UCLA Health

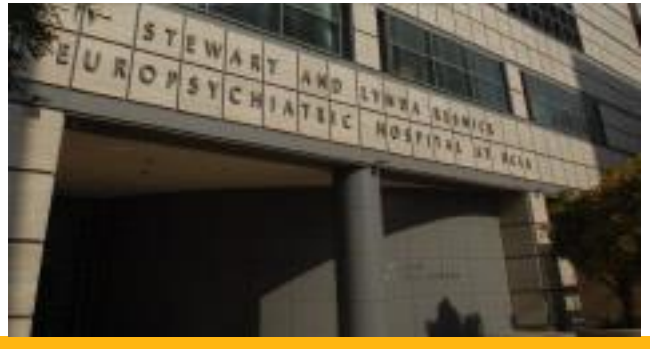
Using Innovation to Drive Value Based Care

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



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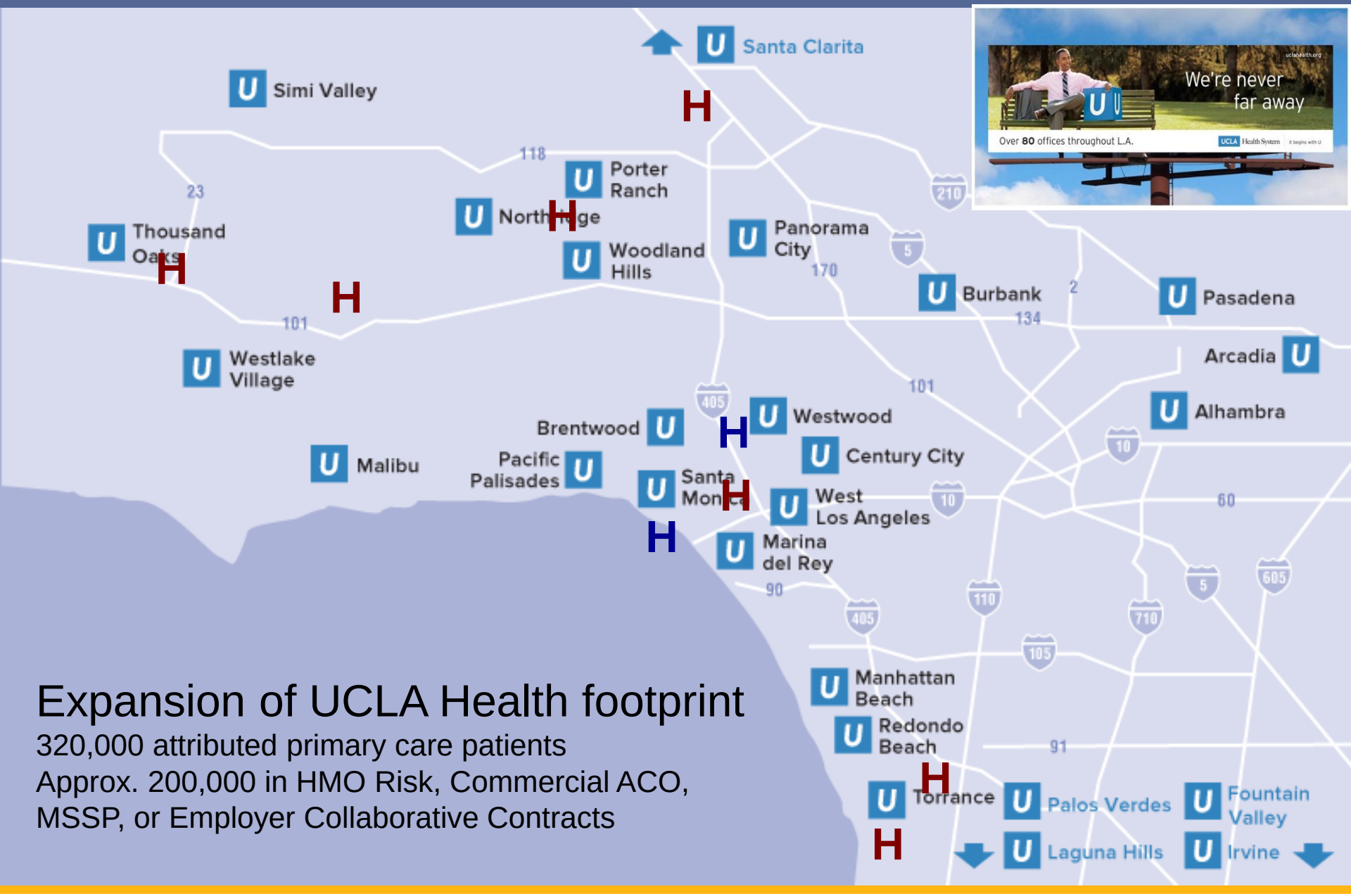
Ambulatory Practices and Clinics

