Dignity Health
Population Health Management and Compliance Programs

Julie Bietsch, VP Population Health Management
Dawnese Kindelt, Senior Compliance Director, Clinical Integration
June 8, 2015

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

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Dignity Health Poised for Innovation

One of the largest health systems in the nation

20 State Network

400+ Care Sites

9,000 Affiliated Physicians

530,000 Attributable Members (Including 270,000 capitated lives)

$16 Billion in Assets

56,000 Employees

39 Acute Care Hospitals

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

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What has been standing in our way?

Population Health Management has it's own evolving dictionary

Common PHM Terms	Application to our model
Population Health Management	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.
Physician Governance	**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.
Clinically Integrated Network	**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.
Continuum of Care	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.
Quality Measurements	Measures that help health care organizations and providers **monitor** quality of patient care to define opportunities for improvement.
Cost Efficiency	Providing members the **right amount of care** at the right location and the right time for the best price.
Attribution	**Members assigned** to a physician or group practice based on defined utilization measures.
Prevalence & Stratification	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.

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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

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What is the value proposition for stakeholders?

Value to Physicians

- Leadership in Model structure of:
  - Care Redesign/Efficiency
  - Reduction of Waste
  - Quality Improvement
  - Patient Satisfaction
  - Shared Savings
  - Access to resources, tools, technology

Value to Patients

- Better Health Outcomes
  - Value-Based Care
  - Patient Navigators
  - Care Coordination
  - Health Care Status

Value to Hospital

- Market Preferred Approach
  - Growth (market and mix)
  - Focus on Shared Goals with physicians
  - Quality Improvement
  - Operational Efficiencies

