# Managing Populations: The Role of a Large Health System

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**EVP Clinical Transformation**
**CHE Trinity Health**
**March 17, 2014**

# Outline

- The Question
- Overview CHE Trinity Health
- The Infrastructure
- The Key Tool
- Preliminary Results

# The Question

Can a Large Health System Manage Populations?

# The Proverb

"All Health Care is Local"

Wise Ancient Muse

# Corollary to The Proverb

"All Health Care Standards are National"

Terry O'Rourke
March 17, 2013

# Reality 2014

Wide Variation in Health Care Delivery

Lesser But Significant Variation in Outcomes

# Industry is faced with the demand for Fundamental Change in how we operate and what we produce

## TODAY

**Producer-Centered**

**Service Volume**

**Drivers**

- Public Payers
- Private Payers
- Exchanges
- Providers

## TOMORROW

**People-Centered**

**Population Value**

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# This will require Fundamental Change in clinical and business model



| | Producer-Centered | People-Centered |
|---|---|---|
| **Measures of Success** | • Volume Driven Revenue<br>• Unit Price / Utilization Driven Margin | • Population Driven Revenue<br>• Triple Aim Results Driven Margin<br>o Better Health<br>o Better Care<br>o Lower Cost through Improvement |
| **Core Capabilities** | • Hospital Management<br>• Medical Staff Relations<br>• Supply Chain | • Population Health Management<br>• Clinically Integrated Networks<br>• Evidence-Based Care Redesign<br>• Improved Quality Outcomes |
| **Prevalent Payment Model** | • Fee-for-Service<br>• DRGs<br>• RBRVS | • Shared Savings<br>• Episode-Based Payments<br>• Value-Based Purchasing<br>• Capitation |

# Our Mission drives our strategy

We, CHE Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

## Core Values guide our decisions

- Reverence
- Justice
- Stewardship
- Commitment to the poor
- Integrity

We serve diverse populations, with over **18M people** in our communities

# Our 20 State Diversified Network now extends across the full continuum of care

**86** Hospitals

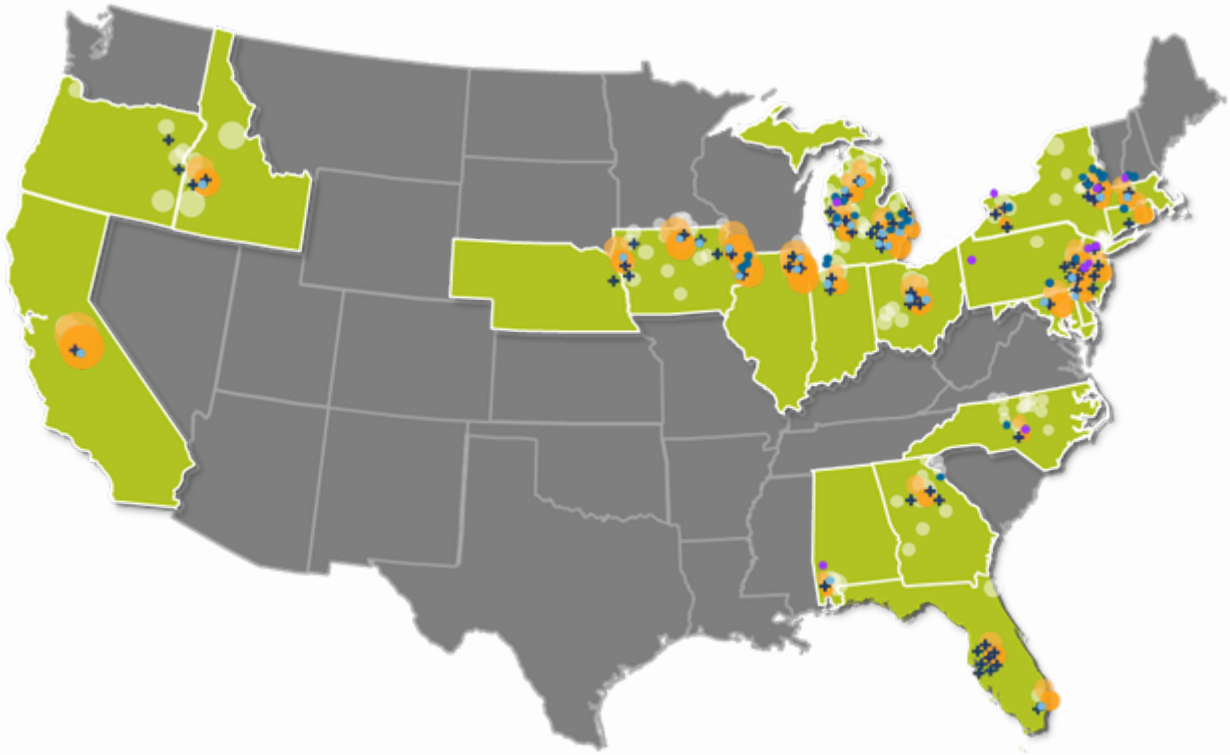
**44** Home Care agencies serving 160+ counties

**13** PACE Programs

**52** Other Continuing Care Facilities

**3,200**
Employed Physicians

**21,600**
Affiliated Physicians



Note: Home Care & Physician coverage based on communities served.

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# We are building on our Population Health Expertise

