KentuckyOne Health Partners

KentuckyOne Health ®

2018 Value Report

Year in Review 2018

KentuckyOne Health Partners (KHP) experienced another year of success in 2018. Our outstanding clinical providers and KHP care management team worked collaboratively to improve outcomes across the spectrum of people we serve. Their focus and commitment to our principle aims resulted in better health, better care, better experience, and lower cost for our nearly 100,000 managed lives.

In response to KentuckyOne Health's Transaction and Transformation work, we've reoriented efforts over the past year to include new strategies, such as expanding Direct-to-Employer solutions and creating new value-based payer arrangements focused in the Lexington/East-Central market. A KentuckyOne Health Employer Solutions Committee was formed, aligning the clinically integrated network with payer strategy, work place care and physician liaisons, coordinating overall business development efforts for the organization. Additionally, we entered into Medicare's Bundled Payment Care Improvement-Advanced initiative for Congestive Heart Failure at Saint Joseph Hospital, Saint Joseph East and Saint Joseph London.

In collaboration with KHP, our medical practices report quality for approximately 4,000 Medicare beneficiaries and have earned nationally-ranking in the 2nd quartile among all US physicians.

As part of Medicare's Next Generation ACO Model, our efforts created over $4.2 million in efficiencies and resulted in a significant gain share for our organization.

KHP was again certified as a 5-Star "Elite" ACO by America's Physician Group (APG), which is the standard of excellence for accountable care organizations. And for the 5th consecutive year, KHP was named by Becker's Hospital Review as one of the 2018 "ACOs to Know". Because of these national recognitions and outreach in the employer market, KHP leaders were invited to speak at several national and state conferences, including the annual Kentucky Society for Human Resource Management (SHRM). In late 2018, KHP was benchmarked by the Johns Hopkins Alliance for Patients.

We are proud to be the largest, most successful Medicare-certified Accountable Care Organization (ACO) in Kentucky and continue our important mission to improve care for all the lives we touch.

Don Lovasz
President

Bruce Tassin
Market CEO

Performance 2018

KHP continues to demonstrate positive performance, working with providers to help lower Total Medical Spend (TMS) on managed lives and improving quality metric outcomes. While KHP stepped away from Medicare's Next Generation ACO Model for the 2018 calendar year, final reports indicate efficiencies of $4.2 million, resulting in $2 million in shared savings.

The second performance year of Medicare's Major Joint Replacement program was also positive, with $2.5 total medical savings, resulting in $1.3 M hospital internal cost savings and $0.5 M gain share distributions to 16 orthopedic surgeons.

New information indicates that KHP's management of the CHI/KentuckyOne Health Medical Plan indicates a five year pattern of a 2.2% year-over-year increase in TMS, as compared to a 5% increase other Kentucky businesses and brokers report.

By the Numbers:

- 100,000 managed lives
- 2,000 physicians and APCs
- 100 provider organizations
- 50 post acute organizations

5 Year Results/Savings:
Medicare - $33 M
CHI Medical Plan - $7 M
Medicare Advantage - $ 3 M
Major Joint Episodes - $4 M

Top Quartile Performing Medicare ACO 2017
(of 450 Medicare ACOs nationally)
Provider Quality Improvement 5 Consecutive Years
Largest ACO in Kentucky
APG Elite 5-Star ACO
Best CMS Episode Program in CHI
Modern Healthcare Top 15 & Becker's Top 100 ACO's
ACO Care Management System deployed

Better Health

Dr. Thomas Coburn
KentuckyOne Health
Primary Care

Dr. Thomas Coburn has experienced success utilizing Annual Wellness Visits to close care gaps. He shares how his office has hardwired these 5 best practices:

1. Schedule patients for their Annual Wellness Visit when they are in your office.

   "Not only do I discuss and encourage annual wellness visits while I am seeing my patients, our office staff reinforces that I recommend a yearly wellness exam to plan their care for the year. As patients check out, we check to see if they have had a wellness visit in the past year – if not, we schedule them before they leave. We explain to patients that wellness visits are 'routine maintenance,' like an oil change for your car or new air filter in your home."

2. Wellness visits provide time to have a discussion with patients about prevention and validate that needed screenings are up to date.

   "Patients often report their preventative studies such as colonoscopies and mammograms are up to date, but the reality is often different than what they remember. Having a set time to get a true picture of their needs, discussing their results, and emphasizing needed compliance can make a significant difference in closing care gaps."

3. It's totally acceptable to combine a wellness visit with a follow up – you can bill for both.

   "As long as your documentation supports both services, you can combine a follow-up visit with a wellness exam. If you have questions about how to appropriately document, ask your fellow providers."

4. Annual Wellness Exams are here to stay – use them to keep you and your patients on track.

   "I believe that the culture of treating illness and emphasizing volume is slowly shifting to encouraging wellness and valuing quality. Annual wellness exams are a necessary part of that paradigm shift. People are living longer and healthier lives, and the focus on wellness is a change that is hopefully here to stay."

5. KHP is an extension of your office team, not another sales rep! Take advantage of this benefit.

   "It's important that my patients know that I know and work with Adonna, my RN care manager on a regular basis - and that she is part of my office team helping my patients. This helps me have better hospital follow-up, closer observation during recovery, and better patient outcomes. My high risk patients' benefit from Adonna's help – reviewing needs, reaching out to me about care gaps, and offering recommendations. In short, the KHP care management team makes providers look better and help improve our outcomes and patient satisfaction."

Better Care

KHP Patient Outreach Leads to Unique New EMS Partnership in Lexington

As a result of helping a patient who was a frequent emergency department visitor, the KHP Care Management Team identified a new opportunity to work with Lexington EMS. The new partnership is already proving to be a great success.

