The Journey to Value Based Care for Population Health: Sharing, Scaling and Replication to Accelerate Results

Stephanie McCutcheon, FACHE, Innovation/Transformation Advisor
Molly Coye, MD, MPH, Chief Innovation Officer, UCLA Health
Michael Spine, Vice President, Business Development, Bon Secours Health System
Laura Ostroff, Vice President, Benefits and HRIS, Bon Secours Health System, Inc.

Session Objectives

• Participants will be able to describe the key components of the Person/Enrollee Journey, the UCLA Innovation/Transformation Process, systems sharing for Scaling and Replication to Accelerate Results Development, an AMC expression, and a multi-state hospital expression and their components for achieving the Triple Aim plus physician/clinician satisfaction.

• Participants will be able to articulate the Innovation-Transformation-Implementation/Operationalization Process and identify ways to scale and replicate the Leadership/Design/ Implementation Team model in their own organizations.

• Participants will be able to identify successful strategies for engaging physicians, clinicians, and administration in a culture of participation, accountability, measurement, and improvement for the delivery of Value-Based Care in multiple settings.
Making Care More Affordable

The Triple Aim: Care, Health, And Cost

The remaining barriers to integrated care are not technical; they are political.

by Donald M. Berwick, Thomas W. Nolan, and John Willingshing

ABSTRACT: Improving the U.S. health care system requires a sustained pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Precursors for this include the enrollment of an eligible population, a commitment to universality for its members, and the existence of an organization (“enhancer”) that accepts responsibility for all three aims for that population.

1 The site’s design includes at least five components: partnership with individuals and families, design of primary care, population health management, financial management, and macro-system integration (Health Affairs 21, no. 6 [2002], 759–768). 10.1377/hlthaff.21.6.759

System Role in the Triple Aim

• Accepts responsibility for quality, satisfaction, and economic performance for a defined population
• Accepts the risk of external constraints on resources
• Accepts role as the active “integrator” of care
  – Redesigns Primary/Secondary/Tertiary-Quaternary
  – Invests in care coordination & care infrastructure
  – Fosters transparency
  – Macro System integration
• Accepts Leadership in Physician/ Clinician/ Staff Satisfaction

Adapted from Berwick, Nolan, Willingshing. The Triple Aim: Care, health, and Cost. Health Affairs 2008

Value-Based Care: The Person Journey Model

Choose a Primary Care Provider, Wellness Visit

‘Triple Aim,’ Physician/Clinician/ Staff Satisfaction, & Team-Based Care

Behavioral Health Access and Management

Chronic Condition Management, care coordinator, pharmacare & adherence

PCP based System, Team Care, System access & navigation, EHR and Patient Portal

HRA, Health & Biometric Screenings & Health Assessment

Health Coaching, System Navigation, Coordination of care

Choose a Primary Care Provider, Wellness Visit

Patient Journey
Health Employer Exchange

• Systems Replicate and Scale Practices to Accelerate Change and Make Sustainable

• Value Based Care Accomplishes The Triple Aim plus Physician/Clinician/Staff Satisfaction

• Innovation/Transformation Process to Accomplish

• 5-6 Systems (UCLA Health, Bon Secours Virginia, & Other AMCs and Community/Regional Healthcare Systems)

• 3-year Duration

Health Employer Exchange Metrics to Measure Value

• Engagement: Participant Engagement for each step of the Person Journey

• Utilization/ Risk Identification/Mitigation
  – Quantification of avoidable ED, inpatient admission, and readmission
  – Quantification of visits to PCPs (MD and System) and electronic alignment with PCP system

• Total Cost of Care: Quantification of Impact on PMPM/PMPY Spend Trend and Total Population Spend Trend

• Workers’ Comp/Absenteeism/Presenteeism: Impact on Worker’s Comp Spend Trend/Absenteeism/Presenteeism

