Jefferson Health

JH QI Training: Introduction to Healthcare Improvement

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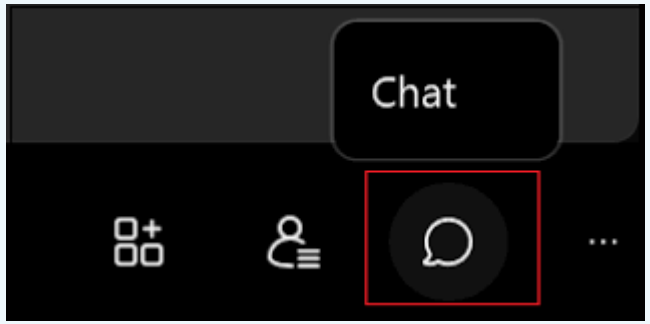
Enterprise Medical Director, Value-Based Care & Quality Improvement

Virtual Format

- Interactive – as much as we can within time frame
- Chat feature – Please use this!
- Hands / exclamations – Encouraged!

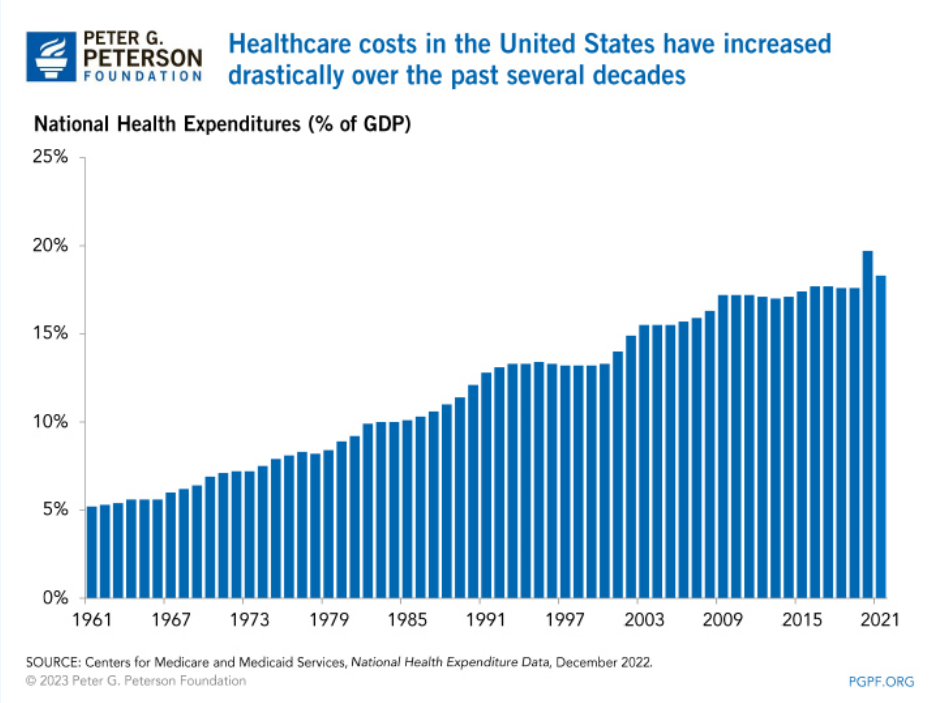


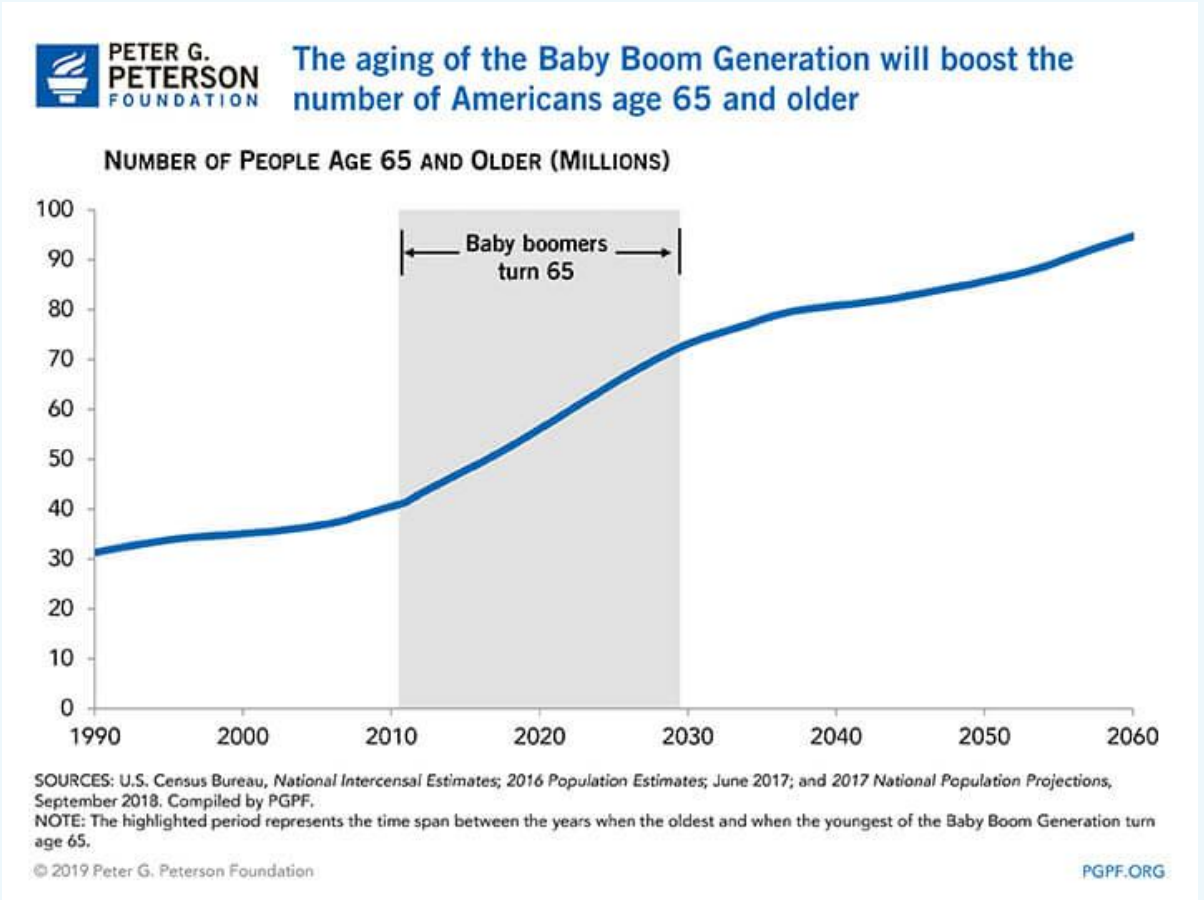
Chat feature discussion

- *One word – how are you feeling about starting this program?*

- My word about YOU starting this program:
  - ***Excited!***
    - It is great to see all of you engaged in this learning program
    - *You are the leaders of today and tomorrow – this education will prepare you to meet the needs of healthcare transformation*

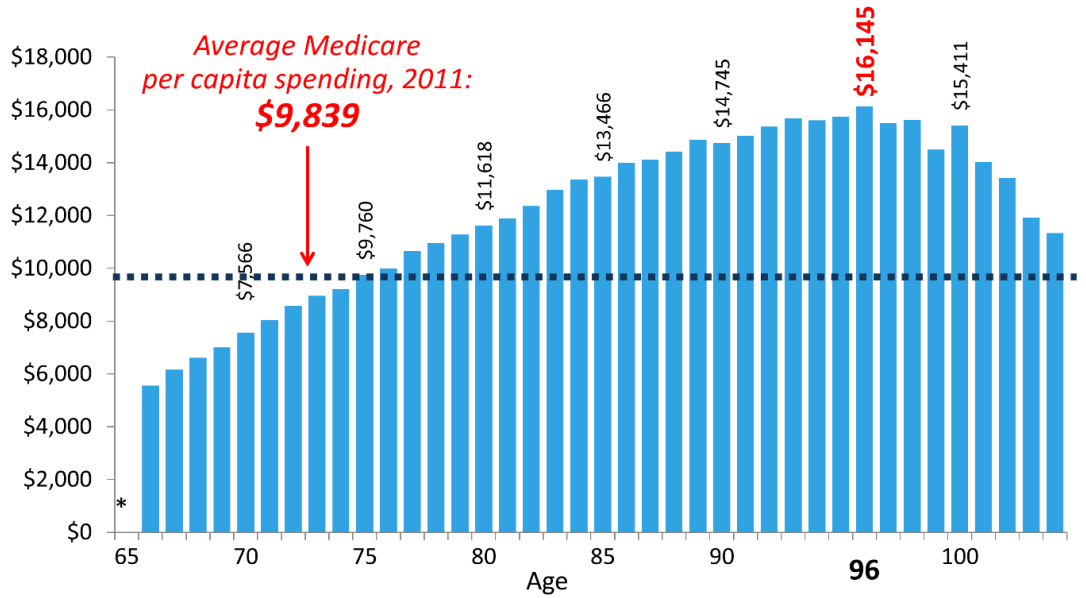
Starting with "Why"





Starting with "WHY"

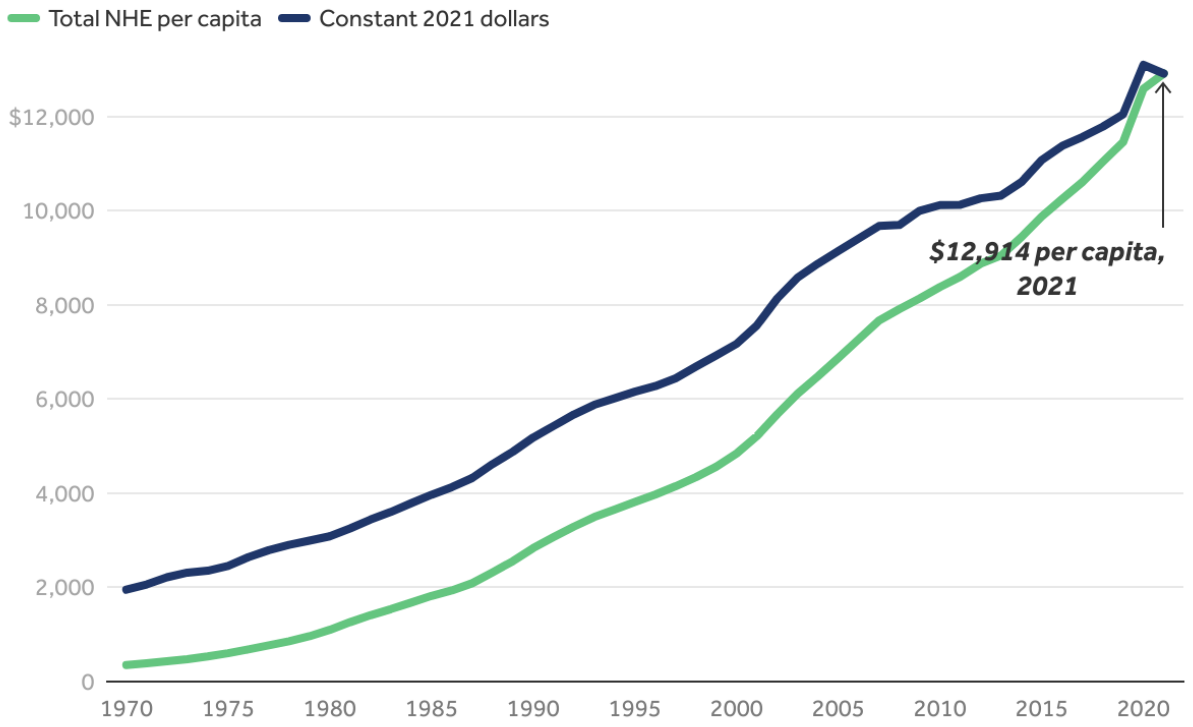
Medicare per capita spending rises with age, peaking at age 96, raising questions about cost and quality



NOTE: Analysis includes beneficiaries in traditional Medicare only (excludes beneficiaries with Medicare Advantage).
SOURCE: Kaiser Family Foundation, "The Rising Cost of Living Longer: Analysis of Medicare Spending by Age for Beneficiaries in Traditional Medicare," January 2015.

THE HENRY J. KAISER FAMILY FOUNDATION

Total national health expenditures, US $ per capita, 1970-2021



Note: A constant dollar is an inflation adjusted value used to compare dollar values from one period to another.

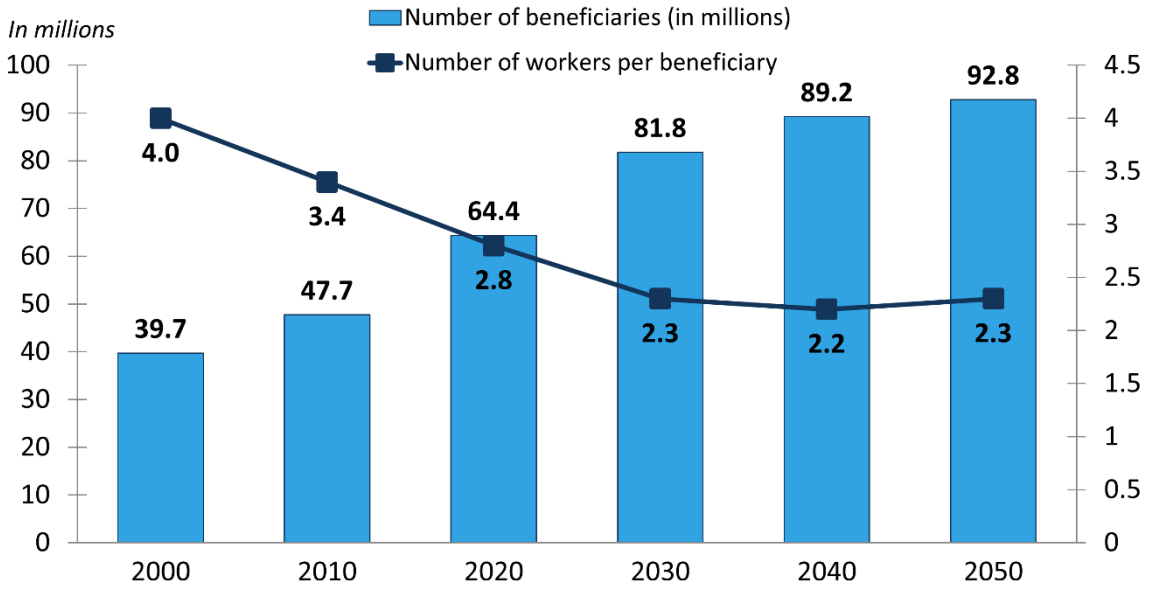
Source: KFF analysis of National Health Expenditure (NHE) data

Peterson-KFF Health System Tracker

Starting with "WHY"

Figure 31

Number of Medicare Beneficiaries and Number of Workers Per Beneficiary, 2000-2050



SOURCE: Kaiser Family Foundation based on the 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

