Using Innovation to Drive Value Based Care

Johnese Spisso, MPA
President, UCLA Health &
CEO, UCLA Hospitals & Clinics
UCLA Health

Hospitals:

- Ronald Reagan UCLA Medical Center
- UCLA Mattel Children’s Hospital
- Resnick Neuropsychiatric Hospital at UCLA
- UCLA Medical Center, Santa Monica
- California Rehabilitation Institute
Physicians provide primary and specialty care in more than 160 clinics:

- Alhambra
- Arcadia
- Beverly Hills
- Brentwood
- Burbank
- Century City
- Fountain Valley
- Irvine
- Laguna Hills
- Malibu
- Manhattan Beach
- Marina Del Rey
- Northridge
- Pacific Palisades
- Palos Verdes
- Panorama City
- Pasadena
- Porter Ranch
- Redondo Beach
- Santa Clarita (Valencia)
- Santa Monica
- Simi Valley
- Thousand Oaks
- Torrance
- Ventura
- West Los Angeles
- Westlake Village
- Westwood
- Woodland Hills
Expansion of UCLA Health footprint
320,000 attributed primary care patients
Approx. 200,000 in HMO Risk, Commercial ACO, MSSP, or Employer Collaborative Contracts
UCLA Health

By the Numbers

• 600,000 unique patients per year
• 2.7 million outpatient clinic visits
• 80,000 Emergency Department visits
• 40,000 inpatient admissions
• 2,000 faculty physicians
• 25,000 employees
UCLA Health Efforts on Value

Population Health Management
- Defined Populations
- Empanelment
- Integrated Care Model
- Social Determinants
- Performance Metrics/Care Gaps
- Total Cost of Care (Price)

Clinical Care Improvement/Care Transformation Projects and Programs
- Advanced Care Coordination Model & Programs (all specialties)
- Improvement Projects of Quality Officers, Clinical Department, and others
- Ambulatory Nursing Standardization and Safety

Patient Experience Enhancement
- Clinic Operations and Staff
- Patient-Physician Communication Workshop for all faculty

Triple Aim + 1 (Provider Sustainability)
UCLA Health’s ValU Care Redesign Department’s mission is to facilitate the redesign of care pathways to improve patient outcomes, improve patient satisfaction, improve the efficiency of resource used and decrease the overall costs of care.
Outcomes that matter to patients:

- Timely care
- Care that meets their needs (right care, right time, right place)
- Recovery time
- No complications
- Quality of Life
- Affordability (Price)
- Survival

Value Based Health Care Delivery
UCLA Health’s Approach to Value Creation

Innovation Report

Building the Infrastructure for Value at UCLA: Engaging Clinicians and Developing Patient-Centric Measurement

Robin Clarke, MD, MSHS, Andrew S. Hackbarth, MS, Christopher Saigal, MD, MS, and Samuel A. Skootsky, MD

Abstract

Problem
Evolving payer and patient expectations have challenged academic health centers (AHCs) to improve the value of clinical care. Traditional quality approaches may be unable to meet this challenge.

Approach
One AHC, UCLA Health, has implemented a systematic approach to delivery system redesign that emphasizes clinician engagement, a patient-centric scope, and condition-specific, clinician-guided measurement. A physician champion serves as quality officer (QO) for each clinical department/division. Each QO, with support from a central measurement team, has developed customized analytics that use clinical data to define targeted populations and measure care across the full treatment episode.

Outcomes
From October 2012 through June 2015, the approach developed rapidly. Forty-three QOs are actively redesigning care delivery protocols within their specialties, and 95% of the departments/divisions have received a customized measure report for at least one patient population. As an example of how these analytics promote systematic redesign, the authors discuss how Department of Urology physicians have used these new measures, first, to better understand the relationship between clinical practice and outcomes for patients with benign prostatic hyperplasia and, then, to work toward reducing unwarranted variation. Physicians have received these efforts positively. Early outcome data are encouraging.

