Reflections
ON HEALTHCARE MANAGEMENT
VOLUME 2 | ISSUE 1 | 2018

STAKEHOLDERS IN THE U.S. HEALTHCARE SYSTEM: A POSSIBLE FUTURE

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ABSTRACT

In 2014, Don Berwick, MD, MPP, compared his months on the Massachusetts Gubernatorial campaign trail with Marco Polo's travels to the legendary city of Xanadu. Instead of finding silk and spaghetti, Berwick found pockets of poverty, despair, and a health system that was penny wise and pound foolish. He also found hope in community programs geared toward breaking the inexorable downward spiral faced by many Americans. Halfway through his presentation, Berwick said, "You can see what it (healthcare savings) might look like. I saw it last week on a trip to Oregon."

Berwick's casual comment opens a path to the discovery of social determinants of health, the role of trauma in disease and healthcare utilization, and the difference between healthcare and sick care. This paper is a thought experiment, set in a fictional tri-county area named for historical, utopian communities, to determine what you might see if a CCO "somewhere down I-5" could bring together a variety of proven, innovative approaches to the problems that plague the American medical system, costing trillions of dollars, and doing very little to improve health.

KEYWORDS

social determinants of health, trauma-informed care, Adverse Childhood Experiences, resilience

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doi: 10.6083/jsj6-3n84

Introduction

Acme CCO operates in the tri-county area comprised of Xanadu, Avalon, and El Dorado counties, with a total population of approximately 350,000 residents, overwhelmingly white and with US citizenship. Nineteen percent of the residents have incomes at or below the US poverty line, with about 80,500 individuals eligible for the Oregon Health Plan (OHP). The largest city in the tri-counties has one university, two hospitals (St. Elsewhere and Gotham General), and a typical number of citizens with substance use disorder and/or mental health issues. Acme was created to coordinate care for OHP members by bringing together founding members, St. Elsewhere and GG (traditional competitors), Zenith Health (the existing MCO), Sam's House (a mental health and addiction treatment clinic with inpatient capabilities), and the three county governments.

Acme's most important healthcare stakeholders include the patients and families it serves, its founding members, and the staff who keep the whole show viable and sustainable, as well as its major funder, the Centers for Medicare and Medicaid Services. In a larger sense, society, as a whole, is an Acme stakeholder since funds spent on healthcare syphon away support for all other public institutions such as schools, social services, physical infrastructure, and emergency services. However, if Acme can advance the Quadruple Aim, through thoughtful management of its stakeholders and their needs, society should recoup some of the dollars currently diverted to healthcare spending.

Stakeholder #1: Patients and Families

For Acme's patients, the stakes are nothing short of health and well-being—physical, mental, and emotional. Fortunately, Acme is committed to advancing health among people experiencing adverse social determinants, not just treating their physical ailments. It realizes that these patients face challenges at every interface with the healthcare system: finding the right provider in the right location, getting established, and getting to appointments despite barriers like transportation, time off work, child care, and remembering an appointment made weeks or months in advance.

Patients may face difficulty understanding their medical conditions, especially if multiple providers use slightly different language or prioritize different aspects of the patient's overall health status. Although most people living in the tri-counties are white, English-speaking, US citizens, healthcare inequities occur even in systems that employ the most explicitly equalitarian healthcare workforce. Implicit biases based on gender, ability, weight, sexual orientation, education, and religion can exist even in a seemingly homogenous population, and Acme's patients do include racial, cultural, and ethnic minorities. Patients accustomed to discrimination may recognize subtle cues emanating from a provider unaware of her own implicit preferences, leading to loss of trust and alignment.

While most patients in the American healthcare system experience fragmented care at transitions between care episodes, navigating the chaos can be more difficult for OHP patients who may have fewer resources and less well-developed resilience. They may have challenges getting prescriptions and adhering to a medical plan or maintaining scheduled follow-up visits for all of the same reasons that challenged them getting to that first appointment. Additionally, the various Acme partners have worked together so that information and educational material at discharge comes in the same format (both print and electronic) has the same look, feel, and language to make it easier to follow, no matter where the patient receives care.