KHP RN Health Coach Teresa Crowell and Outpatient Care Coordinator Elizabeth Atkins, MSW, CSW received a referral from the patient's primary care provider. The older widowed patient has active diagnosis of Congestive Heart Failure, COPD and Hypertension and his failing health made it challenging to care for himself. Teresa and Elizabeth quickly developed a plan that included Wheels transportation, Meals on Wheels, services for bathing assistance, meal prep, housekeeping, medication support and additional medical visits.

After discussing the plan, the patient shared with Elizabeth a local EMTs business card. He said he was given the card because he goes to hospital emergency departments so frequently and the EMT wanted to call Elizabeth to see how their team might be able to assist in the patient's care plan. Elizabeth met with two EMT's that are part of the Kentucky Community Paramedicine Program, focused on reducing unnecessary calls to 911 and unnecessary ED visits. She learned that this particular patient was the 4th highest utilizer in Fayette County, having called emergency services 31 times between November 2017 and March 2018. In all 31 calls, the patient's lowest oxygen saturation was 94% and on the last response, his blood pressure was 126/80 and heart rate was 74.

We attempted unsuccessfully to get the patient placement in a short term skilled facility for PT, nursing, education on medication use, and self-care. However, the new working relationship with EMS helped make placement a reality.

The patient developed a UTI, called 911, and our partner EMT heard the call. He went to the emergency department with the information needed to get the patient admitted. And the tag-team effort allowed Elizabeth to work with the hospital case manager to get a skilled care placement. Following discharge, Elizabeth was able to coordinate a short term stay at a family member's home, begin home health, and get needed home equipment. She has also been able to visit and discuss future housing and other personal care options.

Since KHP's new relationship with the Community Paramedicine Program, this patient has only accessed emergency services once, and that was the day he was actually admitted.

Now the Community Paramedicine Program is reaching out to KHP when they think one of their patients might be a covered life.

Better Experience

A Focus on Preventative Screenings

When it comes to reminding employees of free preventative screenings, Population Health Assistant, Shelly Berry, has taken it to a new level. Shelly immediately breaks through barriers and helps motivate people to take action.

This personal conversation was all one particular employee needed to take better care of her health. It had been 5 or 6 years since her last mammogram and Shelley encouraged her to make the appointment. The next day, this employee visited the KHP office to let Shelly know she had followed through. She told Shelly, "I was thinking about getting a mammogram, but you gave me the push to do it!"

Additionally, this patient was not established with primary care. Shelly utilized KHP care management staff to schedule an initial new patient appointment with a KMG primary care provider.

KHP's team provides personalized care, just in time!

Tracy House, BSW, Outpatient Care Coordinator, received a referral from a Humana nurse in 2017. Over the year to come Tracy developed rapport with the couple who lived in London, KY. Tracy was able to help connect them with United Way who provided a ramp into the couple's home, arrange for home meal delivery, find financial assistance for outstanding medical bills, and overcome transportation barriers.

When the wife, the primary care giver for her husband, was referred for hip surgery at Saint Joseph Hospital London and would likely require a stay in a skilled nursing facility for physical rehab afterwards, Tracy again stepped up to help. Tracy coordinated with their Humana insurance, both primary care providers involved, CHI VNA Health at Home, and the Saint Joseph Hospital London social worker to navigate needed approvals and coordinate options.

On the day of surgery the husband was approved for skilled nursing facility rehab. Tracy and team were able to coordinate placement for the couple, together. After a 20 day stay, they were discharged home. Tracy again worked with the skilled nursing facility discharge planner to coordinate home health care, medical equipment needed, medication delivery and follow up appointments with their providers. Tracy then made a home visit to make sure the couple received everything they needed. Thanks to the personalized support from the KentuckyOne Health Partners team, the couple is doing well.

The providers and nurse navigator at MD2U shared, "Tracy's hard work to coordinate care for our patients made a significant difference for this couple. Patient's often can't appreciate the benefit of having support from the KHP care management team, unless they've had to coordinate their own care in the past."

Lower Cost

Lower cost medications contributes to compliance

When RN Health Coach Teresa Crowell was reviewing patient charts, she identified a patient who was not refilling her needed insulin prescription. At the patient's last primary care visit, the provider documented the patient had been without insulin 4 weeks prior to the appointment.

Teresa reached out to the patient and learned the patient's out-of-pocket cost for insulin is $190 per month. The patient had refilled the prescription at the time of her physician appointment, but would again be out of insulin in just a few days.

Teresa connected the patient to Outpatient Care Coordinator, Shannon Nally, MSW who completed a quick assessment. Shannon learned that not only was the patient's insulin $190 per month, the combined out-of-pocket cost for all of her medications totaled $325 per month- just over a third of her monthly income.

To address the immediate need, the KHP Care Management team reached out to the patient's primary care provider and coordinated insulin samples for the weekend. Thankfully, the story doesn't stop there.

Shannon is now working with the patient to apply for the Federal Extra Help Program which will reduce the cost of her prescription co-pays to a few dollars a month. In addition, KHP Pharmacist, Carrie Schanen is also reviewing the medications to see if less costly medication options are available through the patient's insurance.

The KHP Care Management Team works diligently every day to find solutions for the patient beyond the moment of crisis. High risk patients can be referred to the care management team by any CIN provider. Please call 877.543.5768 to see if patients qualify for help managing their care.

Acknowledgments
KentuckyOne Health Partners would like to extend sincere thanks and recognition to our outstanding providers for their leadership and commitment to quality. Special thanks to our board and associates who dedicate their time, talents and energy to the advancement of our vision – to be the leading clinically integrated network coordinating care for all the lives we touch through population health management.

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