BQA
Transforming Population Health

HFMA

Carl E. Couch, MD, MMM
President
Baylor Quality Alliance
Today’s Update

- Population Health
- BQA Update
- Our Approach to Population Care
- Early Results

3 Population Health Futures

**Incremental Population Health Growth**

- Low Risk; Low Opportunity
- Gradual margin erosion of FFS margin due to Volume declines (caused by reduced utilization)

Source: Hogan, Neil, collaboration conference, Washington DC, October 2013
What is Population Health?

“The health outcomes of a group of individuals, including the distribution of such outcomes within the group”


What is the Top Priority?

SHOW ME THE MONEY!
What We Know

What is Driving Our Agenda?

Value

Value = Quality (+Access)
Cost

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Providers at Risk

• Tipping Point (30%)
• Lowered Costs in an integrated system
  – "Value" wins market share
• Upsets the Revenue Apple Cart
• First Mover Advantage

Source: Hogan, Neil, collaboration conference, Washington DC, October 2013
The New Game of Health Care

First-Curve to Second-Curve Markets

How will health systems successfully navigate the shift from first-curve to second-curve economics?

Volume-Based First Curve
- Fee-for-service reimbursement
- High quality not rewarded
- No shared financial risk
- Acute inpatient hospital
- IT investment incentives not seen by hospital
- Stand-alone care systems can thrive

Value-Based Second Curve
- Payment rewards population value: quality and efficiency
- Quality impacts reimbursement
- Partnerships with shared risk
- IT critical for population health management
- Realigned incentives, encouraged coordination

First-Curve to Second-Curve Markets

Walmart Upping the Ante on Population Health

Moving beyond retail clinics

Potential Evolution of Health Care Products

Scope of Services

Basic Retail Clinic  Full Primary Care  Health Insurance Exchange

4,600+  4.2 Miles  33%
Number of Walmart stores in the United States  Median distance between a residence and Walmart  Estimated portion of US population that visits Walmart every week

Source: The Advisory Board Company, in

That's where we are going now. Full primary care services in five to seven years.”
Vice President Health and Wellness Payer Relations

Baylor Quality Alliance Board of Managers Retreat, November 8, 2013, American Airlines Training and Conference Center, Fort Worth, TX

Baylor Quality Alliance Board of Managers Retreat, November 8, 2013, American Airlines Training and Conference Center, Fort Worth, TX
And not only Walmart….

**Walgreens**
- Phase 1 Locations Identified
- PCP oversight and staffing agreed
- Physician planning meeting completed
- Walgreen clinics to be included in-network for BHCS Employee Health Plan

**CVS**
- Collaboration Agreement Proposal received
- Agreement parameters are currently in “active discussion”

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**Competitive Forces:**

*Meet our Newest Competitors*

**Walgreens Aims to Become the Premier Health Destination**

- **2007:** Acquires Take Care Health Systems
- **2009:** Launches flu vaccine campaign
- **2012:** Launches three ACOs: begins diagnosing and managing chronic disease
- **2013:** Launches three ACOs (one with SW); begins diagnosing and managing chronic disease

**CVS**

- **2007:** Acquires Take Care Health Systems
- **2009:** Launches flu vaccine campaign
- **2012:** Offers three new chronic disease tests

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*Competition or Co-option?*
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Consumers Get Cash
- Consumer Driven
- Employers and Payers give power of price shopping to consumers (CalPers total Hips) - $30K

Source: Hogan, Neil, collaboration conference, Washington DC, October 2013

Empowered Consumers

What is Reference Pricing?
The CalPers Story
- Reference pricing is a shift away from copays and deductibles
- The focus is on reducing the price paid by the insurer
- The insurer tells the enrollee the price it will pay for a given procedure or diagnostic. Any price difference will have to be paid by the enrollee

Reference Price for Total Hip: $30,000

Hospital A:
- Total Hip Price: $30,000
- Out of Pocket Cost to Enrollee: $0

Hospital B:
- Total Hip Price: $42,000
- Out of Pocket Cost to Enrollee: $12,000

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Reference Pricing

Reference Pricing Shifts Market

CalPERS knee and hip replacement surgery compared to Anthem BCBS:

CalPERS PPO members had a $30,000 payment limit to hospital charges in addition to usual coinsurance. Low-price hospitals agreed to value based purchasing design rates, quality and access standards.

