California Community Safety Net Hospitals:

*Embracing Challenges and Opportunities in Meeting the Triple Aim through More Patient-Centered, Accountable Care*
California’s community safety net hospitals provide:

- One-third of all hospital care to Dual Eligible Californians
- 50% of all safety net hospital care to Medi-Cal patients
- 40% of all safety net hospital care to the uninsured
- 44% of their care to Seniors and Persons with Disabilities
- $618 million in uncompensated care for uninsured patients
Differentiating Characteristics of Community Safety Net Hospitals

- Disproportionate Share Hospital (DSH) Status (Medicaid and Medicare DSH)
- Relatively low commercial business/overly reliant on baseline and supplemental government payments
- Strong community ties and high cultural and linguistic competency
- Unlike public safety net hospitals, they do not employ their physicians

- Most often receive no payment for providing care to the uninsured
- Have moved to a DRG Medi-Cal payment system rather than cost-based FFS system
- Use private hospital taxes to draw down increased Medi-Cal payments rather than IGTs/CPEs
Community Disproportionate Share Hospitals Statewide

- Nearly 70 core hospitals located in underserved areas with complex community health needs

- Higher than average HMO penetration due to high Medi-Cal, Healthy Families, Medicare Advantage and Dual Eligible pilot populations

- Anticipated to serve high numbers of newly eligible Medi-Cal & Covered California Bridge Plan enrollees

- Will serve a large portion of the 2.5 million undocumented and remaining uninsured CAs
Challenges to ACA
Delivery System Transformation

Community safety net hospitals and their partnering physicians and physician groups who serve mostly Medi-Cal and low-income communities are challenged in transforming their delivery systems and effectuating population health change.

Greater Vulnerability due to:
- More competitive markets
- Less primary care supply
- High diversity results in lower patient satisfaction
- Greater incidence of disease and chronic illness
- Low commercial payer mix
- Will continue to serve a significant number of the 2.5 million remaining uninsured

PEACH Inc.
Private Essential Access Community Hospitals
Hospital Impact – An Illustrative Example

Despite an increase in the total insured, the net effect of these shifts will be a significant dilution of margin

**Margin Impact**

1. Initial Margin 2.0%  
   \[ \Delta \text{Margin} = +1.2\% \]

2. New Margin -8.3%  
   \[ \Delta \text{Margin} = -10.0\% \]

**Key Shifts**

1. Reduction in the uninsured from 20% to 12% improves margin profile  
   \[ \Delta = +1.2\%, \text{now } 3.2\% \]

2. Aging into Medicare and the Exchanges (SHOP / HBEX) reduce proportion of Commercially insured from 50% to 44% and dilutes margin  
   \[ \Delta = -1.5\%, \text{now } 1.7\% \]

3. With a higher mix of ‘Government’ business, ACA reimbursement reform significantly degrades margin  
   \[ \Delta = -10.0\%, \text{now } -8.3\% \]

**Illustrative Margin Assumptions**

<table>
<thead>
<tr>
<th></th>
<th>2012 Margin (Pre-ACA)</th>
<th>2020 Margin (Post-ACA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>+20%</td>
<td>+25%</td>
</tr>
<tr>
<td>Government</td>
<td>-10%</td>
<td>-30%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>-25%</td>
<td>-45%</td>
</tr>
</tbody>
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Source: Deloitte Analysis, Illustrative 2012 Margins derived from 2008 Milliman Report
Building Accountable Delivery Systems in the Private Hospital Safety Net

- Wide variation amongst community safety net hospitals will determine various starting places in building Accountable Care Delivery Systems.

- Safety net hospitals must also determine their desired and feasible destination / position as they transition from providing care to managing health.
All Community Safety-Net Hospitals are Not Created Equal: Some Key ACO Readiness Factors

INTEGRATION: Independent community DSH hospitals have varying levels of opportunity for clinical integration

- Relationships/shared culture with affiliated or hospital based clinics, IPAs or foundation models that lead to aligned incentives

“SYSTEMNESS”: Participation in an established or nascent integrated health system; some with Knox-Keene plans affects ability to manage diseconomies of scale

Degree of market penetration/community branding and preference

Degree of leverage of the hospital and its associated physicians can determine participation levels in emerging narrow networks and new health plans as well as sustainability

Ability of Academic Medical Centers or Teaching Hospitals that have associated physicians and leadership to provide medical home competencies, chronic care disease management and “best product” innovations

