Alliance Learning Collaborative
Positioning for Partnership:
Home Health Agencies Building Key Relationships for Success

September 16, 2015
About the Alliance

• 501(c)(3) non-profit research foundation

• Mission: To support research and education on the value home health care can offer to patients and the U.S. health care system. Working with researchers, key experts and thought leaders, and providers across the spectrum of care, we strive to foster solutions that will improve health care in America.

• [www.ahhqi.org](http://www.ahhqi.org)
Today’s Speaker

Brent Feorene
Vice President of Policy and Operations, National Association of ACOs

Brent T. Feorene has over 25 years of experience in health care consulting. Mr. Feorene has nationally recognized expertise in identifying and addressing the strategic and management issues in physician-lead, post-acute, and community-based services and programs. His clients have included traditional acute care providers such as health systems and ACOs, managed care organizations, home care agencies, and community-based providers and service agencies. Among his engagements, Mr. Feorene has worked collaboratively with these clients to create integrated delivery models that bridge location and level of care to ensure timely access to appropriate services and high-value care delivery. Mr. Feorene offers clients exceptionally strong strategic and business planning skills seasoned through multiple program implementation engagements.

Mr. Feorene’s areas of expertise include the following: Community-based care management; Business models for post-acute programs; Post-acute medicine.

Previously, Mr. Feorene was founder and president of Colonnade Healthcare Solutions, a consultancy focused on community-based care delivery and management.

Mr. Feorene is an advocate and thought leader in the community-based care delivery and management arena, and has written and spoken on a variety of strategic and management issues impacting post-acute care. He currently serves on the Board of the American Academy of Home Care Medicine.
Today’s Webinar

• During the presentation submit questions to “Teresa Lee” at the Fuze Chat Box.
• Slides will be posted on the “Webinars” portion of the Alliance website. We are also recording the webinar for playback on the website.
Alliance for Home Health Quality and Innovation

Positioning for Partnership:
Home Health Agencies Building Key Relationships for Success

Brent T. Feorene, MBA, VP, Integrative Delivery Models
Health Dimensions Group
Today’s Session

Welcome & Introductions

Top Five Trends in Integrated Care

Early Learnings

Making Your Case

Fitting It All Together
Introduction to Health Dimensions Group
Brent T. Feorene, MBA  
Vice President, Integrative Delivery Models

• Senior-level health care executive with over 20 years’ experience consulting to a breadth of health care organizations on a variety of ambulatory and post-acute strategy and management issues

• Clients include health systems, academic medical centers, home health/home care agencies, SNFs, community service organizations, and managed care organizations

• Serves on the board of the American Academy of Home Care Medicine (AAHCM) and on the executive committee as treasurer

• Respected presenter and author; has written and spoken on a variety of strategic and management issues impacting health care, including editing and authoring grant-supported publications on community-based care management initiatives
Health Dimensions Group: What We Do

Strategic Consulting
- Strategic planning and positioning
- Health care continuum alignments
- Market growth strategies
- PACE development
- Bundling implementation
- Senior service line development
- Post-acute medicine development

Operational and Performance Improvement
- Clinical
- Financial and billing
- Regulatory compliance
- Reimbursement advisory
- Transaction advisory
- Business office support
- Operations re-engineering

Management Solutions
- Strategic planning and positioning
- Turnaround management
- Transitional leadership
- Full-service management
- Acquisitions & divestiture
- Interim management
“If you think you can run your company the next ten years the way you ran it the last ten years, you are out of your mind…”

Roberto Goizueta
Former CEO Coca-Cola
Top Five Trends in Integrated Care
Top Five Trends in Integrated Care

1. Value-based movement:
   - Value- and outcome-based payment growth
   - Dual-eligible population
   - Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act)
   - Medicare spending per beneficiary (MSPB)

2. Social determinants of care

3. Engaged intervention (National Transitions of Care Coalition, NTOCC)

4. Integrated care partnerships

5. Strategic pivots/repositioning
Payment Is Rapidly Shifting from Rewarding Volume to Rewarding Value

Payment Tied to Performance
Value- and Outcome-Based Payment Growth

Health and Human Services set goals for Medicare fee-for-service (FFS) payments linked to quality and alternative payment models in 2016 and 2018 targets.

