BSWQA
Transforming Population Health

Cliff Fullerton, MD, MS, FAAFP
Chief Medical Officer BSWQA
Chief Population Health Officer BSWH

Today’s Update

- Population Health
- BSWQA Update
- Our Approach to Population Care
- Early Results
What is Population Health?

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

What We Know

What is Driving Our Agenda?

Value

Value = Quality (+Access)
Cost
What is the Top Priority?

Transforming Population Health – Achieving accountable, high-quality, cost-effective care for the patients we serve

SHOW ME THE MONEY!

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

The Future of the Healthcare Marketplace: Playing the New Game, Ian Morrison, PhD
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

"That’s where we are going now. Full primary care services in five to seven years."

Vice President Health and Wellness Payer Relations

4,600+
Number of Walmart stores in the United States

4.2 Miles
Median distance between a residence and Walmart

33%
Estimated portion of US population that visits Walmart every week

Source: The Advisory Board Company, in Transforming Population Health – Achieving accountable, high-quality, cost-effective care for the patients we serve

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”
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

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

Reference Pricing

Reference Pricing Shifts Market

CalPERS knee and hip replacement surgery compared to Anthem BCBS:

Patients Choosing High-Price Or Low-Price California Hospitals For Knee Or Hip Replacement Surgery: 2008-12

CalPERS low-price hospitals
Anthem low-price hospitals
Anthem high-price hospitals

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

Forces Evolving Health Care

ACO’s (Most Significant)

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

BSWQA Update
BSWQA Recognized in “top 100”

Others Named to the List Include:
- Advocate 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

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Network Development

Adequate Network
- Serves 250 - 500,000 patients

3,700 physicians

Narrow Network
- Accountable for Quality, Cost, and Integration

BSWQA was never an employment strategy

Patient Access: A Bird’s Eye View...

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

https://fortress.maptive.com/ver3/cb9e95d92a95e448088a9e1e29e
**POD Approach for Deployment**

**Clinical Oversight**
- Physician Champions & Medical Directors

**Performance Support**
- Admin Support
- Analytics Support
- Communication Support
- Care Coordination Support

**Scorecard Strategy Development**
- Steep
  - Safety
  - Timeliness
  - Efficiency
  - Effectiveness
  - Equity
  - Patient Centric

**Designed based on established relationships, established patients, established referral patterns**

**Broad Network Needed**

**Evolve and Continuously Update Network Adequacy**

**Post Acute Care**
- >26 SNF participating members in preferred network
- <12 Home Health Agencies participating actively

**Children’s Hospital Strategy**
- Dallas Childrens’ Hospital participating; discussions underway with Cook Childrens
- Physician inclusion likely to be unique for each facility

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It is about Cultural Transformation
from a Confederacy of Physicians to a Clinically Integrated Network

- 90% In-Network Referral Target (1-800-4BAYLOR)
- View BSWQA Secure Website 8 months out of 12 (Clinical Integration Measure). Current performance up to almost 70%.
- Basic Shared Savings Opportunities created partly by:
  - Generic Drug Utilization
  - Outpatient Imaging
  - Preventable readmission avoidance
  - Low-Back Pain Protocol Adherence (Generally: No Advanced Imaging for Initial Acute Back Pain)

BSWQA Status

- 11 RN Care Managers
- 1 Social Worker
- YTD caseload of 1,900 patients managed (well over their goal of 1,000)
- Transitional episodes managed
- 70+ Care Guidelines approved by BSWQA Board
- Low Back Pain Protocol
- BSWQA 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 BSWQA member physicians expected to be connected to HIE (dbMotion) by end of CY15
- Humedica (Optum 1) fully operational
- 360Fresh (Crimson Real Time) predictive analytics tool operational
- Explorys operational
- Crimson Care Manager in operation
- BSWQA Physician Dashboard tracks performance
- Humedica Reports: Over 400 standard reports for inpatient and outpatient metrics; Fully granular to patient; EHR, claims, HIE feeds

BSWQA Expected to obtain Demonstrable Clinical Integration status by late 2014
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
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Meet Our Three Patient Populations

HIGH PATIENT COMPLEXITY DRIVING OUTSIZED PATIENT COSTS

Percentage of Medicare Beneficiaries

- 22%
- 23%
- 24%
- 25%
- 26%
- 27%
- 28%
- 29%
- 30%
- 31%
- 32%
- 33%
- 34%
- 35%
- 36%
- 37%
- 38%
- 39%
- 40%
- 41%
- 42%

Percentage of Total Medicare Spending

- 4%
- 5%
- 6%
- 7%
- 8%
- 9%
- 10%
- 11%
- 12%
- 13%
- 14%
- 15%
- 16%
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- 39%
- 40%
- 41%
- 42%
- 43%
- 44%
- 45%
- 46%
- 47%
- 48%
- 49%
- 50%

Number of Conditions:

- Zero or One
- Four
- Six or More
- Two or Three
- Five

Source: The Advisory Board Company interviews and analysis

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High-Performing Care Management

1. 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 Care Manager, Others

PROVIDERS SHOULD AIM TO:

