**TABLE OF EXPERTS**

**How Value-Based Care Is Different**

**Value-based care**

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<td>Consumers are at the center of the health care system.</td>
<td>Proactive, preventive care, with an emphasis on keeping people healthy.</td>
<td>Physicians empowered by new technology, data and financial incentives to coordinate care.</td>
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**Traditional Care**

- Complicated health care system confuses and frustrates consumers.
- Reactive, transactional care delivered in response to an injury or illness.
- Lack of technology and incentives for physicians to coordinate patient care.
- Data trapped inside massive repositories; lack of sophisticated analytics.

**ACONVERSATION ON HEALTHCARE**

**Spotted by** United Healthcare

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**Joanna Grange:** There’s a lot of talk in the healthcare industry about value-based care. What is UnitedHealthcare’s model of Value-Based Care and what does it do to offer its consumers, employers, and providers? **Stephen Wilson:** We’re all here because we believe Value-Based Care leads to better health, better outcomes, and lower costs. Collectively, placing greater emphasis on value in healthcare can improve for providers, patients, and employees in the Memphis area. We’re focusing on managing the health of our population, rather than the number of services for better health. We need to shift from the fragmented fee-for-service model, and place the emphasis in the center of the health care experience to increase personal connections between the provider and the member. This leads to more primary care visits, more care opportunities identified, and lower hospital admissions and ER visits. It starts with a relationship. Together, with our high-performing providers, we’re working to make sure our community is more informed. For employees and individuals, the Value-Based Care approach offers real results. Care providers are helping patients get ahead of conditions and better manage medical issues. Their patients spend more time with primary care providers and less time in the ER or in the hospital. These changes, in turn, translate into better value for employers looking for the best care plans for their employees. It’s important because the health of Tennesseans continues to be a major concern. According to United Health Foundation’s America’s Health Rankings® Report, Tennessee ranks 45th for healthcare. Forming this ACO allows us to identify trends and look for solutions.

**Mitch Graves:** The entire healthcare industry is slowly shifting to value-based reimbursement, paying for quality and outcomes. We see this happening with Medicare, TennCare, and commercial insurance. UnitedHealthcare sees very fundamental to this fundamental shift.

**Dr. Ken Worman:** Physicians involved in taking care of the community realize that things have to change. And change is coming. It’s being demanded by employers. Some physicians don’t like it, but it has to be. Value-based Care is clearly a model that’s embraced by MetroCare’s leadership—engaging physicians in that change is a challenge, but it’s the right thing to do. And having partners really helps.

**Dr. Karen Cassidy:** There’s a culture shift in medicine affecting how practices operate. That’s why relationships between providers and payer are so important. It’s critical that we’re supporting for practices to facilitate this change. As we see better outcomes with Value-based Care, we know it’s the way to go. We have great potential with these initiatives to make a difference for people in Memphis.

**Crange:** UnitedHealthcare recently released its second national report about Value-Based Care outcomes. While it reflects national findings, what does it indicate for Memphis?**

**Dr. Cassidy:** UnitedHealthcare’s goal is to help people live healthier lives, and Value-based Care is key. The national Value-Based Care report shows significant differences among employee-sponsored health plans and the quality of care they provide. ACOs perform better in 37 percent of the quality measures tracked in the report. We have a robust data panel—total spend, pharmacy data, claims, etc. The challenge in an ACO setting is how to get the data to the physicians who are seeing the patients so they can take action. To that end, we have a specific team working within the ACO to make sure the data is understood.

**Christopher Parrilo:** It’s important to automate the quality data and cost data, and share it on the physician and individual level to drive better quality outcomes.

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**Mitch Graves:** Practice has made a significant investment in data tools. We’ve installed the Optum Suite of analytic products. It’s an aggregation tool that takes data and allows our team to go through that, look for variations, and build lists for practices to look at patient gaps in care, follow-up on patients, and identify patients who need annual well visits. This also allows us to build scorecards by populations, practices, and individual physicians.