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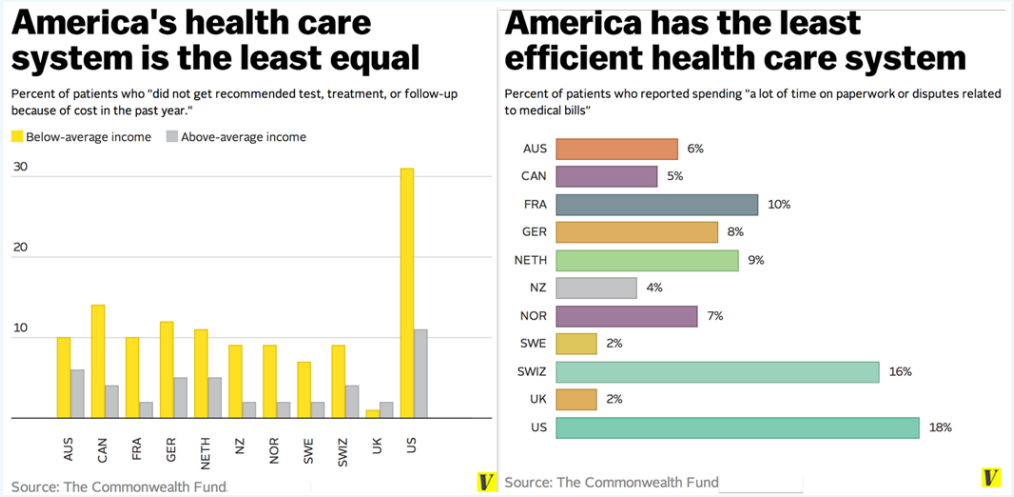
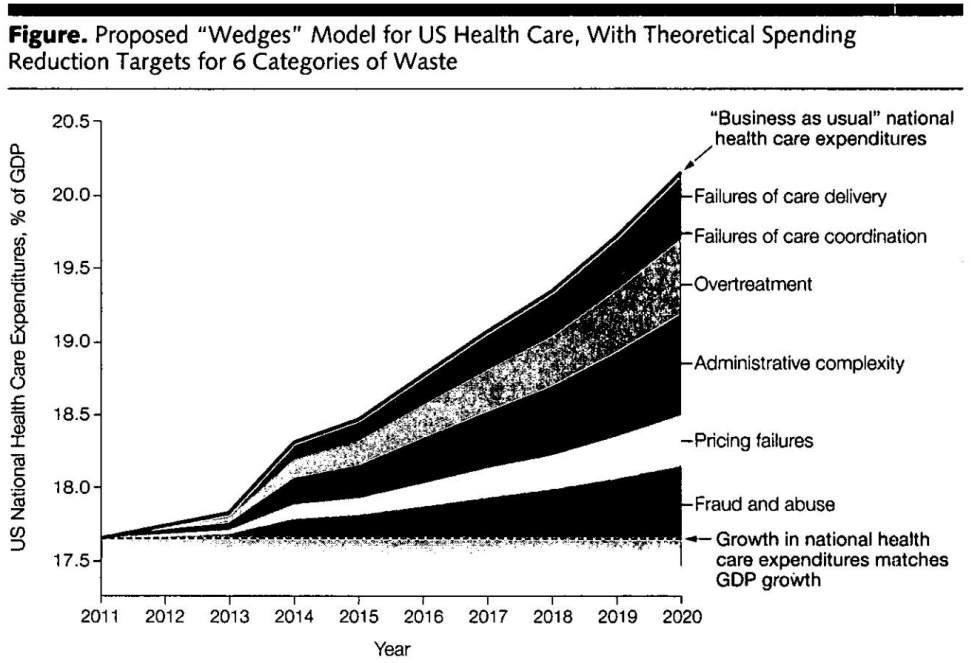
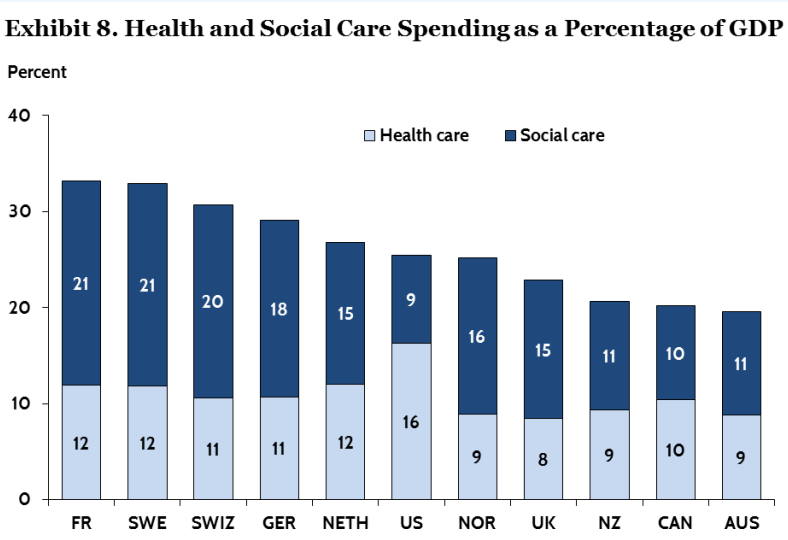
- Price increases, rather than increased utilization, are the primary driver of increased spend

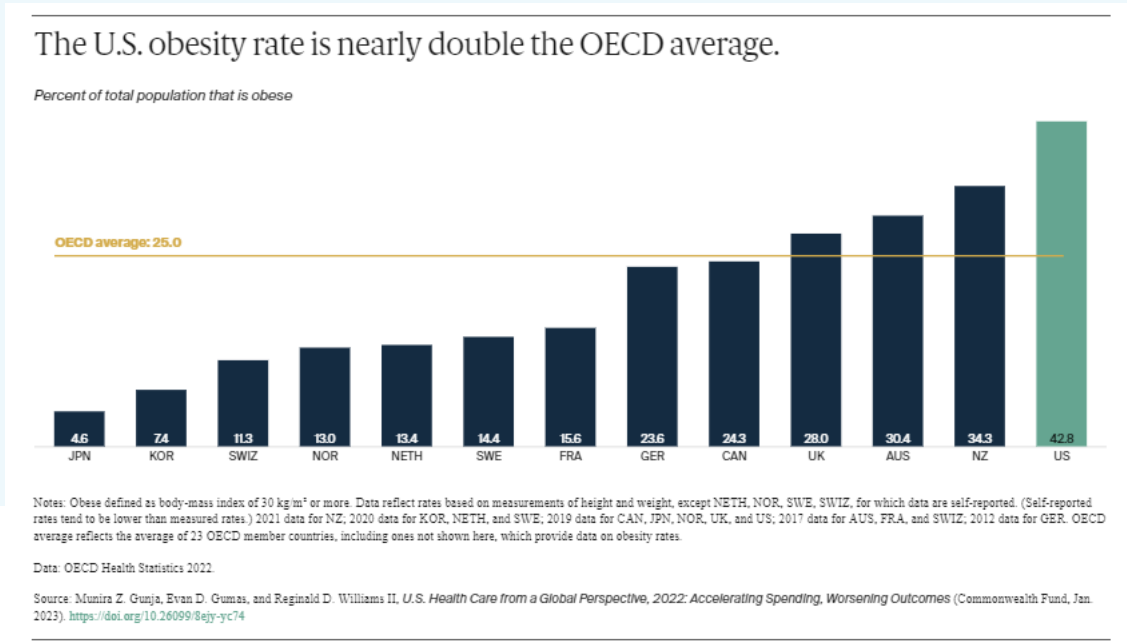
What About Quality?







Notes: GDP refers to gross domestic product.
Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

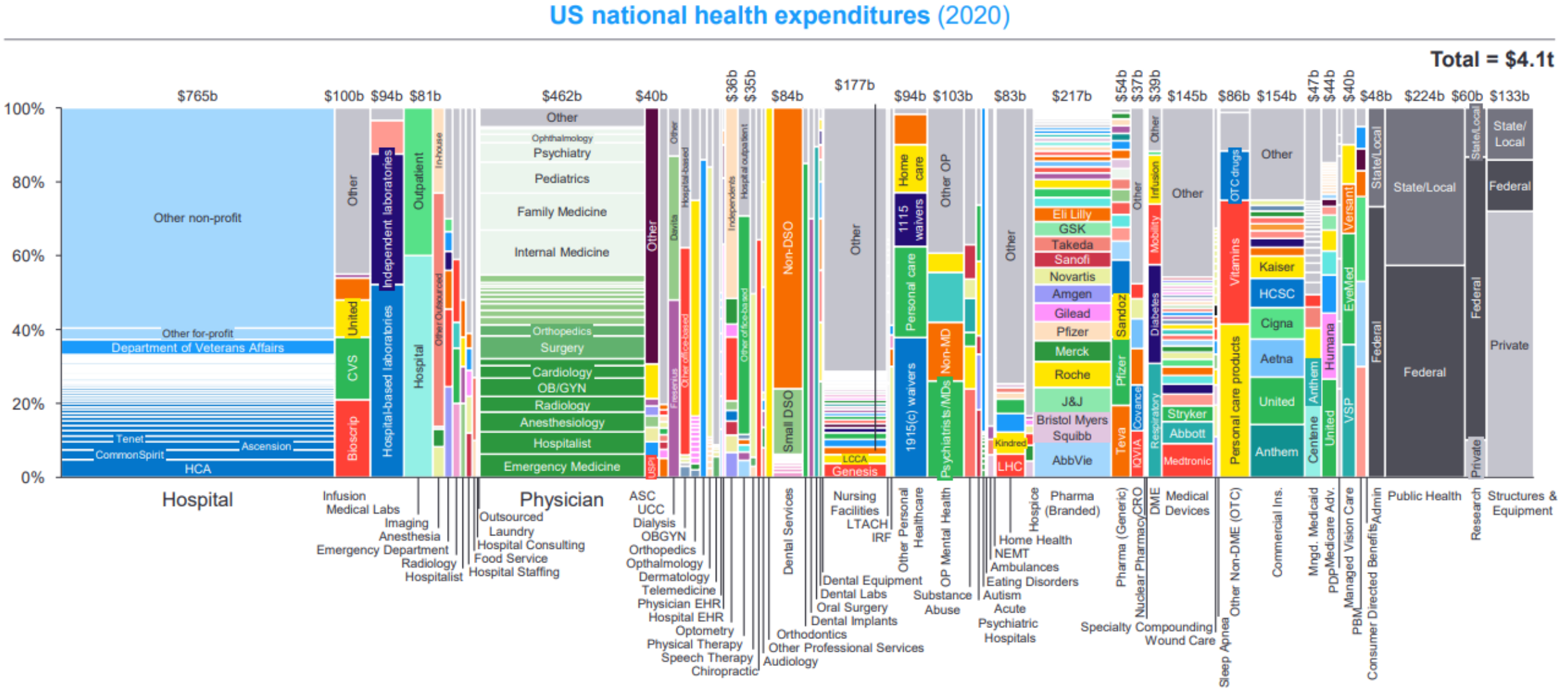


Notes: Obese defined as body-mass index of 30 kg/m² or more. Data reflect rates based on measurements of height and weight, except NETH, NOR, SWE, SWIZ, for which data are self-reported. (Self-reported rates tend to be lower than measured rates.) 2021 data for NZ; 2020 data for KOR, NETH, and SWE; 2019 data for CAN, JPN, NOR, UK, and US; 2017 data for AUS, FRA, and SWIZ; 2012 data for GER. OECD average reflects the average of 23 OECD member countries, including ones not shown here, which provide data on obesity rates.

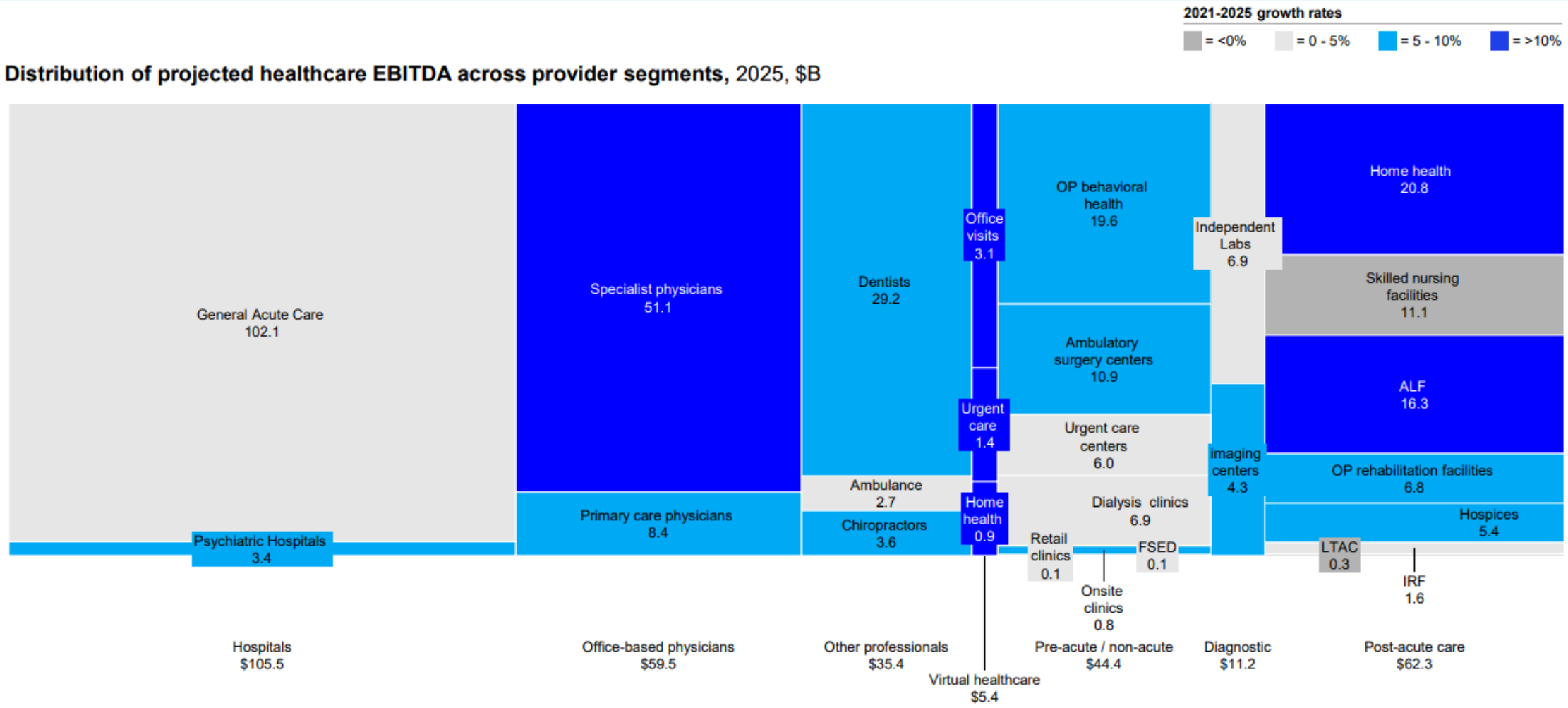
Data: OECD Health Statistics 2022.

