The Journey to Accountable Care

Chris Day
December 4, 2014
Government program cuts cause providers to shift costs to private payers

But, private payers are a shrinking share of total provider business

Source: Avalere Health analysis of American Hospital Association Annual Survey data, published 2014
And, the patient experience needs improvement, too

- Fragmented, frustrating and wasteful
- High cost
- Payer
- Specialist
- Diagnostic imaging
- Primary care doctor
- Clinic
- Hospital
- Pharmacy
- Lab

- Is there a generic?
- What is covered in my plan?
- Does my specialist have all my information?
- Are all of these tests necessary?
- Where do I go for care?
- I can’t get an appt.!
Accountable care delivers a triple aim goal of better health, better care, better cost
Collaboration creates more value than ACOs or payers alone

Together we:

FIND AND ENGAGE MORE patients with technology plus provider records

HELP MORE patients have a streamlined experience

SAVE MORE with efficient care across entire care team

Providers

- Patient relationship
- Clinical credibility

Payers

- Health plan expertise
- Supporting capabilities
We’re already seeing results

28% – 64% increase in patients reaching goals for blood pressure and cholesterol levels

50% fewer impactable bed days

10% reduction in high-tech imaging scans

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1 "Payer-Provider Collaboration in Accountable Care Reduced Use and Improved Quality in Maine Medicare Advantage Plan," Aetna and NovaHealth, Health Affairs, Volume 31, Number 9, September 2012.
2 Aetna ACS Analytics, for the year 2013.
3 Aetna-Carilion ACO, Modern Health Care, December 17, 2013. Actual results may vary.
Memorial Hermann Accountable Care Network

Presented by Dr. Keith Fernandez
Aetna Inc.

Memorial Hermann network coverage area

Network Quick Stats

- 3,500 total physicians
  - 2,100 clinically integrated (CI) physicians
  - 1,850 ACO physicians
  - 325 Patient Centered Medical Homes
  - 550 of the CI physicians are PCPs
  - 600 specialists from University of Texas Medical School, aka UT Health (not clinically integrated)

- Most physicians are not employed
Memorial Hermann Physician Network

**MHMD MISSION**

Our mission is to lead the transformation of medical practice in collaboration with patients, payors and caregivers, through the use of evidence-based medicine. We establish a culture of physician accountability and create and deploy new models of healthcare that will improve the quality, safety and cost efficiency of the care we provide for the populations we manage.

- Transformation of medical practice
- Collaboration with patients, payors and caregivers
- Use of evidence-based medicine
- Culture of physician accountability
- Quality, safety and cost efficiency
- Populations
Physician governance

MHMD Board of Directors

Clinical Programs Committee

- H&V
  - Cardiology
    - CV Surgery
  - Neurology
    - Neurosurgery
  - Neonatal
- Woman/Child
  - OB/Gyn
- Surgery
  - Anesthesia
  - Bariatrics
  - Orthopedics
  - ENT
  - Allergy
- Medicine
  - Critical Care
  - Emergency
  - Ad hoc
  - Hospital Medicine
  - Post Acute
- Oncology
  - Oncology
  - Imaging
  - Pathology
  - Peds
- Contract
  - Adult PCP
- Primary Care
  - Ad hoc
# Foundations: The Advanced Primary Care Practice

## Advanced Primary Care Practice

<table>
<thead>
<tr>
<th>Claims Files/Data</th>
<th>Case Management</th>
<th>Single Signature Contracting</th>
<th>Marketing</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCC Training</td>
<td>Document Training</td>
<td>Quality Metrics</td>
<td>Patient Education</td>
</tr>
<tr>
<td>Schedule NOW</td>
<td>Patient Portal</td>
<td>e Notify</td>
<td>NCQA Level 3</td>
</tr>
<tr>
<td>Practice Assessment</td>
<td>Electronic Medical Record</td>
<td>Point of Care Tool</td>
<td>Health Information Exchange</td>
</tr>
</tbody>
</table>