Health Care Transformation Task Force

Several of nation’s largest health care systems and payers, joined by purchasers and patient stakeholders, have committed 75% of their business into value-based arrangements by 2020.

## Costs Vary by Initial Post-acute Setting

Average Medicare Episode Payment for MS-DRG 291 (CHF) by First-PAC-Setting for 30-day Fixed-length Episodes (2007–2009)

<table>
<thead>
<tr>
<th>Setting</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>HHA</td>
<td>$13,470</td>
</tr>
<tr>
<td>SNF</td>
<td>$20,318</td>
</tr>
<tr>
<td>IRF</td>
<td>$33,295</td>
</tr>
<tr>
<td>LTCH</td>
<td>$45,293</td>
</tr>
<tr>
<td>STACH</td>
<td>$23,679</td>
</tr>
<tr>
<td>Community</td>
<td>$12,388</td>
</tr>
</tbody>
</table>

Notes: Dobson | DaVanzo analysis of research-identifiable 5 percent SAF for all sites of service, 2007-2009, wage index adjusted by setting and geographic region, and standardized to 2009 dollars.

# Medicare’s Bundled Payment for Care Improvement (BPCI)

<table>
<thead>
<tr>
<th>Types of Services Included in Bundle</th>
<th>Model 1 Acute Hospital Stay Only</th>
<th>Model 2 Acute Hospital + Post-Acute</th>
<th>Model 3 Post-Acute Care Only</th>
<th>Model 4 Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Related readmissions</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Other services defined in the bundle (Medicare Parts A &amp; B)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Target to Performance Payment</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>
Number of Bundling Models Continues to Grow

- Medicare BPCI
- Commercial
- Medicaid
- Medicare Managed Care
- Medicare Comprehensive Care for Joint Replacement
Bundles Have Four Similar Components

- Defined population
- Defined period of time
- Quality of care
- Target price

But, may differ:

In payment structure
- Prospective
- Retrospective

And, risk structure
- Upside risk (shared savings)
- Downside risk (cost overruns)
Medicaid Programs Have Begun to Adopt Value-Based Strategies

- **Arkansas** has a Medicaid bundled payment system designed to work with multiple payers
  - Providers are ranked by episodic cost after meeting quality threshold
  - Applies to about a dozen chronic care conditions typical of an under 65 population, with more expected to be added

- **New York State** is requiring that 80% of Medicaid payments be made under value-based framework within five years
Commercial Plans

In the next 5 years, bundled payments will represent 35% of U.S. health systems’ revenue.

Health Systems
Average Percentage of Hospital Revenues by 2018¹

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>Bundled Payments</th>
<th>Capitated or other payments w/insurance risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>35%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Health Plans
Bundled Payment Implementation Plans²

<table>
<thead>
<tr>
<th>Currently Implemented</th>
<th>Planning to Implement</th>
<th>No Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>24%</td>
<td>34%</td>
<td>42%</td>
</tr>
</tbody>
</table>

Bundled Payment Implementation Progress²
What phase of bundled payment plan implementation is your health plan currently in?

Early  | Mid  | Late | Unsure

²Source: Avality, The Health Plan Readiness to Operationalize New Payment Models, April 2013. The study was administered by independent research firm Porter Research in the fourth quarter of 2012. Porter Research completed interviews with qualified participants of 39 health plans that represented more than 50% of total covered lives in the United States. Target participants included: quality management leadership, medical directors, and chief medical officers.
New CMS Bundling Program: Comprehensive Care for Joint Replacement Model (CCJR)

• Announced in July for January 1, 2016, implementation
  – Still in comment period but represents CMS’ intent to grow model participation
• Would be mandatory program in 75 randomly selected metropolitan statistical areas (MSAs)
• Similar to Model 2 (hospital initiated) bundling, except:
  – Limited to joint replacement DRGs
  – Mandatory
  – Some program tweaks
  – Includes quality thresholds
• No downside risk until 2017
What is a Program of All-inclusive Care for the Elderly (PACE)?

