

Integrated Network Engagement Summit

Future Strategies of the Integrated Network

September 21, 2017

Transforming health care, together

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

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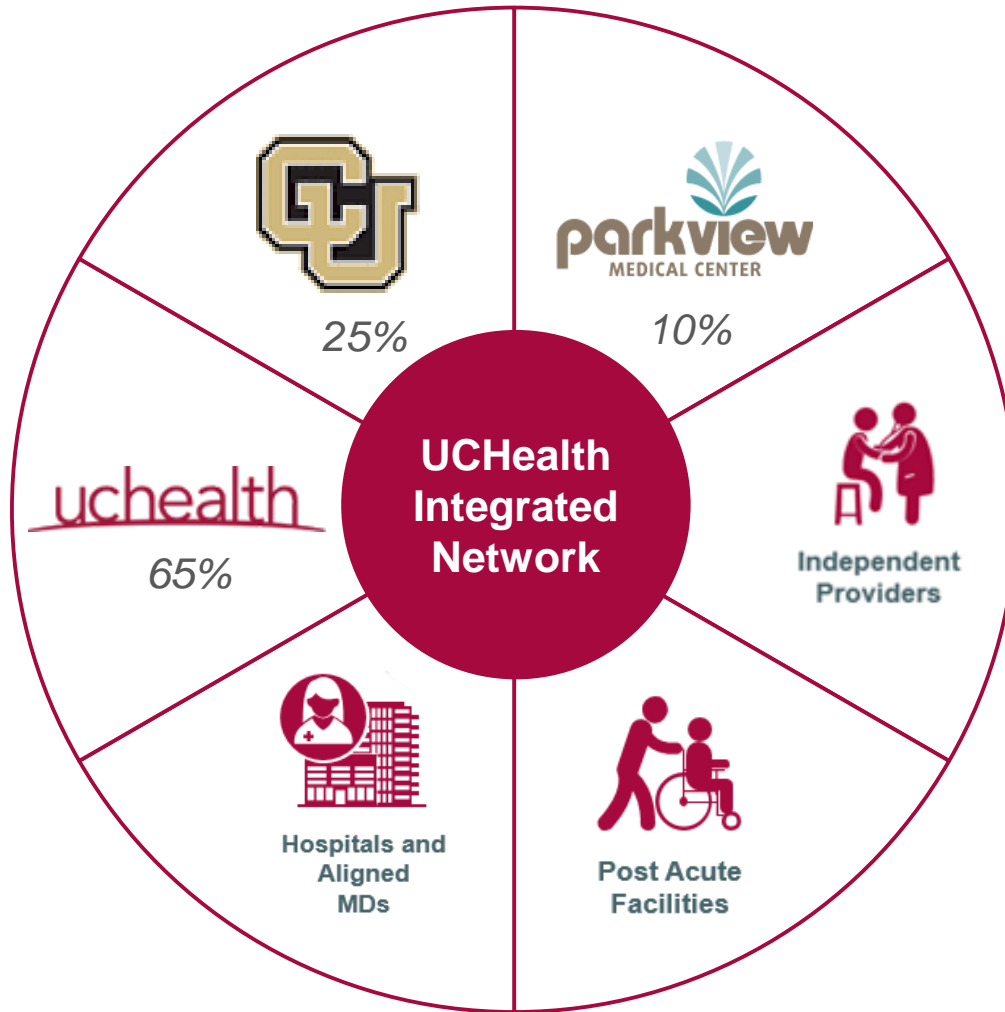
Our 2015 Population Health Strategy

