

# Joining operational and clinical lenses in a value-based world



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times, in operations, we can identify a problem easily,” Brummel said. “What is really helpful is the clinical lens to understand how to *fix* the problem. It is important to see how we can solve a clinical issue with the appropriate infrastructure.”

So, do all our operations leaders need to go to nursing or medical school? Not necessarily, if you maintain an effective dyad or triad relationship, Brummel said. “With a clinical partner, an operations leader has the opportunity to understand healthcare through both lenses.”

Once you have joined the two sides, it’s time to start solving those problems.

**Forget “One-Size-Fits-All”**

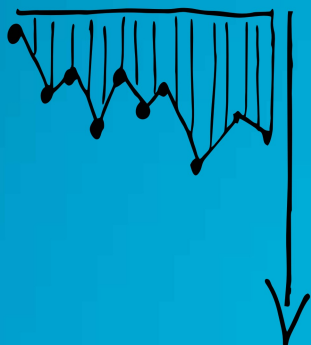
“In Corewell’s primary care transformation work, we know we have an aging population,” Brummel said. “We know that older adults need more care, but how do we manage the cost of care while getting them the care they need in the right place, which is primary care?”

Responding to this opportunity, Corewell Health opened its own advanced primary care clinics. “These are for patients 65 years and

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## CASE STUDY



**"We went from a readmission rate of 23% for our patients at high risk down to 7%. It's really about being intentional in your understanding. Look at your data. What's the problem you need to solve? Create a program and staff it appropriately with the right people who are passionate about the work."**

**—Stacy Brummel, RN, MBA**



older with multiple chronic conditions," she explained. "This setting allows extra time with small provider panels that are really focused on managing those patients within a highly structured clinical model."

As this population continues to age, what happens when they can no longer make it into the office? Brummel said, "As patients age, a significant percentage become homebound. How do we reduce avoidable emergency department visits and hospitalizations?"

The answer may sound a little old fashioned at first, but it makes perfect sense. "We offer home-based primary care. We will go to those patients in their homes, and we have the staffing that can help with that."

Delving deeper into varied populations, Brummel brought up patients on Medicaid. "We have a Medicaid Clinic," she said. "We know this is a vastly different population with unique needs. We knew we needed more behavioral health. We needed a psychiatrist. We needed a community health worker."

In the end, addressing the needs of Corewell Health's Medicaid population came down to access. Brummel explained further, "Where are the patients, many of whom are homeless or in shelters? Having a better understanding of social determinants of health, substance use disorders, and behavioral

health wrapped into that ensures we can manage and meet patients where they are on their journey."

At its core, this iterative transformation is realizing the goal of value-based care (VBC): to deliver the right care to the right patient in the right place.

Of course, the transformation does not happen overnight. For Brummel and Corewell Health, the journey began in 2017.

### **Corewell Health's Value Transition**

"We started in 2017 with a clinically integrated network, and then we formed an ACO [accountable care organization] in 2019," Brummel told me. "We contracted with CMS [the Centers for Medicare and Medicaid Services] for the MSSP [Medicare Shared Savings Program] through the ACO, and that was really our first step into the value arena."

She continued: "As we moved into 2020, with everything that happened with COVID, we decided to take a bigger look at value-based healthcare. We recognized that the best place for us to start was with our own health plan, Priority Health. In effect, it's a full-risk arrangement across our product lines to learn without the fear of losing money—still keeping it within the system. So this was a good test case for us to see how we can perform and gain a better understanding of what

the drivers of avoidable medical expense are and where we have opportunities."

As with the rest of the healthcare world, the COVID-19 pandemic had a significant impact on Corewell Health. "We didn't have a lot of patients coming into the ambulatory space," Brummel said.

Moving into a more normal situation in 2022, Corewell Health "really started to better understand our performance," she explained. "We developed programs and entered other contracts with Blue Cross Blue Shield to really start to dive into more of the upside/downside risk now that we felt we had a better handle on how to manage it. I think the big places we have put intentional focus and resources to are care management, behavioral health, and primary care transformation."