BQA Update
Health Care is Evolving Faster

“Creation of ACO’s represent the most significant force in driving the shift, practically and culturally, from volume to value.”

ACO’s (Most Significant)

- Meaningful use
- Big Data
- Hi Tech
- Decreasing Costs
- Personalized Medicine
- EMR Adoption

Forces Evolving Health Care

2012/13 Accomplishments

**Strategic Development**
- Mission
- Vision
- Culture
- Strategic financial plan and operating budget developed

**Governance**
- Physician-led Board of Managers
- Five primary committees activated
- Twenty-five subcommittees

**Network Development**
- Network adequacy
- Credential verification
- Regional care needs assessment
- Exceeded budgeted revenue stream through FY13

**Information Technology**
- Informatics infrastructure
- Data analytics implementation
- Physician dashboard
- Member website deployment
- EMR subsidy program

**Care Management**
- RN Health Coaches
- Care Coordinators
- PCMH Design
- Population Health

**Contracting/Compensation**
- BHCS Employee Health Plan
- Aetna MA
- Humedica MA
- Scott & White Health Plan
- Shared Savings Distribution Model
BQA Recognized in “top 100”

100 Accountable Care Organizations to Know
Written by Molly Gardelle and Heather Parke | August 14, 2013

A significant number of accountable care organizations have formed since this publication’s 2012 list of 100 Accountable Care Organizations to Know, and there were also some noteworthy developments from exiting ACOs.

Others Named to the List Include:
• Advocare Walgreens Well Network
• Advocate Health Care
• Carolinas HealthCare System
• Cedars-Sinai
• Cleveland Clinic Florida
• Dean Clinic and St. Mary’s Hospital
• Memorial Herman Health System
• Scott & White Healthcare
• Walgreens Well Network
• Texas Health Resources

Network Membership Update

<table>
<thead>
<tr>
<th>Category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Members</td>
<td>2,030</td>
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<tr>
<td>(PCP 338) 17% (SCP 1692) 83%</td>
<td></td>
</tr>
<tr>
<td>In Process (25 physicians approved for membership with outstanding document signatures and/or payment; 179 physicians undergoing credentials verification; and 33 pending credentials verification)</td>
<td>338 (PCP 10) 3% (SCP 328) 97%</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>2,368</td>
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<tr>
<td>(PCP 348) 15% (SCP 2020) 85%</td>
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</table>
Patient Access: A Bird’s Eye View...

The Baylor Preferred Network adds 53 for adult patients for geographic reasons (employees that live as far away as Oklahoma), and some 300 pediatricians who are medical staff members at Cook Children’s (Fort Worth) and Dallas Children’s.

Network Development

Adequate Network

- Serves 250 - 500,000 patients

2,300 physicians

Narrow Network

- Employed: 600
- Independent: 1,700

- Accountable for Quality, Cost, and Integration

BQA was never meant to be an employment strategy
A “Complete” Network

Evolve and Continuously Update Network Adequacy

Post Acute Care
- >26 SNF Selected for contracting
- 10 Home Health Agencies selected for contracting
- 3 Hospices

Children’s Hospital Strategy
- Active discussions and facility commitment for both Dallas and Cook Children’s Hospital
- Physician inclusion likely to be unique for each facility