### Accountable Care
- HCC Training
- Document Training
- Quality Metrics
- Patient Education
- eNotify
- NCQA Level 3
- Electronic Medical Record
- Point of Care Tool
- Health Information Exchange

### Clinical Integration
- Access
- Quality
- Technology
Efficiency and continuous improvement are critical to long term ACO success

Memorial Hermann is more efficient than the market

<table>
<thead>
<tr>
<th>Metric</th>
<th>Memorial Hermann</th>
<th>Houston market</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Days/1000</td>
<td>208</td>
<td>236</td>
<td>13% better</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>3.5</td>
<td>3.9</td>
<td>11% better</td>
</tr>
<tr>
<td>Re-admission rates</td>
<td>5.1%</td>
<td>6.0%</td>
<td>18% better</td>
</tr>
<tr>
<td>ER visits / 1000</td>
<td>164</td>
<td>180</td>
<td>8% better</td>
</tr>
</tbody>
</table>

Memorial Hermann’s continuous improvement efforts are significantly reducing common complications

<table>
<thead>
<tr>
<th>Diabetes Measures</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetics with Hemoglobin A1c Control (&lt;8 percent)</td>
<td>60.20%</td>
<td>72.38%</td>
</tr>
<tr>
<td>Blood Pressure (BP) &lt; 140/90</td>
<td>61.40%</td>
<td>70.76%</td>
</tr>
<tr>
<td>Tobacco Non-Use</td>
<td>68.30%</td>
<td>77.62%</td>
</tr>
<tr>
<td>Aspirin Use</td>
<td>49.40%</td>
<td>86.90%</td>
</tr>
<tr>
<td>Diabetics with HbA1c in poor control (&gt;9 percent)</td>
<td>32.60%</td>
<td>7.22%</td>
</tr>
</tbody>
</table>

Information/data provided by Memorial Hermann
Aetna-Memorial Hermann collaboration improves the member experience

<table>
<thead>
<tr>
<th>Care and disease management</th>
<th>Core capabilities enhanced via MHACN point-of-care data, doctor-patient relationship, and outreach</th>
</tr>
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<tbody>
<tr>
<td>Outreach</td>
<td>Proactive outreach by providers and informed by data from Aetna</td>
</tr>
<tr>
<td>Follow-up</td>
<td>Consistent follow-up with patients and providers informed by Aetna data</td>
</tr>
<tr>
<td>Duplication</td>
<td>Reduced through interconnectivity across MHACN</td>
</tr>
<tr>
<td>Care coordination</td>
<td>Highly coordinated between physicians, plus gains from data sharing from Aetna</td>
</tr>
<tr>
<td>Member cut-of-pocket costs</td>
<td>Reduced, due to improvements in efficiency and quality</td>
</tr>
</tbody>
</table>

Intensity of Service

- **Well**
- **Sick**

Wellness and Prevention

- Chronic Disease Mgmt
- Supportive Care
- OP ICU

Patient Centered Medical Home

- Telemedicine
- Home visits
- High Intensity Clinic
- Intensive Care
- Intensive Care Management

Automated CM

Telephonic Care Management

Aetna and MHMD Integrated Care Management

Aetna Inc.
Aligned incentives with quality and efficiency metrics

Accountable care provides incentives to Memorial Hermann doctors to improve quality and meet efficiency metrics

Preventive Care
- Cervical cancer screenings
- Colorectal cancer screening
- Breast cancer screening

Managing Chronic Conditions
- Diabetes – LDL-C screening, HbHA1c, neuropathy prevention/care
- Asthma – medication adherence for children and adults
- Heart disease – LDL-C screening and beta blockers after MI

Efficiency Metrics
- Hospital admissions and readmissions
- Emergency room usage
- Generic prescribing rates
Baylor Scott & White Quality Alliance

Presented by Dr. Michael Massey
Introducing Baylor Scott & White Quality Alliance

Baylor Scott & White Quality Alliance (BSWQA) was formed in 2011 and considered to be instrumental in leading Baylor Scott & White Health’s (BSWH) vision to become a recognized accountable care network focused on population health management.

