Evolving Towards Value: Aligning Physicians with Population Analytics/Medicare Advantage, Managed Care, ACOs and Other Risk-Based Contracts

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Physician Partners
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Agenda

• Overview of Ochsner Health System

• Population Health Management

• Aligning Physicians for Value
  – Ochsner Physician Partners

• Ochsner’s Pursuit of Value Initiative
  – Cost Engineering
  – Clinical Variation Reduction
  – Process Improvement

• Results and Key Learning
**Ochsner Health System**

*Our Mission is to Serve, Heal, Lead, Educate, and Innovate*

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**Largest Health System In Louisiana**

- 10 Hospitals (Owned & Managed)
- 15 Affiliated Hospitals
- 45 Health Centers
- 950+ group practice physicians in over 80 subspecialties
- 250+ Aligned Community Physicians
- 1,600 Community Physicians
- 14,000+ employees
- #1 fitness chain in Louisiana
- 8 of 12 specialties nationally ranked by U.S. News & World Report

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**2014 Budgeted Patient Activity**

- More than 57,000 discharges
- More than 1.5 Million clinic visits
- More than 270,000 ED visits
- More than 6,600 Deliveries

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**Revenue ($B)**

- 2010: $1.6B
- 2012: $1.8B
- 2013: $2.0B
- 2014: $2.2B
Proven Quality - Top 1% in U.S.

#1 Transplant Of Liver
# 2 Transplant Of Kidney
#2 Trauma Care
#4 Heart Attack Treatment
#6 Overall Surgical Care
#9 Gastrointestinal Care
#9 Interventional Carotid Care
#9 Neurologic Care

THE LEAPFROG GROUP

TRUVENT HEALTH ANALYTICS

100 TOP HOSPITALS

BECKER'S HOSPITAL REVIEW

AMERICA'S 100 BEST HOSPITALS 2014
Ochsner’s Dual Strategy

Center of Excellence Strategy

Being The Place People Want To Come To

Population Health Strategy

Focus on Wellness and Effective Management of Chronic Disease

Fee For Service

Global Payments
Ochsner is Leading the Transition to Value-Based Healthcare

Crossing the Crevasse

**Fee for service**
- All about volume
  - More visits
  - Duplicate tests
  - More procedures
  - Complications
  - Readmissions
- Focus on specialists
- The wrong incentives

**Value-based payment**
- All about quality & cost
  - Transparent data
  - Managing populations
  - Accountable care
  - Clinical variation
  - Reward quality
- Focus on primary care
  - Aligned incentives
Ochsner Risk Populations

- Full risk
  - 30,000 Medicare Advantage seniors (Humana)
  - 17,000 employees + dependents (self-insured)
- Shared Savings
  - 22,000 Medicare (ACO-MSSP)
  - 9,000 Medicare Advantage (PHN)
  - 47,000 BCBSLA commercial
  - 7,500 CIGNA commercial
  - 15,000 United commercial
- Total risk: 137,500 out of 385,000 (>1/3)
The Distribution of Costs Across a Population

Source: AHRQ Healthcare Costs, 2011
Plan, Coordinate & Manage Care

**Goals**

- Population Health
  - Prevention
  - Disease Management
- Patient Experience
  - Access
  - Care Coordination
- Total Cost of Care
  - Resource Stewardship
  - High Value Network

**Tools**

- McKesson Registry
- Quality Metrics (HEDIS)
- CHF Telehealth, COPD program, Diabetes Boot Camp
- Expanded Hours
- Take Care Clinics
- Health Coaches
- Complex Care Managers
- Transition Navigators
- Pursuit of Value
- ED Avoidance Program
- Generic Dispensing
- Post Acute Network
- Clinical Integration Network
Ochsner Infrastructure Investment ready to Deliver Value under Healthcare Reform

**Physician Alignment**
- Ochsner Physician Partners

**Medical Home Infrastructure**
- Embedded Care Coordinators

**Primary Care Access**
- Same/Next Day Appointments
- Extended & Weekend Hours
- Walgreens Take Care Clinics

**Electronic Medical Records**
- Epic

**Patient Activation**
- My Ochsner Patient Portal
- Ochsner Telemedicine
- Ochsner Executive Health
- Ochsner Corp. Wellness

**OHS Post-Acute Affiliations**
- 17 SNF Affiliations
- LTAC JV
- Home Health JV

**Care Management Programs**
- Complex Case Managers
- Transition Navigators
- Pure Healthy Back
- 85% Generic Drugs
  - Project RED
  - Pursuit of Value

**Population Health Analytics**
- Quality Reporting
- Financial Reporting
- Utilization Reporting

**Investment in Patient-Centered Care Management**

**Information Exchange**
- Community Connect
- Epic Care Link
- HIE
Connecting with **More Patients in More Ways**

**31** Telemedicine Sites
- **11** New Sites This Year (Now in MS)
- **1,500** Consults Since Jan 2013
- **17,000** eICU Patients Seen
- **3,000th** Telestroke Consult

**Clinical Support for Providers**
- Specialty Patient Consultations
- Remote Interpretations

**Consumer Direct Services** Coming Soon
Driving Down The Cost Of Care

Cost Trend Per Humana Medicare Advantage Member

2009: 4.80%
2010: 3.70%
2011: 0.60%
2012: -0.90%
2013: -6.40%
2014YTD: -4.70%
It’s About Aligning Around Value…

One Patient
One Team
One Network
Aligning Physicians for Value Creation

- How does aligning physicians fit into a population strategy and why is it so important?
- What are the needs of physicians and what solutions does a system have to help them?
- What alignment models are available and how do they function?
- What are the benefits for both independent physicians and system?
- What progress has our system made to date and what are our future plans?
- What incentive structures are effective?
Vision for Improvement: Institute of Medicine Sept. 2012 report

- Real-time access to knowledge
- Digital capture of the care experience
- Incentives aligned for value
- Full transparency
- Engaged, empowered patients
- Leadership-instilled culture of learning
- Continuous learning and system improvement
Multiple factors making change difficult ...

