a community model case study

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agenda

- Background
- Structure
- Strategies and Initiatives
- Integrated Discharge Planning
- Questions

our brutal reality regarding affordability

- In the past decade, California HMO rates have increased on average 11% per year
- If we manage to reduce that trend to 8% in the next decade, prices will double by 2020. . .
- . . . and our Access +HMO family rate for CalPERS members will be nearly $39,000 per year
- We believe this will not happen: either the private sector will solve this issue or it will be solved for us

employers can hardly afford today's rates

It costs less to hire a software engineer in India than it does to pay for the health benefits of a software engineer in Silicon Valley

—Blue Shield Analysis (after conversation with Venture Capitalist)

"Wow, we're paying almost twice in health care costs as what we're making in earnings…"

—Steve Burd, CEO of Safeway, The New York Times, November 29, 2009

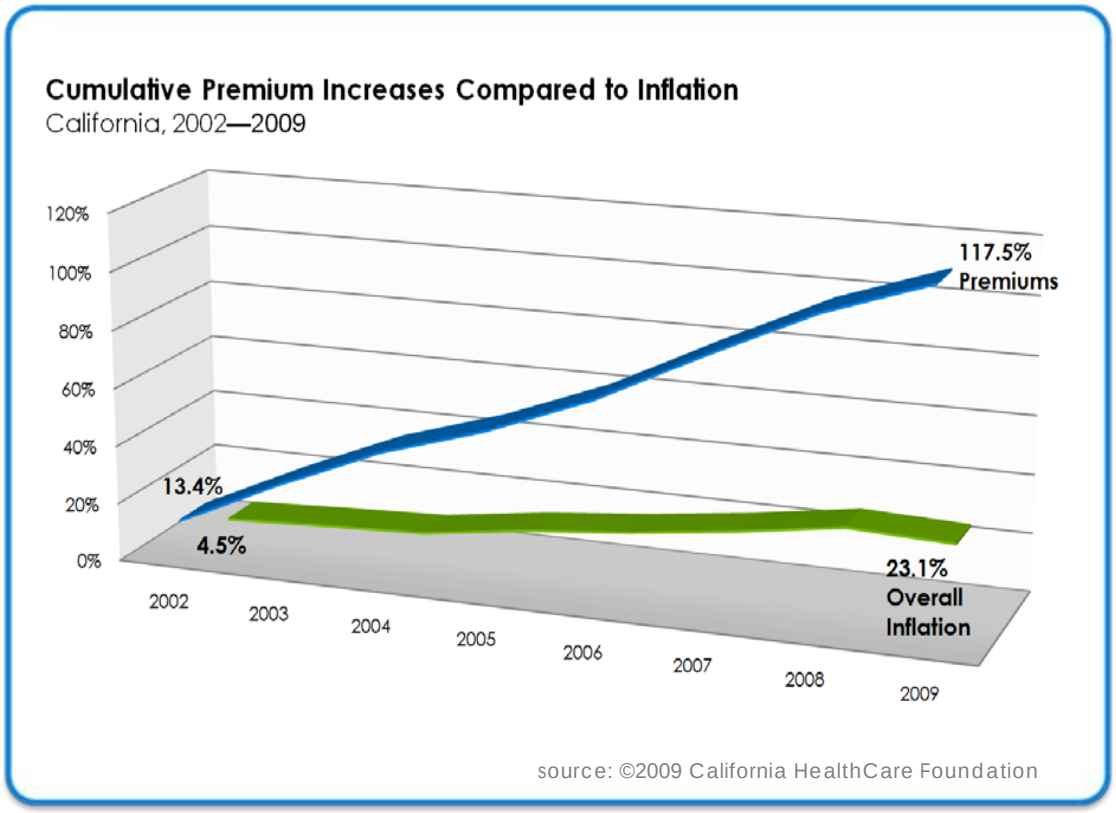
(The company now spends) "almost as much on health care for our partners as we do on the green coffee we buy."

—Howard Schultz, CEO of Starbucks Corp, Thomson Reuters, July 27, 2009

"G.M. has to address how a company that lost more than $20 billion last year can afford $5 billion a year in medical bills. G.M's future obligations for retiree health care are estimated at $47 billion, and by next year it is required by its contract to contribute more than $10 billion to the trust set up in 2007."

