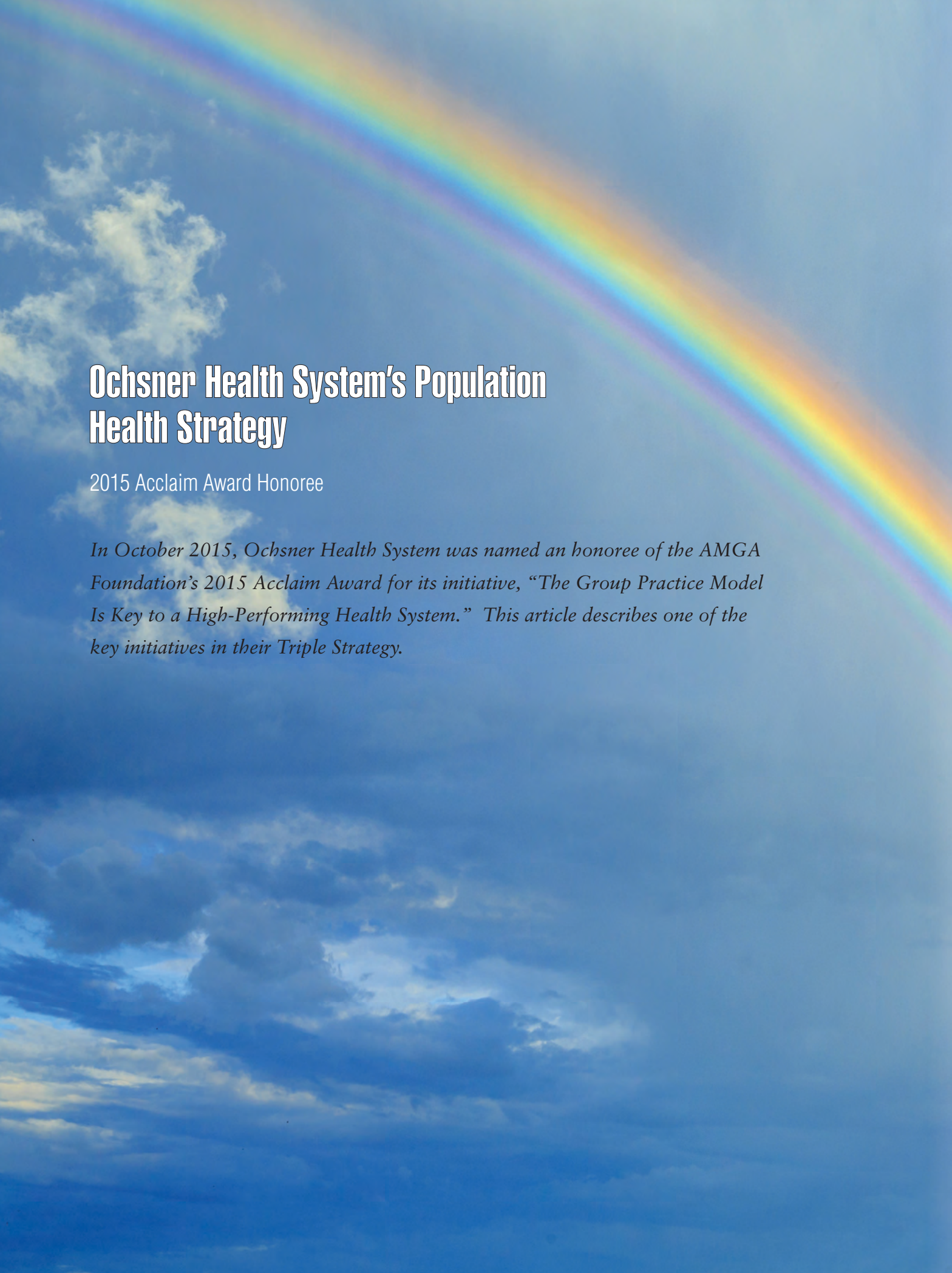


Ochsner Health System's Population Health Strategy

2015 Acclaim Award Honoree

In October 2015, Ochsner Health System was named an honoree of the AMGA Foundation's 2015 Acclaim Award for its initiative, "The Group Practice Model Is Key to a High-Performing Health System." This article describes one of the key initiatives in their Triple Strategy.