- Fragmented system of healthcare leading to:
  - Over-utilization and waste
  - Gaps in care due to miscommunication
- Rising complexity of modern healthcare
- Economic uncertainty for physicians due to changing payment models
- Unsustainable cost increases year-over-year

Issues are compounded as most providers lack the resources and/or infrastructure to handle these issues
Uncoordinated & highly complex ...

- Fragmented system of care
  - Low levels of coordination of care / poor efficiency
  - Poor quality of care / outcomes below potential
- Rising complexities
  - Physicians in private practice interact with as many as 229 other physicians in 117 different practices just for their Medicare patient population (IOM, Sept. 2012)
Physician employment, medical group ownership continue to rise

**Hospitals Employing or Affiliating with Physicians**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Employment</th>
<th>Other Formal Affiliations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>76%</td>
<td>11%</td>
</tr>
<tr>
<td>Orthopedists</td>
<td>39%</td>
<td>24%</td>
</tr>
<tr>
<td>Neurologists</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>General Surgeons</td>
<td>39%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Medical Group Ownership**

- Physician Owned: 2005 (69%), 2006 (26%), 2007 (69%), 2008 (39%), 2009 (58%), 2010 (39%)
- Hospital Owned: 2005 (26%), 2006 (37%), 2007 (39%), 2008 (39%), 2009 (39%), 2010 (39%)

Physicians currently employed or under contract: 44.8%

Hospitals reporting increase in physician employment requests: 70%

The Landscape of Alignment Options

Integration

Level of alignment

Autonomy

Degree of difficulty

Accountability

Hospital-based specialty contracting

Independent MDs with hospital privileges

Clinical integration

EHR

Physician lease

Management services

Practice management

Co-management

Multi-specialty group clinic

Employment of PCPs & specialists
Our Current Physician Landscape

3,500 total MDs in our four regions*

1,000 Ochsner group practice MDs
217 aligned Ochsner physician partners
- 80 primary care
- 137 specialists
96 aligned physician partners in co-management
2,400 independent physicians
High-acuity referral opportunity

* Includes 900 physicians employed by other hospitals
Key Elements of Clinical Integration

- **Participating Physicians agree to furnish care according to mutually approved clinical care protocols**
- **Participating Physicians pay to participate in the CI Entity (typically annual fee)**
- **Participating Physicians agree to use (inter-operative) electronic health records systems**
- **CI Entity imposes sanctions for noncompliance by any Participating Physician**
Clinical Integration Arrangements

- The Clinical Integration Entity is not a clinical services provider, but it has payor contract signatory authority for the participating Providers (requires antitrust review)
- The MSO provides infrastructure and administrative support/services for the Clinical Integration Entity for fair market value fees
- The MSO offers participating Providers EHR access/services and a menu of administrative support/services, all for fair market value fees
Ochsner Physician Partners

• Mission
  – We will enhance the value of care we provide across our network through a partnership with physicians that is patient centric, quality driven and cost effective.

• Vision
  – To be the Clinical Integration network of choice for community physicians committed to realizing clinical, financial and personal rewards associated with their active engagement in Ochsner Physician Partners.
Ochsner Physician Partners: Current State

- **1226 +** MD’s: Community and OHS employed
  - 217 total OPP community members
  - 38 different specialties represented
  - 80 Primary Care (37%)
  - 137 Specialists (63%)
CI Network Success Factors

Value Our Partners Program
Shared Savings

Value Based Contracts
*FFS
*Incentive
*Performance

EMR Subsidy Registry
Connectivity: Epic Care Link-Hyperspace

Flow of Funds

Contracting Options

Information Technology

Performance Improvement

Legal Options

Physician Leadership

Participation Agreement

Criteria: Payor and OPP
Quality Rounds
Practice Coordinator

Subsidiary LLC

Physician Led Dyad Model

Clinical Integration
Ochsner Clinical Integration
Payor Contracting

All Contracts Gated By Quality Metrics

Humana Medicare Rewards Agreement
Effective 5/1/2012
ONLY Community MD

Humana Commercial Rewards Agreement
Effective 10/1/2013
OPP Network: Employed/Community

BCBS Quality Blue Primary Care Agreement
Effective 4/1/2014
OPP Network

BCBS Quality Blue Value Partnership Agreement (shared savings)
Effective 4/1/2014
OPP Network

United Shared Savings Agreement
Effective 8/1/2014
OPP Network

Aetna Shared Savings Agreement
Effective Q1 2015

Value Based Contracts

FFS- Commercial
Aligning for Value with Community Physicians

- Physician leadership and engagement
  - Committees, POV, website

- Information technology
  - High-speed internet, EHR, registry (carrots)

- Care coordination/patient experience
  - Practice coordinator, performance improvement

- Quality/efficiency performance
  - HEDIS, hospital quality metrics
Physician Leadership and Engagement

Operating Committee

• Create and approve strategic plan
• Approve network design
• Recommend network policy
• Approve new partner credentialing & partnership status
• Oversee contract performance
• Appoint subcommittee partners
• Approve payor contracting recommendations
• Approve distribution model
• Present annual report to the Board
• Recommend capital and operational budget for CI Program
Physician Leadership and Engagement

