Clinical Integration in the Era of Healthcare Reform: Partnership Opportunities and Caring for High Risk Patients

P4P Summit: Changing Payment and Managing Care for Medically Complex Patients

March 26, 2014

Robert D. Lerman, M.D.
V.P., Medical Director, Physician Integration
Dignity Health

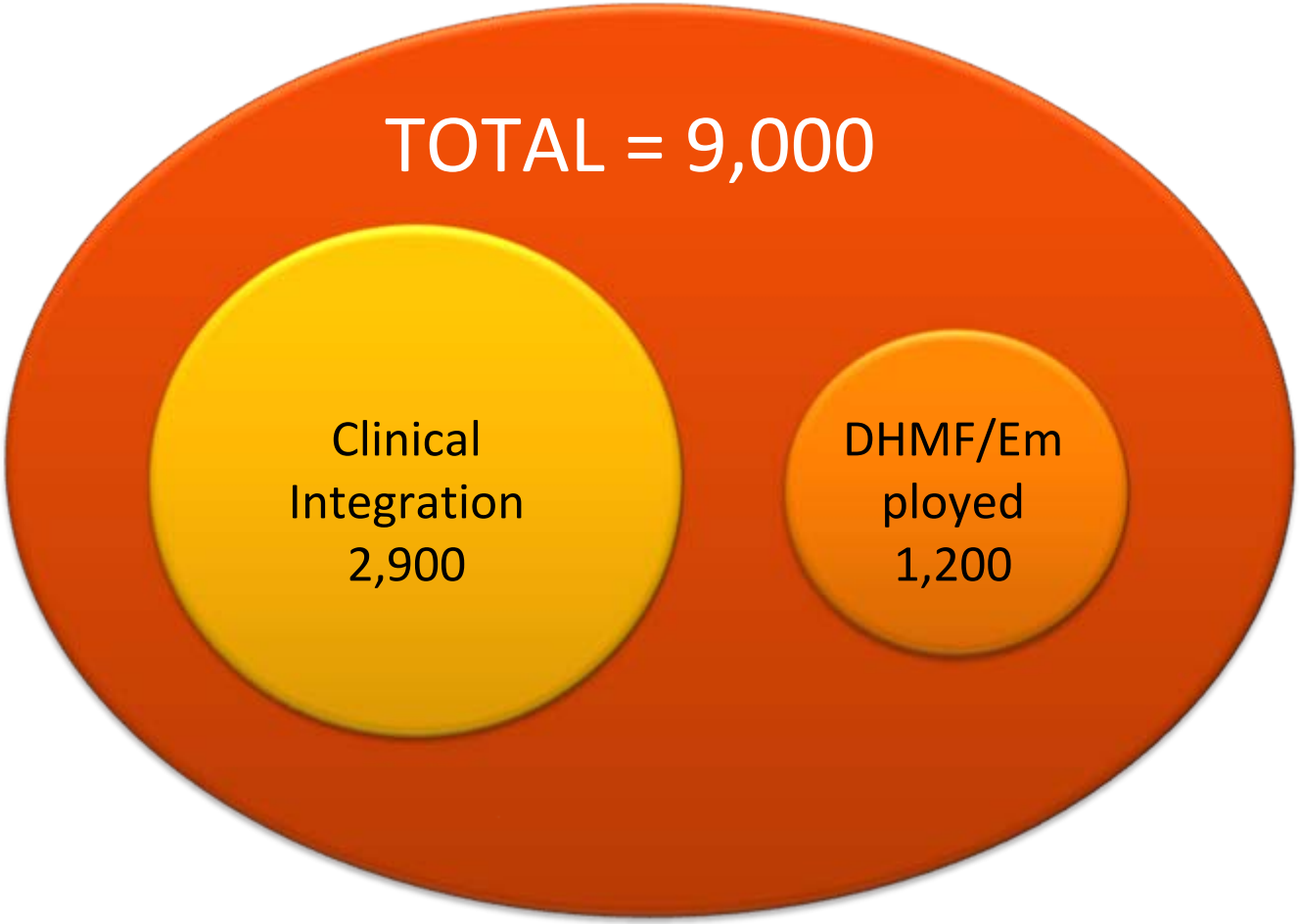
Dignity Health

Dignity Health: System Overview

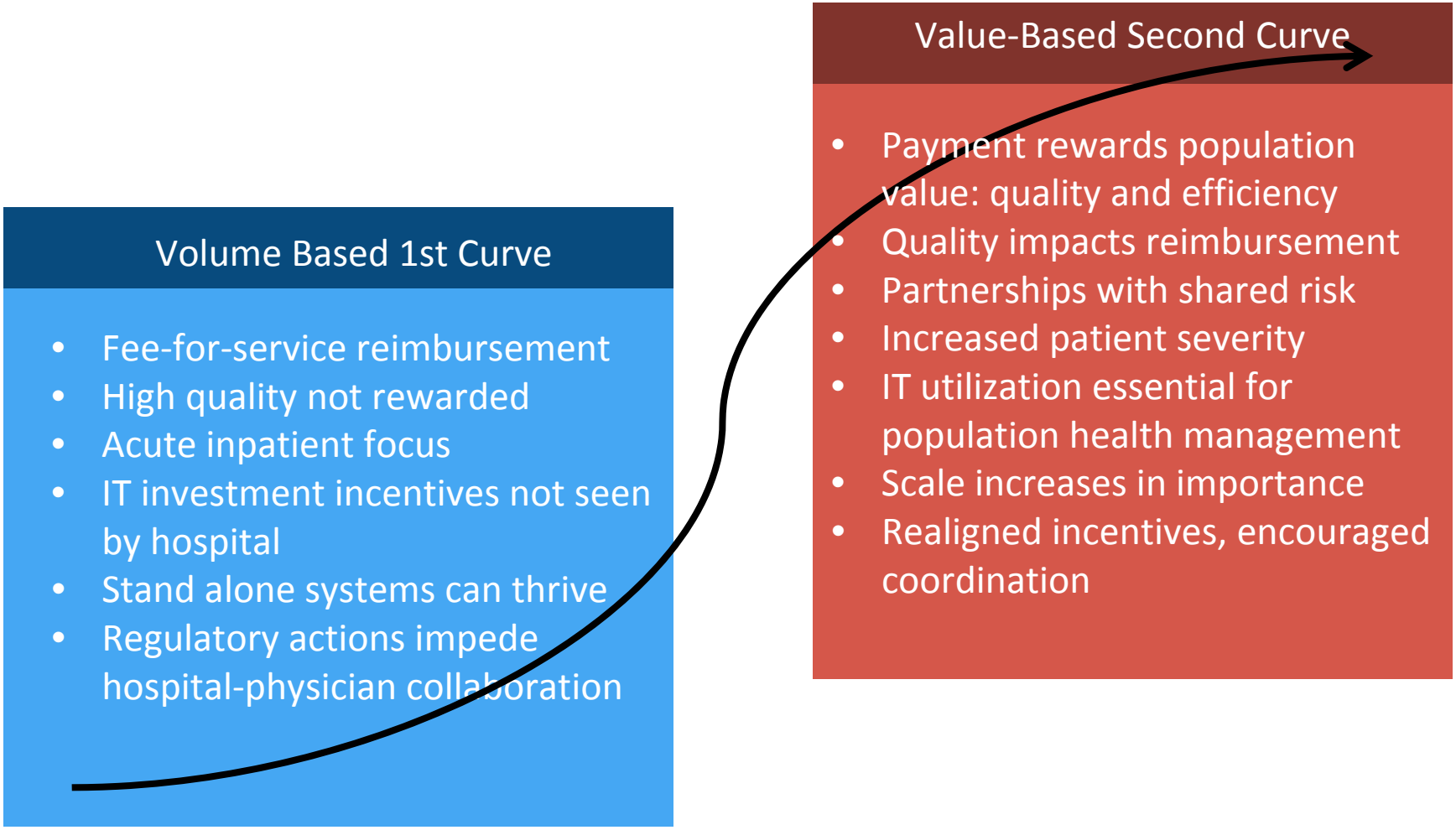
Dignity Health Statistics (FY 12)

Assets:	$13.5 billion
Net Operating Revenue:	$10.5 billion