Ochsner Health System team accepting the 2015 Honoree Award (from left to right):

W. Michael Hill, Jr., J.D., M.H.S.A., Manager, Office of Strategy Management; Joseph Bisordi, M.D., Executive Vice President and Chief Medical Officer; Richard Guthrie, Jr., M.D., CPE, Chief Quality Officer; and Sandra Kemmerly, M.D., MACP, System Medical Director, Hospital Quality

Ochsner Health System began in 1942 as New Orleans' first multispecialty group practice founded by five entrepreneurial surgeons. Over nearly 75 years, it has evolved to become the region's largest not-for-profit, high-performing healthcare delivery system with more than 1,000 employed physicians, 12 hospitals, 17,000 employees, and 60 health centers. More than 623,000 patients come to Ochsner annually from all 50 states and more than 80 countries to seek care from talented physicians and in more than 90 medical specialties and subspecialties. All of its hospitals and clinics are on one electronic health record, which improves care coordination for patients. The organization also has a long history in post-graduate and undergraduate education, training 375 residents and fellows last year in 27 ACGME-accredited programs.

Ochsner's strategy is based on creating value for stakeholders and follows its mission to "Serve, Lead, Heal, Educate, and Innovate." Its employees are committed to providing the highest quality care at an affordable cost, and also to ensuring that when patients must leave home for care, that they don't need to leave the state. In this regard, Ochsner cares for its regional population and is a resource for others through the Centers of Excellence strategy.

In October 2015, Ochsner Health System was named an honoree for the 2015 Acclaim Award presented through AMGA Foundation. As part of the application process, Ochsner was asked to highlight two narratives describing the design and deployment of two major components—projects, phases, or tactical plans—that were part of its plan to transform the way it delivers health care in order to more fully achieve the AMGA High-Performing Health System™ attributes, improving both the quality and cost of care. This article highlights one of those projects.

Ochsner's Vision for the Future

In 2005, New Orleans was devastated by Hurricane Katrina, a natural disaster that displaced much of the population and left real questions around the future of health care in the region. The disaster reduced the city's hospital beds from 4,083 to 1,971, and physicians from 4,486 to 1,877. The side effects of this disaster are still felt today and directly impact social and economic factors as well as health statistics of the area. Access to care, a large homeless population, and high rates of chronic disease all plague southeastern Louisiana. Following the disaster, Ochsner made a deliberate commitment to provide the region with access to a vibrant and renewed high-performing healthcare system by investing in a regional system of care. By acquiring a number of facilities, Ochsner created access for patients while establishing places for returning community physicians to practice. Over the next several years, Ochsner transformed from an exclusively-employed group practice with a single, closed-staff academic medical center to a regional system of care that is open, inclusive, and geographically diverse.

In the face of these shifting dynamics, Ochsner developed a case for change and defined where it wanted to be by 2020. The healthcare provider of the future must **Be Better** through quality, safety, access, and care coordination. It must also **Be Faster** by refining

processes, anticipating market changes, and cooperation. It must **Innovate** by developing new care models, understanding and executing on disease management, implementing technology, and creating best practices. It must also **Be Leaner** through reduced waste and streamlined processes. It must **Be Convenient** for patients to use and access. It must **Be Transparent** in quality, costs, and outcomes. And finally, it must **Be Bigger** through partnerships that allow it to leverage scale to reduce cost.

To achieve this vision, Ochsner operates under a "Triple Strategy."

1. **Destination Center:** Be the place where people want to be cared for in their time of need
2. **Population Health Center:** Create value by improving quality and total cost of care for defined patient populations
3. **Solution Center:** Be the trusted partner in care for other healthcare delivery systems (See Figure 1).

In order to successfully execute on this Triple Strategy, Ochsner developed an operating plan called the *Plan to Win,* comprised of four components: Prove Our Value, Serve More Patients, Make Care Affordable, and Shape the Future. The Plan to Win has specific metrics and goals that allow all leaders and front-line staff to gauge progress around achievement of the Triple Strategy.

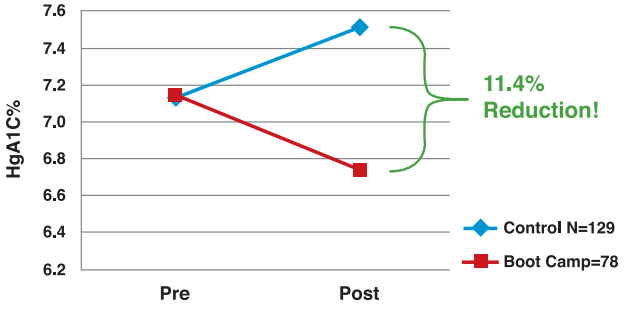
Population Health Center

For Ochsner, becoming a Population Health Center means creating value by improving quality of life and cost of care for targeted populations of patients. The Population Health Center strategy focuses on primary care, care coordination, chronic disease management, and population health.