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan. 2023). https://doi.org/10.26099/8ejy-yc74

Structural Market Characteristics



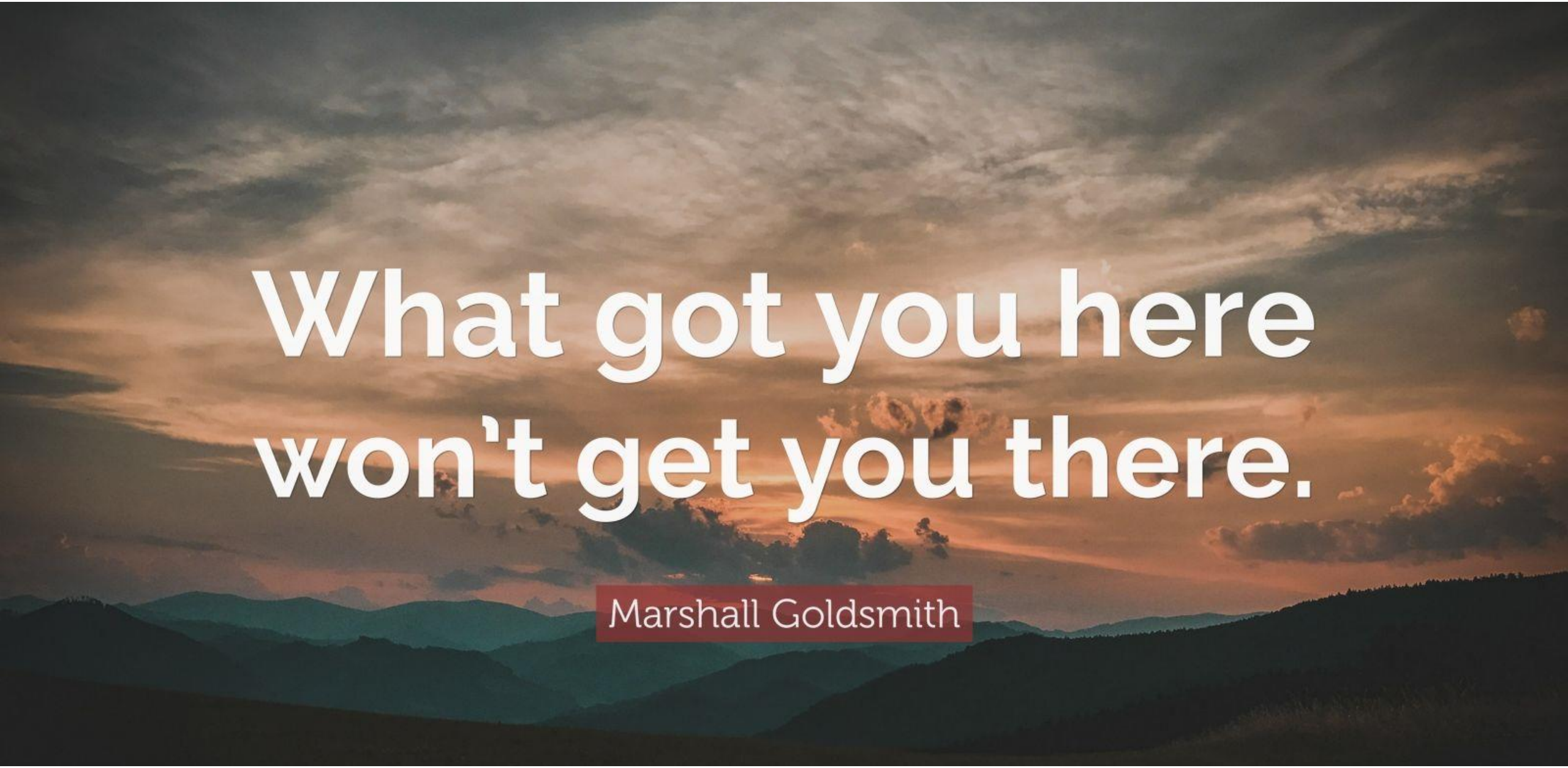
Healthcare = A Shifting Industry



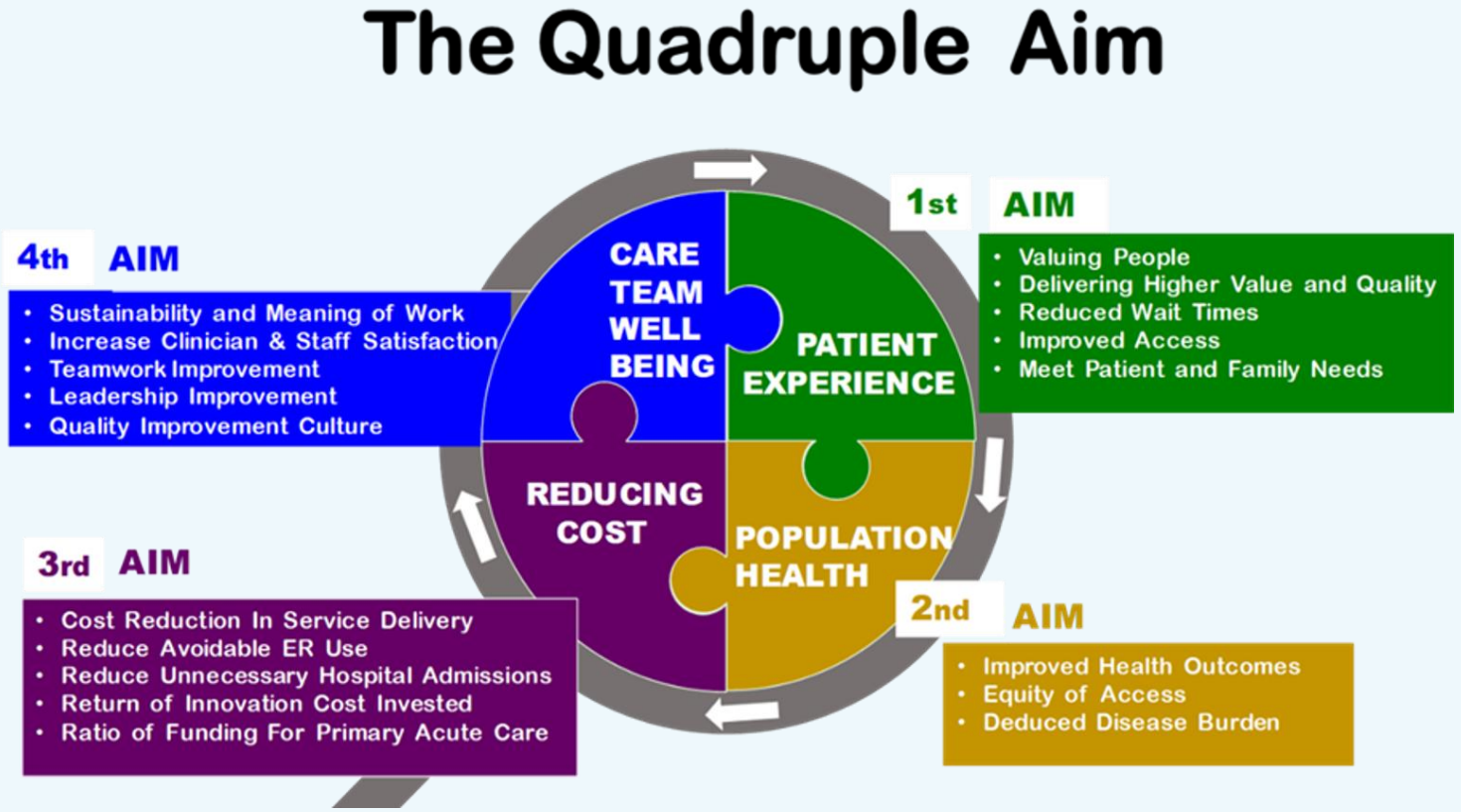
Source: McKinsey Profit Pools Model
Note : FSED – Freestanding Emergency Department; ALF – Assisted Living Facilities; Hospice – includes palliative care centers; IRF – Inpatient Rehabilitation Facilities; LTAC – Long Term Acute Care Hospitals

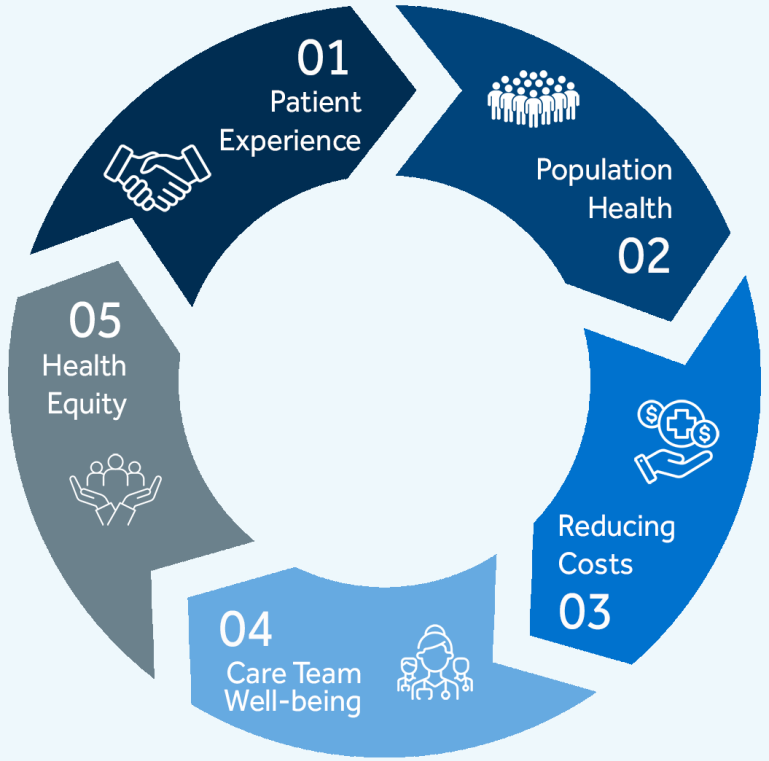
Chat feature discussion

- *Reflect on your clinical experiences and all you know of our overall healthcare system…*
- Keep it at just a few words if you can
- Put a comment into the Chat field regarding how you feel about the state of our current healthcare system and its functioning.. What would be YOUR “why”?


What got you here
won't get you there.
Marshall Goldsmith

Getting from here to there…





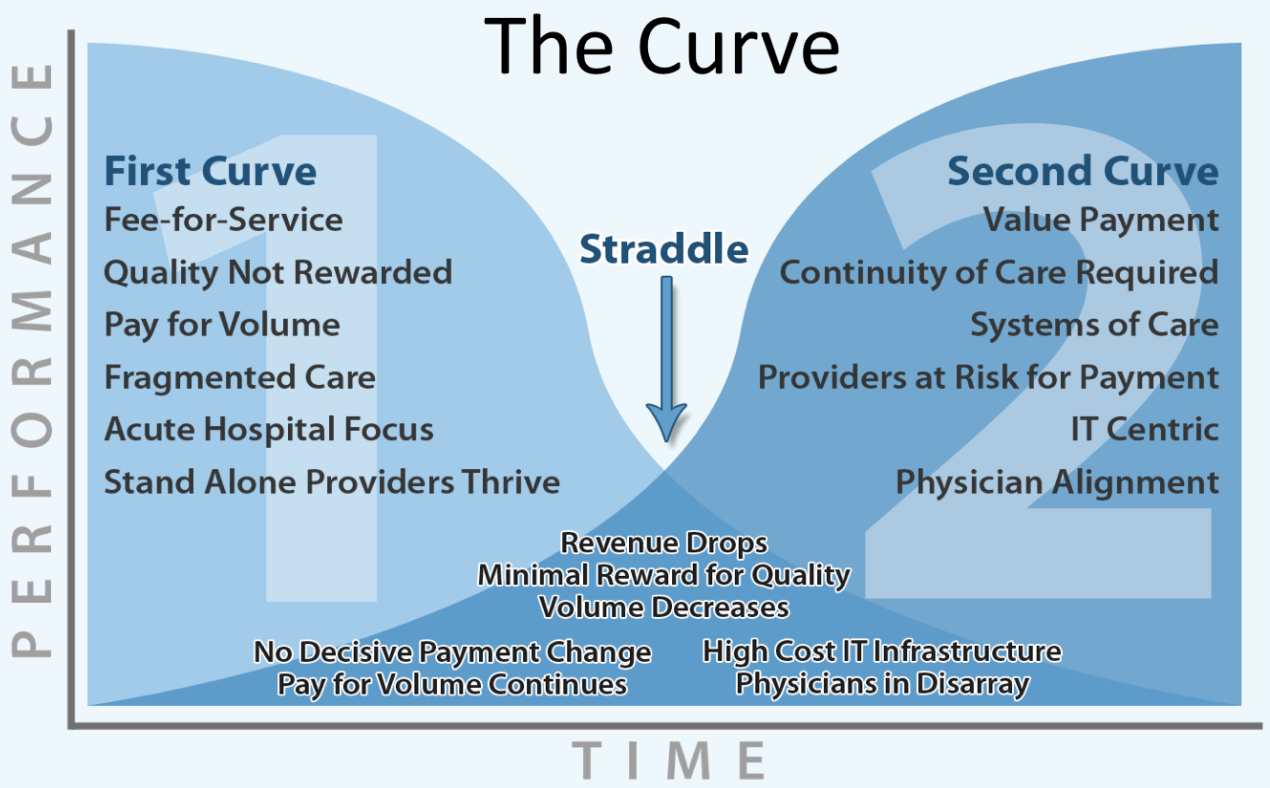
IOM Quality Aims - Crossing the Quality Chasm

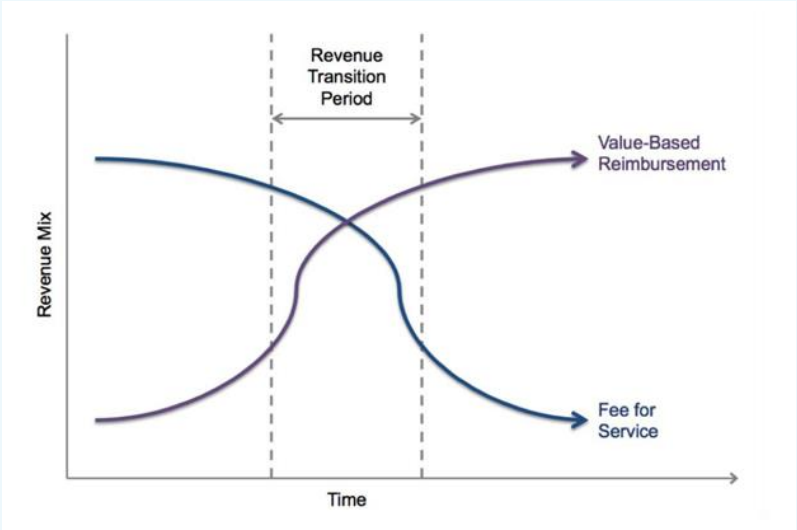
- IOM Quality Aims - STEEEP
  - **Safe** – no harm with care
  - **Timely** – avoid delays
  - **Effective** – match science to care-avoids overuse and underuse
  - **Efficient** – avoid waste- only provide value to patient
  - **Equitable** – every patient, regardless of background or vulnerability receives the best care
  - **Patient centered** – people in control of own care- *nothing about me without me*

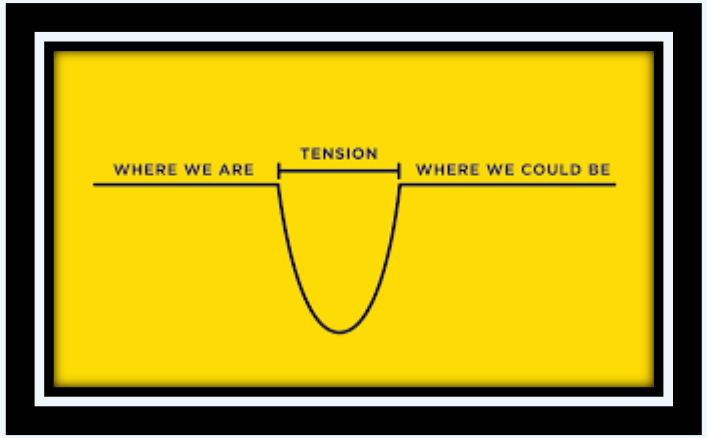
The right care, in the right way, at the right time