**2** Insurance Plans

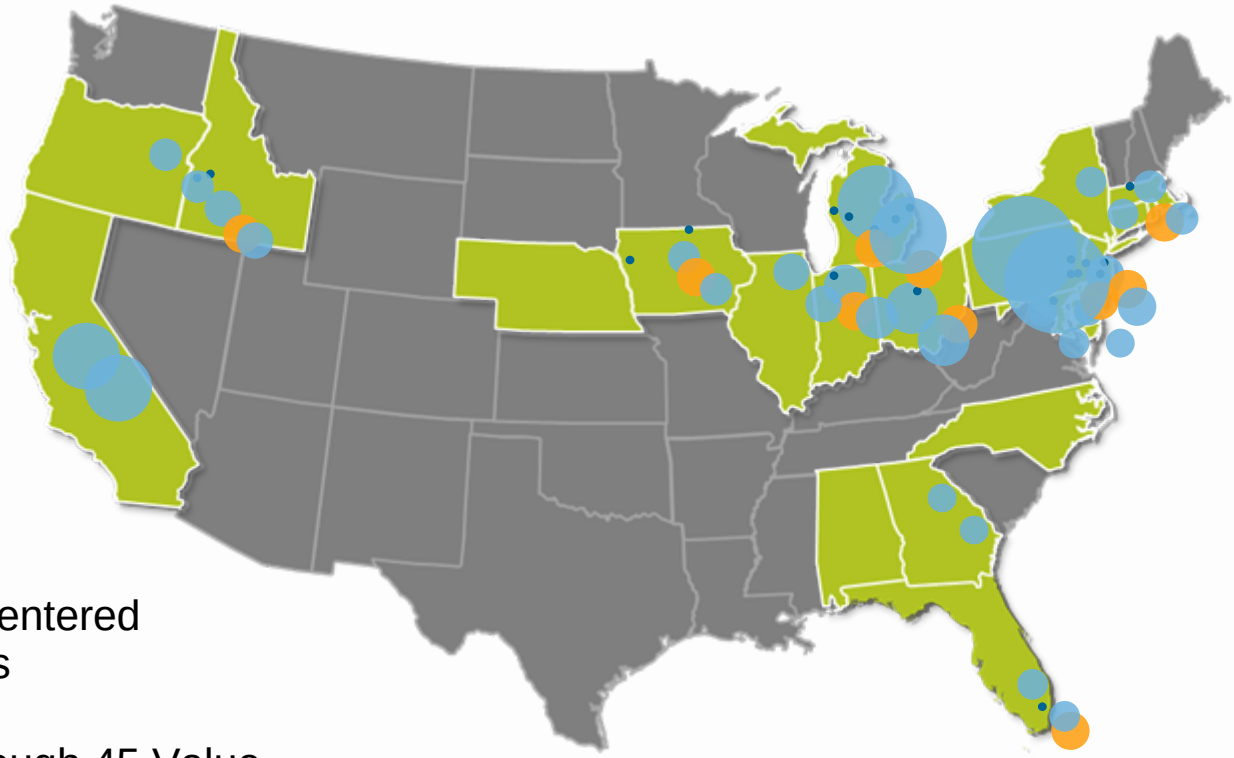
**5** ACOs

**5,400**
Physicians Committed to 10 Clinically Integrated Networks

**6** RHMs* pursuing Bundled Payment Programs

**29** RHMs with 65 Patient-Centered Medical Home Programs

**1M+** Attributed Lives, through 45 Value-Based Reimbursement Programs



*Operations are organized into Regional Health Ministries (“RHMs”), each an operating division which maintains a governing body with managerial oversight subject to authorities

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# Unified Clinical Organization is spreading our Quality Improvement Capability across the entire network

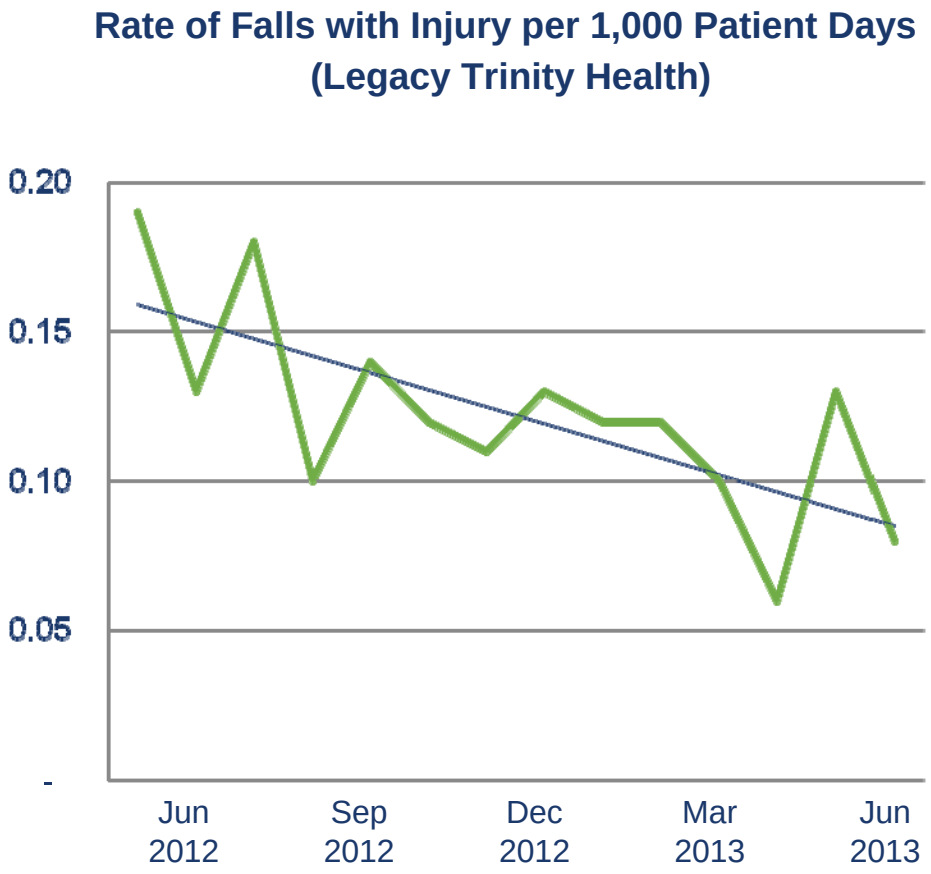
We score and report performance for acute care, home health and long term care organizations on 25 clinical quality metrics that roll up to an overall performance "GPA"

| Hospital | Perfect Patient & Clinical Process Scores (30%) | Patient Safety (30%) | Patient Experience of Care (30%) | Regulatory/BSN Rate (10%) | Clinical Grade Point Average (GPA) |
|---|---|---|---|---|---|
| Hospital A | 4.3 | 4.1 | 2.4 | 3.0 | 3.6 |
| Hospital B | 2.5 | 4.0 | 4.0 | 4.0 | 3.6 |
| Hospital C | 2.0 | 4.3 | 4.8 | 3.0 | 3.6 |
| Hospital D | 3.5 | 2.8 | 3.8 | 4.0 | 3.4 |
| Hospital E | 4.2 | 2.4 | 2.4 | 4.0 | 3.1 |
| Hospital F | 2.3 | 3.2 | 3.0 | 4.5 | 3.0 |
| Hospital G | 2.8 | 2.7 | 1.6 | 4.0 | 2.5 |
| Hospital H | 3.0 | 2.4 | 1.2 | 4.0 | 2.4 |
| Hospital I | 2.6 | 2.3 | 1.6 | 4.0 | 2.3 |
| Hospital J | 3.5 | 2.0 | 0.0 | 4.0 | 2.1 |

Note: The data and related GPAs reflect actual scores for a subset of CHE Trinity Health hospitals.

