Overview of UHC's Ambulatory Care Quality & Accountability Ranking and Study

May 17, 2015

Agenda

Why rank performance on ambulatory care?

Purpose and goals of Ambulatory Care Q&A Ranking and Study

Domains and metrics for 2015

Next steps and timeline for data submission

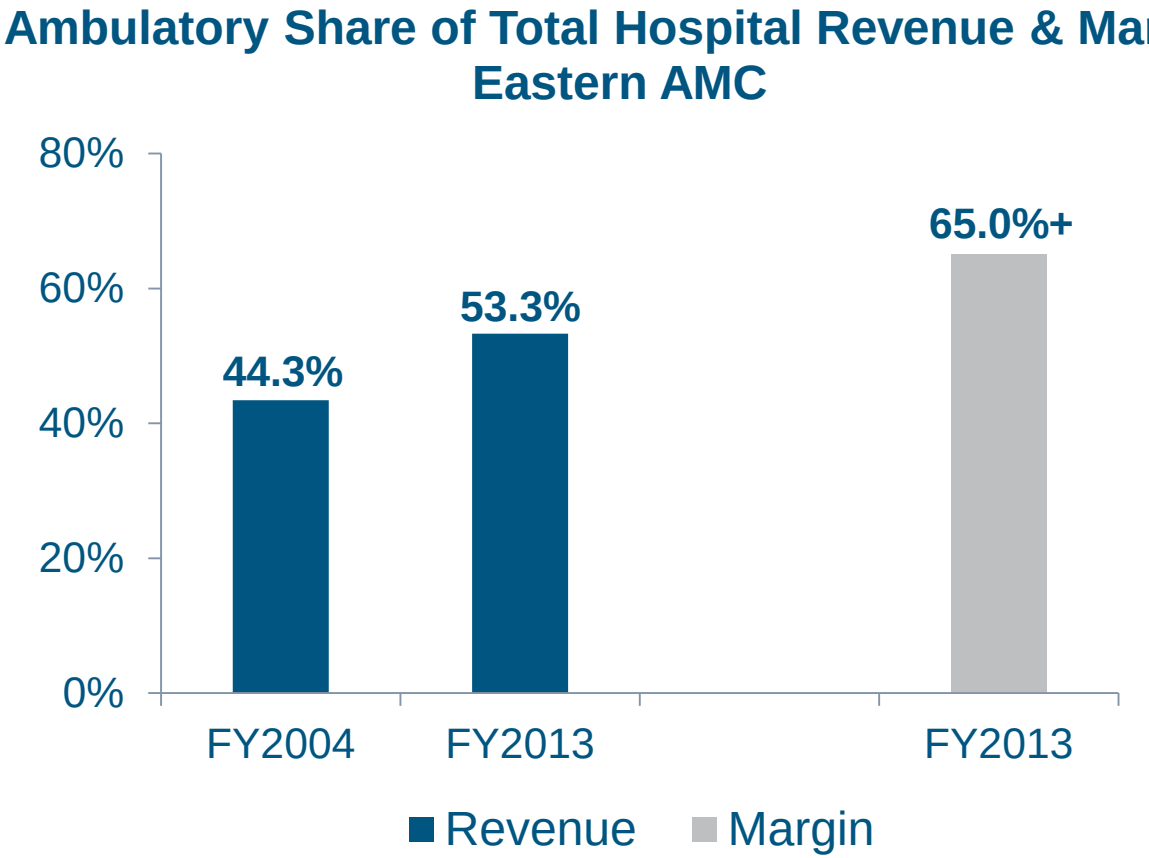
Why rank performance on ambulatory care?

Factors Accelerating the Need to Ensure Success Across Ambulatory Enterprise

- Reimbursement for both hospitals and physicians increasingly linked to quality, costs and patient satisfaction
- Referrals fuel volume and revenue yield for the health system
- Complex chronic patient cohort = AMC core business. Better management of these patients can free up capacity and improve access

Ambulatory care is the critical link to ensuring quality and cost-efficiency across the continuum.