Transitions are Underway

- Revenue Model







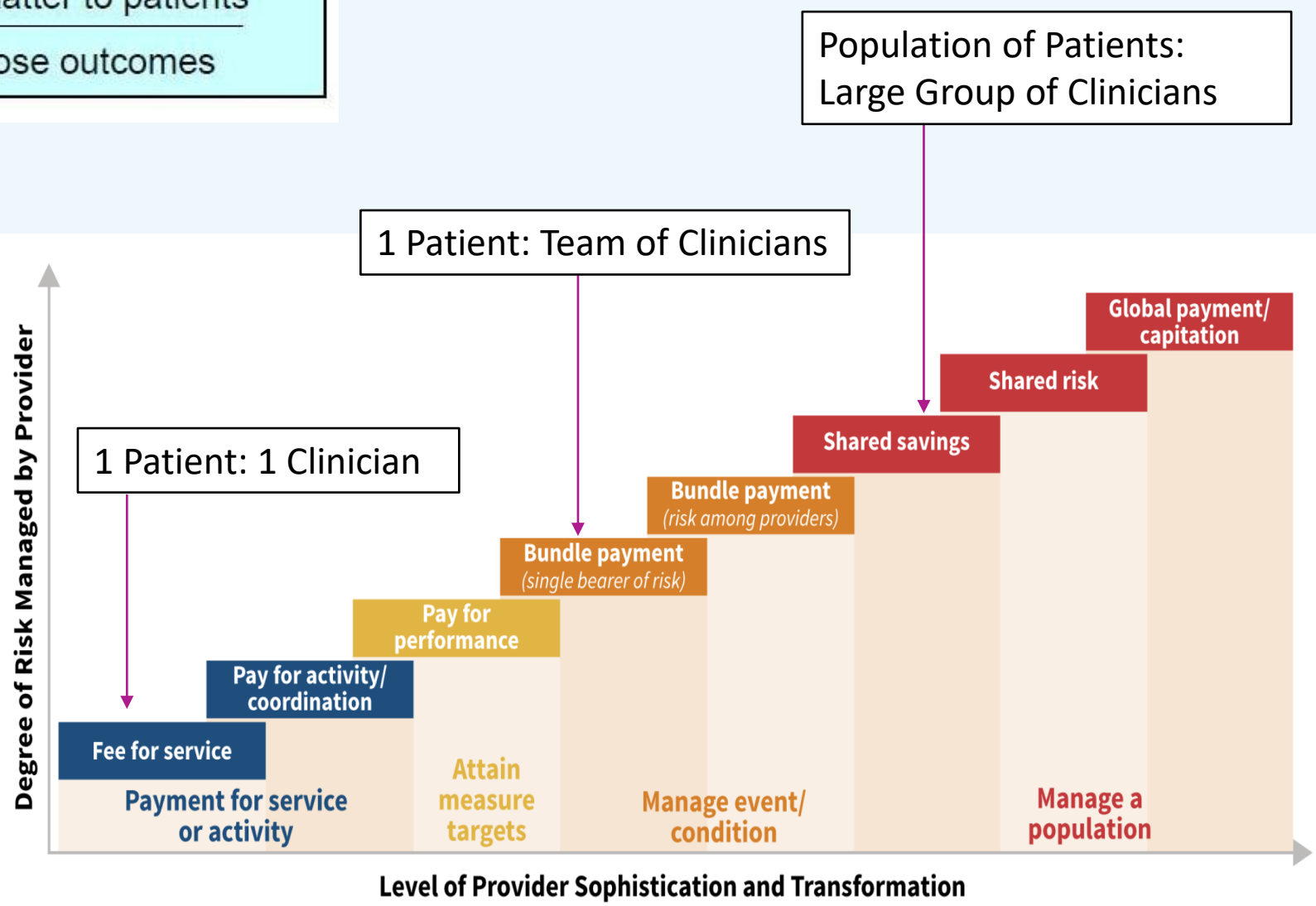
Continuum of Value-Based Care Risk and Transformation

$$\text{Value} = \frac{\text{Health outcomes that matter to patients}}{\text{Costs of delivering those outcomes}}$$

Revenue = FFS

Revenue = FFS + V (Value)

Strong performance on Value-Based Contracts supports our favorable FFS rates

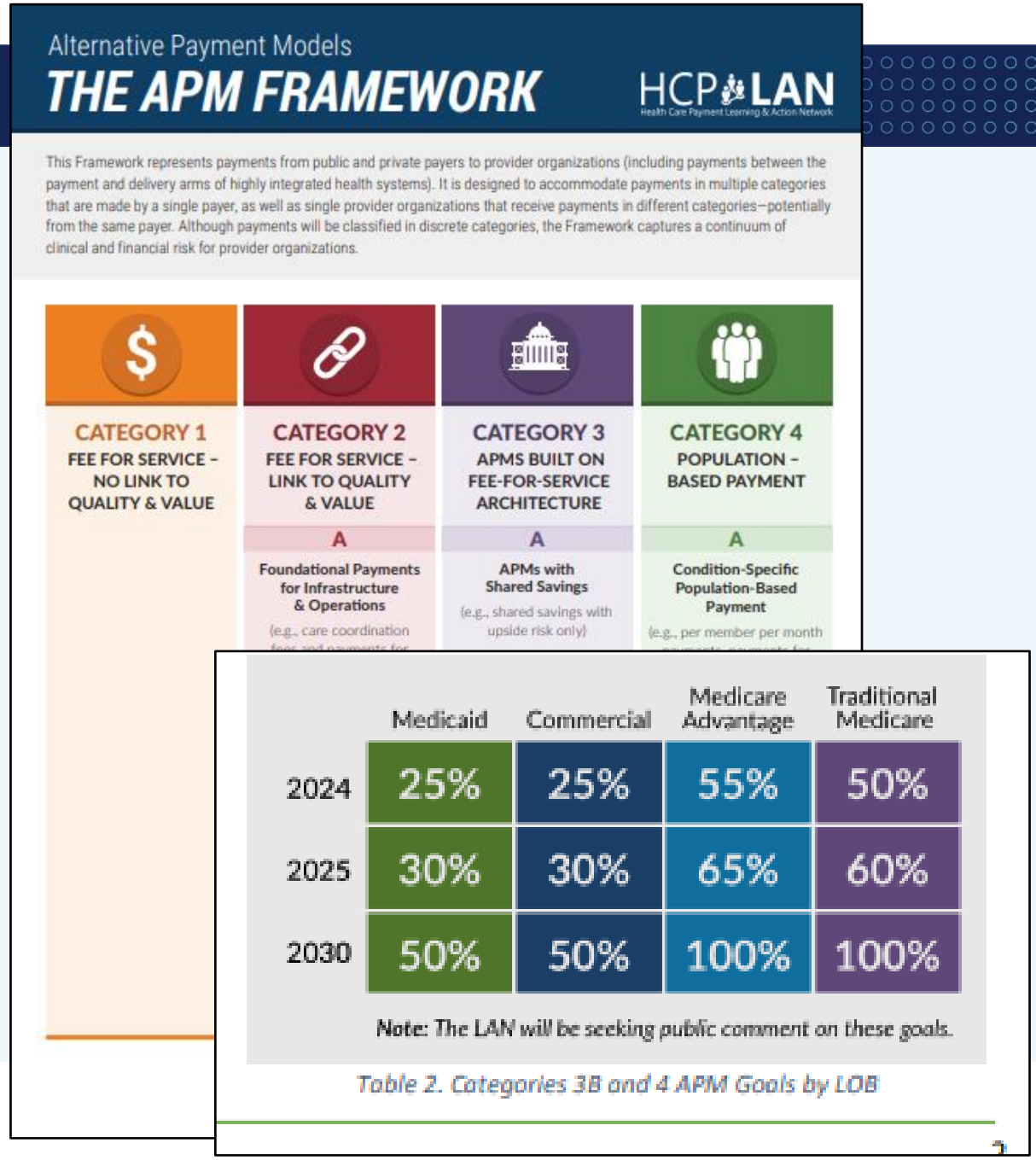


Value Based Care $

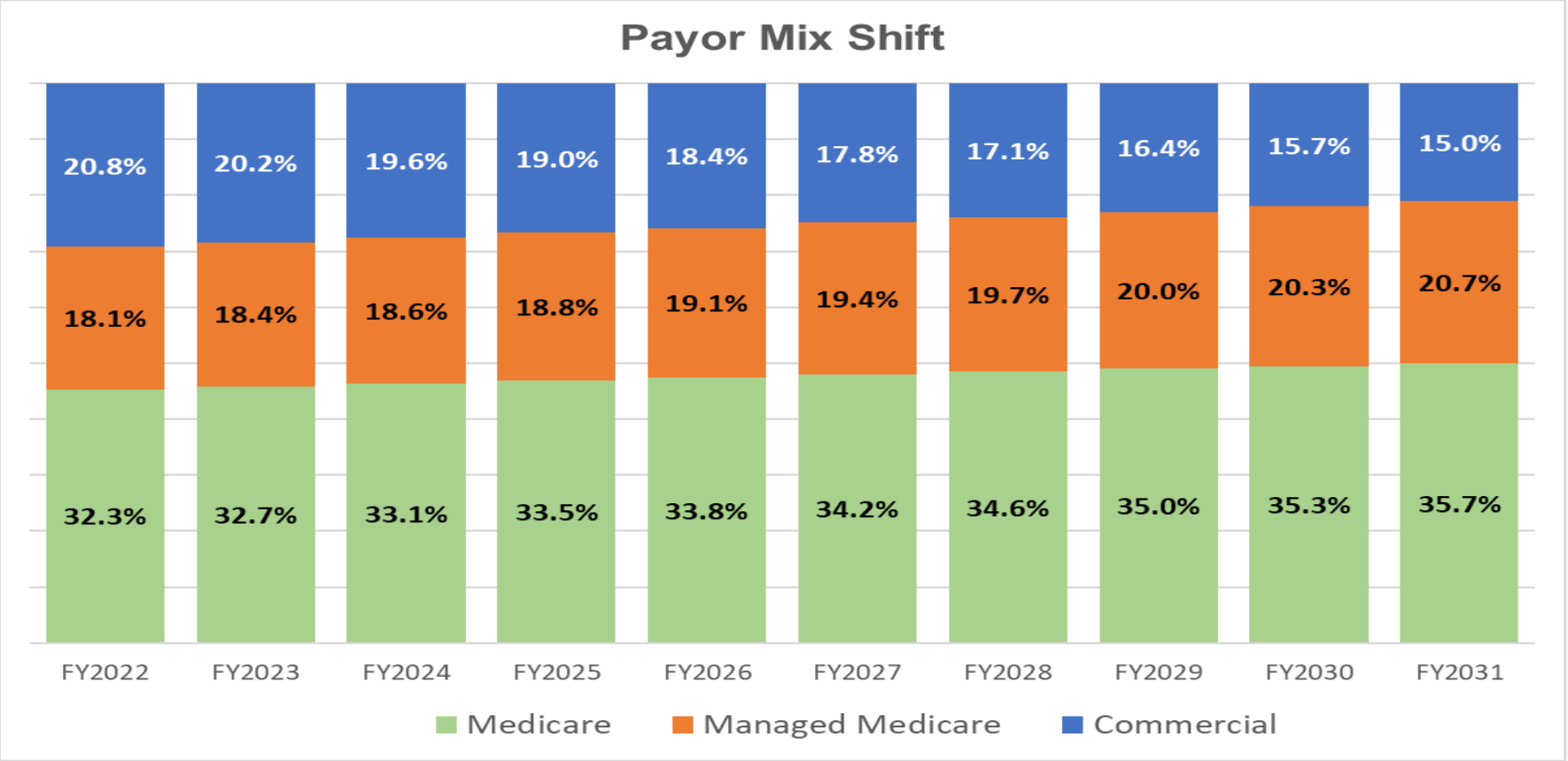
- Different payment models
- Based on risk levels
- Category 1 through 4
  - Highest risk = 4

- Accountable care ≠ FFS
- Only when reimbursement is high enough, or mandatory programs are implemented, will VBC movement occur more rapidly

- Downside risk drives bigger results



Anticipated Payor Mix Shift FY22 through FY31



- Government payers reimburse less than cost
- Commercial payers make up the difference

Academic Integrated Delivery Financial System

Vision Alignment

Mission

We Improve Lives.

Vision

Reimagining health, education and discovery to create unparalleled value.

Our Values

The behaviors our employees demonstrate daily to patients and their fellow staff enable Jefferson to continue to achieve its mission. Jefferson's values define who we are as an organization, what we stand for, and how we continue the work of helping others that began here nearly two centuries ago. These values are:

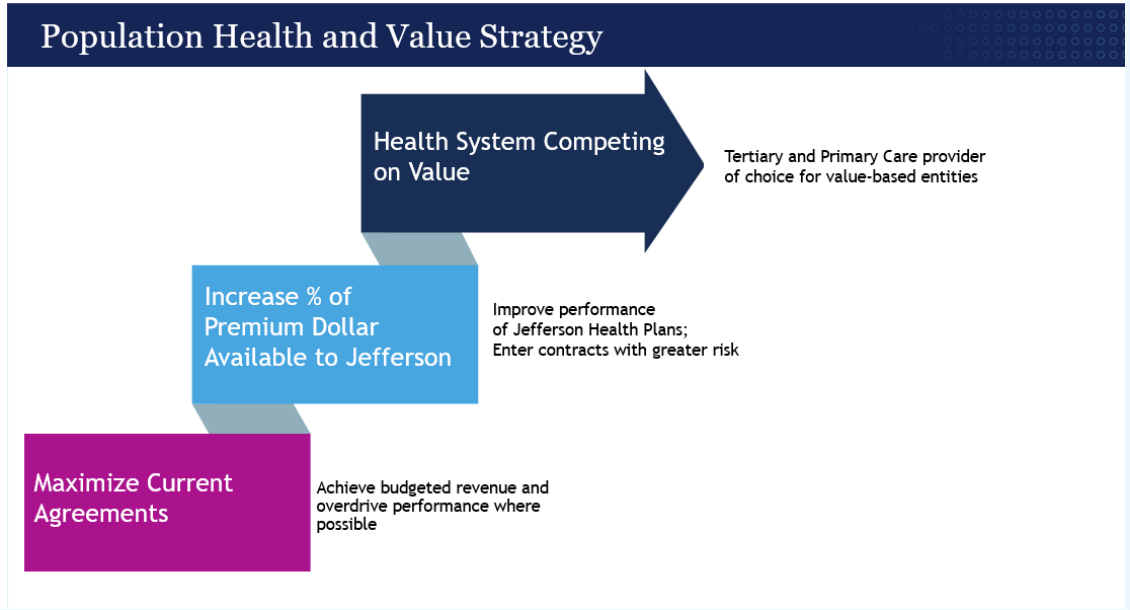
Put People First
Service-Minded, Respectful & Embraces Diversity

Be Bold & Think Differently
Innovative, Courageous & Solution-Oriented

Do the Right Thing
Safety-Focused, Integrity & Accountability

Population Health Vision Statement

Guided by our mission to *Improve Lives* and our vision to *Reimagine health, education, and discovery to create unparalleled value*, Jefferson Health will lead a transformative approach to population health—***one that optimizes value-based care (VBC) performance, empowers a centralized and agile population health team, and influences systemic change to elevate the health and wellness of every community we serve.***



Jefferson Value-Based Care Landscape

2 Billion
Managed Premium Dollars

50+
Value Based Arrangements

760,000
Lives in Value Based Arrangements*

Lines of Business

- Commercial (371K)
- Medicaid (224K)
- Medicare FFS/ACO (87K)
- Medicare Advantage (78K)

3
MSSP ACOs

Confidential- Not for Distribution

Jefferson- LVHN Major Value Based and FFS PHO Contract Offering

$180 Million in total combined VB contract earnings plus FFS messenger model rates on PHO contracts

LVHN PHO	JeffCare CIN	Jeff Care PHO	Einstein Care Partners CIN
• **AmeriHealth Medicaid** • Cigna Commercial • Capital Commercial & MA • **Highmark Commercial & MA** • MSSP ACO • Jefferson Health Plans	• **IBX Commercial** • Cigna MA • United MA • Humana MA • Aetna MA • MSSP ACO	• Keystone First • Cigna MA • Geisinger MA • UPMC MA	• MSSP ACO • **JHP Medicaid & MA** • Aetna Commercial & MA • Humana MA • MSSP ACO

