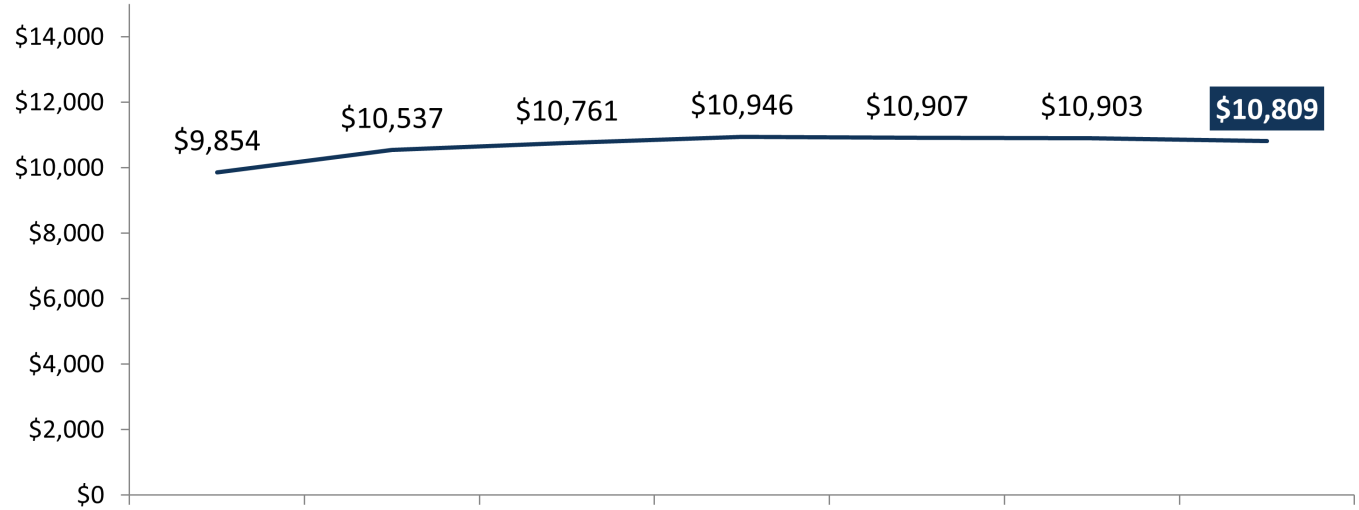
# Health Employer Exchange:
# The Culture of Health as a National Economic Imperative