Sufficient resources to invest in EHR/HIT for care, performance and cost management
Trends in Safety Net Hospital Payment Reforms: From Volume to Value – Medi-Cal Managed Care

- 380,000 SPDs moved to Medi-Cal Managed Care (MMC) – Requires successful coordinated care
- 875,000 Healthy Families Program kids mandatorily moved to MMC (HEDIS score incentives)
- 1.4 Million newly eligible Medi-Cal beneficiaries under ACA & 1.3 million currently eligible who may enroll
- Statewide implementation of mandatory Medi-Cal Managed Care in remaining 28 counties
- Cal MediConnect Dual Eligible pilot program based on patient-centered coordinated care model = 456,000 in April; 1.1 million eventually
Covered California

• Covered California – Chief goal is affordable products with quality and performance metrics for more than 4 million Californians
  – Incentives for alternative payment models and delivery system improvements
  – 55% of Californians are employed by firms with < 100 employees; firms will push workers to Exchange

• Seeking federal approval for Bridge Plans for 670,000 low-income Californians transitioning from Medi-Cal
  – Will include quality metrics and Value Based Reimbursements
  – Possibility of “no-cost” plans for enrollees
ACA and Other Payment Reforms

2% across board Medicare Sequestration cuts for 2013 and likely 2014 and beyond

Medicare DSH reductions of up to 75%, and Medicaid DSH reductions up to 50%

Medicare hospital readmissions program: 2% overall Medicare payment reduction for avoidable readmissions in 2014 and 3% in 2015 and beyond

Hospital Value Based Purchasing Program pays for performance on certain clinical quality measures and patient satisfaction. Poor performing hospitals will be cut by 1% in 2013, with incremental cuts rising to 2% by 2017

In 2015 Medicare reimbursements will be cut by 1% for hospitals in the highest quartile of hospital-acquired infections
Paving the Path to Accountable Care Organizations

“In this industry, there will always be more to do, which is really a wonderful thing, because we’ll always be finding new ways to improve health care. We are not close to perfect, we’re in the middle—somewhere between perfect and abysmal.”

Judy Faulkner, Founder and CEO, Epic Electronic Health Records
“How wonderful it is that nobody need wait a single moment before starting to change the world.”
– Anne Frank
Community Medical Centers

Embracing Accountability
Discussion Topics

• A Little About CMC
• Where We Were 8 Years Ago
• Where We Are Today
• Where We Are Going in the Future
Overview of CMC

• Not-For-Profit, Locally governed since 1897
  – $1.4B Assets and Revenue expected FY12
  – Capital Expenditures over $700M last 8 Years
• Largest Private Employer between LA and Sac
  – Almost 7,000 employees with Payroll >$500M yr
• Provides 54% of Hospital Care in Fresno Market
• The lowest CHARGING hospitals in CA (CA-PIRG)
• Some of the Lowest Cost Hospitals in CA (OSHPD)
• Spending $150M on state-of-the-art IT – EPIC
• Last Year Provided $134M of Community Benefit
• CRMC – Largest Safety Net Hospital in California
Eight Years Ago...

• New Leadership – New Vision
• Focus: Triple Aim Before It Was Called That
  – Cut Costs, Hold Charges Down, Integrate thru IT
  – Quality, Quality, Quality
• Combined Two Hospitals Into One
• Physician Shortage – Expand Teaching
• Losing Market Share, Bruised Reputation
Caregiver Shortage

In addition, primary care physician supply could constrain the ability to manage the increase of chronic disease and other increases in utilization in several parts of the state.

**Health Status**

Percentage of adults with one or more chronic illnesses

- 28-35%
- 35-39%
- 39-43%
- 44-49%
- No data

**Caregiver Supply**

Number of primary care physicians per 1,000

- 1.3-2.5
- 1.1-1.3
- 0.8-1.1
- 0.2-0.7
- No data

The combination of low caregiver supply and poor health status is most acute in Central California.