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

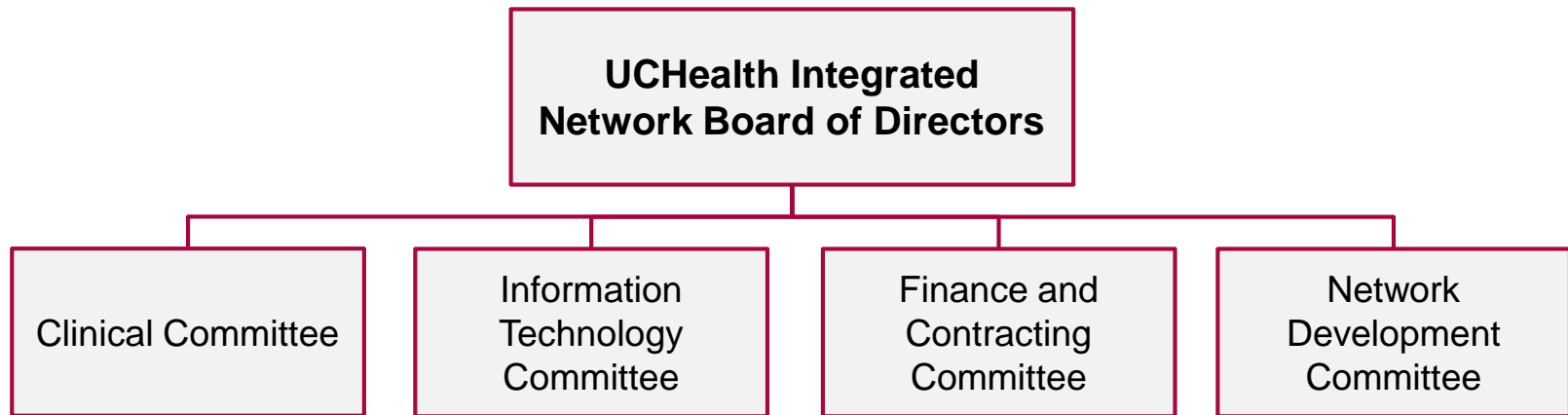


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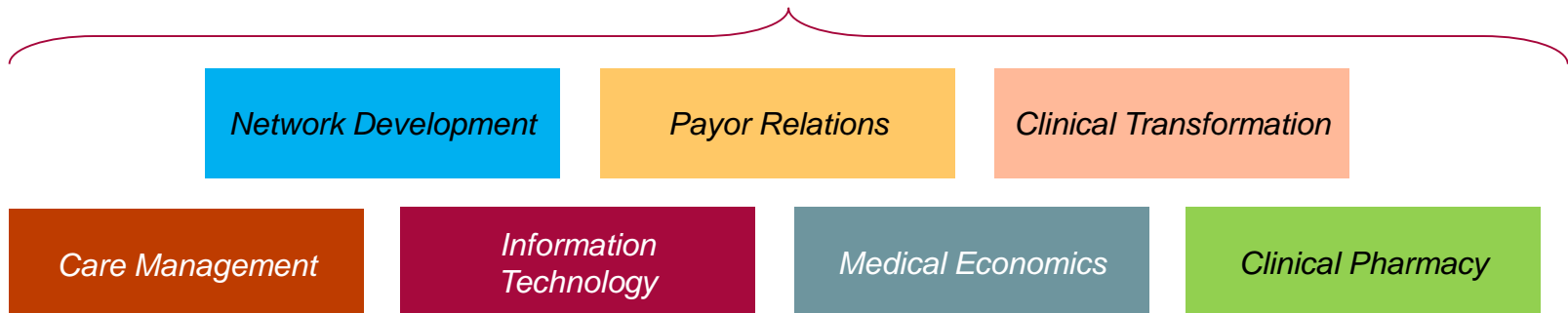


- Clinical integration and care coordination
- Provider leadership and engagement
- Enhanced clinical services and technology
- Value-based payer programs
- Access to new insurance contracts

Strategic operational framework



Population Health Services Organization (PHSO) Operations Workteams



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



ASSOCIATES IN
FAMILY MEDICINE

Be heard. Be well.