Next Steps
This infrastructure of engaged physicians and targeted measurement is being used to implement systematic care redesign that reliably achieves outcomes that are meaningful to patients and clinicians—incorporating both clinical and cost considerations. QOs are using an approach, for multiple newly launched projects, to identify, test, and implement value-oriented interventions tailored to specific patient populations.
## Population Health Management Framework

<table>
<thead>
<tr>
<th>Determinants of Outcome &amp; Cost</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Care</td>
<td>Care Delivery Model, Provider Network, Access to Care</td>
</tr>
<tr>
<td>Individual Behaviors &amp; Wellness</td>
<td>Smoking, Exercise, Healthy Eating, Stress Reduction</td>
</tr>
<tr>
<td>Social Environment</td>
<td>Income, Occupation, Transportation</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>Air, water, places to exercise, safe buildings</td>
</tr>
<tr>
<td>Genetics</td>
<td>Inherited characteristics</td>
</tr>
</tbody>
</table>

Adapted in part from Kindig DA et al. A population health framework for setting national and state health goals JAMA 2008
Attributed & Empanelment
UCLA Primary Care Population
More than 50% in alternative contracts

- Shared Savings Models
- Risk Based Models
- Other models or FFS
What Payors and Purchasers Want

1. Population based Integrated Care Model
   • Multi-channel Access
   • Care Coordination
   • Integrated Behavioral Health
   • Patient Experience

2. Infrastructure for improvement in cost and quality (value)
   • Consistency
   • Reliability

3. Geographic distribution into communities
Convenient Ways to Access Care

https://www.uclahealth.org/appointments-call-click-come-in

When would you like to come in?

Opt In for Text Message Appointment Reminders

UCLA Health

Pediatrics and Family Medicine in Porter Ranch
UCLA’s Primary Care Innovation Model
(Population Health Care Delivery Model)
Innovation in Ambulatory Comprehensive Care Coordination

MANAGERIAL

Innovative Approach to Patient-Centered Care Coordination in Primary Care Practices

Robin Clarke, MD, MSHS; Nazleen Bharmal, MD, PhD; Paul Di Capua, MD, MBA; Chi-Hong Tseng, PhD;
Carol M. Mangione, MD, MSPH; Brian Mittman, PhD; and Samuel A. Skootsky, MD

The passage of the Affordable Care Act (ACA) reinforced primary care practice redesign as the main element for providing optimal population health. This redesign takes many forms, but the term “patient-centered medical home” (PCMH) has come to describe the ideal practice. The PCMH is central to healthcare reform, with national organizations (e.g., National Committee for Quality Assurance, URAC) having certified thousands of practices as PCMHs and some state programs providing financial rewards for acquiring certifications. However, the last decade of experience demonstrates that PCMH transformation is difficult, disruptive, and expensive. Although PCMH demonstrations have shown improved outcomes, real-world applications of PCMH practice redesign have inconsistently improved quality and utilization metrics. Our University of California at Los Angeles health system (UCLA Health), consisting of over 28 primary care practice sites, developed a transformation model to implement practice redesign swiftly and broadly across our network. Our approach included aspects from many PCMH domains, centering on an innovative approach for coordinating patient care.

Care coordination is a core component of the PCMH model and was one of the “7 Joint Principles” promulgated by the primary care societies. Most of the literature on PCMH care

ABSTRACT

Objectives: Although care coordination is an essential component of the patient-centered medical home structure, current care manager models have limited usefulness to population health because they typically serve a small group of patients defined based on disease or utilization. Our objective was to support our health system’s population health by implementing and evaluating a program that embedded nonlicensed coordinators within our primary care practices to support physicians in executing care plans and communicating with patients.

Study Design: Matched case-control differences in differences.

Methods: Comprehensive care coordinators (CCC) were introduced into 14 of the system’s 28 practice sites in 2 waves. After a structured training program, CCCs identified, engaged, and intervened among patients within the practice in conjunction with practice primary care providers. We counted and broadly coded CCC activities that were documented in the intervention database. We examined the impact of CCC intervention on emergency department (ED) utilization at the practice level using a negative binomial multivariate regression model controlling for age, gender, and medical complexity.