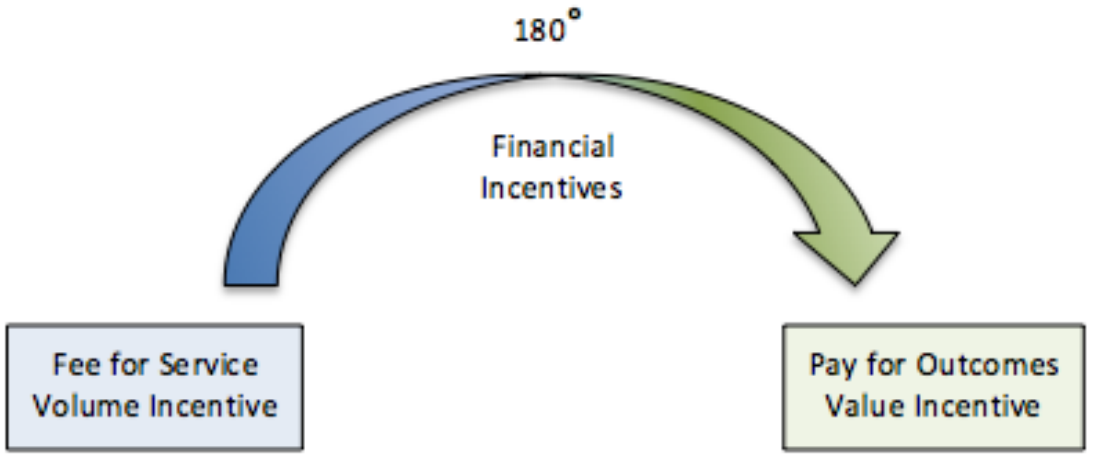
Population Health Services Support

Healthcare Improvement Strategy - Tactics in VBC

- Leadership / Organizational Strategy
- Attribution Management
- Risk / Coding Documentation
- Clinician Engagement
- Quality Performance
- Medical / Rx Spend
  - TOC / Continuity of Care
  - Care Pathways
- Care Navigation

- ***Data Analytics***

Measuring is key to managing

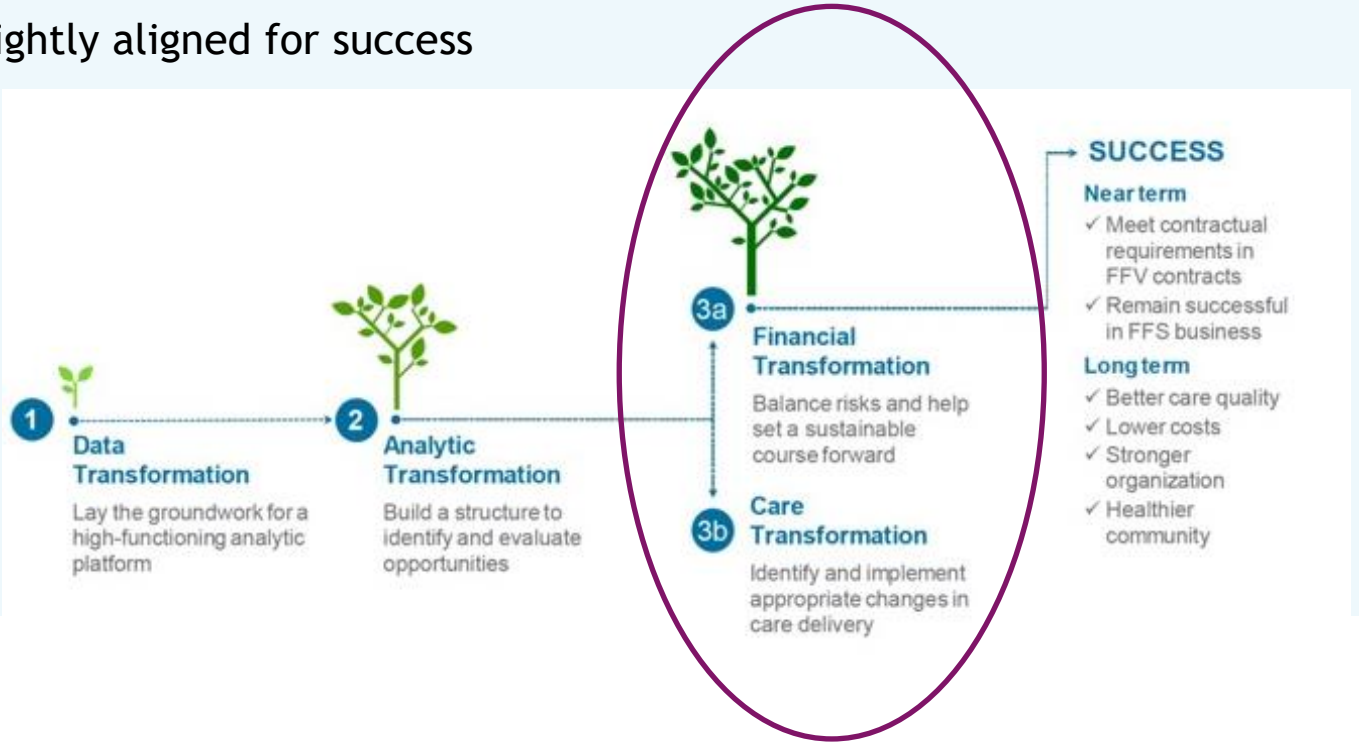


If Incentives are changing 180° . . . Strategy and Behavior must change as well

Strategy-matrix-Health-Care.png (527×222) (osipt.com)

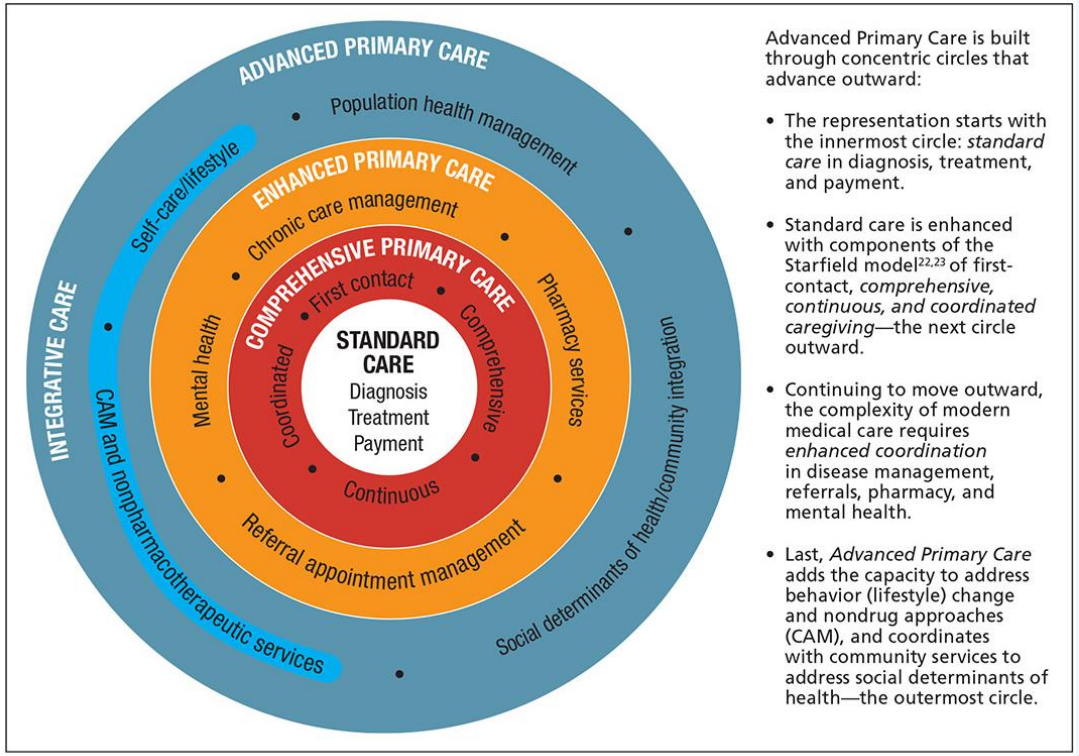
Jefferson Health

- Fee-For-Service organization
  - Clinical care delivery largely built around billable encounters
- Value Based Care focus - with demonstrated success
- Shared Savings in VBC requires decreasing patient utilization of services
  - Contracting and care transformation MUST be tightly aligned for success



Realizing our Vision – *Crucial Elements*

Advanced Primary Care

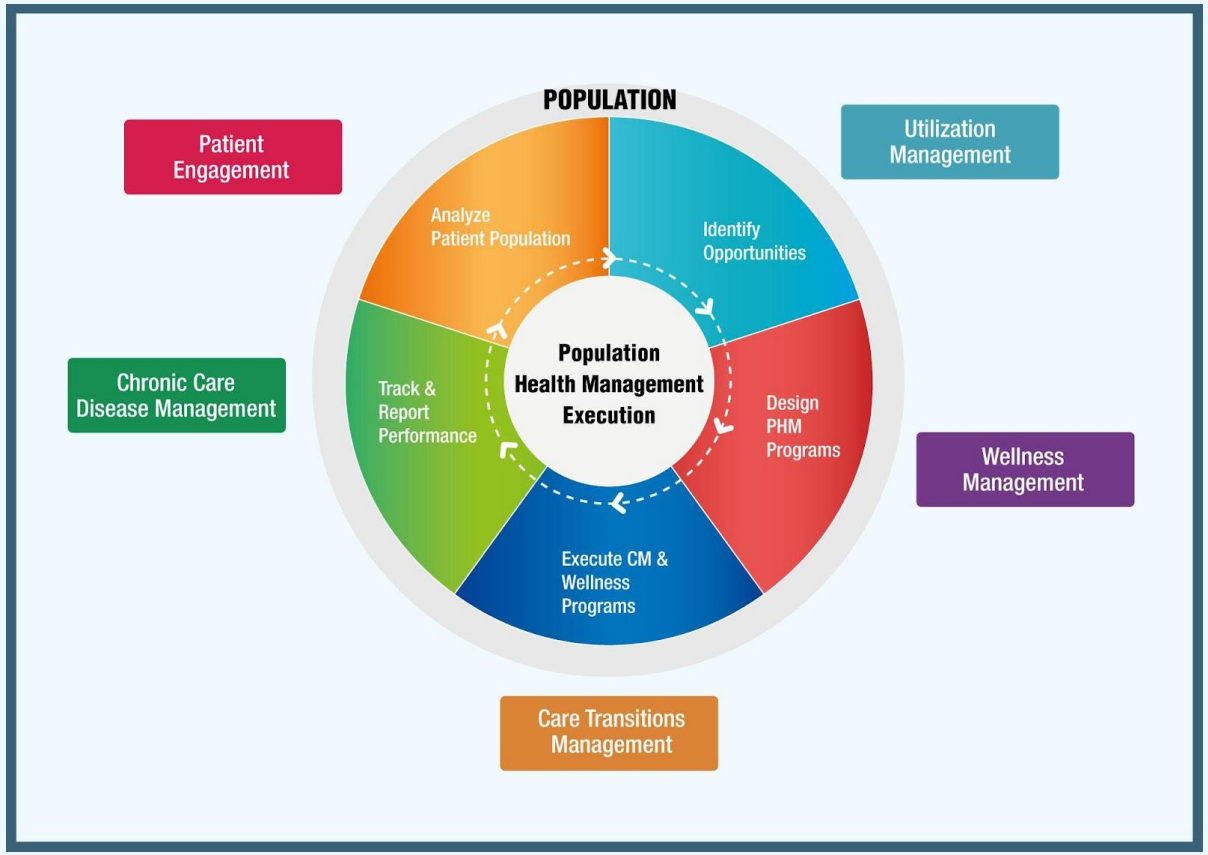


Advanced Primary Care is built through concentric circles that advance outward:

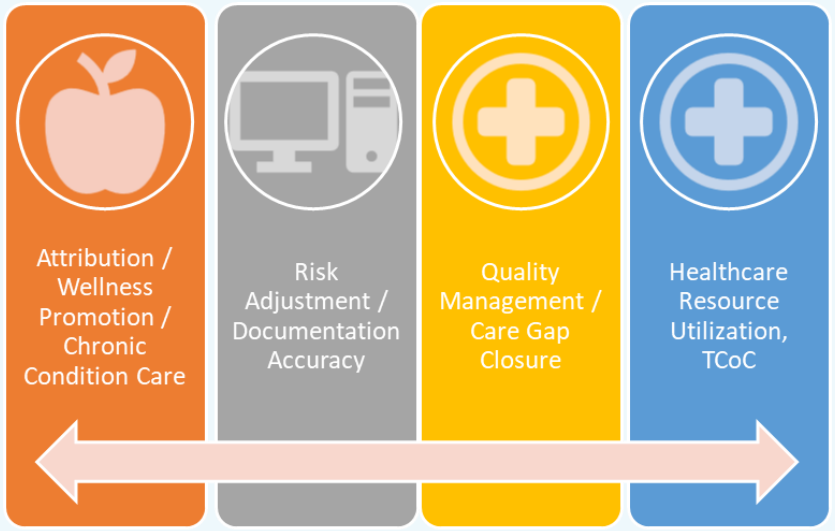
- The representation starts with the innermost circle: *standard care* in diagnosis, treatment, and payment.
- Standard care is enhanced with components of the Starfield model[22,23] of first-contact, *comprehensive, continuous, and coordinated caregiving*—the next circle outward.
- Continuing to move outward, the complexity of modern medical care requires *enhanced coordination* in disease management, referrals, pharmacy, and mental health.
- Last, *Advanced Primary Care* adds the capacity to address behavior (lifestyle) change and nondrug approaches (CAM), and coordinates with community services to address social determinants of health—the outermost circle.

CAM, complementary and alternative medicine.