—The New York Times, February 17, 2009

and our trends threaten the long-term viability of private health insurance



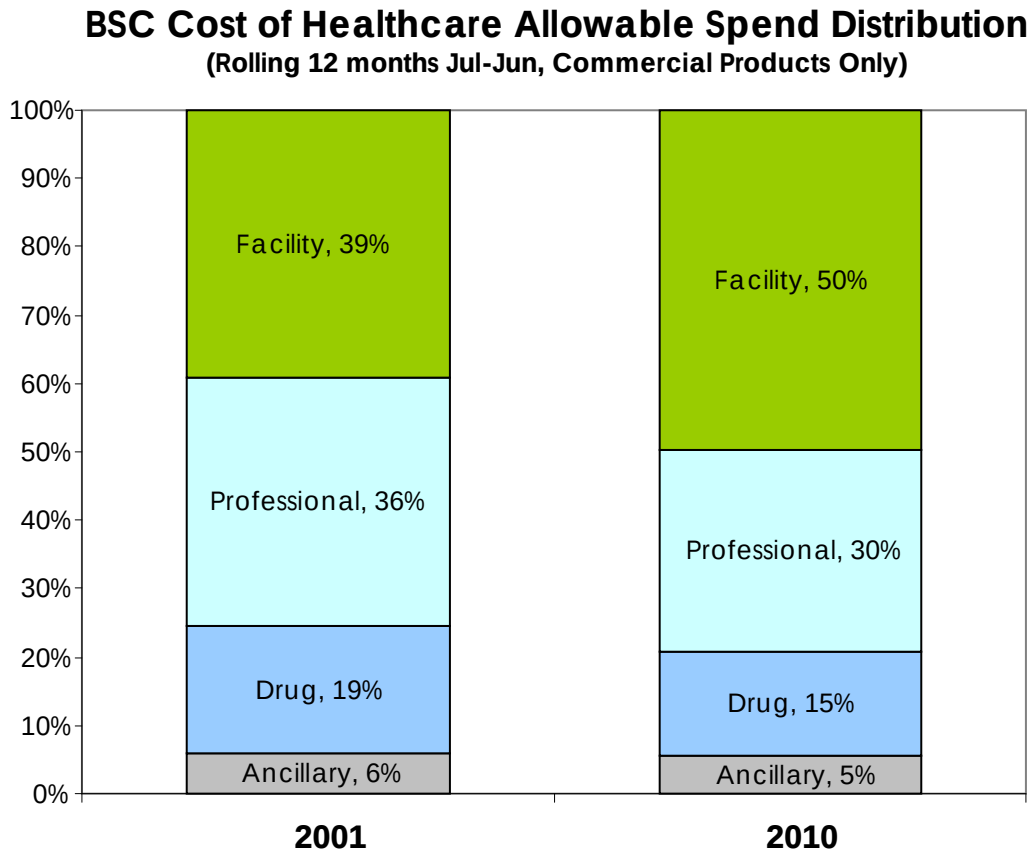
In 2020, $39,000 could …

- purchase a CalPERS, Access+ HMO family insurance policy from Blue Shield
- buy 6 years of a household's groceries
- be 1.6 times higher than the median income for BRIC counties
- buy the newest version of a Toyota Prius

Source: Premium forecasts based upon standard plan manual premium PPO annual increase of 10.3% from the Milliman Group Health Insurance Survey 2008 & Commonwealth Fund California premium data of $12,254 in 2008, "Paying the Price: How Health Insurance Premiums are Eating up Middle-Class Incomes" August 2009. 2020 forecasted median CA household income from IHS Global Insight, annual household food expenditures from the National statistical offices/OECD/Eurostat/Euromonitor International, BRIC & World annual gross income projections from Euromonitor International and from national statistics, Prius pricing from April 2010 Consumer reports ($26,750 with assumed 3% trend per year over 10 years)

hospital costs are rising faster than other areas

rapidly escalating hospital costs are one of the biggest reasons our member are seeing significant premium increases