- **PAYOR STRATEGY**
  - OVERSEE OPP’S PAYOR STRATEGY AND CONTRACTING ACTIVITIES
  - EVALUATE COST/BENEFIT OF CONTRACT OPPORTUNITIES WITH OPP MANAGEMENT
  - APPROVE PAYOR CONTRACTING RECOMMENDATIONS
  - PRESENT ANNUAL REPORT TO THE BOARD
  - RECOMMEND CAPITAL AND OPERATIONAL BUDGET FOR CI PROGRAM
Physician Leadership and Engagement

- **Network Development & Credentialing**
  - Oversee physician recruitment and credentialing process
  - Develop an efficient application and credentialing process for OPP members
  - Develop and implement a process for assessing and managing the performance of physician members
  - Provide the OPP Operating Committee and Board with an annual report of committee activities
Physician Leadership and Engagement

- **Performance Improvement**
  - Oversee design and implementation of OPP Performance Improvement Plan (Quality, Safety, Efficiency and Patient Satisfaction)
  - Ensure CI Program meets regulatory requirements
  - Implement and oversee Population tools
  - Develop plan for monitoring all OPP member quality
  - Recommend clinical initiatives for network focus
  - Recommend performance improvement measures for OPP scorecard
  - Update OPP Operating Committee and Board with activities
## Ochsner IT Platforms for Population Management

<table>
<thead>
<tr>
<th>IT Platform</th>
<th>OHS group practice (950 MDs)</th>
<th>OPP groups (204 MDs)</th>
<th>Other (2,400 MDs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR</td>
<td>Live 12/11 (900+MDs)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>EHR Community Connect</td>
<td>N/A</td>
<td>Live 12/11 (48 MDs)</td>
<td>TBD</td>
</tr>
<tr>
<td>Other EHR</td>
<td>N/A</td>
<td>Non group (115 MDs on 27 EHR platforms)</td>
<td>Unknown</td>
</tr>
<tr>
<td>No EHR</td>
<td></td>
<td>Live (407 MDs in 85 practices)</td>
<td>Live (407 MDs in 85 practices)</td>
</tr>
<tr>
<td>EHR access</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient registry</td>
<td>Live 8/13 (900+MDs)</td>
<td>Go live TBD</td>
<td></td>
</tr>
<tr>
<td>Patient analytics</td>
<td>Live 6/14 (900+MDs)</td>
<td>Go live TBD</td>
<td></td>
</tr>
</tbody>
</table>
IT Elements for Population Management

- Enterprise data warehouse
- EHR platform
- Population registry
- Population analytics
- Predictive modeling
- Interoperability across the continuum of care
Considerations in EHR Rollout

- Physician leadership and engagement
  - Autonomy, lack understanding, willingness to change, cost
- Information technology
  - Competition for resources across platforms
- Care coordination/ patient experience
  - Office support, current workflows
- Quality/efficiency performance
  - Branding, on-going support, ownership
Practice Coordinator Program

• Designated by each practice (clinical or non-clinical)

• Quality improvement curriculum (i.e., Clinical integration, Shared savings, HCCs, ED Avoidance)

• Quarterly meetings to review quality performance and suggest new systems of care delivery
Quality / Efficiency Performance
## OPP Quality Analysis

### Date: 1st-3rd Quarter 2013

| Category | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 | Q1 13 | Q2 13 | Q3 13 |
|----------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| # members in the Practice | 203 | 220 | 220 | 638 | 674 | 644 | 284 | 304 | 270 | 17 | 98 | 49 | 49 | 71 | 104 | 186 | 202 | 44 | 40 | 80 | 503 | 546 | 556 | 27,898 |
| Re-admit Rate, 30-day (Target:<12.5%) | 6.7 | 0 | 8.6 | 11.8 | 10.8 | 9.5 | 9.1 | 5.3 | 0 | 25 | 16.7 | 0 | 50 | 0 | 18.2 | 16 | 16.7 | 33.3 | 0 | 5 | 10.5 | 10 | 14 |
| HEDIS: |
| BMI (Target:61%) | 94 |
| Osteoporosis (Target: 60%) | 28 |
| Colorectal CA Screening (Target:58%) | 94 |
| Breast CA Screening (Target:74%) | 94 |
| Cholesterol Screening(Target:85%) | 94 |
| Glaucoma Screening(Target:70%) | 79 |
| Comprehensive Diabetes Care(Target:71%) | 85 |
| DMARDS in RA (Target:78%) | 77 |
| Diabetes Treatment Management(Target:86%) | 85 |
| High Risk Medications (Target:7%) | 85 |
| Diabetes Care-HbA1C (Target:80%) | 85 |
| Diabetes Care-Cholesterol Screening (Target:53%) | 85 |
| Diabetes Care-DM Retinal Eye (Target:64%) | 85 |
| Diabetes Care-Nephropathy Screening (Target:85%) | 85 |
| Generic RX (Target:>84%) | 85 |
| Mail Order (Target: >36%) | 85 |
| HRA (Target: >50%) | 85 |
| Medical Records Access | Y |

* Table reflects data received for the above 14 practices
Met or exceeded the national benchmark in the following quality metrics (2013):

• Colorectal cancer screening

• Breast cancer screening

• Diabetes control: HgbA1C < 9%

• Diabetes: LDL control <100

• Diabetes Treatment Management

• Glaucoma screening
Areas for improvement:

• Diabetes: Retinal Exam

• High risk medications

• Overall Star Score: 3.30 (2013) has increased to 3.66 (as of 9/9/2014)
# Efficiency Performance

<table>
<thead>
<tr>
<th>Measure</th>
<th>1Q2014</th>
<th>1Q 2013</th>
<th>FY 2013</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members</td>
<td>3,886</td>
<td>2,743</td>
<td>2,695</td>
<td>1,785</td>
</tr>
<tr>
<td>Average Risk Score</td>
<td>.9533</td>
<td>.9528</td>
<td>.9568</td>
<td>.9567</td>
</tr>
<tr>
<td>Premium PMPM</td>
<td>943</td>
<td>972</td>
<td>960</td>
<td>1,005</td>
</tr>
<tr>
<td>Physician Expense PMPM</td>
<td>299</td>
<td>280</td>
<td>274</td>
<td>299</td>
</tr>
<tr>
<td>Hospital Expense PMPM</td>
<td>437</td>
<td>442</td>
<td>382</td>
<td>480</td>
</tr>
<tr>
<td>RX Expense PMPM</td>
<td>111</td>
<td>103</td>
<td>81</td>
<td>92</td>
</tr>
<tr>
<td>Total Expense PMPM</td>
<td>847</td>
<td>825</td>
<td>737</td>
<td>871</td>
</tr>
<tr>
<td>MER</td>
<td>89.8%</td>
<td>84.9%</td>
<td>76.7%</td>
<td>86.6%</td>
</tr>
</tbody>
</table>
Value Our Partners Program

• Access:
  – Healthgrades: Patient Digital Connect™

• Education/Training:
  – Ochsner Learning Institute/Ochsner Learning Network
  – Monthly Newsletter
  – Quality Modules

• Leverage Systems/Processes:
  – Electronic AP Process
  – Affiliated Care Purchasing Group
  – Website
Overview: Member physicians or groups of the CI network must sign a legal participation agreement. This agreement outlines the potential expectations and requirements for participation in the OPP Clinical Integration Program. The legal agreement states “the Clinical Integration Program is designed to:

(i) improve quality of care and clinical outcomes
(ii) improve coordination and continuity of care
(iii) control the total cost of health care
(iv) improve the efficiency of all providers in the network
(v) eliminate unnecessary clinical care variation by the adoption of clinical protocols and pathways
(vi) support comprehensive clinical care with an integrated information technology platform.

The performance of the participation criteria outlined below will assist in not only overall compliance with the OPP legal agreement, but will help create an atmosphere of transparency, communication and coordination.

Performance Measurement: Each participating physicians’ performance will be tracked using the scale below:

<table>
<thead>
<tr>
<th>Performance Level</th>
<th>Range</th>
<th>Annual Payment per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceeds Expectations</td>
<td>75-100</td>
<td>$$$</td>
</tr>
<tr>
<td>Meets Expectations</td>
<td>50-74</td>
<td>$</td>
</tr>
<tr>
<td>Unsatisfactory</td>
<td>0-49</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPP Participation and Performance Criteria</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Leadership and Engagement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>View OPP website (<a href="http://www.ochsner.org/OPP/">http://www.ochsner.org/OPP/</a>) and log into the unique account provided by OPP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly</td>
<td>Federal regulations mandate member physicians of Clinically Integrated Networks be educated on the objectives of Clinical Integration (CI) OPP will publish payer and employer contracts on the website, along with educational updates that will</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>directly impact the members’ performance (financially and operationally).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12 pts total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attend an annual meeting of OPP providers for your specified region (MD required, Office Manager optional).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annually</td>
<td>OPP will sponsor a session to educate and receive feedback on the performance of the network. Member physicians and practice managers will be asked to attend</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>20 pts total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintain Appropriate Information Technology Infrastructure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network Data Warehouse/McKesson Registry: Install and share claims data with McKesson Population Manager and other registries as determined by payor and network requirements.</td>
<td>Required per Practice Agreement</td>
<td>Meaningful use criteria was defined by the American Recovery and Reinvestment Act of 2009 with the inclusion of three main components: (1) The use of a certified EHR in a meaningful manner, such as e-prescribing (2) The use of certified EHR technology for electronic exchange of health information to improve quality of health care (3) The use of certified EHR technology to submit clinical quality and other measures Meaningful use criteria is required to qualify for incentive payments by CMS (Centers of Medicare and Medicaid)</td>
<td>10</td>
</tr>
<tr>
<td>Install and maintain an EMR and attest to Meaningful Use Stage I or II requirements</td>
<td>Annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Epic Care Link / Epic Hyperspace</td>
<td>Annually</td>
<td>As a critical component to the success of OPP Performance Improvement initiatives, member physicians will be asked to utilize the selected data registry</td>
<td>5</td>
</tr>
<tr>
<td>Care Coordination and Patient Experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify a practice coordinator to participate in monthly quality improvement program</td>
<td>Annually</td>
<td>Improve quality of care and clinical outcomes and improve the efficiency of all providers in the network</td>
<td>5</td>
</tr>
<tr>
<td>Practice coordinator participates in monthly quality improvement program</td>
<td>Monthly</td>
<td>Improve quality of care and clinical outcomes and improve the efficiency of all providers in the network</td>
<td>10 pts max (1 pt per month)</td>
</tr>
<tr>
<td>Complete ICD-10 education provided by OPP.</td>
<td>Annually</td>
<td>Improve the efficiency of all providers in the network</td>
<td>1</td>
</tr>
<tr>
<td>Complete HCC coding education provided by OPP</td>
<td>Annually</td>
<td>Improve the efficiency of all providers in the network</td>
<td>1</td>
</tr>
<tr>
<td>Complete HIPAA education provided by OPP</td>
<td>Annually</td>
<td>Improve the efficiency of all providers in the network</td>
<td>1</td>
</tr>
<tr>
<td>Quality and Efficiency Performance Review (Includes either specialist OR primary care measure below plus Hospital Based Metrics)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialization (Includes pediatricians)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POV: Participate in Pursuit of Value meetings (Specialists, including Pediatrics)</td>
<td>Monthly/Quarterly</td>
<td>Improve quality of care and clinical outcomes, control the total cost of health care, and eliminate unnecessary clinical care variation.</td>
<td>25 pts max (5 pts per meeting)</td>
</tr>
</tbody>
</table>
# Ochsner Physician Partners: Future Areas of Focus