Preventive care and health maintenance may be difficult for patients living in a food desert or who never learned how to get along without "convenience" foods full of sugar, salt, and preservatives. Children who do not play outside whether due to traffic, the built environment, or the risk of violence are at higher risk of chronic disease. Living with untreated trauma, developmental or PTSD, not only contributes to the patient's health burden, but carries a risk of intergenerational transmission and contributes to substance

dependency and compromised mental health for the individual and family members.

Most healthcare systems include the words, "patient-centered," in their mission and vision. At Acme, we realize that inconvenient location, hours, and tone-deaf staff create a wide gap between the promise and the reality of "patient first."

We have challenged providers and staff to a program we call, "Walk in Their Shoes," and they have devised ingenious solutions to minimize these barriers.

The counties have supported development of daycare centers adjacent to several grade schools with "pop-up" primary care clinics before and after care-hours for both pediatric and adult medical appointments. Every high school has clinic hours for students, as well.

Acme worked with all healthcare entities in the tri-counties to create an integrated EHR, so "pop-ups" can occur at any convenient location. Appointments are made online or by phone, with at least half of a provider's slots open 24 hours in advance. Providers split work days between their "home base" clinic and several assigned pop-up locations. Patients can use an app to match provider, location, and time that suits them best. Patients are even encouraged to suggest locations for pop-ups in their communities. Frail, homebound patients are cared for by a house call team of providers. In-home palliative care and hospice care are also covered by the plan.

Further, the EHR has a convenient patient portal that can be accessed as an app or as a desktop feature. It also connects patients to a community network of non-medical service providers, nonprofit organizations, and other agencies useful to low-income families organized on the Parkland Center for Clinical Innovation's IEP model.

Navigators, community health workers, and peer mentors are an important part of Acme's services. These resources are available by phone 24/7/365 and can come to the patient at home, at work, or even in the hospital to help with more complex needs. They assist with intensive case management for patients with high healthcare utilization and/or frequent transitions of care. Birth and death doulas help patients and families prepare for life's most important and difficult transitions.

Acme helps coordinate educational opportunities through its partners on issues from healthy cooking/eating to parenting to illness-specific classes to support groups, in every format, live and virtual. Staff at the hospitals, clinics, and health plan receive ongoing training in trauma-informed care, social determinants of healthy, culturally responsive care, and self-care to keep them happy and healthy in their important role supporting a thriving community.

At every turn, Acme seeks innovation input from its service providers and its community members.

Stakeholder #2: St. Elsewhere and Gotham General Hospitals

With the ever-changing healthcare financing practices, regulations, and data requirements, the tri-county hospitals' stakes are similar to the patients they care for. Both patients and healthcare organizations are concerned about physical health, well-being, and the cost of healthcare. The hospitals worry about the organization's fiscal health and the well-being of staff working within their walls.

While St. Elsewhere and Gotham General are key stakeholders in the Acme CCO, OHP patients make up only about one-third of their daily census and represent an even smaller proportion of their revenue. On the other hand, these patients pose special challenges to the organizations due to their disproportionate level of medical and social complexity and higher rates of utilization. It is also more difficult to create a safe and durable discharge plan for these patients who may have suboptimal housing, home support, or other resources.

If the "what should be happening" in hospital admission, care, and discharge was modeled on the

well-informed, commercially-insured, resilient patient with excellent support in the home and the community, then the typical Acme patient story represented a tremendous gap in "what was actually happening." Hospitals and health plans used to pass these patients back and forth like hot potatoes. However, Acme's enhanced community support, transition case management, intensive case management for super-users, and the cadre of navigators and mentors has decreased costly readmissions substantially. The PCCI-like IEP network has provided patients with additional social support and resources, significantly reducing ED over-utilization.

The integrated EHR has cut down on redundancy, improved communication between inpatient and outpatient services, and improved safety. It has also made data mining easier for gathering and reporting required metrics since information comes from all of the "touches" patients experience. Acme has also coordinated Lean training and implementation through a web-based portal program called ImprovementFlow that makes quality an integral part of front line work. Its data fulfills many reporting requirements, has saved additional dollars in the hospitals and clinics, and improved both patient experience and staff satisfaction.