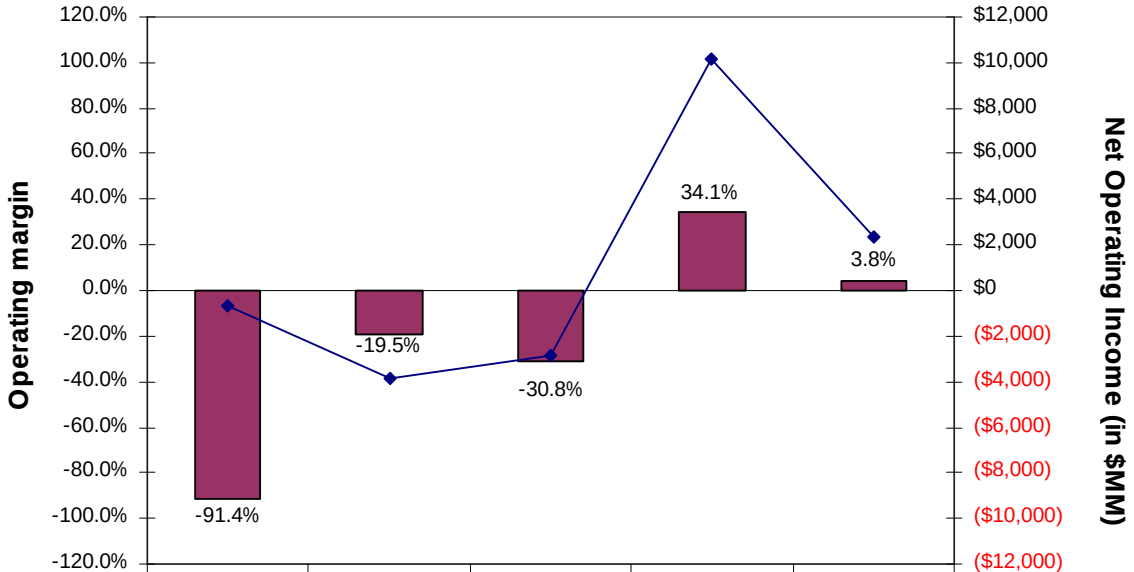


Source: Internal Blue Shield claims data

We know hospitals have their challenges

with the significant expansion of Medi-Cal resulting from federal health reform, it is vital that hospitals work to break even on government programs. on average, CA hospitals lose over **-20%** on public programs and earn a **34%** profit margin on their private health plan contracts in CA.