## Quality

<table>
<thead>
<tr>
<th>Cost</th>
<th>Care Coordination</th>
</tr>
</thead>
</table>

## Strategic Growth

- Comprehensive Access to Services

## Enhanced Value Our Partners Program

| Medical Insurance Training | Education: ICD-10 Training | Preferred Billing Vendor Agreement |
Efficient provision of care

Organized system of care

Quality measurement and improvement activities

Accountability

Coordinated management

Data analytics

Integrated EMR

High performance network products

Ochsner clinical integration network

Our Developing Network...
A sustainability gap is forming where rising costs are outpacing reimbursements.
### Ochsner’s Healthcare Economics

#### Revenue ( - ) Reimbursement Cuts

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>$M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncompensated Care 2009-2012</td>
<td>9.5</td>
</tr>
<tr>
<td>February 2009</td>
<td>2.1</td>
</tr>
<tr>
<td>August 2009</td>
<td>6.4</td>
</tr>
<tr>
<td>February 2010</td>
<td>6.7</td>
</tr>
<tr>
<td>August 2010</td>
<td>6.0</td>
</tr>
<tr>
<td>January 2011</td>
<td>2.6</td>
</tr>
<tr>
<td>March 2011</td>
<td>11.2</td>
</tr>
<tr>
<td>July/August 2012</td>
<td>5.5</td>
</tr>
<tr>
<td>Q1 2013</td>
<td>6.6</td>
</tr>
<tr>
<td>Q2 2013</td>
<td>6.6</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>6.6</td>
</tr>
<tr>
<td>Q4 2013</td>
<td>8.6</td>
</tr>
<tr>
<td>2014</td>
<td>17</td>
</tr>
</tbody>
</table>

**Revenue Reduction** $95.4

#### Expense (+) Supply Cost

- Labor and Supply Expense are the highest costs for healthcare organizations, representing approximately 51% of total annual operating expenses.
Supply Cost 2nd Only to Salaries as % of Hospitals Cost Structure (cross over 2020)

Salaries & Supplies = 51%
In our experience, cost reduction efforts have traditionally taken place in silos.
Our Mission: Highest Quality Care at an Affordable Cost

Our Approach:
1. Cost Engineering
2. Variation Reduction
3. Process Improvement

Our Structure:
- Physician Led
- Project Mgmt.
- Clinicians
- Supply
- Analytics
Deployment Strategy:
Cost Engineering
1. Cost Engineering

- Review Cost by DRG / Service Line
- Select highest (supply) cost inpatient DRGs
- Set Savings Targets
- Reverse Cost Engineer Target

Cost Accounting

- Purchasing Data
- P&L Metrics

Challenges

- Standardizing metrics that would be used to capture cost savings
- Most efficient way to process and provide data
- Creating a data-driven culture
Review Cost by DRG / Service Line

Select highest (supply) cost inpatient DRGs

Set Savings Targets

Reverse Cost Engineer Target

Challenges

• Narrowing focus of the organization from diving into all DRGs to selecting the highest impact DRGs

• Understanding the overlap in supply costs between common DRGs

Top 16 Highest Supply Cost DRGs selected were in the Spine, Orthopedics and Cardiology Service Lines
Case Study: Total Knee & Hip Replacement

How do we break even **IF** all cases were reimbursed at Medicare rates?

50% Cost Reduction Target – **Not Realistic!**

<table>
<thead>
<tr>
<th>Objective 1: Set Realistic Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011 Cost per Case</td>
</tr>
<tr>
<td>Target Cost per Case</td>
</tr>
<tr>
<td>Reduction Target per Case</td>
</tr>
<tr>
<td>Reduction Target %</td>
</tr>
</tbody>
</table>

**Challenges**

- Defining a realistic target for the service line to aim to achieve
- Overcoming organizational inertia that although the entire service line is profitable, the Medicare case population is not
## Objective 2: Reverse Engineer Reduction Target

- LOS Management (.5 Day) $324
- OR Time (15 mins) $420
- Implant Pricing $364
- Utilization $656
- Reduction Target $1,764

## Objective 3: Develop Cost Reduction Strategies

- Expectation Setting of 2-3 Days $65
- Patient Care Map Implementation $65
- Pre-Op Patient Education $65
- Increased PT (7 days a week) $65
- Day of the week for surgery $65
- LOS Reduction Target $324
- OR Time Savings $420
- New Pricing (10% Goal) $364
- Non-Chargeables (OR) $250
- Bone Cement Utilization $229
- Utilization $177
- Implant / Utilization Target $1,020

### Challenges

- Defining savings opportunities associated with each of the cost reduction strategies required assumptions to be made
- Ensuring unrealistic targets were not set for each of the cost reduction strategies
Deployment Strategy: Variation Reduction
Case Study 1: Total Knee & Hip Replacement

