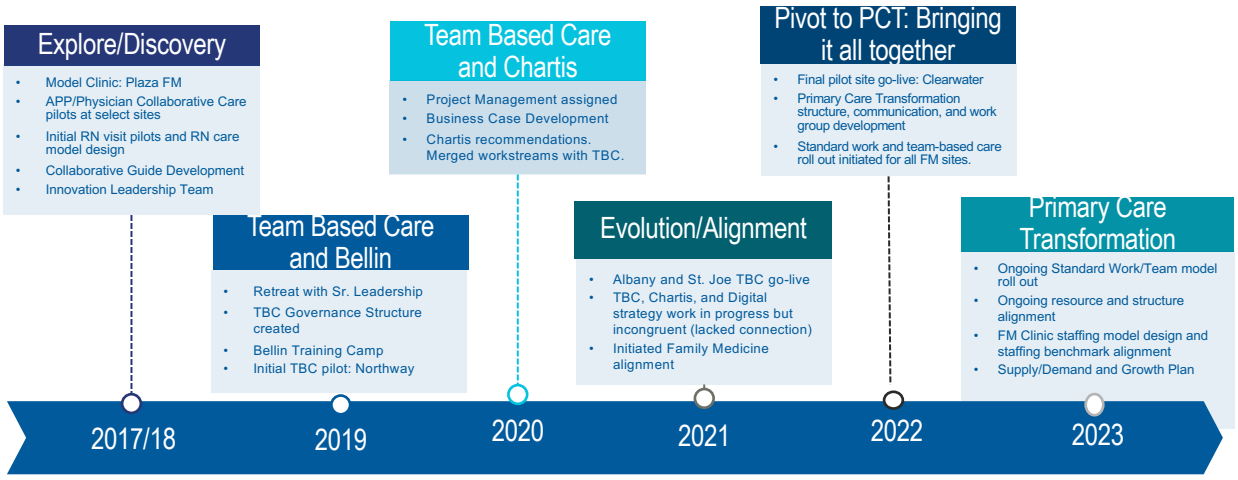
25

Managing the Polarity of FFS and VBC

- Embrace it
- Strategic Alignment
- Commitment to the quadruple aim
- Nimbleness
- Our topics for today:
  - Primary Care Transformation
  - Primary Care Compensation Redesign

26

Journey to Primary Care Transformation



27

So, What is Primary Care Transformation?

It is a structure that fosters alignment and continuous improvement within Primary Care.

It is a vehicle for advancing standard work.

It is how we focus our teams on both quick wins and larger strategy discussions.

It is a balance of many priorities – ensuring that no one area receives too much or too little emphasis and that multiple aims are achieved.

It is our OneCentraCare primary care approach to achieving the quadruple aim.

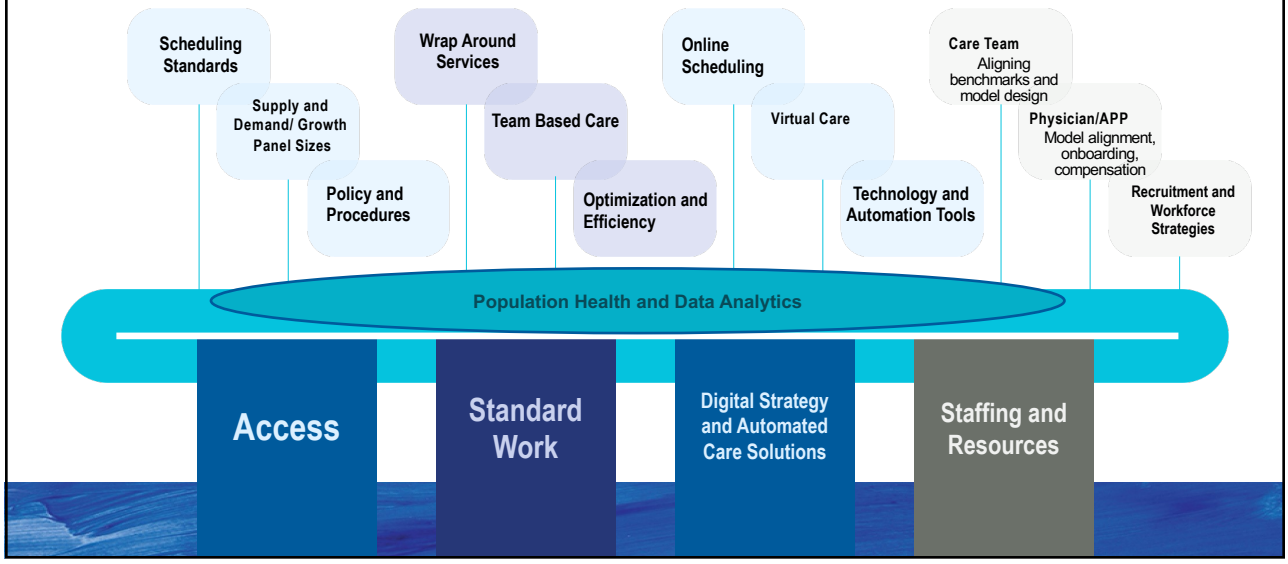
It is a common language and structure that improves our ability to work with our internal partners, and their ability to work with us.

