Value-based Care programs are driving improvements in quality and people’s health

sponsored by UnitedHealthcare®
Value-based Care is creating the personal connection for the consumer, really putting that patient in the middle. What a lot of people don’t know is Value-based Care can come in many different arrangements—through an incentive-based plan with primary care physicians; a set of payments for bundled and episodic services or in the form of an Accountable Care Organization (ACO). Accountable Care Organization starts with high performing network providers. And through those high performing providers and Insurance Carriers, they are focused on managing a population. Through UnitedHealthCare and partners like Ochsner Health Network, we define quality metrics. Manage population according to those quality metrics to demonstrate savings and improved outcomes for the patients. It’s about rewarding our partners in regards to value based outcomes versus fee for service. If you deliver Value-based Care well, by keeping that patient at the center, you hit the triple aim; that is, driving high quality, low cost, and better health outcomes.

Ochsner Health Network. I like to think about it as being proactive versus reactive. Historically in healthcare, we’ve been reactive. For example, we wait for patients to come to the physician’s office or to come to the emergency department. Today, we view it as being much more proactive. Conducting outreach to make sure people are getting their screenings and looking at it as a partnership with our patients to make sure they are working to live healthier more productive lives. We are working hard at a federal and state level to see the governmental programs change to embrace this type of payment mechanism with all insurers, including UnitedHealthcare, to try and change the way healthcare is reimbursed and to reward organizations that take this type of approach. Our partners across the Ochsner Health Network — St. Tammany Parish Hospital, Slidell Memorial, Lafayette General Health and then Terrebonne General — are all coming together to try and drive that agenda across the state for more affordable, better access and higher quality healthcare in the state.
CHANDLER: Dr. Carmouche, what should people in the region know about Ochsner Health Network?

CARMOUCHE: When Warner asked me to take a leadership role at Ochsner Health Network, I was really gratified that they had picked the exact partners across each of their metro service areas in Louisiana that I would have chosen had I put a network together.

First of all, I think we’ve got a set of tremendously aligned partners – aligned culturally and in our vision of what we’re trying to deliver for Louisiana. None of us like the 50th health outcomes that we unfortunately suffer here. Most of us live here and raise our children here and want a better state. We view the network as a change agent and positive force for improving health. Secondly, we want people to view us as a partner to do this type of work with and it’s a journey. What we like about our relationship with UnitedHealthcare and where we’re going is that they’re seeking to align the payment with what we’re trying to do so that when we’re successful at delivering better health outcomes at a lower price point, we win, UnitedHealthcare wins and UnitedHealthcare policyholders win. I think that’s what excites us about this.

CHANDLER: Joe, how many members and spending does UnitedHealthcare have under Value-based Care nationally and locally in Louisiana?

OCHIPINTI: When you think about Value-based Care, you have to think of it in several different arrangements: primary care physician incentives; bundling episodic payments; and then the more comprehensive Accountable Care Organization. When you think of UnitedHealthcare nationally, you think of commercial and group insurance, Medicaid and Medicare. When you tie all that together, we are servicing about 15 million members under Value-based Care and that equates to about $2 billion dollars’ worth of total payment under Value-based Care. In Louisiana, Mississippi and the Gulf South region, we have just under 500,000 lives that we treat under a Value-based Care arrangement. That’s about 850 million dollars’ worth of spend tied to value-based incentives.

CHANDLER: Are there specific categories that UnitedHealthcare is focused on how Value-based Care gets delivered?

OCHIPINTI: If you focus on what’s core for an Accountable Care Organization, it’s making sure the primary care physician and specialists are driving the care, while making sure we strengthen the personal connection between these physicians and the consumer. We want to simplify the interactions through technology, whether that’s, integrating different systems to give that primary care physician or specialist a full view of that patient care, allowing them to provide the right care at the right time. When you tie the interactions together through technology, you empower the physicians and improve the consumer experience, and that’s what we think we’ve created here with our ACO with Ochsner Health Network.

CHANDLER: How many ACOs and Value-based Care arrangements have you implemented in Louisiana and what do you hope to achieve?

OCHIPINTI: There are several different arrangements. Within UnitedHealthcare in Louisiana when you think of primary care incentives, bundled payments and Accountable Care Organizations, we have over 300 arrangements that we have established today that span over about 191 hospital or physician contracts. Taking that to a more granular level, we really have four primary Accountable Care Organizations that provide coverage across the entire state of LA and Southern MS. Our first one launched in 2014 with Ochsner Health Network. That’s been the more mature ACO that we’ve been experienced and accustomed with working with in the past two years. In 2016, we launched three of the four: Gulf South Quality Network (April 2016), Hattiesburg Clinic (September 2016) in Mississippi and most recently, Franciscan Missionaries of Our Lady (FMOL) Health Leaders Network (October 2016). Each of these ACO’s are establishing a personal connection with the patient.