Acute Care Beds:	7,500
Skilled Nursing Beds	631
Active Physicians	9,000
Total Employees:	53,000
General Acute Patient Days:	1.7 million
Community Benefits and Care for the Poor:	$1.6 billion

Dignity Health Affiliated Physicians



As We Shift from Fee-for-Volume to Fee-for-Value…




hello humankindness

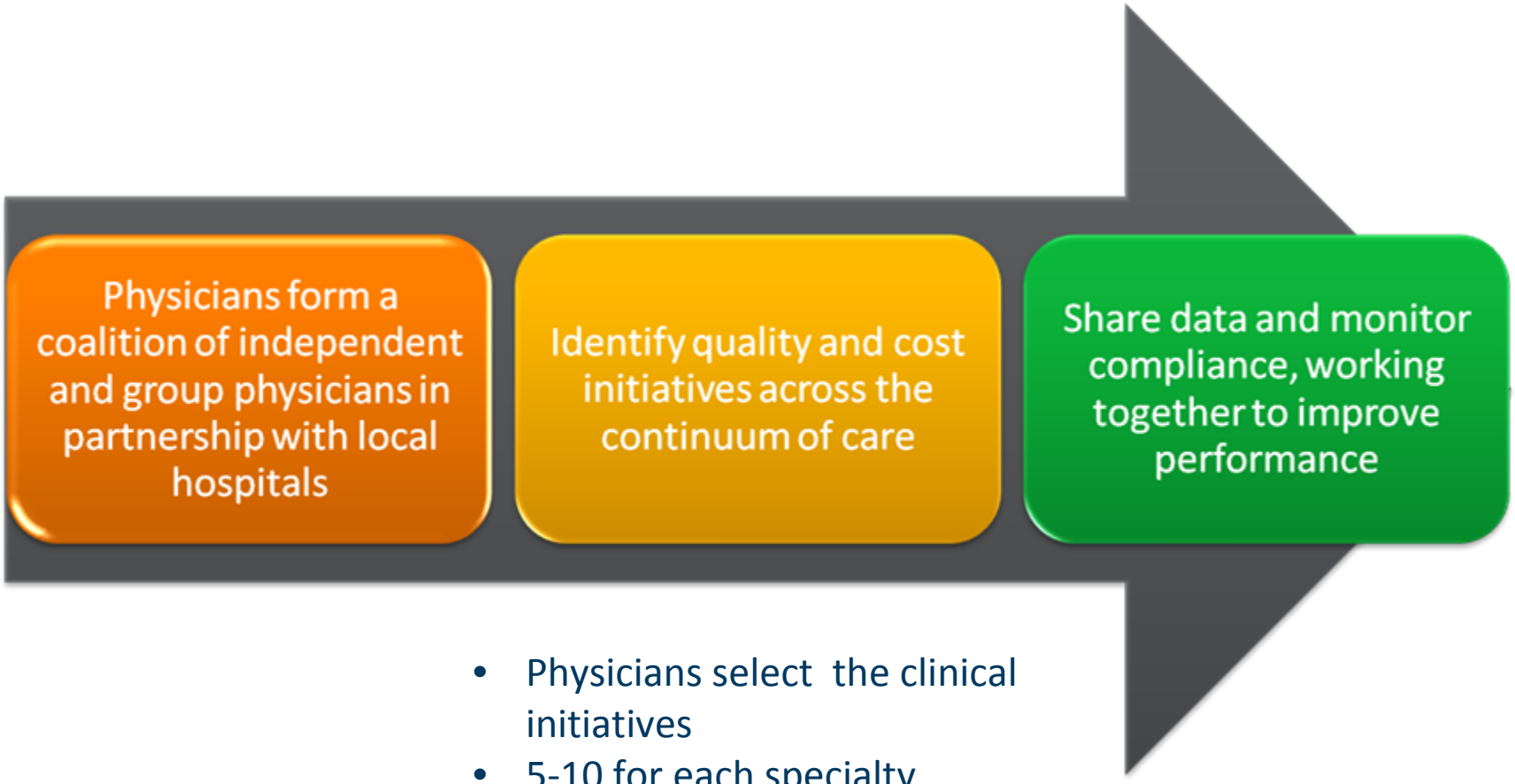

no outcome, no income

Old Model of Stakeholders is Obsolete

Clinical Integration: The Bridge to Accountable Care

Dignity Health Clinical Integration

What is Clinical Integration?