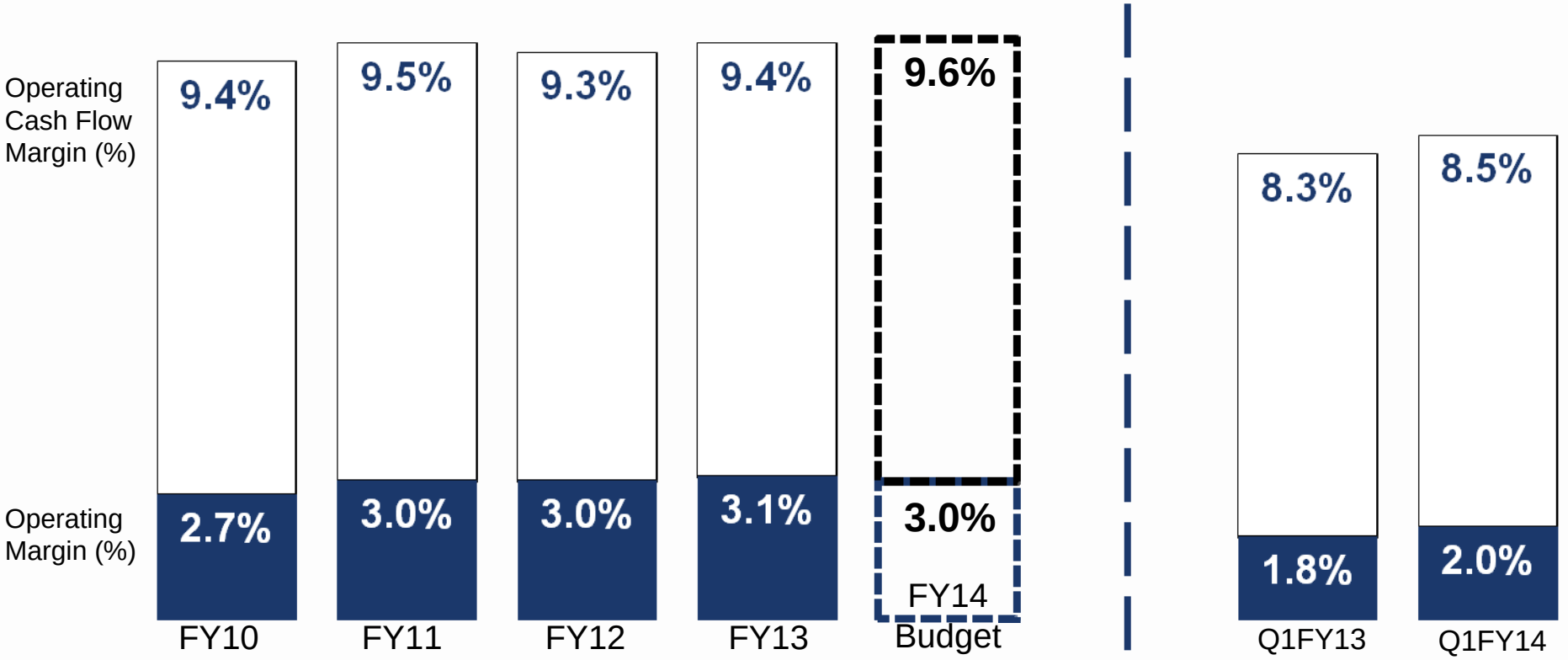
# … resulting in Significantly Improved Outcomes

| Hospital | Clinical Grade Point Average (GPA) |
|---|---|
| Hospital A | 3.6 |
| Hospital B | 3.6 |
| Hospital C | 3.6 |
| Hospital D | 3.4 |
| Hospital E | 3.1 |
| Hospital F | 3.0 |
| Hospital G | 2.5 |
| Hospital H | 2.4 |
| Hospital I | 2.3 |
| Hospital J | 2.1 |




Note: The data and related GPAs reflect actual scores for a subset of CHE Trinity Health hospitals.

# We continue to produce Strong and Consistent financial results…




Note: All time periods reflect the change of accounting for bad debt as a net patient revenue deduction and exclude discontinued operations. CHE Trinity Health data has been adjusted to reflect June 30 fiscal year end.

# The Infrastructure

## The Goal of the Unified Clinical Organization (UCO)

***Consistent*** *delivery of the highest quality, safest and the most efficient care for every person, every time, in every CHE-Trinity Health location*

# The Unified Clinical Organization (UCO) Approach

- Allows clinicians to lead the effort
- Leverages the system intellectual capital and leverages system scale to design once and implement many
- Keeps clinical work *sacred*
- Standardize care across the continuum
- Advance clinical leadership and collaboration
- Leverage technology, particularly the integration of electronic health records to improve clinical processes and practices
- Promote accountability
- Builds upon existing high performance
- Encourages data-driven decision making
- Makes it easy to do the right thing
- Comprehensive organizational support