Best Care/Clinical Integration

Best Care/Clinical Integration Subcommittees and Chairmen

Anesthesia
- Scott Merril MD/Scott Holliday MD
- Mark Miller MD

Asthma/COPD
- Mark Millard MD

Cardiology
- Bob Kowal MD

Colorectal Surgery
- Randy Crim MD

Diabetes
- Catherine Raver MD

Emergency Medicine
- Robert Risch MD

Endocrinology
- Sumana Gangi MD

General Surgery
- Sina Matin MD

Heart Failure
- Shelly Hall MD

Inpatient/Hospitallists
- Matt Cantrell MD/ Roger Khetan MD

Musculoskeletal
- Alan Jones MD

Nephrology
- Steven Hays MD

Neurosciences
- Stuart Black MD

Pulmonary/Critical Care
- Stuart McDonald MD

Post Acute Care
- Jill Studdley MD

Primary Care
- Mike Massey MD

Readmissions
- Brad Lembcke MD

Women’s Health
- Steve Harris MD

Cris Brown/Megan Harkey
Staff Support

Brad Lembcke, Committee Chair,
BQA Board Member and Medical Director
Stuart Black MD
Julie Campbell
Andrew Chung MD (Med Dir)
Marsha Cox
Robert Fine MD
CFF Fuller MD (CMO)
Rob Goldstein MD
Steve Harris MD
Steve Hays MD
Scott Holliday DO (Med Dir)
Beth House
Roger Khetan MD
Rob Kowal MD (Med Dir)
Glenn Ledbetter MD
Mike Massey MD (Med Dir)
Sina Matin MD
Stuart McDonald MD
Natalie Murray MD
Amy Wilson MD
Nick Zenarosa MD

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Nick Zenarosa MD
Care Protocols/Metrics

- BQA care protocols establish baselines for which improvements in care can be compared against and monitored.
- These evidence-based protocols assist BQA’s efforts to standardize care and ultimately reduce unnecessary health care costs.

Subcommittees Producing Approved Care Protocols/Metrics

<table>
<thead>
<tr>
<th>Protocols</th>
<th>Metrics</th>
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</thead>
<tbody>
<tr>
<td>Low Back Pain</td>
<td>1 Payer Performance</td>
</tr>
<tr>
<td>Primary Care/Cardiology</td>
<td>6 Cardiology</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>1 Neurology</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>3 Women’s Health</td>
</tr>
<tr>
<td>Hospitalists</td>
<td>2 Primary Care Diabetes</td>
</tr>
<tr>
<td>Primary Care APHS</td>
<td>6 Primary Care Depression</td>
</tr>
<tr>
<td>Primary Care Women’s Health APHS</td>
<td>3 Readmissions</td>
</tr>
<tr>
<td>Primary Care Hypertension</td>
<td>1 PAC SNF</td>
</tr>
<tr>
<td>Readmissions</td>
<td>2 PAC HH</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1 PAC Hospice</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1 Recommendations</td>
</tr>
</tbody>
</table>

Initial Priorities

- 90% In-Network Referral Target
- View BQA Secure Website 8 months out of 12 (Clinical Integration Measure). Current performance up to almost 70%.
- Basic Shared Savings Opportunities
  - Generic Drug Utilization
  - Outpatient Imaging
  - Preventable readmission avoidance
  - Low-Back Pain Protocol Adherence (Generally: No Advanced Imaging for Initial Acute Back Pain)
**Keys to Clinical Integration**

- **BQA Status**
  - 11 RN Health Coaches
  - 1 Social Worker
  - Monthly RN HC cases have increased tenfold from (170 – 1700)
  - 78 Care Protocols/Metrics approved by BQA Board
  - BQA has over 300 NCQA recognized Level 3 PCMH physicians
  - Certification for 65 independent PCP physicians in progress
  - PCMH model presents substantial financial opportunities
  - 75% of BQA member physicians expected to be connected to HIE by end of CY13
  - Baylor HIE Sandlot connectivity go live: 4Q13
  - BQA added to BHCS 360Fresh Predictive Analytics Tool
  - Explorys added to BIS' pre-approved projects list
  - BQA Physician Dashboard tracks performance
  - Humedica fully implemented by end of CY13
  - BQA added to BHCS 360Fresh Predictive Analytics Tool
  - Humedica Reports: Over 400 standard reports for inpatient and outpatient metrics; Fully Granular to patient; EHR, Claims, HIE feeds

**(BQA Expected to obtain Demonstrable Clinical Integration status by End of FY13)**

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**Building the Population Health Infrastructure**

- **ACO Cautions**
  - Build adequate Network
  - Invest in Informatics
  - Don’t underestimate difficulty of changing culture
  - Don’t overestimate your capability for risk
  - Focus on highest opportunities

- **Playbook for Population Health**
  - Set a prioritized list of key initiatives
  - Invest in basic information exchange, analytics, and patient-facing technology
  - Develop preferred partner network with shared culture and accountability
  - Train and deploy existing staff to match new demand for patient services

Source: Health Care Advisory Board interviews and analysis
Our Approach to Population Care

• Key Populations
• IT/Informatics
• PCMH
• Care coordination

Meet Our Three Patient Populations

HIGH PATIENT COMPLEXITY DRIVING OUTSIZED PATIENT COSTS

...REQUIRES CREATING THREE UNIQUE PATIENT POPULATIONS, WITH THREE COMPLEMENTARY CARE MODELS

Source: The Advisory Board Company interviews and analysis
High-Performing Care Management

The **High-Risk** Patient
These patients have at least one complex illness, multiple comorbidities and psychosocial problems.