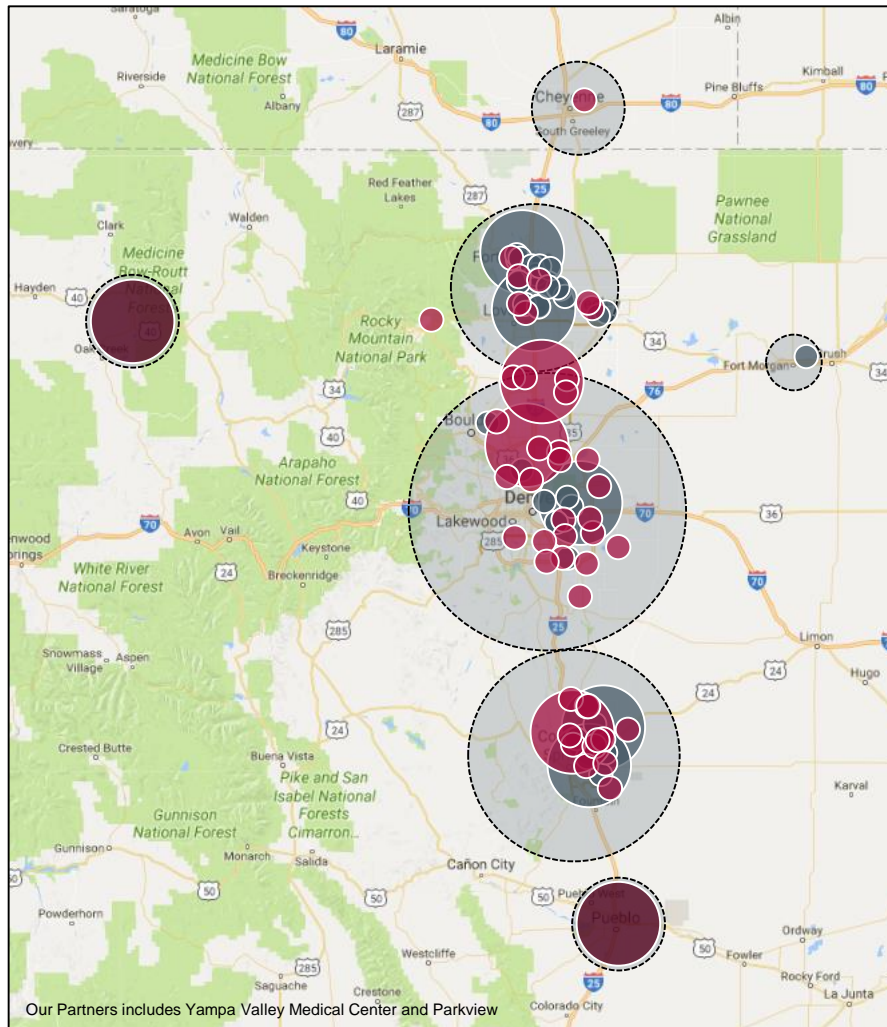


What does a Clinically-Integrated Network do?

UCHealth Integrated Network is a separate legal entity that satisfies all CMS requirements and delivers the following:

- ✔ Provides a vehicle for independent entities to collaborate, facilitate decision-making and demonstrate value to the market.
- ✔ Measures quality and cost performance and establishes policies and procedures to affect performance across the network.
- ✔ Provides support and services to facilitate integration across the network.
- ✔ Contracts with governmental and commercial payers to facilitate alignment of financial incentives across the network.
- ✔ Generates and distributes financial incentives and shared savings among network membership.

We have made significant strides in expanding our provider network footprint since 2015



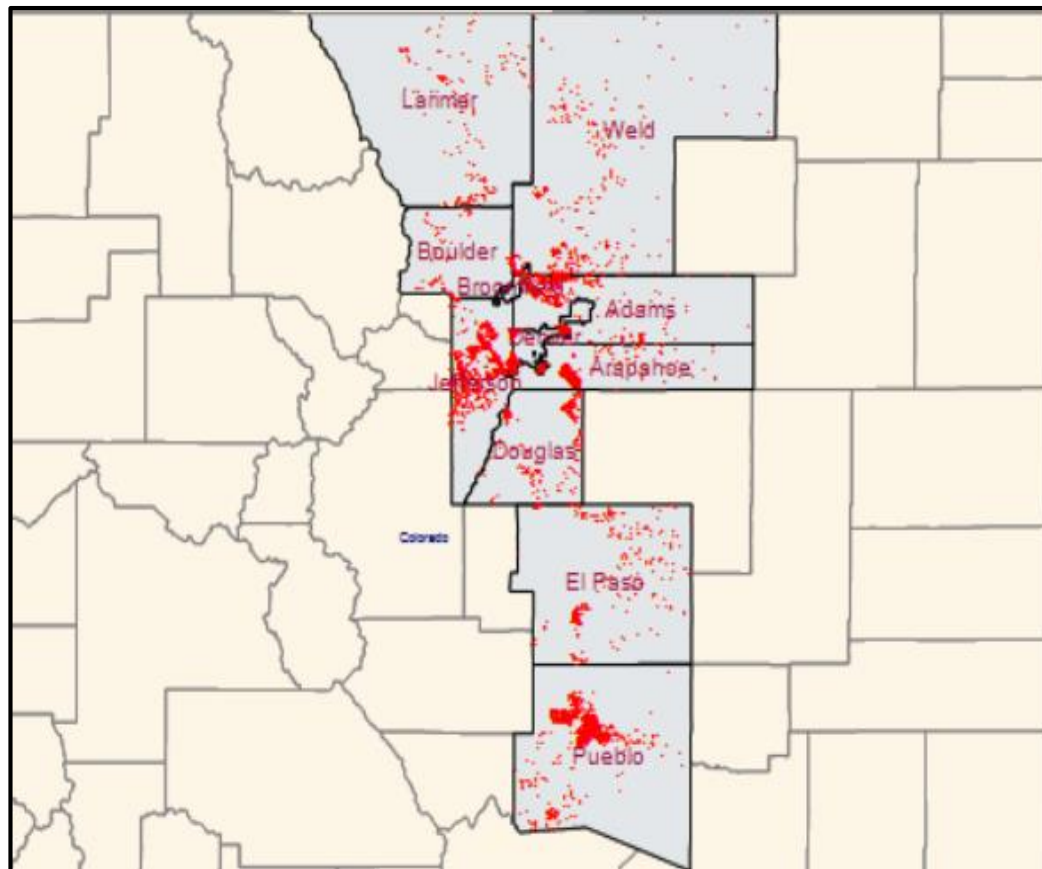
- UCHealth facilities and JVs
- Yampa Valley Medical Center
- Parkview Medical Center
- Skilled Nursing Facilities
- Community Physician Groups

