a community model case study

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October 26, 2010

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agenda

- Background
- Structure
- Initiatives
- Lessons Learned

our brutal reality regarding affordability

- in the past decade, California HMO rates have increased on average 11% per year
- if we manage to reduce that trend to 8% in the next decade, prices will double by 2020. . .
- . . . and our Access +HMO family rate for CalPERS members will be nearly $39,000 per year
- we believe this will not happen: either the private sector will solve this issue or it will be solved for us

employers can hardly afford today's rates

It costs less to hire a software engineer in India than it does to pay for the health benefits of a software engineer in Silicon Valley

—*Blue Shield Analysis (after conversation with Venture Capitalist)*

"Wow, we're paying almost twice in health care costs as what we're making in earnings…"

—*Steve Burd, CEO of Safeway, The New York Times, November 29, 2009*

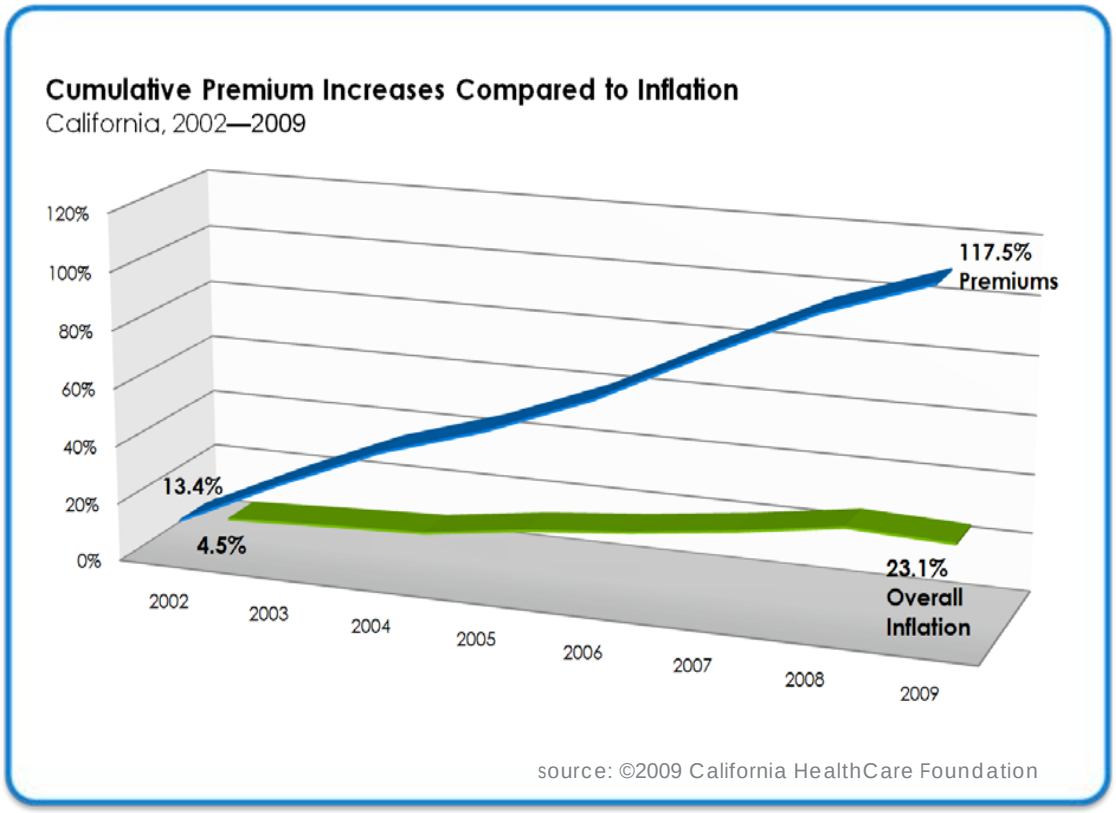
(The company now spends) "almost as much on health care for our partners as we do on the green coffee we buy."

—*Howard Schultz, CEO of Starbucks Corp, Thomson Reuters, July 27, 2009*

"G.M. has to address how a company that lost more than $20 billion last year can afford $5 billion a year in medical bills. G.M's future obligations for retiree health care are estimated at $47 billion, and by next year it is required by its contract to contribute more than $10 billion to the trust set up in 2007."