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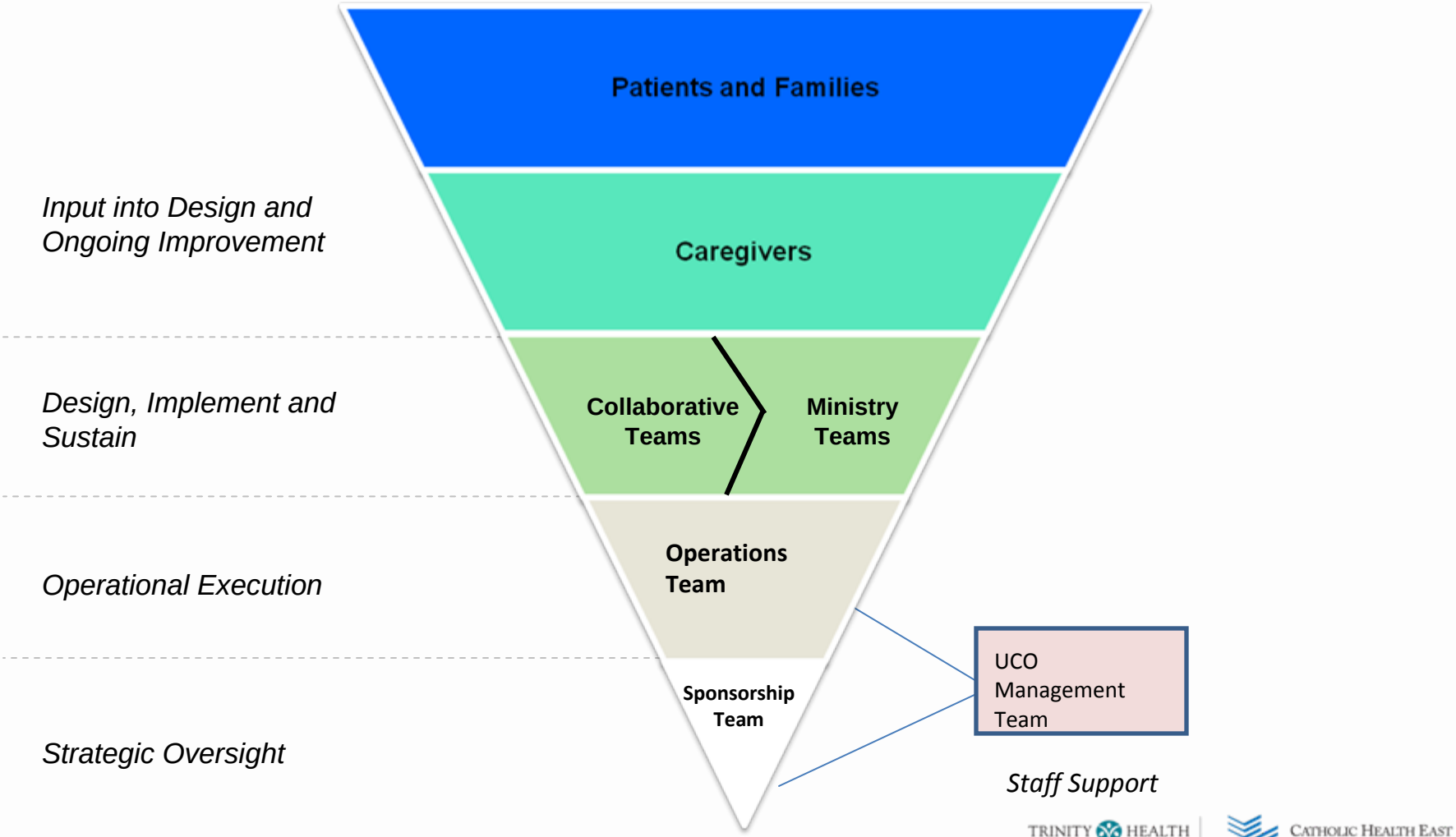
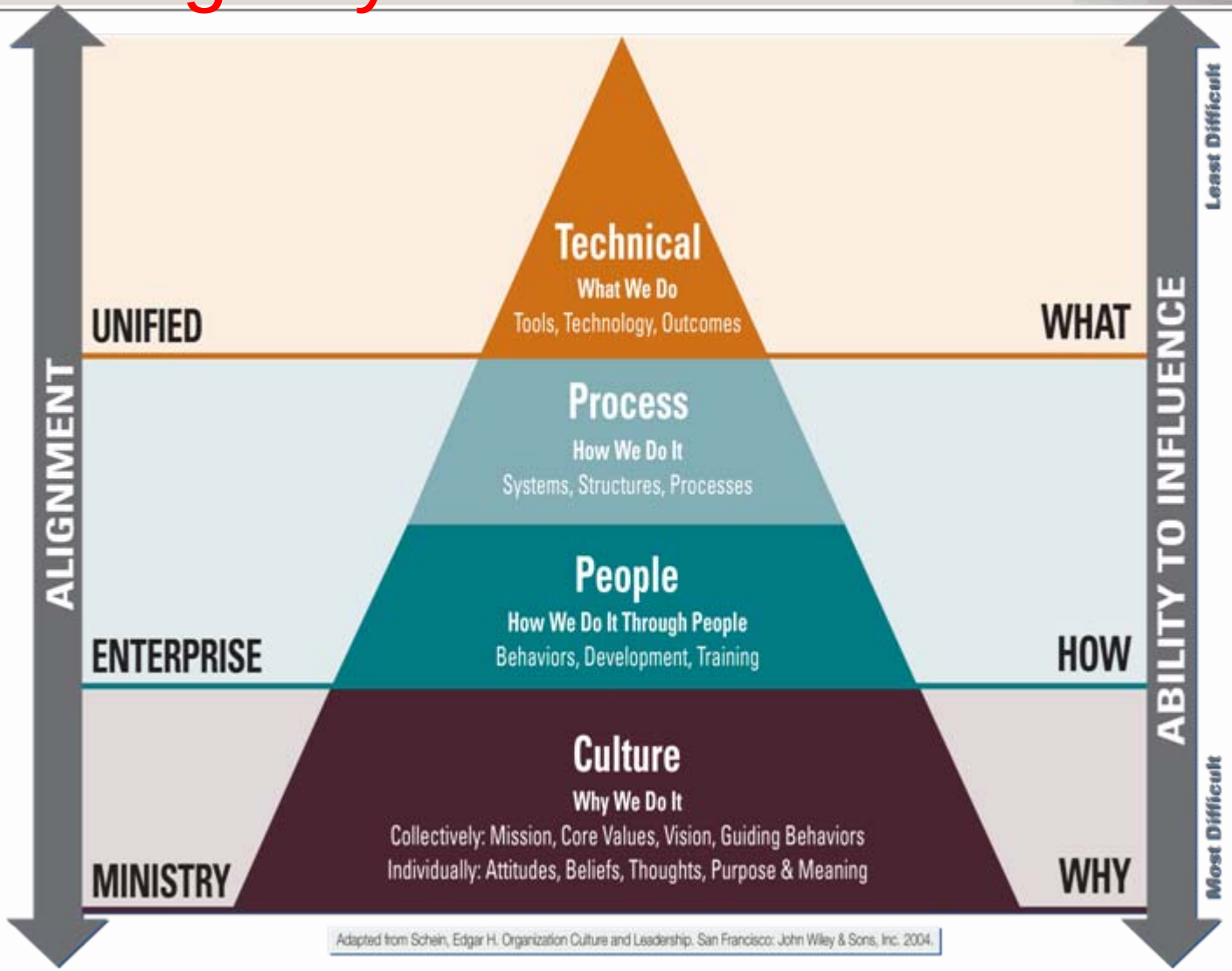
# Unified Clinical Organization:
# Governance and Decision Making Role

UCO Governance puts patients, families and caregivers at the forefront.



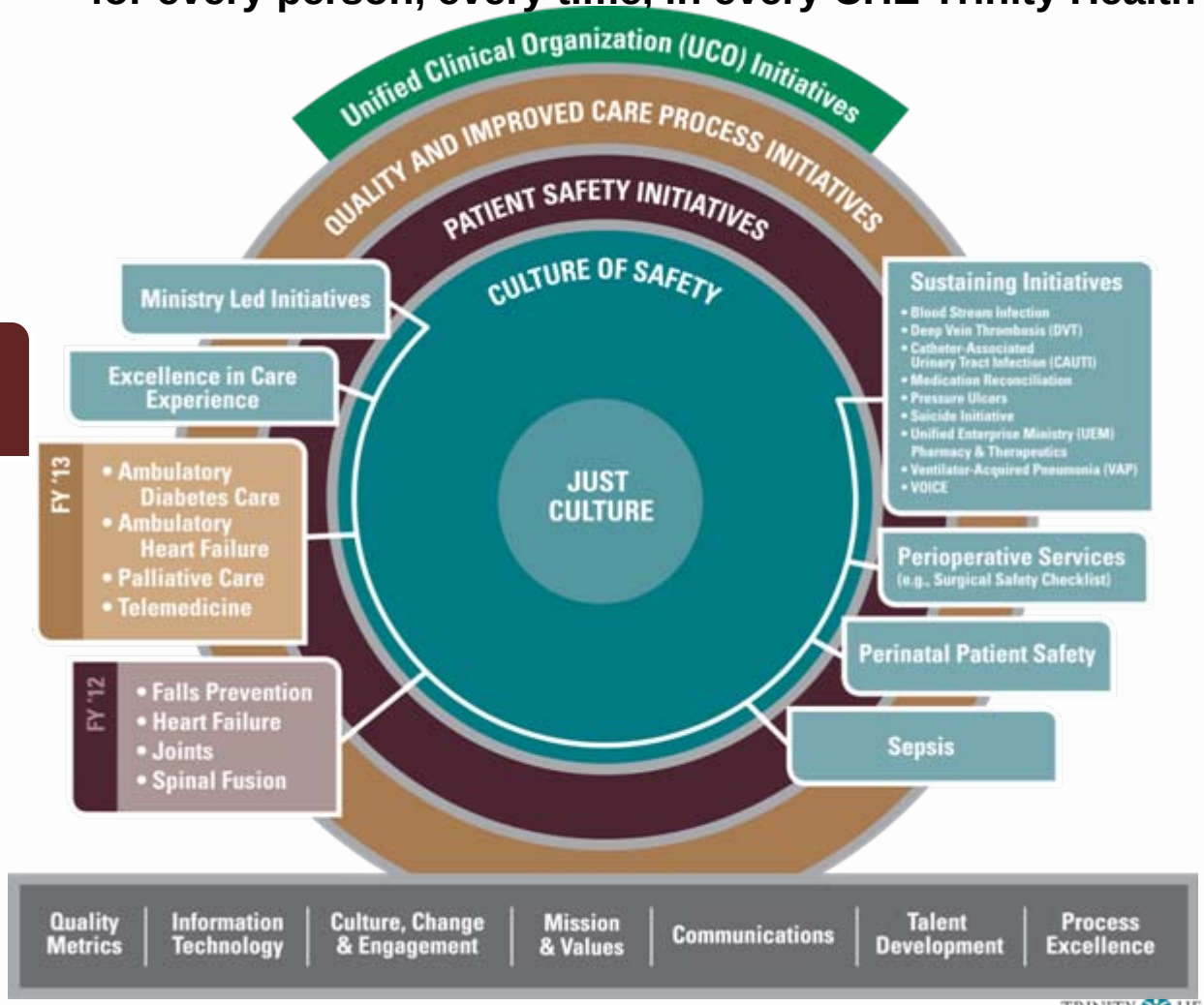
# CHE Trinity Health's Approach to Change