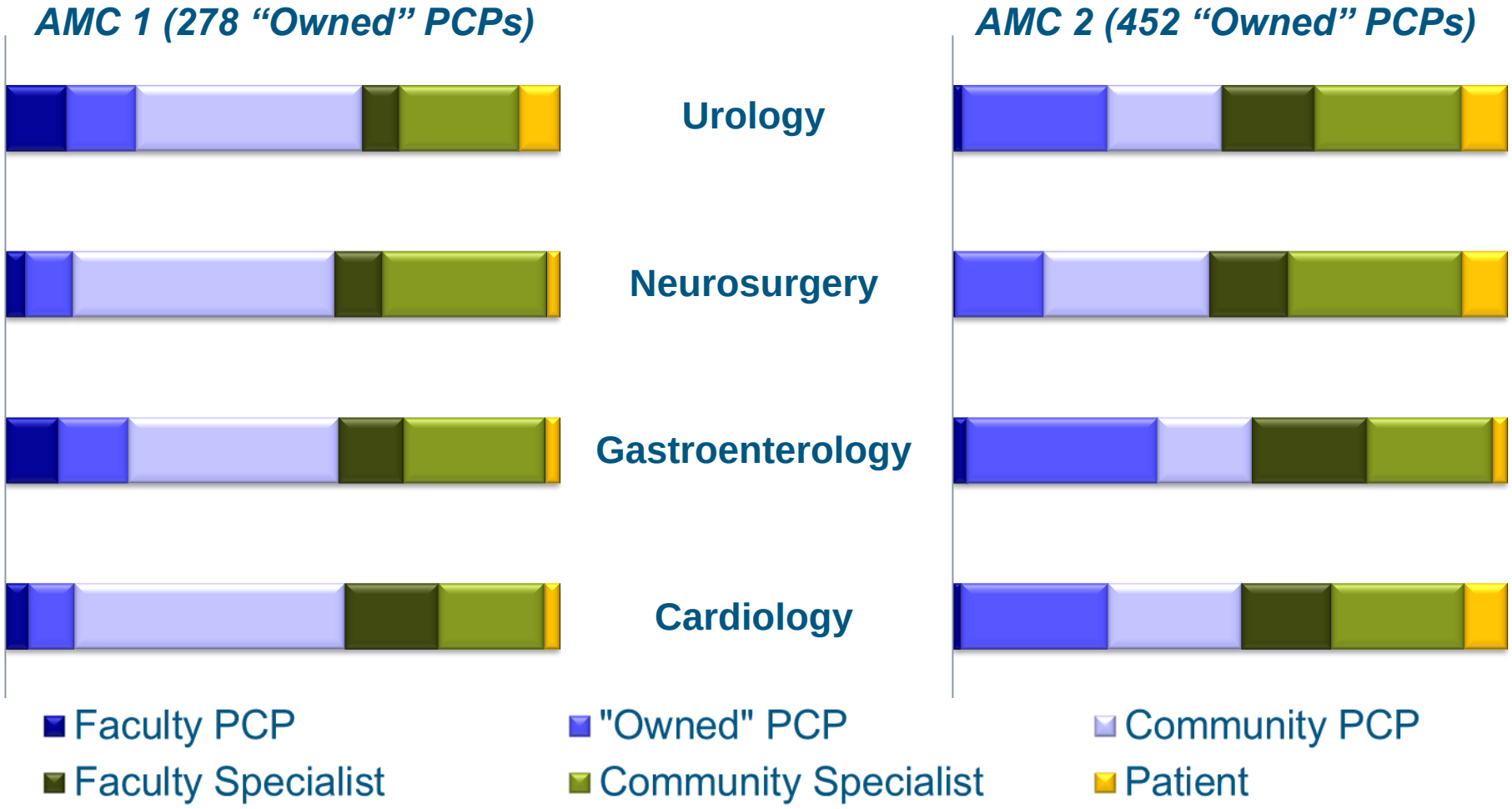
Ambulatory Care Core and Growing Component of AMC Clinical Enterprise



High quality, accessible, and cost-efficient ambulatory care integral to success of broader clinical enterprise.

Referrals from Primary Care Important Feeder of AMC Subspecialty Business

Distribution of New Patients by Referral Source



Source: FPSC and UHC Access Initiative, January 2013 – December 2014 data.

Specialist Yields from Community PCP Referrals Higher Than from AMC PCPs

Downstream Yield from PCP Referrals
Community:AMC

	Major Imaging	Major Procedures
Urology	154.1%	149.0%
Neurosurgery	124.2%	141.3%
Gastroenterology	132.3%	142.2%
Cardiology	112.8%	122.7%

Relative to those from community PCPs, referrals from AMC PCPs more often result in only office visits and/or minor procedures.

Source: FPSC and UHC Access Initiative, January 2013 – December 2014 data.

Referrals from Specialists Generate Higher Yield of Major Procedures Than Referrals from PCPs

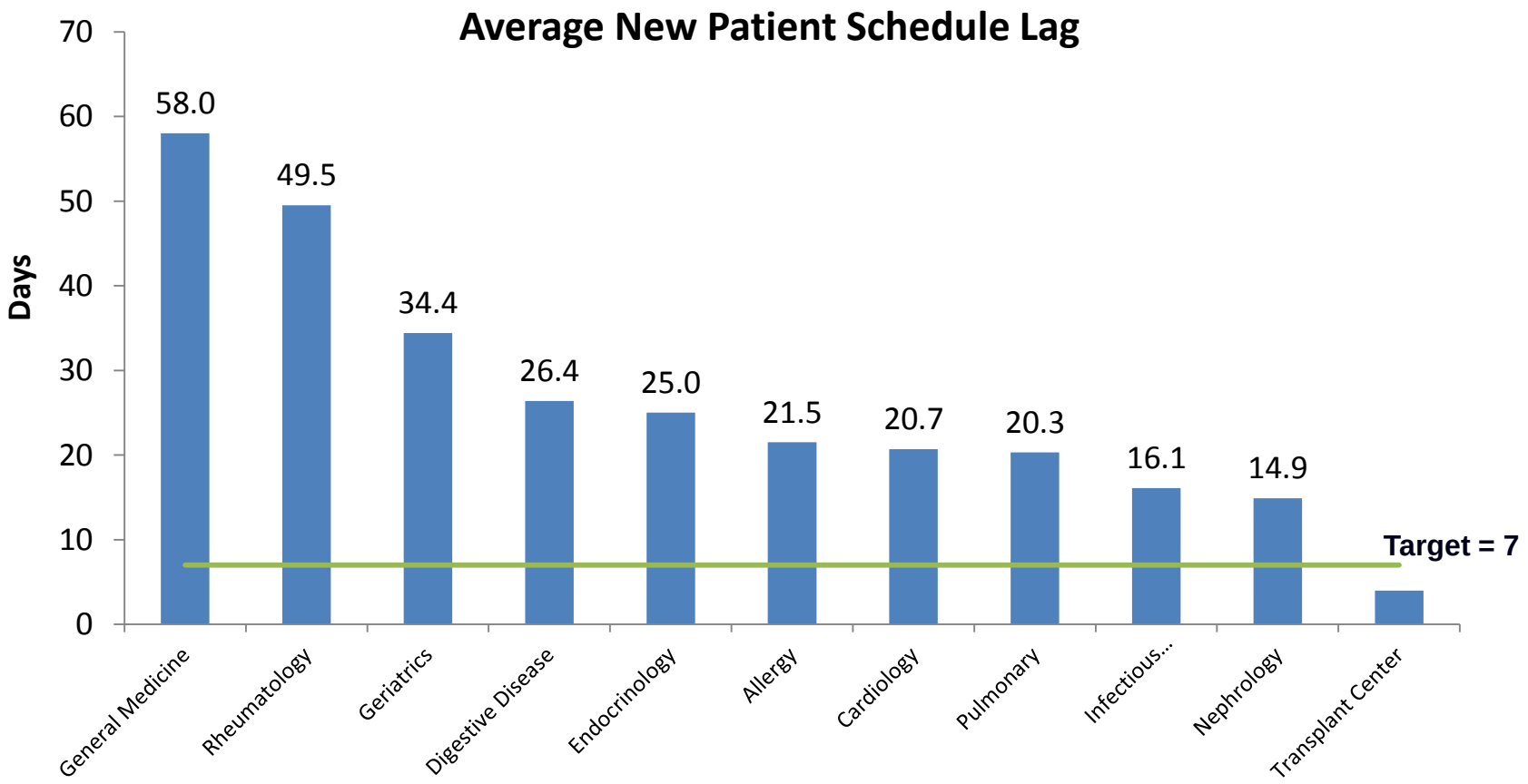
Major Procedures Per 100 New Patient Referrals