### **The Right Leaders**

As we have heard from so many others making the transition from fee-for-service to VBC, what enabled the transition started at the top with leadership. Brummel said, "One huge benefit for us that really pushed us forward is that Tina Freese Decker, our CEO, just said, 'Value is it. This is where we need to be, this is what we need to do, and this is part of our strategy.'"

Corewell Health named Alejandro Quiroga, MD, as the physician



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leader to oversee population health. “They said, ‘This is your job. You need to take this and drive it,’” she told me. “And he really stood up that department at about the same time we began our risk contracting in 2020 and 2021. Quiroga is a disruptor within our own environment, and he’s right when he says we need to do things differently.”

## Moving Beyond Two Touches

Brummel explained that a big piece of realizing that difference was in examining how Corewell Health was being paid by its own insurance company: “For example, our plan was set up so that as long as you have two touches with a patient, you’re going to get paid for care management. We thought, ‘Well, we do that, but there are no outcomes.’ How do know the patient improved just because we touched them?”

I had to chuckle when Brummel said, “This is probably crazy, but we went to our payer to say, ‘Can you stop paying us that way?’ They agreed and asked us what we wanted to do. I said, ‘We’re going to put programs around readmissions. We’re going to look at disease management. We will measure outcomes and be paid accordingly. We want to see what our teams are doing and how it is making a difference.’”

She explained: “Flipping around how our care managers are paid

freed up our care managers to really think differently about their work. We started to look at our data to see where we have big opportunities in this space. We could see that readmissions was an issue for us, so we asked ourselves whether we needed to have all these care managers embedded

within primary care. Could we pull them out and centralize them? If we did that, what would it look like and what would we want them to work on? That’s what really created our transition care team, who focus on patients at those transition points.”

## Focused Intention

Knowing that readmissions were a problem, Corewell Health assigned the transition team to follow patients for 30 days after discharge. “We started with our high-risk patients,” she told me, “and really put in intentional focus to make sure that they had the right medications and follow-up appointments. Can they get to their follow-up appointment? What are their concerns, issues, and things that are going on that might make them bounce back?”

The effort paid off. “We went from a readmission rate of 23% for our patients at high risk down to 7%,” Brummel shared. “It’s really about being intentional in your understanding. Look at your data. What’s the problem you need to solve? Create a program and staff it appropriately with the right people who are passionate about the work.”


Brummel believes firmly in the importance of passionate workers for this space. “These roles are so connected to the patients that if you don’t have someone who is passionate about the work, it’s

really going to be a struggle. We can train them on the job. We can create work standards and clinical programs. We have pathways. But if that person doesn’t really want to do this work—likes this work, is passionate about this work—that’s where we see trouble a lot of times. We have had nurses come into the care management role from the inpatient side of things saying, ‘I just want better hours and lifestyle.’ But they get into the work and realize it’s not for them.”

## Advice to AMGA Members

When I asked what advice she had for AMGA members, Brummel said, “I think you have to be open to new ideas. Now is a great time to learn, because there are so many other people who are doing this work. There’s a lot you can pull from other colleagues and other organizations. Don’t be afraid to reach out. Don’t be afraid to ask questions. Get a good understanding of your data, and make sure you’re involving your clinical team members—especially those closest to the work.”

She said, “I think sometimes we in operations think we need to fix the problems outright. We say, ‘This is what we’re going to do,’ and we move on. But really involving the clinical team members will not only get them to buy into what you’re doing, but also offer you a lot of insight you might not have.”

Finally, Brummel warns that as we look at tackling the problems of team member shortages, we need to take an approach of “constant iteration.” I think that’s the perfect reminder that our work will never truly be done, but as long as we staff our organizations with passionate people, we’ll keep inching closer to realizing all of the benefits of VBC. 

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