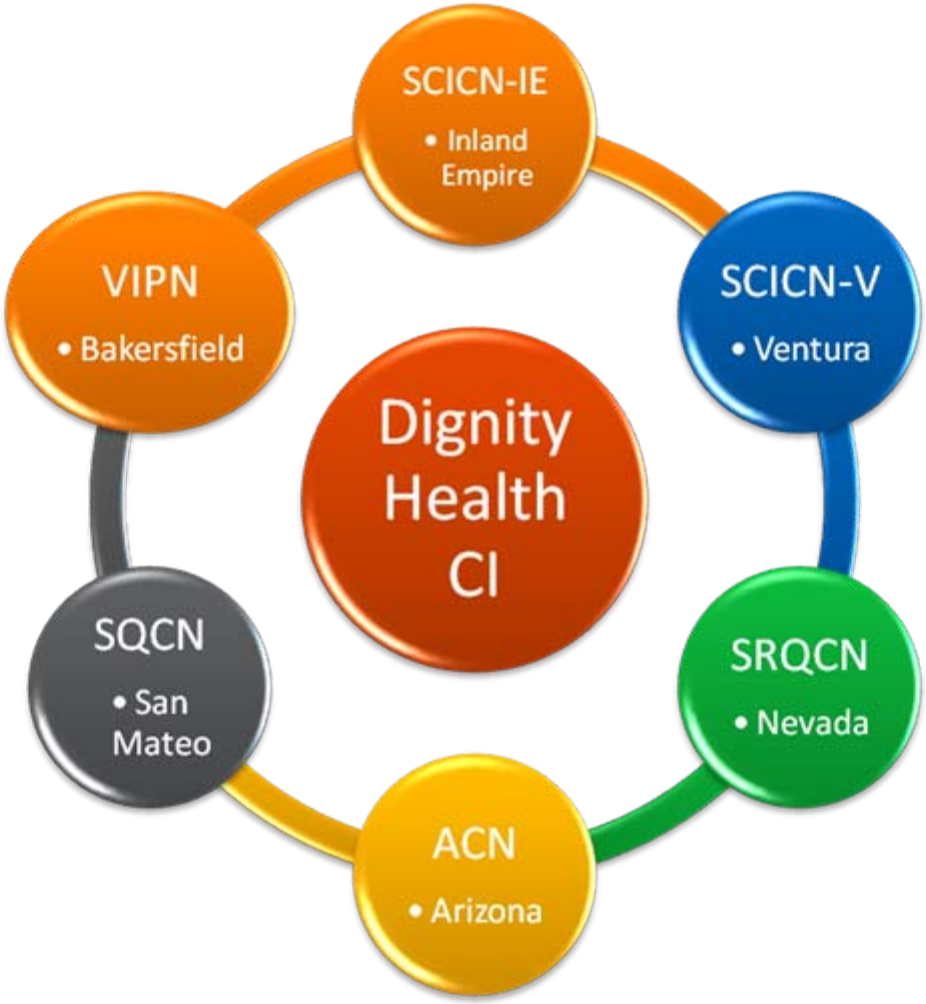


- Physicians select the clinical initiatives
- 5-10 for each specialty
- Both inpatient and ambulatory initiatives

Clinical Integration Goals:

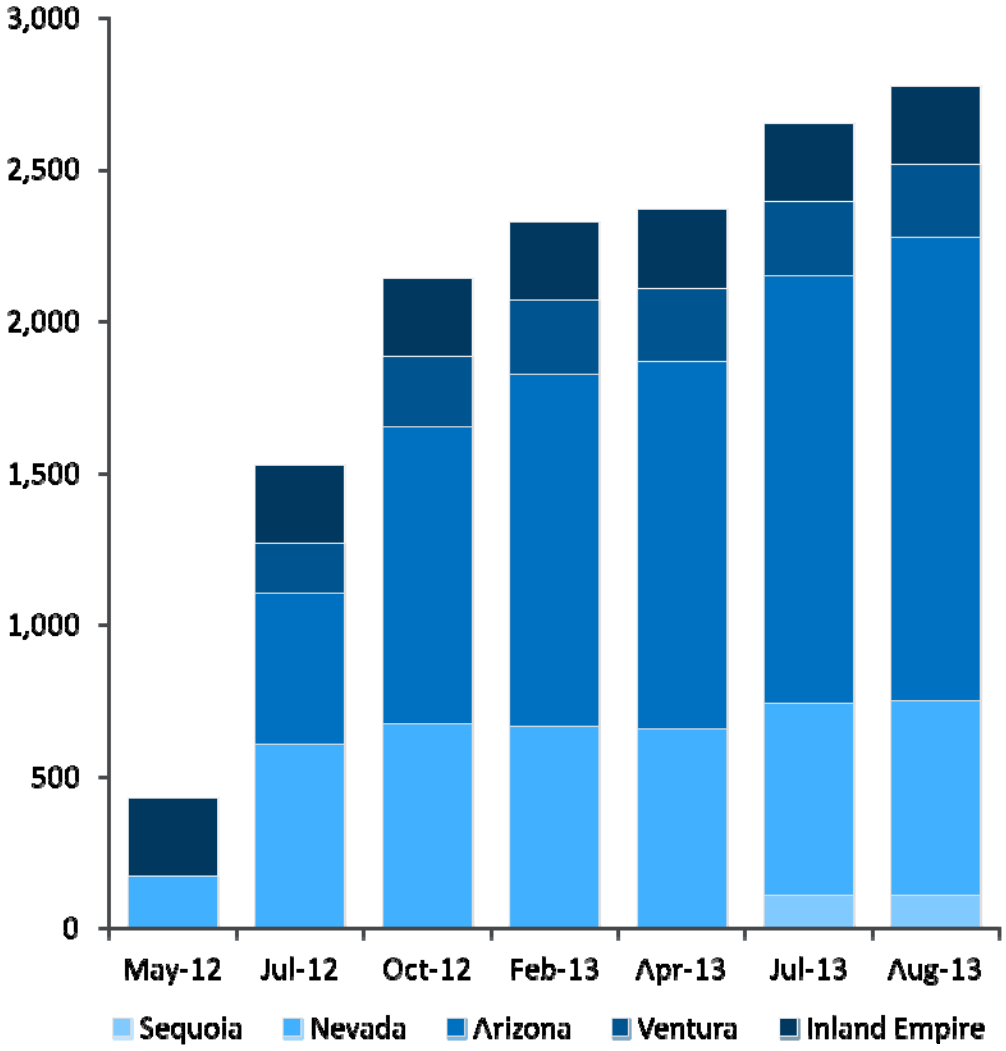
1. Improve quality of care
2. Increase efficiency/reduce cost
3. Provide a structure for independent and aligned physicians to come together in partnership with our hospitals
4. Give physicians an opportunity to get an economic reward for their hard work via beneficial contracts
5. Facilitate physician buy-in for hospital quality and cost initiatives