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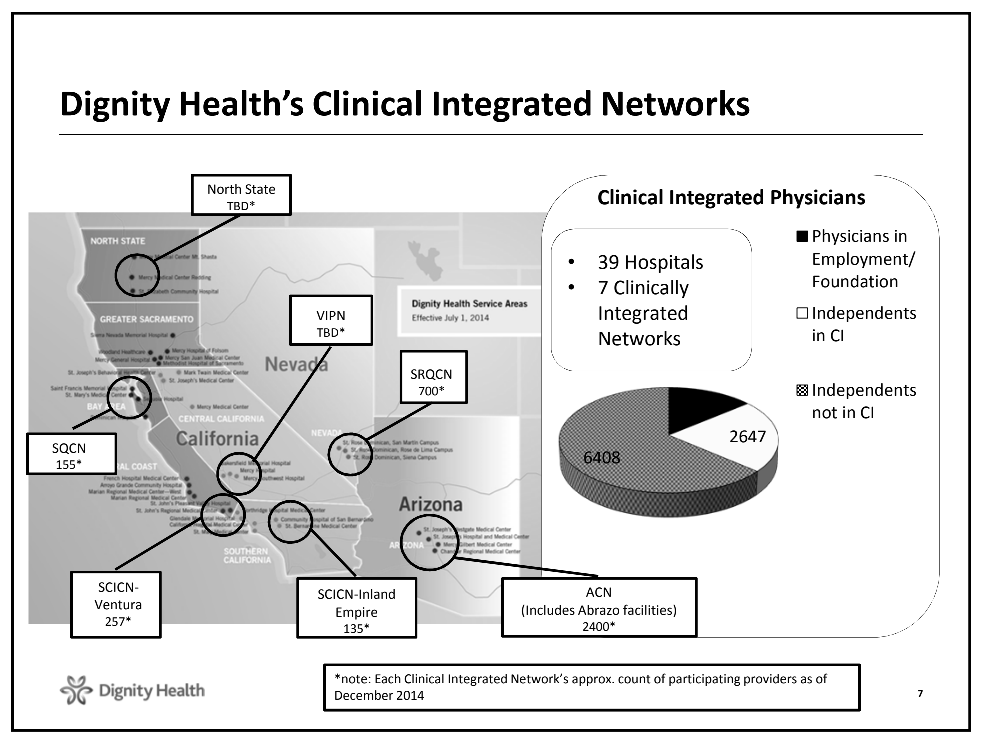
Dignity Health's Clinical Integrated Networks
North State
TBD*
VIPN
TBD*
SRQCN
700*
SQCN
155*
SCICN-
Ventura
257*
SCICN-Inland
Empire
135*
ACN
(Includes Abrazo facilities)
2400*
Nevada
California
Arizona
Dignity Health Service Areas
Effective July 1, 2014
Clinical Integrated Physicians
39 Hospitals
7 Clinically Integrated Networks
Physicians in Employment/ Foundation
Independents in CI
Independents not in CI
2647
6408
*note: Each Clinical Integrated Network's approx. count of participating providers as of December 2014
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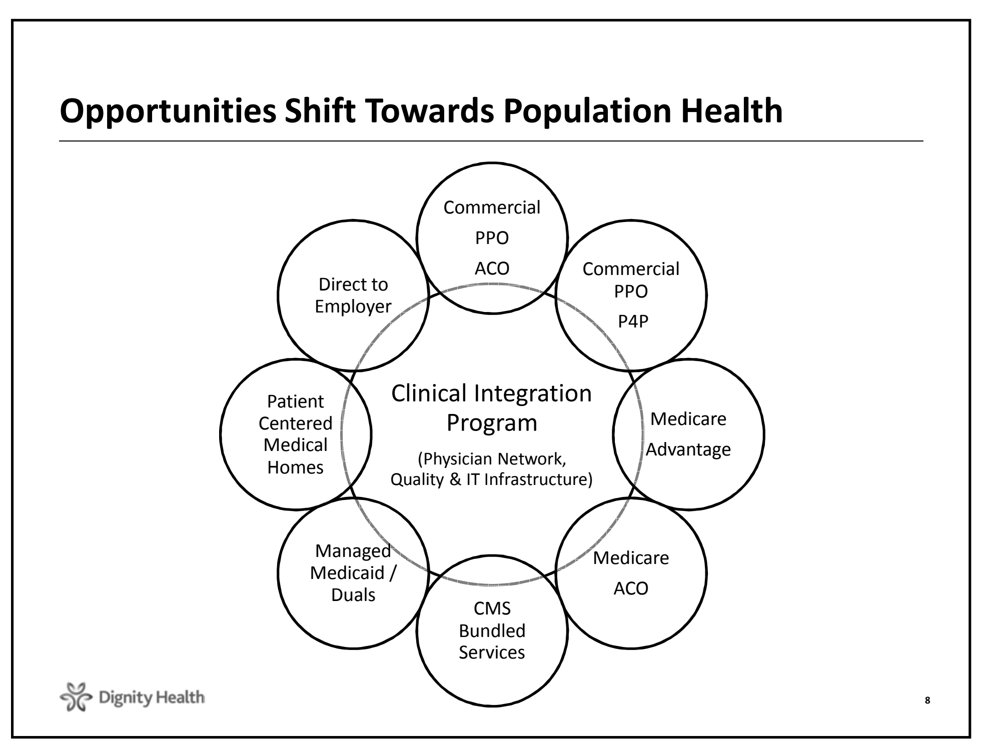
Opportunities Shift Towards Population Health
Commercial
PPO
ACO
Commercial
PPO
P4P
Medicare
Advantage
Medicare
ACO
CMS
Bundled
Services
Managed
Medicaid /
Duals
Patient
Centered
Medical
Homes
Direct to
Employer
Clinical Integration
Program
(Physician Network,
Quality & IT Infrastructure)
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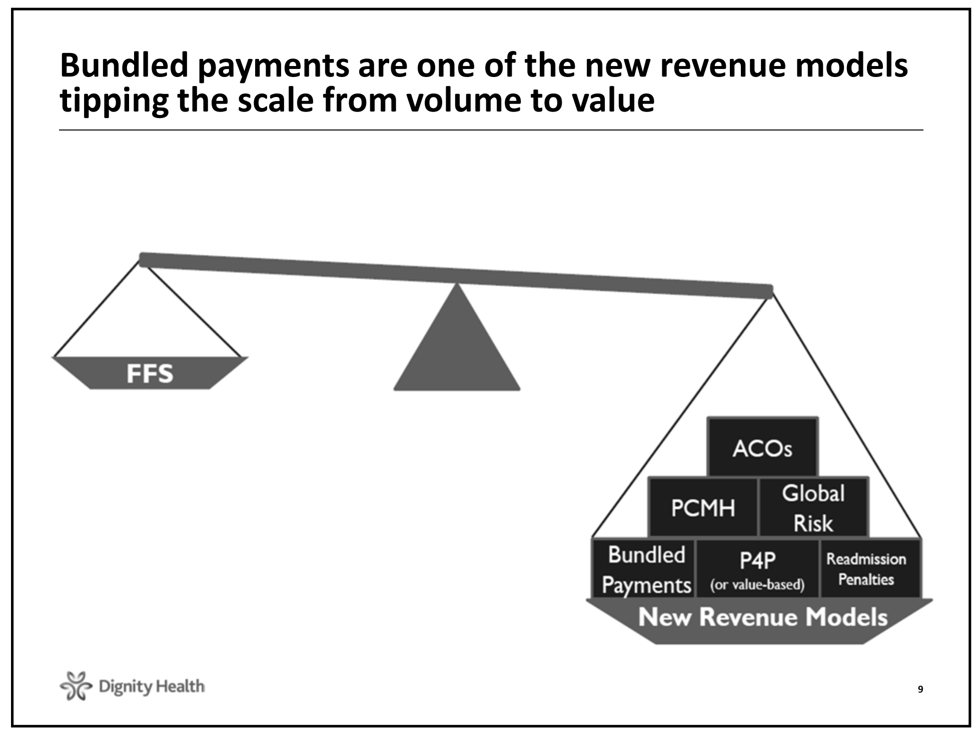
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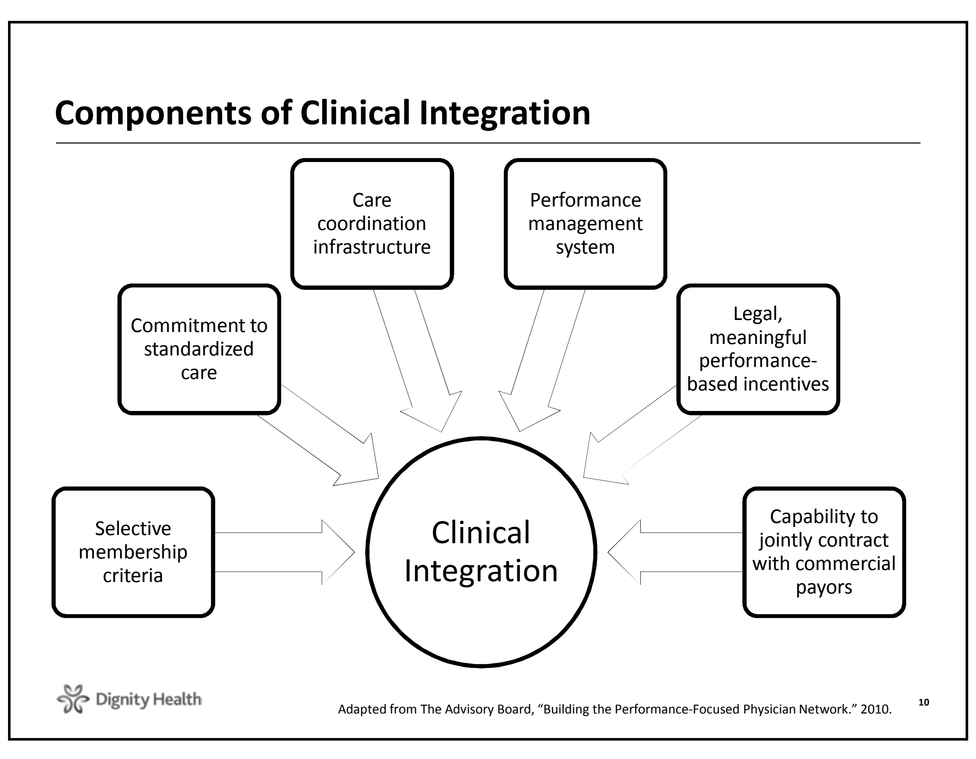
ACOs
PCMH
Global Risk
Bundled Payments
P4P
(or value-based)
Readmission Penalties
New Revenue Models
Dignity Health
9


Components of Clinical Integration
Care coordination infrastructure
Performance management system
Commitment to standardized care
Legal, meaningful performance-based incentives
Selective membership criteria
Clinical Integration
Capability to jointly contract with commercial payors
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Adapted from The Advisory Board, "Building the Performance-Focused Physician Network." 2010.
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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

Drive Positive Health Outcomes Based on Clinical Evidence

- 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

Improve Margins by Driving Network Efficiency

- 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

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Open Approach

Continuum of Care

Information Technology Strategies

Physician Integration Strategies

High Access Care

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

U.S. HealthWorks MEDICAL GROUP A Dignity Health Member

CVS/pharmacy

Outpatient Diagnostic and Treatment

- Imaging
- Ambulatory Surgery Centers
- Labs
- Cancer Centers
- Infusion Centers

United Surgical Partners INTERNATIONAL

SimonMed

Acute Care

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

Vanguard HEALTH SYSTEMS health.forward.