Health Employer Exchange Process

Plan/Design

• Health Employer Exchange Overview/Briefing
• Site Visits if Desired
• Commitment from CEO/COO
• Appoint Internal Leadership and Design Teams
• Select Areas of Focus from Principles to Contribute and One to Replicate
• Define Internal Objectives, Approach, and Timeline (OAT)
• Concur with the Refined, Co-Created Principles, Define Membership, Define Boundaries, and Determine Pricing

January – April 2014

Implementation/Operationalization

• Begin Monthly Meetings of Leadership Teams
• Begin Twice Monthly Meetings of Design Teams
• Establish Implementation Teams as Needed
• Attend In-Person Meetings Twice Yearly
• Participate in Webinars In Between In-Person Meetings
• Contribute to the Learning Process and Further Refinement to Replicate and Scale Value Based Care among the participants and within your own systems

• May 2014 – May 2017
Molly Coye, MD
Chief Innovation Officer
UCLA Health

Our Physicians

- UCLA Medical Group ranks among the top physician organizations in California for CAPG and NCQA
- More than 75 neighborhood clinics throughout the greater Los Angeles area
- 1,200 physicians who are clinical faculty members at the David Geffen School of Medicine
Our Hospitals

- Ronald Reagan UCLA Medical Center (RRUMC)
  - Internationally recognized care
  - 300,000 patients/year
  - 520 private rooms
  - 1,500 physicians
  - 2,500 staff

- UCLA Medical Center, Santa Monica
  - Home of #3 ranked geriatrics program
  - 300 private rooms

- Stewart and Lynda Resnick Neuropsychiatric Hospital
  - 80,000 patients/year
  - Inpatient and Outpatient Programs
  - 75 private rooms

- Mattel Children’s Hospital UCLA
  - 34,000 patients/year
  - Located within RRUMC
  - 90-bed inpatient unit

Our Academic and Research Mission

- Training the next generation of physicians
- Invented 1st PET Scanner
- Reported the world’s first cases of AIDS
- Discovered HER-2/neu gene leading to development of Herceptin
- Nobel Prize winning research

CICARE and Commitment To Care

Connect
Introduce
Communicate
Ask
Respond
Exit
Academic Health Centers and the Evolution of the Health Care System

“... indeed to survive...”

- Patient Focus
- Population Health
- Big Data
- Value Conscious


A key aspect of Innovation is Engaging Stakeholders in the Process of Transformation

- Planning Phase
- Design Phase
- Implementation Phase
- Operations Phase

- PCMH + population health management components
- Five clinics in six months: 13,000 patients
- Rapid replication to 14 clinics: 100,000 patients
- Completed replication to 26 clinics: 160,000 patients
- Platform for continuous introduction, design, testing and deployment

The Transformation Process

- Leadership Team
- Design Team
- Implementation Teams
- Evaluation Team
- Sustainable Operations

- Establish High Level Project Objectives
- Establish Initial Priorities
- Define Design Team Charge
- Define metrics for success
- Apply the specific approach and methodology to accelerate the implementation of and sustainability of the objectives
- Apply the process of rapid cycle scalability and replicability
- Define the application of the implementation and operationalization processes
- Implements/operates omniates across the systems
- Innovation Science teams
UCLA Innovation/Transformation Model
Replication and Scalability

- Design Processes, Refine Metrics
- Share, Advise Others, Replicate and Scale, Accelerated Spread
- Document Processes and Metrics, Identify Scalable and Replicable Components

Making Organizational Change Possible

Health Care System

- Supportive Payment & Regulatory Environment
- Organizations that facilitate the work of patient-centered teams
- High performing patient-centered teams
- Outcomes: Safe, Effective, Efficient, Personalized, Timely, Equitable

UCLA Strategy for Population Management:
Primary Care Innovation Model (PCIM)

I. Implement Practice Re-Design
   - Primary Care Re-Design
   - Related “System” Re-Design & Macro System Integration
II. Increase Covered Lives Under UCLA Management
   - Growth in Primary Care capacity
   - Geographic Expansion
III. Expand Primary Care System Capabilities
   - Pre-primary Care, retail clinics, telemedicine, home services
IV. Collaboration
   - Internally & Externally
   - Collaborations with payors that support care management
V. Replication
   - Internally & Externally
VI. Evaluation
UCLA Primary Care Population Base