Operating Margin & Net Operating Income by Payers for CA hospitals

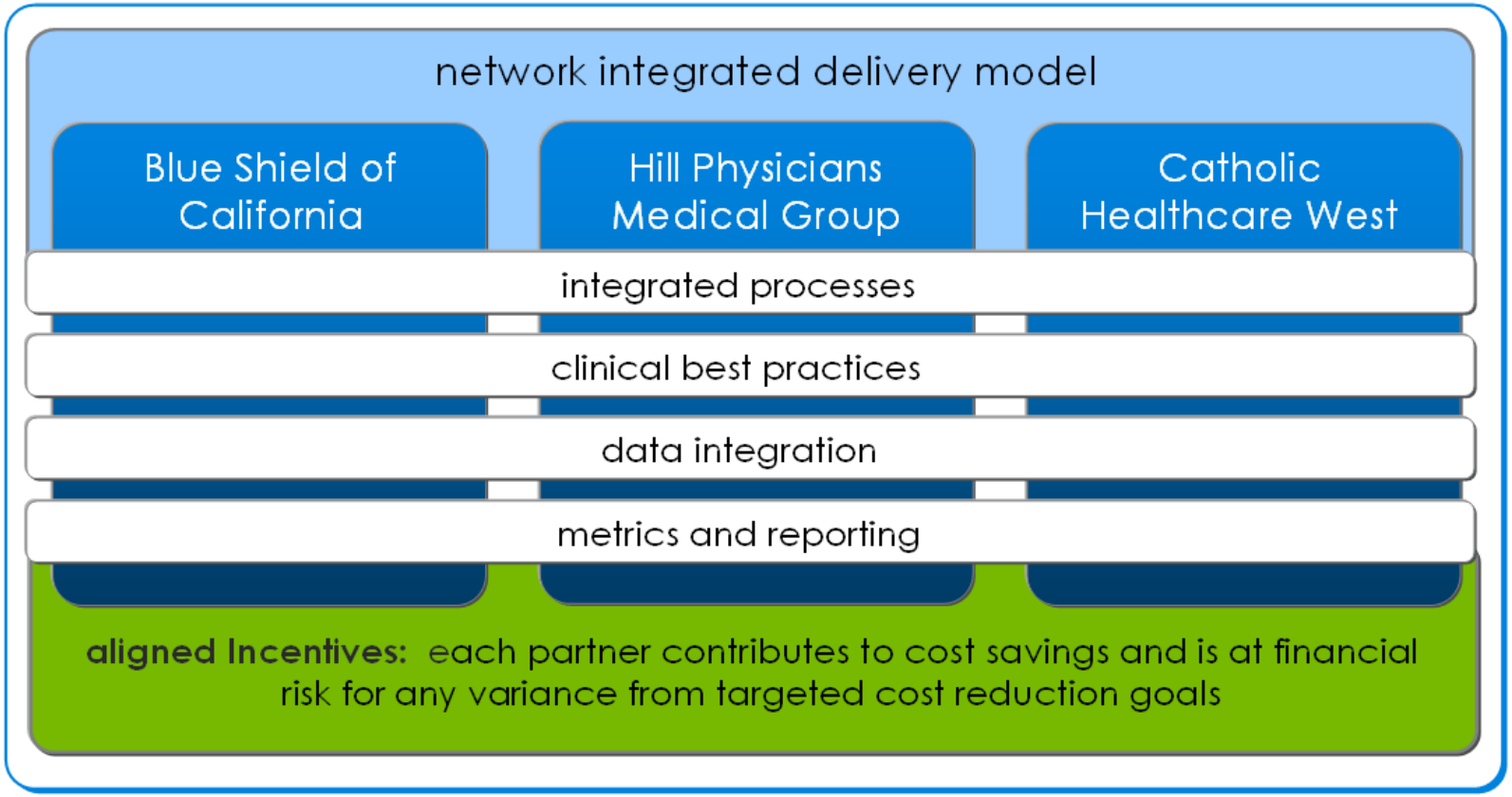


	Uninsured	Medicare	Medi-Cal	Third Party	All Payers
Operating Margin	-91.4%	-19.5%	-30.8%	34.1%	3.8%
Net Income (in millions)	($694)	($3,823)	($2,865)	$10,162	$2,317

source: BSC contracted facility population (using the OSHPD quarterly data for Q3 2009- Q2 2010)

collaboration is required to…

- Develop an integrated delivery model
- Provide coordinated care
- Improve quality outcomes
- Drive out cost

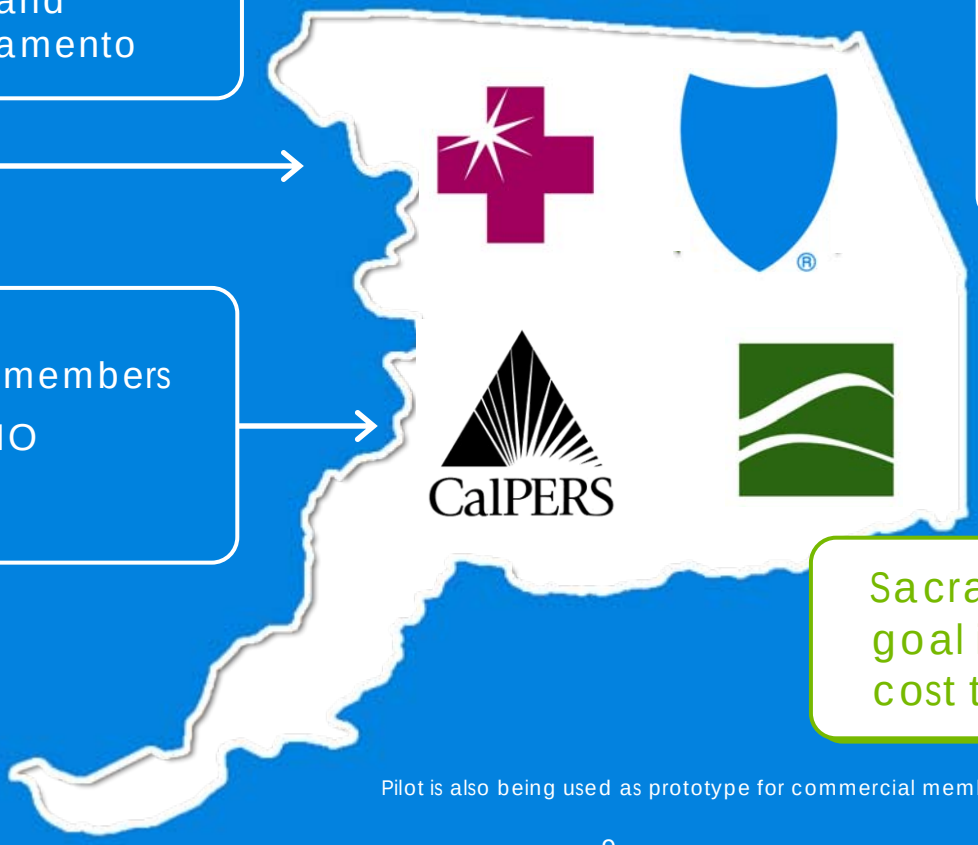


why Sacramento?