- UCHealth, CU Medicine, AFM 2015
- UCHealth, CU Medicine, AFM 2017
- New Partners
- Aspirational Footprint

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However, opportunities remain to fill gaps across Colorado's Front Range

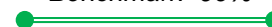
2017 US Census Populations Without Access



The Access and Adequacy Composite Score

represents the ability to serve populations based on location and volume of providers...

CMS and Commercial Benchmark- 90%



UCHealthIN Composite Score - 81%



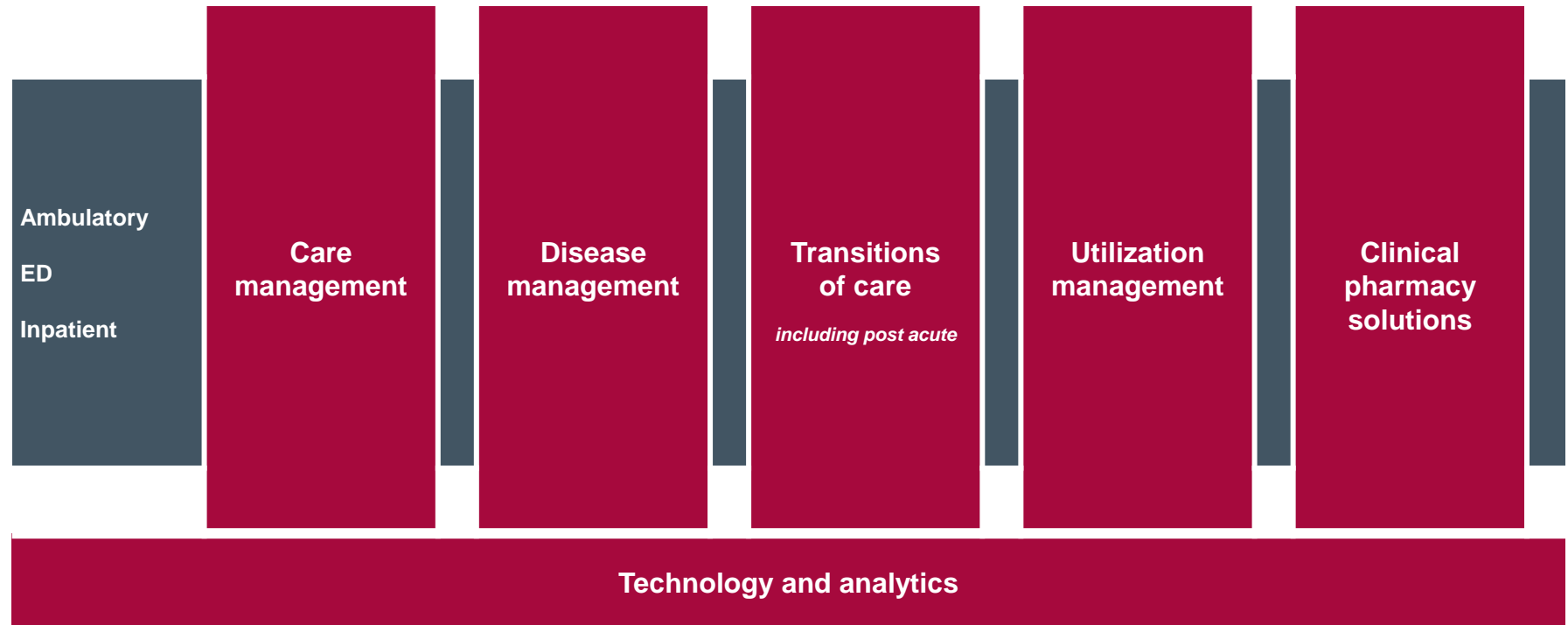
Notes:

Time, distance, provider count and population size are taken into account when measuring adequacy. Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo, and Weld counties UCHealthIN provider directory assessed against 2017 US Census.

