Embarking on the Journey from Volume to Value: Four Questions To Ask

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VP, Integrated Health Networks, CHI

Megan North
President, Value-Based Care, Conifer Health Solutions

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American Hospital Association Leadership Summit
Agenda

• About Jim Slaggert and Megan North

• About Catholic Health Initiatives

• About Conifer Health Solutions

• Creating Risk-Sharing Models: Four Common Questions

• Lessons Learned

Please note that the views expressed by the conference speakers do not necessarily reflect the views of Health Forum and the American Hospital Association.
James Slaggert
Vice President, Integrated Health Networks

- James Slaggert, a seasoned executive with more than 20 years of healthcare management experience, is vice president of integrated health networks at Catholic Health Initiatives.

- Provides leadership to the executive management of CHI’s clinically integrated networks across all market-based organizations.

- Establishing operational standards and assuring compliance at the market level.

- Development, operations and integration of all national shared services that will be provided to market-based clinically integrated networks.

- Includes network development, care management, data warehouse solutions capability, managed care contracting/product development and employee health management.

- 15 years of multi specialty physician group CEO experience.
- B.S. degree from Rochester Institute of Technology, Rochester NY
- M.B.A. degree from the University of Cincinnati.
Ms. North leads a nationwide team of healthcare transformation experts who provide Clinical Integration, Population Health Management and Financial Risk Management for more than 300 Conifer Health clients in 20 states. She brings more than 20 years of experience to her role and has earned a reputation for creating risk-based care delivery models that successfully align hospitals and physicians. These models, originally developed for the state of California, are now adopted as nationwide best practice for providers ranging from large health systems to Independent Physician Associations.

- Led several key initiatives around health care reform and the formation of clinically integrated organizations throughout the country for Tenet Healthcare
- 20 years of risk-based hospital and physician practice operational expertise
- Created a highly successful model for physician and hospital alignment in California, including services and technology infrastructure

- Bachelor of Arts, Boston University
- M.B.A., Pepperdine University Graduate School of Management
About Catholic Health Initiatives

- Catholic Health Initiatives (CHI) is a national, faith based nonprofit health system with headquarters in Englewood, Colorado
- CHI operates in 18 states and includes 93 hospitals; 40 long-term care, assisted- and residential-living facilities; three academic medical centers; two community health-services organizations; two accredited nursing colleges; and home health agencies
- Currently ranks as the nation’s third-largest faith-based health system
- Annual operating revenues of more than $12 billion and approximately 90,500 employees
- In fiscal year 2013, CHI provided more than $762 million in charity care and community benefit, including services for the poor, free clinics, education and research
About Catholic Health Initiatives

Strong Nationwide Presence

Pacific Northwest
Franciscan Health System
Multi-state system serving OR & WA
• 8 Hospitals
• 596 Employed MDs
• $2.1B Revenues

KentuckyOne Health
Statewide system, includes University of Louisville Medical Center
• 20 Hospitals
• 333 Employed MDs
• $2.5B Revenues

Market-Based Organization
Total Operating Revenue
- Less than $40 million
- $40 to $100 million
- $100 to $350 million
- $350 million to $1 billion
- Greater than $1 billion
About Conifer Health Solutions
To Provide the Foundation for Better Health

Facts

• Service clients in more than 40 states
• 20 Service Centers
• 700+ clients
• 11,000+ employees
• $25+ billion net revenue processed annually
• 19+ million patient touch-points annually
• 4+ million managed lives
• $17+ billion medically managed spend
• 1+ million 1st-level clinical admission reviews
• 60,000 patient satisfaction surveys annually

Key
- Conifer Health – Service Centers
- Revenue Cycle Management Client Locations
- Patient Communications Client Locations
- Value-Based Care Client Locations
About Conifer Health Solutions

We understand that all of these challenges make the journey to accountable care even more daunting.