Stakeholder #3: Zenith Health Plan

In the past, balancing payment to the hospitals and providers created friction for Zenith, the area's MCO. With the programs created together as the area's CCO, savings have been realized in both worlds. As value-based care begins to edge out fee-for-service, the foundation laid by Acme has positioned the hospitals, clinics, and health plan to harvest the fruits of their joint labor. Of all the stakeholders at Acme, Zenith fit into the new format most seamlessly, while also serving OHP patients in adjacent Olympus and Eden counties.

Stakeholder #4: Providers

For many years, providers played a central stakeholder role in any healthcare innovation since most were independent businessmen (and occasionally women). Anything that threatened their livelihood or autonomy was anathema, as demonstrated by the organized opposition to "socialized" medicine in the US and Saskatchewan. However, all primary doctors, NPs, and PAs in Xanadu and the other Acme counties are employed. Many are Millennials and have a different set of values than their elders.

For them, the baseline requires a salary that will allow them to repay their student loans (and eat some avocado toast). Beyond that, the stakes are: work they enjoy, colleagues they enjoy, and the flexibility to do things that matter to them. Unfortunately, the tri-county culture had not caught up with times and it became apparent that there was a gap between it and the old-school values of "long hours and short visits" typical of the fee-for-service, churn-the-RVUs mindset.

Acme held a series of provider town halls to find common ground between the need to care for patients and the lifestyle preferred by the next generation of providers. They led the "Walk in Their Shoes" initiative and took great ownership in innovation. They have embraced the use of apps, virtual visits, and pop up clinics. They have sorted themselves into the providers who like early start/end, late start/end, and some weekend work. Rather than insisting on autonomy over how to treat patients, they have settled on autonomy over how to set their hours, while maintaining true patient-centered care.

We have corrected the productivity models to reward low-cost solutions like telemedicine and HIPAA-compliant e-chats. There is also incentive pay for other things like team-based care and group visits, especially in unusually settings. Quality and process work is also supported using ImprovementFlow, which allows providers to get rid of wasted time and effort. For a group of doctors who cut their teeth on The Oregon Trail game, this sort of process is reported to be very intuitive.

Groups are encouraged to use their own initiative to find ways to better meet patient needs without

proscriptive edicts from the C-suite, and to spread their innovation throughout Acme's membership.

Stakeholder #5 Sam's House

Prior to the creation of Acme CCO, Sam's House was something of a mystery to the other healthcare entities in the tri-counties. Patient information was protected under 42 CFR part 2 and there was little opportunity for providers from Sam's to meet with those from the hospitals and clinics. This created a gap in patient care with serious risks due to occasionally competing treatment plans.

As a partner in Acme, Sam's leadership is in conversation with the other members of the healthcare team. Peer mentors move with patients, when asked, across the invisible boundaries between physical and behavioral health and help patients understand how to integrate mind, body, and soul within the healthcare system. Sam's has coached Acme and its provider partners in understanding the role of trauma in chronic illness, mental illness, and substance use disorder. Sam's training has helped healthcare team members take a deeper dive in the "Walk in Their Shoes" program, which has decreased unconscious bias and enhanced cooperation.

In turn, Sam's has benefited from better medical care for its SUD patients, knowing providers are more well-educated and understanding. Even for patients who have not waived 42 CFR confidentiality, providers at least know who to call for general information.

Conclusion

Healthcare in the tri-counties developed over many decades, along paths similar to those in other parts of the Oregon, buffeted by the changes in payment, regulations, and the mountains of paperwork required by government and commercial payers. It participated enthusiastically in the Oregon Health Plan and the Medicaid expansion under Obamacare, despite a strong Conservative tradition in the area.

The creation of Acme as one of the State's CCOs, brought disparate members of the healthcare community, some of whom had been adversaries, together at the proverbial table. They created a vision of a system in pursuit of the Quadruple Aim from the vantage point of their most vulnerable citizens. Gaps were found between "how it should be" and "how it actually exists" at every interface between entities, between patients and the system, and between patients and healthcare workers, at all levels.

Acme and its member/partners continue to focus on bridging or eliminating gaps for its many stakeholders in order to build a healthier, more resilient community, with enough money left over to begin rebuilding all the other necessary social services and infrastructure.

Suggested Resources

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