Results: CCCs touched 10,000 unique patients over a 1-year period. CCC interventions included education of care (8%), coordination of transitions (32%), self-management support/link to community resources (15%), monitor and follow-up (10%), and patient assessment (11%). The CCC intervention group had a 26% greater reduction in its prepost ED visit rate compared with the control group (p<0.0001).

Conclusions: Our CCC intervention demonstrated a significant reduction in ED visits by focusing on the centrality of the primary care provider and practice. Our model may serve as a cost-effective and scalable alternative for care coordination in primary care.
Integrated Behavioral Health

Delivering On Accountable Care: Lessons From A Behavioral Health Program To Improve Access And Outcomes

ABSTRACT Patients with behavioral health disorders often have worse health outcomes and have higher health care utilization than patients with medical diseases alone. As such, people with behavioral health conditions are important populations for accountable care organizations (ACOs) seeking to improve the efficiency of their delivery systems. However, ACOs have historically faced numerous barriers in implementing behavioral health population-based programs, including acquiring reimbursement, recruiting providers, and integrating new services. We developed an evidence-based, all-payer collaborative care program called Behavioral Health Associates (BHA), operated as part of UCLA Health, an integrated academic medical center. Building BHA required several innovations, which included using our enterprise electronic medical record for behavioral health referrals and documentation; registering BHA providers with insurance plans’ mental health carve-out products; and embedding BHA providers in primary care practices throughout the UCLA Health system. Since 2012 BHA has more than tripled the number of patients receiving behavioral health services through UCLA Health. After receiving BHA treatment, patients had a 13 percent reduction in emergency department use. Our efforts can serve as a model for other ACOs seeking to integrate behavioral health care into routine practice.
Focus on the Patient Experience

Specialties Differ in Which Aspects of Doctor Communication Predict Overall Physician Ratings

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1SAND Corporation, Santa Monica, CA, USA; 2UCLA Division of General Internal Medicine & Health Services Research, Los Angeles, CA, USA.

BACKGROUND: Effective doctor communication is critical to positive doctor–patient relationships and predicts better health outcomes. Doctor communication is the strongest predictor of patient ratings of doctors, but the most important aspects of communication may vary by specialty.

OBJECTIVE: To determine the importance of five aspects of doctor communication to overall physician ratings by specialty.

DESIGN: For each of 28 specialties, we calculated partial correlations of five communication items with a customized approaches to measurement, reporting, and quality improvement efforts are important.

KEY WORDS: doctor–patient relationship; specialty care; quality improvement; patient satisfaction.

Required CICARE Online Training

As part of the workforce required training, we ask that you please watch these videos, complete the quiz at the end and print out the certificate to receive credit for completing the training. Please be sure to have your employee ID ready.

*The minimum requirement to play these training videos is Adobe Flash 9. If you are having difficulty viewing these videos on Internet Explorer, please view in Firefox.

For Physicians:
NO CICARE Online Training

For RNs:
RN CICARE Annual Online Training

For All Other Staff:
CICARE Annual Online Training
Examples of Value Creation: Patient Experience Improvement

• Interventions to drive change
  • Ambulatory LEAN Academy/A3 for all clinic managers
  • CICARE Training all staff and physicians & Physician-Patient Communication Workshop
  • Distribution of all specialty CG-CAHPS data
• Interventions to sustain change
  • ART (Ambulatory Resource team)
    • Team members are currently visiting nearly 144 practices on a weekly to bi-monthly basis
    • Observation reports are sent to managers, directors and CAO’s
    • Coaching is provided to staff as applicable
Patient Experience Improvement:
Patient Experience with in Clinic Wait Time

Are patients seen within 15 min?:

Higher is better

Source: UCLA FPG Survey/QDM Website
Patient Experience Improvement: Patient Experience with Clinic Staff

Overall Rating of Clinic Staff:

How has Office Staff been evolving over time?

