

# Preparing Your Organization For New Payment Models

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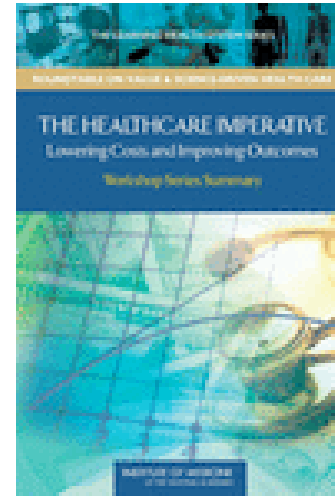
# How good could it get?



IOM Roundtable on Value & Science-Driven Health /care  
Workshop on The Healthcare Imperative: Lowering  
Costs and Improving Outcomes, 2010

How good could it get?

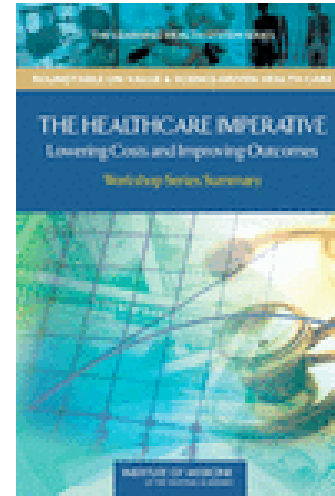
OECD \$650 b



How good could it get?

OECD \$650 b

Dartmouth \$750 b

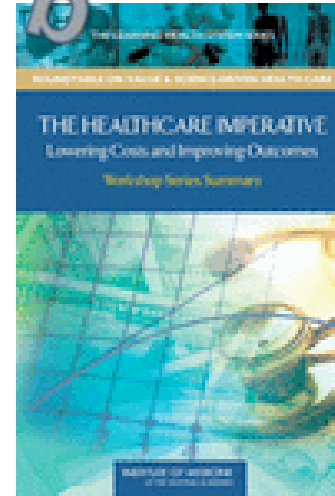


How good could it get?

McKinsey \$760 b

OECD \$650 b

Dartmouth \$750 b



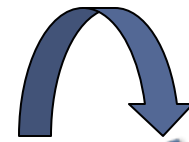
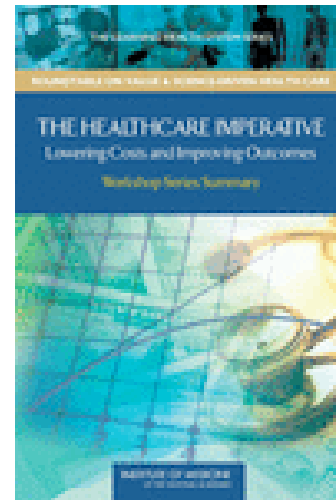
How good could it get?

McKinsey \$760 b

OECD \$650 b

Dartmouth \$750 b

~~IOM \$765 b~~



**\$550 b**

# Where are the opportunities?

## *Opportunity*

## *Savings*

Missed prevention opportunities

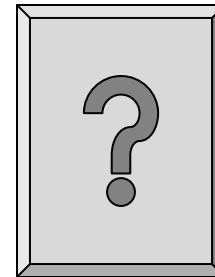
Prices too high

Excess administrative costs

Unnecessary services

Fraud

Inefficiently delivered services



# Ranking the opportunities -

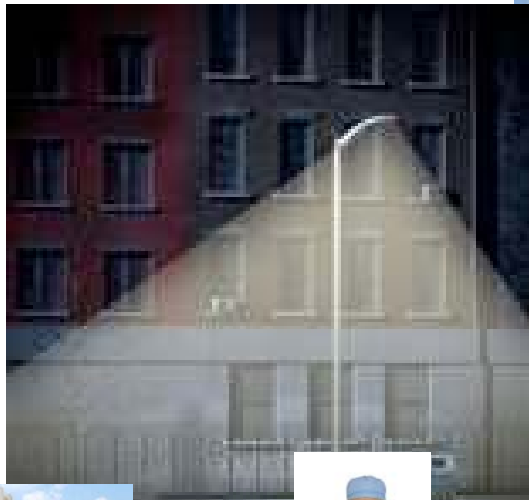
Missed prevention opportunities	\$210 b
Prices too high	\$130 b
Excess administrative costs	\$190 b
Unnecessary services	\$105 b
Fraud	\$ 55 b
Inefficiently delivered services	\$ 75 b



## Unnecessary and inefficient -

<b>Unnecessary services</b>	<b>\$210</b>
<b>Inefficiently delivered services</b>	<b>\$130</b>
<i>Excess administrative costs</i>	<i>\$190</i>
Prices too high	\$105
Missed prevention opportunities	\$ 55
Fraud	\$ 75

**And even more importantly, what is the easiest and quickest way to extract them?**



# UCLA Medical Group

- We have ~90,000 managed care lives, we're top tier P4P, patient satisfaction, other measures.
- We already have case management, predictive profiling, many other tools and programs ~ California medical group model.