O:A:S:I:S Hospital

Post Acute Care

- Home Health
- Skilled Nursing Facilities
- Long Term Acute Care
- Rehab Hospitals

naviHealth

Kindred Healthcare Dedicated to Hope, Healing and Recovery

Population Management Capabilities

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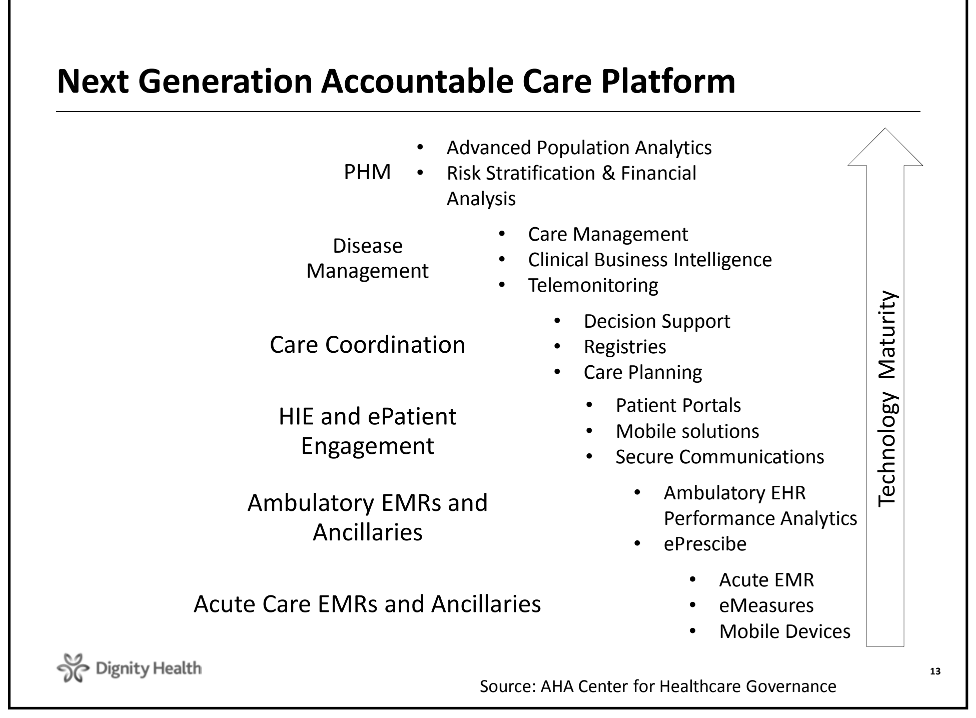
Next Generation Accountable Care Platform
PHM
Advanced Population Analytics
Risk Stratification & Financial Analysis
Disease Management
Care Management
Clinical Business Intelligence
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Decision Support
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Ambulatory EHR Performance Analytics
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Acute Care EMRs and Ancillaries
Acute EMR
eMeasures
Mobile Devices
Technology Maturity
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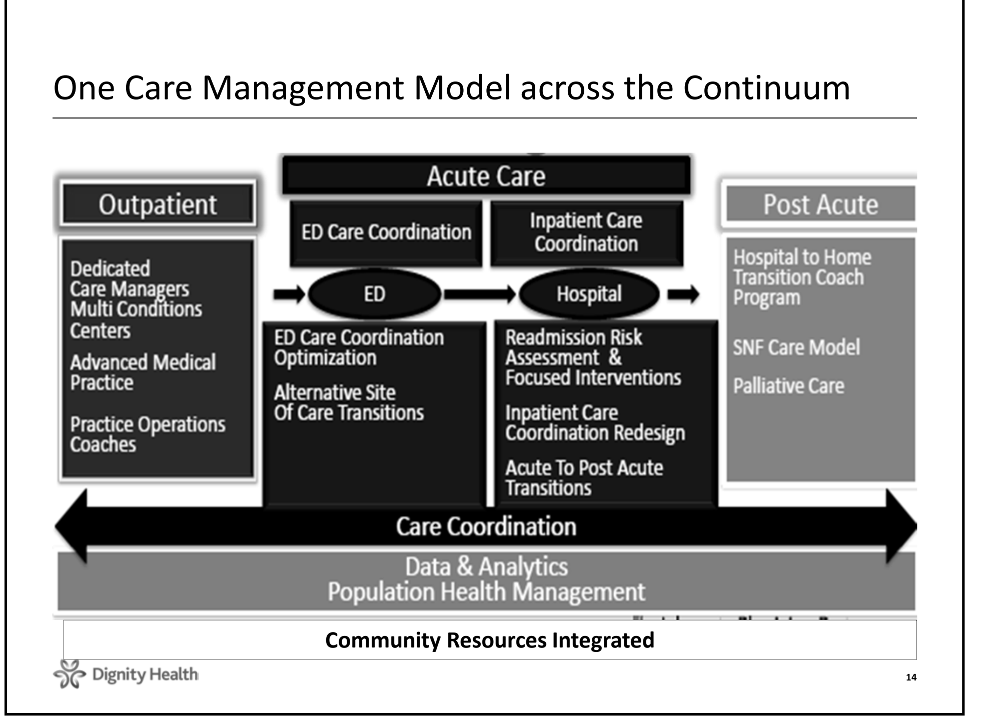
Source: AHA Center for Healthcare Governance