Enhance the patient experience and support consumer health & wellness

Manage the reduction in reimbursements, increase yield and improve the bottom line.
Beginning The Journey from Volume To Value

Four Common Questions From Providers

1. Where should we start?
2. What data should we gather and from what source(s)?
3. How do we chose what to measure?
4. What next steps should we plan to take?
Q1: Where CHI Started

The New Normal: Navigating to Future Models of Care

Maximize Clinical Operations
“Highly effective delivery systems”
(2010-2013)

- Maximize performance to manage to Medicare rates
- Capitalize on payment incentives
- Relentless pursuit of value
  - Clinical excellence
  - Cost of care
  - Eliminate “waste”
  - Safety
- Reduce variation in performance across CHI
- Balance the portfolio through selective MBO and system growth

Assume Performance Risk
“Integrated health care delivery systems”
(2012-2015)

- Develop interim levels of risk assumption for defined payers, complex procedures, and disease states
- Manage episodes and systems of care across defined settings
- Translate current financial models to greater risk assumption capability
- Build physician alignment models to support integrated care delivery
- Data and analytics to ensure an understanding of how we practice today and how it must change—Clinical Data Warehouse

Manage Population Health
“Clinical and financial risk”
(2014 +)

- Move to integrated care capability and capitated models
- Establish insurance risk capability
- Manage and measure population health
Q1: Considerations
A Strategic Partnership

CIN formation & provider recruitment

<table>
<thead>
<tr>
<th>CHI leads</th>
<th>Conifer leads</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data acquisition and aggregation</strong></td>
<td><strong>Data standardization</strong></td>
</tr>
<tr>
<td><strong>Operational improvements</strong></td>
<td><strong>Population health analytics</strong></td>
</tr>
<tr>
<td><strong>Contract negotiations</strong></td>
<td></td>
</tr>
</tbody>
</table>
Q1: Considerations
Governance

Nebraska CIN Governing Body
Physician Chair, Majority Physicians, Statewide representation (12 max)
Fiduciary Duties to Network as whole
Major Decisions: Policy, Contracting and Infrastructure Decisions

Nebraska CIN Committee Layer
- Clinical Committee
- Finance Committee
- Other Committees
Duties: Statewide Coordination, Consistency

Omaha
- Clinical Committee
- Medical Director (Chair)
- Quality
- Allocation/Finance
- Other
Duties: Local CIN
Chapter Committee

Lincoln
- Clinical Committee
- Medical Director (Chair)
- Quality
- Allocation/Finance
- Other
Duties: Local CIN
Chapter Committee

Grand Island
- Clinical Committee
- Medical Director (Chair)
- Quality
- Allocation/Finance
- Other
Duties: Local CIN
Chapter Committee

Kearney
- Clinical Committee
- Medical Director (Chair)
- Quality
- Allocation/Finance
- Other
Duties: Local CIN
Chapter Committee

MSO Services/ Administration
- Admin from UniNet
- Council for medical directors
Q1: Considerations
ACO Structure - Employer

- Organized as separate legal entities
- Each with own governance
- Composed of contracted MDs
- Legal structures may vary – Equity
- Local control by MDs – Allows for market specific strategy and focus
- Separation of risk and isolation of performance

Mutual Benefit
Not-for-profit

- Organization membership (as opposed to equity)
- Equal physician/hospital representation – CAP CEO Tie breaker
- Seats may increase based on new players
- All revenue and expenses distributed to members based on actual experience
Q1: Considerations
ACO Structure - Commercial

- Formed as a **contractual arrangement**, not a separate business entity

- Physician organization already had infrastructure to manage risk-based payments, including care management and network

- Paneled patient population

- Services that are hospital’s financial responsibility charged to institutional services pool, health plan retained financial responsibility for non-hospital services (e.g. Transplants)
Q2: Data Collection
Multiple systems; integrated to support many uses