—*The New York Times, February 17, 2009*

and our trends threaten the long-term viability of private health insurance

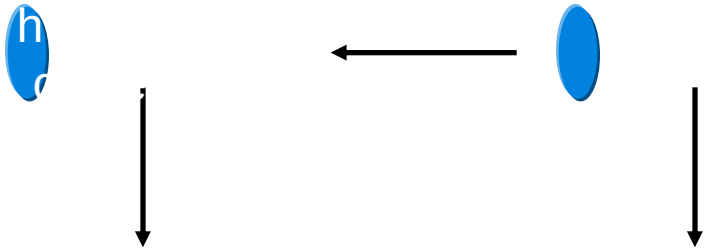


In 2020, $39,000 could …

- purchase a CalPERS, Access+ HMO family insurance policy from Blue Shield
- buy 6 years of a household's groceries
- be 1.6 times higher than the median income for BRIC counties
- buy the newest version of a Toyota Prius

Source: Premium forecasts based upon standard plan manual premium PPO annual increase of 10.3% from the Milliman Group Health Insurance Survey 2008 & Commonwealth Fund California premium data of $12,254 in 2008, "Paying the Price: How Health Insurance Premiums are Eating up Middle-Class Incomes" August 2009. 2020 forecasted median CA household income from IHS Global Insight, annual household food expenditures from the National statistical offices/OECD/Eurostat/Euromonitor International, BRIC & World annual gross income projections from Euromonitor International and from national statistics, Prius pricing from April 2010 Consumer reports ($26,750 with assumed 3% trend per year over 10 years)

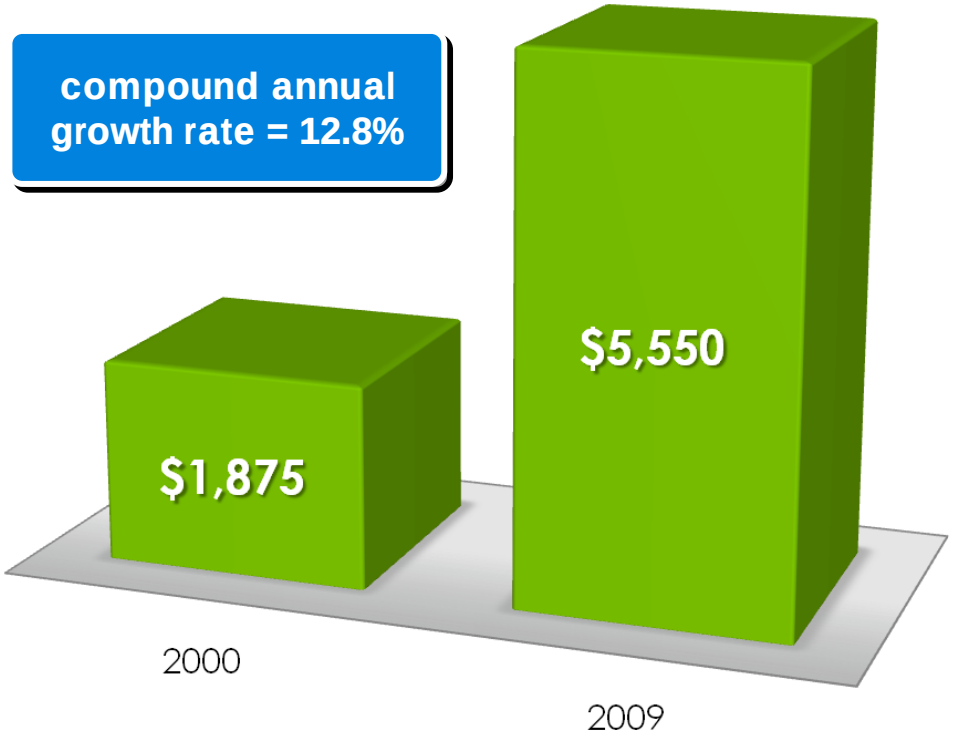
what drives cost?



cost and quality of health care

what drives costs (continued)?