Population Health Management



Value-Based Care Delivery Transformation

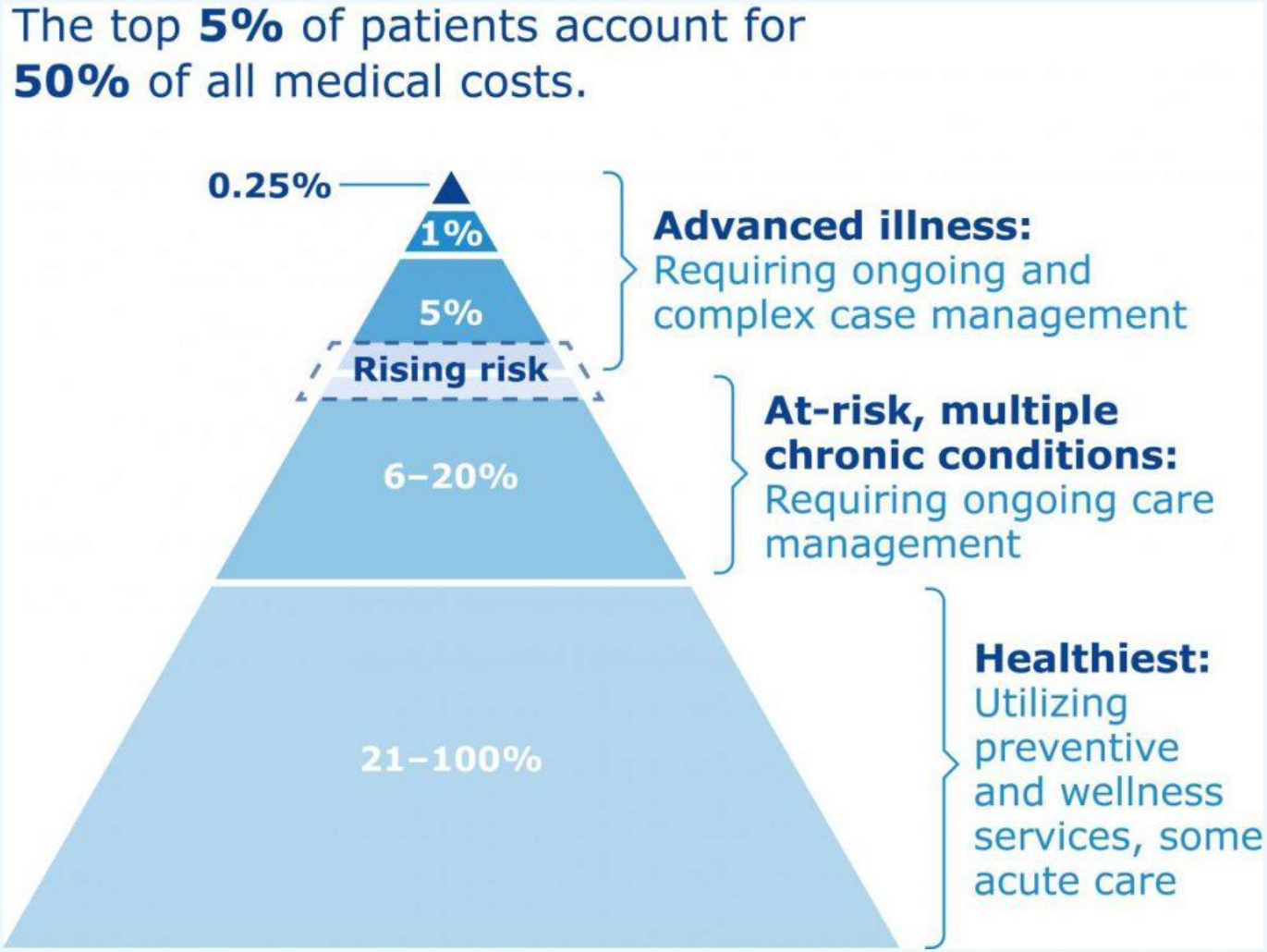


Value Based Program Performance

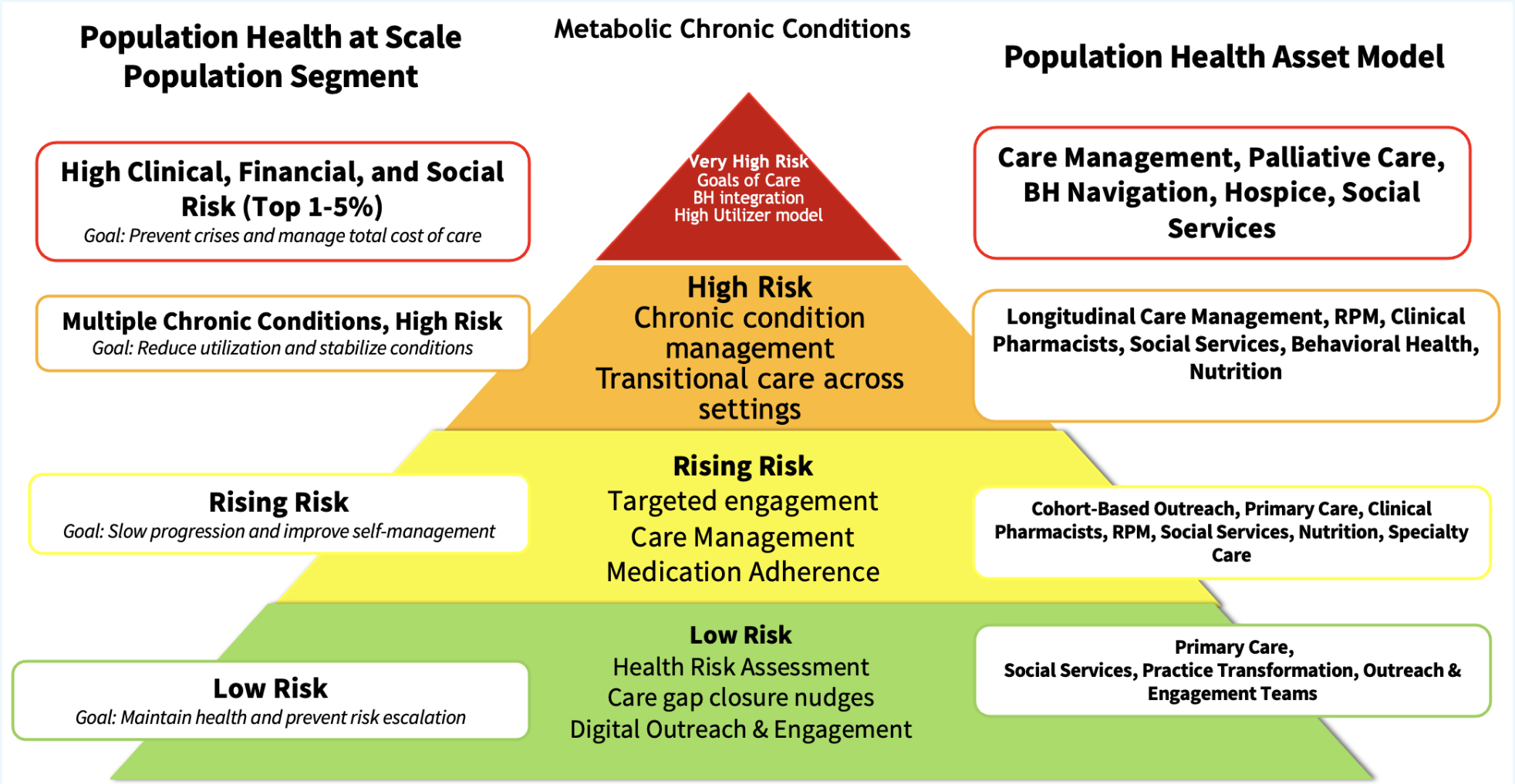
Population Health / Care Management

Interdisciplinary teams that span the continuum of care to coordinate services for our community.

Population Health Pyramid



Population Health Pyramid- Risk Tiering and Team-Based Care



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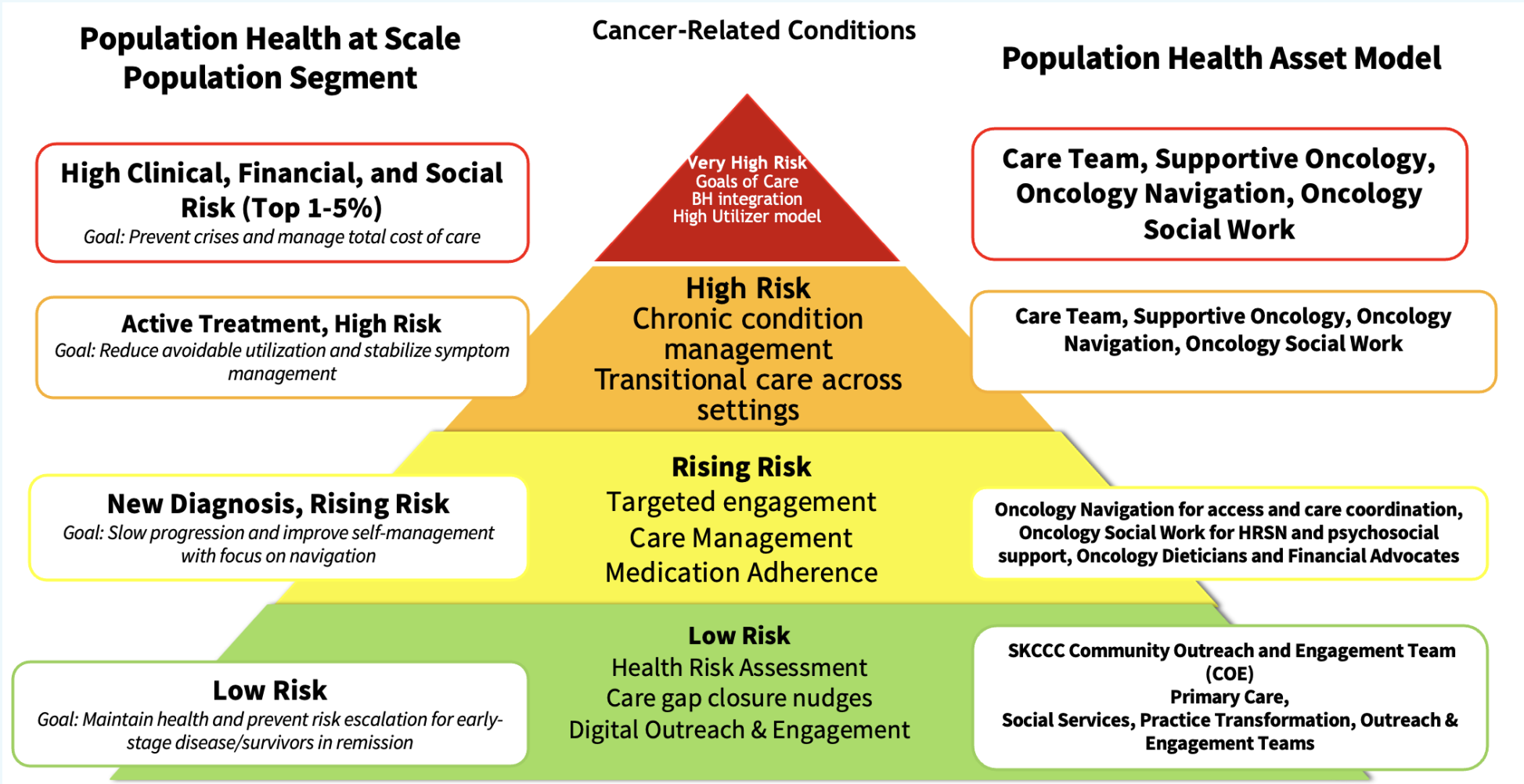


Preventive Services / Screenings

- Initiatives:
  - Immunizations
  - Breast Cancer screening
  - Colon Cancer screening
  - Lung Cancer screening
  - BP screening
  - Bone Density screening
  - AAA screening
  - Depression screening
  - Pediatric Lead screening
  - Infectious disease screening (HIV, HCV, etc.)
- Wellness campaigns:
  - Centralized blast campaigns
  - Partnering with Payers
  - Practice-directed outreach
  - Mailing campaigns
  - EMR Portal messages, SMS messages
  - AI agentic outreach
- Social media / LVHN aligned
- Data / Analytics – direct / guide focused efforts
- Extensive performance tracking

Risk Adjustment Accuracy / Documentation & Coding Improvement

- Technology solutions
- RA Coding team
- Real time feedback Incentive linkage
- Extensive education

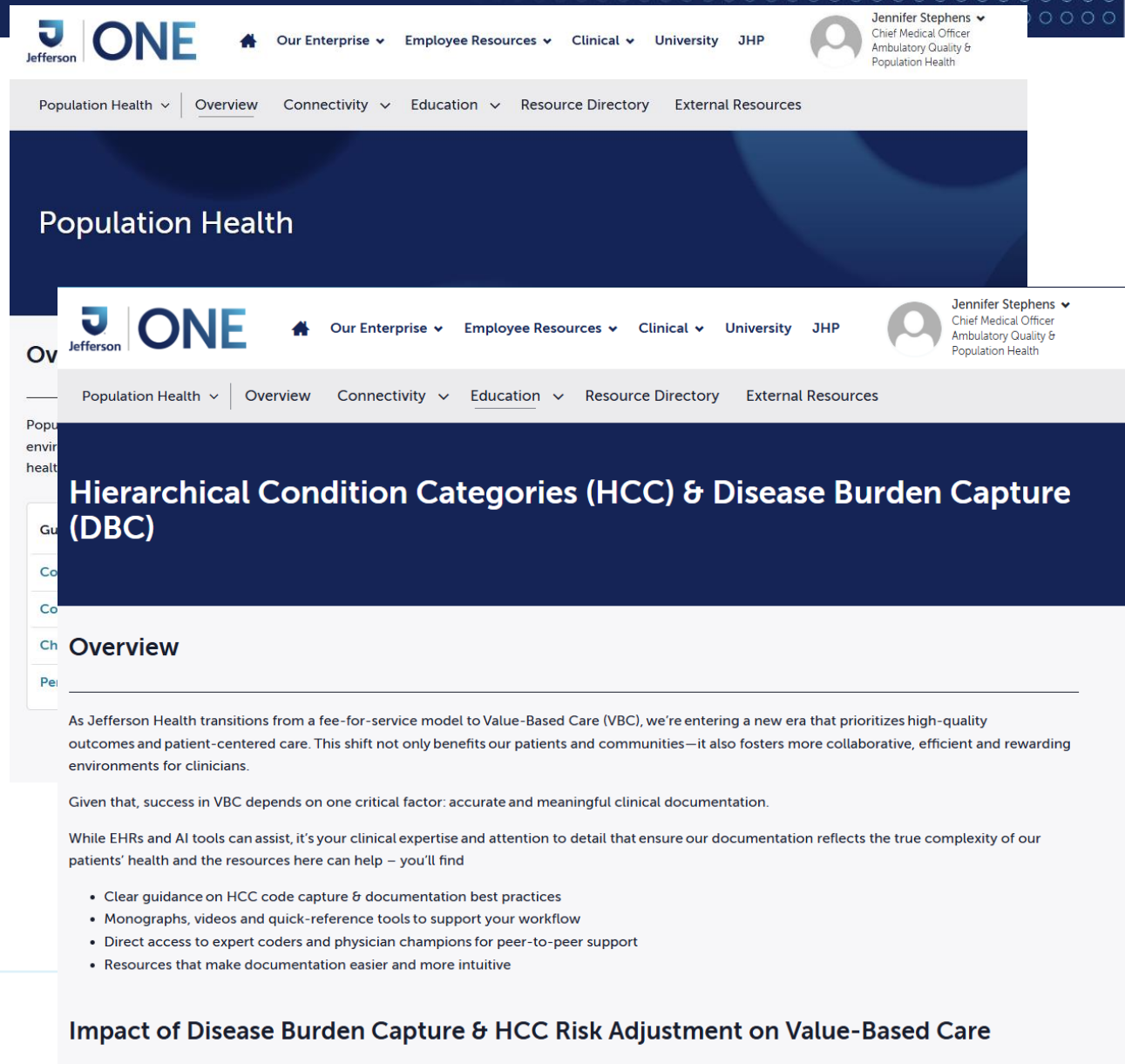
- Health plans are funded based on Risk Adjustment Factors
- Under coding leads to underpayment and loss of revenue
- Over coding leads to audit risk and compliance actions
- Example taken from AAPC:

HCC Financial Differences in Coding Specificity

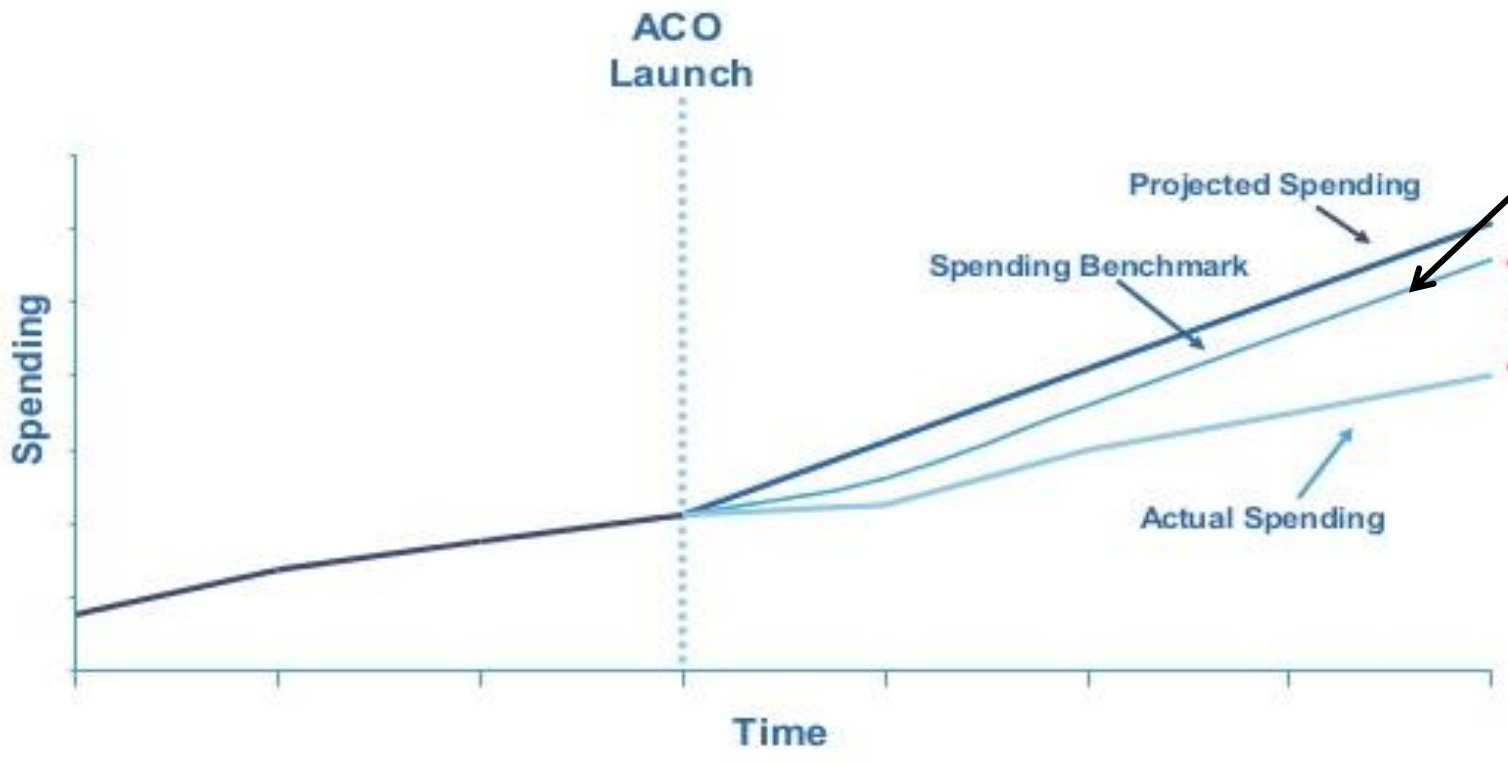
No Conditions Coded (Demographics Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76 year-old female	.468	76 year-old female	.468	76 year-old female	.468
Medicaid Eligible	.177	Medicaid Eligible	.177	Medicaid Eligible	.177
DM Not Coded		DM (no manifestations)	.118	DM with Vascular Manifestations	.368
Vascular Disease not coded		Vascular Disease without complication	.299	Vascular Disease with complication	.41
CHF not coded		CHF not coded		CHF coded	.368
No interaction		No interaction		+ Disease Interaction bonus RAF (DM + CHF)	.182
Patient Total RAF	.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	$452	PMPM Payment for Care	$743	PMPM Payment for Care	$1,381
Yearly Reserve for Care	$ 5,418	Yearly Reserve for Care	$8,921	Yearly Reserve for Care	$16,573