We are seeing Employers Groups sign up in these geographies to provide their employees greater access to care. We hope to see increased satisfaction between Providers, Employers and consumers through higher quality care, while seeing costs go down and improved outcomes on quality metrics defined in each of these ACO’s.

CHANDLER: Christine, how is your vision of an ACO product different from products that have been offered in the past?

O’BRIEN: Our ACO members will have a better overall healthcare experience and they’re going to start with choosing a primary care physician for themselves and their family members. The primary care physician and the Ochsner physicians exclusively will help the patient and their families, guide them to make sure that they are proactively receiving care. Our members will receive timely and appropriate healthcare screenings and avoid the duplicate healthcare screenings that occur a lot of times when you’re seeing multiple different providers in multiple different systems. And lastly, the primary care providers are going to help members manage chronic diseases such as diabetes, heart disease, and arthritis. We think in the end overall this will offer a better healthcare experience at a better cost and better care for the patient.

CHANDLER: Is there a proven track record that demonstrates that ACOs perform better than non-ACOs?

O’BRIEN: Yes, there is. Commercial ACOs perform better than non-ACOs on 83 percent of the most common quality measures that we monitor. And ACOs have been proven to have fewer hospital admissions as well as fewer emergency room visits. The top ten percent of ACOs closed 74.7% of the care opportunities identified for patients versus 56 percent for non-ACOs. So this translates into better health for the patient, better care for the patient, as well as lower cost for both the patient and the employer.

THOMAS: David, could you comment on the care gaps?

CARMOUCHE: We have about 25 registries – a condition defined list of patients who fall within a care gap and meet certain criteria – that are live within our Epic (electronic medical record system) environment. For example, we populated our diabetes registry – primarily patients receiving primary care at Ochsner Health System not including the network level – and when we turned it on we identified about 46,000 care gaps. That could be a lab that hasn’t been done on time or a patient who hasn’t had an office visit in a reasonable period of time; a number of different things. What we’re able to do now is create processes to conduct proactive outreach. We can do bulk orders; communicate via our secure portal, MyOchsner, that patients have
access to do direct mailings or text messages to outpatients to identify these care gaps. And when we did that, we expected about a 15 percent care gap closure. However, we were pleasantly surprised we had an 85 percent care gap closure. This is an incredible way for us to kind of keep track of patients who frequently just lose track themselves. I think we all have the experience through other industries, but frequently we don’t get those kinds of reminders from the healthcare system. I think Ochsner has tried to correct that now. For 25 of the more common chronic conditions that we’re interested in closing care gaps for, we have these registries and programs built and I think it’s totally transformed how we think about patients.

CHANDLER: To that point, how does Ochsner create and integrate its technology to offer integrated care?

CARMOUNCHE: It starts with Epic. Ochsner’s made a major investment in one of the leading system-wide electronic medical record systems in the country that we use in our hospital environment and in our ambulatory environment across all of Ochsner Health System and several of our partners who have chosen to go on our instance of Epic. I think that’s allowed us to conduct numerous efforts like this proactive outreach and create care pathways and standardized care based on evidence-based medicine to reduce this kind of unnecessary variation that can exist in healthcare to drive better outcomes. We also extend that to our patients and some of the community physicians so patients have access through MyOchsner in order to be able to see their own office notes, go online to schedule their own appointments, review reminders and message their physician. There’s a communication element to technology that I think goes a long way to putting the patient at the center of what we do. Additionally, technology that integrates with Epic allows us to deliver innovated care. For example, we have a hypertension program for patients who have poorly controlled blood pressure after so many months of routine care that we can refer patients to. It involves them having a Bluetooth-enabled mobile home blood pressure monitor that uploads blood pressures to an Apple phone into the cloud and into Epic so that a care team using an algorithm can in real time send prompts to patients and adjust medications based on these algorithms. We’ve been very successful and about 80 percent of those patients are controlled at six months versus about 25 percent being controlled if they had stayed in their usual environment.

Across the system and our whole network, we have providers who are on disparate electronic medical records systems (not Epic). We would like to connect the entire network and pair all claims data with clinical data so we’ve made an investment to partner with IBM to use their Explorys product. We’re in the process right now of taking in claims data from UnitedHealthcare, and other payers and marrying that up with clinical data from different types of electronic medical records to see views of populations to help us drive performance across a much broader network. Those are just some of the examples that come to mind. But there’s a lot of technology investment required to be a proactive healthcare system and be successful in this Value-based Care world.