## The Change Pyramid



# UCO Initiatives

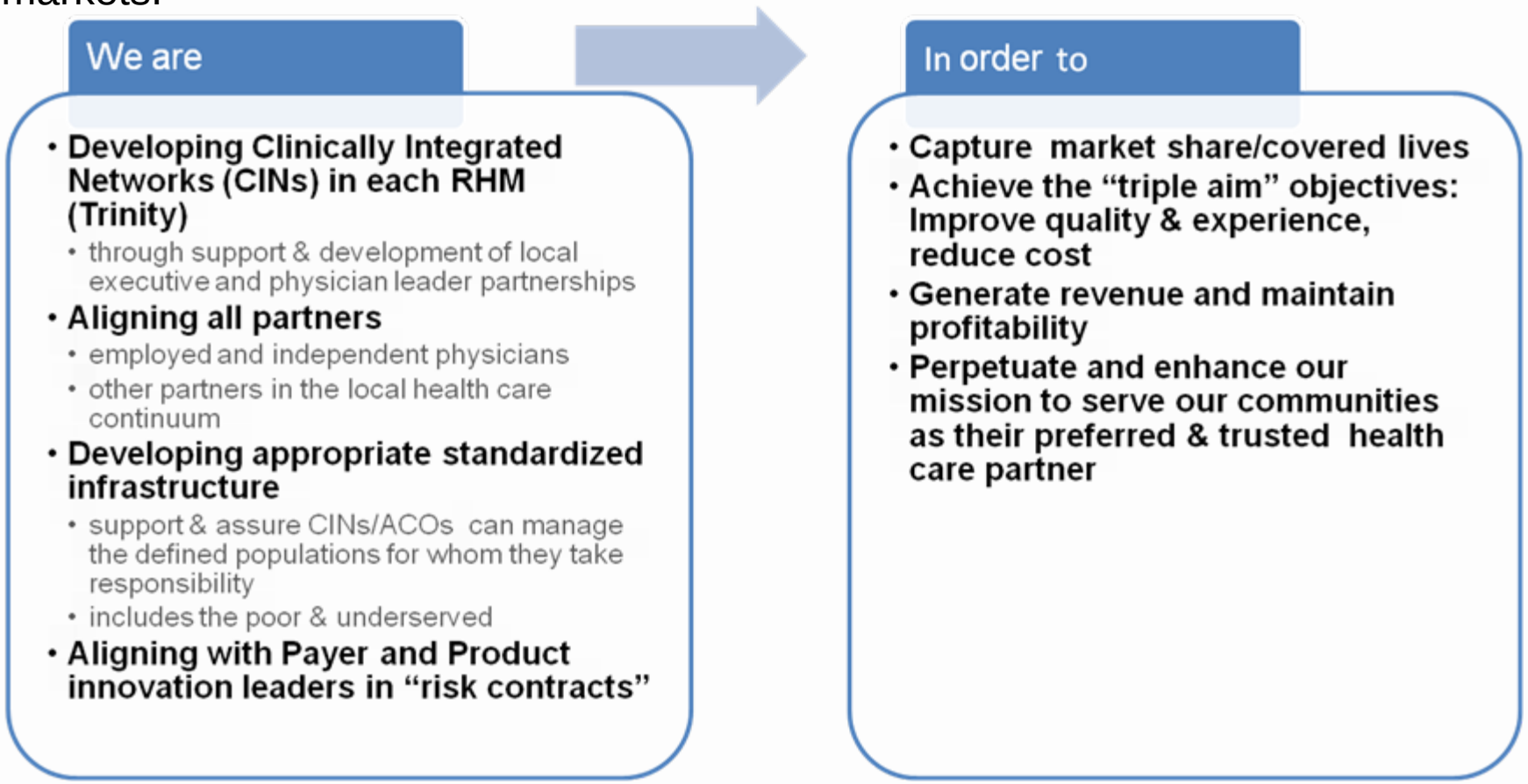
**UCO GOAL: Consistent delivery of the highest quality, safest and the most efficient care for every person, every time, in every CHE Trinity Health location**




FY'14
- Emergency Department

# The Key Tool – Clinical Integration

**Vision:** Through effective collaboration, Trinity Health will integrate with physicians and others to manage the health of defined populations and become the highest quality and lowest cost health system in each of our markets.