DBC / HCC Engagement

Division	Practice	July 25	Dec 25	Change Since July
EPPI	Einstein Geriatrics at Bustleton Avenue	83%	98%	16%
ECHA	Einstein Primary Medicine at Elders Hall	94%	98%	3%
ECHA	Einstein Primary Medicine at Front and Olney	96%	97%	1%
EPM	Norristown Family Physicians	95%	97%	2%
ECHA	Einstein Primary Medicine at Center One	95%	96%	1%
EPM	Broad Axe Family Medicine	93%	96%	3%
EPPI	Einstein Geriatrics at Moss Building	89%	96%	7%
ECHA	Einstein Primary Medicine at Wayne Avenue	93%	96%	3%
EPM	Trappe Family Practice	91%	95%	4%
EPM	Plymouth Meeting Family Medicine	92%	95%	3%
EPM	Einstein Physicians Collegeville	85%	94%	9%
ECHA	Einstein Pediatrics at Township Line Road	84%	93%	9%
EPM	North Wales Family Medicine	90%	93%	3%
ECHA	Einstein Pediatrics at Holland	80%	92%	12%
EPM	Montgomery Family Practice (RC)	90%	92%	2%
EPM	King of Prussia Family Medicine Mall Blvd	88%	91%	3%
ECHA	Einstein Primary Medicine at Roxborough	84%	91%	7%
EPM	Einstein Physicians Norriton (RC)	85%	91%	5%
EPPI	Einstein Geriatrics at Klein 300 MSS	88%	90%	2%
EPPI	Einstein Geriatric Home Visits	86%	89%	3%
ECHA	Einstein Pediatrics at Center One	67%	89%	22%
ECHA	Einstein Primary Medicine at Klein Building	84%	89%	4%
ECHA	Einstein Primary Care at Logan Plaza (RC)	85%	88%	3%
ECHA	Einstein Primary Medicine at Mayfair	84%	87%	3%
ECHA	Einstein Pediatrics at Pennypack	84%	87%	3%
ECHA	Einstein Pediatrics at Frankford Avenue	66%	84%	18%
ECHA	Einstein Pediatric Adolescent & Ambulatory Center	73%	80%	7%
EPPI	CPC Immunodeficiency Clinic	60%	76%	17%
EPM	Trappe Pediatric Care	54%	76%	22%
EPPI	CPC Northern Medical Associates (RC)	50%	70%	19%



Accountable Care Reimbursement



Spending Benchmark developed based on attribution size and calculated risk of the population

Shared Savings models vary with programs as well

+ Quality Metric performance

Teams Chat Comment

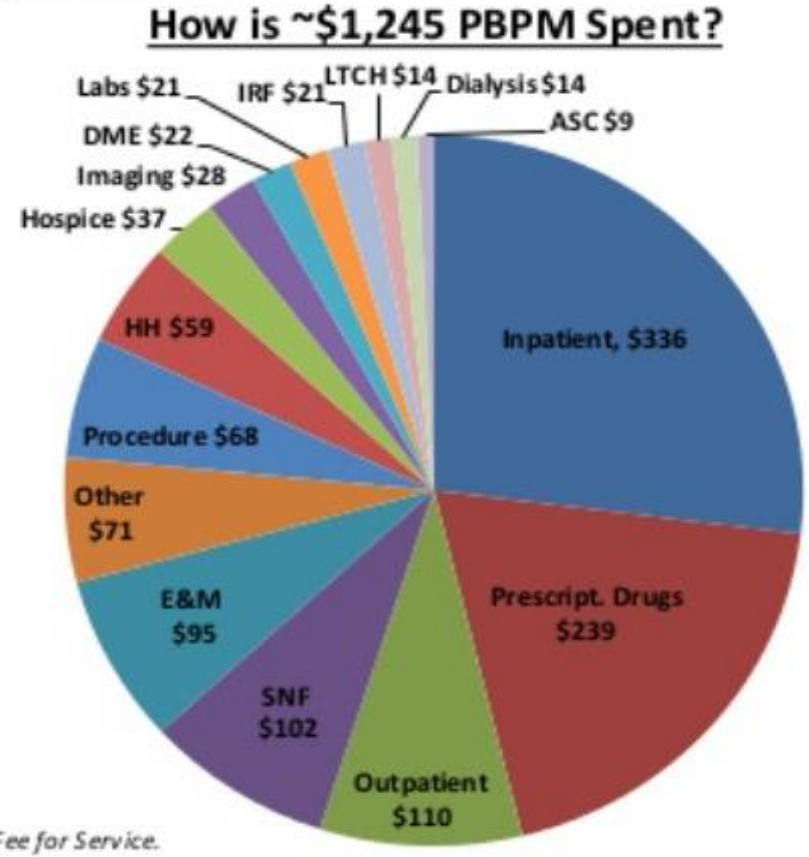
- *Do you think value is a better approach to healthcare payment – meaning, do you think it will be successful at changing the healthcare economics in our country?*

- *One sentence answer – brevity is ok ☺*

What Is Included in Total Cost of Care

Total Cost of Care includes the complete range of health care services

For Medicare patients, including beneficiary contribution, the average total cost of care is ~$1,245 Per Beneficiary Per Month ("PBPM") for the following basket of services



Figures include ~20% more PBPM to account for patient contribution

Definitions

SNF: Skilled Nursing Facility
HH: Home Health
DME: Durable Medical Equipment
LTCH: Long Term

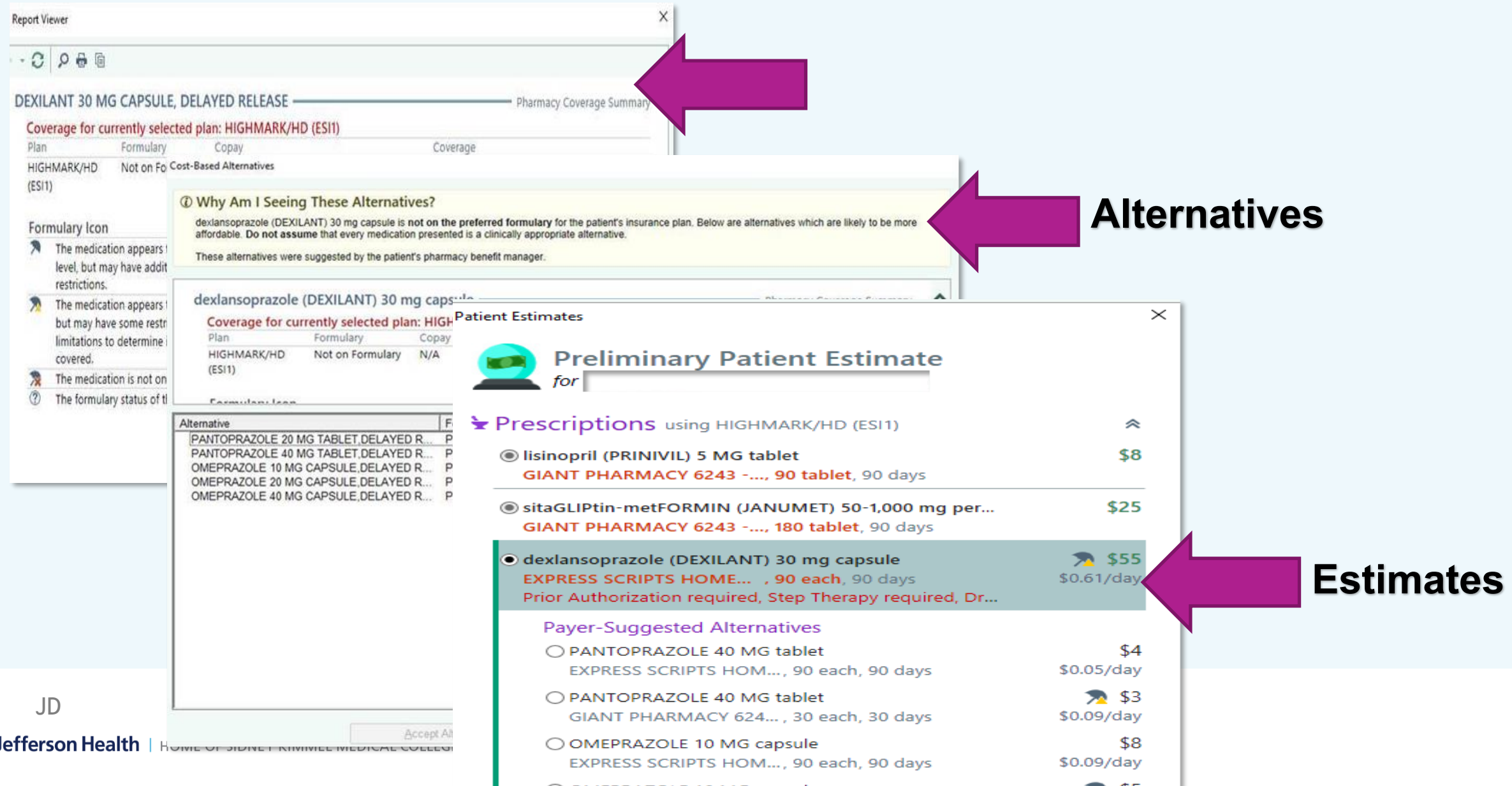
E&M: Evaluation and Mgmt.
ASC: Ambulatory Surgery Center

Source: Data adjusted from 2011 Medicare Fee for Service. Claims for illustrative purposes.

Multiple Levers Impact PMPM and Outcomes

Utilization Management	• Shadow UM processes with peer-to-peer review • EBM based conservative treatment requirements
Site of Service	• Outpatient surgical programs • Clinic-based infusions • Free-standing radiology or laboratories
Pharmacy	• Generic substitution • Step therapy • MTM / medication reduction & optimization
Clinical Variation	• EBC clinical pathway development and adherence. Clinical pathways must include the full spectrum of care (e.g. ambulatory, urgent care/ED, acute hospitalization, transitions, post-acute)
ED Management	• Enhanced primary care access (extended hours/weekends) • Urgent care site education & optimization • ED onsite care management & frequent utilizer management
Postacute Management	• Preferred partner SNF and HH networks • SNFist program • LOS management • Standardized discharge criteria
Primary Care service delivery	• Optimize primary care management of common conditions (e.g. diabetes, HTN) • Established referral criteria & expectations

Epic RX Cost Functionality - Example



Patient Value Story- Einstein Philly ED Decant Program

Patient Journey

63 Year Old Male

Patient: 63M c/o chronic abdominal pain and unintentional weight loss. **Diagnosis:** Metastatic Colon Cancer (liver, lung, kidney, and T12 involvement), Type 2 Diabetes, and RUQ Abdominal Pain.

Clinical Rationale: Recent ED workup confirmed stage IV malignancy. Acute obstructive or embolic concerns were ruled out. The primary clinical focus is transitioning from acute diagnostics to chronic symptom management and oncological care. Patient is safely managed at home with a multimodal pain regimen while awaiting specialist intervention.

ACAH Plan: Telehealth/Field Responder visit completed. Multi-disciplinary coordination secured an immediate/ same-day Oncology follow-up. Education provided on the safe use of oxycodone and constipation management. Patient counseled on diabetes monitoring and red-flag symptoms. CM and RN teams are mobilized to address social determinants, specifically financial and insurance barriers identified during screening.

Outcome: Pain is stable on current home regimen. A high-priority specialist pathway is established with Oncology and PCP to manage the new cancer diagnosis and chronic comorbidities. Ongoing RN follow-up to ensure care continuity, facilitate insurance support, and monitor for any acute clinical changes during this high-risk transition.

Operational Guiding Principles

Clinical Quality Metrics linked to VBR Contracts

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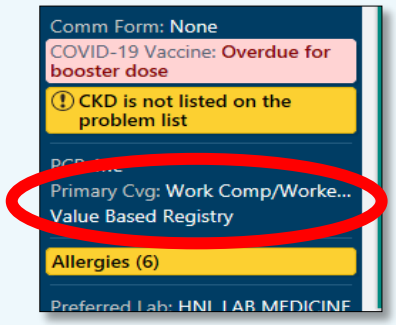
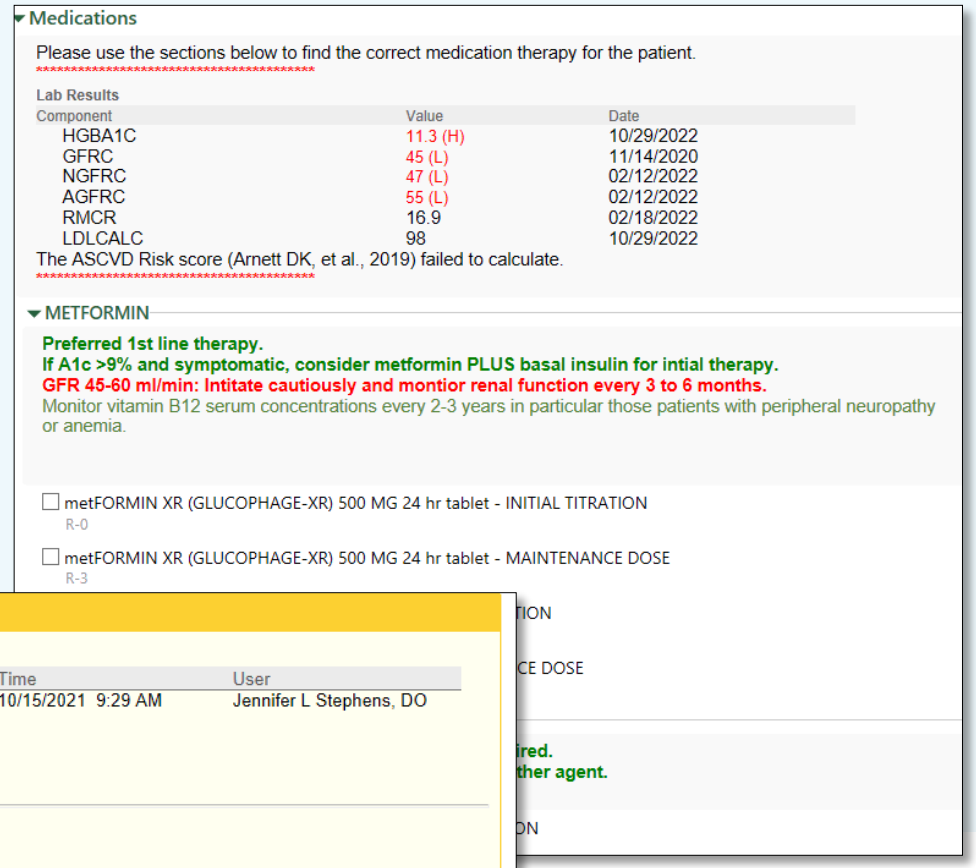
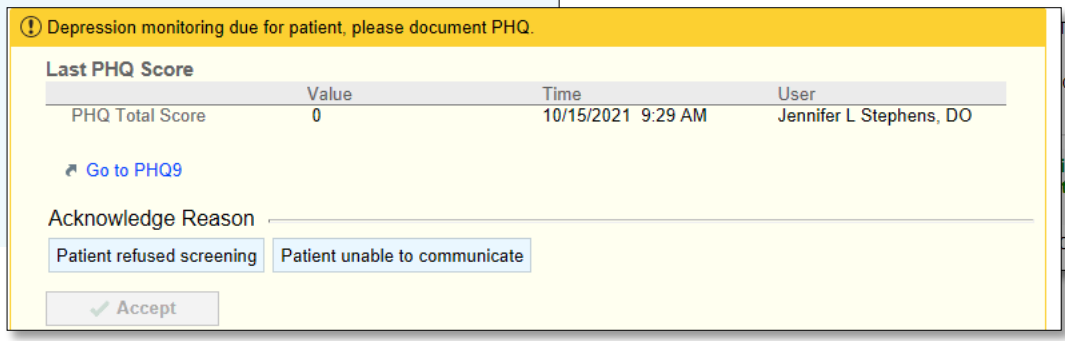
MAKE IT EASIER TO DO THE RIGHT THING AND MUCH HARDER TO DO THE WRONG THING

Simplify Attribution







Chat feature discussion

- Do you see areas that can improve total cost of care or clinical outcomes for your patients?