28

28

CentraCare™

Primary Care Transformation



29

Ambulatory Rural/Central Alignment: Family Medicine

Primary Care Transformation Steering

Care for Kids Council

Ambulatory Cabinet

Ambulatory Quality Council

PCT Standard Work
Kristen Guthmiller, Stacey Heiling, Katie Trosdahl, Dr. Libby Brever, Dr. Chris Thompson, Dr. Deb Peterson, Dr. Alan Roiseland, Dr. Jen Boelter, Janelle Terhaar, Jessica Martinez, Gini Pilles, Renee Doetkott, Hannah Wieshalla, Catie Robak, Heidi Albrecht, Atlas AnagnoS, Tressa Schmidt, Caryn McGeary

PCT Digital
Dr. Joe Blonski, Ryan Engdal, Dr. Lynn McFarling, Amy Porwoll, Bryan Lydick, Kristen Guthmiller, Stacey Heiling, Heidi Albrecht, Atlas Anagnos, Steph Hagen

PCT Staffing and Resources Physician/APP Models
Kristen Guthmiller, Stacey Heiling, Dr. Ulrika Wigert, Dr. Libby Brever, Dr. Deb Peterson, Dr. Chris Thompson, Bobbie Bertram, Cheryl Huls, Elaine Thelen, Christy Ringsmuth – Mohs, Kelsey King, Gini Pilles
Ad Hoc: Clinic Directors, Denise Christie

PCT Access
Kristen Guthmiller, Stacey Heiling, Dr. Ulrika Wigert, Dr. Libby Brever, Dr. Sharon Ruggiero, Dr. Dave Kruse, Dr. Julie Youngs, Hannah Wieshalla, Atlas Anagnos, Heidi Albrecht, Lisa Baron, Erin Woodman, Julie Devore

Scheduling Governance

Regional Primary Care Leadership
- Monthly

PCT Leader Summit
Annually TBD

Central Executive
- Monthly

Regional Physician and APP Meetings
- Clinical Partners (bi-monthly)
- Site Panel and Provider Meetings (monthly/bi-monthly)
- APP Meetings (PRN)

Stacey/Kristen (Weekly)

Primary Care Sr. Directors (Bi-weekly)

Central Physician and APP Meetings
- Provider Huddle (weekly)
- Provider Site Meetings (monthly)
- All Provider Meetings (qtrly)
- APP Meetings (PRN)

Regional Clinic Directors Huddle
- Weekly

Family Medicine All Director Huddle
(Weekly)

Central Clinic Directors Huddle
- 4 days per week

Regional 1:1's
- Sr. Director: Clinic Directors: (monthly)
- Sr. Director: Presidents (monthly)
- Sr. Director: Dyads (monthly)
- Sr. Director: APP leads (monthly)
- Sr. Director: Vice President (biweekly)

Work Groups and System Touch Points:
- Primary Care/Call Center/Patient Access Huddle (Bi-weekly)
- Sr. Directors/Pop Health: Monthly
- Sr. Directors/Patient Exp: Quarterly
- Sr. Directors/TMO: Bi-monthly
- Sr. Directors/Dir. Epic Optimizer: Quarterly
- Refill Center Provider Meeting: Quarterly

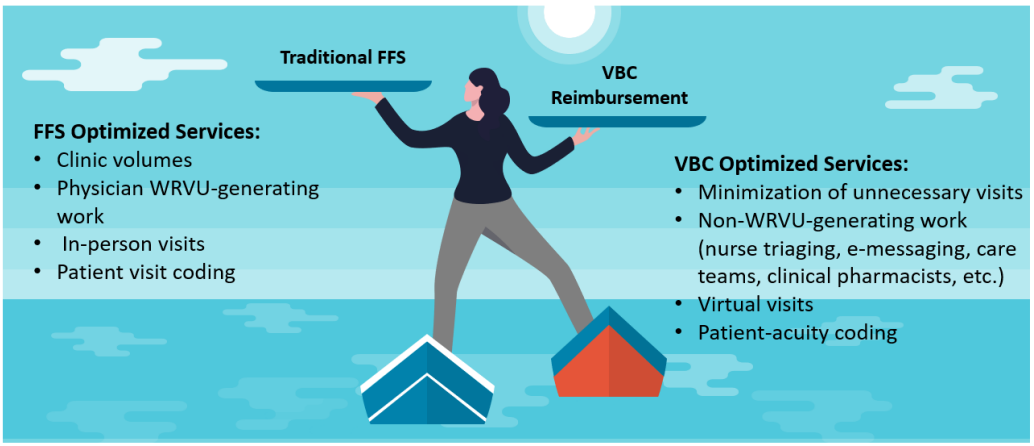
Central 1:1's
- Dyads: Ambulatory VPs (monthly)
- Sr. Director: Clinic Directors (weekly)
- Dyad Partners (weekly)
- Dyads: APP Lead (monthly)
- Dyads: Sub-Section Dyads (twice monthly)

30

Aligning the work with Compensation

31

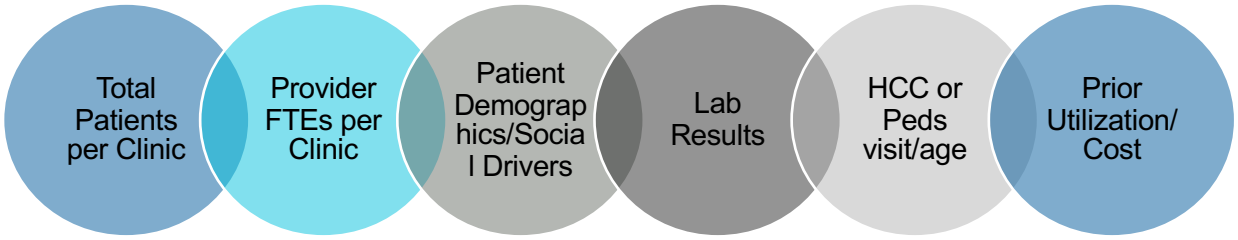
Balancing Fee-for-Service (FFS) and Value-Based Care (VBC) Reimbursement



32

Primary Care Compensation Redesign - Components

- Increased pool of value/quality
- wRVUs
- Risk Adjusted Panel



33

33

34

34