September 1, 2015 Update

# Medicare Spending Trend Relatively Flat

**Exhibit 1**

## Medicare spending per beneficiary has been relatively flat in recent years

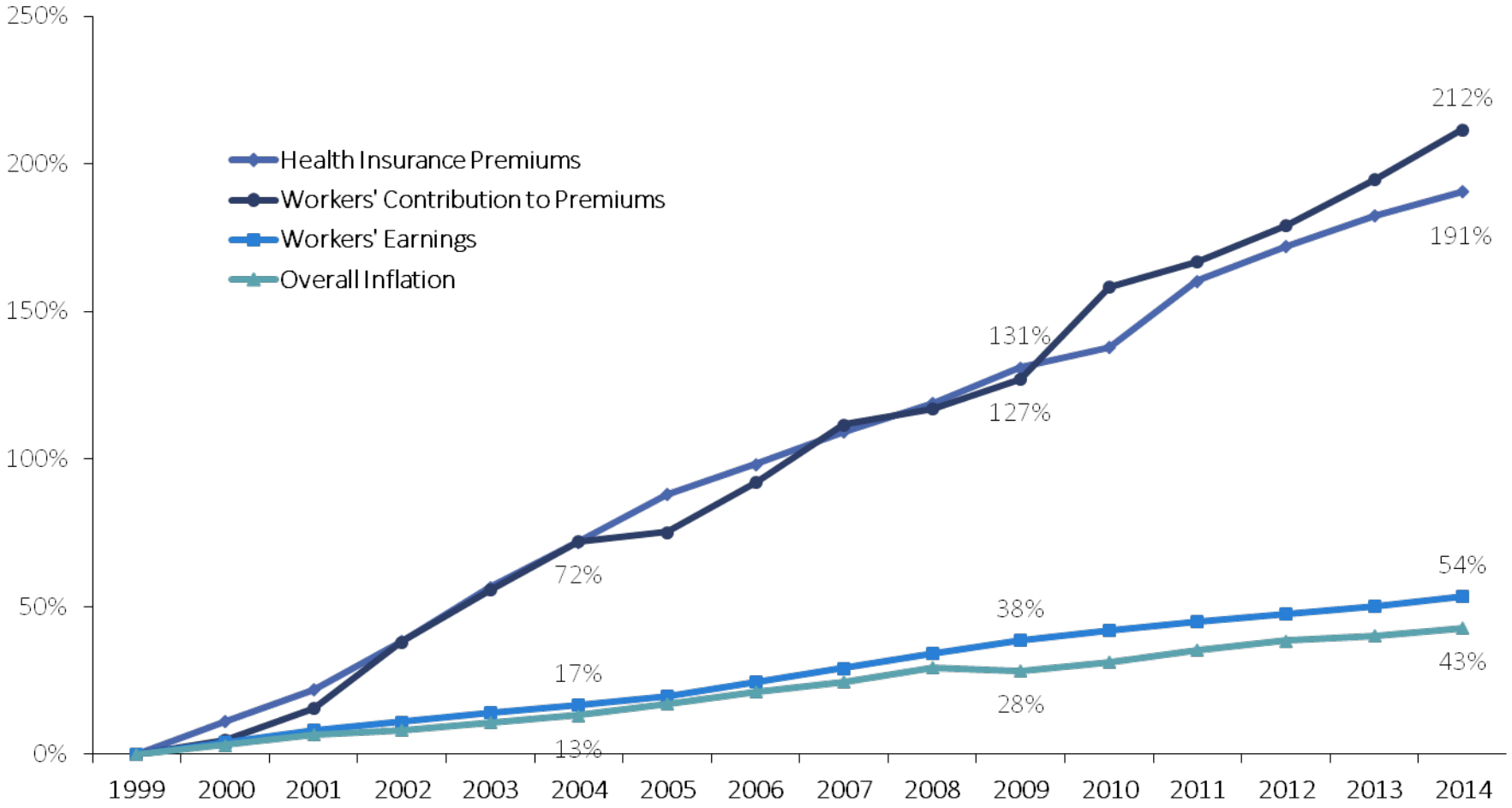



| | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|---|---|
| Total Medicare spending (in billions) | $445 | $487 | $510 | $531 | $551 | $566 | $580 |
| Number of beneficiaries (in millions) | 45.2 | 46.3 | 47.4 | 48.5 | 50.5 | 51.9 | 53.7 |

NOTE: Medicare spending equals payments for benefits, net of recoveries from providers for improper payments, adjusted for shifts in the timing of capitated payments. Years are federal fiscal years, which run from October through September.
SOURCE: RAND/Kaiser Family Foundation analysis of Congressional Budget Office, actual Medicare benefit payments, various years. Medicare Trustees historical enrollment (through 2013) and projected for 2014 from the 2014 Medicare Trustees report (enrollees in the Hospital Insurance program).

THE HENRY J. KAISER FAMILY FOUNDATION

# Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2014




SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2014 (April to April).

# Value-Based Care System for Culture of Health

- CEO-led Culture of Health as an economic imperative deeply rooted in the organization and the community
- Population health system
- Restructured delivery system

# Results

- 15% reduction in health plan costs over three years at Bon Secours Virginia Health System
- 20 % reduction in ED visits following implementation of Primary Care Innovation Model pilot initiative by UCLA Health Faculty Practice Group
- 56% reduction in workers' comp costs when Value-Based Care model was applied to UCLA Health Employees
- 5.4% reduction at Baylor, Scott & White Health in 2013 for total medical and Rx claims paid ($143M total annual health plan costs), and 7.1% reduction ($4,475) total per eligible per year on total eligible population of 31,978 (up 1.9% from previous year)