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

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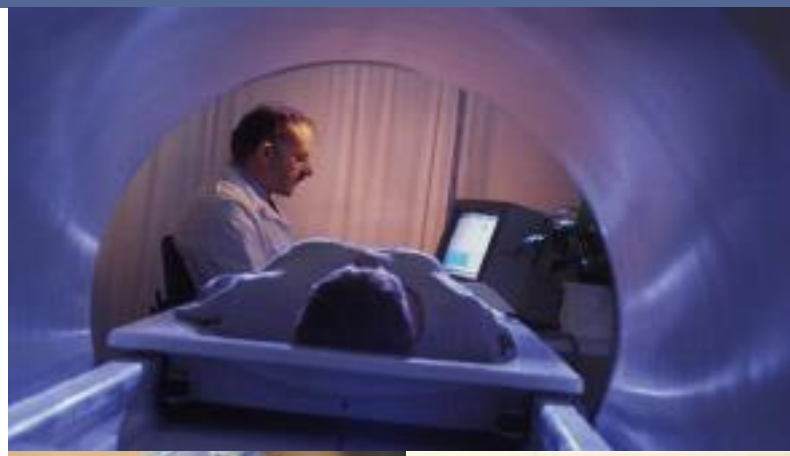
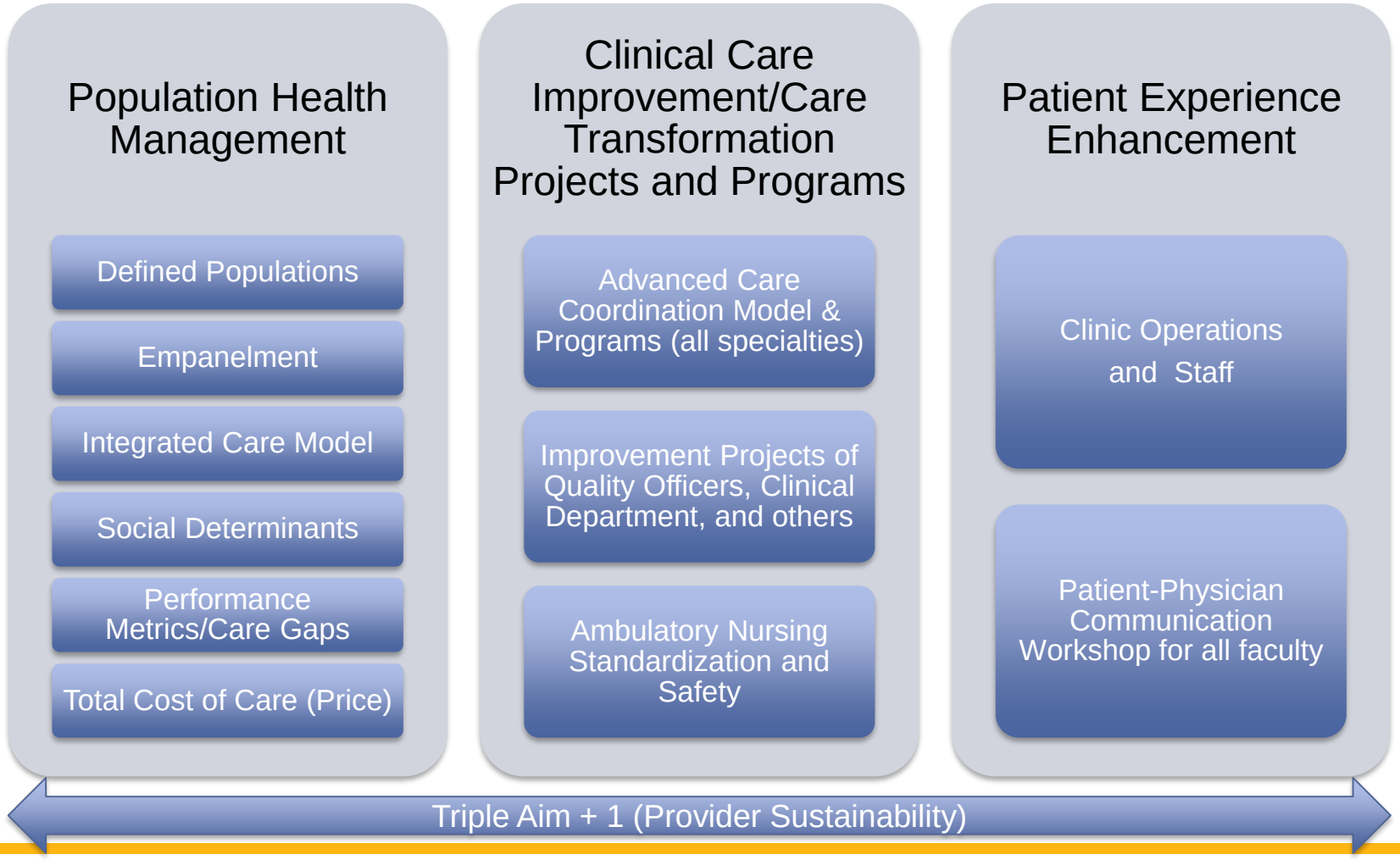
By the Numbers

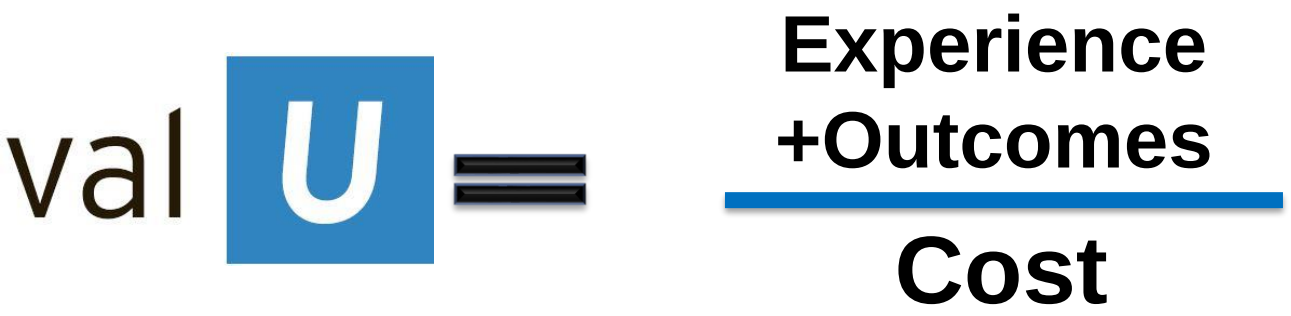
- 600,000 unique patients per year
- 2.7 million outpatient clinic visits
- 80,000 Emergency Department visits
- 40,000 inpatient admissions
- 2,000 faculty physicians
- 25,000 employees