One Care Management Model across the Continuum
Outpatient
Dedicated Care Managers Multi Conditions Centers
Advanced Medical Practice
Practice Operations Coaches
Acute Care
ED Care Coordination
Inpatient Care Coordination
ED
Hospital
ED Care Coordination Optimization
Alternative Site Of Care Transitions
Readmission Risk Assessment & Focused Interventions
Inpatient Care Coordination Redesign
Acute To Post Acute Transitions
Post Acute
Hospital to Home Transition Coach Program
SNF Care Model
Palliative Care
Care Coordination
Data & Analytics
Population Health Management
Community Resources Integrated
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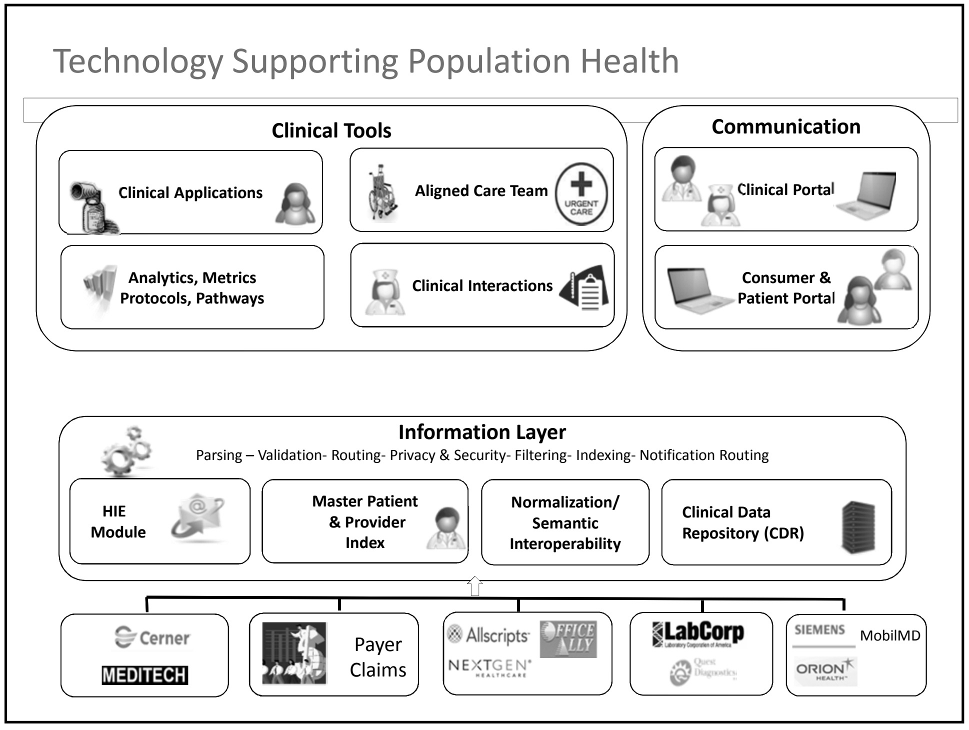
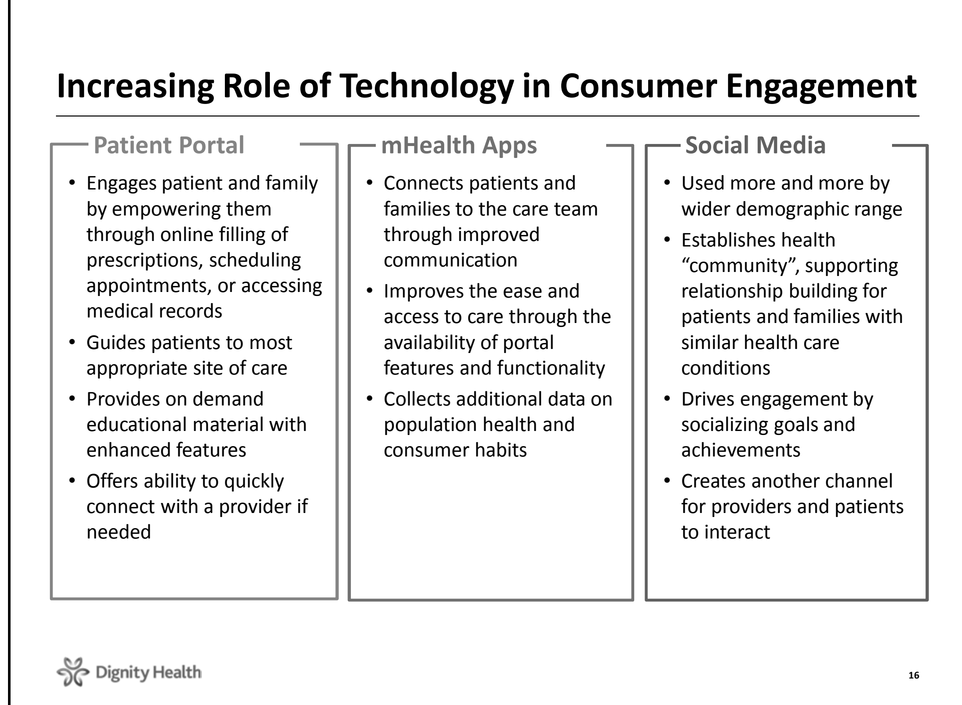

Technology Supporting Population Health
Clinical Tools
Clinical Applications
Aligned Care Team
URGENT CARE
Analytics, Metrics
Protocols, Pathways
Clinical Interactions
Communication
Clinical Portal
Consumer &
Patient Portal
Information Layer
Parsing – Validation- Routing- Privacy & Security- Filtering- Indexing- Notification Routing
HIE
Module
Master Patient
& Provider
Index
Normalization/
Semantic
Interoperability
Clinical Data
Repository (CDR)
Cerner
MEDITECH
Payer
Claims
Allscripts
OFFICE ALLY
NEXTGEN HEALTHCARE
LabCorp
Quest Diagnostics
SIEMENS
MobilMD
ORION HEALTH


