Orlando Health

• **Founded 1918**
  ✓ *Considered a disproportionate share organization*
    - Only Level 1 Trauma Center in Central Florida (8 hospitals across central FL)
    - 15, 132 employees
    - More than 3000 affiliated physicians (500 employed)
    - 116 outpt practices, both primary and specialty care
    - IRF, SNF, HHC
    - Affiliations with PCAN, Hospice, Walgreens, YMCA
    - 1st hospital-based ACO in the state—Collaborative Care of Florida
    - Orlando Health Network (Launched May 2015)

• **Goals:**
  – Reduce unnecessary ED visits and hospitalizations, while reducing hospital LOS
  – Increase access in outpatient setting (including e-visits, RPM, etc.)
  – Improve community integration and resource allocation
  – Promote wellness: chronic disease mgmt; preventive services
Corp Director, PHCC Responsibilities Have Included:

- Re-organization/Implementation of a new care coordination model in the hospitals and outpatient settings (mental health therapy, care coordination and utilization review).
- Clinical oversight and guidance on the deployment of a Population Health Management (PHM) platform that integrates multiple disparate systems into a single, comprehensive data analytics engine that is used to provide best care to patients (both preventive and chronic disease management) across the continuum of care.
- Guidance/participation in the organization’s multiple ACO (Accountable Care Organization) contracts.
- Achievement of NCQA Level 3 PCMH Recognition in Orlando Health’s Primary Care Practices
- Implementation of Chronic Care Management in primary care
- Initiation of Shared Medical Appointments within the Orlando Health Physician Group (OHPG), to include the specialty practices.
- Development of Patient & Family Advisory Councils within OHPG
- Implementation of new Virtual Care modalities (Advanced Remote Patient Monitoring/Virtual Visits)
- Participation in CMS’ Patient Centered Medical Neighborhood (PCMN) demonstration
- Participation in CMS’ Bundled Payment for Care Improvement (BPCI) project.
What did we tackle first?
#1. Culture: **Everything we do starts with you!**

Every story along the way makes us who we are...

...John is the story of Orlando Health.

“You don’t have to quit doing what you’re doing just because you have cancer; you don’t have to give up your dreams.”

...Judith is the story of Orlando Health.

“They really made me want to change ... to be a better person. They gave me the strength I needed to get better.”

...Marcia is the story of Orlando Health.

“It’s your life, your body. You have to take care of your own needs first; you need someone you can trust.”

...You are the story of Orlando Health.

Join us on our journey. Hear the stories of these and other inspiring patients. Share in our milestones and highlights of the past year. Discover how Orlando Health’s Patient-First journey is redesigning care delivery. Learn about our innovative collaborative initiatives. Take a look at our role in the community, in the outstanding services we provide and in the amazing work of our philanthropic foundation.

The Orlando Health 2011 Annual Careholders’ Report, available online now at [orlandohealth.com/careholders](http://orlandohealth.com/careholders)
1. Culture (cont’d)

• Vision:
  – A trusted leader inspiring hope through the advancement of health.

• Leadership:
  – Articulate and accomplish the plan with speed, enthusiasm, engagement and accountability
  – Set an achievable roadmap with measurable milestones along the way
  – Remain focused on the fulfillment of our mission

• Strategy:
  – Assure ongoing improvement of clinical quality, management of risks, patient experience and financial performance
  – Strengthen our partnerships with physicians, team members, patients, donors and the community
  – Identify best opportunities to grow profitable market share
  – Make Orlando Health an easier place to give and receive care
  – Invest in innovation
  – Use factual information to prioritize strategic investment decisions
Journey to Excellence!

- Growth: Profitable market share gains, Service line performance, Capital investment
- Quality & Safety: Truven Top 100, Top 10 percent satisfaction
- Physician Loyalty: Physician engagement, Clinical & financial alignment
- Best Place to Work: Engaged team members
- Innovation: Process, Product, Procedures
- Value: Affordability, Transparency, Financial Discipline
- Ease of Use: Access & convenience, Consumer engagement & satisfaction, Ambulatory development
2. Governance, Operational & Financial Model

Commercial payors are monitoring CMS programs and will be fast followers with the common goal of lowering costs, improving outcomes and increasing access.