**The Ideal Care Team**
The typical high-risk patient should have a **one-on-one relationship** with the health system, principally through a PCMH and a high-risk RN Health Coach, Others.

**PROVIDERS SHOULD AIM TO:**
1. Deliver intensive, comprehensive, and coordinated management.
2. Avoid unnecessary care by proactive management.

Source: The Advisory Board Company interviews and analysis.

The **Rising-Risk** Patient
Represent **15% of the population** and have conditions and risk factors that could push them into the high-risk category if not addressed.

**The Ideal Care Team**
The typical rising-risk patient should be managed in the **medical home**.

**PROVIDERS SHOULD AIM TO:**
1. Avoid unnecessary spending and keep these patients from becoming high-risk by carefully managing HTN, Diabetes, COPD, Asthma, CAD.
2. Manage these patients in enhanced primary care such as the medical home.

The **Low-Risk** Patient
Roughly **80% of patients** fall into this category. Either healthy or a single well-managed chronic condition. Typically looking for convenient access to the services they need the most.

**The Ideal Care Team**
Available primary care, accessible after hours care, Virtual visits, Extensive Self-help and Wellness.

**PROVIDERS SHOULD AIM TO:**
1. Keep the patient healthy.
2. Maintain their loyalty to the system.
3. Collect data on the patient so you can treat them more effectively with easy access when they do need care.

Source: The Advisory Board Company interviews and analysis.

Baylor Quality Alliance Board of Managers Retreat, November 6, 2013, American Airlines Training and Conference Center, Fort Worth, TX.
Four Chronic Conditions Comprise 74% of Costs

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Percentage of Total Health Care Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>33%</td>
</tr>
<tr>
<td>Cancer</td>
<td>20%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>11%</td>
</tr>
<tr>
<td>Obesity</td>
<td>10%</td>
</tr>
<tr>
<td>Other Chronic</td>
<td>9%</td>
</tr>
<tr>
<td>All Other</td>
<td>17%</td>
</tr>
<tr>
<td>Total Health Care Costs</td>
<td>100%</td>
</tr>
</tbody>
</table>

80% Heart Disease/Stroke 30% - 60% Type II Nearly all can improve

% Preventable


IT/Informatics

- **Humedica**
  - Humedica provides integrated clinical and financial analytics reports
  - Phase I implementation of Humedica ambulatory data completed July 17th
  - Phase II implementation of Humedica claims and inpatient data to be complete October 18th
  - Majority of BQA data currently direct to Humedica

- **Explorys**
  - As we implement Explorys (a cloud-based big data solution), we will gradually move to the overall IT structure vision as depicted

- **360Fresh**
  - Explorys overall data aggregator of BHCS’ comprehensive clinical/financial data (includes data from BQA members not otherwise represented in BHCS data repositories)

- **Care Coordination Tool** (in Evaluation)

BQA Vision for IT Structure

Tools needed to manage BQA in fiscal year 2013
Patient centered, safe, high quality, coordinate care, timely, efficient, equitable. Which is more likely to deliver? Which is more work and has more cost? Which do you want?
FY13 PCMH Statistics

- 68 Primary Care Clinics are NCQA recognized
- 281 physicians
- 59 Nurse Practitioners or Physician Assistants
- First clinic applying for rerecognition
- Spreading to independent practices

Care Coordination
RN HEALTH COACH

RN Health Coaches (11)/Social Worker (1)

Certified Diabetes Educator | Advanced Asthma Certification | Case Management Experience

Augments PCMH for high risk populations

Supports Transitions of Care and Navigation | Care Coordination | Chronic Disease Management

Payer investment growing

2012: 2 contracts covering 9,000 members
2013: 5 contracts covering approx. 60,000 members

RN Health Coach responsibilities
- Self-management support and goal setting
- Health status assessment
- Medication management
- Health system navigation (facilitates access to appropriate levels of care)
- Care coordination among providers and services
- Care plan development and communication with health team