Challenges

- Physician Understanding & Acceptance of the Data
- Patient acuity and complexity makes it difficult to show apples to apples comparisons

Variation Reduction

Identify High Variation Areas

Facilitate Analysis of Alternatives to Minimize Variation

Deploy Variation Reduction Strategies

Focused on Closing Gaps
Variation Reduction

Identify High Variation Areas

Facilitate Analysis of Alternatives to Minimize Variation

Deploy Variation Reduction Strategies

Case Study 1: Total Knee & Hip Replacement

Option 1: Target Standard Price for All Constructs
- **Benefits**: Enables physicians to maintain choice in vendor selection
- **Disadvantages**: Sub-optimizes cost savings

Option 2: Vendor Reduction
- **Benefits**: Optimizes cost savings through driving volume to lowest cost vendor
- **Disadvantages**: Minimizes physician choice

Option 3: Reverse Auction Pricing
- **Benefits**: Enables better pricing to be obtained
- **Disadvantages**: Eliminates physician choice

Challenges
- Obtaining common agreement from physicians on strategy
- Sustaining commitment to the supply chain strategy chosen
Variation Reduction

Identify High Variation Areas

Facilitate Analysis of Alternatives to Minimize Variation

Deploy Variation Reduction Strategies

Case Study 1: Total Knee & Hip Replacement

Challenges

- Vendor communications to physicians
- Vendors not responding to the RFP
- Vendors coming in with new pricing at the last minute

### Formulary Pricing

<table>
<thead>
<tr>
<th>Formulary Category</th>
<th>Formulary Category Description</th>
<th>Formulary Pricing Not to Exceed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monoaxial Pedicle Screw (Not Including Minimally Invasive)</td>
<td>$550</td>
</tr>
<tr>
<td>2</td>
<td>Polyaxial Pedicle Screw (Not Including Minimally Invasive)</td>
<td>$800</td>
</tr>
<tr>
<td>3</td>
<td>Minimally Invasive (MIS) and/or Specialty Pedicle Screw Construct</td>
<td>$950</td>
</tr>
</tbody>
</table>

Note: Any complete monoaxial screw construct - including pedicle screw, head, locking cap, break off head, connector, washer, nut, etc. - should not exceed $550.

Note: Any complete polyaxial screw construct - including pedicle screw, head, locking cap, break off head, connector, washer, nut, etc. - should not exceed $800.

Includes PEEK, HA-coated screws.
## Results

<table>
<thead>
<tr>
<th>Company</th>
<th>Market Share</th>
<th>Target Savings</th>
<th>Response from Vendor</th>
<th>Total Savings</th>
<th>Target Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor 1</td>
<td>31%</td>
<td>6%</td>
<td>6.0%</td>
<td>$160,008</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 2</td>
<td>26%</td>
<td>6%</td>
<td>6.1%</td>
<td>$147,583</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 3</td>
<td>16%</td>
<td>6%</td>
<td>7.0%</td>
<td>$101,364</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 4</td>
<td>14%</td>
<td>6%</td>
<td>9.0%</td>
<td>$116,709</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 5</td>
<td>4%</td>
<td>6%</td>
<td>21.9%</td>
<td>$84,815</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 6</td>
<td>3%</td>
<td>6%</td>
<td>26.6%</td>
<td>$68,373</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 7</td>
<td>2%</td>
<td>6%</td>
<td>14.7%</td>
<td>$29,315</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 8</td>
<td>1%</td>
<td>6%</td>
<td>21.9%</td>
<td>$17,446</td>
<td>✔</td>
</tr>
<tr>
<td>Vendor 9</td>
<td>1%</td>
<td>6%</td>
<td>0%</td>
<td>$0</td>
<td>✗</td>
</tr>
</tbody>
</table>

Total Net Projected Savings: $725,613 representing a net 8.0% Savings

## Lessons

- Physicians pushing back on vendors to meet pricing was critical
- Holding firm on dates with vendors and presenting feedback to physicians in a timely manner is critical
Deployment Strategy:
Variation Reduction
Case Study 2: Bone Cement Utilization

10 DIFFERENT CEMENTS
- PALACOS LV+G
- SMARTSET GHV
- SIMPLEX P WITH TOBRAMYCIN
- PALACOS R+G
- CEMENT WHOLE BATCH 10/BX
- CEMENT BONE G-HV 40GR
- HV SINGLE 40GR
- ENDURANCE 40GR
- SMARTSET HV 40 GR
- VERSABON 40 GRAM CEMENT

OMC SOUTHSHORE

<table>
<thead>
<tr>
<th>Physician</th>
<th>Antibiotic Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>80%</td>
</tr>
<tr>
<td>B</td>
<td>100%</td>
</tr>
<tr>
<td>C</td>
<td>50%</td>
</tr>
<tr>
<td>D</td>
<td>40%</td>
</tr>
<tr>
<td>E</td>
<td>25%</td>
</tr>
</tbody>
</table>

OMC SOUTHSHORE

<table>
<thead>
<tr>
<th>Facility</th>
<th>Antibiotic Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMC Southshore</td>
<td>51%</td>
</tr>
<tr>
<td>OMC Baptist</td>
<td>69%</td>
</tr>
<tr>
<td>OMC Baton Rouge</td>
<td>89%</td>
</tr>
<tr>
<td>OMC Kenner</td>
<td>80%</td>
</tr>
<tr>
<td>OMC Westbank</td>
<td>100%</td>
</tr>
</tbody>
</table>