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**Continuum of Medicare Risk Models**

<table>
<thead>
<tr>
<th>Pay-for-Performance</th>
<th>Bundled Payments</th>
<th>Shared Savings</th>
<th>Shared Risk</th>
<th>Full Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First Generation Accountable Care Organizations (ACOs)</td>
<td>Bundled Payments for Care Improvement Initiative (BPCI)</td>
<td>Medicare Shared Savings Program (MSSP) Track 1 (50% sharing)</td>
<td>MSSP Track 2 (60% sharing)</td>
</tr>
<tr>
<td></td>
<td>Hospital VBP Program</td>
<td></td>
<td></td>
<td>MSSP Track 3 (up to 75% sharing)</td>
</tr>
<tr>
<td></td>
<td>Hospital Readmissions Reduction Program</td>
<td></td>
<td></td>
<td>Next-Generation ACO (80-85% sharing)</td>
</tr>
<tr>
<td></td>
<td>HAC Reduction Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Merit-Based Incentive Payment System (MIPS) for Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Increasing Financial Risk**

Source: Advisory Board, 2015
Initial ACO Performance

**MEDICARE**
- **Effective Date:** January 1, 2013
- **Covered Population:** ~12,000 Medicare FFS Patients
- **First Year Performance Results:**
  - $2.99M Savings Generated
  - 100% Quality Reporting Score
  - Increased Panel Size & Risk

**CIGNA**
- **Effective Date:** January 1, 2013
- **Covered Population:** ~35,000 Commercial Patients
- **First Year Performance Results:**
  - $3.64M Savings Generated
  - 4% Better than Market based on Quality Performance Index
  - Increased Panel Size & Risk

**FLORIDA BLUE**
- **Effective Date:** January 1, 2014
- **Covered Population:** ~13,000 Commercial Patients
- **First Year Performance Results:**
  - Projected $2M Savings
  - Currently Better/Same on all Market Quality Score Metrics
  - Increased Panel Size & Risk
MSSP Performance CY2014 (8-28-15)

- $5.34M in shared savings
  - We exceeded the CMS goal of $2.91M

- 92.57% Quality Score
  - The highest (top score): 95.41%

- We are ranked #17 nationally for performance
  - Only 86/333 (26%) participating ACOs achieved shared savings (247 ACOs were not successful)
Clinical Integration/ Care Infrastructure

Hospitals

Employed Physicians

Community Physicians

Ambulatory and Acute Care Coordination

Telehealth & mHealth

Population Analytics
3. Continuum of Care

Integration of shared patient information
## Comparing Provider Performance

<table>
<thead>
<tr>
<th>Selected Provider:</th>
<th>Aggregate Quality Score:</th>
<th>Eligible for Savings (70% Rule):</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Provider Report Card</td>
<td>92.72%</td>
<td>ELIGIBLE</td>
</tr>
</tbody>
</table>