Soooooo.....

- Where are the greatest potential improvements in cost and value... effective within 12 – 24 months?
- And for each of those interventions, how heavy is the lift? Investment costs, change management demands, and how does it fit in our transformation portfolio?

We look at many ACO roadmaps...

***Current Quick hits:***

- Health Risk Assessment
- Health screening
- Coaching models for chronic conditions
- Identification of a Primary Care Provider
- EHR-fed PHR utilization
- Formulary compliance, generics utilization
- Transitions of care – med reconciliation

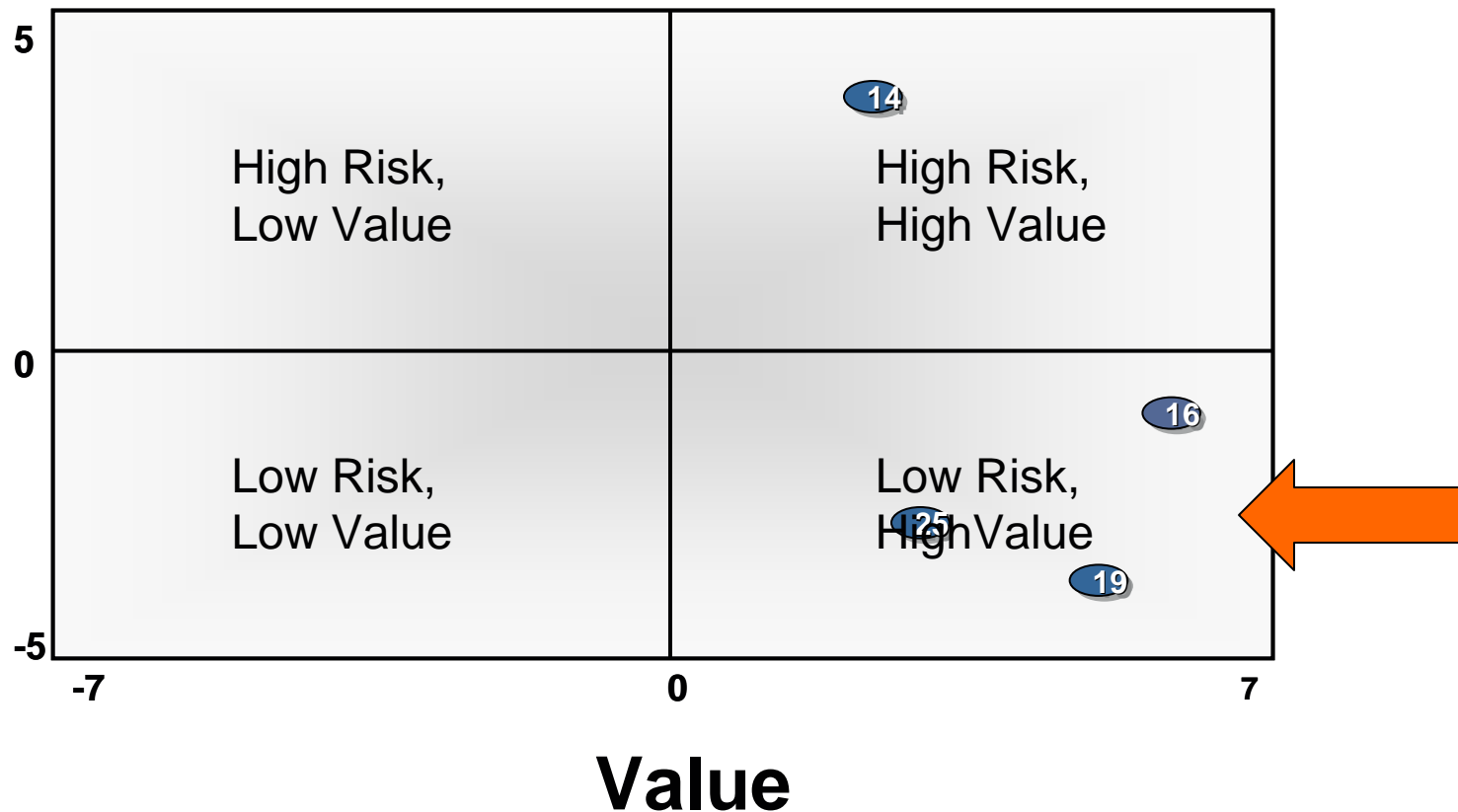
But there is more.  
And there should be a sense of  
urgency.