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Our future areas of collaboration

Population Health Support Services

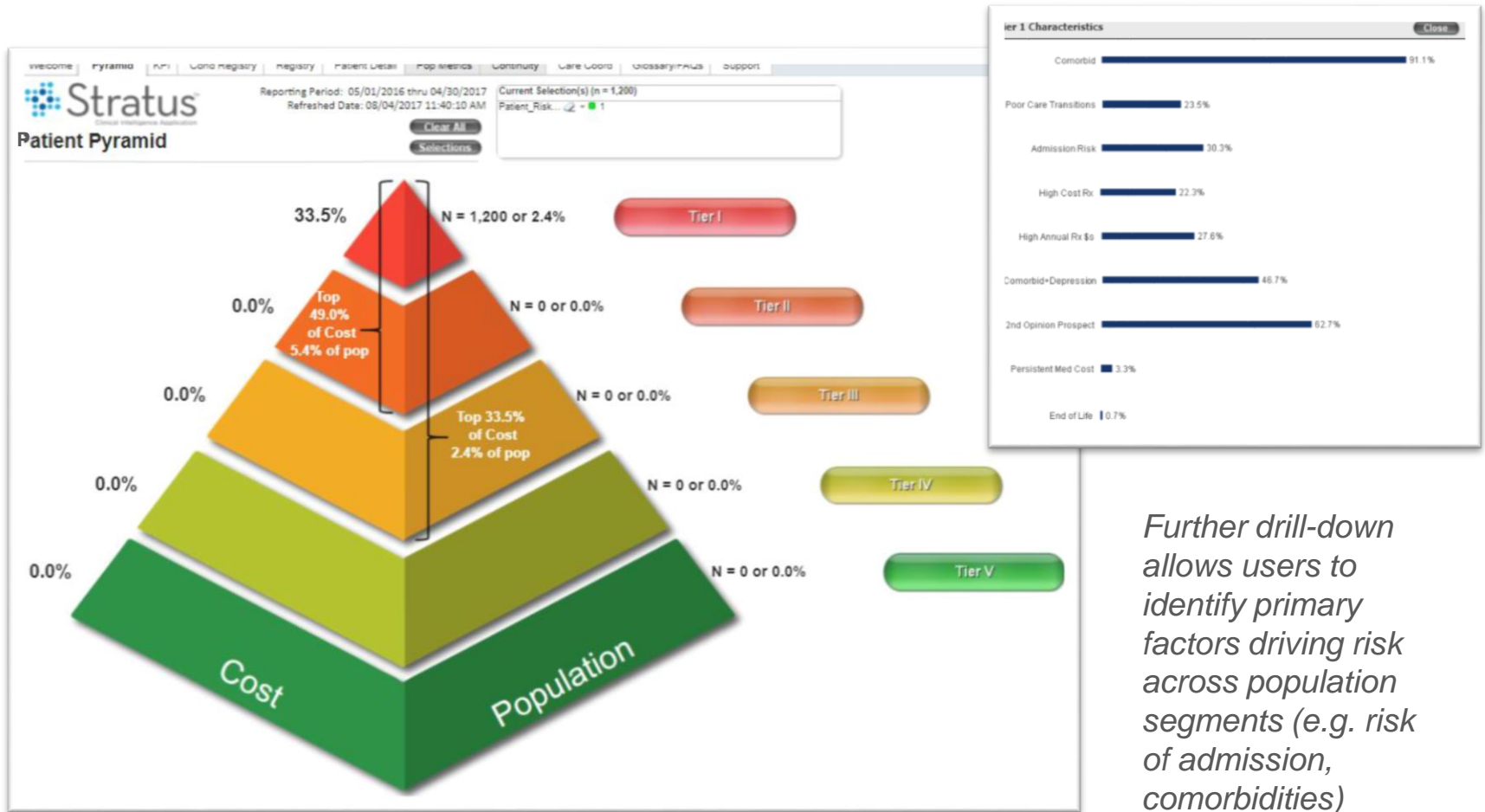


Our population health approach

Our approach is predicated upon designing and implementing targeted, customized solutions specific to the unique needs of the populations we serve.