UCLA Health Efforts on Value



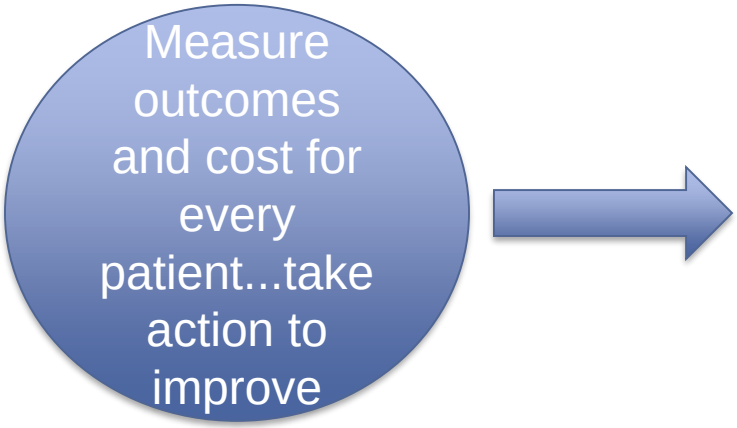
UCLA Health's ValU Care Redesign



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.

val U

Value Based Health Care Delivery



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

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

Determinants of Outcome & Cost	Examples
Medical Care	Care Delivery Model, Provider Network, Access to Care
Individual Behaviors & Wellness	Smoking, Exercise, Healthy Eating, Stress Reduction
Social Environment	Income, Occupation, Transportation
Physical Environment	Air, water, places to exercise, safe buildings
Genetics	Inherited characteristics

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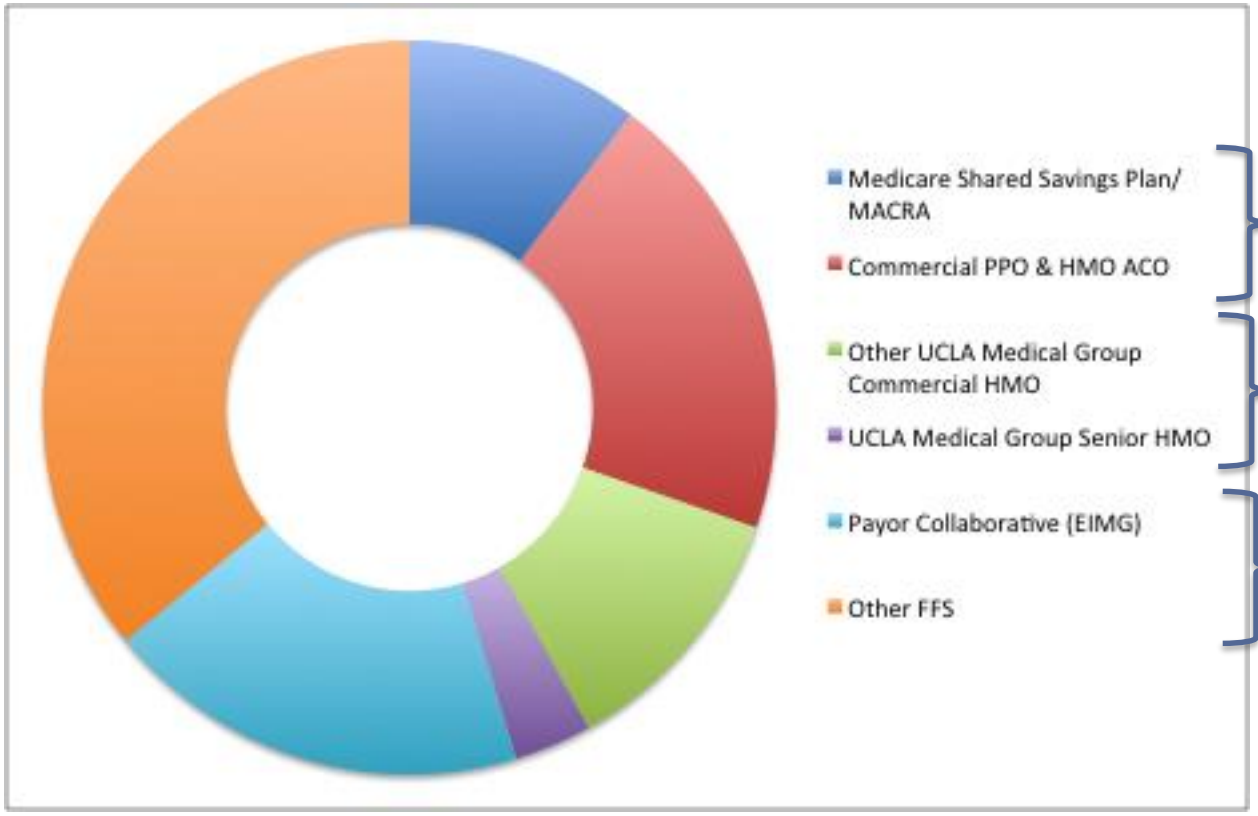
Adapted in part from Kindig DA et al. A population health framework for setting national and state health goals JAMA 2008

Attributed & Empanelment
UCLA Primary Care Population
More than 50% in alternative contracts



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

Appointments: Call, Click, Come in

Share this

We're Here for You

Providing you with easy access to the best healthcare possible is our priority. Contact us however you like, and we'll take it from there.