Referred from PCP		Referred from Community Specialist	
36.1	Urology	50.2	+ 39.1%
159.4	Neurosurgery	192.5	+ 20.8%
21.0	Gastroenterology	39.3	+ 87.1%
43.7	Cardiology	119.6	+ 173.7%
155.5	Cardiac Surgery	282.8	+ 81.9%
24.7	ENT	81.6	+ 230.4%

Intramural specialist referrals yield 15-30% less than community specialists. May reflect community retaining low acuity cases.

Source: FPSC and UHC Access Initiative, January 2013 – December 2014 data.

Yet, AMCs Offer Poor Access to Care For New Patients



Schedule lags suggests pent-up demand for specialists.

Source: UHC Access Initiative, arrived patients July – December 2013.

Despite This, Most AMCs' Specialty Clinics Have Substantial Idle Capacity

Western AMC's Medical Specialty Clinic Daily Visit Volumes

~ March 2012 ~

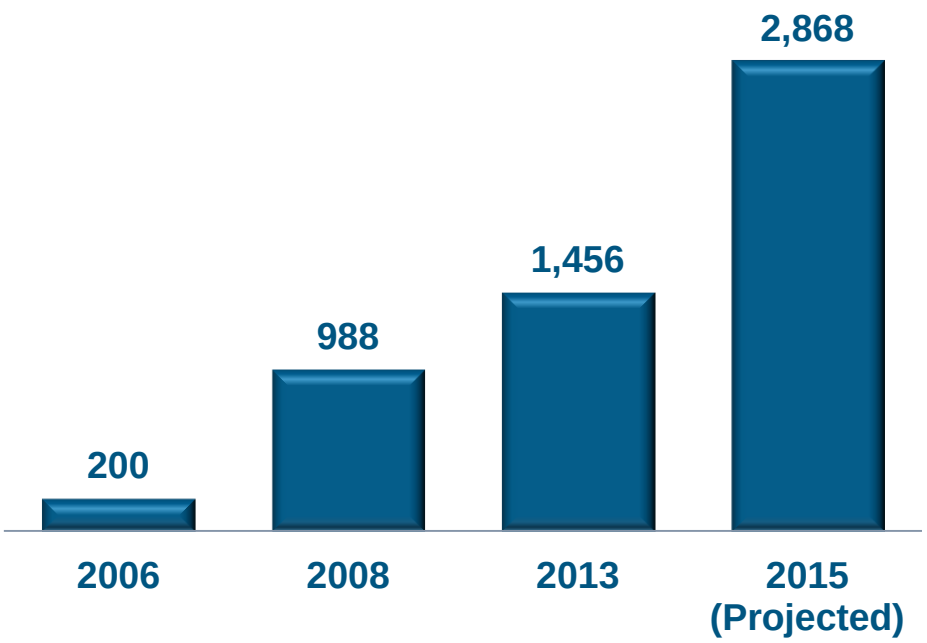
? February | April ?

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1 106	2 62	3
4	5 109	6 87	7 117	8 90	9 52	10
11	12 122	13 84	14 129	15 93	16 33	17
18	19 125	20 78	21 112	22 96	23 31	24
25	26 122	27 86	28 104	29 97	30 61	31

"I once put together a graph showing our capacity utilization by day for the month, and it looked like a seismograph." -- Clinic Administrator

Growth of Low Acuity "Walk-In" Clinics a Harbinger of the Future?

Number of Retail Clinics in the U.S.