- A PACE organization meets the needs of its enrolled population by providing comprehensive medical, social, and preventative services
- Participants are at a nursing facility level of care
- PACE has integrated financing arrangement
- Scale, state Medicaid rates, and strong population health management capabilities are keys to success
PACE Nationally
In 32 states serving more than 34,000 participants...

Source: PACE in the States; www.npaonline.org

...sponsored by 115 organizations
## Eligibility Criteria

- 55 years of age or older
- Live in a PACE service area
- Certified as eligible to receive nursing home level of care
- Able to live safely in community at point of enrollment

## Enrollees Snapshot

- Mean age: 80
- Gender: approx. 75% women
- Average number of basic ADL deficits: 3.5
- Cognitive impairment: 63%
- Average enrollment: 2.2 years
- Dually eligible: 95%
Post-Acute Medicine

• Medical model not bound by traditional delivery locales or roles
• Certain population segments require medical care outside of the acute and ambulatory settings
• Focus on timely access and collaborative, team-based care to achieve success in a future defined by value
• Post-acute medicine delivers care in *patient-centered health home* model, integrating and collaborating with other health care and community-based services
446 Medicare ACOs Serving 47 States

MSSP ACOs (Serving 34 states)
Both MSSP and Pioneer ACOs (Serving 13 states)
No Medicare ACOs (3 states)

Source: CMS.gov, January 2015
Senior/Dual Population Force Move Toward Value-Based Care

- By 2025, nearly 1 in 5 U.S. residents will be elderly
- Nearly 50,000,000 seniors in the U.S. in 2015; by 2060, will be nearly 100,000,000
- Nearly 25% of those seniors are dual eligible
- Dual eligibles have higher incidence of disease

<table>
<thead>
<tr>
<th>Disease</th>
<th>Non-Dual Prevalence</th>
<th>Dual Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s</td>
<td>9%</td>
<td>19%</td>
</tr>
<tr>
<td>COPD</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>25%</td>
<td>36%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>15%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: Medicare.gov
14 States Pursuing Financial Alignment Demonstration (12 States Approved)

Source: CMS.gov and Nasuad.org, July 2015

© HDG 2015
IMPACT Act

Improving Post-Acute Care Transformation Act (IMPACT) of 2014

- Standardization of PAC quality and data reporting
  - Streamlines collection of post-acute assessment data
  - Additional data categories also included
  - Providers report on resource use measures including estimated Medicare spending per beneficiary
- Expands and strengthens Medicare five-star quality rating system (Nursing Home Compare)
- Requires inpatient hospice to undergo routine surveys

Understand that, ultimately, the IMPACT Act will lead to significant changes in post-acute payment methodologies likely outcome-based and site-neutral
**Impact Act (continued)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Requirements</th>
</tr>
</thead>
</table>
| Post-acute care (PAC) providers must report: | • Standardized assessment data  
• Data on quality measures  
• Data on resource use and other measures |
| Data must be standardized and interoperable to allow: | • Exchange of data using common standards and definitions  
• Facilitation of care coordination  
• Improvement of Medicare beneficiary outcomes |
| PAC assessment instruments must be modified to: | • Enable submission of standardized data  
• Compare data across all applicable providers |
Medicare Spending per Beneficiary (MSPB)

- MSPB measure is Medicare’s way of measuring hospital financial efficiency
- MSPB measure is average amount a hospital spends (Part A & Part B) versus risk-adjusted average of all hospitals in the nation during a Medicare spending episode
- Medicare spending episode begins:
  - 3 days prior to hospital admission
  - Continues through hospitalization
  - Ends 30 days after hospital discharge
Home Health VBP Model
Recently Proposed by CMS