Did you know?
You can now opt in to **receive text message appointment reminders**. See more below.

Call

If you already have a UCLA doctor:

During normal office hours, call your doctor's office.

After hours, call your doctor's office. Some offices may offer the Nurse Advice Line, where a nurse can answer medical questions, guide you to the appropriate care, schedule an appointment, or direct you to a UCLA Urgent Care location.

If you are new to UCLA, call **800-UCLA-MD1 (800-825-2631)** for a referral to a UCLA doctor or request an appointment online.

Click

Send a non-urgent message: Contact your doctor's office through my.UCLAhealth.org, your electronic health record.

eVisit: Zipnosis offers online diagnosis and treatment services by UCLA physicians for common medical conditions, seven days a week from 8 am to 8 pm. Visit uclahealth.org/zipnosis

Virtual urgent care visits: Visit livehealthonline.com

Come in

Same-day appointments: Call your doctor's office or **800-UCLA-MD1**. For locations, visit uclahealth.org

Urgent Care: visit our Urgent Care offices when your primary care physician is unavailable and it can't wait. These offices have extended evening and weekend hours. For locations, visit uclahealth.org/urgentcare

You can also visit a CVS Minute Clinic near you. Visit cvs.com/minuteclinic for a list of services.

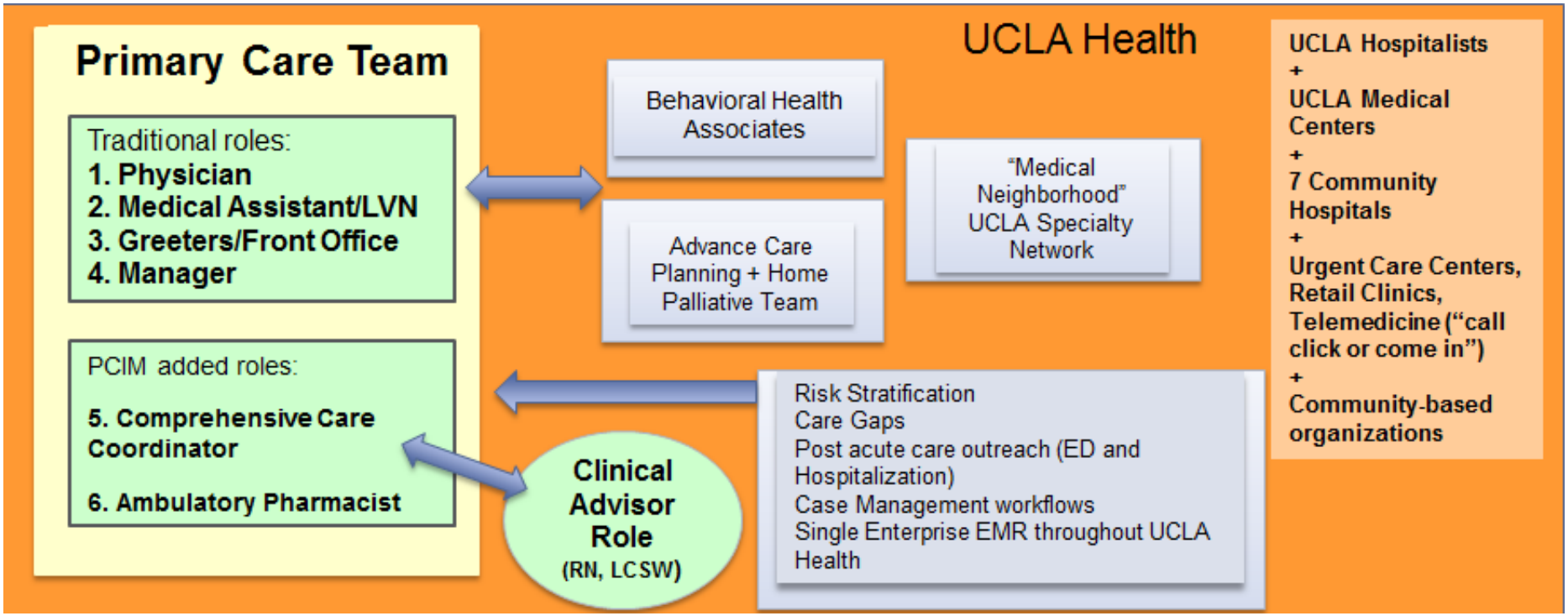
True Emergency, call 911 or go to your closest emergency department.

Opt in for Text Message Appointment Reminders

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

When would you like to come in?

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.[1] This redesign takes many forms, but the term "patient-centered medical home" (PCMH) has come to describe the ideal practice.[2-4] The PCMH is central to healthcare reform, with national organizations (eg, National Committee for Quality Assurance, URAC) having certified thousands of practices as PCMHs and some state programs providing financial rewards for acquiring certifications.[5-7] However, the last decade of experience demonstrates that PCMH transformation is difficult, disruptive, and expensive.[6,8] Although PCMH demonstrations have shown improved outcomes, real-world applications of PCMH practice redesign have inconsistently improved quality and utilization metrics.[9-12] 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[13] and was one of the "7 Joint Principles" promulgated by the primary care societies.[14] Most of the literature on PCMH care

ABSTRACT

Objectives: Although care coordination is an essential component of the patient-centered medical home structure, current case 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 10,500 unique patients over a 1-year period. CCC interventions included execution of care (38%), coordination of transitions (32%), self-management support/link to community resources (15%), monitor and follow-up (10%), and patient assessment (1%). The CCC intervention group had a 20% greater reduction in its prepost ED visit rate compared with the control group ($P < .0001$).