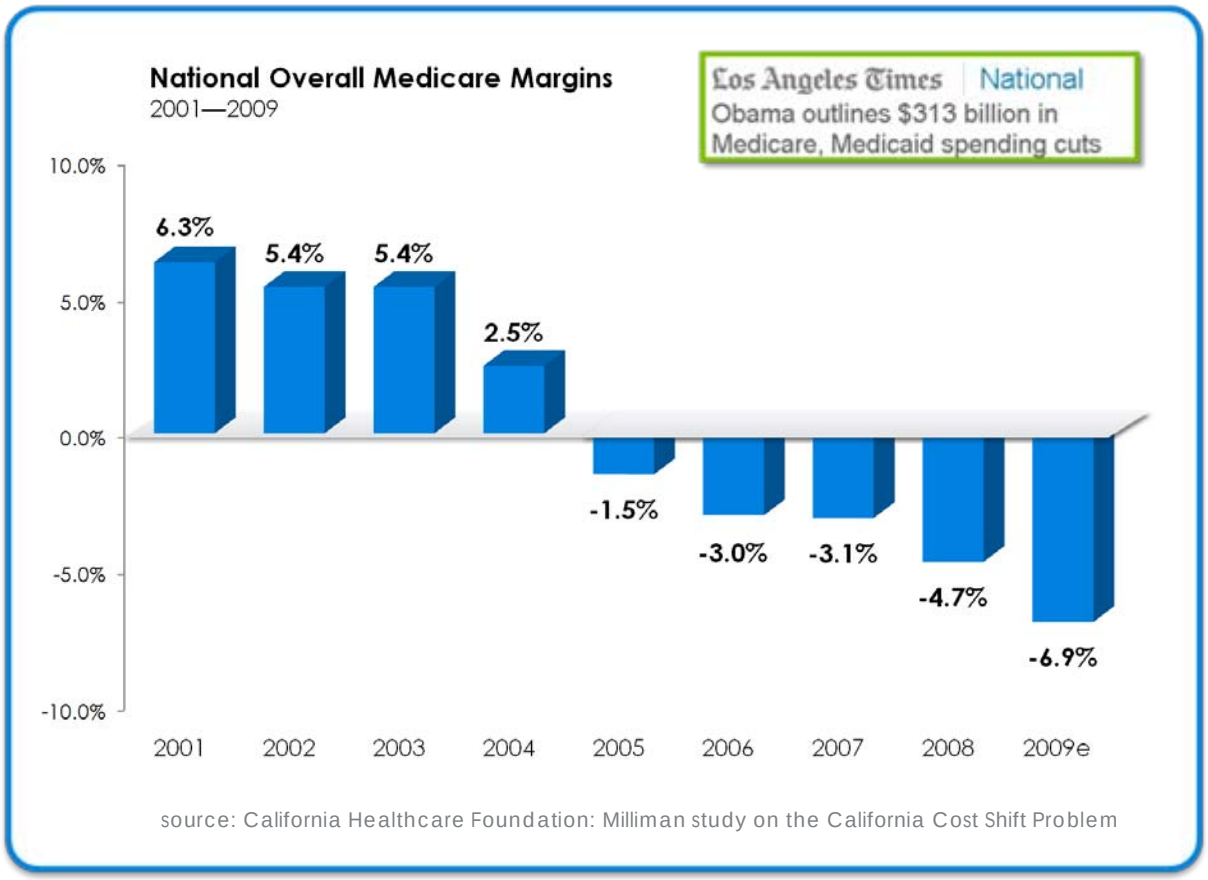
average cost per acute inpatient bed day in California



what drives costs (continued)?

Hospital Costs/Profits

- nearly $10 billion in under reimbursement from medicare and medicaid in CA
- increasing number of uninsured
- infrastructure upgrades
- nurse staffing ratios
- costs of new technologies



THE WALL STREET JOURNAL. | POLITICS

JANUARY 28, 2009

States Take Aim At Medicaid

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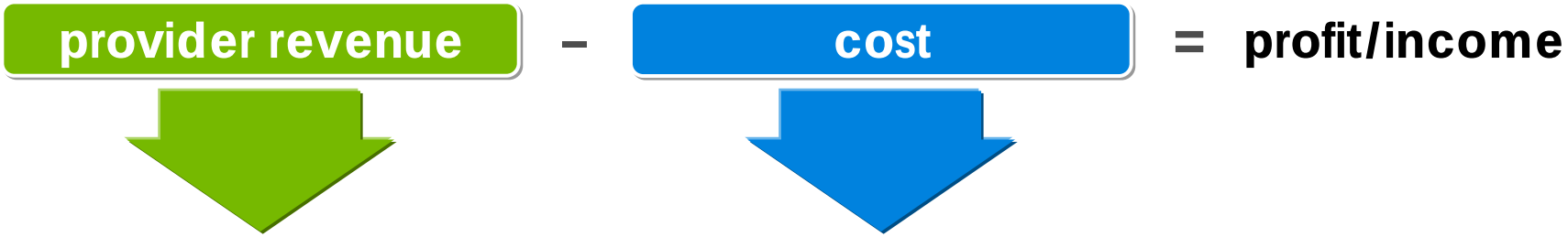
collaboration is required if trend reduction is to be sustainable in the long term



Current model:

Solve profit needs by increasing revenue from all commercial payers

Future model (value proposition):