The inspiration behind Ochsner's commitment to transform this aspect of primary care was the national transition from fee-for-service to value-based payments. Fee-for-service focuses on volume, specialists, and incentives that encourage overutilization.Value-based payments, on the other hand, focus on quality and cost, primary care, and aligned—or the *right*—incentives. The result is a change in the balance of primary care from expense per visit, more visits, and RVUs to expense per capita, outside provider expense, clinical documentation that permits accurate severity assessment, and longitudinal quality measures that assess primary and secondary prevention. This transformation meant a total culture shift within Ochsner's Primary Care Department (the Department)—both at OMC-Jefferson Highway (Ochsner's flagship campus) and across the Ochsner Health System.

FIGURE 1
Triple Strategy Venn Diagram

FIGURE 2
Diabetes Bootcamp Pilot



The design process was led by the Chair of Primary Care, also a member of Ochsner's Board of Directors. The Chief Medical Officer, Medical Director of Accountable Care, and Vice President of Accountable Care all contributed to the design and provided executive support for the project. In the early stages of development, the Department outlined a vision for primary care: Better Patient Experience, Serve More Patients, Lower Cost, and Care for the Caretaker. For the new model to be successful, it had to be patient-centered and engage the patient as part of the health team. Ochsner invested heavily in the project, opening a new, 82,000-square-foot, 90-exam-room Center for Primary Care and Wellness across the street from OMC-Jefferson Highway in February of 2013 and recruited 25 additional primary care physicians. The Center accommodates 36 clinical teams in three separate clinic pods, using a "teamlet" approach to care.

The Center for Primary Care and Wellness provides a team-based approach to patient care, including MAs, LPNs, RN clinical care coordinators, health coaches, complex case managers, social workers, certified

diabetes educators, nurse practitioners, physician assistants, physicians, pharmacists, DME representatives, receptionists, financial coordinators, and revenue cycle professionals. This approach represents a significant transformation from the previous encounter-based model featuring one physician and one MA overseeing the care of every patient. The new approach ensures that Ochsner can provide a broader range of services required to accept population health responsibility.

Part of the success of the team-based approach to care was the recruitment of primary care providers that fit the new culture. The Department Chair of Primary Care appointed a senior primary care physician with a great knack for recruitment to "fill up" the Center for Primary Care & Wellness.The department had a three-year recruitment plan to attract primary care providers to Ochsner and away from local competitors. The plan involved marketing Ochsner as "THE best place to work," and treating each and every recruit "as a bar of gold." The goal was to have 50 primary care physicians and advanced practice providers added across the region and throughout Ochsner Health System. The department surpassed that goal by adding 42 primary care physicians and 12 advanced practice providers. With these providers, Ochsner was better able to see the 130,000 unique primary care patients in 2014. Finally, provider engagement is rated in the 99th percentile.

Access

The Department of Primary Care developed a plan to provide patients with access to the great care they deserve. Ochsner began to introduce weekend and after-hour access in the Department with hours ranging from 8:00 a.m. to 8:00 p.m. on the weekdays, and Saturday and Sunday clinic hours throughout the region. The Department also collaborated with an urgent care group and retail nurse practitioner based clinics to provide additional access for patients who could not be seen during work hours. A "Do You Feel You Need to Be Seen Today?" initiative worked well in the Department, and almost all patients who needed same-day access to care were seen the same day. The Chief Operating Officer and Chief Medical Officer provided the executive encouragement for achieving same-day access at leadership retreats.

Many areas needed rework prior to the primary care group moving to the new Center for Primary Care and Wellness. Fortunately, Ochsner has a Project Management Office (PMO) that is proficient in Lean methodology, Six-Sigma techniques, and change management. The PMO teaches employees and leaders the basics of Lean with the expectation that they will complete Lean projects in their respective departments. The Department solicited the help of the PMO for a number of projects, including clinic space design, registration, rooming, checkout, depression and fall risk screenings, clinical documentation, standardized work, and physician messaging. RVUs, unique patients, visits, throughput, and employee engagement increased year over year after the implementation of these projects.

Out of the many project workouts, a few great ideas were born. One was to create a rooming standard, which was a checklist of items that the MA or LPN goes over with the patient to standardize care—the individual reviews the chief complaint, vital signs, allergies, medications, pharmacy, MyOchsner patient portal signup, and fall and depression screenings before handing off the patient to the physician. Another idea was to create written order guidelines, which permit an MA, LPN, or RN (without the physician) to order age- and gender-appropriate preventive health screening interventions.

An important piece in the success of the primary care transformation was the engagement of leadership, physicians, and front-line staff in decision-making.

An important piece in the success of the primary care transformation was the engagement of leadership, physicians, and front-line staff in decision-making. The "workouts" associated with the projects involved management, MAs, LPNs, primary care physicians, APPs, etc. These "workouts" allowed those doing the work to get together and develop the answer to a problem. After the solution was identified, each individual was invested in the outcome. The transformation of primary care did not happen by top-down ultimatums. It came about through solidarity, teamwork, and collaboration, which can readily be replicated at other organizations.