“Don Berwick told me in no uncertain terms that it is time, and that some of us who have done this in multistate systems with dull things like revenue cycle, labor cost and supply chain management need to step up and help others to accelerate and advance performance in the population health area.”

- *Stephanie McCutcheon*  
*Former CEO, Multi-State Integrated Delivery Systems*

# A Value-Improvement Portfolio

## Risk



# A Map Of Population Health Management

- Keep families and communities healthy
- Support self-management of acute conditions
- Support remote provider management of acute conditions
- Support self-management of chronic conditions
- Support remote provider management of chronic conditions
- Keep patients independent in the community
- Reduce high-cost utilization by most high-risk chronic disease patients (A-ICU models)

# Support self-management of acute conditions:

Incentives
Social media networks (e.g., HealthTap)
Self-serve user-based Personal Health Records (Mobile or internet-based)
Self-serve wellness monitoring applications
Fitness applications for athletes and sports enthusiasts (Mobile or internet-based)
Social gaming applications (Mobile or internet-based)
Health information hubs (e.g., WebMD)
Text-message health education applications
Self-serve preventive services kiosks

Warning...



Thinking like a purchaser – or a payor..

## 1. Shared Decision Making

Health Dialog 



## 2. Incentives for behavior change



Health Plans	Health Partners	Employers
CIGNA Kaiser Permanente Blue Cross Blue Shield of North Carolina Blue Cross Blue Shield of Michigan	Quest Diagnostics ActiveHealth OptumHealth	Motorola JPMorgan Chase Nissan American Airlines

### 3. Provider access outside the workstreams of clinic and office or institutional care



# Home-Based Palliative care



Cost savings ranged from 37% to 45% for terminally ill patients vs. traditional care.

[http://www.picf.org/landing\\_pages/17,3.html](http://www.picf.org/landing_pages/17,3.html)

# Home health barriers

It's not the technology,

**It's the service !**

**.. the value of community-  
based organizations...**

# The substitute for RTCs...

- ✓ Rapid response evaluation teams
  - Design rapid cycle evaluations
  - Support iterative evolution of interventions
  - Methodology will evolve / AHRQ, PCORI
  
- ✓ Evidence-based collaboratives
  - Pattern of CMS/Premier demonstrations
  - Within large multi-hospital systems or medical groups
  - Find one bent on measurable results, not endless process

Key may be “intention to treat” the health system – how much of an effect do you want to create?

- Act like a plan, (or at least, ask yourself – “what would a plan do?” .... then revise
- Start with employer/government/consumer:
  - Urgent need to reduce prices
  - Overwhelming need to simplify access and interactions
  - Patient satisfaction, patient participation guide transformation
- Could argue that you should just reduce costs, let this improve quality...and the market sets the price...



# Literature Review Methodology: Cost-Effectiveness of PHM Interventions

## Search strategy for identification of studies:

An online literature review of Google Scholar was completed. The following keywords were search terms: cost, effective, savings, economic, analysis, evaluation, as well as specific key words from pre-identified population health management (PHM) interventions, such as personal health records, kiosks, retail clinics, etc. Relevant research studies, focusing on cost-effectiveness or cost-savings of these PHM interventions, were scanned to determine whether they met the inclusion criteria.

### Methods of the review

- The following inclusion criteria were used for this review:
- Peer-reviewed research studies published on or after 2004 were included, but the primary focus was on research published on or after 2009.
- Systematic review and meta-analyses articles were given priority, followed by Randomized Control Trials (RCTs), cohort studies, observational studies, and case studies, respectively.
- Individual studies were evaluated for matches in their evaluation of cost impact of interventions.
- Stages in the review process were as follows:
  - Stage 1: Potentially relevant articles were pre-screened from online search results for inclusion or for background information.
  - Stage 2: Pre-screened articles were assessed for inclusion.
  - Stage 3: Studies were evaluated for quality. Quality criteria included factors such as robustness of cost-effectiveness analysis.
- Patricia Lin, UCLA Innovation Initiative Intern