THOMAS: This goes back to regardless of which hospital, which clinic location, which imaging center you go to at Ochsner, all of your hospital and clinic data is in one location. As David indicated, we have now extended Epic to St. Tammany Parish Hospital and we’re getting ready to install that at Terrebonne General Medical Center and Slidell Memorial Hospital in 2017. We’re really trying to be a much more consumer-focused organization because our patients are consumers, consumers of healthcare.

CARMOUNCHE: To add to that, I think the next iteration of how technology transforms healthcare is in telemedicine. Ochsner has been at the forefront in telemedicine. We have a leading system-wide electronic medical record systems in the country called Epic. And we’ve invested in the system, we’ve partnered with IBM to use their Explorys product. We’re in the process right now of taking in claims data from UnitedHealthcare and other payers and marrying that up with clinical data from different types of electronic medical records to see views of populations to help us drive performance across a much broader network. Those are just some of the examples that come to mind. But there’s a lot of technology investment required to be a proactive healthcare system and be successful in this Value-based Care world.

WALKER: We receive data from laboratories, pharmacy claims and some actual claims, and we package that information for our physicians so that they can identify gaps in care, like those already mentioned, to help close those gaps. It helps compare themselves to their peers. Every specialty has things that they are supposed to do for the patients that they are seeing, so they can see if they are in line with that and also in line with the costs. The other thing that we do is we have real time data where we share ER visits and discharges from the hospital and that helps us activate our care coordination program and also helps us share that information with both physicians and hospitals so they can help prevent further ER visits.

CHANDLER: How does United share data with providers to impact clinical outcomes?

WALKER: This is threefold. We definitely need to have a primary care focus. The primary care doctor is the coordinator of all the care. They can help the patient avoid admissions and make sure they have gaps in their care closed. Primary care physicians really need to be a champion in an ACO. When we have a physician champion, we’ve seen the results like Christine and Dr. Carmouche mentioned.

The second part of the ACO that we have noticed is data. It’s very data driven, so we have provided daily reports, weekly reports, monthly reports, and quarterly reports, especially the real time reports and the ER information that is very important. Then, as you move further along, we help close gaps in care such as mammograms, colonoscopies, immunizations, things that patients wouldn’t normally even think about. And then the third part is it’s very important to have both the physician and executive champions. When a physician champion and an executive champion all meet up, it really helps provide that leadership that keeps an ACO functioning and very fruitful.

CARMOUNCHE: One study said that only about 50 percent of the care that an individual person should be getting based on the current evidence in their age and their conditions is actually being provided in the United States. That means...
about half the things that the best practices would suggest any individual should be doing or getting doesn’t happen in this country. That is why we’ve developed the registries mentioned earlier to hopefully better close those gaps in care. We also agree that the relationship between a primary physician or a primary care physician and a patient is critical to success. But physicians alone in traditional practices can’t do this work. If you take all of the wellness needs of a population and then add in all of the chronic disease needs of a population and then try to manage all the acute care needs walk-ins or urgent needs of a population, it would take about 16 hours a day for a typical panel size. When you start to understand that and when you start to have tools like Epic that allow you to identify all these care gaps, you rapidly start to realize that you need a care team who is jointly responsible for patients in making sure that we bring more than 50 percent of the appropriate care to these patients. It’s not just about care gaps; it’s about the care team and how we transformed our design of delivery care practices to become successful.

CHANDLER: If you look a few years down the road, what do you see being offered in collaboration with Ochsner and UnitedHealthcare?

OCHIPINTI: UnitedHealthcare brings national resources to our care provider relationships to strengthen how care is delivered locally. We have tremendous assets with technology and our Optum brand. We need to continue to collaborate on the learnings of how we’re addressing the gaps in care and how we’re integrating new areas like telemedicine. We need to maintain the strengths of Ochsner, FMOL, GSQN or Hattiesburg Clinic and together we can increase quality, drive down costs and create better outcomes to our consumers and employers. Employers want more access at affordable prices, consumers know their PCP and they have trust with their PCP. I expect to see more Value-Based Care programs putting PCP’s at the front entrance, but allowing consumers more flexibility in the ACO, while the care provider uses social media and interactive applications to engage with consumers at the right time and how they want to be engaged.