Facilities

- OMC Southshore 51%
- OMC Baptist 69%
- OMC Baton Rouge 89%
- OMC Kenner 80%
- OMC Westbank 100%

Challenges

- Physician preferences for 1 type of cement
- The merits of using antibiotic cement for total knee and hip procedures
Case Study 2: Bone Cement Utilization

Discussion from Advisory Board

- "Clinical literature suggests that ABLC is most effective at preventing infection in high-risk patients with compromised immunity; however, when removing these "outliers", there does not seem to be any statistically significant benefit of the prophylactic (ABLC)"

- "Routine use of ABLC in primary joint replacement is highly controversial, as some surgeons believe overutilization may lead to anti-microbial drug resistance"

- "While some surgeons are implanting low-dose antibiotic bone cement in all of their primary and revision cases, more conservative surgeons view this practice as clinically irresponsible as it could lead to antibiotic resistance"

Other Discussion Points:
1. Some surgeons are only using antibiotic cement and others are using it more sparingly. What is the medical best practice?
2. Can we model best practices and shift more cases from Level 3 Bone Cement to Level 2 or 1 Bone Cement?

…”when removing outliers, there does not seem to be any statistically significant benefit of “antibiotic cement”

Leveraged the Evidence Based Best Practice to present a case for using non-antibiotic cement over antibiotic cement when clinically appropriate

Challenges

- Obtaining common agreement from physicians on a strategy
- Conflicting literature on the appropriate use of bone cement
Case Study 2: Bone Cement Utilization

Developed cost effective protocols for cement utilization

- **Elective low risk patient:** Product A non-antibiotic cement
- **Elective high risk patient:** Product B antibiotic cement
- **Acute infections:** Product C

**Results:**
- Achieved best in class pricing on non-antibiotic and antibiotic cement
- Minimized vendors from 10 to 3

**Challenges**
- Convincing surgeons that were not in attendance at the decision meetings
- Hardwiring the cement selections at each of Ochsner’s 7 locations
### Results

#### Lower Utilization of Expensive Cement

<table>
<thead>
<tr>
<th>Charge Item</th>
<th>2011 Baseline</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Units</td>
<td>Units/Case</td>
</tr>
<tr>
<td>Non-Antibiotic Cement</td>
<td>172</td>
<td>0.24</td>
</tr>
<tr>
<td>Low Cost Antibiotic</td>
<td>419</td>
<td>0.57</td>
</tr>
<tr>
<td>High Cost Antibiotic</td>
<td>491</td>
<td>0.67</td>
</tr>
</tbody>
</table>

#### Cost Savings

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>Change ($)</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spend</td>
<td>Annualized Spend</td>
<td>Fav/(Unfav)</td>
<td></td>
</tr>
<tr>
<td>Bone Cement, Antibiotic</td>
<td>486,956</td>
<td>359,226</td>
<td>127,729</td>
<td>-26%</td>
</tr>
<tr>
<td>Bone Cement, Regular</td>
<td>89,832</td>
<td>99,596</td>
<td>(9,764)</td>
<td>11%</td>
</tr>
<tr>
<td>Total</td>
<td>576,788</td>
<td>458,823</td>
<td>117,965</td>
<td>-20%</td>
</tr>
</tbody>
</table>

### Lessons

- When conversing with physicians on clinical product selection, leverage the literature to build your business case.
- Develop mechanisms to track utilization / cost savings, and provide transparency around this data.
Deployment Strategy:
Variation Reduction
Variation Reduction

Identify High Variation Areas

Facilitate Analysis of Alternatives to Minimize Variation

Deploy Variation Reduction Strategies

Case Study 2: Colonoscopy Sedation Utilization

Challenges

• Physician preference for moderate vs. deep sedation varied by site and specialty

• Moderate and deep sedation approaches would need to be agreed upon by surgeons and anesthetists
Variation Reduction

Identify High Variation Areas

Facilitate Analysis of Alternatives to Minimize Variation

Deploy Variation Reduction Strategies

Case Study 2: Colonoscopy Sedation Utilization

Deep Sedation (w/Propofol)
- Avg. Procedure Time: No Difference
- Avg. Recovery Time: 30 Minutes
- Patient Satisfaction: 20% Higher

Moderate Sedation (Fentanyl, Versad, Mepiridime)
- Avg. Procedure Time: No Difference
- Avg. Recovery Time: 45-60 Minutes

Challenges
- Changing physician practice in choosing between deep and moderate sedation
- Obtaining buy-in from anesthesia for the new approach
Variation Reduction

2

Identify High Variation Areas
Facilitate Analysis of Alternatives to Minimize Variation
Deploy Variation Reduction Strategies

Challenges

- Deploying the project plan system wide required local site operations and physician leaders to implement and sustain standards.