4 hospitals in Sacramento County including Mercy General, Mercy San Juan, Mercy Folsom, and Methodist Sacramento

- 207,000 total Sacramento members
- 90% in an HMO

Sacramento market



- ~ 520 MDs in Sacramento County
- ~ 40,000 CalPERS members
- ~1,500 member growth in 2010

Sacramento pilot goal is to reduce the cost trend ~10%

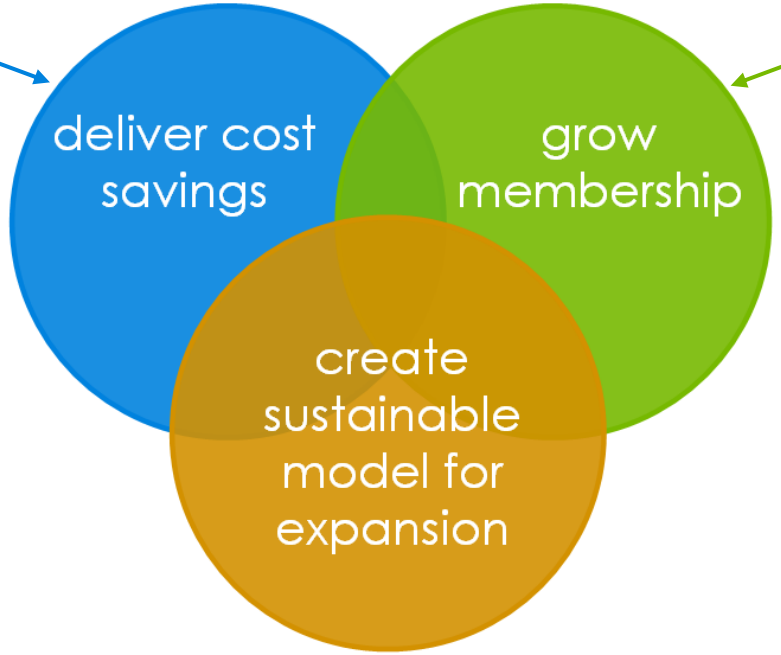
Pilot is also being used as prototype for commercial membership with intent to scale model to other segments.

our guiding principles

1. Reward the customer
2. Keep it simple
3. Be transparent
4. Focus on the target
5. **Be bold**

result-oriented goals

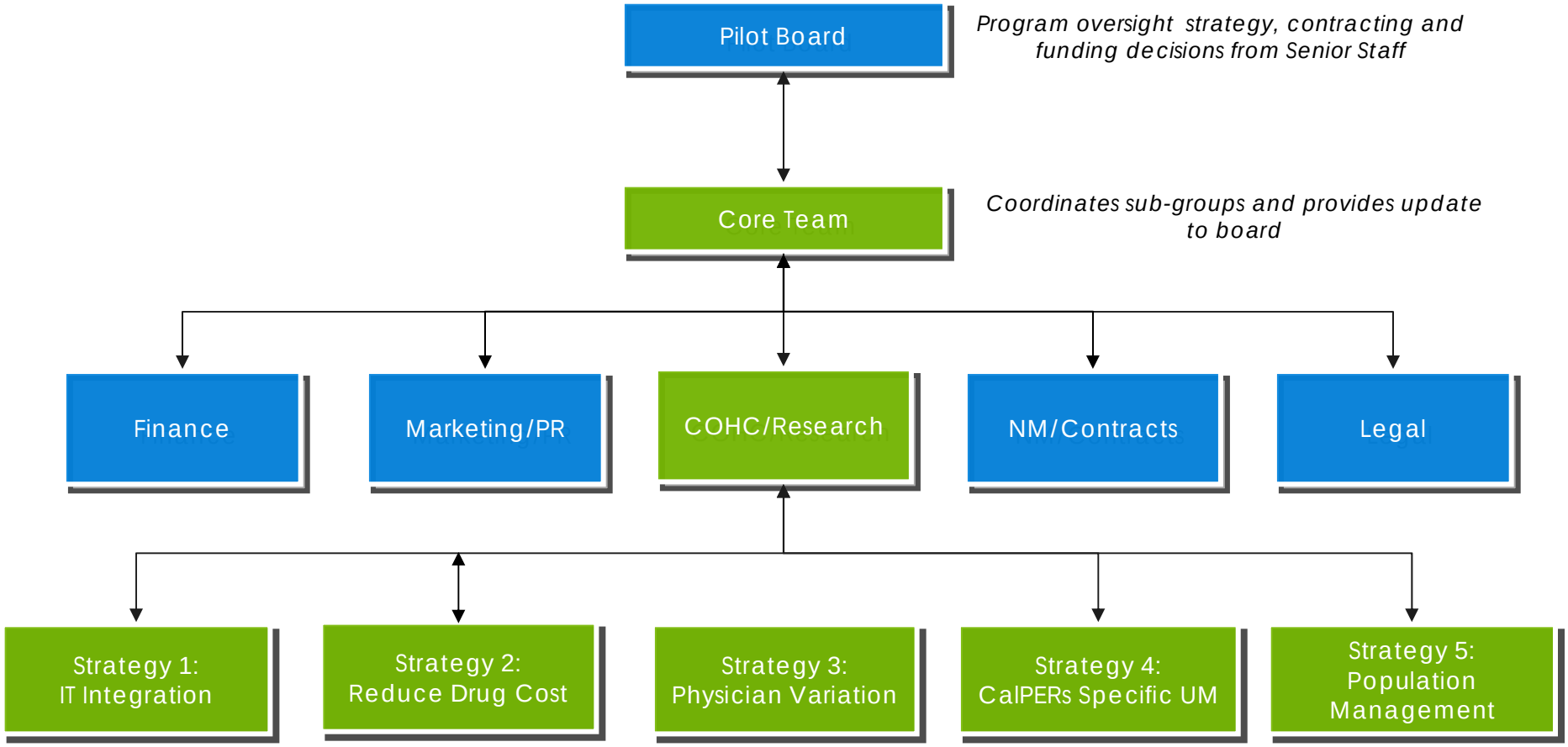
Reduce cost of healthcare trend to 0% in aggregate for members in the pilot