RN Health Coach/PCP Workflow

Data-driven High Risk Reports
PCP Referrals
Transitional Care (High Risk Inpatient/ED)
Handoffs from inpatient Care Coordinators

RN Health Coach/Patient Interventions
Care Plan

PCP
Review/Revise Care Plan
**Monthly RN Health Coach Cases**

- **All** = active chronic care management, transition, and patients in outreach process
- Average September caseload per active RN Health Coach (post-training period) = 210
- Benchmark caseloads: Hartford Healthcare Medical Group (GPIN) 150-175, Gordian Consulting 150 – 200

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**Patient Success Story: “Doris”**

**Patient Background**
- Female patient, single mom of three in her early 30s, diagnosed with:
  - Diabetes
  - Asthma
  - Hypertension
  - Anxiety disorder

**Health Status**
- Blood Sugar = 350
- A1c = 13.8
- “Feels terrible all the time”

**RN Health Coach Intervention**
- RN health coach gained the patient’s trust
- Patient agreed to focus on taking her medications for diabetes
- Initial compliance was 20%

**Positive Patient Outcome**
- Patient **compliance improved** to 85%
- **Lowered A1c to 11.4** in three months
- Recently acknowledged “I feel good for the first time in a long time”
Evaluators include leadership representing:
- Information Technology
- Care Coordination (BHCS, HTPN, BQA)
- BQA Administration

Tool will support workflow and automate patient tracking and reporting.

Early Results
Generic Prescribing

- To further improve the generic prescribing rate for both BCBS and Baylor Employee Health Plan
- We will focus on four medication classes:
  - Antihyperlipidemic medications
  - Antihypertensive medications
  - Proton pump inhibitors
  - Antidepressant medications

Low Back Pain

- Analysis reveals that imaging within 28 days accounts for only 10% of the total cost associated with low back pain
- Task Force continues work and analysis of claims data to break down costs by site of care
Preventive Services

**Flu Vax**

![Graph showing flu vaccination rates over years]

- **Colon Cancer Scr**

![Graph showing colon cancer screening rates over years]

**Pap Smear**

![Graph showing Pap smear rates over years]

*HEDIS number is FY12

Diabetes Management

**Diabetes POA (D5)**

![Graph showing diabetes POA rates over years]

**A1C**

![Graph showing A1C rates over years]

*HEDIS number is FY12

**Blood Pressure**

- **Anceta 62%**

**LDL**

![Graph showing LDL rates over years]

*HEDIS average 97.9%
197 physicians with “Bridges To Excellence” for DM recognition
21% of BCBS Texas total

Controller Therapy

Severity Assessment
Inpatient Utilization by Disease Cohort

ED Visits Disease Cohort

Humedica Reporting

Readmission Penalty Comparison

<table>
<thead>
<tr>
<th>Performance Period</th>
<th>2013 (July 1, 2008 to June 30, 2011)</th>
<th>2014 (July 1, 2009 to June 30, 2012)</th>
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<tbody>
<tr>
<td>Percent of Hospitals Penalized</td>
<td>BHCS System 2 System 3 US</td>
<td>BHCS System 2 System 3 US</td>
</tr>
<tr>
<td>18%</td>
<td>61% 84% 65%</td>
<td>36% 66% 72% 67%</td>
</tr>
<tr>
<td>Average Penalty</td>
<td>0.24% 0.31% 0.27% 0.27%</td>
<td>0.12% 0.27% 0.24% 0.38%</td>
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<tr>
<td>BHCS Penalty</td>
<td>$202K</td>
<td>$425K</td>
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<tr>
<td>BHCS Potential Penalty</td>
<td>$3.8m</td>
<td>$7.6m</td>
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Quality Measures and Operational Efficiencies

Operational Efficiency

Quality Measures

Manage Resources
- Use existing BHCS/HTPN resources as appropriate

Meet Our Targets
- “Heavy Lifting” essential to meet/exceed targets resides with Best Care Committee and clinical sub-committees
- Care Coordination/Care Management team AND the Individual Physician and Hospitals

Understand/Manage Costs
- To provide services (i.e. Care Coordination, Disease Management)
- Deliver them efficiently using automated resources where possible

Let’s Not Forget

- To remember the importance of our relationship with the patient. That trust is key to improving care.
- To improve quality and service while protecting the care team.
- To create a Checklist culture that manages populations but not one that causes a checklist to block your view of the individual.