Current Dignity Health CI Programs

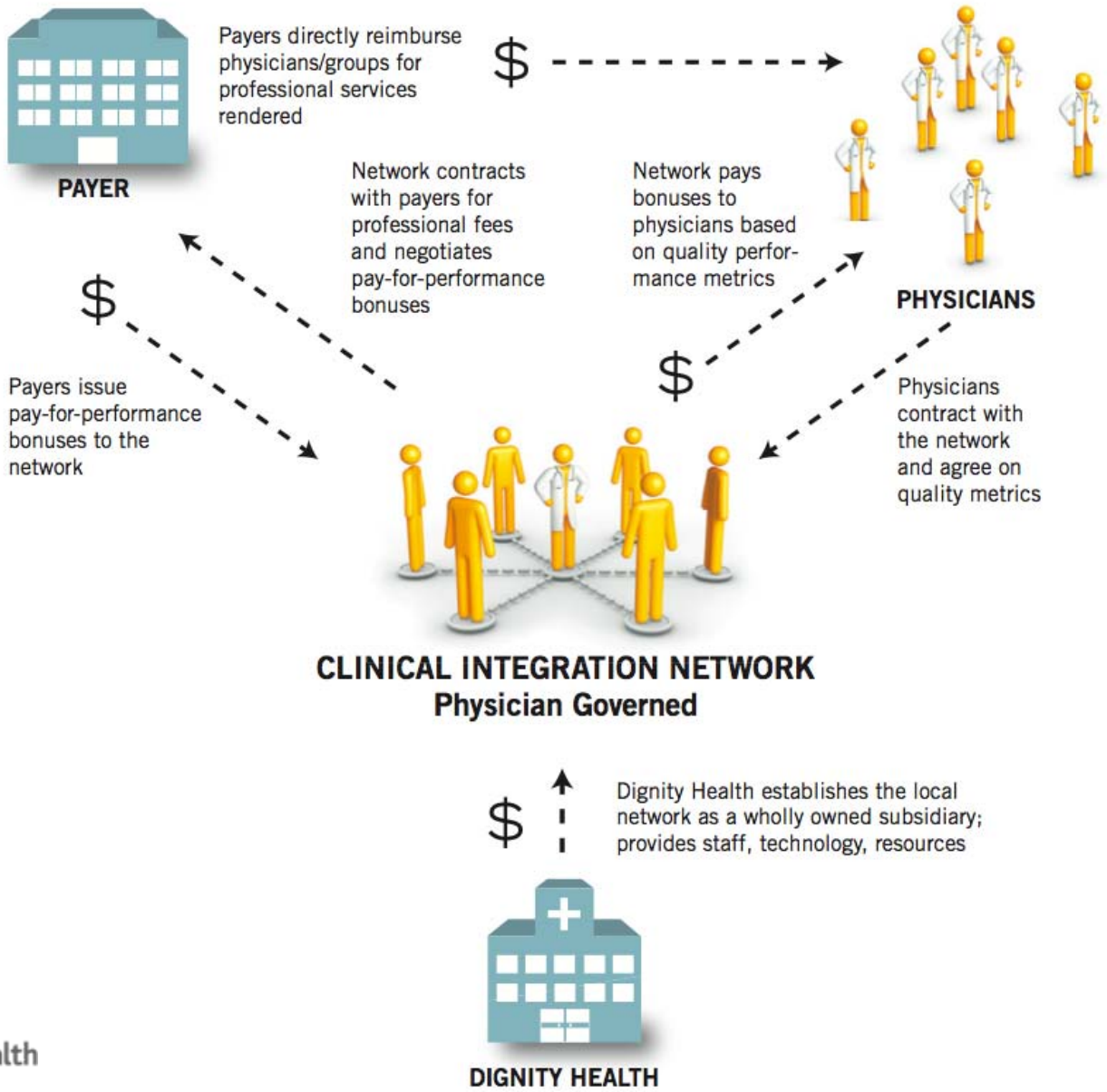


Clinical Integration: If We Build It, Will They Come?