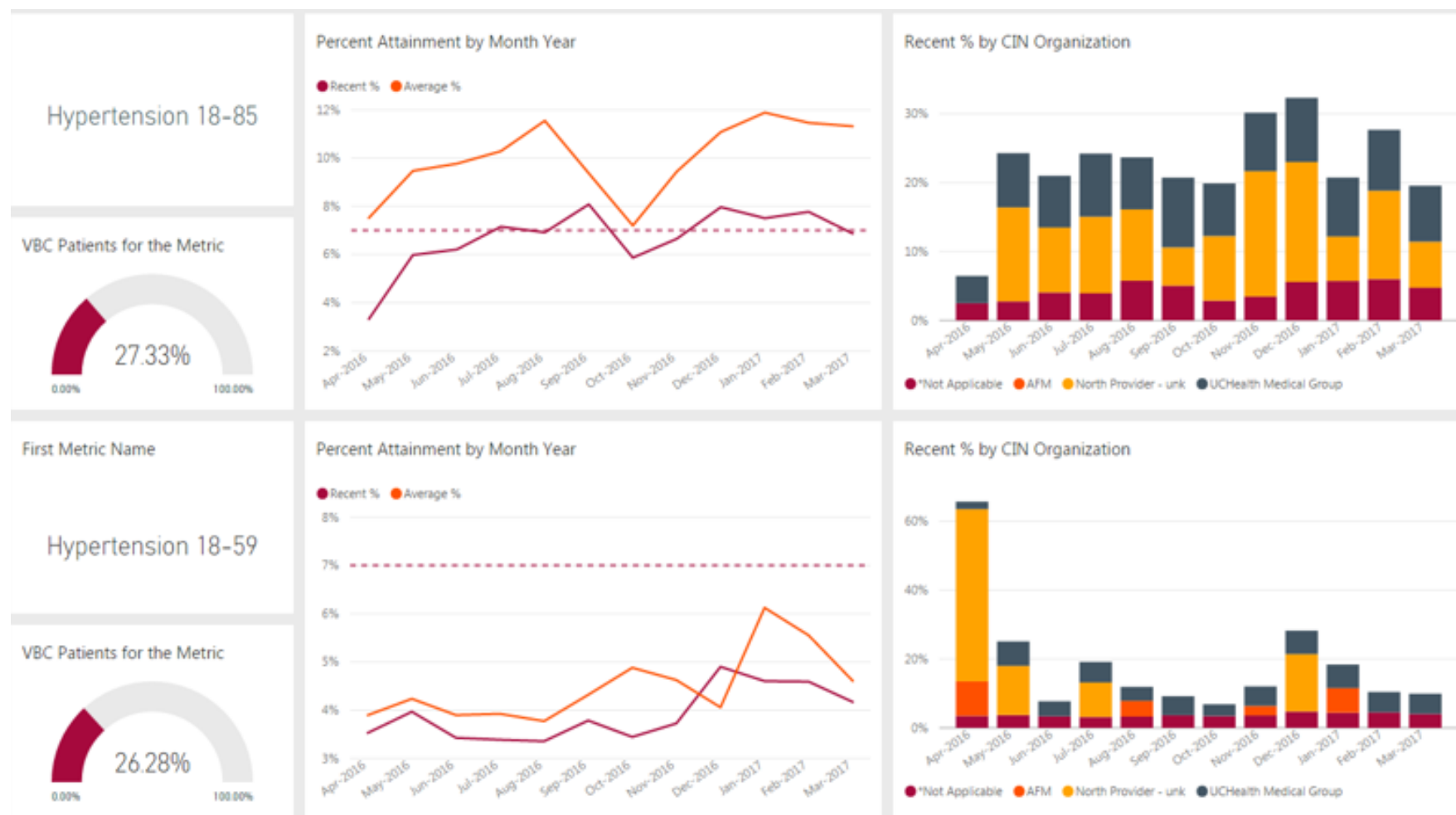
	Description	Sample Diagnoses	Our Approach
High-risk	One or more complex illnesses or multiple co-morbidities	Transplant Cancer COPD	Proactive identification Multi-disciplinary management
Rising-risk	Early chronic conditions or onset chronic disease	Diabetes Hypertension	Avoid escalation to high-risk Preventive and disease management programs
Low-risk	Healthy	Exercise or cold induced asthma	Support wellness Provide convenient, low cost resources