Source: AMA Physicians Master File, California Health Care Foundation
CMC and the County

• 1996 – Fresno County opted out of the hospital business required by state mandate
• Medically Indigent Services Program
• CMC took over Valley Medical Center/Clinics
• County Pays CMC $20M a year and the MISP costs CMC $85M per year – CAPITATION
• CMC Saw 17,000 MISP Patients Last Year
• Low Income Health Program (LIHP) – FAILURE
• All this changes in 2014
Challenges in Fresno Market

• Consolidation – Regional - Manage Patient
• Lots more People Get Health Insurance 2014
• Staff Shortages – Nurses, Techs, Pharmacists
• Doctor Shortages – Primary Care - Deloitte
• Bed Shortages? 2008 CA HealthCare Foundation
• Medicare and Medi-Cal Pay Less to All
Delivering on 5-year Vision

1. Top 5% in Clinical Quality
2. Service Integration & Value (ACO)
3. M.D. Collaboration (medical foundation)
4. Region’s Leader in Info Technology (EHR)
5. Network Expansion in Central California
6. Bed Capacity to 1,000 – and more
7. Growing our Workforce & Medical Staff
Medical Foundation

- Management began serious discussion of physician foundation model in 2008
- Launched as Santé Health Foundation in FY 2011
- More than 150 physicians now members, including Fresno’s largest primary-care groups
- Another 250+ doctors waiting to join
Our Own HMO – Community Care

- California Knox-Keene license obtained, after considerable legal work
- Allows CMC to provide its own HMO plan to employees and provide future flexibility
- Will begin in January 2014
- All employees will then be CMC self-insured for both PPO and HMO
- C-FIT Wellness Program for the community
“EHR” and “HIE”

• **Physician office integration**
  • Epic’s electronic health record (EHR) system installed for 115 physicians, with 213,000 patient records
  • Ongoing installation for CMP & CCFMG

• **Health information exchange (HIE)**
  • For MDs and hospitals not on Epic, CMC records will be shared through exchange technology
  • Collaborating with hospitals/clinics in 4 counties
Next Steps: Patient Management

- Move away from volume-based, fee-for-service model to Value-Based
- CMC Medicare Shared Savings Accountable Care Organization – January 2014
- Pursue risk-based contracting strategies in exchange for exclusive relationships with health plans
- “Community Connections – Indigent Medical Home” for Frequent Flyers – Chronic Disease Programs
Patient Management, continued

- Chronic Diseases
  - Medical Homes: Lung, Diabetes, CHF
  - Increased Resources for Psych/Social Needs

- After Hours Nurse Call System

- Prescription Refill Clinic

- Hospital Discharge Clinic (readmissions)

- Readmission SWAT Team

- Integrated Behavioral Health Clinics
Opportunities

• Open FQHCs if Existing Primary Care Sites are Unable to Meet Provider Demand – ED
• Acquisitions in the Central Valley
• Technology for Chronic Diseases
• Expand HMO if market forces dictate
• Continue driving down costs through innovation and LEAN techniques
POMONA VALLEY HOSPITAL
MEDICAL CENTER
COMMUNITY SAFETY NET HOSPITALS
MEETING THE TRIPLE AIM THROUGH ACCOUNTABLE CARE
Communities We Serve

Primary Service Area includes:

- Pomona
- Claremont
- Chino
- Chino Hills
- La Verne
- Montclair
- Ontario
- Rancho Cucamonga
- Alta Loma
- Upland
- San Dimas
Pomona Valley Hospital Medical Center is:

- MISSION DRIVEN COMMUNITY BOARD OF DIRECTORS
- 600 PHYSICIANS
- 3,000 EMPLOYEES
- 3 MEDI-CAL ELIGIBILITY WORKERS STATIONED AT HOSPITAL
- CERTIFIED ENROLLMENT ENTITY (CEE) FOR COVERED CA
  - 20 CERTIFIED ENROLLMENT COUNSELORS
- 7,000 DELIVERIES PER YEAR
- INTENSIVE CARE NURSERY 46 PATIENTS DAILY
- STEMI CENTER
- STROKE CENTER
- HEART SURGERY / CATH
Our Community

Highly disproportionate share of Medi-Cal and low-income patients including seniors

- 52% Medi-Cal
- 21% Medicare
- 18% Commercial
- 9% other (including self-pay and charity)

Hospital Supplemental Payment Programs = $67 million (2013)

- Hospital Quality Assurance Fee: Potential Federal Reduction
- Medicare DSH: Potential 75% decrease through ACA
- Medi-Cal DSH: Potential 50% decrease through ACA
Vision of Future
PVHMC Leadership Assessment

- U. S. HEALTHCARE IS TOO COSTLY AND HAS BAD METRICS
- POPULATION AGING
- FUTURE OF CONSTANT HEALTHCARE SYSTEM REORGANIZATION AND CHANGE