Solve profit needs by reducing per member costs

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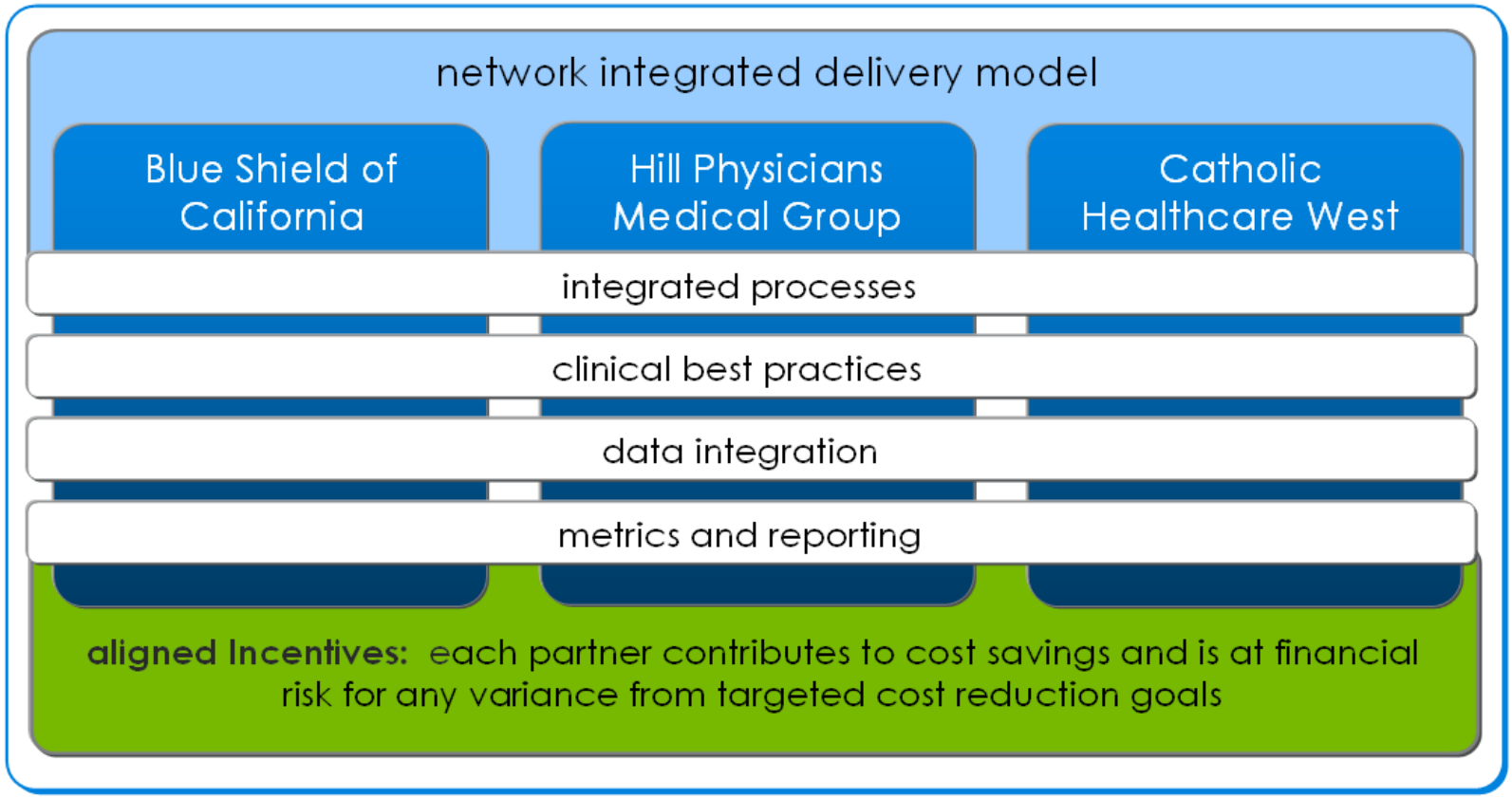
structure

collaboration is required to…

- develop an integrated delivery model
- provide coordinated care
- improve quality outcomes
- drive out cost



