UCHealth Integrated Network
How far we have come and where we are going.

UCHealth Integrated Network Engagement Summit

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Transforming health care, together

We see an opportunity to change the way health care is delivered.

Not a member? Learn more
Our 2015 Population Health Strategy

UCHealth needs to be positioned to take the accountability and risk for the clinical quality and outcomes, patient experience, and cost for a population by January 1, 2017

1. Develop the **capabilities** necessary to manage the health of a population and the infrastructure needed to take on risk

2. Demonstrate **value** to payers, providers, employers, and consumers via quantifiable results in a transparent manner

3. Ensure that UCHealth and its affiliates/partners **go-to-market as one** to payers offering a high performing network

4. Create a new **clinically integrated network** comprised of owned and partnered assets across the care continuum

5. Select **strategic payer partner(s)** to collaborate with in new risk-based offerings
Strategic operational framework

UCHealth Integrated Network Board of Directors

- Clinical Committee
- Information Technology Committee
- Finance and Contracting Committee
- Network Development Committee

Population Health Services Organization (PHSO) Operations Workstreams

- Network Development
- Payor Relations
- Clinical Transformation
- Care Management
- Information Technology
- Medical Economics
- Clinical Pharmacy
Create a new clinically integrated network comprised of owned and partnered assets across the care continuum

ASSOCIATES IN FAMILY MEDICINE
Be heard. Be well.

CU Medicine

Yampa Valley Medical Center
Steamboat Springs, Colorado

Parkview Medical Center
UCHealth Integrated Network overview

UCHealthIN provides a platform for health care providers to collaborate, integrate and coordinate care to improve quality and reduce health care cost.

Lives under management

116,000
Total lives

66,500
Commercial lives

49,500
Medicare lives

Program participation (non-exhaustive)

- Anthem Enhanced Personal Health Care (EPHC)
- CIGNA Colorado Accountable Care Collaborative
- Medicare Shared Savings Program – Track 3
- Medicare Comprehensive Primary Care Initiative (CPCi / CPC+)
- Anthem Medicare Advantage
- UnitedHealthcare CPC+
Our areas of collaboration

The Integrated Network will provide the tools to help practices manage their complex patients across the continuum of care.

Population health support services

- Care management
- Disease management
- Transitions of care (including post acute)
- Utilization management
- Clinical pharmacy solutions

Technology and analytics
Care management

Through centralized and embedded resources, we coordinate care across the continuum to prevent gaps in services, provide cost-effective care and avoid unnecessary services.

Our programs

- Care management in the outpatient, inpatient and emergency department settings
- Disease management of chronic and early-onset conditions
- Complex care management for patients with catastrophic illness or injury
- Management of care transitions between acute and post-acute care settings
- Preventive care services to minimize gaps in care and encourage wellness
An example of our care management success

Care managers were assigned to patients with a joint replacement as part of a bundled payment from Medicare that includes post-acute services.

Average Length of Stay in a SNF (Q2 2016 – Q4 2016)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Average Length of Stay (days)</th>
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<tbody>
<tr>
<td>Q2 2016</td>
<td>32</td>
</tr>
<tr>
<td>Q4 2016</td>
<td>20</td>
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Percent of Discharges to Home Health and SNFs (Q2 2016 – Q4 2016)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Home Health</th>
<th>Skill Nursing Facilities</th>
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<tbody>
<tr>
<td>Q2 2016</td>
<td>72%</td>
<td>28%</td>
</tr>
<tr>
<td>Q4 2016</td>
<td>81%</td>
<td>19%</td>
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SNF: Skilled nursing facility
UCHealth Medicare patients with a joint replacement
CJR PAC Summary for CY 2016 Q2 – Q4
A focus on reducing pharmaceutical expenses

*Our goal is to augment and enhance existing PBM efforts through a narrow and individualized clinical approach.*

**Traditional PBM services and cost control framework**

1. PBM administrative overhead efficiency
2. Benefit plan design
3. Rebate management
4. Mail order services
5. Generic substitution
6. Formulary management
7. Narrow pharmacy networks
8. Clinical pharmacy solutions

*Solutions that require a more patient-specific approach or a new way of interacting with the care team have proven more challenging for PBMs.*
Our clinical pharmacy solutions

Our targeted clinical pharmacy solutions

- Medication reconciliation, adherence and monitoring
- Monitoring of brand name drug utilization and appropriate transition to generics
- Reduction in unnecessary medication use
- Management of high-cost, specialty drugs
- Clinical pharmacy management during inpatient admissions and transitions of care

Example of our success

- **40%**
  Of patients taking select high-cost medications were doing so unnecessarily

- **$50,000**
  Annual savings generated from discontinued unnecessary medications

- **Zero**
  Adverse events occurred following discontinuation

Source: “Unnecessary Lipid-Lowering Drugs in an Outpatient Geriatric Clinic”; University of Colorado Seniors Clinic, 2012;
Our technology platform

The CIN’s technological infrastructure provides the ability to implement solutions in a streamlined, coordinated and timely manner.

1 Common electronic medical record platform across UCHHealth, CU Medicine, AFM and other aligned partners with ability to share information with non-Epic providers

2 Integrated care and disease management software tools with access to nationally recognized standards of care

3 Innovative platforms for patients to receive advanced care close to home (e.g., virtual care)
Analytics to support improving population health

**Combining clinical and claims data enables us to proactively identify targeted solutions for patients in need of additional care services.**

1. **Stratus tool and integration of claims data**

2. **Risk stratification**

3. **Performance tracking and reporting**
Examples of our performance

**Anthem EPHC Performance**

- UCHealth and AFM collectively generated more than **$12 million** in total cost of care savings during CY 2016 (actuarially validated)
- Both organizations received significant shared savings payouts as a result of these efforts

**CPCi Performance at UCHealth Timberline Clinic (2013 – 2016)**

- **16% decrease** in total cost of care
- **45% decline** in annual hospital admissions per 1,000
- **20% decrease** in annual emergency department visits per 1,000

2013 – 2016 change for Medicare patients at Timberline clinic
Annual hospital admissions per 1,000 for any cause (248 to 136)
Our ideal network in 2018 would provide coverage for all of the major population centers across the region via both owned assets and strongly aligned partnerships.

- **Recruitment underway**
  - Physician groups
  - Skilled Nursing Facilities
  - UCHealth Facilities and JVs

- **New partnerships**
  - Yampa Valley Medical Center
  - Parkview Health System
Strategic operational framework

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Questions and discussion