Chronic Disease Management

Ochsner recognizes that population health management requires prevention and chronic disease management. Ochsner is focusing its attention on ambulatory quality metrics, such as the Healthcare Effectiveness Data and Information Set (HEDIS), and the quality metrics associated with Ochsner's Medicare Shared Savings Plan Accountable Care Organization. Physicians and APPs are engaged in the "Drive for Five," meaning the organization's goal is to reach 5

Stars in HEDIS in their Medicare Advantage population. Data is trending upwards, as HEDIS scores moved from 5 stars in 9 of 15 measures to 5 stars in 11 of 15 measures, i.e., 4.08 in 2012 to 4.17 in 2013.

As part of HEDIS analysis and a continued example of Lean work in action, Ochsner found that not all primary care physicians and APPs were conducting or documenting screenings for depression or fall risk. In fact, there was no workflow to screen for these risks. The Department collaborated to create a workflow in Epic (Ochsner's electronic health record) as well as a Standard Operating Procedure for all clinical staff. The new workflow was incorporated into the Intake process and piloted for two weeks to gain feedback. Following the successful pilot, the workflow was implemented system-wide. Physicians reported that the workflow was efficient and did not interfere with their activities. Ochsner now screens 99.57% of patients for fall risk and 77.21% for depression. Ochsner compares well to the HEDIS target of 73.3% and 51.8%, respectively.

Ochsner is actively utilizing disease registries and chronic disease management tools, such as Healthy Planet (Epic's population health module). Healthy Planet has five registries—diabetes, hypertension, asthma/COPD, tobacco cessation, and CHF. These registries allow the organization to better identify care gaps for patients with chronic diseases. Based on the results in the registry, a patient with diabetes can receive proper interventional care. This functionality has permitted Ochsner to do better on HEDIS chronic disease management metrics

In addition to identifying patients with chronic disease, Ochsner has proactively developed initiatives to educate newly diagnosed patients. For example, Ochsner introduced a Diabetes LifePlan for patients newly diagnosed with diabetes. The continuum of the LifePlan begins with the initial diagnosis by primary care, where the patient receives counseling and information. The primary care physician follows all protocols for testing and follow-up intervals. The patient is then referred to Diabetes Bootcamp, which is run by a diabetes-trained nurse practitioner, diabetic educator, dietitian, and pharmacist. The visit is two hours, with all three providers rotating with the patient.The results are tremendous and show that the boot camp population drastically improved their HgA1c% over the control group (see Figure 2). The patient is then sent back to his/her primary care physician. If the primary care intervention isn't working well, then the patient is referred to the Diabetes Empowerment Clinic.

The multidisciplinary Diabetes Empowerment Clinic keeps the care within the patient's "medical home." There is a standardized intervention of labs, diabetes education, provider visits, and health coaching. The goal is to end intensive care at six months with a clear transition back to the primary care provider with better individual results for the patient. Finally, the patient is introduced to long-term diabetes management, which might take the form of a physician, nurse practitioner, optometrist, nephrologist, neurologist, podiatrist, and vascular specialist.

Similar to the Diabetic LifePlan, the organization utilizes a tobacco cessation registry to identify current smokers and refers them to a Tobacco Cessation Program. The program is a partnership with Louisiana's Tobacco Trust which offers free cessation counseling and medication for smokers. It is estimated that there are 200,000 individuals who meet this criteria in the state, and 80,000 of Ochsner's patients. This intervention is just getting off the ground, but is showing great progress.

The transformation of primary care from volume to value is a continuing lesson in hard work and perseverance. It is clear that physicians must be involved in the decision-making process, along with those individuals affected by the workflow. Ochsner's Chief Medical Officer created a Primary Care Council composed of providers from all sites in the Health System and included committees on compensation, practice reengineering, population health and quality, academics, and recruitment/retention/growth. The Council was empowered to make decisions with support of the Chief Medical Officer. Executive buy-in on a clear vision and strategy is also incredibly important to success.

A Rainbow

Ochsner Health System has come a long way since its founding in 1942. Ochsner survived a natural disaster that could have very well destroyed health care in New Orleans. The disaster did have a rainbow, as it led Ochsner to commit to serving the health needs of a regional population focusing on providing the highest quality care at an affordable cost. The large, multispecialty group practice model once again leads the way. Indeed, Ochsner physicians are providers who are better together than apart.

Based on the Acclaim Award application of Ochsner Health System, submitted by W. Michael Hill, Jr., J.D., M.S.H.A., manager, Office of Strategy Management.