Increase enrollment in NetValue as a means to gain market share for partners

Develop way to work together that aligns parties to drive continuous improvement (cost, quality, service) and allows for expansion to other geographic areas

team approach



strategy development is all about data

Compiled datasets from disparate sources to determine a comprehensive look at the population

- What are the cost drivers?
- Who is driving the cost and for what?
- Spotlight on chronically ill members
  - Identified top 5K patients accounting for 75% of total pilot population spend
  - Identified opportunities to expand care program and develop additional programs

Identified utilization outliers at the MSDRG level/established benchmarks for improved care in key areas, e.g.:

- OB/GYN
- Knees and Hips
- Bariatric

strategies and initiatives

strategy one: IT integration

initiatives

Physician Technology Acceptance	• Increase the adoption and use of existing technologies (Relay Health, NextGen, Mobile MD, etc.) to facilitate the rapid and efficient communication of patient medical information to care providers • Interconnect cross-organization technologies to streamline processes and support consistent communication
CCD to Mobile MD	Allow selected physicians to 'push' the ambulatory continuity of care (CCD) from the Hill Electronic Health Record (EHR) to CHW hospitalists upon scheduling of patient admissions
Mercy Health Information Exchange (MHIE)	Build a tool on the Mobile MD platform for the sharing of clinical information such as the clinical summary, patient summary and lab/radiology results

expected outcomes and status

- Strong technological framework to automate processes

strategy two: reduce drug costs

initiatives

Oncology Co-Hort Case Rate	Provide support to physician offices for the implementation of processes/workflows that support oncology case rate methodologies to reduce injectable medication costs
Generic Drug Interventions	• Increase use of generic medications through evaluation of PCP and specialist prescribing patterns • Expanded BSC's Generic Smart program to drive generic utilization • Identify brand users and perform pharmacist member outreach to promote conversion to generic
Injectable Cost Management	Affiliate Hill with CHW's drug purchasing program to reduce costs of injectable drug costs

expected outcomes and status

- Reduce drug cost

strategy three: physician variation

initiatives

ER utilization strategy and management	Reduce ER costs and utilization by shifting non-emergent ER visits to an urgent care clinic (UCC) setting or the primary care provider (PCP) office for improved patient management
Outpatient surgery	Optimize outpatient surgery utilization and reimbursement to lower cost alternatives; shift ASC from non-CHW facilities to CHW facilities
Program development	Developed end to end programs to include preauthorization, clinical pathways, care planning and adherence; educate and monitor physicians on outlier behavior based on accepted protocols with possibility for provider stratification • Knee and hips • Bariatric • Ob/gyn

expected outcomes and status

- Narrow practice patterns
- Address inappropriate and over or under utilization of key services
- Reduce unnecessary LOS, admissions and readmissions