Clinical Integration: Physician Members



Classic CI Contract: Example of How Funds Flow

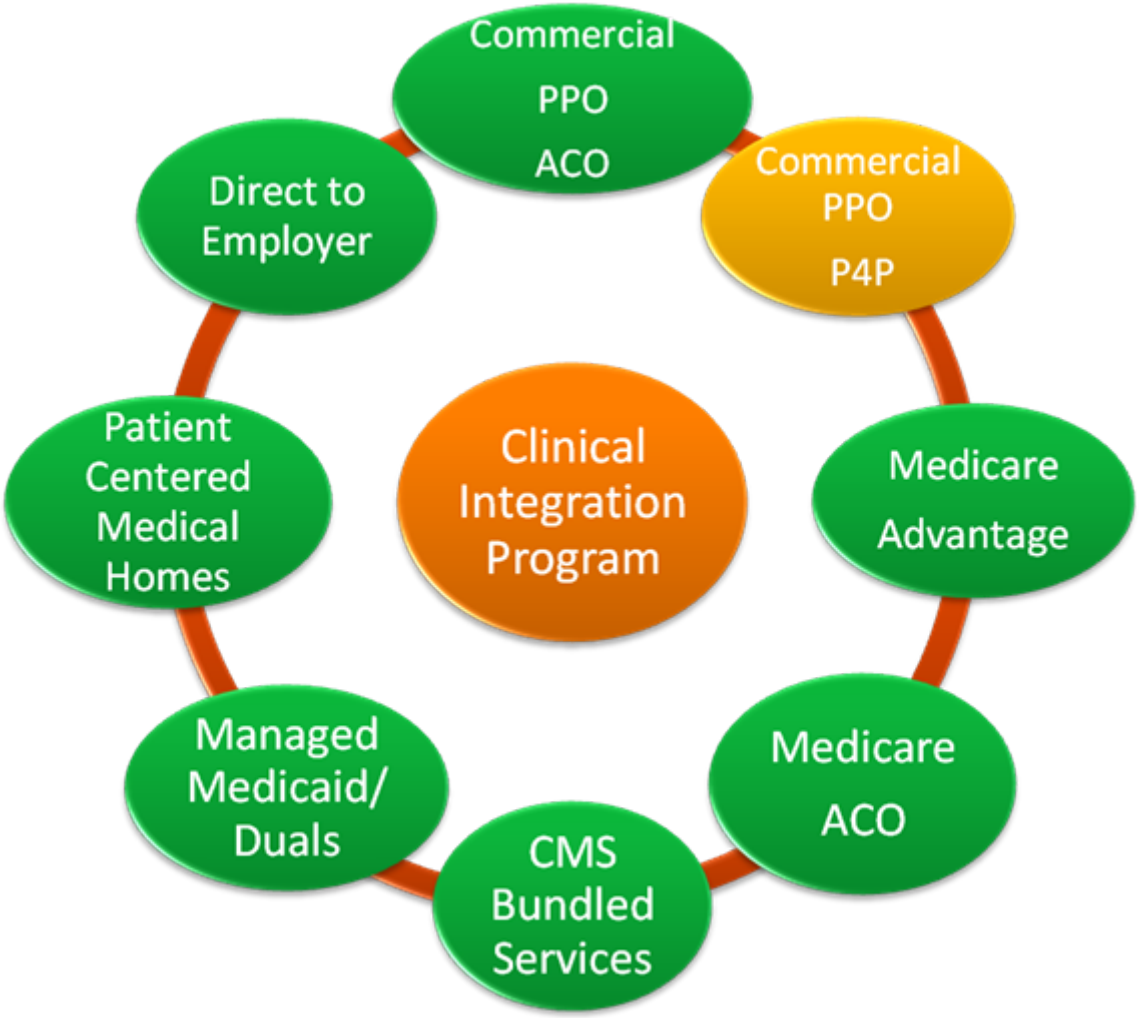


Clinical Integration in the Healthcare Reform Era

There are few, if ANY, "classic CI" PPO pay-for-performance contracts available!!

- Health Plans in California are already paying $50 M/yr. for HMO P4P
- Quality is viewed as "Price of Admission"
- Must be able to bend the cost curve!

Opportunities Shift Towards Population Health



Some Physicians Have Accused Us of a “Bait and Switch”

CI Challenges

1. Physicians are hesitant to have someone else contracting on their behalf
2. Markets where FFS still king are hesitant to move into performance or risk based contracting
3. Health plans requiring a threshold number of “attributed lives” before considering a commercial ACO
4. Some health plans insisting on statewide agreements instead of market-by-market contracting
5. Creation of infrastructure (IT and care management) is very expensive, with little outside support to date for upfront costs