- We have a mix of fee-for-service (attributed by visit model) and capitation (health plan assigned) empaneled primary care patients N~275,000

<table>
<thead>
<tr>
<th>Financial Model</th>
<th>Fee-for-service</th>
<th>Fee-for-service</th>
<th>Shared Savings</th>
<th>Shared Savings</th>
<th>Capitation</th>
<th>Capitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Size</td>
<td>104,000</td>
<td>70,000</td>
<td>15,000</td>
<td>20,000</td>
<td>55,000</td>
<td>11,000</td>
</tr>
</tbody>
</table>

*Includes Entertainment Industry Medical Group (EIMG) population as of June 1, 2014

Primary Care Innovation Model (PCIM): Embracing System Attributes

Primary Care Practice Team
- Existing roles:
  1. Physician
  2. MA/LVN
  3. Front Office
  4. Manager

- New roles in practice:
  1. Care Coordinator Role
  2. Ambulatory trained PharmD

Behavioral Health Associates

- Clinical Advisor Role

UCLA Health

Community Hospitals & Macro-System Integration

- "Real time" 24 hr discharge notification (ED & Acute Hospital)

- Access to community resources

- Disease specific programs (CHF, Diabetes)

- Patient Registries (risk, quality gaps)

- Expanded services
PCIM Primary Care Re-design:
Care Coordinator Innovation

- UCLA Care Coordinator model does not require licensure
  - New job description developed for FTE position
- Embedded within physician practice site
- Care Coordinator panel = the practice panel
- Varied backgrounds
  - Medical Assistant (MA); Licensed Vocational Nurse (LVN); Military Trained Medics & Corpsman (Veterans); Emergency Medical Technician (EMT); Patient Service Representative (PSR); Community Health Professionals (MHA or MPH)
- Initial curriculum-based training an ongoing training
- Clinical Advisor-led telephonic and in-person ongoing support and training

Care Coordinator Training

- Problem Solving Techniques
- Patient Engagement
- Post Acute Care Planning
- Behavioral Economics
- Motivational Interviewing
- Risk Identification for Care Coordination
- Socio-Behavioral Risk Assessment
- Communicating with Physicians
- Shared Decision Making
- Transitions of Care strategies
- Community Resources
- Health Plan Navigation

What does a office based care coordinator do?

"When Marjorie Crear, 66, left Ronald Reagan U.C.L.A. Medical Center after a stroke, she struggled to keep track of her medications and to remember her doctor appointments. [A newly] hired care manager [in her doctor’s office] helped with those tasks and has also been trying to find public housing with a shower instead of a hard-to-navigate bathtub."
PCIM: RN Clinical Advisor Role

- Direct involvement with patients who need a step up in clinical intervention
  - Answer questions or re-enforce plan of care
  - Direct complex care coordination in higher risk situations
  - Targeted home assessments
  - Patient returns to care of the local office after interventions
- Consultation
  - Suggest resources or interventions that care coordinator could bring to physician
  - More clinical expertise in facilitating care being provided by Home Health or other external or internal source
  - Any other question from care coordinator

PCIM: UCLA Behavioral Health Associates
Mental Health Needs for PCIM Practices*

<table>
<thead>
<tr>
<th>UCLA PCP Patients</th>
<th>Patients with identified psychiatric illness</th>
<th>Psychiatric emergency visits</th>
<th>Psychiatric hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>215,287</td>
<td>44,737</td>
<td>1,054</td>
<td>232</td>
</tr>
</tbody>
</table>

*Chronic anxiety and depression most common

Overview of MYMeds: Managing Your Medication for Education and Daily Support

- Physician-PharmD collaboration
  - Embedded into office, integrated into team, 1-1 communication, PCP can refer directly from EHR
- Access to pertinent patient medical records
  - Timely communication
  - Documentation of interventions into EHR
- Targeted groups
  - HypertensionDiabetes not controlled or 5 or more medications, anticoagulation, multiple chronic illnesses, > 65 with multiple admissions and chronic disease, plus MD referrals
- Focus is on Barriers to Adherence
  - Cost, Complexity, Patients beliefs about medications, Social-ecology
Update on Clinical Impact of MyMeds