strategy four: CalPERS specific um

initiatives

Pre-surgical checklist	Developed pre-surgical checklists to use as part of patient calls performed for certain procedures including: knee/hip replacement, hysterectomy, and spinal surgery
Variant days	Built a process to identify, review and correct the root causes that lead to variant days (i.e., delay in service) to determine opportunities to modify the process or change behaviors for physicians, hospitals and/or support teams
Readmissions Review	Built a process to identify, review and correct the root causes for high-risk patients with 3+ readmissions
Discharge planning	Implemented coordinated pre- and post- discharge planning process to avoid discharge delays and readmissions
Enhance prior authorization	Defined and implemented enhanced evidence based guidelines for surgeries targeting high volume, high cost MSDRG's. Identify by procedure the use of ineffective and marginal procedures (e.g. Spinal Fusion, Carotid Endarterectomy) and proactively monitor for avoidance
Medical access planning	Ensure CalPERS patients receive medical treatment and CHW hospitals, when possible, through the process of pre-patriation and/or repatriation

expected outcomes and status

- Reduction in LOS, admissions, readmissions OON spend

strategy five: population management

initiatives

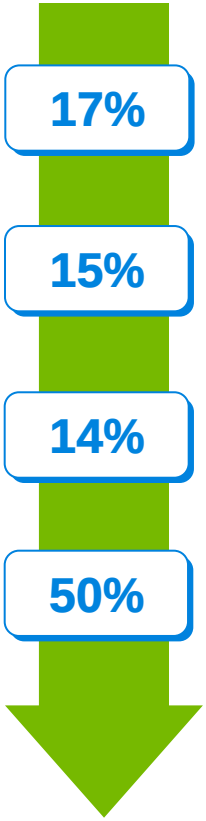
Chronic and Complex Care Mgmt	Actively manage high risk patients and high costs through synchronized stratification, innovation, outreach and coordinated processes
Palliative Care	Developing a comprehensive palliative care program across hospital, physicians and care managers to proactively engage members and their families in end of life decisions
Professional Home Visits	Implementing home based medical care to high risk home-bound commercial and frail elderly patients which will enhance quality of life for the patients
PT Centers of Excellence	Identify PT Centers of Excellence partners to provide services to chronic pain patients so that patients will learn new behaviors and explore their underlying issues related to pain
Patient Education	Created back pain management website to support case managers and providers as well as for use by self-referral among patients receiving outreach materials
Lose to Win	Pilot a 12 week 'Lose to Win' program geared towards helping participants lose weight and promoting a safe transition to a healthier lifestyle

expected outcomes and status

- More CalPERs members actively managed in a dm/cm program
- Better coordination and hand-off between programs
- Fewer members “falling through the cracks”

2010 results exceeded targets

Exceeded 2010 target of **$15.5M** healthcare cost savings for the 42,000 member pilot population



17% Reduction in inpatient readmissions

15% Reduction in average length of stay for inpatient admissions

14% Reduction in inpatient days per thousand

50% Reduction in inpatient stays per thousand of 20 or more days

integrated discharge planning

CHW/Hill physicians/CalPERS ACO pilot: sample of key 2010 accomplishments

Implemented industry best practice for:

- Discharge planning process including hospital teach back
- Follow-up visit within 7-10 days, including measure adherence
- Sharing of discharge plan with PCP and care managers within 24 hours

Expanded Health Information Exchange (HIE) including:

- Hospital discharge summary and patient discharge summary to IPA Electronic Medical Record (EMR) and/or physician portal
- IPA continuity of care (CCD message) data into the hospital EMR
- Re-admission discharge plan into hospital portal
- Automation of ER 'time of day' report to expedite member outreach following ER encounters

integrated discharge planning process

- A problem-oriented post-discharge needs assessment and summary of the key medical issues
- Analysis of the clinical course and major events of the hospitalization
- Integration of labs into confirming diagnoses
- Identification of principal and relevant secondary discharge clinical diagnoses
- Review of medication errors and interactions
- Safety and studies
- Ensuring follow-up appointments are scheduled within appropriate timelines
- Redesign of the patient education process to improve patient and family/caregiver understanding of discharge plan and self-care
- Provide patient a written discharge plan in lay terminology and forward to medical group

primary cross-organizational stakeholders needed for integrated discharge

Hospital

- Case manager communicates prospective discharge date and patient needs upon discharge
- Clinical nurse performs medication reconciliation and patient/caregiver education
- Discharge planner initiates discharge planning on day one or 48 hours after admission and coordinates services to meet patient needs upon discharge
- Concurrent care review nurse communicates discharge summary to PCP
- Director of case management educates case/clinical managers on new discharge planning tools/processes; educates physicians/ hospitalists on new discharge planning processes/UM best practices; establishes toolkit for patient education
- Analyst creates and run reports
- Project resource manages implementation plan based on defined scope/timeline; serves as point of contact to Blue Shield program managers to provide project updates/issue escalation

Medical Group

- Attending physicians discharge in a timely manner
- Staff schedule patient appointment with PCP
- Director of case management serves as project driver