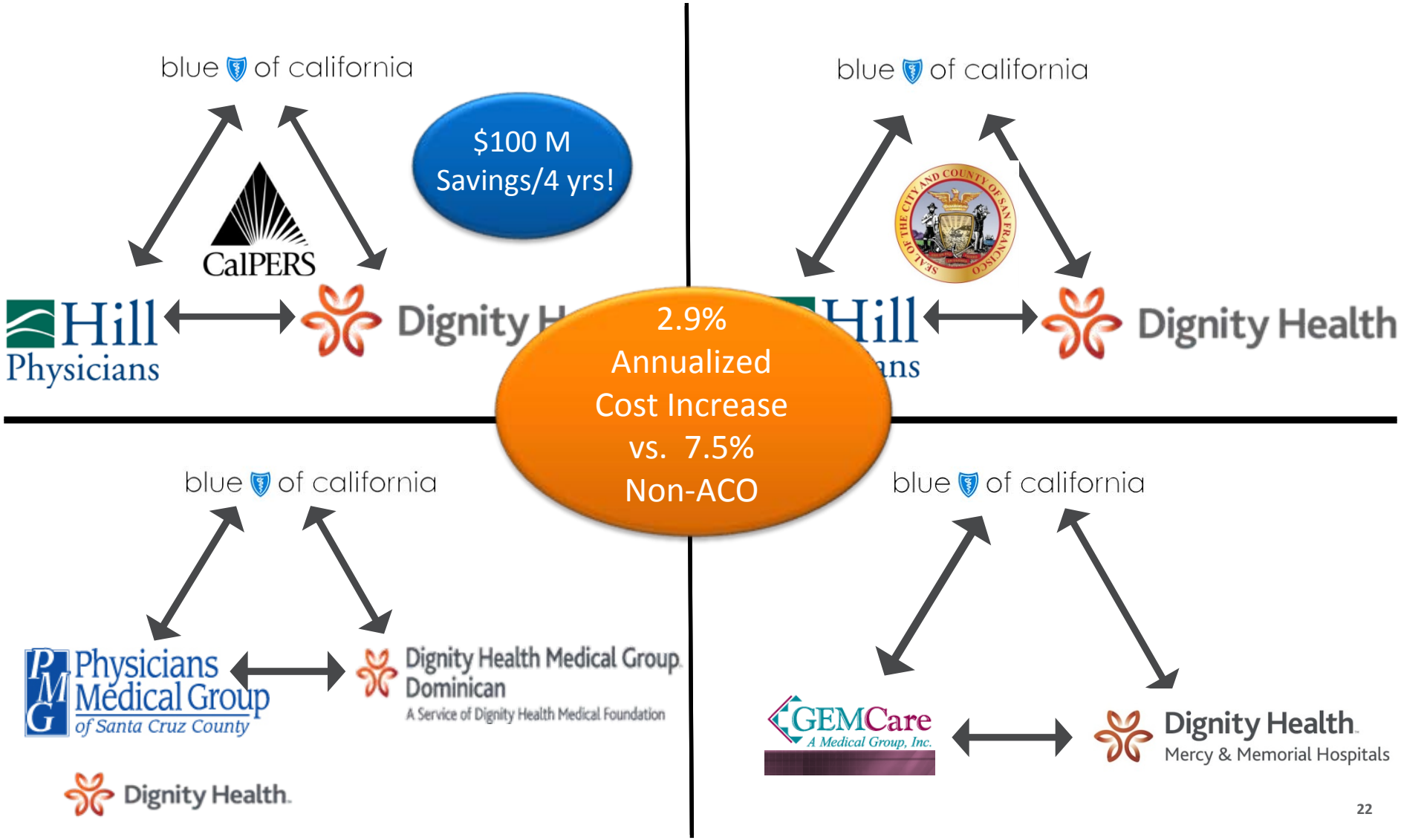
Current CI Contract Status

Market	CI Entity	Health Plan	Product	Status
CA Markets (6)	All	Confidential	Indiv. Exchange	PPO ACO MOU signed
Arizona	ACN	Aetna	ACO and Narrow Net.	Contract executed
Arizona	ACN	Confidential	MCR HMO w/gainsharing	In Discussions
Arizona	ACN	HealthSpring	MCR HMO	Contract Signed
Arizona	ACN	Confidential	ACO	In Discussions
Inland Empire	SCICN-IE	Health Net	Indiv. Exchange	Effective 1.1.14
Inland Empire	SCICN-IE	Confidential	Dual Eligible Capitation	Negotiations in Progress
Inland Empire	SCICN-IE	Confidential	MCR HMO Hosp/Physician cap	Negotiations in Progress
San Mateo	SQCN	Confidential	PPO ACO	Negotiations in progress
Nevada	SRQCN	Confidential	Commercial PPO/DH employees	Negotiations in progress
Nevada	SRQCN	CareMore	MCR HMO	Effective 1.1.13
Ventura	SCICN-V	Confidential	TriCare Product	Concept Phase

Dignity Health-Blue Shield of California

Covered California Program

Dignity Health-Blue Shield HMO ACOs



Our Missions are Aligned

- "…to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value."*

- to ensure that Californians have access to high quality health care at an affordable price**

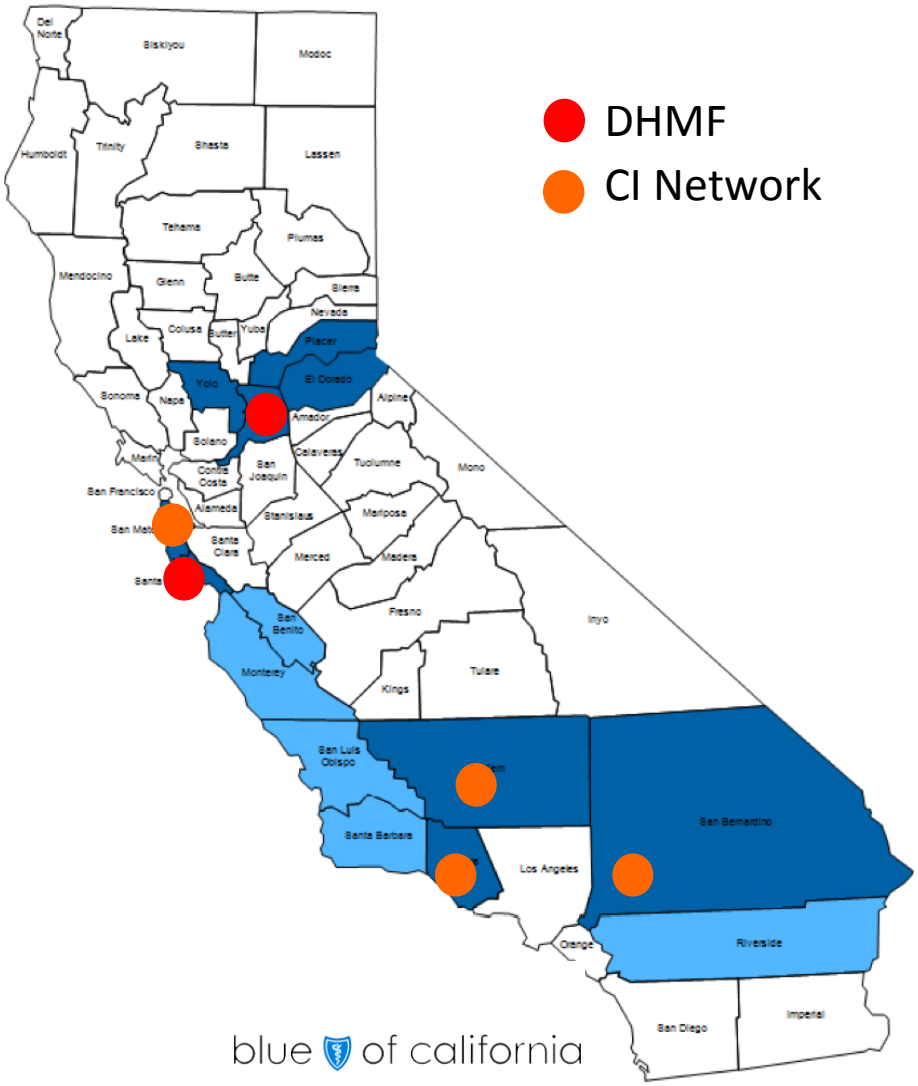
- "Delivering compassionate, high-quality, affordable health services; serving and advocating for our sisters and brothers who are poor and disenfranchised; and partnering with others in the community to improve the quality of life."