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.

Am J Manag Care. 2015;21(9):623-630

UCLA Health

Integrated Behavioral Health

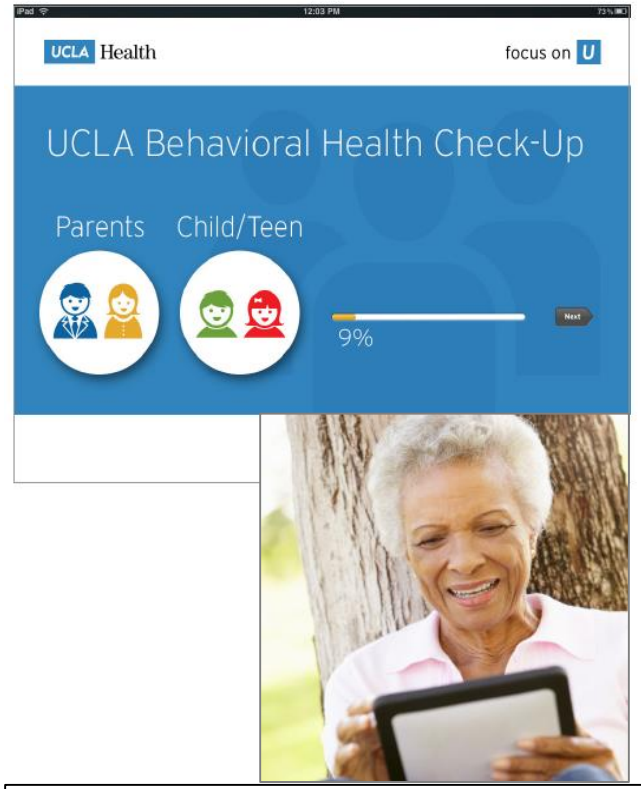
BEHAVIORAL HEALTH

By Robin M. A. Clarke, Jessica Jeffrey, Mark Grossman, Thomas Strouse, Michael Gitlin, and Samuel A. Skootsky

IMPLEMENTATION PROFILE

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.



Behavioral Health Registry Data Management System

HealthAffairs
At the Intersection of Health, Health Care and Policy
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Health Affairs 35, no.8 (2016):1487-1493
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Focus on the Patient Experience

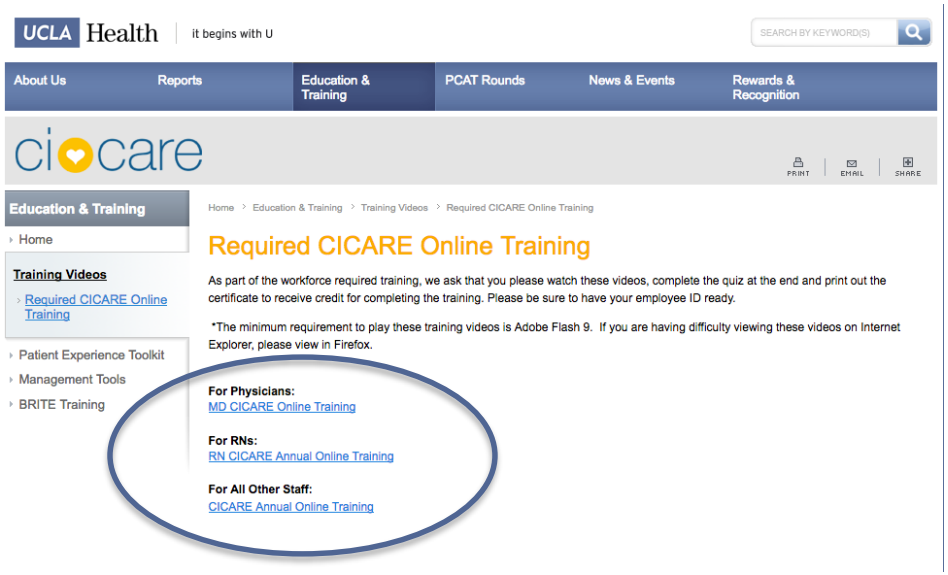
Specialties Differ in Which Aspects of Doctor Communication Predict Overall Physician Ratings

Denise D. Quigley, PhD[1], Marc N. Elliott, PhD[1], Donna O. Farley, PhD[1], Q Burkhart, MS[1], Samuel A. Skootsky, MD[2], and Ron D. Hays, PhD[1,2]

[1]RAND Corporation, Santa Monica, CA, USA; [2]UCLA 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.
J Gen Intern Med 29(3):447–54
DOI: 10.1007/s11606-013-2663-2