**Dr. Worman:** About 15-20 years ago, when managed care came into practice, there was a velocity of data that was transferred to the doctor. Now, it’s like a giant fine hose: valuable data is coming from every direction to physician practices, and it’s overwhelming. The job we see at the ACO is to take that massive amount of data, summarize it, and put it into forms so practices can use it. We can’t just give it to them. We have to educate people with our transformation teams, on exactly how to take that information and integrate it into their practices, and then we measure and give feedback about outcomes. The ACOs that do it the best are the most successful.

**Mitch Graves:** Small practices don’t have the infrastructure in place, so we have to do workshops. Methodist has taken on that project in a big way in their employed physicians practice, trained physician and medical home recognition—insisting on all the concepts about value-based care into practice. It’s done to the level of the physician and provider. There’s a challenge to make sure the information is different formats, for different practices and consumers at different levels. UnitedHealthcare has provided a lot of tools; we filter tools for individual practices and provide our practice with a top tool bag, which we didn’t have.

**Dr. Cassidy:** Primary care provider (PCP) practices are busy—working hard and seeing patients all day. If we ask them to review a report, we have to make it actionable for each patient, and it’s not always readily apparent. A provider may have created a hemogram for a specific patient and not realize the patient never followed through to get the screening. We can see that there is not a claim in the system and alert the provider of the gap in care.

The data has to drill it down to individual members. If you’ve got a PCP and it’s not coming in, you lose the face of the problem. The opportunity to reacquaint those people, we need outreach and encouragement for them to come back and receive care—it makes a difference.

**Parrilo:** It’s about working with providers to share population data to drive toward quality outcomes. Internal medicine physicians, for example, see several hundred diabetic patients a year. They likely have patients that need a diabetic eye exam but don’t have the will to identify who may need to have that gap in care closed. UnitedHealthcare has that data, and can bring it to practices to close that gap in care.

With technology and quality data, we need to think about members who have to make decisions on who their provider should be. If there are 10 surgeons to choose from, who does the member choose? The online tool on the app or website offers transparency into cost and quality to help them decide on the right care.

**Graves:** The actionable data is what’s necessary.

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Helping people live healthier lives and making the health system work better for everyone.

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Important – providing easy access to useful patient information that allows physicians to take specific actions with the patient. I never understood the term big data until now. Value-based healthcare holds a physician accountable for the patient they see. Our strategy is to help them with patient data, allowing them to be successful in the new environment.

That’s the nuts and bolts of population health. Identify the population, measure outcomes, and give support. It’s not measured, it’s not measured – and it’s pretty clear that those reports help physicians attend to this.

We’ve seen substantial improvement of patient outcomes. Everywhere we’ve looked, much of the work we’ve done so far is to prevent patients from having chronic diseases for which there is not an immediate ROI. The payoff comes 5-10 years down the road when we have a percentage of the population having fewer diseases such as diabetes.

In addition to data, Optum has risk adjustments that look at diagnoses, procedures, and medical history and outcomes, which allows us to identify the populations to work with.

**CareExemptions: How are you integrating better care through ACOs?**

Graves: The Optum system is our tool that allows us to monitor both quality and financial outcomes. We then pass the results of our reviews which allows us to identify opportunities. The technology allows us to roll up multiple sources of data which allows us to see trends across a larger group of practices.

Wilson: Optum is part of the UnitedHealth Group family, and includes hospital services such as data analytics; pharmacy care services; population health management, health care delivery, and health care operations. They are a leader in innovation and are at the forefront of technology and data use, and really seek to serve all of the healthcare systems – providers, government entities, like academic companies, and even other payers.

These services are critical in helping turn data into usable information that leads to better health outcomes. And as our partnership grows, Optum will play a bigger role as how we work with ACOs. We know the value they provide is absolutely needed to turn that data into actionable information to ultimately improve the overall health of the community.

**Parillo: We want to simplify the information through technologies and integrating different systems to give that primary care physician or specialist a full view of that patient’s care, and allowing them to provide the right care at the right time.**

**Dr. Wortham: Optum aggregates information from all those different lines of business in one location, helping patients take care of anything other than disease burdens. We can identify populations that way.

Hospitals are challenged with that – disparate systems and reports. Practices are challenged, and where we’re inserting Optum to create that summary to help physicians do the right thing.**

**CareExemptions: What should people in the region know about HealthChoice?**

Graeven: HealthChoice is the largest ACO organization in the area. There are 130,000 lives in our accountable care organization.