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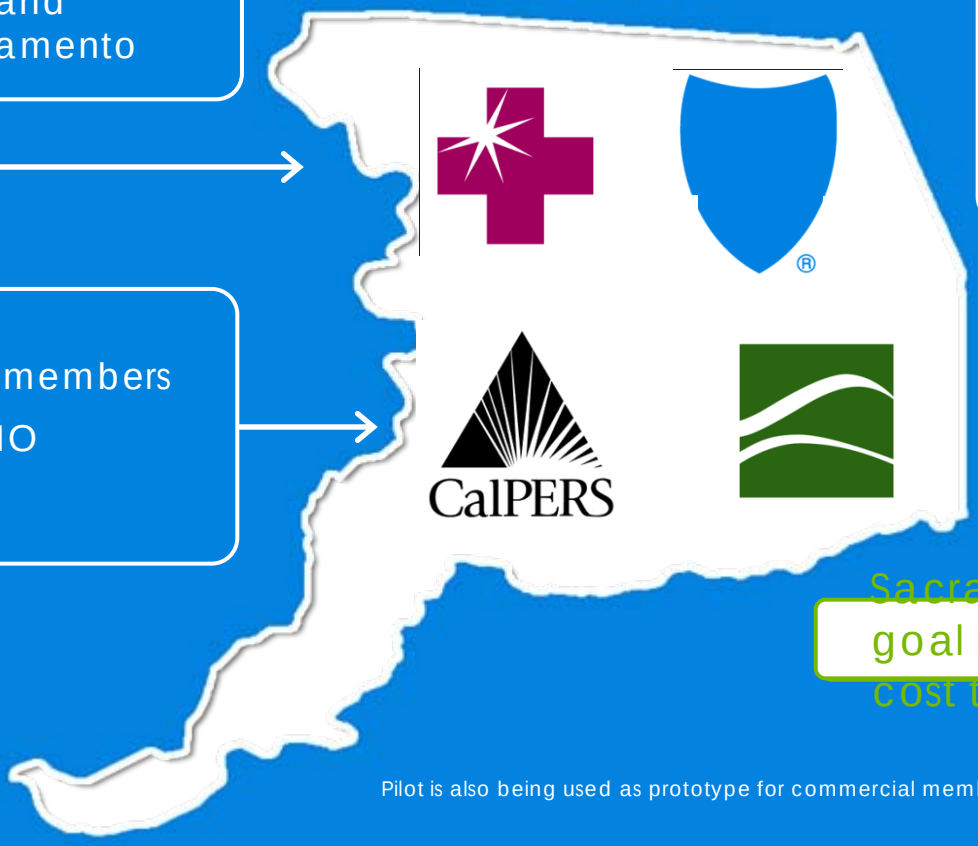
why Sacramento?

4 hospitals in Sacramento County including Mercy General, Mercy San Juan, Mercy Folsom, and Methodist Sacramento

- 207,000 total Sacramento members