### Measure Title and Details

<table>
<thead>
<tr>
<th>#</th>
<th>Measure Title</th>
<th>Measure Category</th>
<th>Target Score</th>
<th>Actual Score</th>
<th>Current Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Getting Timely Care, Appointments, &amp; Information</td>
<td>Patient/Caregiver Experience</td>
<td>90.00</td>
<td>80.20</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>2</td>
<td>How Did Your Doctors Communicate</td>
<td>Patient/Caregiver Experience</td>
<td>90.00</td>
<td>93.57</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>3</td>
<td>Patient/ Family Rating of Doctor</td>
<td>Patient/Caregiver Experience</td>
<td>90.00</td>
<td>93.16</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>4</td>
<td>Access to Specialists</td>
<td>Patient/Caregiver Experience</td>
<td>90.00</td>
<td>97.05</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>5</td>
<td>Health Promotion and Education</td>
<td>Patient/Caregiver Experience</td>
<td>60.71</td>
<td>61.07</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>6</td>
<td>Shared Decision Making</td>
<td>Patient/Caregiver Experience</td>
<td>76.71</td>
<td>76.95</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>7</td>
<td>Health Status/Functional Status</td>
<td>Patient/Caregiver Experience</td>
<td>REPORT</td>
<td>72.98</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>8</td>
<td>Usefulness of Patient Resources</td>
<td>Patient/Caregiver Experience</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>9</td>
<td>Risk Standardized, All Conditions Readmissions*</td>
<td>Care Coordination/ Patient Safety</td>
<td>15.45</td>
<td>15.69</td>
<td>80th Percentile</td>
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<tr>
<td>10</td>
<td>Skilled Nursing Facility 30-Day All-Cause Readmission</td>
<td>Care Coordination/ Patient Safety</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>11</td>
<td>All-Cause Unplanned Admissions for Patients with Diabetes*</td>
<td>Care Coordination/ Patient Safety</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
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<tr>
<td>12</td>
<td>All-Cause Unplanned Admissions for Patients with Heart Failure*</td>
<td>Care Coordination/ Patient Safety</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>13</td>
<td>All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions*</td>
<td>Care Coordination/ Patient Safety</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>14</td>
<td>Ambulatory sensitive conditions admissions: COPD or Asthma in Older Adults*</td>
<td>Care Coordination/ Patient Safety</td>
<td>0.27</td>
<td>1.40</td>
<td>40th Percentile</td>
</tr>
<tr>
<td>15</td>
<td>Ambulatory sensitive conditions admissions: Heart Failure*</td>
<td>Care Coordination/ Patient Safety</td>
<td>0.38</td>
<td>1.15</td>
<td>40th Percentile</td>
</tr>
<tr>
<td>16</td>
<td>Percent of adults who successfully meet meaningful use requirements</td>
<td>Care Coordination/ Patient Safety</td>
<td>90.91</td>
<td>96.56</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>17</td>
<td>Documentation of current medications in the medical record</td>
<td>Care Coordination/ Patient Safety</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>18</td>
<td>Falls screening for fall risk</td>
<td>Care Coordination/ Patient Safety</td>
<td>75.38</td>
<td>71.05</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>19</td>
<td>Influenza immunization</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>88.94</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>20</td>
<td>Pneumococcal vaccination</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>90.13</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>21</td>
<td>Adult Weight Screening and Followup</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>74.27</td>
<td>70th Percentile</td>
</tr>
<tr>
<td>22</td>
<td>Tobacco Use Assessment and Cessation Intervention</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>93.43</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>23</td>
<td>Depression Screening</td>
<td>Preventive Health</td>
<td>51.81</td>
<td>76.42</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>24</td>
<td>Colonoscopy Screening</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>74.59</td>
<td>70th Percentile</td>
</tr>
<tr>
<td>25</td>
<td>Mammography Screening</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>80.44</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>26</td>
<td>Proportion of Adults who had Blood Pressure Screened</td>
<td>Preventive Health</td>
<td>90.00</td>
<td>88.03</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>27</td>
<td>Depression Resistant at Twelve Months</td>
<td>Adult Risk Population</td>
<td>REPORT</td>
<td>0.00</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>28</td>
<td>Percent of beneficiaries with diabetes whose A1c in poor control (≥8.0)</td>
<td>All-Risk Population</td>
<td>REPORT</td>
<td>N/A</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>29</td>
<td>Diabetic Eye Exam for Retinopathy</td>
<td>Diabetes Comorbid</td>
<td>REPORT</td>
<td>0.00</td>
<td>REPORT ONLY</td>
</tr>
<tr>
<td>30</td>
<td>Percent of beneficiaries with hypertension whose BP ≤120/80</td>
<td>All-Risk Population</td>
<td>78.65</td>
<td>73.73</td>
<td>70th Percentile</td>
</tr>
<tr>
<td>31</td>
<td>Percent of beneficiaries with HTN who use Aspirin or Another Antithrombotic</td>
<td>All-Risk Population</td>
<td>90.00</td>
<td>81.99</td>
<td>80th Percentile</td>
</tr>
<tr>
<td>32</td>
<td>Anticoagulant Therapy for LVD</td>
<td>All-Risk Population</td>
<td>90.00</td>
<td>96.43</td>
<td>90th Percentile</td>
</tr>
<tr>
<td>33</td>
<td>Use antihypertensive or statin therapy for patients with CAD and diabetes and/or LVSD</td>
<td>All-Risk Population</td>
<td>91.67</td>
<td>89.21</td>
<td>80th Percentile</td>
</tr>
</tbody>
</table>

* Denotes measures in which lower rates/scores are indicative of better performance.

Report Generated on November 20, 2015

Orlando Health®
5. Evidence-based Practices

**PROTOCOL: CHEST PAIN**

The Internal Medicine Providers authorize their clinical staff to perform the following tasks when presented with a patient experiencing chest pain:

1. Registration will notify the nursing staff for assessment and the patient will be placed in an available room immediately.
2. Patient will be placed on O$_2$ sat monitor and vital signs obtained including pain level.
3. Patient will be placed on O$_2$ @ 2L via NC.
4. Provider will be notified of patient status.
5. An EKG will be obtained by nursing staff, and copy of report presented to provider for review.
6. If patient is to be admitted, they will be kept under close observation by the nursing staff, with vital signs to be taken every 15 minutes and documentation appropriately. Further orders per provider/physician.