Patient risk pyramid – sample data



Further drill-down allows users to identify primary factors driving risk across population segments (e.g. risk of admission, comorbidities)

Network Performance Dashboard Update



As of May 10, 2017

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Best practices to impact performance

UCHealth Integrated Network - Quality Dashboard

Measure Name and ID	Numerator	Denominator	Percentage	Benchmark
CARE1 - Med Rec Post-Discharge	890	961	93%	TBD
CARE2 - Fall Risk	24,337	36,999	66%	47%
DM2 - Control	4,472	5,401	83%	72%
DM7 - Diabetic Eye Exam	2,217	5,401	41%	86%
HTN2 - Controlling High BP	14,419	20,814	69%	69%
IVD2 - Aspirin or Antithrombotic Use	10,030	12,691	79%	80%
MH1 - Depression Remission	13	640	2%	TBD
PREV 5 - Breast Cancer Screening	10,860	13,638	80%	55%
PREV 6 - Colorectal Cancer Screening	17,896	26,040	69%	48%
PREV 7 - Influenza Vaccination	26,396	40,783	65%	48%
PREV 8 - Pneumonia Vaccination	29,225	36,999	79%	50%
PREV 9 - BMI Screening and Follow Up	31,566	41,574	76%	64%
PREV 10 - Tobacco Use and Cessation	40,899	41,495	99%	86%
PREV 12 - Depression Screening	21,776	32,975	66%	31%
PREV 13 - Statin Use	10,809	14,123	77%	TBD

Key Performance Indicator
■ More than 5% above benchmark
■ 0-5% above benchmark
■ 1-5% below benchmark
■ More than 5% below benchmark
■ New measure, no benchmark set

- Clinical protocols and guidelines
- Continuous quality improvement
- Industry certifications (e.g. Patient-Centered Medical Home)
- Clinical programs and support services

Note: April 1, 2016 through March 31, 2017

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 UCHealth, 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



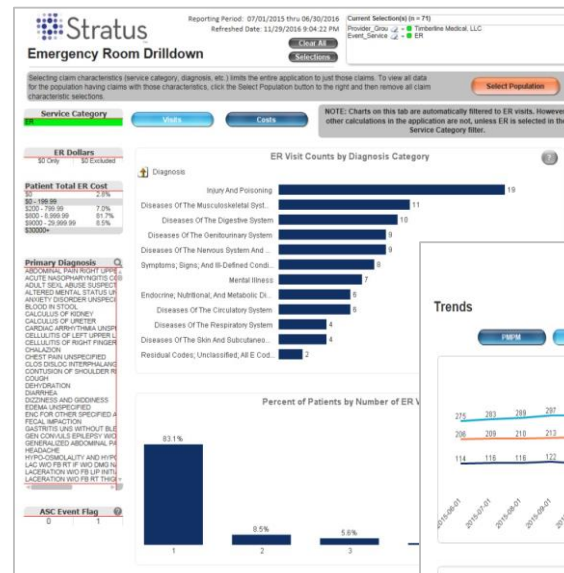
- 3 Innovative platforms for patients to receive advanced care close to home (e.g., virtual care)



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Population management technology

- Best-of-breed partnerships
- Quality, utilization and cost reporting
- Risk stratification
- Integrated clinical and payer data