- 90% in an HMO

Sacramento market



- ~ 520 MDs in Sacramento County
- ~ 38,000 CalPERS members
- 1,000 member growth in 2010

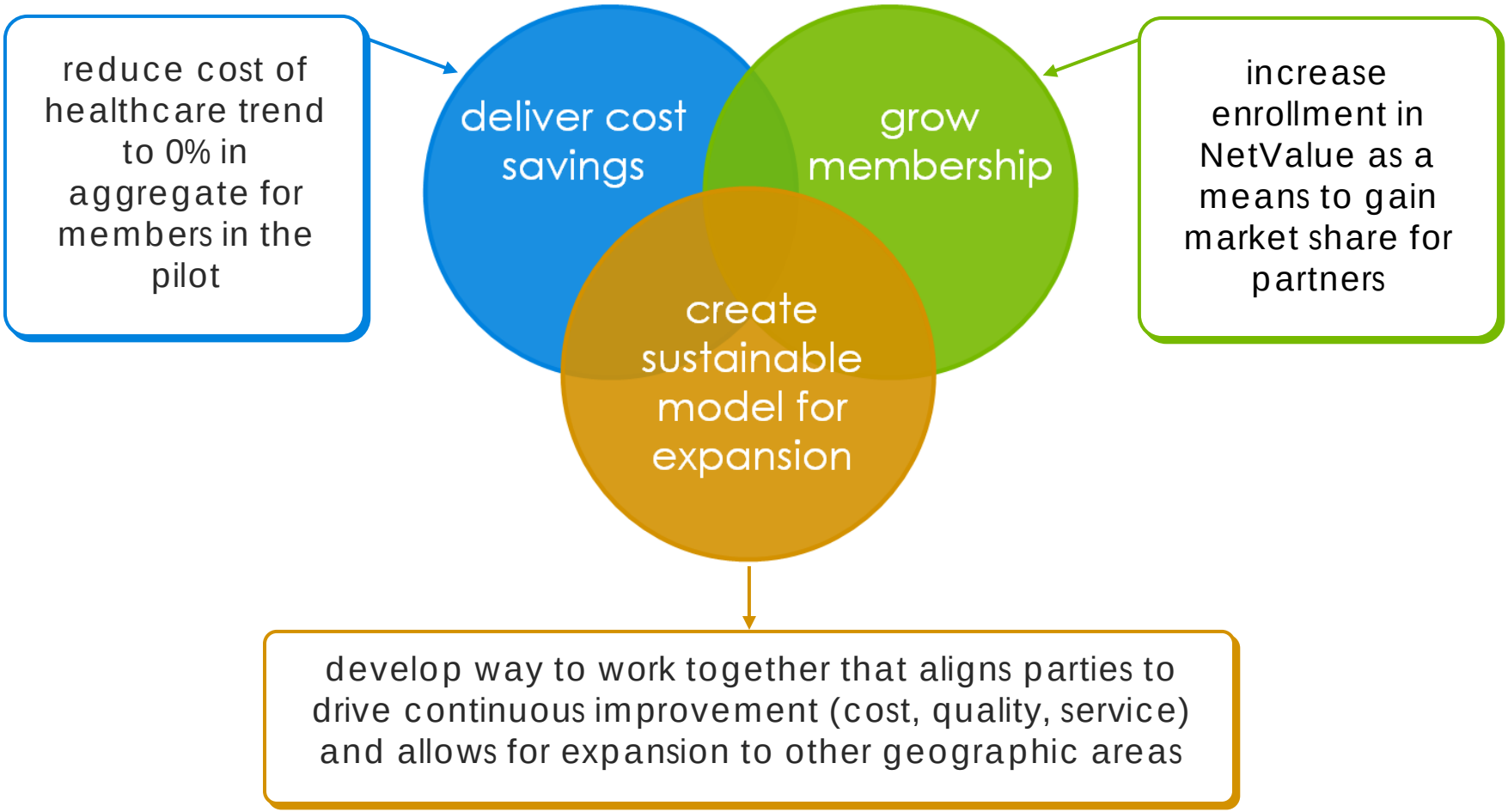
Sacramento pilot goal is to reduce the cost trend ~10%