- Driven by requirement in Affordable Care Act, CMS proposed VBP program for home health agencies (HHAs) that would begin in 2016 and run for five years:
  - HHAs in selected states would experience up to plus/minus 5% Medicare payment adjustment for first two years, eventually ramping up to plus/minus 8% adjustment
  - Attainment and improvement on quality metrics determines adjustment
  - Nine states proposed (may change in final rule): Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington
Home Health VBP Model (continued)

• Quality metrics consider **ATTAINMENT** and **IMPROVEMENT** in:
  
  – 25 metrics currently in use, many from OASIS (clinical quality of care & outcomes, efficiency and person/caregiver-centered experiences)
  
  – 4 new measures (advance care planning, adverse medication events, staff influenza vaccination, and patient shingles vaccination)

• Comparisons are made to similarly sized in-state cohort or to previous performance, and points are awarded
Social Determinants of Care

Greater impact on outcomes than health behaviors, clinical care, physical environment, and genetics

The Seven Essentials of Engaged Intervention

Seven essential intervention categories for reaching the Triple Aim (better patient care, healthy people/healthy communities, lower cost):

1. Medication management
2. Transition planning
3. Patient and family engagement/education
4. Health care providers engagement
5. Follow-up care
6. Information transfer
7. Shared accountability across providers and organizations
Value-Based Movement: Redefining The Value Statement

Offering An Integrated Solution to Population Health Management

- Medical care delivery in the patient’s residence
- Alternative for follow-up visit to busy PCP office with access and scope limitations
- Offering ED physicians clinically appropriate options to an I/P admission
- Integrated, collaborative care in a SNF using physicians and advanced practice providers
- Medical House Calls
- Care Transitions
- Acute Care
- Complex Care Clinic
- SNF
- Home Health
- ED Diversion
- Technology
- Psychosocial Support
Partnerships

• Preferred PAC network (acute to PAC)
• Joint venture:
  ✓ Interlude
  ✓ Ascension Health & Envision
  ✓ PACE with CCRC and senior housing
  ✓ Humana and AMC Health
• PAC network alignment (PAC to PAC)
Post-acute Care Network

- Hospital
  - ACO/MCO

- PACN
  - Tiered Membership
  - Contracted Vendors

- PACN Patient Intake/Management

- SNF
- Home Care
- Hospice

- Patient residence
Four Essentials of PACN Relationships

• Standardization of referral protocols ensures rapid placement of patients in appropriate PAC settings

• PAC facilities must regularly report quality metrics to ensure continued eligibility in affiliation networks

• Patient Acceptance Tracking generates data for future conversations between hospitals and PAC facilities

• Ongoing Communication:

  - Acceptance tracking generates data for future conversations between hospitals and PAC facilities

  - Standardization of referral protocols ensures rapid placement of patients in appropriate PAC settings

  - Clinical Quality Reporting

  - Require Ongoing Communication

  - Attendance at ongoing meetings in conjunction with reactive communication is a necessity
Hospitals Need Strong PAC Partners

**Hospital-Owned PAC Underperforms Financially**

### SNF Costs Per Day

<table>
<thead>
<tr>
<th></th>
<th>Hospital-Based</th>
<th>Freestanding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost</strong></td>
<td>$483</td>
<td>$239</td>
</tr>
</tbody>
</table>

### Percentage of Hospital-Based PAC Facilities

<table>
<thead>
<tr>
<th></th>
<th>SNFs</th>
<th>HHAs</th>
<th>IRFs</th>
<th>LTACHs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong></td>
<td>7%</td>
<td>18%</td>
<td>80%</td>
<td>33%</td>
</tr>
</tbody>
</table>

### HHA Profit Margin

<table>
<thead>
<tr>
<th></th>
<th>All Agencies</th>
<th>Hospital-Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Profit Margin</strong></td>
<td>2%</td>
<td>-7%</td>
</tr>
</tbody>
</table>

© HDG 2015
A “Health Care Neighborhood” for Those with Advanced and Chronic Illness

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Complex Care Clinic</th>
<th>Home Care, Private Duty &amp; DME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Care</td>
<td>Patient-Centered Health Care Neighborhood</td>
<td>Palliative Care Clinic/Hospice</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Telemedicine/Telemonitoring</td>
<td>Geriatric Assessment &amp; Consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Area Agency on Aging &amp; Other Community Agencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>House Calls</td>
</tr>
</tbody>
</table>
Competitive Dynamics of Post-acute Care Industry....