**Team-based approach**

**Standing orders/ Protocols/ Care Pathways**

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**TREATMENT AND PATIENT EDUCATION**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Tests/Parameters</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>Integument/ ECG (EKG) OR Creatinine/ BUN (Serum)</td>
<td>12 months</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>TSH</td>
<td>11 months</td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td>Lipid Panel, ALT/AST</td>
<td>11 months, and/or before initiation and after titration of lipid lowering agent</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis, Osteopenia, Vitamin D deficiency (diagnosed or lab proven)</td>
<td>Vitamin D</td>
<td>11 months</td>
</tr>
<tr>
<td>Vitamin B-12 Deficiency</td>
<td>Vitamin B-12</td>
<td>11 months</td>
</tr>
<tr>
<td>Fe-Deficient Anemia</td>
<td>Ferritin</td>
<td>11 months</td>
</tr>
<tr>
<td>CKD</td>
<td>Ferritin, Vitamin D, Parathyroid hormone (PTH), Phos, CMP, Spot Protein, Spot Creatinine</td>
<td>5 months</td>
</tr>
<tr>
<td>Bariatric Surgery (Gastric Bypass)</td>
<td>Thiamine, Selenium, Folate, Ferritin, Zinc, B-12</td>
<td>11 months</td>
</tr>
<tr>
<td>UTI</td>
<td>UA by Chemstrip</td>
<td>As needed, 5/5 UTI</td>
</tr>
</tbody>
</table>

**Note:** The patient's chart will be reviewed to determine if the above laboratory tests need to be ordered. Abnormal values will be reported to the primary care physician.
6. Consumer/ Caregiver Engagement
Patient-Family Advisory Councils

Consumerism/Empowerment/Shared Decisions

Making Interventions for total population
Example of PFAC Takeaways/Action Items (OHHI)

Transitioning to Home (Care Transitions)
- Start discharge conversation early
- Address all concerns and fears about going home, before discussing discharge instructions
- Remember patients have been waiting for discharge all day, absorbing information at time of discharge is difficult.
- Utilize a discharge checklist. Make sure you have covered everything before letting patients go.
- Patients would rather be told a specific time or window of time they will be discharged

Heart Failure - In Hand Program
- Love bedside medication delivery
- Requested for someone to follow up with patients after they have been discharged to make sure they are taking their meds.
Shared Medical Appointments

• Educational session with the components of individual patient visit
  – 1-on-1 medical evaluations conducted by the provider
  – Dietitian and/or RN CDE
  – Social Work (LCSW and MSW Interns)
  – PT/OT, Exercise Physiologist
  – RN Care Coordinator
  – Pharmacist
  – Other community health partners/providers (i.e. Hospice—5 wishes, advanced directives, goal setting)
Patient Engagement is Key!

Results (after 12 months):

- 14.1 pound weight loss
- 2% decrease in HgbA1c
- 46mg/dl drop in LDL
- 16mm Hg drop in SBP
- 11mm Hg drop in DBP

"Shared medical appointments' are part support group, part education"
ROI on Patient Engagement (SMA)

- **Standard visit:**
  - 99213: $72.88 (15 min visit) per patient
  - 99214: $107.56 (25 min visit) per patient

- **SMA:**
  - 99215: $144.08 (90 min visit) per patient
  - Average: 10 (to 12) patients per 90 min visit

- **Comparison (looking at patients seen in 90 minutes):**
  - **Standard:**
    - 99213: $72.88 \times 6 \text{ patients} = $437.28 \quad (90/15 = 6)
    - 99214: $107.56 \times 4 \text{ patients} = $430.24 \quad (90/25 = 3.6)
  - **SMA:**
    - 99215: $144.08 \times 10 = $1,440.80 \quad (All 10 patients get 90 minutes)
What about RVUs???

- 99213: 0.97 wRVU x 6 patients = 5.82 wRVU
  - 5.82 x $37/ RVU = $216.45

- 99214: 1.5 wRVU x 4 patients = 6 wRVU
  - 6 x $37/ RVU = $222

- 99215: 2.11wRVU x 10 patients = 21.1 wRVU
  - 21.1 x $37/ RVU = $780.70

- That’s money back to the physician.
- Not to mention closing gaps in care.
  - *Shared savings contract anyone?*
Virtual Care

- Tele-ICU
- Tele-Psych
- Stroke Care
- Logistics Center (C4)
- TeleCare (Nurse Triage)
- eVisits—UFHCC, OPN
Advanced Remote Patient Monitoring
Advanced Remote Patient Monitoring

How much did your breathing affect your activities yesterday?

- I did everything I wanted to do.
- I did almost everything I wanted to do.
- I wanted to do more, but was unable.
- I had difficulty doing anything.
- I could not get out of bed without help.
Advanced Remote Patient Monitoring

About Statins
Advanced Remote Patient Monitoring
Please hold questions until the end