We’ve mentioned Triple Aim – to improve the health system, we focus on outcomes, satisfaction, and cost, and, we add, physician engagement and satisfaction. The transition from fee-based care to value-based care is painful for physicians. So part of our goal is to make that journey easier.

The Center of Excellence has a team that goes into practices to help them integrate the data into their daily routine. In addition to data aggregation, we have population health management. For instance, we have specialists at the center: nutritionists, pharmacists, etc., to help individual patients who have been in the hospital. We help them improve and prevent them from being readmitted.

**Dr. Wortham: We have Care Coordination Teams and Management Teams. But we have a 21st century hurdles – providers are allowed into ambulatory care or hospital care. The connection between the two is fragmented. In hospitals, the staff inside don’t go outside of the group, yet they get a patient turned down, so they have to be able to do that.**

**CareExemptions:** That’s a critical piece that the ACO is trying to fulfill: that connection between in an patient who stays and the ambulatory services side. As we know over the past 20 years, there’s been a huge migration of care out of hospital services to an outpatient setting. Yet there’s a significant number of surgical services in physicians’ offices. We have to consider the migration of care on the outpatient side, and making the connection to the hospitals.

**Dr. Cassidy:** I wish that last part had more legs that addressed the ambulatory care providers and saw them in hospitals. When we started in clinical practice there weren’t hospitalists in facilities. Now there’s a disconnect between the care in the inpatient and outpatient setting. ACOs can build relationships so there is a warm handoff from the inpatient care team to the ACO’s outpatient care team.

**CareExemptions: How many members and how much spending does UnitedHealthcare have under value-based care nationally and locally in Tennessee?**

Parillo: I don’t just think about the ACO. There are primary care incentive arrangements that fall into value-based arrangements, and episodic arrangements. We know that an ACO can have the same provider, which is probably more than 90% of patients, that equates to $1 billion in annual healthcare payments. By 2021, we’ll see that increase to upwards of $700 billion.

In Tennessee as a whole there’s $1.4 billion in value-based care. In Memphis, it’s $500 million – that’s a pretty big number. We have 20,000 employer-sponsored members receiving care in an ACO, for a total of $70 million annual spend. Looking at other value-based programs, there’s another $100 million for the same employer-sponsored health plan participants.

In short, you can see that we have incentives in place in Value-based Care that will continue to grow over the next three to five years. The ACO arrangements aren’t the only incentive-based programs that drive Triple Aim to improve outcomes, improve population health, and reduce costs.

Graeven: Other examples of successful partnerships that fit into value-based care include West Clinic which is a oncology medical home, and Le Bonheur Children’s Hospital that treats TenCare asthma patients. We have more dialysis centers per capita than any place in the country. It’s a horrible statistic. It’s from a culmination of the things we’re trying to prevent or improve on the front, so a Memphian never gets to pay that. We’re measuring the state of what we’re trying to do; there’ll be no reason to see another dialysis center. The only way is to start early in the preventive-care process.

**Dr. Wortham: One thing that’s commendable is what UnitedHealthcare decides differently than say, another ACO, huge migration of care out of hospital services to an outpatient setting. In other areas, there’s a significant number of surgical services in physicians’ offices. We have to consider the migration of care on the outpatient side, and making the connection to the hospitals.**

**Dr. Cassidy:** We have to think of that and the needs of the local market and where it struggles. We look at metrics, and where the need is in a community becomes our focus – that’s where we make a difference.

There’s an employer perspective, too. Not only is dialysis and renal disease difficult for a patient, it’s costly for the employer. If we can improve that patient’s health with coordinated care in an ACO setting, it benefits the employer and can lower costs.

**CareExemptions: Are there specific categories that UnitedHealthcare is focused on when it comes to Value-based Care?**

Parillo: There’s a series of quality metrics we’re focused on, and the approach is different from market to market, based on the burden of illness in that population. If we have already have high, positive metrics, we have to consider if that is part of the ACO arrangement and where we need to see the most improvement.