Total consults from 2/2012 - 2/2014 = 1,142

- Medication reconciliation
  - 24% had inaccurate medication lists
  - 37% were not taking a medication as directed, or needed clarification
- Non-adherence
  - 46% were non-adherent based on standardized assessment
  - Most common reasons were intolerable side effects, memory issues, cost issues, and beliefs about medications/conditions
- Medication adjustments (e.g. therapeutic substitution)
  - 775 recommendations made to primary care physician

MyMeds Linkage with Home Based Program

Patients who meet criteria for CMS funded Community Based Care Transitions Program (CCTP) were eligible for home based medication review

Post-acute hospital discharge HOME visit

- Review with physician
- Medication review
- Identification of “medication related problems”

PCIM Evaluation: Physician survey

Sent to 119 PCPs (44% response rate)
Primary Care Processes: UCLA PCIM vs. Non-PCIM Practices

Per year, per patient averages:

<table>
<thead>
<tr>
<th></th>
<th>Total PCP visits</th>
<th># of visits with attributed PCP</th>
<th># of different PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCIM</td>
<td>2.0</td>
<td>1.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Non-PCIM</td>
<td>2.2</td>
<td>1.6</td>
<td>1.7</td>
</tr>
</tbody>
</table>

PCP follow-up visit rate within 14 days of acute event:

<table>
<thead>
<tr>
<th></th>
<th>ED visit</th>
<th>Non-elective, non-maternity admission</th>
<th>Ambulatory care-sensitive admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCIM</td>
<td>22.9%</td>
<td>32.7%</td>
<td>40.3%</td>
</tr>
<tr>
<td>Non-PCIM</td>
<td>21.3%</td>
<td>27.5%</td>
<td>33.1%</td>
</tr>
</tbody>
</table>

Unadjusted Primary Care Outcomes: UCLA PCIM vs. Non-PCIM Practices

Events per 1000 patient-years:

<table>
<thead>
<tr>
<th></th>
<th>ED visit</th>
<th>Non-elective, non-maternity admission</th>
<th>Ambulatory care-sensitive admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCIM</td>
<td>127.9</td>
<td>42.6</td>
<td>14.3</td>
</tr>
<tr>
<td>Non-PCIM</td>
<td>135.3</td>
<td>47.0</td>
<td>14.1</td>
</tr>
</tbody>
</table>

Readmission rate (attributed population):

<table>
<thead>
<tr>
<th></th>
<th>PCIM</th>
<th>Non-PCIM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.5%</td>
<td>18.4%</td>
</tr>
</tbody>
</table>

Risk Adjusted Outcomes*: UCLA PCIM vs. Non-PCIM Practices

- 22% reduction (p<.0001) in ED visits compared to non-PCIM control clinics
- Estimated 1185 ED visits avoided with reduction in Total Cost of Care of $2.4 million
- Projected to entire primary care population, reduction in Total Cost of Care would be $13 million

* Communication in preparation. Differences-in-differences analysis conducted that adjust for gender, age, and medical complexity. Limited to commercial HMO and Medicare Advantage populations. Data courtesy of Dr. Robin Clarke.
PCIM: Rapid adoption & spread

Timeline of Patient and PCP Growth

- Number of Patient Covered
- Number of PCPs Included

Provider-Employer Collaboration:
Provider role in evidence based population health

Corp. Wellness Programs
HRA & Biometric Screen, "person journey"
Web-based Engagement Platform with Mobile app

Employment Realm
Medical care Realm

Employee
Patient

Key Individual Risk Reduction Measures

- Blood Pressure
- Fasting Blood Sugar
- Smoke
- Perception of Health
- Alcohol
- Chest pain
- Physical Activity
- Body Mass Index
- Fatty Diet


March 2013
The Next Step: Provider-Employer Collaboration/The Person Journey Model

Putting together all the pieces: Provider-Employee Collaboration

“Imagination abounds at all levels, and all promising routes for innovation should be encouraged”

From: Crossing the Quality Chasm: A New Health System for the 21st Century IOM 2001
Michael Spine  
Vice President, Business Development  
Bon Secours Health System, Inc.