Case Study 2: Colonoscopy Sedation Utilization

Currently Deploying Project Plan

<table>
<thead>
<tr>
<th>Status</th>
<th>Leads</th>
<th>Strategy</th>
<th>Bowel Prep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Favorable to move forward</td>
<td>Physicians</td>
<td>Physicians across facilities all agreed to narrow down bowel prep to top three products: Golytely, Nulypid, and MoviPrep.</td>
<td></td>
</tr>
<tr>
<td>CRNA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Favorable to move forward</td>
<td>POV Team led by Dr. Milani to coordinate for Main Campus</td>
<td>For anesthesia cases, Baton Rouge has a strong (and economic) model around utilizing all CRNA’s rather than Anesthesiologists. The POV Team has reached out to the Chair of Anesthesiology to discuss Main Campus moving towards a similar model and away from a staff anesthesiologist.</td>
<td></td>
</tr>
<tr>
<td>Patient Recovery</td>
<td>Stacie Falati</td>
<td>Baton Rouge does not perform procedures unless family is in the clinic from check-in to immediately after the procedure. As soon as a patient is out of surgery in BR, the Physician goes and speaks to the family, eliminating Recovery Patient-to-Physician communication bottlenecks.</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Ellen Bartholomeu, Michael Louviere</td>
<td>Physicians agree to negotiate this as a system rather than as a hospital.</td>
<td></td>
</tr>
</tbody>
</table>
Variation Reduction

2

Identify High Variation Areas
Facilitate Analysis of Alternatives to Minimize Variation
Deploy Variation Reduction Strategies

Results

Cost Savings Results: Shift Case Volumes to Deep Sedation using Propofol

- Enables an increase in throughput of **12 additional cases per day** due to time savings for recovery
- Resulting in a **Total Annualized Incremental Margin of $600K**

Lessons

- Engaging physicians across the region and in different specialties resulted in clinical standards that improved the quality of care and reduced cost
Deployment Strategy: Process Improvement
Case Study 1: Vendor Management

**Challenges**

- Physician / Vendor relationships
- No standards to eliminate non-approved products from entering Ochsner facilities

**Previous Process:** Vendors would meet with physicians, advise them to use new technologies, and Supply Chain would find out after the fact.

**Identify Areas of Opportunity**

**Deploy guidelines and standards across the system**

**Process Improvement**
**Case Study 1: Vendor Management**

**New Process:** Supply Chain and Physicians Aligned. Vendor Management Guideline implemented eliminating unapproved products from entering OHS facilities.

**Results**
- Improved alignment between Supply Chain and physicians
- Elimination of unapproved products from entering OHS facilities
Case Study 2: Care Mapping

Challenges

• Different care processes in each region
• Patient LOS expectation set at 4-5 days
• Minimal to no pre-operative care planning
Identify Areas of Opportunity

Deployment guidelines and standards across the system

Case Study 2: Care Mapping

Standardized Patient Care and LOS as 3 days for typical Total Knee and Total Hip Replacement through Care Mapping

Results

• .5 Day reduction in Length of stay system wide
• Reduced supply expense through shorter hospital stays
Results and Key Learnings
Results

Knee / Hip Replacement
- $1.3M Annualized Savings
- 94% LOS Target Achieved for Primary Knee/Hip (DRG 470)
- 120% LOS Target Achieved for Bilateral Knee Replacement (DRG 462)

Spine
- $1.1M Annualized Savings
- Price Reductions
- Reduction in vendors
- Reduction in BMP utilization

Cardiology / CTS
- $700K Annualized Savings
- Preferred Vendor Program

Endovascular Surgery
- $350K Annualized Savings
- 92% LOS Target Achieved for Major Cardio Procedures (DRG 238)

$27 Million Annualized Savings in 2013
Sustaining Results: Dashboard Deployment

**S/L Executive Scorecard**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Q4 Actual</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Cost Per Case</td>
<td>$11,760</td>
<td>$11,039</td>
<td>$9,996</td>
</tr>
</tbody>
</table>

**Physician Scorecard**

**Clinical Registries**

**LOS Per Case**

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Q4 Actual</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.79</td>
<td>3.33</td>
<td>3.29</td>
<td></td>
</tr>
</tbody>
</table>
It is our belief that in addition to financial savings, our team has driven a cultural shift.
Key Lesson 1: This is an effort in physician change management

**Understand the Data**: Review reports, dashboards, and scorecards for variation reduction opportunities.

**Educate Physicians**: Highlight areas of cost / quality variation. Focus on avoidable practice expenses. Standardize best practice.

**Engage Physicians**: Physician Champion to speak with other Service Line Physicians about variation reduction opportunities.

**Hold Physicians Accountable**: Continue to provide transparency around the data so physicians have an understanding of key drivers.

**Drive Sustainability**: Track results and refine approach if necessary.
Key Lesson 2:
Do’s and Don’ts for Engaging Physicians

**Do’s**

• Lead discussions with data.

• Continue to provide transparency around data.

• Engage physician champion to help lead discussions.

• Discuss best practices with other sites.

• Celebrate service line successes.

• Ensure discussion is value based (components of cost / quality).

**Don’ts**

• Accept status quo.

• Abuse physicians’ time. Make sure you are prepared for meetings and discussions.

• Assume data is the 100% answer. There may be a good clinical reason for poor cost / quality performance that needs to be discussed with the physicians.
Key Lesson 3:
Continuous Improvement is a Never Ending Journey

- The team iterated and repeated the cost engineering, variation reduction, process improvement approach several times for each service line it worked with.
First, understand we have to change and lead by example

Build stronger collaboration – hospitals, physicians, post-acute care, insurers, and ACOs

Embrace population management and global payments by creating entities together to manage populations of people

Be proactive to change incentives internally and with insurers and physicians

Fight fragmentation of the delivery system and build strong connectivity with information systems – don’t build islands of data
The Future Healthcare Organization: Survival of the Fittest

Be Better
- Quality
- Safety
- Access
- Coordination

Be Faster
- Process Change
- Market Changes
- Teamwork

Innovate
- Care Models
- Disease Mgmt
- Technology
- Best Practices

Be Leaner
- Reduce Waste
- Improve Processes

Be Bigger
- Consolidate to Leverage
- Scale
- and Reduce Cost
Questions?
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