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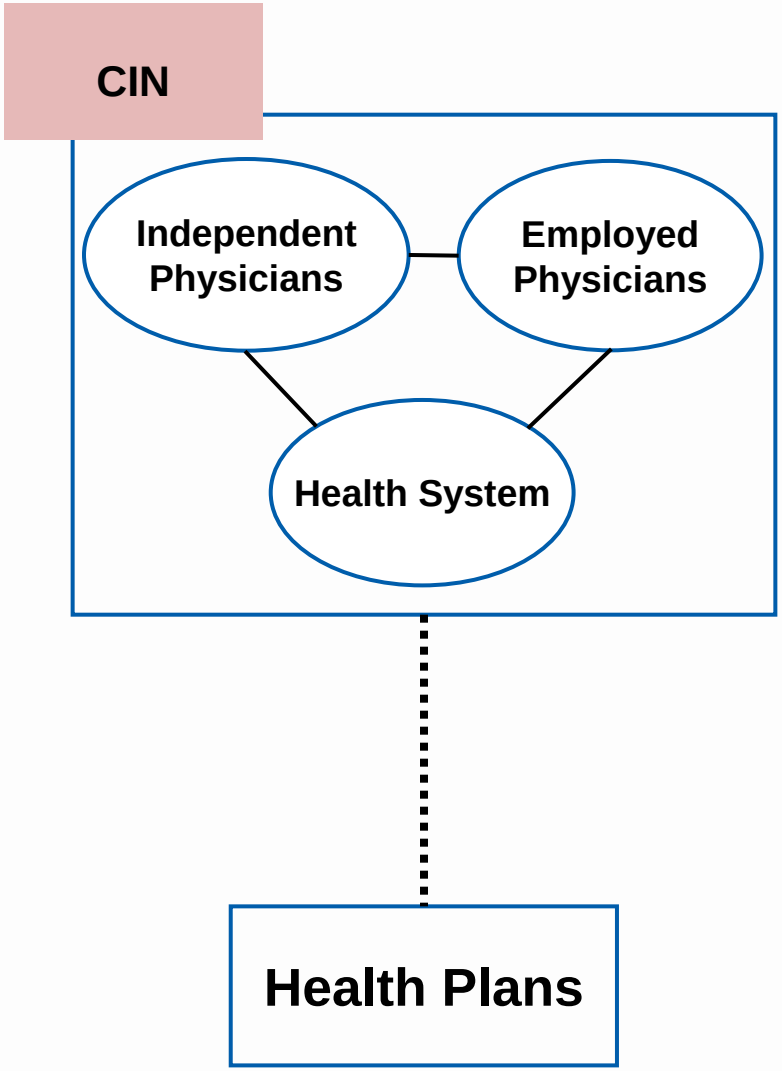
# Clinically Integrated Network (CIN) Scope




## Key Elements

**Network membership / credentialing**
Participating providers commit to active participation in performance improvement initiatives and care redesign

**Clinical management infrastructure**

- Evidence based clinical protocols to reduce variation in care
- Clinical IT system to share information across entire network
- CIN staff works with and enhances practices
- Care Management

**Joint contracting** for health system and physicians (employed and independent) to enable sharing value for improved performance

**Accountability** for joint agreed on attainable goals (Payer-blind – System administers)

**New governance model** engaging both employed and independent physicians

# Governing Board Design Board Composition

## Steering Committee followed by

## Governing "Board" Membership

Two Classes of Members:

- ➔ P = independent and employed
- ➔ H =2to 4 Health System Executives (at large)

1 Community Member


Independent

Employed Physicians

Health System Executives

P = Physician
H = Non-Physician

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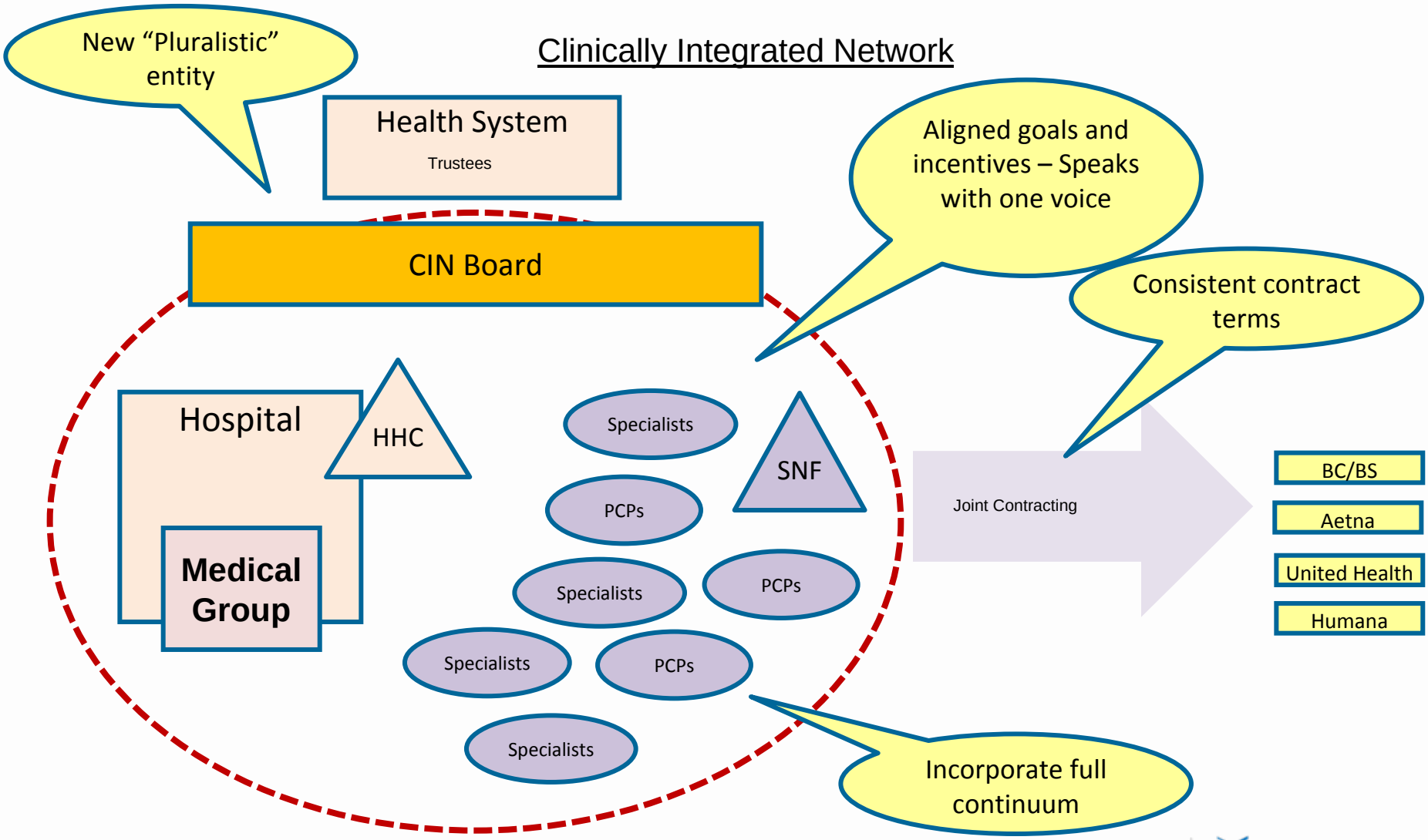
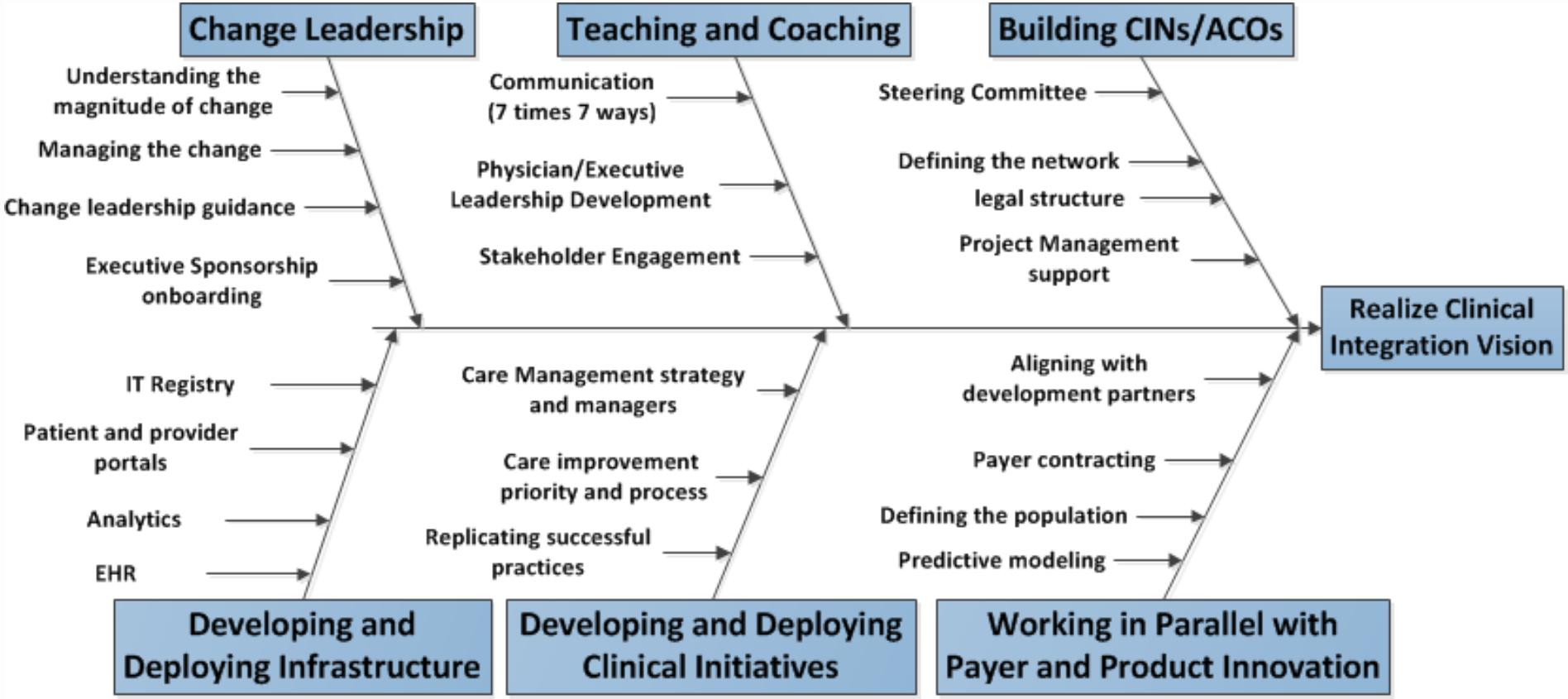
# Clinical Integrated Network (CIN )