Increasing Role of Technology in Consumer Engagement
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
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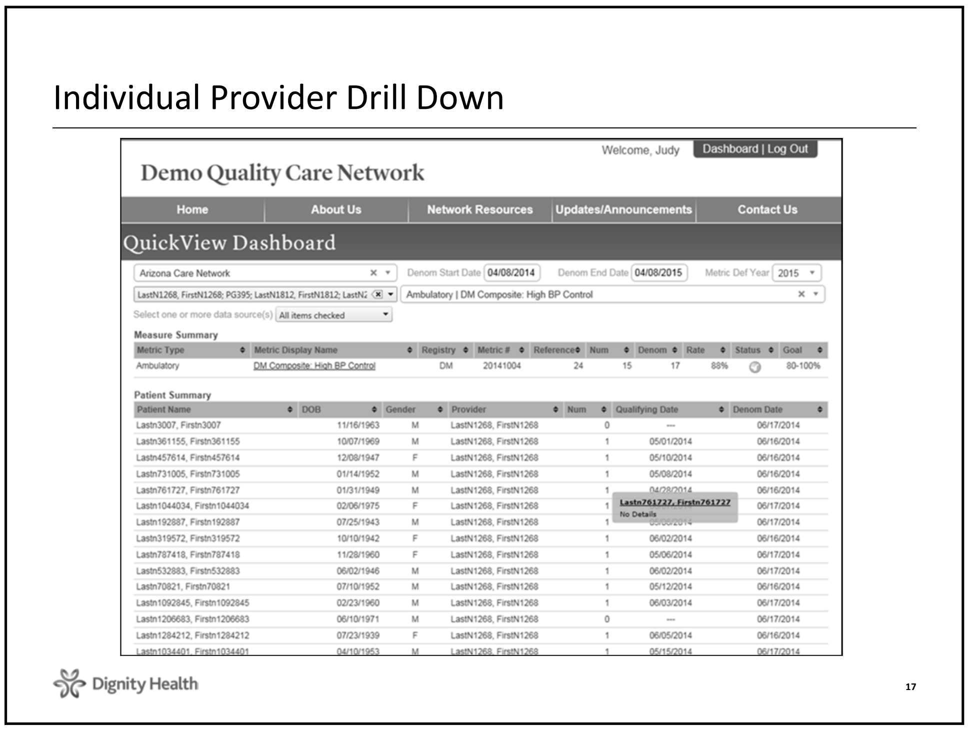
Individual Provider Drill Down
Welcome, Judy
Dashboard | Log Out
Demo Quality Care Network
Home
About Us
Network Resources
Updates/Announcements
Contact Us
QuickView Dashboard
Arizona Care Network
Denom Start Date 04/08/2014
Denom End Date 04/08/2015
Metric Def Year 2015
LastN1268, FirstN1268; PG395; LastN1812, FirstN1812; LastN
Ambulatory | DM Composite: High BP Control
Select one or more data source(s) All items checked
Measure Summary
Metric Type | Metric Display Name | Registry | Metric # | Reference | Num | Denom | Rate | Status | Goal
Ambulatory | DM Composite: High BP Control | DM | 20141004 | 24 | 15 | 17 | 88% | | 80-100%
Patient Summary
Patient Name | DOB | Gender | Provider | Num | Qualifying Date | Denom Date
Lastn3007, Firstn3007 | 11/16/1963 | M | LastN1268, FirstN1268 | 0 | --- | 06/17/2014
Lastn361155, Firstn361155 | 10/07/1969 | M | LastN1268, FirstN1268 | 1 | 05/01/2014 | 06/16/2014
Lastn457614, Firstn457614 | 12/08/1947 | F | LastN1268, FirstN1268 | 1 | 05/10/2014 | 06/16/2014
Lastn731005, Firstn731005 | 01/14/1952 | M | LastN1268, FirstN1268 | 1 | 05/08/2014 | 06/16/2014
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Dignity Health
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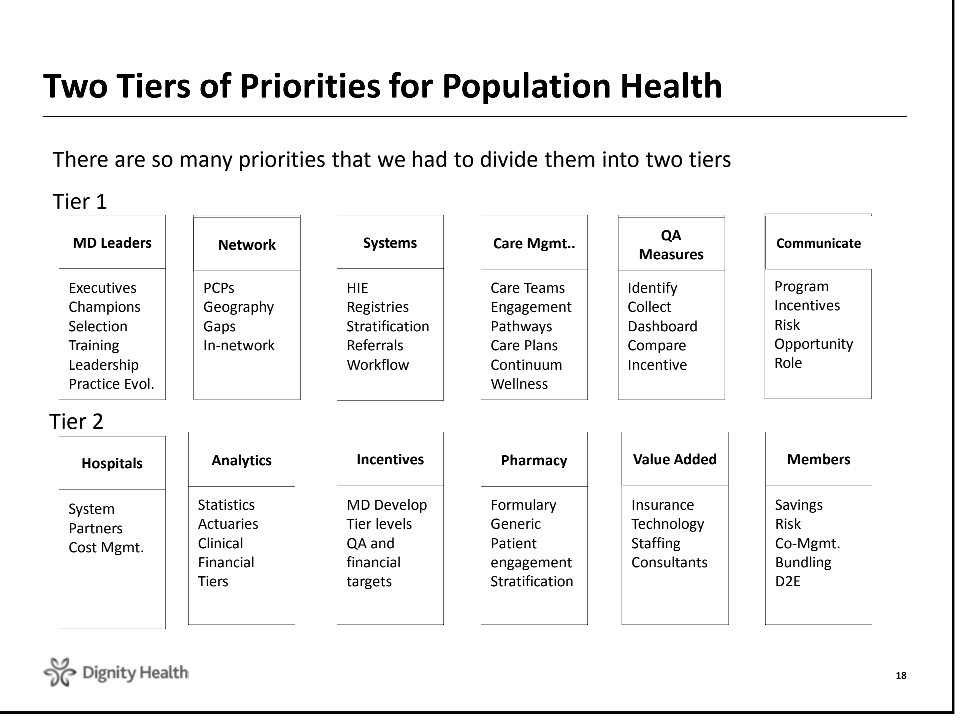
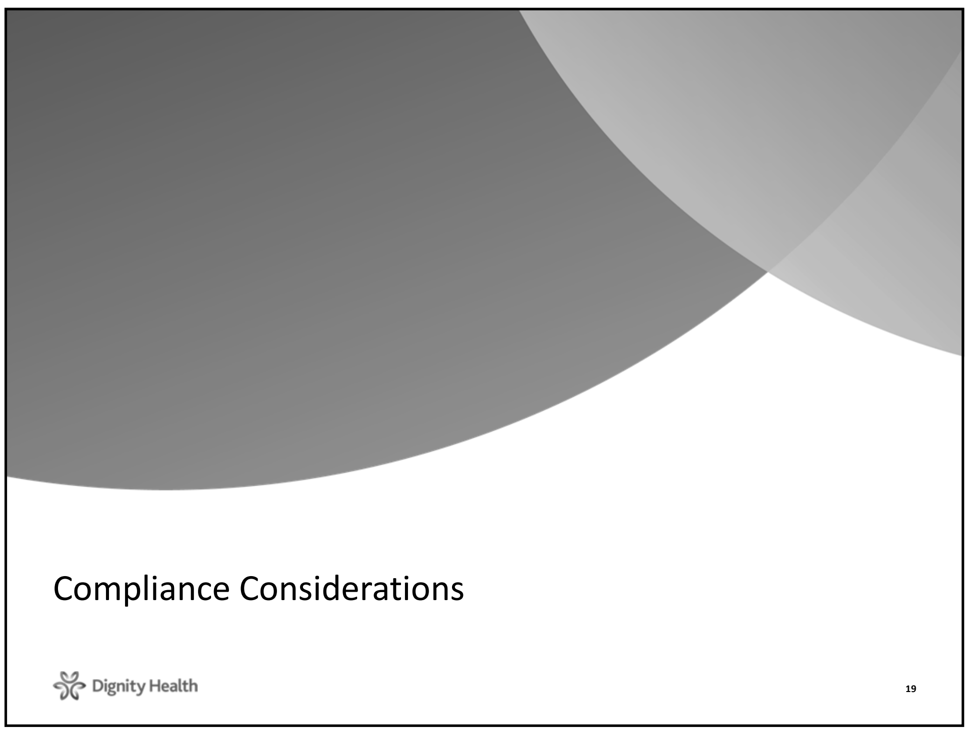

Two Tiers of Priorities for Population Health
There are so many priorities that we had to divide them into two tiers
Tier 1
MD Leaders
Executives
Champions
Selection
Training
Leadership
Practice Evol.
Network
PCPs
Geography
Gaps
In-network
Systems
HIE
Registries
Stratification
Referrals
Workflow
Care Mgmt..
Care Teams
Engagement
Pathways
Care Plans
Continuum
Wellness
QA Measures
Identify
Collect
Dashboard
Compare
Incentive
Communicate
Program
Incentives
Risk
Opportunity
Role
Tier 2
Hospitals
System
Partners
Cost Mgmt.
Analytics
Statistics
Actuaries
Clinical
Financial
Tiers
Incentives
MD Develop
Tier levels
QA and
financial
targets
Pharmacy
Formulary
Generic
Patient
engagement
Stratification
Value Added
Insurance
Technology
Staffing
Consultants
Members
Savings
Risk
Co-Mgmt.
Bundling
D2E
Dignity Health
18