- List some in the chat feature

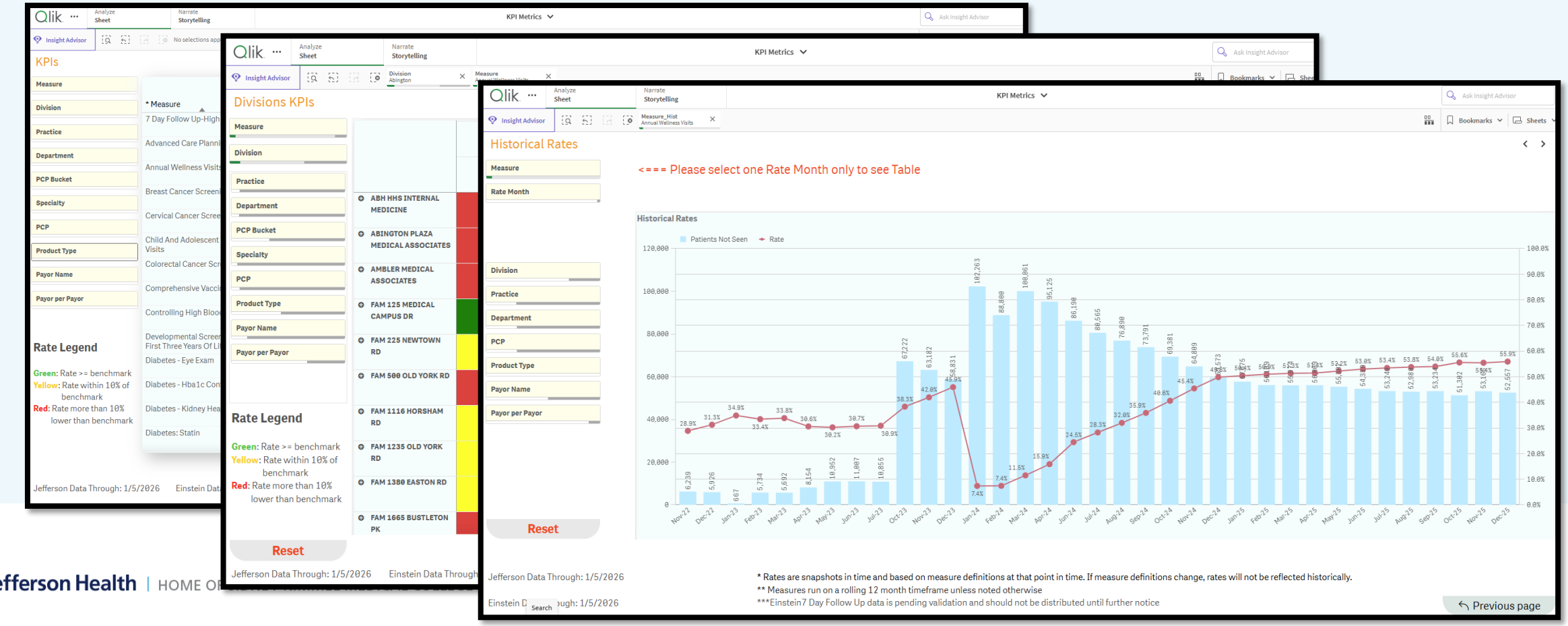
How Do We Manage Quality Performance?

- Leadership Role Clarity with Cascading Accountability
- Clinical Standardization - Care Pathways
  - Ambulatory and Inpatient pathway development / deployment / utilization
  - Team-based approach for success
- Integrate change into the EMR, real-time data
- Incentive models across clinicians and staff
- Robust data analytics, dashboard alignment, metric standardization

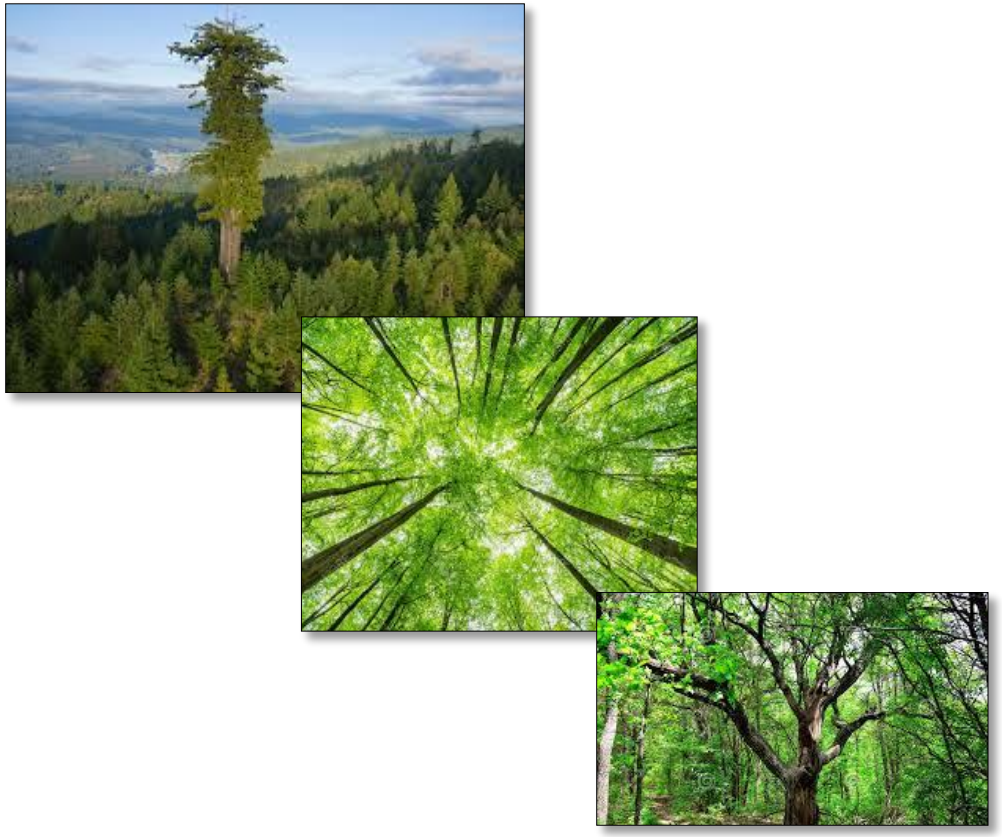
Quality Measures

- Manage your quality metric performance
  - As applicable to your specialty

- Team engagement, clinical coordinators and practice team alignment key for success



Measurement Data / Metrics – Feedback is CRUCIAL



- High to Low Lens
  - Executive, Practice, Individual
- Attribution Levels
  - All patients / all payers
  - VBC payers
  - Incentive program performance
- Filtering / Cohorting
  - Laser focus versus Pop Health
  - Value-directed, Central campaigns
  - DEI filtering

Non-Productivity Incentive Measures (Quality)

- Question – what does it take to engage clinicians and clinical care teams around quality and improvement work?

NAME
Abdominal Aortic Aneurysm (AAA) Screening
Breast Cancer Screening
Cervical Cancer Screening
Chronic Opioids: Pain Management Agreement
Chronic Opioids: Urine Drug Screen
Colonoscopy
Colorectal Cancer Screening
Diabetes: Eye Exam
Diabetes: Foot Exam
Diabetes: Hemoglobin A1C
Diabetes: Kidney health (eGFR)
Diabetes: Kidney health (urine microalbumin)
DTaP,Tdap and Td Vaccines
Hepatitis A Vaccines
Hepatitis B Screening
Hepatitis B Vaccines
Hepatitis C Screening
HIB Vaccines
HPV Vaccines
Influenza Vaccine
Lead Screening
Lung Cancer Screening
Lung Cancer Screening Eligible
Medicare Annual Wellness Visit
Meningococcal A Vaccine
Meningococcal B Vaccine
MMR Vaccines
Monkeypox Vaccine
Osteoporosis Screening
Pneumococcal immunization (0-49)
Pneumococcal immunization (50+)
Prostate Cancer Screening
Rotavirus Vaccines
Sigmoidoscopy/CT Virtual Colonoscopy
Statin Therapy
Varicella Vaccines
Zoster Vaccines

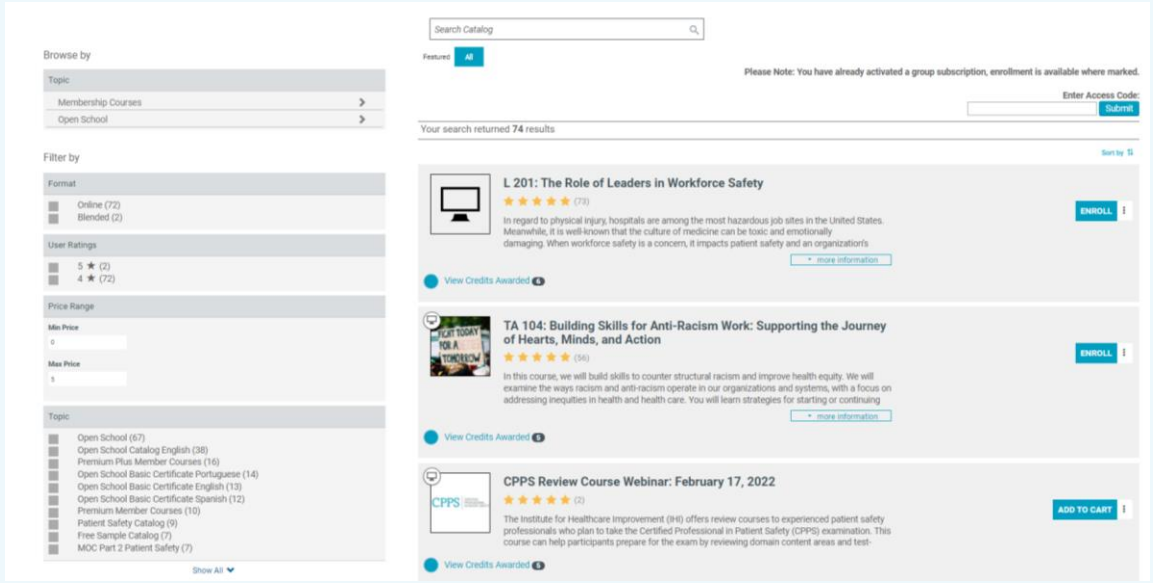
Leverage Epic Dashboards

Chat feature discussion

- Have you viewed your metrics / dashboard?
- If so, have you ever tried to close care gaps to improve your metrics?
  - Was it difficult?
- List some reflections in the chat feature

QI Model for Improvement

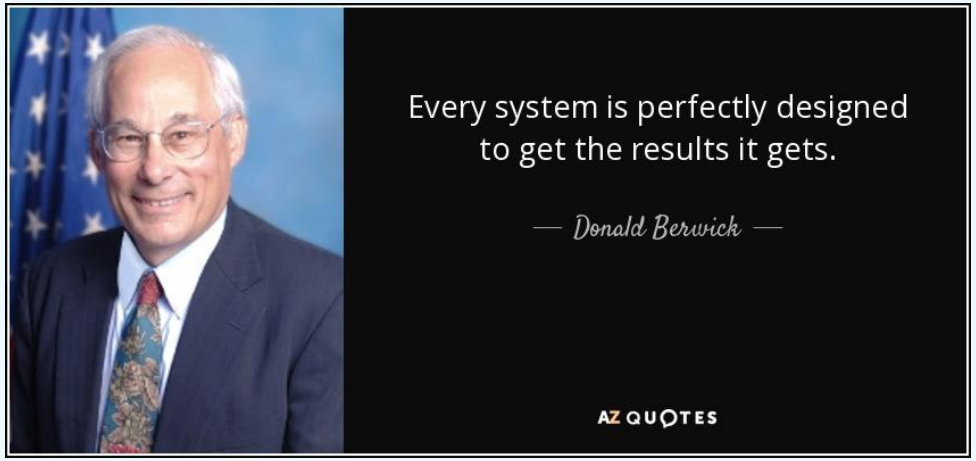
- IHI Modules
  - Review / concepts / brief discuss



Objectives

After completing this course, you will be able to:

1. Describe the need to integrate quality improvement and patient safety into health education training.
2. Discuss what the IHI Open School is and how it fits into IHI.
3. Explain tools and recommendations for building a vibrant IHI Open School Chapter.
4. Identify tactics that IHI Open School Chapters can use to maintain momentum.



steeep

- Safe,
- Timely,
- Effective,
- Efficient,
- Equitable
- Patient centered

Healthcare quality should be STEEEP Institute of Medicine report Crossing the Quality Chasm

Quality Improvement Work

- Follow the IHI Model for Improvement
- Ensure you clearly know your AIM
- Go through every step of team formation, quality and change cycle (PDCA)

- Common pitfalls
  - Lacking detailed AIM
  - Solution jumping
  - Poor process mapping to identify key issues
  - Lacking appropriate metrics
  - Only doing one PDCA cycle
  - Not listening to feedback
  - Ignoring warning signs
  - Failure to engage senior leadership for resourcing / support

Quality Improvement Premortem

If 6 months from now we were to have found that this project failed spectacularly, what would be the most likely reasons?

Uncover blind spots and weak points before the project starts

Return on Investment

- Mission-Based Outcomes – *Patient outcomes, Population health improvement*
- Financial impact / value
  - True bottom-line value (FTE reductions, revenue generation, expense mitigation, service growth)
- VBR performance
  - Expense reduction
    - High cost, low value medications
    - Decreased resource utilization
  - Enhanced condition management
    - Improved care, driving less hospitalizations / ER visits
  - Care gap closure success
  - Attribution growth / improvement
  - Coding optimization – risk enhancement
- Clinician wellness / team engagement
  - Increasing patient satisfaction
  - Clinician wellness / engagement enhancement

Questions / Review

- Write down questions for discussion?
- What areas do you want to learn more about?
- What resources do you feel you need for success?

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Jefferson Health

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