Covered California is a registered trademark of the State of California
Blue Shield of California is an independent member of the Blue Shield Association

*Source: www.coveredca.com
**Source: www.blueshieldca.com

Dignity Health-BSC Comprehensive Care Management Model

- **Goal**: Reduce cost and improve care for BSC's Covered California members
- **Components**:
  - Accountable Care Organization
  - Comprehensive Care Management Model (CCMM)
- **Locations**: Six statewide Covered California markets
- **Population for inclusion**: All attributed Blue Shield non-grandfathered individual and family plan ("IFP") members



Dignity Health

blue of california

ACO/Comprehensive Care Management Model

- **Objective**: Deliver comprehensive healthcare services using a coordinated care model to improve quality and service and reduce cost

- **Challenges**:
  - New CI programs comprised predominantly of independent physicians with little experience working collaboratively and few care management resources
  - Multiple disparate EHR systems
  - New patient population of unknown size and risk profile
  - No historical claims data
  - PPO model with no clear-cut attribution model

Making it Work Economically

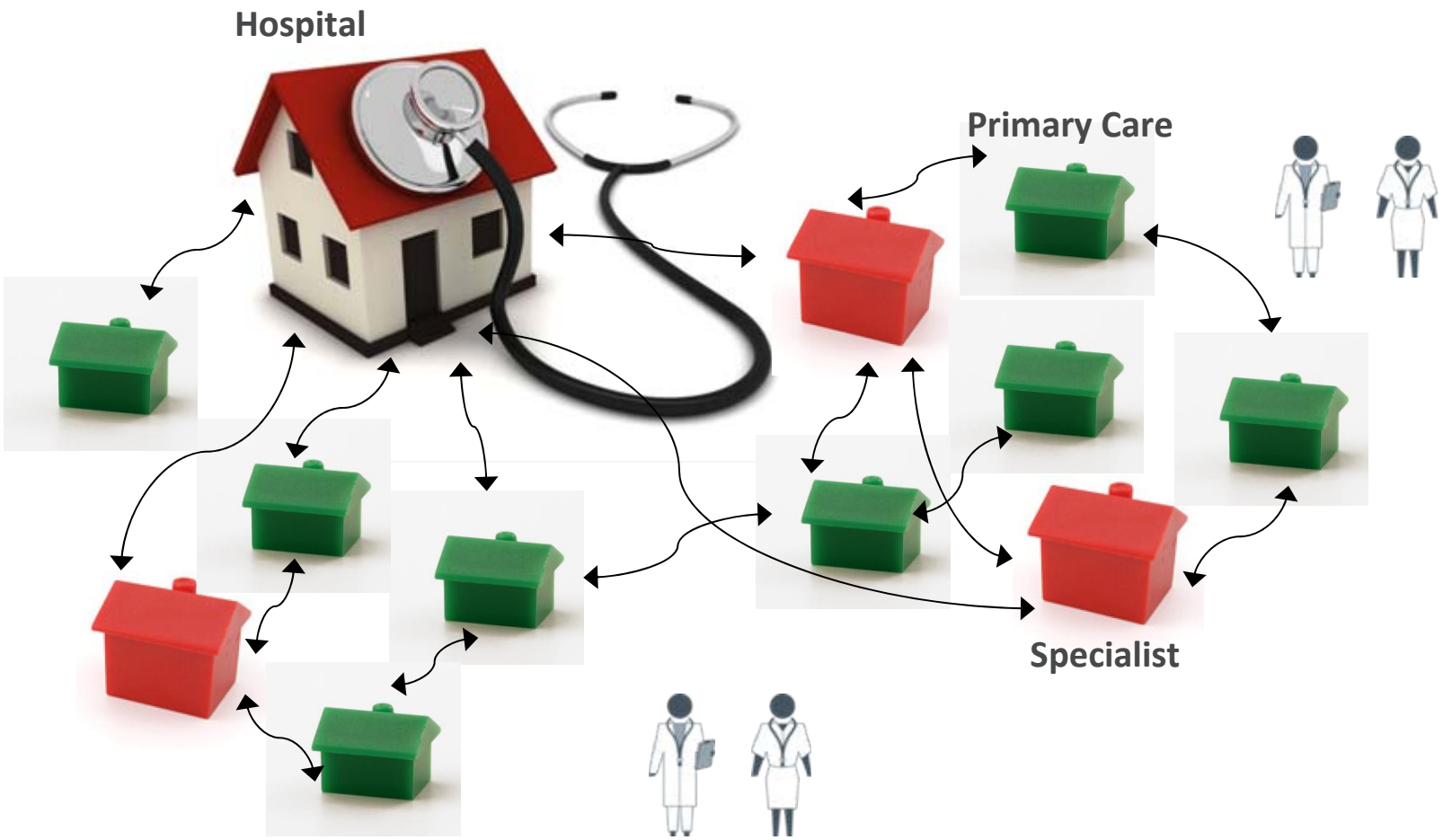
Comprehensive Care Management Model

- **Objective**: Provide high-touch team-based care to the high-risk Covered California members who need it most.