*Note: Further rigor through UCLA Health Services Research will be applied to verify results, but "directionally significant."*

# Opportunity Analysis & Impact Extrapolation

## Groups A, B, and C Population Health Management Opportunity Analysis

**Potential *Medical Cost Only* Savings from Evidence Based Population Health Management (Care Management of 8 Conditions and Health Management of 15 Health Risks)**

| Group A | |
|---|---|
| Potential Savings over 3 years | |
| 8 Conditions | $15.44 M |
| 15 Health Risks | $8.58 M |
| TOTAL | $24.02 M |

| Group B | |
|---|---|
| Potential Savings over 3 years | |
| 8 Conditions | $11.07 M |
| 15 Health Risks | $18.21 M |
| TOTAL | $29.28 M |

| Group C | |
|---|---|
| Potential Savings over 3 years | |
| 8 Conditions | $5.98 M |
| 15 Health Risks | $5.46 M |
| TOTAL | $11.44 M |

**These are Potential *Medical Cost Only* Savings (not taking into account the Health-related Productivity Savings from reduced Absenteeism/Presenteeism)**

# Health Employer Exchange: Metrics to Measure Value

- **Engagement**: Participant Engagement for each step of the Person Journey
- **Utilization/ Risk Identification/Mitigation**
  - Quantification of reduction in avoidable ED, inpatient admission, and readmission
  - Quantification of visits to PCPs (MD and System) and electronic alignment with PCP system
  - Utilization of the Markov Chain to reduce risk and cost to health plan and workers' comp
- **Impact on Health Plan Cost:** Impact on PMPM/PMPY Spend Trend and Total Population Spend Trend
- **Impact on Workers' Comp/Absenteeism/Presenteeism:** Impact on Worker's Comp Spend Trend/Absenteeism / Presenteeism

# The Model for Value-Based Care

- Delineate the Economic Imperative Targets for Savings
  - % Reduction in Increase of Health Plan Costs on PMPY basis
  - % Reduction of Actual Costs on PMPY basis
  - Move to or under Inflation Based Upon Opportunity/ Analysis and Impact/Extrapolation
- Sources of Savings
  - Design the Person Journey Coordinated by a Preferred Health System that Adds Partners
  - Redesign Health System Contributions
  - Community Partner Models

# Value-Based Care: The Person Journey Model for the Health Plan

HRA, Health & Biometric Screenings & Health Assessment

Health Coaching, System Navigation, Coordination of care

Choose a Primary Care Provider, Wellness Visit

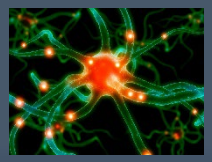
Patient Journey

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

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


Chronic Condition Management, care coordinator, Pharma management & adherence

Behavioral Health Access and Management



Medical Home

# Value-Based Care: The Person Journey Model for Workers' Comp

Identify Candidates (2 WC Claims in last 2 years)

Workers' Comp Coordinator Receives potential candidates from TPA

Workers' Comp Coordinator reviews candidates with HR and medical staff for possible participation

Workers' Comp Home

**"Triple Aim," Physician/Clinician/ Staff Satisfaction, & Team-Based Care**

Coordinator Invites Candidate to Office to enroll in the program

Candidate Visits Coordinator and Physician. Program designed.

Participant info sent to Occ. Health for services. Coordinator follows up weekly until program graduation.

Colleague Journey

# Value-Based Care: The Health System Journey

- Better Health
- Better Healthcare
- Reduce Costs

2010 +

POPULATION HEALTH MANAGEMENT

ENROLL → HRA/HEALTH SCREEN/COACH-CONCIERGE /MEDICAL HOME/PCP/PHR → DISEASE MGMT. → PHARMA MGMT → PHYSICIAN ENTERPRISE/OUTPATIENT CARE → INPATIENT CARE → POST-ACUTE CARE