Compliance Considerations
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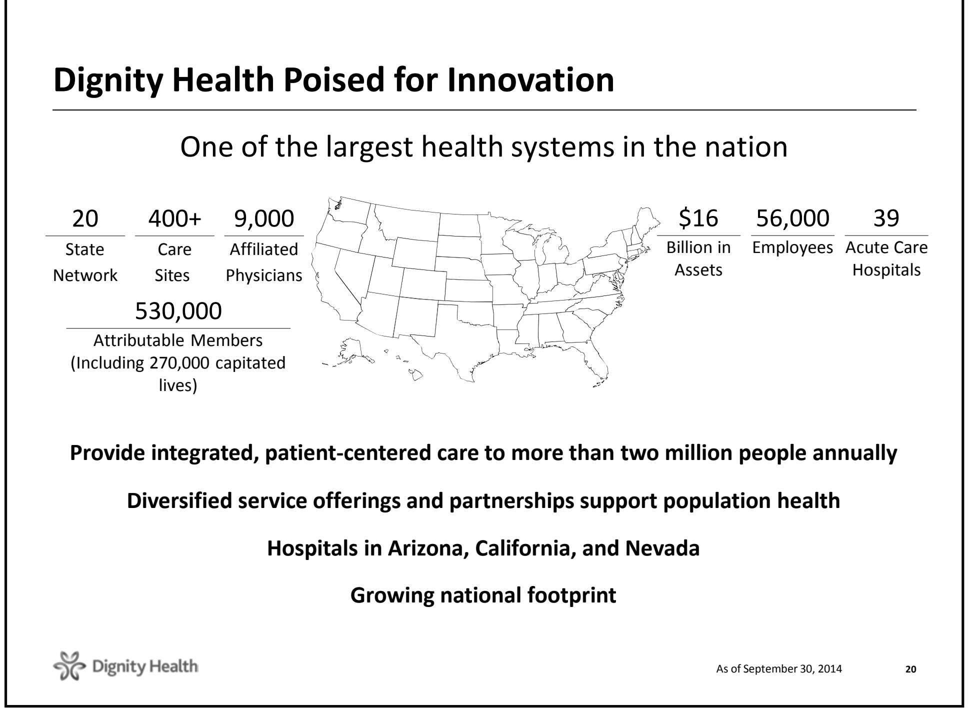
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Value to Physicians

- Leadership in Model structure of:
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  - Quality Improvement
  - Patient Satisfaction
  - Shared Savings
  - Access to resources, tools, technology

Value to Patients

- Better Health Outcomes
  - Value-Based Care
  - Patient Navigators
  - Care Coordination
  - Health Care Status

Value to Hospital

- Market Preferred Approach
  - Growth (market and mix)
  - Focus on Shared Goals with physicians
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  - Operational Efficiencies

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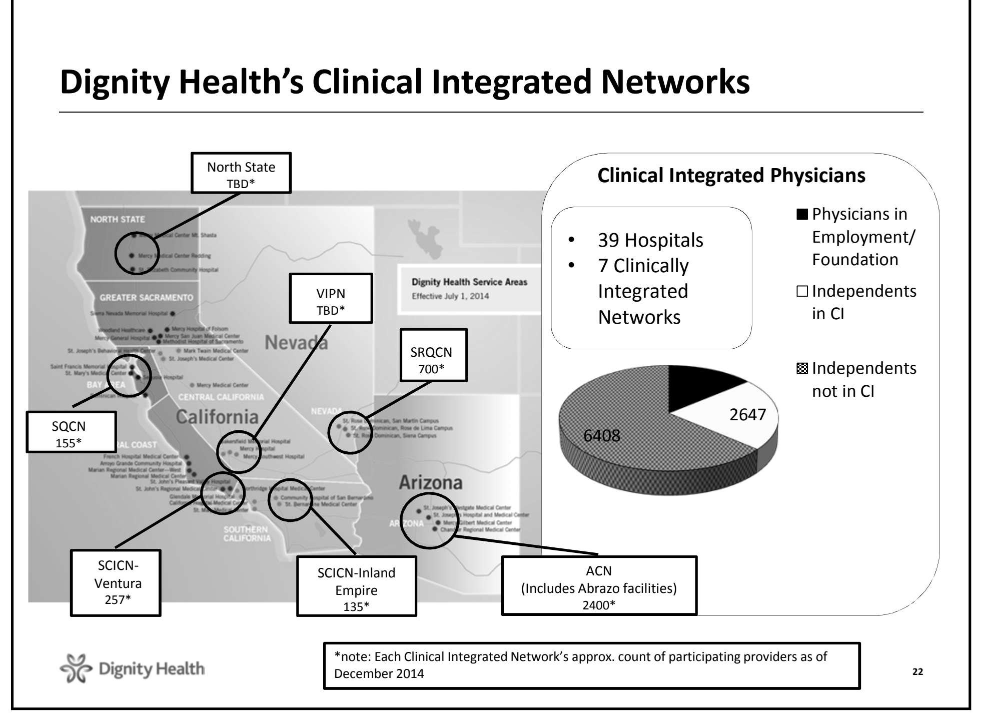
Dignity Health's Clinical Integrated Networks