- Race to be aligned with health systems, ACOs, and MCOs across all service lines
- Most markets dominated by local and regional providers
- Consolidation has slowed significantly
- Squeezing reimbursement and regulatory requirements have challenged the industry

1. Value-based movement
2. Social determinants of care
3. Engaged intervention (NTOCC)
4. Integrated care partnerships
5. Strategic pivots/repositioning
Innovations occurring in community-based services include:

- National home care investments in hospital-at-home, medical house call programs, and care coordination
- Growth in post-acute care management companies focused on medically complex patients—post-acute networks
- National providers pursuing exclusive contracts with commercial payers
- Technology

HHAs/SNFs are positioning themselves as post-acute coordinators

Payers are crossing over into the provider side of the equation
Strategic Delineation

Dual Strategy

Solutions Provider

Vendor
Which Post-acute Vendors Will Win?

- Large, market/geographic dominate providers
- Hospital-based providers that are valued by their system
- Providers with aligned interest of payers and referring partners
  - Lowest-cost provider
  - Focused on same quality metrics as partners
- Proven partner with verifiable data
Strategic Pivots/Repositioning: Solutions Provider

- Focus operational strategies on building care coordination infrastructure
- Have or willing to build/buy capability to manage at-risk or high-cost patients
- Ability to communicate their value proposition as a solutions provider
- Capable or moving towards an ability to manage risk
Early Learnings
Early Learnings: Changing Continuum Relationships

Hospitals and physician groups are forming new partnerships with post-acute care (PAC) providers by:

• Discussing quality with the PAC providers likely to receive their patients, even if the providers were not contractually involved in bundling

• Identifying higher quality providers for preferred list, although they must maintain patient choice

Early Learnings: Changing Utilization

CMS analysis of early Model 2 bundlers indicates:

– Use of institutional post-acute care (SNF, LTACH, IRF) after the acute care stay for ortho bundles fell from 66% to 47% of episodes

– Use of HHA after acute care stayed about the same

– Total spending for episodes with post-acute care fell in comparison to the base period by more than the comparison group (while episodes without post-acute care stayed about the same)

Early Learnings: PAC Provider Care Redesign Strategies

- Palliative Care
- Telehealth
- Care Coordination Role
- Health Coach Certification
- Care Pathways
- INTERACT Home Health
- INTERACT 4.0
- PAC Medicine
- Risk-Stratification
- Evidence-based Care Practices
- Patient Education Teach-back
Early Learnings:
Strategy of Care Coordination Throughout Episode

• Transitions management:
  – Between acute care and PAC settings
  – Coordination with primary care
  – Coordination with specialty care
• Risk stratification integration
• Patient activation, teaching, and self-care
• Medication reconciliation at every transition
• Primary care engagement
• Utilization of telehealth
Making Your Case
Value-Based Transformation Checklist

- Become highly knowledgeable about value-based payment transformation occurring in your market
- Obtain data and develop analytic capacity to support articulation of your organization’s value proposition around VBP
- Undergo clinical and operational transformation by implementing standardized care pathways and protocols for reduction of avoidable hospitalizations
- Engage referring health systems and at-risk payers about your value proposition around VBP
- Define path to implement VBP arrangements for the majority of your payers
To prepare for value-based care, define your value-proposition in three key areas and then reach out to value-based payers:

- **Ability to Manage Readmissions**
  Capabilities to manage the patient aggressively in situ, including telemonitoring and medical management strategies, all with lengths of stay within expected norms.

- **Patient Outcomes (Versus Inputs) Relative to Peers**
  Performance better than your peer group on key outcomes such as functional status relative to therapy provided.

- **Episodic Management Capabilities**
  Capacity to manage seamlessly across multiple settings, effectively communicate with the bundler.
Data to focus on?