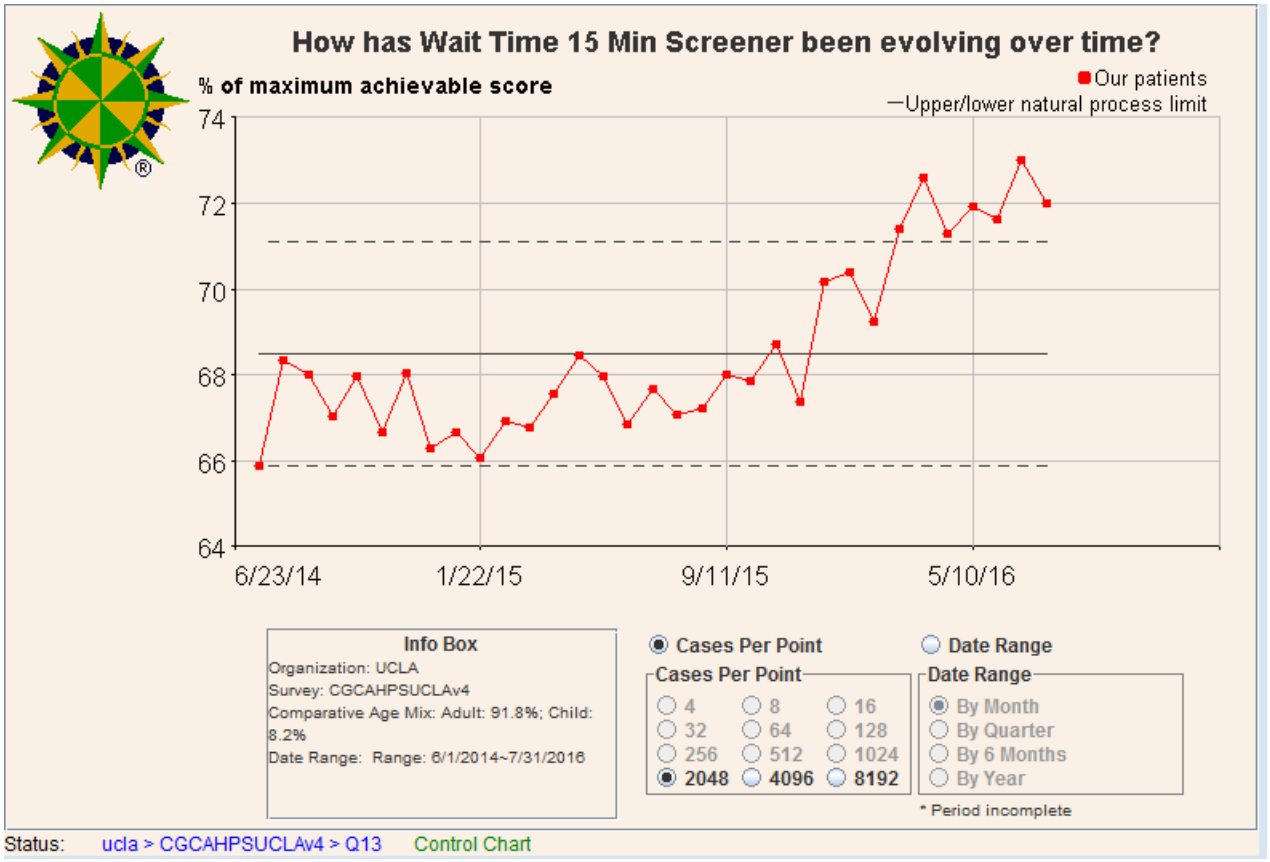
Examples of Value Creation: Patient Experience Improvement

- 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?:

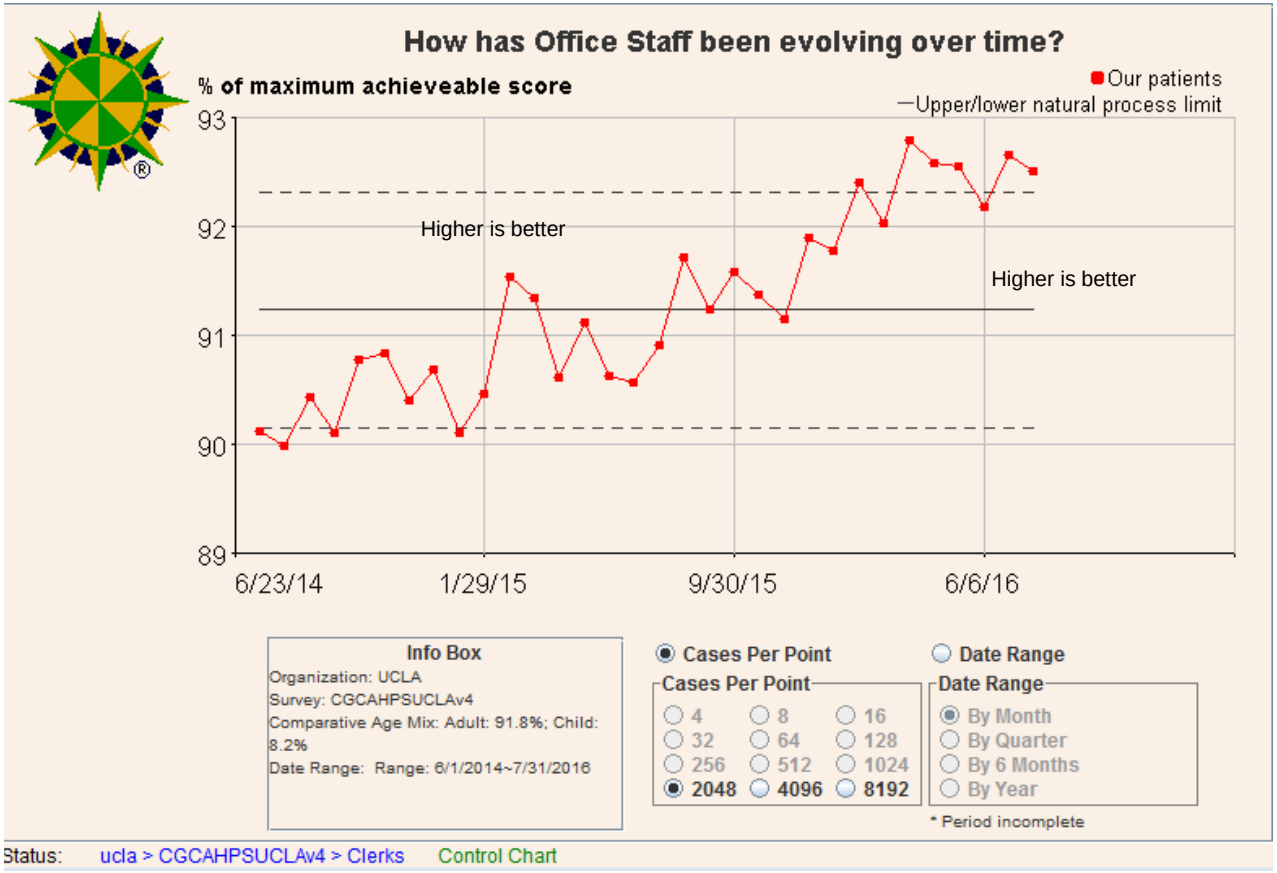
Higher is better



Source: UCLA FPG Survey/QDM Website

Patient Experience Improvement: Patient Experience with Clinic Staff

Overall Rating of Clinic Staff:



Source: UCLA FPG Survey/QDM Website

Patient Experience/Satisfaction

	Press Ganey Percentile Rank				
	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2016 Q1
Santa Monica UCLA Medical Center (Adult)					
HCAHPS-Hospital Rating	71	74	83	74	87
HCAHPS-Likelihood to Recommend	77	84	87	78	92
Ronald Reagan UCLA Medical Center (Adult)					
HCAHPS-Hospital Rating	78	88	87	90	90
HCAHPS-Likelihood to Recommend	89	93	91	90	92

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

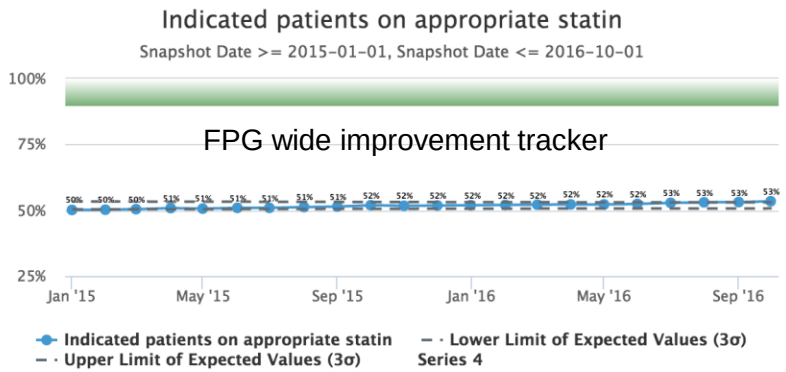
- **Inpatient hospice beds**
- **Nursing Home POLST transition intervention**
- **ACP social worker for prospective work with high risk inpatients**

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

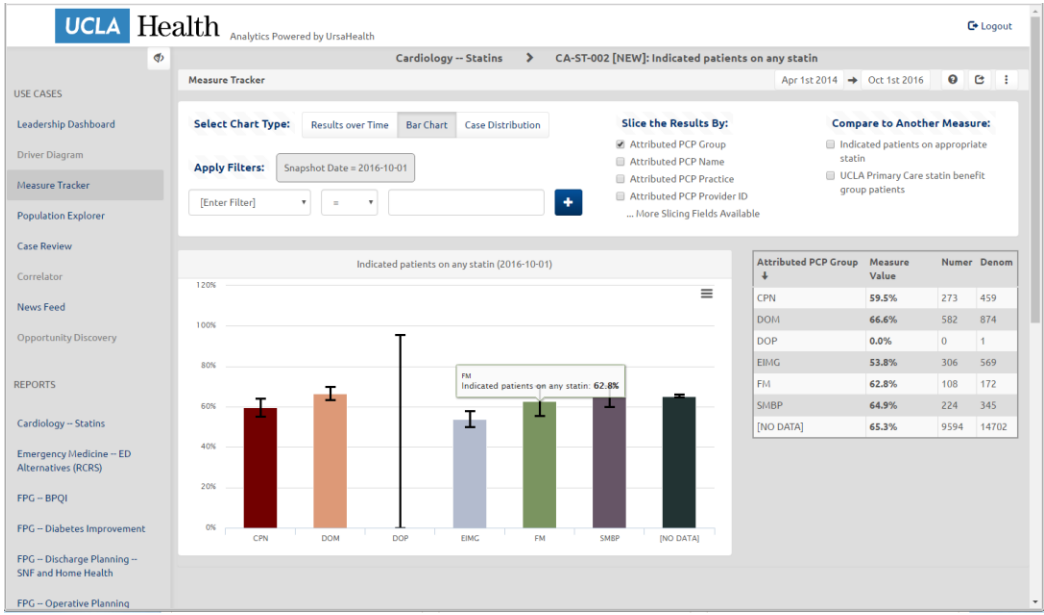
Pharmacy & Therapeutics
Appropriate Statin Use at UCLA Health