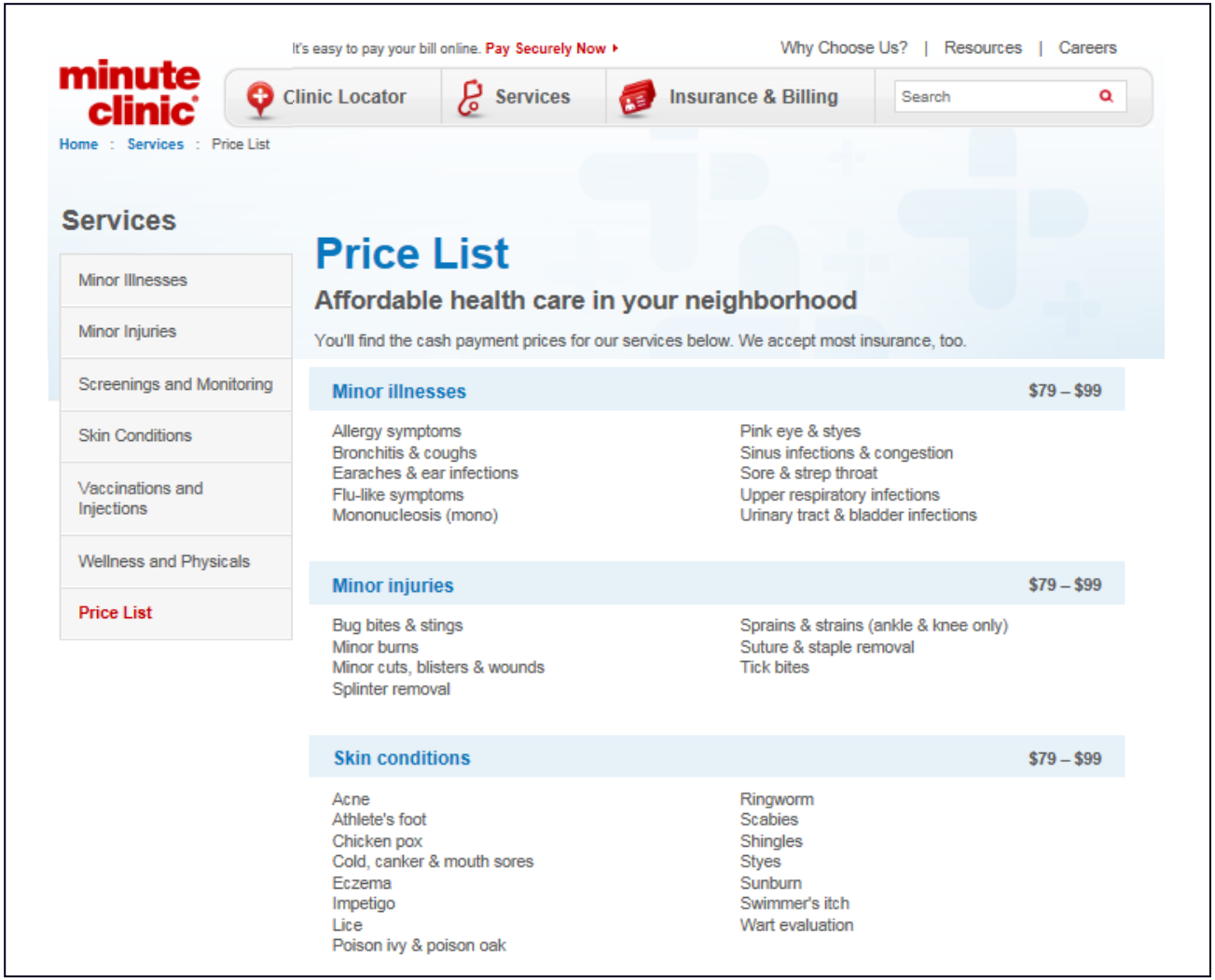


- Convenient, low cost access for ad hoc sub-acute needs
- Patients seek immediate solutions to minor problems, not long-term relationships
- Well-suited for the healthy majority, particularly millennium generation
- May operate completely outside of higher deductible benefit plan

May be the point of the spear in a move back toward medical insurance – protection against catastrophic economic loss – and away from "everything is free" expectations from 1980s.

Source: Accenture "Retail Medical Clinics: From Foe to Friend?", June 2013; Merchant Medicine.com

Retail Medical Clinic or AMC?



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- Screenings and Monitoring
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Price List

Affordable health care in your neighborhood

You'll find the cash payment prices for our services below. We accept most insurance, too.

Minor illnesses — $79 – $99

Allergy symptoms
Bronchitis & coughs
Earaches & ear infections
Flu-like symptoms
Mononucleosis (mono)
Pink eye & styes
Sinus infections & congestion
Sore & strep throat
Upper respiratory infections
Urinary tract & bladder infections