Pilot is also being used as prototype for commercial membership with intent to scale model to other segments.

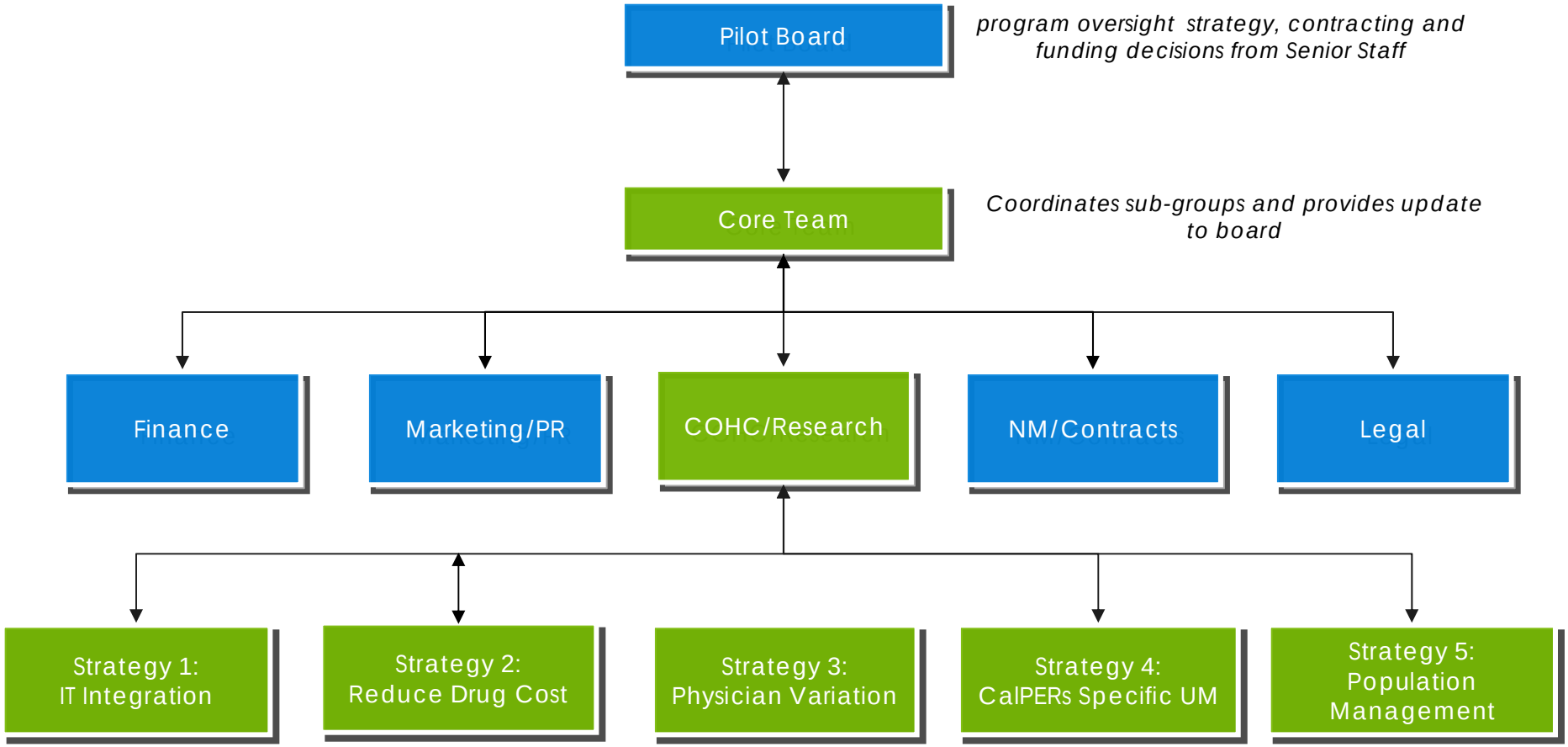
our guiding principles

1. reward the customer
2. keep it simple
3. be transparent
4. focus on the target
5. **be bold**

result-oriented goals



team approach



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strategy development is all about data

compiled datasets from disparate sources to determine a comprehensive look at the population

- what are the cost drivers?
- who is driving the cost and for what?
- spotlight on chronically ill members
  - identified top 5K patients accounting for 75% of total pilot population spend
  - identified opportunities to expand care program and develop additional programs

identified utilization outliers at the MSDRG level/established benchmarks for improved care in key areas, e.g.:

- OB/GYN
- Knees and Hips
- Bariatric

initiatives

strategy one: IT integration

initiatives

- physician technology acceptance
- master patient index (mpi)
- registry integration
- personal health record (phr)

expected outcomes and status

- strong technological framework to automate processes

strategy two: reduce drug costs

initiatives

- generic utilization
- injectable drug utilization and costs

expected outcomes and status

- reduce drug cost

strategy three: physician variation

initiatives

- er utilization
- program development
- outpatient surgery redirection

expected outcomes and status

- narrow practice patterns
- address inappropriate and over or under utilization of key services
- reduce unnecessary LOS, admissions and readmissions

strategy four: CalPERS specific um

initiatives

- enhanced inpatient clinical management
  - ✓ enhanced prior authorization
  - ✓ LOS management
  - ✓ integrated discharge planning
- medical access planning: collaborate to repatriate non-CHW CalPERs to CHW and Hill aligned provider entities

expected outcomes and status

- reduction in LOS, admissions, readmissions OON spend

strategy five: population management

initiatives

- targeted chronic and complex care management
- global palliative care
- chronic case management

expected outcomes and status

- more CalPERs members actively managed in a dm/cm program
- better coordination and hand-off between programs
- fewer members “falling through the cracks”