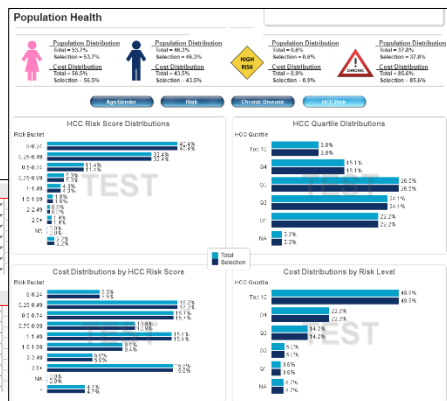


Analytics to support improving population health

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

1 Stratus tool and integration of claims data

Provider		Utilization	
Provider Name	<input type="checkbox"/>	PCP Visits	<input type="checkbox"/>
TIN	<input type="checkbox"/>	Specialist Visits	<input type="checkbox"/>
IPA Filters		Disease	
Contract Name	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
IPA Name	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
IPA All Name	<input type="checkbox"/>	CAD	<input type="checkbox"/>
IPA Carrier	<input type="checkbox"/>	CHF	<input type="checkbox"/>
IPA Carrier Product	<input type="checkbox"/>	COPD	<input type="checkbox"/>
IPA LOB	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>
IPA Market	<input type="checkbox"/>	Depression	<input type="checkbox"/>
IPA Product	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>
IPA Risk	<input type="checkbox"/>	Risk Filters	
IPA State	<input type="checkbox"/>	Risk Level	<input type="checkbox"/>
Patient		Care Gaps Count	<input type="checkbox"/>
Patient Name	<input type="checkbox"/>	HCC Risk Quartile	<input type="checkbox"/>
Gender	<input type="checkbox"/>	Q1	<input type="checkbox"/>
Age Bucket	<input type="checkbox"/>	Q2	<input type="checkbox"/>
Pediatric Ages	<input type="checkbox"/>	Q3	<input type="checkbox"/>
Patient Status	<input type="checkbox"/>	Q4	<input type="checkbox"/>
		Top 10	<input type="checkbox"/>



2 Risk stratification

12 Knerim Complexity Index (KCI) score

This score indicates the patient's Knerim Complexity Index (KCI) score. Scores: 0-2 = Low Risk / 3 = Moderate Low-Risk / 4-5 = Moderate Risk / 6-9 = Moderate High-Risk / 10-12 = High Risk / 13+ = Very High Risk

Points Metrics

- 0 Age: 30
- 0 # of ED Visits: 0
- 0 # of Hospital Admissions: 0
- 0 Is Encounter a Readmission: 0
- 0 # of Medications: 0
- 1 Has AIDS/HIV DX: Yes
- 1 Has Anxiety DX: Yes
- 1 Has Asthma DX: Yes
- 0 Systolic BP: Not on file
- 0 Diastolic BP: Not on file
- 1 Has Cardiovascular Disease: Yes
- 1 Has Cerebrovascular Disease: Yes
- 0 Has Chronic Pulmonary Disease: Not on file
- 0 Has Dementia DX: Not on file
- 1 Has Depression DX: Yes
- 1 Has Diabetes DX: Yes
- 0 Hemoglobin A1c: Not on file
- 0 Glomerular Filtration Rate: Not on file
- 1 Has Heart Failure DX: Yes
- 1 Has Hemiplegia/Paraplegia DX: Not on file
- 1 Has Hypertension DX: Yes
- 0 Has Liver Disease (Mild): Not on file
- 0 Has Liver Disease (Severe): Not on file
- 1 Has Myocardial Infarction DX: Yes
- 1 Has Peptic Ulcer Disease: Yes
- 0 Has Peripheral Vas. Disease: Not on file
- 0 Has Renal Disease: Not on file
- 0 Has Rheumatic Disease: Not on file

Planet, Healthy

01/02/1980, Male, 37 y.o.,

CSN: N/A
MRN: 5301030,
Gender Identity: N/A

Pref Name: None

KCI Risk Score

Snapshot

Knerim Complexity Index (KCI) score

0 - 2 Points: Low Risk
3 Points: Low Risk
4 - 5 Points: Medium Risk
6 - 9 Points: Medium Risk
10 - 12 Points: High Risk
≥ 13 Points: High Risk

5

Chart Review

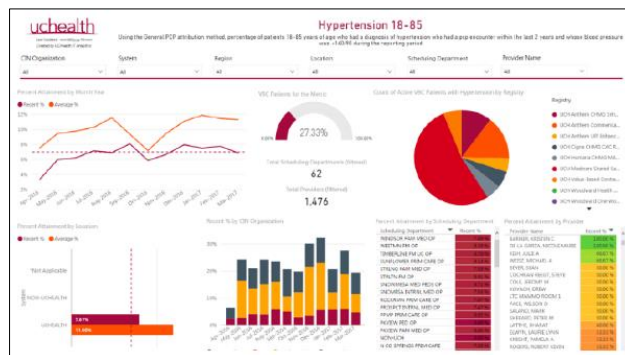
Episodes of ...

Clinical Archive

SnapShot with Recent Visits

PPS Snapshot

3 Performance tracking and reporting



Emerging national employer and health insurance offerings



- High Deductible Health Plans
- Reemergence of HMO
- Single Product Offering for Employees
- Utilizing ACOs & Networks

Questions and discussion