Laura Ostroff  
Vice President, Benefits and Human Resource Information Systems  
Bon Secours Health System, Inc.

Bon Secours Virginia Health System

**Volume 2013**
- Acute Care: 6 hospitals
- Inpatient Beds: 1,900 licensed
- Employee Physicians: 500 MD/DO
- Total Medical Staff: 3,000 MD
- Total Employees: 11,000 individuals
- Emergency: 380,000 visits
- Discharges: 75,000 patient
- Surgeries: 75,000 procedures

**Vitals 2013**
- HCAMPS Inpatient: 72nd percentile
- CMS Appropriations: 95.5% compliance
- Employee Engagement: 57th percentile
- Turnover: 10.2% employee

**Financials 2013**
- Community Commitment: $21 million
- Net Patient Revenue: $1.9 billion
- Margin from Operations: 5.4%
- EBITDA: 11.0%

Bon Secours Value Based Care  
Employee Journey 2013 & 2014

*Partner for Health registration was capped for FY2014 pilot year*
Why it matters? - The cost behind poor health

<table>
<thead>
<tr>
<th>Total PMPY (Allowed)</th>
<th>$1,037</th>
<th>$6,233</th>
<th>$34,170</th>
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<tbody>
<tr>
<td>Medical</td>
<td>$698</td>
<td>$4,632</td>
<td>$29,644</td>
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<tr>
<td>Pharmacy</td>
<td>$339</td>
<td>$1,601</td>
<td>$4,526</td>
</tr>
<tr>
<td>% Non-claimants</td>
<td>14%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>% HCCs (&gt;$50k Allowed)</td>
<td>0.0%</td>
<td>0.4%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Member Cost Share %</td>
<td>19%</td>
<td>14%</td>
<td>6%</td>
</tr>
<tr>
<td>% Share of Total Allowed</td>
<td>8.0%</td>
<td>43.0%</td>
<td>49.1%</td>
</tr>
</tbody>
</table>

| Hypertension        | 30.0  | 197.1 | 321.5   |
| Coronary Artery Disease | 0.3  | 17.0  | 106.2   |
| Congestive Heart Failure | 0.0  | 1.1   | 31.8    |
| Asthma              | 16.1  | 46.1  | 60.7    |
| COPD                | 0.0   | 6.5   | 37.0    |
| Diabetes            | 9.4   | 116.0 | 204.2   |
| Osteoarthritis      | 3.0   | 85.9  | 253.4   |
| Rheumatoid Arthritis | 0.0  | 7.0   | 21.1    |
| Low Back Disorder   | 17.9  | 110.1 | 210.5   |
| Other Conditions    |        |       |         |
| Cardiovascular      |        |       |         |

Key Levers to Move the Dial

- Benefits Design
- Culture of Health and Wellbeing
- Primary Care Redesign (PCMH)
- Risk Stratification
- Targeted Programs for all Segments

Timeline

- Bon Secours Employee ACO: Established 2010-present
- Bon Secours Employee Health Plan: Long Term Strategy
- Medicare ACO Established: 2013
- Analytics and Reporting Trends: 2014
- Partner for Health ACO to Employees/Spouses: 2015
- Expand to Other States and Major Employers: 2015
- BSV Expansion to Spouses/Significant Others: 2013
- Advanced Laboratory Testing: 2014

Sources: Bon Secours Virginia Health System, 2013
Bon Secours’ Employee ACO Journey

Transition from High Risk Condition Management to Population Health

Strategic Partners: Engagement, Target, Coaching, PCP

ACO I
- 204 Participants
- High Risk Condition Management: Asthma, Diabetes
- PCP Referral