Minor injuries — $79 – $99

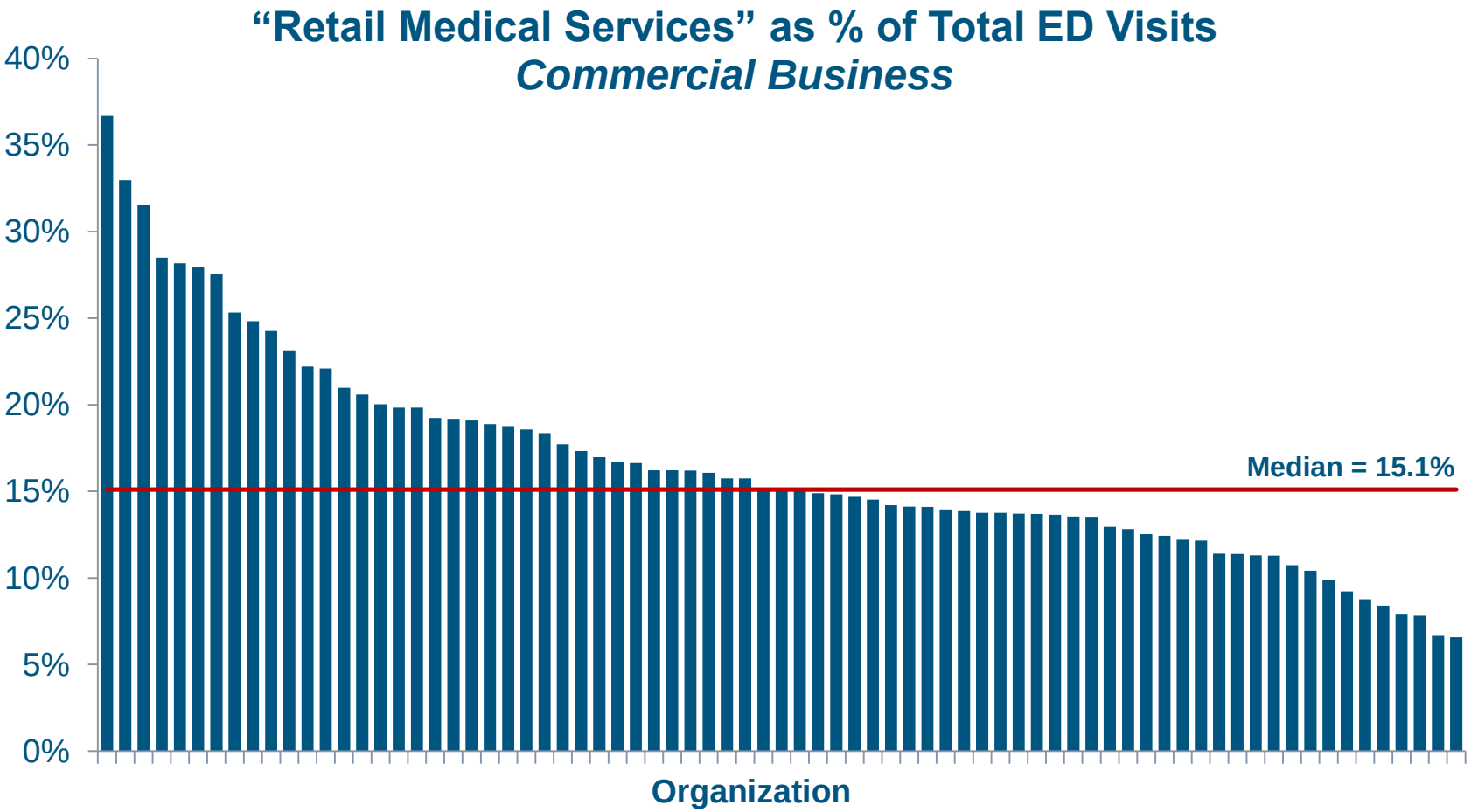
Bug bites & stings
Minor burns
Minor cuts, blisters & wounds
Splinter removal
Sprains & strains (ankle & knee only)
Suture & staple removal
Tick bites

Skin conditions — $79 – $99

Acne
Athlete's foot
Chicken pox
Cold, canker & mouth sores
Eczema
Impetigo
Lice
Poison ivy & poison oak
Ringworm
Scabies
Shingles
Styes
Sunburn
Swimmer's itch
Wart evaluation

Source: http://www.cvs.com/minuteclinic/services

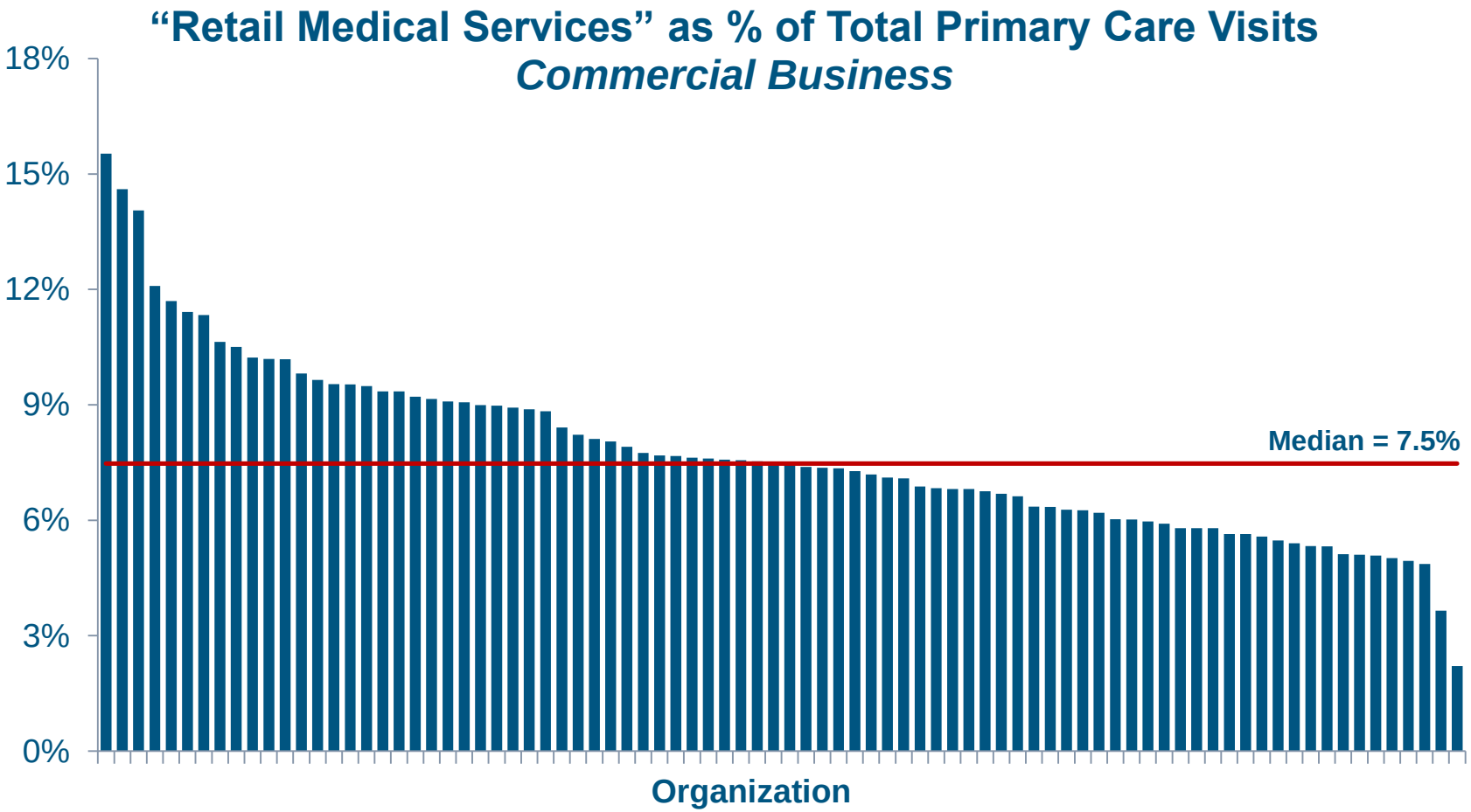
Low Acuity "Retail Medical Services" Represent Sizeable Portion of AMC Emergency Department Activity*….