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

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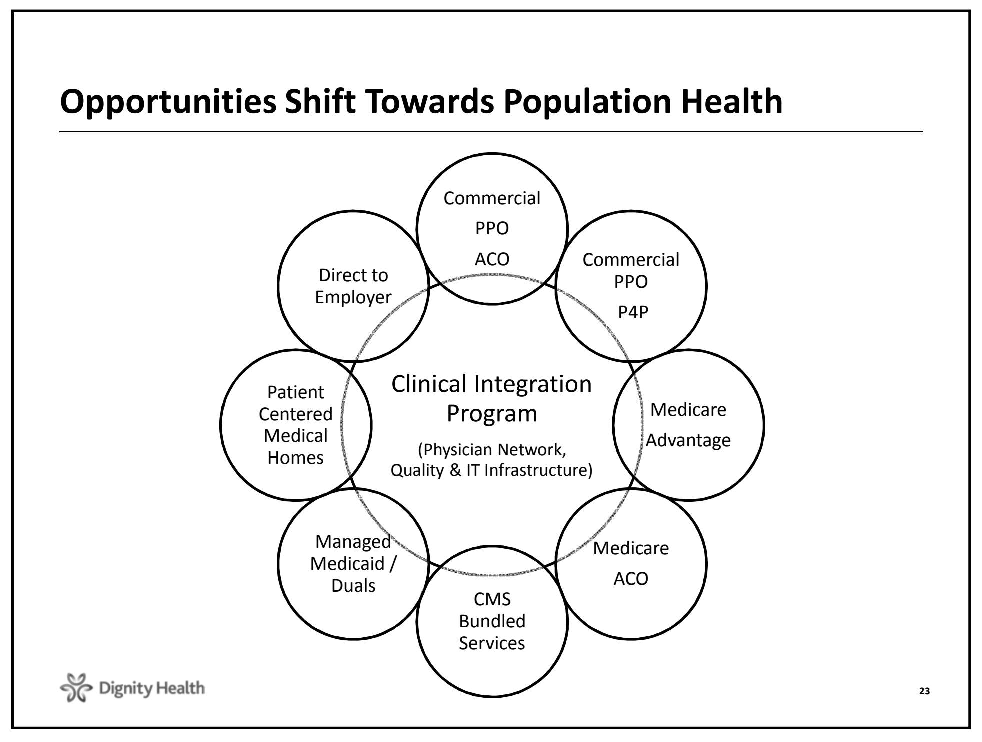
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PPO
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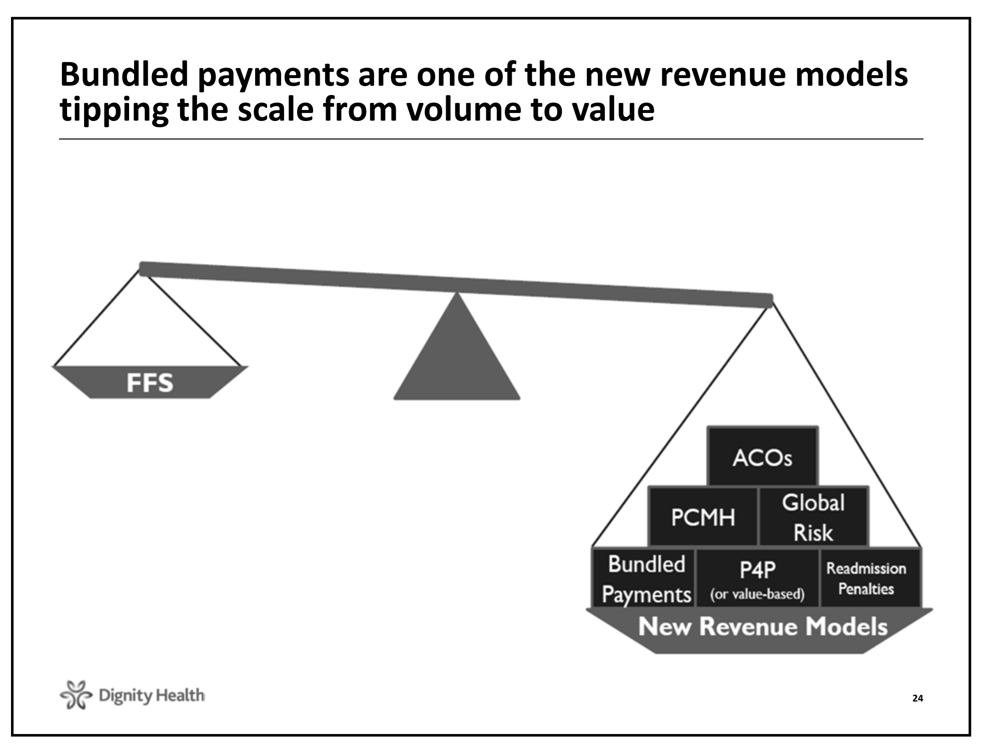
Bundled
Services
Dignity Health
23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ACOs
PCMH
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Risk
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Dignity Health
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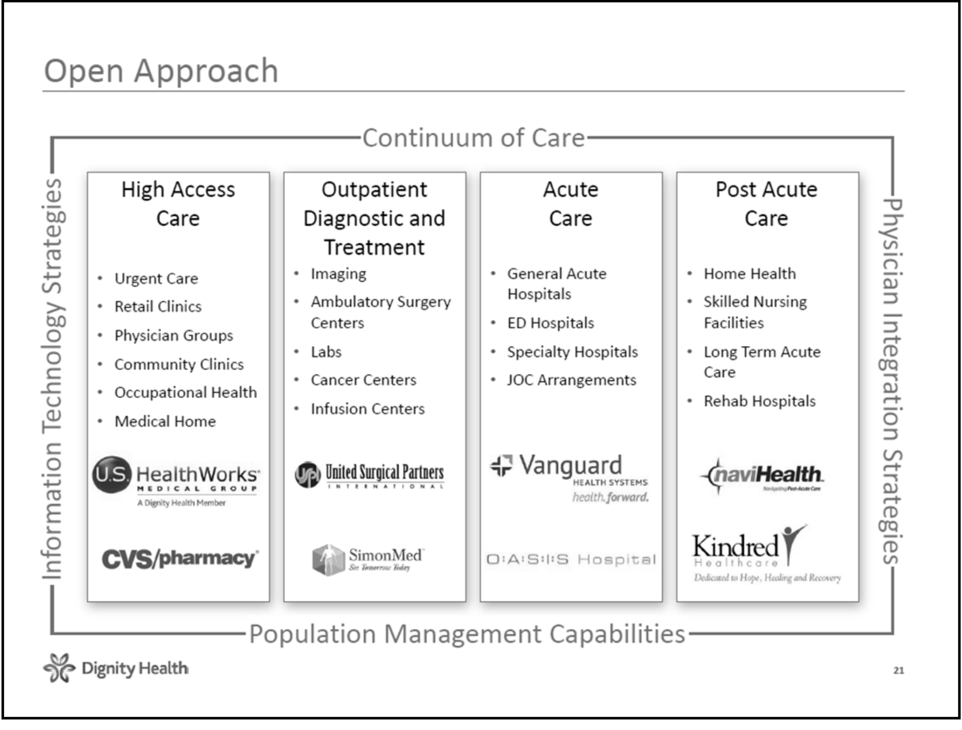
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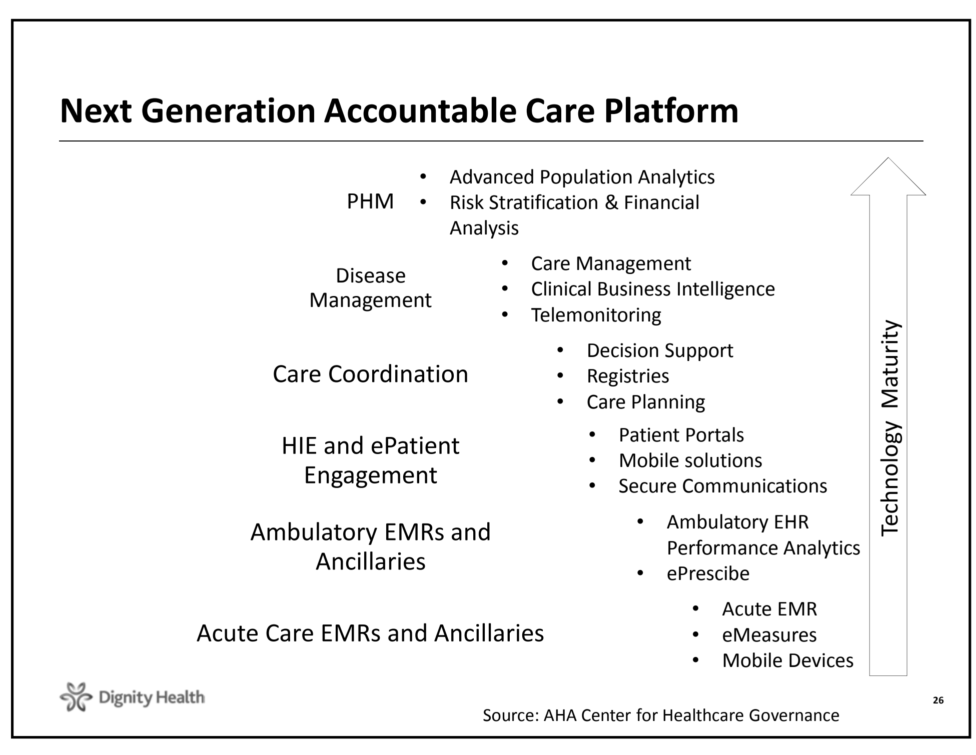
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Dignity Health
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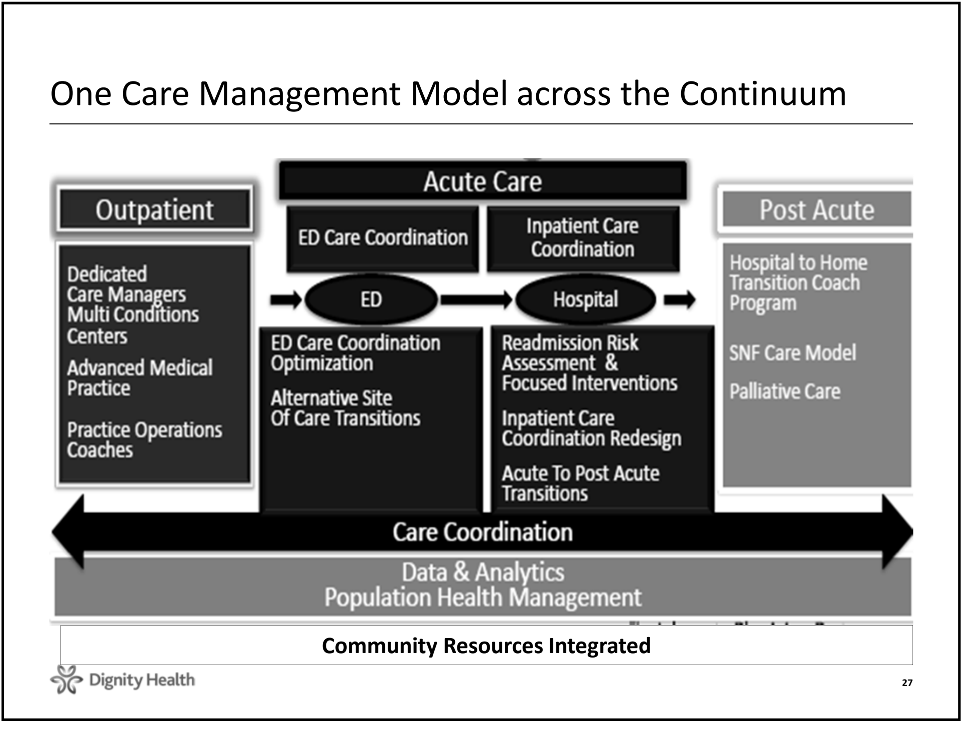
Source: AHA Center for Healthcare Governance