- AFFORDABLE CARE ACT (ACA)
- CURRENT CYCLE
- EXPANDED COVERAGE INITIATIVES
- ACCOUNTABLE CARE MOVEMENT
- VALUE BASED PURCHASING
PVHMC Innovation Pathways to a Healthy Community

Clinical Integration and Key Access Points

- INTER VALLEY HEALTH PLAN (MEDICARE ADVANTAGE)
- SATELLITE DIVISION - FACULTY(1206b) FAMILY PRACTICE RESIDENCY
- POMONA COMMUNITY HEALTH CLINIC (FQHC)
  - HOMELESS RESPITE CARE
- COMMUNITY SENIOR SERVICES
- CANCER CENTER 1206d WITH MEDICAL ONCOLOGISTS (EVALUATION)
Inter Valley Health Plan (Medicare Advantage)

- 20,000 Members
- Largest Senior Plan in Service Area
- Started in 1979 by PVHMC and Medical Staff
- Governance (Not for Profit)
  - 1/3 Hospital
  - 1/3 Physician
  - 1/3 Community Leaders
- Serves Service and Physician Integration Goals
PVHMC Patient Centered Health Centers

- PARTNERSHIP WITH FACULTY GROUP FOR FAMILY PRACTICE RESIDENCY PROGRAM (1206b)

- 5 SITES FOR EXPANDED ACCESS
  - ELECTRONIC HEALTH RECORDS
  - 22 PRACTIONERS
  - PRIMARY CARE
  - URGENT CARE
  - IMAGING
  - PHYSICAL THERAPY

- INTEGRATED
  - GOVERNANCE
  - STRATEGY
  - PVHMC IS MSO FOR PHYSICIAN GROUP CONTRACTING
PVHC at Claremont
Family Medicine, Urgent Care, Imaging, Physical Therapy, Sleep Disorders

PVHC at Chino Hills
Family Medicine, Imaging, Physical Therapy

PVHC at Crossroads – Chino Hills
Family Medicine, Urgent Care, Imaging

PVHC at Pomona – Family Health Center
Family Medicine, Residency Program
FMRP/PMG Impact on Hospital Staff

- Average age of active FM Medical Staff is 52.6
- Premier Group and Independent FMRP Graduates make up 39% of active FM Staff
- However, they make up 72% of staff under the age of 50
Pomona Community Health Clinic

FEDERALLY QUALIFIED HEALTH CLINIC (FQHC)

PUBLIC-PRIVATE PARTNERSHIP TO RUN L.A. COUNTY CLINIC

OPENED SECOND SITE AS FQHC FOURTH QUARTER 2012

PVHMC PROVIDES $3 MILLION LOC TO FUND START UP

RECEIVED GRANT FOR HOMELESS RESPITE CARE
Homeless Respite Care

- MULTI-PARTNER PROJECT TO PROVIDE A SAFE PLACE FOR HOSPITALS TO DISCHARGE HOMELESS PATIENTS

- GOALS:
  - REDUCE
    - DELAYED DISCHARGES
    - AVOIDABLE READMISSIONS
    - EMERGENCY ROOM VISITS
  - CONNECT HOMELESS TO MEDICAL PRIMARY CARE “HOME”
  - MANAGE CHRONIC DISEASES
  - IDENTIFY HEAVY USERS FOR PLACEMENT
Moving Toward Population Health and Accountable Care

PVHMC IS NOT A PARTICIPANT IN CMS ACO MODEL

PVHMC’S ACCOUNTABLE CARE PATHWAYS:

- FULL SCALE POPULATION MANAGEMENT FOR SENIOR MEDICARE ADVANTAGE
- MOVE TOWARD “MEDICAL HOME” IN CLINICS
- MEANINGFUL USE PHASE 1 ATTESTATION (HOSPITAL & CLINICS)
- BUNDLED PAYMENT APPLICANT (CMS)
- STEMI AND PRIMARY STROKE CENTER
- INTEGRATION WITH COMMUNITY SNFs
Loma Linda University Health

Building accountability for Whole-Person Care
LLUAHSC Strategic Plan 2010-2014

Motto: To Make Man Whole

Mission: To continue the teaching and healing ministry of Jesus Christ

Vision: Transforming lives through education, healthcare, and research

World Class Distinction  Quality & Service Excellence  Teamwork & Synergy  Partnerships  Leadership & Stewardship

Shared Values: Compassion, integrity, excellence, wholeness, and teamwork

LOMA LINDA UNIVERSITY
ADVENTIST HEALTH SCIENCES CENTER

LOMA LINDA UNIVERSITY
MEDICAL CENTER
Our Strengths . . .