- Dignity Health is developing a system-wide care management program, modeled on our successful program in the DHMF.
- Similar to PBGH IOCP "Distributed" model
  - Shared cohorts of RN care coordinators, social workers, and pharmacists
  - Supplemented where appropriate by health coaches, an inpatient RN liaison, an RN intake nurse, and psychiatric technician or nurse.
  - Highest touch component in first months after enrollment and/or hospital discharge
  - Supported by health IT provided by networks to facilitate transitions of care

- Provides independent CI physicians access to resources never before available

Medical Neighborhoods: Better Communication, Fewer Readmissions

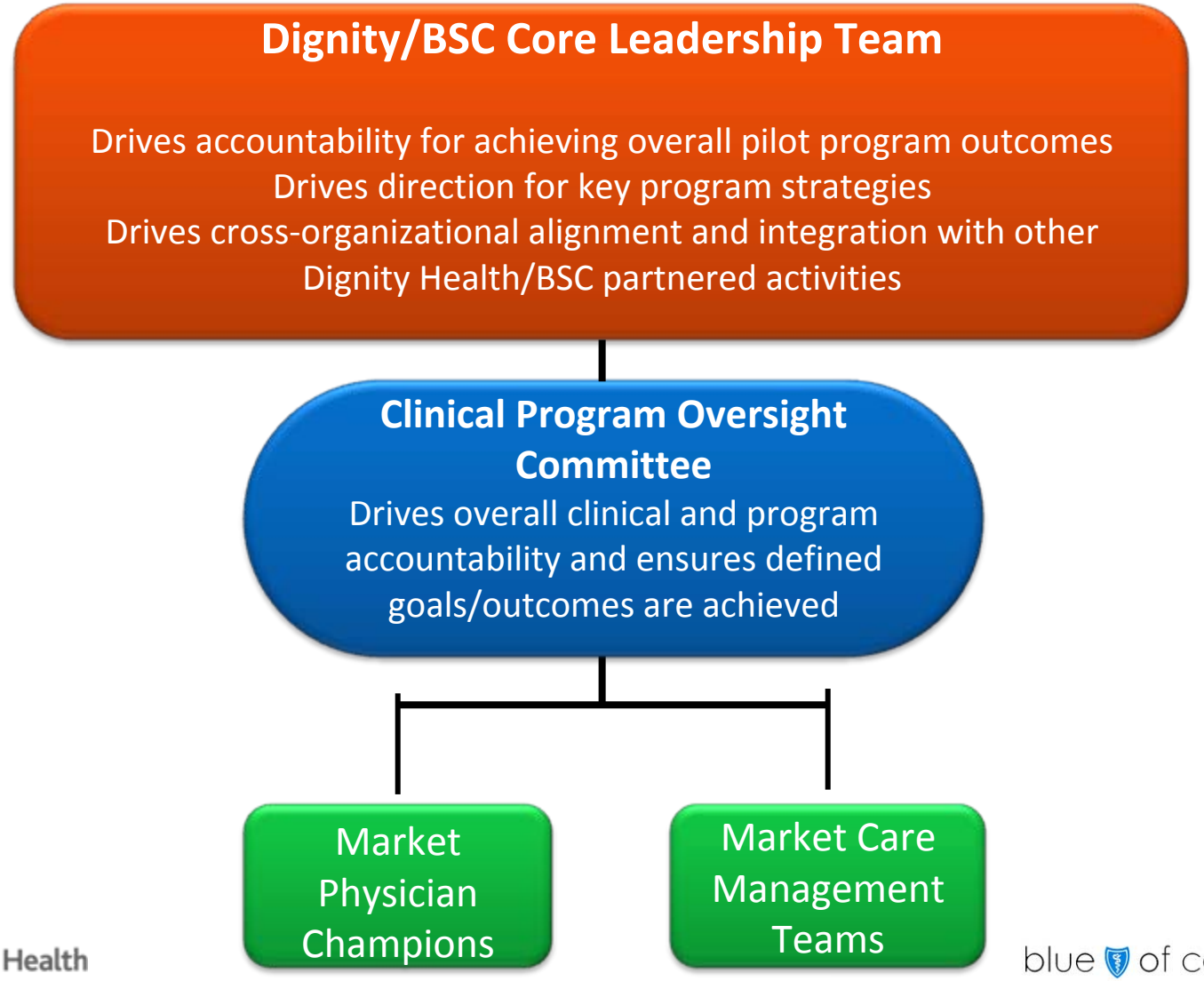


Shared Care Management Team
RN, Social Worker, Pharmacist

Selection of Patients for CCMM

- Patients identified by either triage of claims data (BSC) or physician offices as meeting any of 6 criteria:
  - Presence of 2 or more high risk conditions
  - 5 or more unique chronic medications
  - ≥ 3 inpatient admissions in the last 12 months
  - ≥ 3 emergency department visits in the last 12 months
  - Presence of high risk medications
  - Physician direct referrals
- Criteria will be reviewed by clinical team in 6 months

Shared Governance is Key!



Dignity Health

blue of california

Thank you!

Robert.Lerman@dignityhealth.org

Accountable Care Organization

- **Efficiency will be Assessed**
  - To attain shared savings, Dignity Health will be measured by certain metrics and be required to achieve better results than agreed upon benchmarks
  - **Year One:** ALOS and readmissions
- **Quality will be Monitored**
  - **Year One**: Focus on five key hospital inpatient quality measures
    - Core AMI 8a: Primary PCI within 90 min of arrival
    - Core AMI 10: Statin prescribed at discharge
    - Core HF 3: ACE-I or ARB for LVSD
    - Core IMM 2: Influenza immunization
    - Core VTE 1: VTE prophylaxis
  - **Year Two**: Broaden scope to incorporate ambulatory and patient satisfaction measures
- **Savings will be Shared**
  - **Year One**: Upside only, tied to efficiency and quality metrics
  - **Year Two**: Move towards BSC's standard ACO risk-share arrangement (upside and downside)