Moving Towards Accountable Care

• Leveraging Horizon 2020 strategies to build a system poised to address the demands of accountable care

Current Health Care Model
- Episodic Care
- Volume Driven/Fee-For-Service Payment Systems
- Acute Care Provider
- IT Systems in Silos
- Hospital-Physician Centric Interactions

Future Health Care Model
- Population Management
- Bundled Payments/Pay-For-Performance
- Diversified and Integrated Delivery System
- Integrated Information Systems Across Multiple Care Delivery Locations (Acute, Ambulatory, Home Health, Retail)

Horizon 2020 Strategies
Growth, Cost, Quality, Integration, Connectivity, Leadership

Mission, Vision and Values
Dignity Health Poised for Innovation

One of the largest health systems in the nation

| State Network | 20 |
| Care Sites | 400+ |
| Affiliated Physicians | 9,000 |
| $16 Billion in Assets | 530,000 Attributable Members (Including 270,000 capitated lives) |
| Employees | 56,000 |
| Acute Care Hospitals | 39 |

Provide integrated, patient-centered care to more than two million people annually

Diversified service offerings and partnerships support population health

Hospitals in Arizona, California, and Nevada

Growing national footprint

As of September 30, 2014

What has been standing in our way?

Population Health Management has its own evolving dictionary

<table>
<thead>
<tr>
<th>Common PHM Terms</th>
<th>Application to our model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Health Management</td>
<td>The management of a patient population to keep them as healthy as possible, minimizing the need for expensive interventions. PHM focuses partly on the high-risk patients who generate the majority of health care costs but it also systematically addresses the preventive and chronic care needs of every patient.</td>
</tr>
<tr>
<td>Physician Governance</td>
<td>Physician led engagement and decision making in what are the key deliverables needed to support population health management and how we are going to effectively deliver them.</td>
</tr>
<tr>
<td>Clinically Integrated Network</td>
<td>An organized team of care providers that is wholly accountable for a patient’s physician and mental health care needs, including prevention and wellness, acute care and chronic care management. Includes physicians, hospitals, care managers, social workers, pharmacist and many others.</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>From wellness to death people are engaging in practices that influence their health. People are different places along the continuum during different times in their lives.</td>
</tr>
<tr>
<td>Quality Measurements</td>
<td>Measures that help health care organizations and providers monitor quality of patient care to define opportunities for improvement.</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>Providing members the right amount of care at the right location and the right time for the best price.</td>
</tr>
<tr>
<td>Attribution</td>
<td>Members assigned to a physician or group practice based on defined utilization measures.</td>
</tr>
<tr>
<td>Prevalence &amp; Stratification</td>
<td>Systematically assessing population needs and stratifying the population based on geography, health status, resource utilization, demographics and patient willingness to actively engage in the management of their health.</td>
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Population Health Management Directional Focus

Through an integrated Population Health Management Strategy, Dignity Health will provide health care that improves the well-being and quality of life for the individuals and communities we serve.

**Mission**
- To transform patient behavior and health outcomes through the implementation of innovative Population Health Management strategies.

**Vision**
- To empower consumers through new Population Health Management care models consistent with our healing ministry

**Shared Values & Beliefs**
- Provide whole-person, patient-centered care to patients and their families
- Build compassionate clinically-integrated care management teams to improve access and quality of care and excellence in patient experience
- Offer technology and resources to ensure information access, effective communication and coordination of care
- Develop innovative solutions to engage and empower patients to manage their health wherever they are along the continuum
- Provide high-quality, evidence-based health care to improve overall health of the communities we serve

What is the value proposition for stakeholders?

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<thead>
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<th>Value to Physicians</th>
<th>Value to Patients</th>
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<td>Better Health Outcomes</td>
<td>• Leadership in Model structure of:</td>
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<tr>
<td>Value-Based Care</td>
<td>• Care Redesign/Efficiency</td>
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<td>Patient Navigators</td>
<td>• Reduction of Waste</td>
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<td>Care Coordination</td>
<td>• Quality Improvement</td>
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<td>Health Care Status</td>
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<td>• Shared Savings</td>
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<td>• Access to resources, tools, technology</td>
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<th>Value to Hospital</th>
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<tr>
<td>• Market Preferred Approach</td>
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<td>• Growth (market and mix)</td>
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<td>• Focus on Shared Goals with physicians</td>
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<td>• Quality Improvement</td>
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<td>• Operational Efficiencies</td>
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Dignity Health’s Clinical Integrated Networks

Clinical Integrated Physicians
- 39 Hospitals
- 7 Clinically Integrated Networks

- Physicians in Employment/Foundation
- Independents in CI
- Independents not in CI

*Note: Each Clinical Integrated Network’s approx. count of participating providers as of December 2014

Opportunities Shift Towards Population Health

Commercial PPO ACO
Commercial PPO P4P

Direct to Employer
Clinical Integration Program (Physician Network, Quality & IT Infrastructure)
Managed Medicaid/Duals
CMS Bundled Services
Medicare Advantage
Medicare ACO
Bundled payments are one of the new revenue models tipping the scale from volume to value

Components of Clinical Integration

Adapted from The Advisory Board, "Building the Performance-Focused Physician Network." 2010.
Key Pillars: Drive toward Future State

Enhance Member and Patient Satisfaction and Long-Term Loyalty
- Individual, family, caregiver profiles, opt-in, and communication preferences
- Rich secure, collaboration between Member, Care Giver, and Provider
- Self Service Access:
  - Clinical information
  - Schedule appointments
  - Targeted care advice and individualized plan based on health history