<table>
<thead>
<tr>
<th>Data Sources</th>
<th>Data Processing and Analytics</th>
<th>Different Views/Interfaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMRs</td>
<td>Conifer Health Global Healthcare Data Center and Reporting</td>
<td></td>
</tr>
<tr>
<td>HRAs</td>
<td></td>
<td>PHNs</td>
</tr>
<tr>
<td>Medical Claims</td>
<td></td>
<td>Administrators/Managers</td>
</tr>
<tr>
<td>Rx Claims</td>
<td></td>
<td>Physician Offices</td>
</tr>
<tr>
<td>Lab Results</td>
<td></td>
<td>Individual Patients</td>
</tr>
<tr>
<td>Health Histories</td>
<td></td>
<td>Others</td>
</tr>
<tr>
<td>PHNs</td>
<td></td>
<td>Includes users at self-insured employers, providers, care managers, health plans</td>
</tr>
<tr>
<td>Eligibility</td>
<td></td>
<td></td>
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<tr>
<td>Physician Offices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imaging Links</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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</tbody>
</table>

Includes users at self-insured employers, providers, care managers, health plans.
Q3: Data Analysis
Risk stratification to understand the population’s needs

Participant stratification levels
Percent of population

Benchmark

Client population

Triggers high present in population
Percent of high-risk participants

- Poor or ineffective utilization patterns: 89.20%
- Condition related to instability: 78.30%
- High Predicted cost: 76.40%
- Lab results out of range: 24.20%
- High retrospective costs: 23.10%
- Non-compliance with EBM guidelines: 12.30%
- Total unique: 100%
## Q3: Measurement Results – Year-Over-Year (Tacoma)

<table>
<thead>
<tr>
<th>Measure_ID</th>
<th>Measure_Name</th>
<th>2012</th>
<th>2013</th>
<th>Change (Green=improve)</th>
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<tbody>
<tr>
<td>31</td>
<td>HF: Beta-Blocker Therapy for LVSD</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>10</td>
<td>Heart Failure Admission per 1,000 members***</td>
<td>79.9</td>
<td>64.3</td>
<td>15.6</td>
</tr>
<tr>
<td>9</td>
<td>COPD or Asthma Admission per 1,000 members***</td>
<td>24.7</td>
<td>12.5</td>
<td>12.2</td>
</tr>
<tr>
<td>14</td>
<td>Influenza Immunization</td>
<td>8.1%</td>
<td>53.2%</td>
<td>45.1%</td>
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<tr>
<td>20</td>
<td>Breast cancer screening</td>
<td>51.4%</td>
<td>62.9%</td>
<td>11.5%</td>
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<tr>
<td>19</td>
<td>Colorectal cancer screening</td>
<td>19.3%</td>
<td>28.2%</td>
<td>8.9%</td>
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<tr>
<td>12</td>
<td>Medication Reconciliation</td>
<td>0.0%</td>
<td>8.3%</td>
<td>8.3%</td>
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<tr>
<td>15</td>
<td>Pneumococcal Vaccination</td>
<td>9.8%</td>
<td>14.3%</td>
<td>4.5%</td>
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<tr>
<td>17</td>
<td>Tobacco Use Screening and Cessation Intervention</td>
<td>5.3%</td>
<td>9.5%</td>
<td>4.2%</td>
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<tr>
<td>25</td>
<td>Diabetes Composite (All or Nothing Scoring): Tobacco Non-use</td>
<td>4.8%</td>
<td>7.0%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>
Q3: Measurement
Results – Influenza Screening
Q3: Measurement Results – Breast Cancer Screening

Patients List for '...
Report Period: 01/2013 - 10/2013
Measure: Breast cancer screening
Market: Tacoma ACO

# patients with mammogram in 24 months

Measure 23 Rate 88.5% Trend↑

26 # female patients, age 40-69

88.5 Rate 88.5%
22 Domain 22%

22 ACO 22%

<table>
<thead>
<tr>
<th>Seq #</th>
<th>Patient Name</th>
<th>Claim Number</th>
<th>Member ID</th>
<th>Date of Service</th>
<th>Physician</th>
<th>Measure Compliance</th>
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<td>2013-10-16</td>
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<td>2</td>
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<td>0035687266539</td>
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<td>2013-10-14</td>
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<td>3</td>
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<td>00356812940845</td>
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<td>2013-10-14</td>
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<td>0035687271318</td>
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<td>0035687270505</td>
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<td>2013-10-11</td>
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<td>0035687271049</td>
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<td>2013-10-09</td>
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<td>Y</td>
</tr>
</tbody>
</table>
Q3: Considerations
Plan an approach for success - Franciscan Health System