% of maximum achievable score

- Higher is better

- Upper/lower natural process limit

Source: UCLA FPG Survey/QDM Website
## Patient Experience/Satisfaction

<table>
<thead>
<tr>
<th></th>
<th>Press Ganey Percentile Rank</th>
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<tbody>
<tr>
<td></td>
<td>2015 Q1</td>
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<tr>
<td><strong>Santa Monica UCLA Medical Center (Adult)</strong></td>
<td></td>
</tr>
<tr>
<td>HCAHPS-Hospital Rating</td>
<td>71</td>
</tr>
<tr>
<td>HCAHPS-Likelihood to Recommend</td>
<td>77</td>
</tr>
<tr>
<td><strong>Ronald Reagan UCLA Medical Center (Adult)</strong></td>
<td></td>
</tr>
<tr>
<td>HCAHPS-Hospital Rating</td>
<td>78</td>
</tr>
<tr>
<td>HCAHPS-Likelihood to Recommend</td>
<td>89</td>
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</table>
UCLA Health Measurement of Meaningful Outcomes

• Custom and Regulatory Measurement
  • Important patient and clinical outcomes defined by clinicians
  • Utilization trends
  • ICD10 Coding/HCC trends
  • Care Gaps (custom, HEDIS, P4P, MIPS)
  • PCP & Specialist attribution model to drive reporting

• Standard reporting via commercial products

• Custom CG-CAHPS 3.0 patient experience reporting for all physicians, offices, administrative units
Improved Care Coordination: UCLA Advance Care Planning and Services

Advance Care Planning (ACP) Program
UCLA advance directive and materials, Training program, EHR structure

Inpatient

- Inpatient hospice beds
- Nursing Home POLST transition intervention
- ACP social worker for prospective work with high risk inpatients

Outpatient

- Palliative NP integrated into high risk clinics
- Home palliative care program linked to outpatient palliative care
- Outpatient Palliative Care Coordinator (new FTE)

Bereavement materials
Pharmacy & Therapeutics
Appropriate Statin Use at UCLA Health

• Based on providing 100% care over 5 years:
  • Secondary prevention for 'Clinical ASCVD' group will avert approximately 1145 MIs/Strokes and 385 deaths
  • Primary prevention for the 'LDL >190' and 'DM' groups will avert approximately 175 CVD events and 40 deaths
Development of CCJR bundles tracker
Custom measures defined by clinicians
<table>
<thead>
<tr>
<th>ACO Metric or Activity</th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Bed Days (LOS, Admissions, Readmissions)</td>
<td>Reduce OB C/S; Reduce NTSV</td>
</tr>
<tr>
<td></td>
<td>Reduce Short Stay Admits</td>
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<tr>
<td></td>
<td>Care Management Linkage to Ambulatory</td>
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<tr>
<td></td>
<td>ValU Care Redesign</td>
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<tr>
<td></td>
<td>PCIM components/Ambulatory Care Coordination</td>
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<tr>
<td></td>
<td>Inpatient Utilization (in and out of network)</td>
</tr>
<tr>
<td></td>
<td>Home IV Care Coordination</td>
</tr>
<tr>
<td></td>
<td>Hospital Readmissions</td>
</tr>
<tr>
<td>Post-Acute Care (LOS, Admissions, Readmissions)</td>
<td>SNF Management</td>
</tr>
<tr>
<td></td>
<td>Home Health/Home Care</td>
</tr>
<tr>
<td>ED Utilization</td>
<td>ED Optimization</td>
</tr>
<tr>
<td>OPH Surgery</td>
<td>Amb. Surgery Center Development</td>
</tr>
<tr>
<td>Appropriate Use of Observation Status &amp; Extended Recovery</td>
<td>Appropriate Use of Observation</td>
</tr>
<tr>
<td>Advance Care Planning &amp; Palliative Care</td>
<td>Amb ACP, Inpt &amp; Home Palliative, Hospice</td>
</tr>
<tr>
<td>FPG Value Analysis</td>
<td>Creation of Improvement dashboards</td>
</tr>
<tr>
<td>Generic Utilization/Pharmacy</td>
<td>High Cost Monitoring/Generic Utilization Rate</td>
</tr>
<tr>
<td>Care Gap Improvement</td>
<td>CareConnect Optimization</td>
</tr>
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</table>
The Challenge of Accountable Care Organizations (ACOs)

• Unlike HMO contracts, patients in ACOs are not required to receive all covered services within the contracted health care system.