sample end-to-end initiative: bariatric

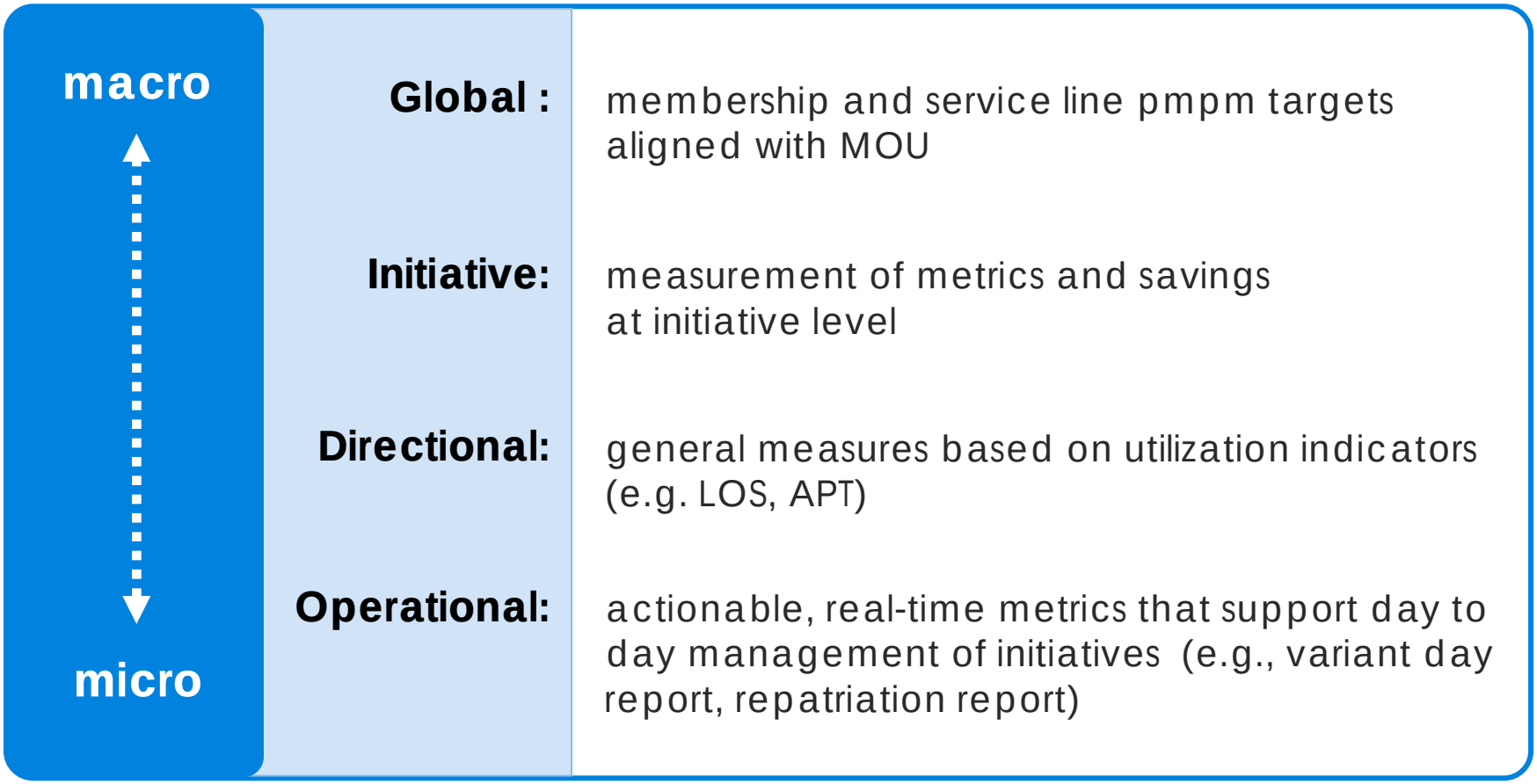
Prevention	Patient Engagement	Physician Variability	Utilization Management
Lose to Win: onsite wellness program to encourage weight loss and healthy eating	My True Body (MTB), a pre-surgical pathway program	Physician outcomes for Sacramento region • Readmissions • LOS • Procedure Type	Modified authorization process to ensure patients complete MTB program

lessons learned

preliminary outcomes after six months

- grew new NetValue membership by over 2,500 members since open enrollment in Fall 2009
- reduced readmissions by 2%
- reduced ALOS by 0.72 day for all admissions
- reduced ER/Urgent Care Admissions by 7.6%
- reduced total bed days by 15%

measuring success is critical and occurs at multiple levels



sample of key accomplishments

strong commitment by all organizations to work on an improved care delivery system

implemented industry best practice for:

- ✓ discharge planning process including hospital teach back,
- ✓ follow-up visit within 8-10 days,
- ✓ welcome home calls
- ✓ sharing of discharge plan with PCP

sample of key accomplishments (continued)

expanded Health Information Exchange (HIE) including:

- ✓ clinical results (lab, rad),
- ✓ hospital discharge summary and patient discharge summary to IPA EMR and/or physician portal
- ✓ IPA continuity of care (CCD) data into the hospital EMR
- ✓ re-admission discharge plan into hospital portal

benchmarked acute care admissions/LOS

- ✓ implemented changes by service line including physician variability, hospital variability and clinical practices (i.e. knee replacement and hysterectomies)
- ✓ in-house development of a high-risk patient tracking and stratification tool integrating health plan and IPA risk scores and disease management enrollment status

key learnings

- **data is critical** and needs to be the starting point for program development
- all organizations bring unique value to the partnership—**leverage** the **strengths** of what each organization has to offer
- **aligning incentives** and structure measurable goals for
  - ✓ cost reduction
  - ✓ quality
- quality improvement **requires philosophical alignment** around the issues and a new approach to negotiation
- real **change takes time** due to:
  - ✓ cultural differences
  - ✓ historical working relationships
  - ✓ internal and external challenges
  - ✓ impact on community providers and hospital staff
- refining and improving performance is an ongoing process

questions?