» Leadership commitment to tertiary and quaternary services

» University Association:
  ~ Teaching
  ~ Research
  ~ Hospitals

» History: Serving our community since 1905

» National Recognition
Transforming Lives Through

• 13,000 Employees
• 4,521 Students
• 674 Residents in 28 programs and 22 fellowships
• 746 Faculty MDs in 67 specialties and subspecialties
• 6 Hospitals
• 8 Schools
• 9 Institutes

Who serve 1.5 million patients annually
2014 Goal: Accountability for Health

To fulfill its Mission and Vision, the Health Ministry will foster a Christ-centered environment that is dedicated to:

- **Care of the whole person** across the continuum of wellness, acute intervention, and sustaining care
- **Exemplary quality & service excellence**: access, patient-centered and family care, and best clinical practice
- **Alignment and teamwork** across the spectrum of patient care, education & research
- **Close partnerships** with providers, community organizations, and businesses in the region
- **Strong leadership** and values-driven faculty and staff
LLUMC Financial Context

Patient Days
~ 46% - Medi-Cal
~ 25% - Medicare
~ 22% - Commercial
~ 7% - Other

$1.04b - Patient Rev.
$ 71m - Net Income
~ $139m – DSH/QAF/IME/GME
~ $77m – Uncompensated Care

5,514 FTEs
7 FTEs/AOB
26,000 surgeries/yr
85,000 ER & Urgent Care visits/yr
700,000 O/P visits/yr

*2012 figures
LLUMC – circa 2010

» Overwhelming regional health needs
» Lacking adult primary care MDs
» Little experience taking risk
» Poorly-integrated with LLU School of Medicine
» Mix of paper- and electronic-documentation
» Broken access points into LLUMC
Challenges

» San Bernardino
   ~ 2nd most impoverished city in U.S.
   ~ 4th most obese region in U.S.
   ~ 3rd highest county in CA for heart disease
   ~ Worst ratio of fast-food/convenience stores to grocery stores in CA

» SB 1953/Seismic Safety Compliance = ~ $800m

» EMR Optimization

» Creating a culture of Process Improvement

» Managing Population Health
Intervention #1: Better quality, lower costs

» Physician Preference Items
  ~ Endo mechanicals, sutures, mesh
  ~ Hip & knee implants

» Intermountain Training
  ~ QI methods for clinical & non-clinical processes
  ~ Ortho Spine & Maternal-Fetal Medicine

» Critical Care Center
  ~ 24x7 intensivists
  ~ Reduction of CLABSI, CAUTI

» Lean/Six Sigma/Process Improvement
20-Day Course for Executives & QI Leaders - Advanced Training Program (ATP)

The Advanced Training Program (ATP) offers a practical, in-depth course for health care professionals who need to teach, implement and investigate quality improvement, outcome measurement and management of both clinical and non-clinical processes.

Objectives

The Advanced Training Course (ATP) is designed to train in advanced methodologies.
Intervention #2: Network Integration

» LLU Health
  ~ All LLU practice corps into one employing organization
  ~ LLU Health as system-wide brand

» Partnerships: Planning an IDN with community providers and hospitals
  ~ Epic Management / Beaver Medical Group
  ~ Various hospital partners
  ~ Considering a 1206 foundation for community MDs

» Prevention & Wellness

» EHR: Installed Epic in February 2013
Intervention #3: Community Health

» Converted an indigent health clinic to an FQHC
  ~ Present: All family medicine and some pediatric residency clinics
  ~ Future: Building a health campus in downtown San Bernardino to house ALL LLU residency clinics
  ~ 1° goal: improve access for underserved, underinsured, and low-income populations
  ~ 2° goal: decrease unnecessary ER visits and provide the right care/right time/right setting/right price

» Received a Covered CA grant for outreach & education

» School of Public Health: re-organizing around the programmatic objectives of community resilience, healthy lifestyle and disease prevention, and health care leadership
Future Goals. . .

» A trusted, faith-based, patient-centered provider and educator of whole-person health in the region
» Inland Empire’s Kaiser alternative
» The Faith-based Mayo Clinic