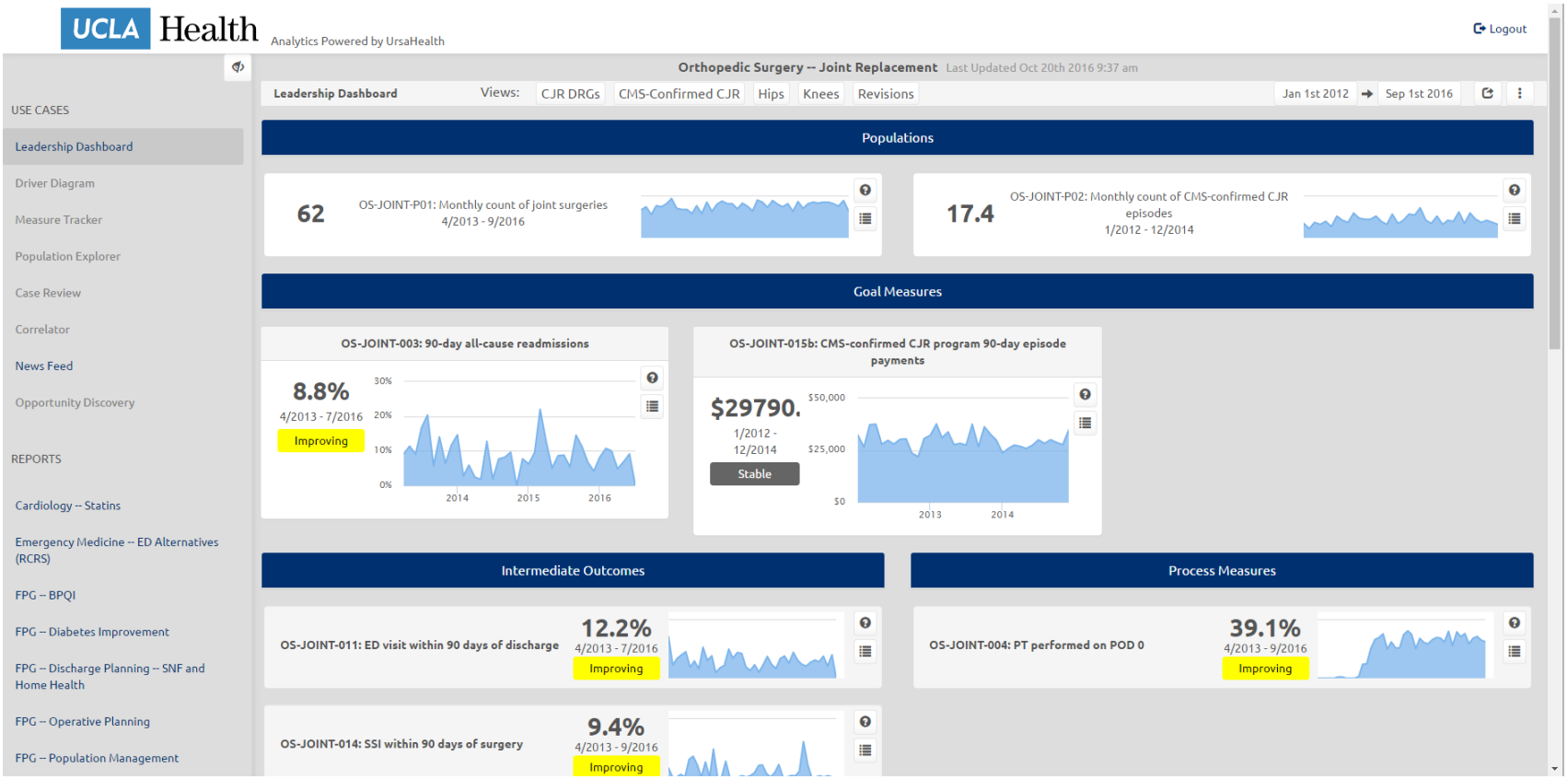
FPG wide improvement tracker

- 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

Custom tracking by PCP administrative unit



Development of CCJR bundles tracker
Custom measures defined by clinicians



UCLA ACO ValU Design Team Collaborative Initiatives

ACO Metric or Activity	Initiative
Reduce Bed Days (LOS, Admissions, Readmissions)	Reduce OB C/S; Reduce NTSV
	Reduce Short Stay Admits
	Care Management Linkage to Ambulatory
	ValU Care Redesign
	PCIM components/Ambulatory Care Coordination
	Inpatient Utilization (in and out of network)
	Home IV Care Coordination
	Hospital Readmissions
Post-Acute Care (LOS, Admissions, Readmissions)	SNF Management
	Home Health/Home Care
ED Utilization	ED Optimization
OPH Surgery	Amb. Surgery Center Development
Appropriate Use of Observation Status & Extended Recovery	Appropriate Use of Observation
Advance Care Planning & Palliative Care	Amb ACP, Inpt & Home Palliative, Hospice
FPG Value Analysis	Creation of Improvement dashboards
Generic Utilization/Pharmacy	High Cost Monitoring/Generic Utilization Rate
Care Gap Improvement	CareConnect Optimization

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**

Example: UCLA-Payor ACO: Involves Joint Operational Activities and Ongoing Commitment

- 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

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

UCLA Health Innovation Ideas that Address System-Wide Goals in Hospitals & Clinics

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.

Leveraging Innovation at UCLA Health

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

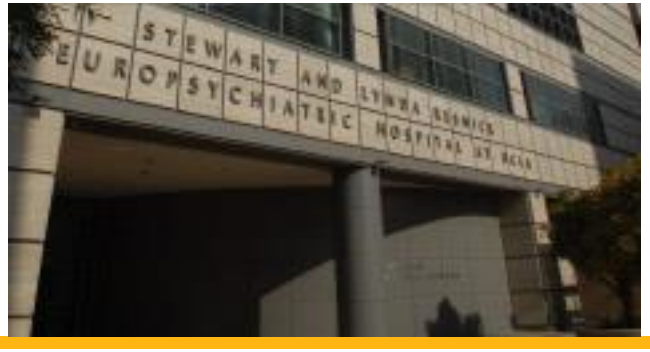
We actively lead and collaborate with other organizations in the local, national and international communities.

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

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THANK YOU !!