• Thus, in ACO contracts, we are responsible for care provided by out of network providers. Variability in:
  • Cost
  • Quality
• **Initial Orientation** for both UCLA and Payor
  - Understanding roles of both Payor and UCLA & success factors

• **Four types of ongoing collaborative meetings**
  - Monthly (operations)
  - Quarterly (opportunity review)
  - Bi-Annual Statewide (sharing best practices)
  - Yearly (performance review)

• **Five different actionable population reports used by CCC/Clinical Advisor staff**
  - High risk members, care gaps, readmission risk, ADT facility feed, ad hoc high risk identification

Example: UCLA-Payor ACO: Involves Joint Operational Activities and Ongoing Commitment
What are the Total Cost of Care drivers?

• Acute Hospital
  • LOS (Surgical, Medical, Maternity, Catastrophic)
  • Admissions (& Readmissions)
• Observation and Extended Recovery Status
• Outpatient Hospital Facilities
  • ED versus ED alternatives
  • OPH versus Ambulatory Surgery Centers & Procedural Units
• Pharmacy
  • Prescription drug generic drug use rate

* In our Health Net contract, infused pharmaceuticals expense are assigned to the professional risk pool
The Goal of Innovation at UCLA Health is to:

*Identify, pilot and deploy high-value innovations that deliver better health and greater value to more people.*
IDENTIFY INNOVATIONS TO TEST

Innovations may come from within or outside UCLA, from healthcare providers and payors and other sectors. We work with internal and external partners to design a pilot that matches priorities and resources availability. We measure results and we help scale ideas worth growing.

BUILD A STRONG INNOVATION PROCESS AND CULTURE

We embed the innovation process within the strategic priorities of UCLA Health, foster innovation competencies and encourage broad participation in innovation initiatives.

CONVENE AND CONNECT WITH THE GLOBAL INNOVATION COMMUNITY

We actively lead and collaborate with other organizations in the local, national and international communities.
UCLA Health Research & Discovery

David Geffen School of Medicine

Research Centers:

- Semel Institute for Neuroscience
- Jonsson Cancer Center
- Institute for Precision Health
- Broad Center for Regenerative Medicine and Stem Cell
Internal Resource Coordination

• **ValU**: Use evidence based best practices (and lean methodology) to redesign and standardize care pathways to move from Volume to ValU

• **Performance Excellence**: Use lean methodology to eliminate waste, improve efficiencies, improve quality and lower costs

• **Patient Experience**: Foster a patient centered culture and build CICARE principles into all aspects of the Health System

• **Information Technology**: Test and validate IT and telehealth services to scale and operationalize across system

• **Innovation**: Identify, evaluate, and build business cases around innovations (process/service/technology) for leadership, and then collaborate with operational leaders to transform the delivery of care
An Effective Strategy and Set of Metrics Drive Sustainability and Return on Innovation at UCLA Health

Became the Focal point for healthcare innovation
- Investing in the infrastructure, Accelerator Board
- Attracting and retaining key thought leaders/inventors to UCLA Health
- Exposure locally and nationally positioning UCLA Health as an innovation leader

Developed an infrastructure where innovations can be shared, developed and scaled
- Reach a broad cross-section of employees, track those who are on the platform, and evaluate their activity
- Identify if this has an impact on improved employee retention, talent acquisition, or employee satisfaction
- Focus on innovations that align with system objectives – decreasing costs, increasing revenue, improving patient experience
Key Lessons Learned that are Critical for Future Success

Investment and collaboration to advance innovation at UCLA
• Successful innovation requires dedicated people, time, money and leadership and frontline buy-in
• Internal and external partners to effectively scale innovations

Culture change takes time
• The appetite for innovation is endless at UCLA!!
• Align projects with the overall strategic plan and research themes
• System-wide alignment on priority areas for innovation is key for efficiency and scalability
THANK YOU!!