Full Care Coordination

1990 - 2010

INTEGRATED SYSTEM

PHYSICIAN ENTERPRISE ⟷ HOSPITALS/HEALTH SYSTEMS

- PRIMARY CARE SYSTEM
- MULTI-SPECIALTY GROUP(S)
- SINGLE SPECIALTY GROUP(S)
- CLINICAL INTEGRATED NETWORK
- FACULTY PRACTICE PLAN

1970 - 1990

Hospital/Health Systems

Patient

Physicians

# UCLA Growth Strategy


**Leadership: Growth Strategy Design Team - Evolution of the UCLA Health System Patricia Kapur, MD and Santiago Muñoz**

## Primary Care Innovation Model
Samuel Skootsky, MD

October 2011-present

- Practice Re-Design
- Increase Covered Lives
- Expansion
- Collaborations
- Replication
- Evaluation]
- Post Acute Care Coordination
- Advance Care Planning and Services*

## Secondary Strategy
Eric Esrailian, MD
Steve Cohen

Q1-2 FY 2013

- Define health system relationships and aligned inpatient/ancillary capacity
- System of Physician Services at UCLA Off-Site Practices
- Seamless links/ expedited access across system
- Bilateral quality, service, & price/IT commitments/ guarantees

## Tertiary Quaternary Innovation Model
Patricia Kapur, MD,
Shannon O'Kelly,
Laura Yost

Q1-2 FY 2013

- Target 60% TQ at RRUMC
- Value Proposition to Health System/ Medical Groups
- Referral and Transfer Support/ Single Call Access
- Constant Communications
- Telemedicine Linkages
- Bundling/Pricing Alignment
- Seamless links/ expedited access across system
- Bilateral quality, service, & price/IT commitments/ guarantees
- Virtual Private Narrow Network

## Affiliations and Partnerships
Santiago Munoz
Michael Steinberg, MD

Sept. 2012 – present

- Physicians/ Medical Groups
- Hospitals/Health Systems
- Insurance
- Clinical Integration Network
- Others
- Clinical Network Development (Telehealth, ASC, and Imaging)
- Downstream Revenue Capture

## Accountable Care Design Team
Samuel Skootsky, MD

Nov. 2013 – Present

Medical Group Contracts

- Commercial HMO
- Medicare Adv. FFS and Risk Share
- UCLA/UC Care
- Anthem
- HealthNet
- Vivity
- Blue Shield
- United SCAN
- MSSP

Clinical Redesign

UCLA Health

* ACPS: Longitudinal, continuum impact, especially TQ

# The Process

- Choose One or More of Principle Sets of Innovative/ Transformative Practices that Deliver Results

- Innovation/ Transformation Approach and Methodology

# Participation Matrix

*Updated 3/4/2015*

Health Employer Exchange Innovation/Transformation Model
Plan/Design and Implementation/Operationalization Phases Participation Matrix

| Principle | UCLA Health | Bon Secours | Baylor Scott & White | YNHHS | North-western | Cleveland Clinic | UVA | MUSC | Trinity |
|---|---|---|---|---|---|---|---|---|---|
| ***Plan/Design Launch*** | **2011** | **2011** | **3/21/2014** | **2/17/2014, 1/13/2015** | **3/25/14, 9/5/14,** | **2/12/2015** | **1/23/2015** | **9/8/2014** | **1/27/14, 2/24/14** |
| ***Implementation/ Operationalization Launch*** | **7/30/2014** | **8/7/2014** | **8/28/2014** | | | | **7/21/2015** | | |
| A. Reduction in the trend of Cost Per Person Per Year for a specific employee group | Learn | Share | Share | Learn | | Share | | | |
| B. Specifics of the Value-Based Care "Person Journey" (example attached) that increase employee/enrollee engagement and adherence | Learn | Share | Share/Learn | Learn | Learn | | | | |
| C. Specifics of the incentive systems for enrollees/employees, physicians/clinicians/staffs, health systems, employers, private insurers, and governmental payers as a sequential population targets | Learn | Share | Share/Learn | Learn | Learn | | Learn | | |
| D. Programs that articulate Primary Care System Re-Design (i.e. UCLA Primary Care Innovation Model) | Share | Learn/Share | Share | | | Share | Learn | | |
| E. Programs that address high-risk "hot spotters," chronically ill patients, and other high utilizers to reduce high end spend | Share | Learn | Share | Share | Share | Learn | Learn | | |
| F. Programs for low/medium-risk employees so they remain in low/medium risk categories and reduce risk with quantified results | Learn | Share | | | | | | | |
| G. Programs that address appropriate preparation in care for "end of life," (i.e. UCLA Advance Care Planning and Services Model) | Share | Learn | | | | Share | | | |
| H. Applicable/scalable programs will be identified with specific targeted organizations for increased profound results and replication. | | Learn/Share | | | | | | | |
| I. Plan/Design, and Implementation of the Clinical Enterprise Expansion | | Learn/Shar | | Share | Learn | | | | |
| J. Programs that articulate the Tertiary/Quaternary System Re-Design (i.e. UCLA Tertiary/ Quaternary Innovation Model) | Share | Learn | | | Learn | | Learn | | |
| K. Replication and Scaling of the Value-Based Care System to Self-Insured Employers | | Share | | | | | | | |
| L. Replication and Scaling of the Value-Based Care System to Workers' Comp Management | Share | | | | | | | | |