# System Role in Clinical Integration



# Preliminary Results

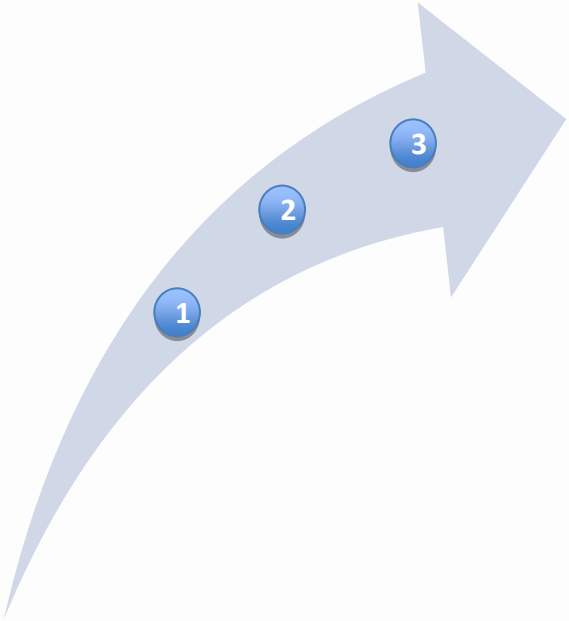
Ambulatory Diabetes

Sepsis

Perinatal Patient Safety

# Ambulatory Diabetes Collaborative

**1. Care Transformation Model* created with front-line Clinicians/Staff**
**Based on Chronic Care Model*




**2. Mason City, IA Pilot (2 clinics)**

***Interventions:***

1. Pre-visit Planning/Huddles
2. Patient Stratification related to diabetes control
3. Pharmacy Medication Therapy Component

***Outcomes:***

**a) Improved Outcomes on Diabetic Metrics**

| | March | Nov. |
|---|---|---|
| • BP < 140/90 | 52.17% | 76.33% |
| • Urine Screening | 65.22% | 81.66% |
| • LDL < 100 | 16.77% | 27.22% |
| • A1c < 8% | 37.27% | 46.15% |

**b) Practice Teams Engagement**

- "Have created processes that are being valued by the Medical Assistants"
- "When it came time to roll to next provider, they all wanted to start"

**3. Spread pilot learnings to entire collaborative *Feb– June 2014***

- Start with Foundational components of Pre-visit Planning & Huddles
- ***Next Phase*** – Care Management & Self-management support