* "Retail medical services" defined as minor illness, minor injuries, and skin condition services available within retail medical clinics (see previous slide for menu).

Source: FPSC, analysis of July 2013 – June 2014 data.

….and AMC Primary Care Visits



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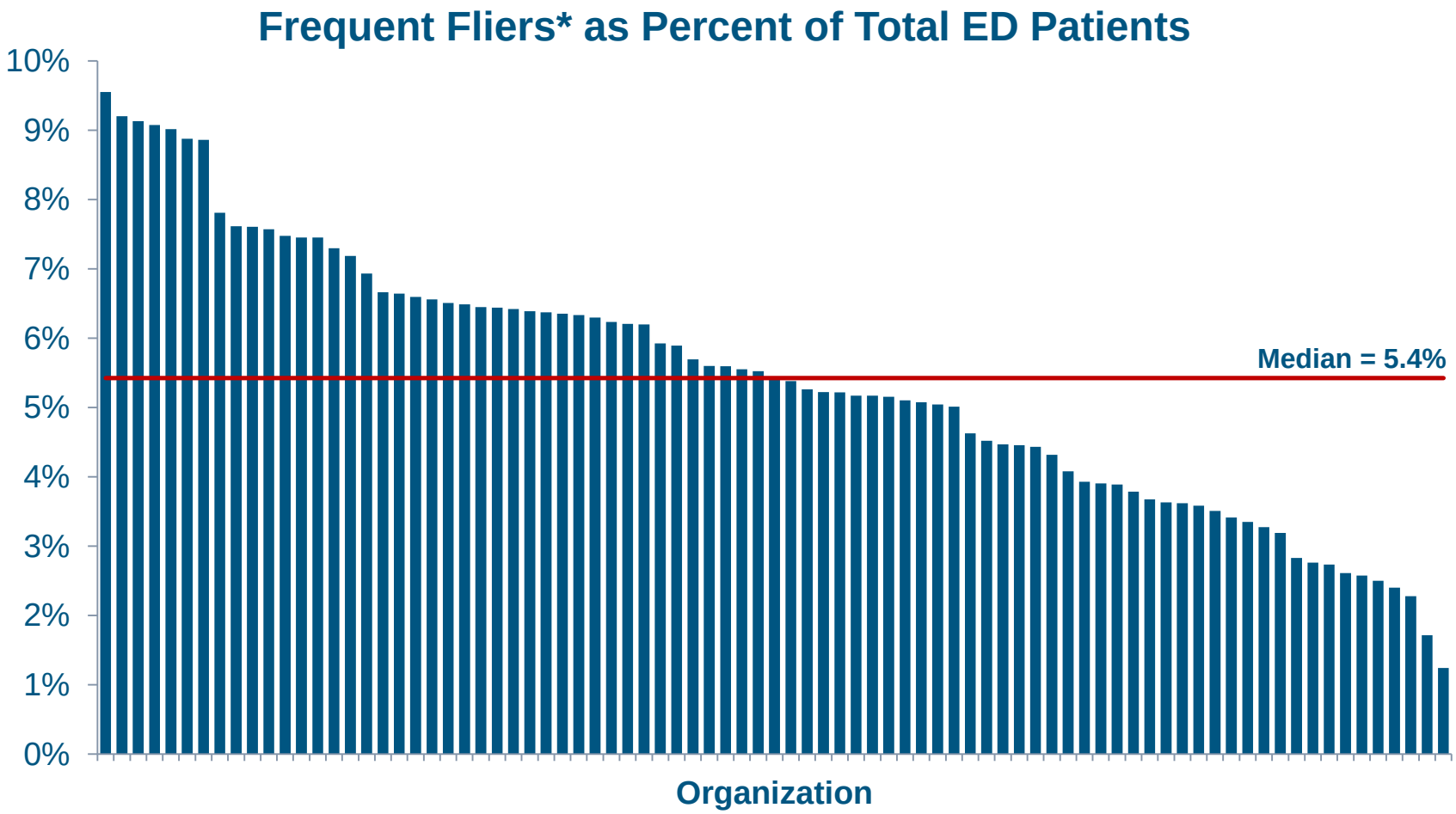
Source: FPSC, analysis of July 2013 – June 2014 data.