1. Deliver intensive, comprehensive, and coordinated management
2. Avoid unnecessary care by proactive management

2. 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

Source: The Advisory Board Company interviews and analysis

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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

Provider's 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

Four Chronic Conditions Comprise 74% of Costs

Cardiovascular Disease Cancer Diabetes Obesity Other Chronic All Other Total Health Care Costs
33% 20% 11% 10% 9% 17% 100%

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

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IT/ Informatics

- **Optum One**
  - Optum One provides integrated clinical and financial analytics reports and population based predictive modeling
  - All EHR Data, Billing Data, Claims, and HIE feed
  - Majority of BSWQA data currently direct to Humedica

- **Explorys**
  - Big Data Solution; full EMR, Financial and HIE feed current

- **360Fresh**
  - Robust Predictive Modeling in real time

- **Care Team Connect** (Care Coordination tool)

- **HIE – DbMotion** (approved, installing)

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BSWQA Vision for IT Structure

Tools needed to population health

Patient Centered Medical Home

Intent:
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?

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## 2011 PCMH Content and Scoring

<table>
<thead>
<tr>
<th>Standard 1: Enhance Access and Continuity</th>
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<tbody>
<tr>
<td>A. Access During Office Hours**</td>
<td>A</td>
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<tr>
<td>B. Written Access</td>
<td>A</td>
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<tr>
<td>C. Scheduling Access</td>
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<tr>
<td>D. Continuity</td>
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<td>E. Medical Home Responsibilities</td>
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<td>F. Uniformity and Appropriately Appropriate Services</td>
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<td>G. Patient team</td>
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<th>Standard 2: Identify and Manage Patient Populations</th>
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<td>A. Indirect Information</td>
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<td>B. Clinical Data</td>
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<td>C. Comprehensive Health Assessment</td>
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<td>D. Use Data for Population Management*</td>
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<tr>
<th>Standard 3: Plan and Manage Care</th>
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<tr>
<td>A. Implement evidence-based guidelines</td>
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<td>B. Identify high-risk patients</td>
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<tr>
<td>C. Care Management**</td>
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<td>D. Medication Management</td>
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<td>E. Use Electronic Prescribing</td>
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<td>G. Use Electronic Referral</td>
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<td>H. Use Electronic Referral</td>
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<tr>
<td>I. Use Electronic Referral</td>
<td>3</td>
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<td>J. Use Electronic Referral</td>
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<th>Standard 4: Provide Self-Care Support and Community Resources</th>
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<tbody>
<tr>
<td>A. Inc. at the time of follow-up**</td>
<td>A</td>
</tr>
<tr>
<td>B. Updated clinical summary and follow-up***</td>
<td>A</td>
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<tr>
<td>C. Collaboration with outside care providers</td>
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<table>
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<tr>
<th>FY14 PCMH Statistics</th>
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<tbody>
<tr>
<td>60 Primary Care Clinics are NCQA recognized</td>
</tr>
<tr>
<td>~280 physicians</td>
</tr>
<tr>
<td>&gt;63 Nurse Practitioners or Physician Assistants</td>
</tr>
<tr>
<td>Four clinics re-recognized in FY2014, remaining in progress</td>
</tr>
<tr>
<td>Spreading to independent practices and Scott and White. Both with early success.</td>
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Care Coordination

RN Care Manager

RN Care Managers (15)/Social Workers (2)

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 Care Manager 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
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RN Care Manager/PCP Workflow

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

RN Care Manager/Patient Interventions
Care Plan
Review/Revise Care Plan

PCP

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 Care Manager Intervention
- RN Care Manager 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”
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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

*BSW North Texas employee population
Low Back Pain Protocol

The development of a low back pain protocol directly influenced our increase in appropriate use of lumbar spine MRI’s from 37.4% to 79.8%.

Preventive Services

Flu Vax

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<th>2011</th>
<th>2012</th>
<th>2013</th>
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<td>HEDIS</td>
<td>87.3%</td>
<td>88.2%</td>
<td>88.4%</td>
<td>89.3%</td>
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Colon Cancer Scr

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tbody>
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<td>HEDIS</td>
<td>75.0%</td>
<td>75.8%</td>
<td>76.5%</td>
<td>77.5%</td>
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Pap Smear

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<th>Year</th>
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<th>2013</th>
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<tbody>
<tr>
<td>HEDIS</td>
<td>75.3%</td>
<td>75.7%</td>
<td>76.0%</td>
<td>76.3%</td>
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*HEDIS number is FY12
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Optum One Reporting

DM patients with ALL recommended testing

Hypertension

197 physicians with BTE for DM recognition
21% of BCBS Texas total

Optum One Reporting

ED Visits Disease Cohort

Inpatient Utilization by Disease Cohort

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BSWQA Year 1 Results

Source: Optum One
- BHCS Employee Health Plan Population
- Towers Watson Shared Savings Methodology

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Quality Measures and Operational Efficiencies

Analytics team beginning to provide actionable information to physician leadership/committees

Operational Efficiency

Manage Resources
- Use existing BHCS/HTPN resources as appropriate

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

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

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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.

Baylor Scott & White Quality Alliance

www.BaylorQualityAlliance.com
https://members.baylorqualityalliance.com/pages/default.aspx