Influenza Immunization
- Educated clinicians and clinic staff on CDC recommendations & internal immunization policies
- Communicated focus on immunizations thru e-newsletters and other communications (clinicians, staff and patients)
- Created standing orders for influenza immunizations in CHI clinics (easier to vaccinate walk in patients)
- Distributed an updated pediatric dosing algorithm to primary care clinics
- Posted clinical reminder within EHR for influenza immunizations

Breast cancer screening
- Formed a multi-departmental Executive Committee which helped develop a Breast Center of Excellence and forge consensus recommendations for breast cancer screening
- Communicated consensus recommendations with clinicians through the e-updates and in person at regional clinician business meetings
Q4: Next Steps
*Build capabilities for each step of the journey to value*

- Clinical Integration
- Population Health Management
- Episodic & bundled payments
- Condition or population-focused ACO
- Financial Risk Management
- Global ACO/Full Capitation
- Fee-for-service
- P4P/incentives
Q4: Considerations

Multiple care management models

- **Degree of centralization**
  - Local
  - Centralized

- **Structure of specialization**
  - By Disease
  - By function
  - By population

- **Ownership**
  - Buy
  - Partner
  - Build
Q4: Considerations

Model examples

**PCMH program**
- Physician office based
- Care manager has patient panel
- Outreach for gaps in care, coordinate follow-up appointments, run care team patient-focus meetings
- Employed by physician group, all on single workflow tool

**Employee program 1**
- Local working from centralized location
- Focused on diabetes management
- Develop care plan, coach individual on care plan, track progress
- Employed by VBC to provide independent face

**Employee program 2**
- Some in physician offices and some centralized
- Specialized by function: centralized care managers focus on UM/CR, Local nurses focus on chronic care management
- Split between VBC and health system
CHI - Where We Are Now

• Clinically integrated networks are up and running in 11 CHI markets. We have engaged with both commercial and government payers in several value-based contract arrangements.

• More than 100,000 attributed lives in Medicare Shared Savings Program accountable care organizations across six markets;

• Commercial ACOs with payers in multiple markets; and Emerging direct-to-employer relationships and Medicaid capitation contracts.

• Managing our self-insured population of employees and dependents through our clinically integrated networks in three markets for 2014, with additional networks to participate in 2015.
Thank You
Digging Deeper

Defining Strategies
Inputs for Choosing a Care Model
Q1: Considerations

Define Core Strategies & Strategic Objectives

CHI’s four core strategies and twelve strategic objectives (2012-2016):
- better serve our communities with improved value
- better access and convenience
- greater focus on personal and community health.
There are several inputs into choosing the right care management model

What delivery model is in place in the market?

<table>
<thead>
<tr>
<th>Primary care medical home</th>
<th>ACO</th>
<th>Employed physicians</th>
<th>No structure</th>
</tr>
</thead>
</table>

What care management capabilities exists in the market?

<table>
<thead>
<tr>
<th>None</th>
<th>Transitions of care nurses</th>
<th>Full care management</th>
</tr>
</thead>
</table>

What population will the market be caring for? Does the population have specific characteristics?

<table>
<thead>
<tr>
<th>Population age</th>
<th>Chronic conditions</th>
<th>Behavior patterns</th>
</tr>
</thead>
</table>

What payment model will the population be covered under?

<table>
<thead>
<tr>
<th>P4P or penalties</th>
<th>Upside risk</th>
<th>Employee ACO</th>
<th>Upside/Downside</th>
<th>Full risk</th>
</tr>
</thead>
</table>

What are the operational strengths and weaknesses of the market?

<table>
<thead>
<tr>
<th>ED Through-put</th>
<th>Engaged physicians</th>
<th>Social services</th>
</tr>
</thead>
</table>