THOMAS: The way I look at this is we need to make healthcare better in Louisiana and in the whole Gulf South. Ochsner Health System can’t do it alone. And that’s why Ochsner Health Network was created to bring in other like-minded organizations across the entire state so that we can change healthcare and change it to improve qualities, improve access to care and make healthcare more affordable. Ochsner Health System can’t do that alone. The Ochsner Health Network with organizations like UnitedHealthcare and the other major insurers in the state -- Blue Cross, Humana and others -- all have to work together. Because at the end of the day, we’re here -- we at Ochsner are here to serve the community. We’re a not-for-profit organization. We give back to the community. The relationships like what we’re talking about with UnitedHealthcare are important to allow us to make sure we have the right financial models set up that facilitate all the things we talked about today with care gaps, with proactive versus reactive type of care. We have to work together to engage employers and their employees in a very different conversation so that they can. People want to be healthy, but we have to remind them, make it obvious and handle this in a different way. I think one of our key goals is to also engage more with employers to help them think about how they can do this with their employees base. We’re a healthcare provider, but we’re also the largest private employer in the State of Louisiana employing over 17,000 people so we really kind of look at it on both sides. How do we help our own employees live healthier lives and take the strategies and ideas we have there and bring them to other employers? At the end of the day, it’s about making healthcare better and relationships like what we have with Joe and with UnitedHealthcare are critical to that. We need to continue to build our relationships with our partners in Ochsner Health Network. Together, we can and will change healthcare in the state and that is our goal over the next couple of years.

CHANDLER: Does anybody else have anything to add?

CARMOUACHE: I’d like to just pick up a little bit on what Warner said about our thoughts around employers and how we want to work with employers. I think the fact of the matter is most people access healthcare services through their insurance products. I think if you think about it, all of the great things that we’ve talked about that Ochsner’s investing in and doing are sometimes not easily translated to the actual individual consumer who’s purchasing an insurance product that then allows them access to healthcare services. So from our perspective, the value proposition of working as an ACO with UnitedHealthcare is to hopefully have those folks help bring our story to employers who are offering insurance benefits to their employees.

The types of products that have been sold in Louisiana traditionally have been broad access products. I think what half of all of us are recognizing is that if we really want to create the optimal care experience, an organized experience, a coordinated experience where the information flows to patients and across providers, we can’t do that easily in broad networks. So I think for Ochsner what we’d like to see from UnitedHealthcare is assistance in translating what they know as to be good work and a better care experience and better health outcomes into the insurance products that they sell to employers. I think if we’re successful at doing our part, then we would hope that our partners can help better position us with employers who are increasingly looking to avoid a 10 percent annual increase in their premium or increasingly looking to these new types of relationships and narrower higher performing network type products to drive value for their employees.

THOMAS: The other thing is this is not just Ochsner Clinic physicians. Within Ochsner Health Network, we have hundreds of community physicians that we’re working with. For example, St. Tammany Parish Hospital has partnered with their physicians to create St. Tammany Quality Network who are many community physicians that are coming together along with these same goals of improving quality, improving access, reducing cost. Ochsner is partnering with hundreds of community physicians to help them understand and create models that work for them and really continue to make sure we’re proactive within our entire network, not just in the Ochsner Clinic. I was sitting here thinking about how do we know we’re successful when we’re really making progress here. To me when we are successful, we’re going to have people come up to us saying, “Thank you for helping me or my husband keep his blood pressure under control” or “Thank you for helping my wife keep her diabetes under control.” We’ll be successful when we are making sure we’re addressing chronic disease in the right way. Part of our job is to make sure that we’re continuing to communicate and educate our patients and the insurer, the employer, and the individual to make sure they’re being proactive to deal with these preventative challenges. We’re human and we forget about these things sometimes, but it’s so important: the wellness activities, the being proactive around your health and your own life. That would be great success and I think that’s coming in the near future.

O’BRIEN: We continue to work very closely with Ochsner and the other ACO partner’s that Joe mentioned to use data to offer ACO-type products and develop plan designs that Employers want in the marketplace. If you offer a benefit design that supports an integrated experience for the consumer, greater access to care and that model offers an affordable plan and coverage to a family and to an employer, it is a win for all parties involved.

CHANDLER: Thank you all so much for participating in this round table discussion.
Consumers are at the center with Value-based Care

Value-based Care is health care that works smarter and better to help people live healthier lives. It’s a health care model that promotes better health, better care and lower costs through innovative partnerships with care providers and consumers.

15 MILLION UnitedHealthcare members benefit from value-based programs.

Better Health
• Physicians encourage patients to be active in their health care and to be engaged in their diagnosis and treatment options.
• Actionable data shared with physicians, such as a missed screening or follow-up appointment, makes it easier to close gaps in care with individual patients.
• Premium Tier 1 physicians assure consumers of measurably stronger outcomes.

Better Care
• Care providers have a complete view of patients’ health by sharing information among every health professional involved in an individual’s treatment, from a doctor at a walk-in clinic to a specialist.
• Consumers build stronger connections with their physicians, find it easier to access care (including home visits in some cases) and have more information at their fingertips.
• Care providers receive the time and compensation to provide more coordinated care – which ultimately can reduce costs by minimizing unnecessary care such as re-hospitalization and redone procedures.

Lower Cost
• Mobile tools and more transparent information make it easier to research and compare quality, cost and provider-specific information.
• Financial incentives reward consumers for choosing high-performing doctors who are identified as having measurably stronger outcomes.

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