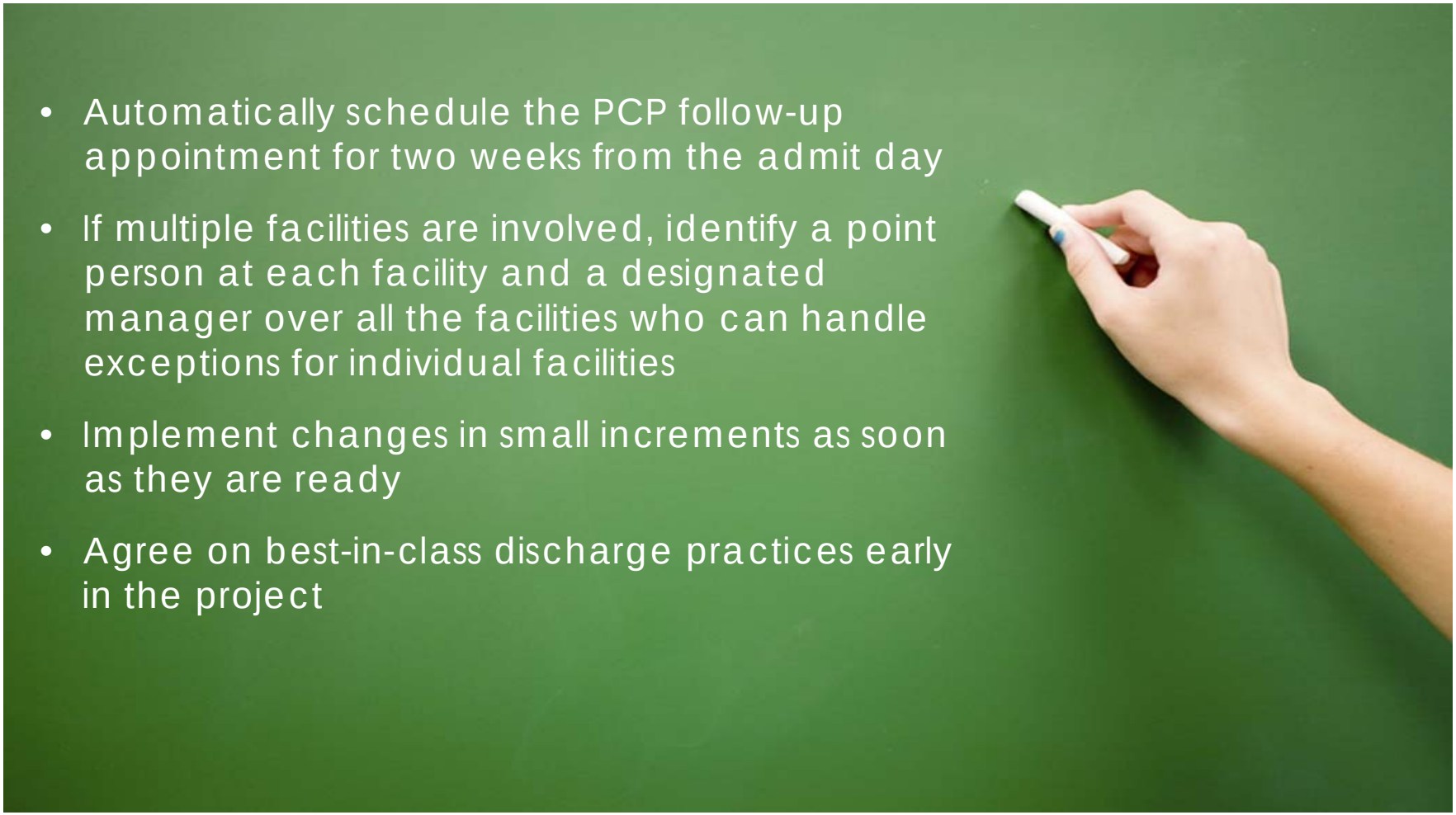
Blue Shield

- Program manager engages stakeholders to define scope and implementation plan; provides ongoing project monitoring

project risks and constraints

- Delays in access to admission data
- Changing the process for a subset of patients (i.e. only ACO patients) can be challenging for the facility
- Project team needs on-site access to the facility for as-is process mapping

lessons learned



- Automatically schedule the PCP follow-up appointment for two weeks from the admit day
- If multiple facilities are involved, identify a point person at each facility and a designated manager over all the facilities who can handle exceptions for individual facilities
- Implement changes in small increments as soon as they are ready
- Agree on best-in-class discharge practices early in the project

questions?