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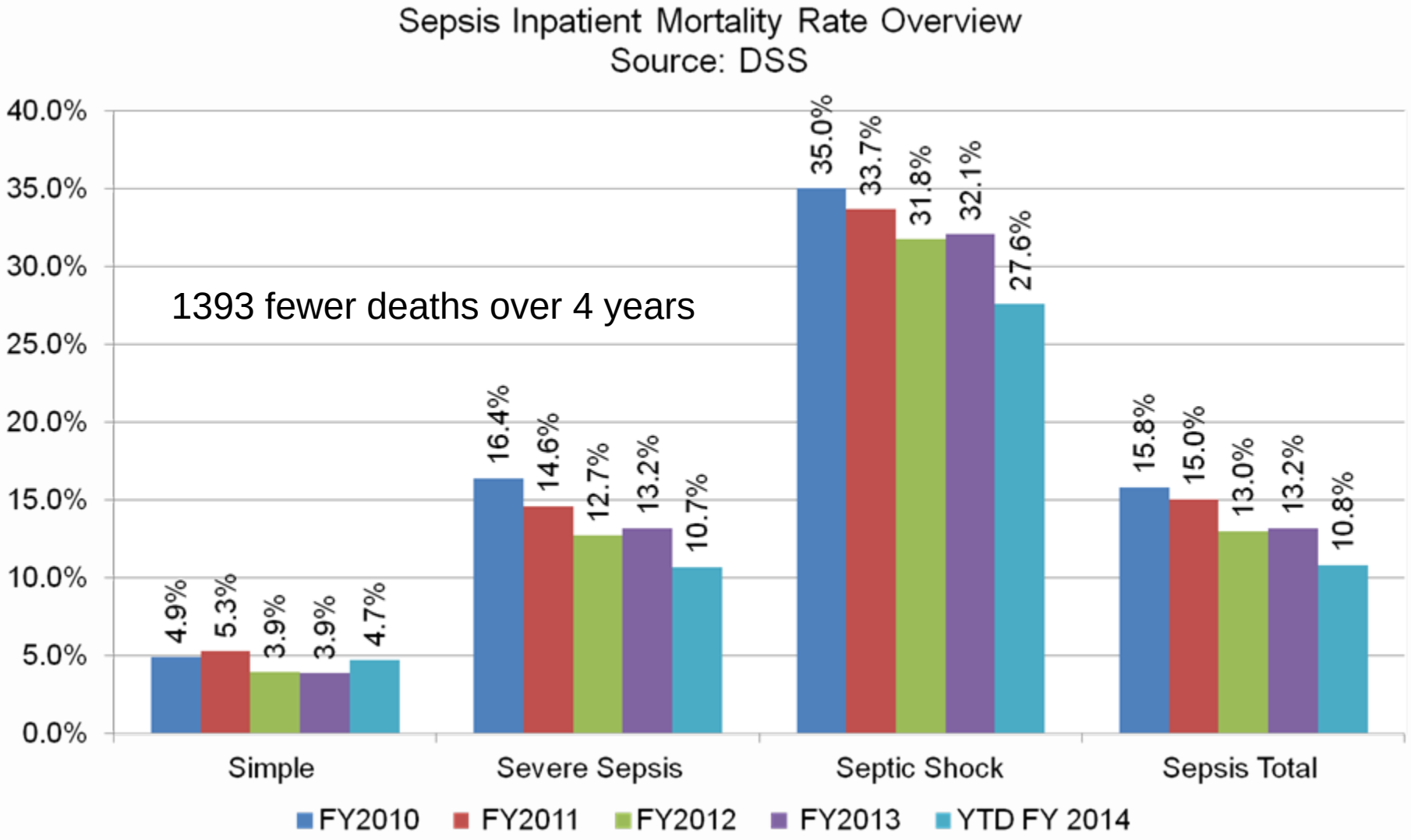
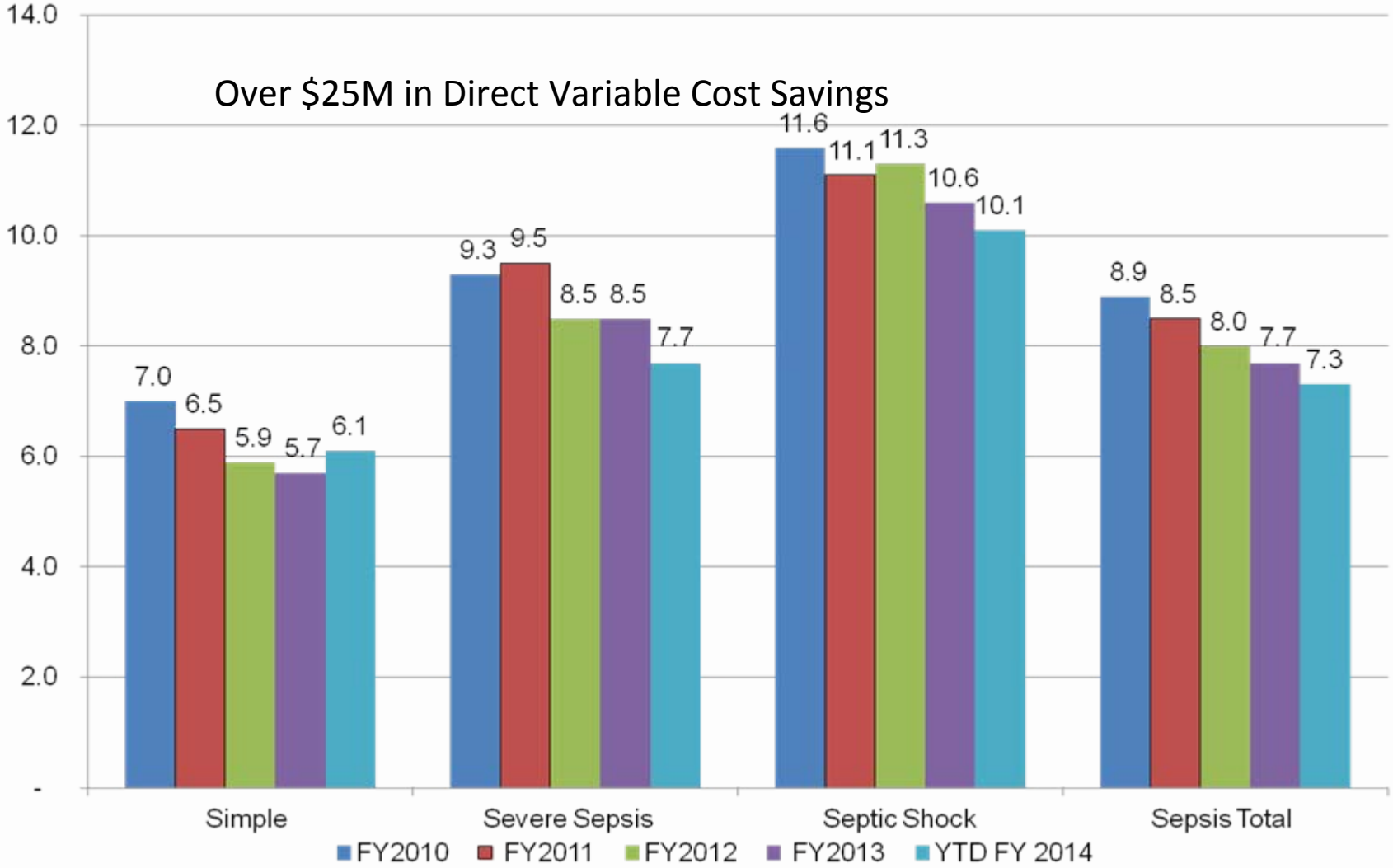
# Sepsis Inpatient Mortality FY 2010 – YTD FY 2014 (Sep.13)



# ALOS for sepsis FY 2010 – YTD FY 2014 (Sep.13)



# Perinatal Patient Safety Initiatives

- Trinity Health Data:
  - ✓ 41 children & families avoided life changing injuries since FY 2009
  - ✓ Losses as a percentage of total professional liability costs and average cost per claim have steadily declined.
  - ✓ Claims/10K Discharges have decreased from 5.5 % (FY09 Q1&2) to 0.7% (FY12 Q1&2)
  - ✓ SREs/10K Discharges have decreased from 97 (FY10 Q1&2) to 74 (FY12 Q1&2)

- CHE Trinity Health: Elective Delivery <39 Wks 1/14 Scorecard (target <=1%) Combined : 0.9% CHE: 2.5% TH: 0.7%

# CHE Trinity Health is well-positioned to Bridge the Transition

**TODAY**

**TOMORROW**

**Producer-Centered**

Mission-Centered Culture

Diversified Broad Network

Population Health Experience

Quality Improvement Capability

Strong Management Team

Strong Operating Results & Balance Sheet

**People-Centered**

**Service Volume**

**Population Value**

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# Happy St. Patrick's Day

May the road rise to meet you
May the wind be always at your back
May the sun shine warm upon your face
The rains fall soft upon your fields and,
Until we meet again
May God hold you in the palm of His hand