Covering the North and Central regions of Texas, BSWQA is an extensive network committed to collaboratively improving health outcomes across all care settings, pursuing cost containment initiatives, and increasing the value of health care for employers, hospitals, and patient communities.

BSWQA’s Mission: “To achieve the highest quality, cost effective care possible for the patients that we serve through clinical integration.”

BSWQA’s key strategies are:
• Comprehensive care delivery and a patient–centered medical home model
• Sophisticated data analytics and population management
• Enhanced case management and care coordination
Aetna Whole Health – Baylor Scott & White Quality Alliance network coverage area

The Aetna Whole Health – Baylor Scott & White Quality Alliance network includes:
- 900+ primary care doctors
- 2,800 specialists
- 27 hospitals

To enroll, employees must live or work in the Baylor Scott & White Quality Alliance service area.

*Please consult DocFind® for the most up-to-date information on doctors and facilities in the Aetna Whole Health – Baylor Scott & White Quality Alliance network.

**Collin, Dallas, Denton, Ellis, Parker, Rockwall and Tarrant counties.

For illustrative purposes only.
Baylor Scott & White Health – Vision 2020

Integrated Delivery System
Build a Fully Integrated and Digitally Connected Care Delivery Network

New Models of Care
Deliver the Right Care at the Right Time in the Right Setting for our Patients

Scale and Synergy
Achieve Economies of Scale and Influence to Enable Future Success

Population Health
Achieve the Triple Aim of Health Care

The Work of BSWQA

VISION:
To be the most trusted name in giving and receiving safe, quality, compassionate care.
## BSWQA is capable

<table>
<thead>
<tr>
<th>Population Health Infrastructure</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Accountable for Care</strong></td>
<td>3,500+ physicians • 46 hospitals • Post-acute care • Other members of the care continuum</td>
</tr>
<tr>
<td><strong>Integrated Health System</strong></td>
<td>Baylor Scott and White Health • HealthTexas Provider Network • Baylor Scott &amp; White Quality Alliance</td>
</tr>
</tbody>
</table>
| **Care Management**              | • Largest network of NCQA recognized PCMH (60 and growing)  
• Established Care Coordination Services  
• Preventive Services (Above national standards)  
• Disease Management (Above national standards)  
• Evidence-based medicine (*90+ protocols/metrics*)  
• Established payer strategy |
| **Access**                       | Extended Hours • Care Teams • Patient Portal • Retail Clinics |
| **Data Analytics/Reporting**      | Risk-stratification • Predictive modeling • Workflow analysis • Financial analysis • Resource allocation |
| **EHR/HIE**                      | Common EHR across the network • HIE implementation coming soon |
| **PCMH**                         | Important for all patients, but particularly important to the sickest patients to have a PCMH |
Data analytics tools

Explorys
- Overall data aggregator of BSWH comprehensive data:
  - Clinical
  - Financial
  - BSWQA independent physician members

Optum One
- Risk stratification and predictive modeling for our individual patients and patient populations.
- Enables identification of at-risk patients earlier, preserves patient health, reduces costs and prevents complications.

Crimson Real Time
- Identify critical areas for awareness and prediction
- Use integrated workflow support to hardwire process improvements and accountability across EMRs and other frontline tools

Crimson Care Management
- Web-based platform to communicate care plans throughout the continuum, including:
  - Inpatient care coordination
  - Post-acute care
  - Payer based case management
Connectivity

dbMotion Connects the Health Neighborhood

BSWQA’s Health Information Exchange Solution

- EHRs and data repositories at other sites across the care community are queried for usable information that can help complete the patient record

- Clinical information comes directly to your EHR

September 2016: Goal of 150 practices/systems connected
Evidence-based guidelines assist BSWQA’s efforts to standardize care and ultimately reduce unnecessary health care costs