# Innovation/Transformation Model Replication and Scalability

**Design Processes,**

**Refine Metrics**

**Document Processes and Metrics,**

**Identify Scalable and Replicable Components**

**Share, Advise Others, Replicate and Scale,**

**Accelerated Spread**

# A Key Aspect of Innovation Is Engaging Stakeholders in the *Process* of Transformation

Define | Charter | Design | Pilot | Deploy | Evaluate | Exchange

**Innovation Life Cycle**

**TRANSFORMATION**

Planning Phase → Design Phase → Implementation Phase → Operations Phase

# The Transformation Process to Accelerate Replication and Scaling

| Leadership Team | Design Team | Implementation Team(s) | Evaluation Team | Sustainable Operations |
|---|---|---|---|---|
| • Establish High Level Project Objectives<br>• Establish Initial Priorities<br>• Define Design Team Charge<br>• Define metrics for success | • Apply the specific approach and methodology to accelerate the implementation of and sustainability of the objectives<br>• Apply the process of rapid cycle scalability and replicability | • Define the application of the implementation and operationalization process<br>• Implements/operationalizes across the systems | | |

***The Leadership Team and Design Teams – start with twice monthly meetings and transition to monthly meetings as the rigor for deliverables is established and expectations are met.***

# Health Employer Exchange

Plan

Design

Implement

Operationalize

- Bon Secours Virginia Health System
- UCLA Health
- Baylor Scott & White Health
- Yale New Haven Health System
- Northwestern Memorial Hospital
- UVA
- Cleveland Clinic

# Next Steps for Current Health Employer Exchange

- Culture of Health: Economic Imperative Planning
  - Submit Claims and HRA Results to Determine Savings Target for a 3 Year Period
  - “OAT Document” (Objectives, Approach, and Timeframe)
  - Establish Work Plan with Deliverables, Responsible Parties, and Timeframes
  - Choice of Principles for Learning and Sharing to Accomplish Results
  - Establish Leadership and Design Team Membership with Metrics to Achieve
- Population Health Management System
  - Choose population(s): health system employees or others
- Restructured Delivery System
  - Establish the network
  - Establish the corollary providers
- Frame Stories of Success from Perspective of Community Resident/Patient, Physician, and Clinical System

# For Consideration: Next Steps

- Formalization of the Value-Based Care Replication/Scaling Process: Proof of Concept System
- Movement of Systems from Plan/Design into Implementation/Operationalization
- Identification of New Sets of Innovative/ Transformative Principles to Accomplish Results
- Community/System Relationships and Formalizing the Person/Patient/Caregiver Experience

# For More Information

- Stephanie McCutcheon
  Principal

  McCutcheon & Co.
  Baltimore Office
  5143 Mountain Rd.
  Pasadena, Maryland 21122

  410-804-9308 (Cell)
  410-439-9764 (Fax)
  smccutcheon@mccutcheonandco.net