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

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
### 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 whenever 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 has been standing in our way?

**Common PHM Terms Application to our model**

<table>
<thead>
<tr>
<th>Term</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, reducing the need for expensive interventions. PHM focuses partly on high-risk patients who generate the majority of health care costs but 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 on what care and the key information needed to support preventative health management and how we are going to effectively deliver them.</td>
</tr>
<tr>
<td>Clinically Integrated Network</td>
<td>An organized team of practitioners that is wholly accountable for a patient's overall health care needs, including preventive and wellness, acute care and chronic care management. Includes physicians, hospitals, care managers, social workers, pharmacists and 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>Measure the key health care organizations and provide meaningful 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>Continuously learning population needs and matching the population based on geography, health status, resource utilization, demographics and patient willingness to actively engage in the management of their health.</td>
</tr>
</tbody>
</table>

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### What is the value proposition for stakeholders?

**Value to Physicians**
- Leadership in Model Structure
- Care Redesign/Efficiency
- Reduction of Waste
- Quality Improvement
- Patient Satisfaction
- 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
Dignity Health’s Clinical Integrated Networks

Opportunities Shift Towards Population Health

Bundled payments are one of the new revenue models tipping the scale from volume to value
Components of Clinical Integration

- Commitment to standardized care
- Selective membership criteria
- Care coordination infrastructure
- Performance management system
- Meaningful performance-based incentives
- Capability to jointly contract with commercial payers

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
  - Web, email, collaboration between member, care giver, and provider
  - Self-service access: clinical information, schedule appointments, targeted care advice and individualized plans based on health history

- **Integrate care and Care Management Through Physician Partnerships**
  - Physician care teams, involving chronic illness, acute care, and preventive care
  - Information sharing for care teams, patients, and providers
  - Information sharing for care teams, patients, and providers at all points
  - Access to health history driven by targeted care plans
  - Stratification of patient at first visit optimizes care coordination

- **Drive Positive Health Outcomes Based on Clinical Evidence**
  - Defined clinical pathways based on evidence, best practices, and research
  - Physician knowledge-sharing with best practices across system
  - Predictive analytics on high risk patients and recommended care
  - Standardized protocols for chronic improvement

- **Improve Margins by Driving Network Efficiency**
  - Predictive analytics for improved financial performance
  - Alerts on high cost patients and encounters
  - Provider profiling and performance
  - Cost and care patient hospital cost information sharing across operational algorithms

Open Approach
Next Generation Accountable Care Platform

- PHM
- Risk Stratification & Financial Analysis
- Clinical Business Intelligence
- Telemonitoring
- Decision Support
- Care Planning
- Patient Portals
- Mobile solutions
- Secure Communications
- Ambulatory EHR
- Performance Analytics
- ePrescribe
- Acute EMR
- eMeasures
- Mobile Devices
- Clinical Interactions
- Clinical Business Intelligence
- Clinical Tools
- Clinical Applications
- Aligned Care Tools
- Analytics, Metrics
- Protocols, Pathways
- Communication
- Clinical Interactions
- Clinical Portal
- Consumer & Patient Portal
- Technology Supporting Population Health
- Information Layer
- HIE Module
- Master Patient & Provider Index
- Normalization/Interoperability
- Clinical Data Repository (CDR)
- Technology Maturity
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

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

**Tier 1**
- MD Leaders
  - System Changes
  - Incentives
  - Practice Management
- Networks
  - Value Added
  - Financial
  - Analytics
  - Pharmacy
  - Engagement
- Care Management
  - Disease Management
  - Cost Management
  - Quality
  - Engagement
- QA
  - Measures
  - Feedback
  - Performance

**Tier 2**
- Hospitals
  - System Changes
  - Incentives
  - Practice Management
- Networks
  - Value Added
  - Financial
  - Analytics
  - Pharmacy
  - Engagement
- Care Management
  - Disease Management
  - Cost Management
  - Quality
  - Engagement
- QA
  - Measures
  - Feedback
  - Performance
Compliance Considerations

Dignity Health Poised for Innovation

One of the largest health systems in the nation

<p>| 20 | 480+ | 9,000 | $16B | 86,000 | 99 |</p>
<table>
<thead>
<tr>
<th>Network</th>
<th>Sites</th>
<th>Physicians</th>
<th>Assets</th>
<th>Employees</th>
<th>Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>(including 370,000 capitated lives)</td>
<td></td>
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Value to Hospital

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- Operational Efficiencies
Dignity Health’s Clinical Integrated Networks

- 39 Hospitals
- 7 Clinically Integrated Networks

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

• 22 Hospitals
• 25 Clinically Integrated Networks

North State TBD*
SQCN 155*
SCICN- Ventura 257*
VIPN TBD*
SRQCN 700*
ACN 2400*
SCICN-Inland Empire 135*

*note: Each Clinical Integrated Network’s approximate count of participating providers as of December 2014

Opportunities Shift Towards Population Health

- Commercial PPO
- ACO
- Medicare Advantage
- Bundled Services
- Patient Centered Medical Homes
- Direct to Employer
- Managed Medical Dental
- Clinical Integration Program
- (Physician Network, Quality & IT Infrastructure)

CMS Bundled Services

Bundled payments are one of the new revenue models tipping the scale from volume to value

- FFS
- ACOs
- P4P
- Global Risk
- Bundled Payments
- New Revenue Models
Increasing Role of Technology in Consumer Engagement

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Thank You