### Subcommittees Producing Approved Care Guidelines

<table>
<thead>
<tr>
<th>Website Logins</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Prescribing</td>
<td>Primary Care APS</td>
</tr>
<tr>
<td>Patient Satisfaction Surveying</td>
<td>Primary Care Diabetes</td>
</tr>
<tr>
<td>Payer Performance Metric</td>
<td>Primary Care Depression</td>
</tr>
<tr>
<td>Low Back Pain</td>
<td>Readmissions TF</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Emergency Med</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>PAC SNF Metric</td>
</tr>
<tr>
<td>Neurology</td>
<td>PAC HH Metric</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>PAC Hospice Metric</td>
</tr>
<tr>
<td>Hospitalists</td>
<td></td>
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</table>

**90+ evidence-based care protocols approved by BSWQA Board of Managers**
“BSWQA care” essentials for lowering employer costs, improving quality

<table>
<thead>
<tr>
<th>What Baylor Scott &amp; White Health can bring</th>
<th>How Employer and Benefit Design can help</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High quality select Network</strong></td>
<td>“In-network” benefits need to be communicated (higher quality, clinical integration, lower cost, access)</td>
</tr>
<tr>
<td>Complete Physician • Hospital • Post-acute care network • Excellent geographic and specialty capacity</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care in a PCMH</strong></td>
<td>Strong incentives and plan design to assure attribution to PCP</td>
</tr>
<tr>
<td>Largest NCQA recognized PCMH PCP Group in US • Proven superior disease management, preventive service results</td>
<td></td>
</tr>
<tr>
<td><strong>Care Coordination</strong></td>
<td>1. CC less effective if patients not attributable to PCP 2. Must redirect Disease management $ to BSWQA to fund Care Coordination</td>
</tr>
<tr>
<td>Fully developed CC/ Disease management structure coordinated between PCP and Specialists with positive results • Integrated team <em>(RN care managers highest acuity patients)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Integration</strong></td>
<td>Employer can share patient examples of CI benefit</td>
</tr>
<tr>
<td>Committed delivery network • Common Protocols • Pathways • Communication</td>
<td></td>
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### “BSWQA care” essentials for lowering employer costs, improving quality (cont’d)

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<th><strong>How Employer and Benefit Design can help</strong></th>
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<tr>
<td><strong>Analytics</strong></td>
<td>Full suite of EMR • Interoperability • Analytic tools • Proven Predictive models • Risk Stratification</td>
<td>Employer share clinical performance data with staff</td>
</tr>
<tr>
<td><strong>Cost Reduction</strong></td>
<td>• Proven cost reduction experience • Realistic intense focus on “top 5%” who drive half the cost • Intensive case management for top 5% • BSWQA “at risk” for performance or no reward</td>
<td>• Strong incentives to select “narrow network” • Very strong incentives to encourage top 5% to be under care of exceptional PCMH/PCP team • Must have Claims Download from TPA</td>
</tr>
<tr>
<td><strong>Employee Satisfaction</strong></td>
<td>Proven “top box” Press Ganey and CG-CAHPS performance</td>
<td>Socialize benefits of Clinical Integration – case examples</td>
</tr>
<tr>
<td><strong>Wellness</strong></td>
<td>Full integration of HRA, Biometric Screening and other wellness resources with PCP encounters</td>
<td>Ideally integrate wellness into overall clinical care and medical home</td>
</tr>
</tbody>
</table>
BSWQA Year 1 results

**All Cause Re-Admission Rate**

<table>
<thead>
<tr>
<th>Year</th>
<th>30 Day Re-Admission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>20.0%</td>
</tr>
<tr>
<td>2013</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

18% drop

**Admissions per Thousand**

<table>
<thead>
<tr>
<th>Year</th>
<th>Admissions per Thousand</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>97</td>
</tr>
<tr>
<td>2013</td>
<td>93.0</td>
</tr>
</tbody>
</table>

4.3% drop

**Employee Health Plan Medical Costs Reductions (PMPM)**

- Budget Expenses: $516.22
- Actual Expenses: $480.63
- 7% cost reduction vs. expected expenses

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

7% cost reduction (as compared to expected expenses) in our employee health plan medical costs generated savings approaching $14 million overall (based on 34,000 lives)
Questions?
Thank you

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