Star Ratings Still Matter

• **Process of care measures**—how often the agency:
  1. Initiated patient care in a timely manner
  2. Provided patient/caregiver drug education on all medications
  3. Ensured patients received flu vaccine for the current season

• **Outcome of care measures**—how often the patient:
  4. Got better at walking or moving around
  5. Got better at getting in and out of bed
  6. Got better at bathing themselves
  7. Was able to engage in activity with less pain
  8. Experienced less shortness of breath
  9. Required acute care hospitalization
Home Health Compare: Two New Measures

Beginning in July 2015, two new NQF-endorsed quality measures added to HHC:

• Rehospitalization During the First 30 Days of Home Health (NQF #2380)
• Emergency Department Use without Hospital Readmission During the First 30 Days of Home Health (NQF #2505)
Making Your Case: Differentiate Yourself as a Preferred Provider

Know your performance history through benchmarked metrics

**Data**
- E.g., readmissions rates, costs, ED use (by key diagnosis)

**Quality**
- E.g., patient safety (wounds, falls, infections), patient satisfaction

**Process**
- E.g., care transitions, care pathways
Making Your Case: Position Yourself as a Solution

Know your “upstream” providers’ and payers’ needs

• Benchmarked metrics
  – E.g., discharge volumes, length of stay (by DRG), readmission penalties, Medicare spending per beneficiary

• Program participation
  – ACO (Pioneer, MSSP, Next Generation), BPCI, CCJR

• Managed Care
  – Medicare Advantage: Market penetration of primary payers
### Potential Partners

<table>
<thead>
<tr>
<th>BPCI Model 3 SNFs</th>
<th>Medicare Advantage</th>
<th>ACOs/Health Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HHA a key strategy: potential to provide high-quality outcomes at lowest cost setting</td>
<td>• Potential to influence Medicare Advantage Five-Star Measures</td>
<td>• Readmissions</td>
</tr>
<tr>
<td>• Need HHA partners that can offer telemonitoring and care management</td>
<td>• Medication review &amp; adherence, falls risk, and diabetes</td>
<td>• ED diversion to home</td>
</tr>
<tr>
<td>• Continue to manage care within patient’s bundling episode</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Focus on % of recertifications, % of LUPAs, ED visits, and therapy utilization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Readmissions
A Major Opportunity for HHAs to Shine

National Averages for HHA-Initiated 90-day Episodes by Major Group

Opportunity for Robust Telemonitoring Programs

Source: Dobson | DaVanzo analysis of Medicare claims data (100% file - July 2009 through June 2012)
Fitting It All Together
Dual Strategy
Volume and Solutions Provider

**Vendor**
- Growth for the sake of scale
- Streamlined and efficient culture
- Consistent evaluation of winning and losing business lines

**Solutions Provider**
- Packaged solution with niche value proposition
- Build versus buy to fill needed capacity
- Focused with building care coordination infrastructure

**Both**
- Dedicated leadership vendor and solutions strategy
- Clear vision for each strategy
- Alignment of resources
Future Investment

• Network alignment and development
• Care transformation
• Care teams/Interdisciplinary teams
• Technology
  ✓ Analytics
  ✓ EMR
  ✓ Reporting
  ✓ Telehealth
• Engaged physicians
Assessment

Evaluate your ability to add value

✓ Clinical services
✓ Operational
✓ Talent
✓ Competitors
✓ Payers
✓ Vendors
✓ Access to investment capital
The Transition Requires Careful Navigation

• Requires knowledge of the market and your position in it

• Broad-based application of care redesign and targeted interventions

• Knowledge of pertinent quality & utilization metrics (by diagnosis) in comparison to peers will be crucial

• Getting a seat at the table with your value proposition right now!
Not Taking Risk May Not Be an Option in the Future

"I'm not interested in minimum risk. I want long term gains without risk."
Discussion & Questions

• Submit questions to “Teresa Lee” at the Fuze Chat Box.

• Presentation slides and video replay will be available at http://ahhqi.org/education/webinars
Thank You!