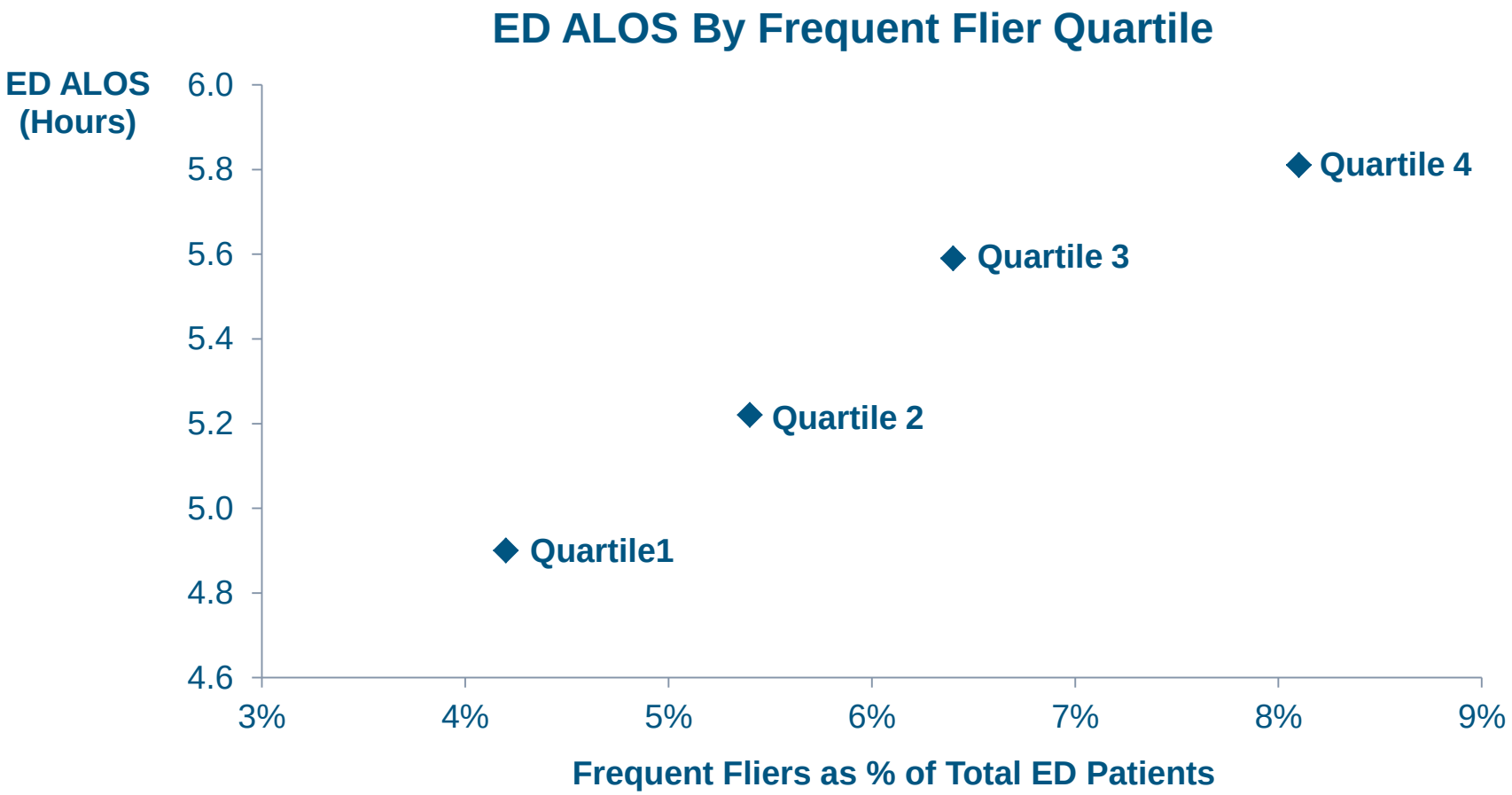
Emergency Department “Frequent Fliers” Put Strain on Scarce Resource….



* Frequent fliers identified as patients seen in ED 4+ times in 12 months.

Source: FPSC, analysis of July 2013 – June 2014 data.

….Duration of ED Stay Compounds Disproportionate Visits → More Strain on Scarce Resource



Source: FPSC and ODB, analysis of July 2013 – June 2014 data, n = 37 organizations in both datasets.