Integrate care and Care Management Through Physician Partnerships
- Proactive care team monitoring across acute, ambulatory, post-acute, prevention, and wellness
- Information sharing for clinical care, payer, product, and network attribution at all points
- Access to health history drives targeted care plan
- Stratification of patient at first visit optimizes care coordination
- Defined clinical pathways based on evidence, disease registries, and research
- Physician knowledge-sharing of best practices across system
- Predictive analytics on high risk patient and recommended care
- Standard shared metrics to drive improvement opportunities

Drive Positive Health Outcomes Based on Clinical Evidence
- Predictive Analytics drives improved financial margins and transparency
- Alerts on high cost patients and encounters
- Provider Profiling and Performance
- Collect and store patient hospital cost information to support financial algorithms

Improve Margins by Driving Network Efficiency
- Predictive Analytics drives improved financial margins and transparency
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Open Approach

Continuum of Care

Physician Integration Strategies

Information Technology Strategies

Population Management Capabilities

High Access Care
- Urgent Care
- Retail Clinics
- Physician Groups
- Community Clinics
- Occupational Health
- Medical Home

Outpatient Diagnostic and Treatment
- Imaging
- Ambulatory Surgery Centers
- Labs
- Cancer Centers
- Infusion Centers

Acute Care
- General Acute Hospitals
- ED Hospitals
- Specialty Hospitals
- JOC Arrangements

Post Acute Care
- Home Health
- Skilled Nursing Facilities
- Long Term Acute Care
- Rehab Hospitals
Next Generation Accountable Care Platform

- PHM
  - Advanced Population Analytics
  - Risk Stratification & Financial Analysis
- Disease Management
  - Care Management
  - Clinical Business Intelligence
  - Telemonitoring
- Care Coordination
  - Decision Support
  - Registries
  - Care Planning
- HIE and ePatient Engagement
  - Patient Portals
  - Mobile solutions
  - Secure Communications
  - Ambulatory EHR Performance Analytics
  - ePrescribe
    - Acute EMR
    - eMeasures
    - Mobile Devices
- Ambulatory EMRs and Ancillaries
- Acute Care EMRs and Ancillaries

Source: AHA Center for Healthcare Governance

One Care Management Model across the Continuum

- Outpatient
  - Dedicated Care Managers
  - Multi Conditions Centers
  - Advanced Medical Practice
  - Practice Operations Coaches
- ED Care Coordination Optimization
- Alternative Site Of Care Transitions
- Inpatient Care Coordination
- Readmission Risk Assessment & Focused Interventions
- Inpatient Care Coordination Redesign
- Acute To Post Acute Transitions

Source: Dignity Health
Technology Supporting Population Health

Clinical Tools
- Clinical Applications
- Analytics, Metrics Protocols, Pathways
- Aligned Care Team
- Clinical Interactions
- Filteriing
- Indexing
- Notification Routing
- Privacy & Security

Communication
- HIE Portal
- Clinical Portal
- Consumer & Patient Portal

Information Layer
- Parsing – Validation
- Routing
- Privacy & Security
- Filtering
- Indexing
- Notification Routing

Patient Portal
- Engages patient and family by empowering them through online filling of prescriptions, scheduling appointments, or accessing medical records
- Guides patients to most appropriate site of care
- Provides on demand educational material with enhanced features
- Offers ability to quickly connect with a provider if needed

mHealth Apps
- Connects patients and families to the care team through improved communication
- Improves the ease and access to care through the availability of portal features and functionality
- Collects additional data on population health and consumer habits

Social Media
- Used more and more by wider demographic range
- Establishes health “community”, supporting relationship building for patients and families with similar health care conditions
- Drives engagement by socializing goals and achievements
- Creates another channel for providers and patients to interact

Increasing Role of Technology in Consumer Engagement

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Dignity Health
**Individual Provider Drill Down**

**Two Tiers of Priorities for Population Health**

There are so many priorities that we had to divide them into two tiers

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<th>Tier 1</th>
<th>Tier 2</th>
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<tr>
<td>MD Leaders</td>
<td>Hospitals</td>
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<td>Executives Champions</td>
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<td>Members</td>
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<td>Care Teams Engagement Pathways Care Plans Continuum Wellness</td>
<td>Savings Risk Co-Mgmt. Bundling D2E</td>
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| QA Measures | Communicate |
| Identify Collect Dashboard Compare Incentive | Program Incentives Risk Opportunity Role |
| Stratification Referrals Workflow | Tier 2 |
| Tier 1 |
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| Hospitals | System Partners Cost Mgmt. |
| Analytics | Incentives |
| Statistics Actuaries Financial Tiers | MD Develop Tier levels QA and financial targets |
| Pharmacy | Value Added |
| Formulary Generic Patient engagement Stratification | Insurance Technology Staffing Consultants |
| Tier 2 | Members |
| Savings Risk Co-Mgmt. Bundling D2E | Tier 2 |
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Compliance Considerations

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<td>North State FD*</td>
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<tr>
<td>VIPN 764*</td>
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<td>SCICN 155*</td>
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<tr>
<td>SCICN- Ventura 25*</td>
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<tr>
<td>SCICN-inland Empire 135*</td>
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<tr>
<td>SCN (includes Abrazo facilities) 2402*</td>
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Thank You