It’s not just happening at a physician’s office. It’s also in an acute-care setting. Things like length of stay sacrifices, quality, infection rates as it relates to a procedure or surgical outcomes. It all gets back to a quality-per-capita cost and making sure the ACO and each of the physicians are aligned with that.

**Graves: A friend of mine is 57 years old with a family history of colon cancer. She never went for a colonoscopy. She was just diagnosed with stage 4 colon cancer. Those are the folks we hope to reach in our outreach to push forward the importance of preventive visits and screenings. If she had gone in at age 50, would that have prevented her from stage 4? I’m going to say the answer is probably yes.**

There is patient responsibility, but if a quality gap in care had been performed. If someone had followed up with her saying she needed to get checked by a GI because of her family history, maybe she would be alive today. As a chemotheraphy and radiation treatment, she would have a better outcome, and the cost would be much lower. This is the perfect example of ACOs at work. We have the data, we have to stay on it and engage.

**CareExemptions: If we look a few years down the road, what do you see being offered offsite to patients with their physician. The population is changing. Everyone seems to depend on their smartphones for nearly everything in life. With the ER, for instance, provide quick access to patients to triage health issues. Then you can ask if there is a problem they can solve in an e-visit? Do they need to see the ER? I think that’s looking forward to where the next populations will take us.**

**The social determinants of health in a community plays a huge role in education, household income, access to fresh fruits and vegetables in the area, access to a safety net to be able to find the right risk factors long term as to how we look at patient populations and what we do.**

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decide to attack. There are different strategies needed around Memphis. We must be mindful going forward together and look at improving the health of the entire population.

Wilson: Employers and consumers are demanding from us higher quality, lower costs, and more access points to care. We'll see continued investments in technology. We're committed to that at UnitedHealthcare, where we annually invest more than $3 billion in data, technology and innovation. You'll see us continue to collaborate on new ways to bring care through mobile apps and telemedicine. And we're making available to our members and all consumers online and mobile resources that allow people to comparison shop for health care based on quality and cost.

UnitedHealthcare Motion®, a wellness program available to employers, enables people to earn more than $1,000 per year by meeting certain daily walking goals. If people meet daily walking targets, incentives are deposited into health savings or health reimbursement accounts (HSA/HRA). It helps employers reduce healthcare costs, while encouraging employees to walk more and take better care of their health. The program is unique to UnitedHealthcare, and the initiative has seen tremendous demand due to the easy administration for employers and the significant incentives for employees.

Dr. Wortham: From the physician's perspective, the patient engagement piece has seemingly been pushed to the physician practice in a big way. That's the pushback I hear, and it's critical to getting full engagement. We can't expect one spoke of the wheel to do the job. We have to attack from multiple points and different angles. Those are things physicians want to see, some incentives, reward, or penalty. The key is aligning incentives of everyone involved. It hasn't been done.

Crangle: Final words about health and ACO?

Wilson: The relationships we have with the organizations in our ACO are strong. The collaboration has been tremendously successful. It's satisfying to see results through our value-based arrangement. We hope to do more and we thank these health systems for collaborating.

Graves: The heavy lifting is being done with our physician partners at MetroCare. For years, insurance plans and hospitals have tried to change physicians' behavior, but it's physicians talking to physicians with data that makes that happen.

As we look at data, it's all about building trust. The physicians need to trust the data, as patients trust physicians to do evidence-based medicine. In the population health department, if we don't develop trust with patients, we don't see any changes. It's got to be centered around the patient, and I think we're all becoming very focused on that and it should help the patient.

Parrillo: Our ACO relationship is about how the member is connected. What we talk about with our collaborative partner day to day focuses on how we can improve to Triple Aim, through things like member outcomes and how we're positively improving their lives. We share the same set of core culture and values—our interactions are already aligned. We embrace the opportunity to do more and go forward.

Dr. Wortham: From the physician perspective, collaboration and alignment of incentives are important and critical. Physicians have always had patients' interests at heart. We see them as people not members, not stats, not gap in care lists—that's our mission, being able to do the right things at the right time for each patient.

Physicians want to be partners. In the past, it hasn't been the greatest experience. This time around, we bring more of the right tools and pieces to make it successful. It's taking time for physicians to get over the less beneficial circumstances, but we're moving in the right direction and gaining more and more support.