Purpose and goals of Ambulatory Care Q&A Ranking and Study

Goals of UHC's Ambulatory Care Quality & Accountability Ranking and Study

- Define the characteristics and competencies required to consistently deliver high quality, cost-efficient, and accessible care across the ambulatory enterprise
- Help members to understand where they stand and where to focus improvement efforts with respect to care that is delivered beyond the inpatient setting
- Help the AMC community to be market leaders by innovating to deliver ambulatory care that is high-quality, accessible, and cost efficient
- Results will be announced at UHC Annual Conference 2015: Advance, October 1-2 in Orlando, Fl

Ambulatory Q&A Participation

- Joint outreach to hospital and practice plan CEOs
- Outreach made to 75 organizations based on initial eligibility criteria
- 60% response rate from member CEOs
- 95% commitment from all CEOs that have responded
- All committed organizations have identified liaisons, and almost all have co-liaisons from both the hospital and practice organization

Participation Summary

- Beaumont Health System
- Denver Health
- Duke University Health System
- Froedtert and the Medical College of Wisconsin
- Georgetown Medical Center
- Medical University of South Carolina
- Montefiore Medical Center
- Nebraska Medicine
- NYU Langone / NYU Faculty Practice Group
- OHSU
- Penn Medicine
- Rush University Health System
- Stanford Health Care
- SUNY Upstate
- Temple University Health System
- Thomas Jefferson University / Jefferson University Physicians
- The Emory Clinic, Inc.
- The Ohio State University/Wexner Medical Center
- Thomas Jefferson University/Jefferson University Physicians
- Truman Medical Center
- UC Davis Health System
- UC Irvine
- UCSD
- University of Alabama Health System
- University of Chicago
- University of Iowa Health System
- University of Cincinnati Health
- University of Colorado Health
- University of Florida Physicians, Shands Medical Center
- University of Kansas Medical Center
- University of Kentucky
- University of Louisville
- University of Minnesota
- University of Missouri-Columbia
- University of New Mexico
- University of Toledo Medical Center
- University of Texas Southwestern Medical Center
- University Utah Health
- University of Vermont / Fletcher Allen Health Care
- University of Michigan Health System
- USC, Keck
- UW Medicine (Washington and Harborview)
- Vanderbilt Health System
- Yale New Haven Health System

Domains and metrics for 2015

Multiple Stakeholder Groups Have Contributed Ideas for Domains and Metrics

- Ambulatory Care / Physician Practice Councils
- Strategy Officers and CFOs
- PI and CD Operations Committee
- PI and CD Subcommittee of the Board
- SOO Council
- Chief Quality Officers and Medical Leadership Councils

Measures and performance criteria are reviewed and endorsed by UHC's Q&A Steering Committee

Guidelines for Domain and Metric Selection

- Domains should align with areas related to ambulatory enterprise and, where appropriate, create synergy with current Q&A ranking

- Metrics should:
  - Be quantifiable
  - Be created from existing data sources (preferably data sources UHC already collects)
  - Meaningfully relate to the Q&A domain it resides in
  - Create actionable insight

Domains and Metrics Identified for Consideration

Satisfaction

- Patient
- Staff
- Referring physician

Capacity Management and Throughput

- Space allocation
- Encounter volume and flow

Access to Care

- Schedule lag
- Bumps, cancellations, and no shows

Quality And Efficiency

- PQRS
- Meaningful use
- Cost of care

Workforce

- MD effort allocation
- Non-MD staffing
- Production standards

Revenue Cycle Operations

- POS collections
- Pre-authorization/pre-certification

Continuum of Care

- Timely post-discharge follow-up
- ED LOS

Safety

- Screening for Fall Risk
- Medication Rec

Equity

- Schedule lag by payer
- Medicaid served vs. population

Metrics Update

- Testing and validation underway and will be wrapped up in June
- Methodologies document will be developed to detail metrics – available this Summer
  - "Office Hours" with AQA liaisons to answer questions about the metrics after methodologies document is published
- Webinar after Annual Conference to review 2015 ranking and discuss plans for 2016

Timeline for Metric Testing and Development

Domain	Metric	Data Source	Metric Testing Deadline	Data Submission Deadline	Performance Calculation Deadline
Access to Care	% new patient visits	FPSC 2Q14-1Q15	Complete	June 1	September 8
Access to Care	New patient visit schedule lag	Access Initiative 2Q14-1Q15	June 1	July 15	September 8
Quality & Efficiency	CMS Value-Based Modifier Quality Composite Score	CMS QRUR Report CY 2013	Complete	June 1	August 14
Quality & Efficiency	CMS Value-Based Modifier Cost Composite Score	CMS QRUR Report CY 2013	Complete	June 1	August 14
Equity	New patient visit schedule lag by payer class	Access Initiative 2Q14-1Q15	Complete	July 15	September 8
Workforce	Encounters per physician per session	Access Initiative 2Q14-1Q15	June 1	July 15	September 8
Continuum of Care	% of ED patients that are low acuity	FPSC 2Q14-1Q15	May 18	June 1	July 31
Continuum of Care	% of total ED patients that have 4+ ED visits in last 12 months	FPSC 2Q14-1Q15	Complete	June 1	July 31
Continuum of Care	ED Length of Stay (ED-1b and ED-OP18b)	Core Measures 2Q14-4Q14	Complete	July 6	July 31
Capacity Management & Throughput	Encounters per room per day	FPSC/Access Initiative/ODB 2Q14-1Q15	June 1	June 4	July 31

Additional Measures UHC is Testing for Inclusion

- AHRQ Patient Quality Indicators (part of CMS Physician Value Modifier program)

- Imaging Utilization – potential metrics
  - ODB measure related to imaging resource utilization

  - FPSC measure on repeat imaging: % of patients with high cost imaging study during ED visit that had a repeat high cost imaging study within 14 days of ED visit

For More Information

Visit the new Ambulatory Q&A Webpage: https://www.uhc.edu/27072

Questions?