One Care Management Model across the Continuum



Community Resources Integrated

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Increasing Role of Technology in Consumer Engagement

Patient Portal

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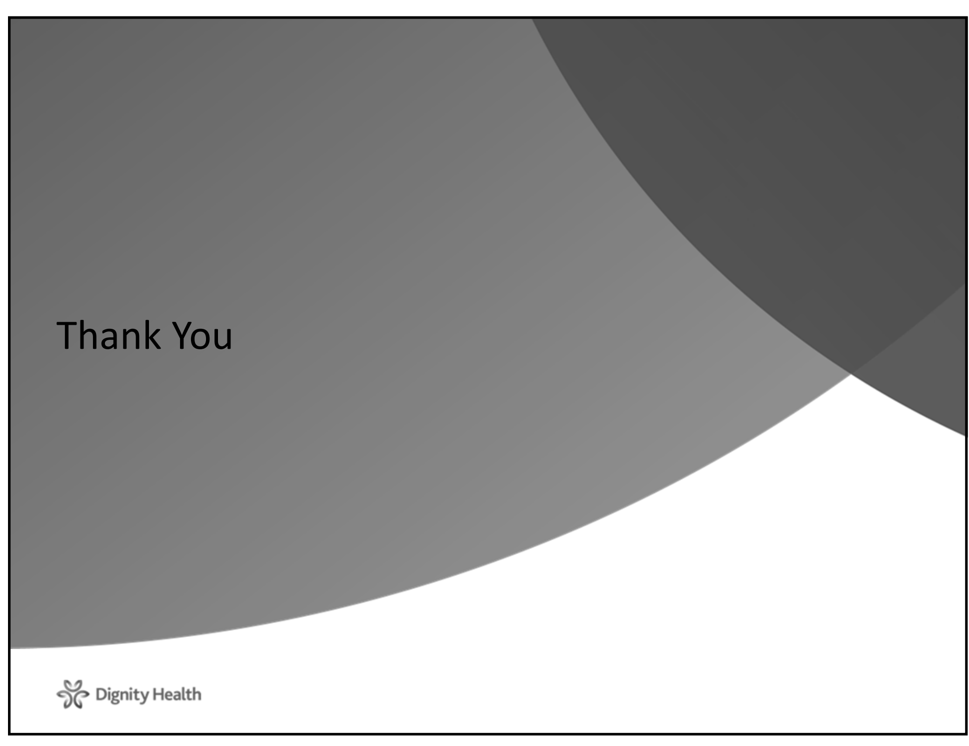
Thank You
Dignity Health