ACO II
- 204 Participants
- High Risk Condition Management: Asthma, Diabetes
- PCP Referral

ACO III
- 2024 Participants
- PHA, Advanced Testing, Lifestyle Coaching
- PCP Referral & PCMH

Bon Secours’ Employee ACO Journey

Incentivizing Healthy Behaviors through program design

• Targeted Health Coaching
  - Telephonic, Web Based, 1:1
• Condition Management
  - Diabetes (Medical Home)
  - Hypertension
• Building the Culture (Commit to be Fit Campaign)
  - Commitment Day
  - Cycling
  - Walking paths
  - Stairwell Campaign
  - Healthy Foods
  - Wellness Focused Leader Day
  - Leadership Challenges
• Dedicated Web Portal for Wellness
• Wellness Wednesday’s
• Good Health Onsite Clinics
• Cleveland Clinic-Stress Management
• HDL Advanced Laboratory Screenings
• Nutrition and Cafeteria changes

Starting at the Top: Program Highlights

© 2014 by the Catholic Health Association of the United States
Shifting Population Risks Lower (Despite Our Aging Workforce)

Risk Factor Count (average count for participants)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2013</th>
<th>Change</th>
<th>2011</th>
<th>2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richmond</td>
<td>2.28</td>
<td>2.11</td>
<td>-0.17</td>
<td>2.47</td>
<td>2.35</td>
<td>-0.12</td>
</tr>
<tr>
<td>Hampton Roads</td>
<td>2.14</td>
<td>2.10</td>
<td>-0.04</td>
<td>2.50</td>
<td>2.45</td>
<td>-0.05</td>
</tr>
</tbody>
</table>

Risk Stratification (% of participants within a given risk level)

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>2011</th>
<th>2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>9.85</td>
<td>9.07</td>
<td>-0.78</td>
</tr>
<tr>
<td>Moderate</td>
<td>30.68</td>
<td>27.99</td>
<td>-2.70</td>
</tr>
<tr>
<td>Low</td>
<td>59.47</td>
<td>62.95</td>
<td>3.48</td>
</tr>
</tbody>
</table>

Richmond | Hampton Roads

Risk Factor Count (average count for participants)

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<td>2.47</td>
<td>2.38</td>
<td>-0.10</td>
</tr>
</tbody>
</table>

Moving Away from Costly ED Visits Through Plan Design and Health Improvement

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>% CHG from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits</td>
<td>328.6</td>
<td>300.9</td>
<td>295.5</td>
<td>-10%</td>
</tr>
<tr>
<td>Admissions</td>
<td>72.7</td>
<td>72.1</td>
<td>75.2</td>
<td>3%</td>
</tr>
</tbody>
</table>

Patient Type FY11 FY12 FY13 % CHG from Baseline

| ER Visits per 1,000 | 245.8 | 224.8 | 211.8 | -14% |
| Admissions per 1,000 | 71.5  | 67.4  | 68.2  | -5%  |

Good Health Care Outcomes: Risk Count & Stratification Change

Hypertension $216K per year saved

Diabetes $146K per year saved
What Advanced Lab Testing Taught Us Related to Diabetes and Cardiovascular Disease

- Advanced lab testing uncovered 32% of participants with high risk for developing diabetes. A total of participants with high risk for CVD were not identified by the typical Bon Secours PHA test.

| Note: participants with optimal glucose and HbA1c. |

High Risk
Optimal

62% of participants with high risk for CVD were not identified by the typical Bon Secours PHA test. (Total cholesterol, HDL)

Targeted Coaching to reduce risks identified through advanced laboratory testing.

Tracking Progress Through Metrics

- Decreased admissions per 1,000 (3%)
- Decreased ED Visits per 1,000 (12%)
- Increased in-Network Utilization
- Increased Urgent Care & PCP Visits per 1,000
- Increased Wellness Exams for the Population (36%)

Sources: Bon Secours Virginia Health System, 2013

Beyond Employee Populations