a community model case study

Kristen Miranda
Vice President
Network Management
Blue Shield of California

October 19, 2011

blue of california

challenges in delivery system

delivery system works in silos

- current delivery system creates health plan, hospital and medical group silos that do not work together to control cost and offer optimal patient care

provider reimbursement

- fee for service provider reimbursement rewards more utilization and provides limited or no recognition for quality or efficiency

sustainable approach for reducing costs & improving care

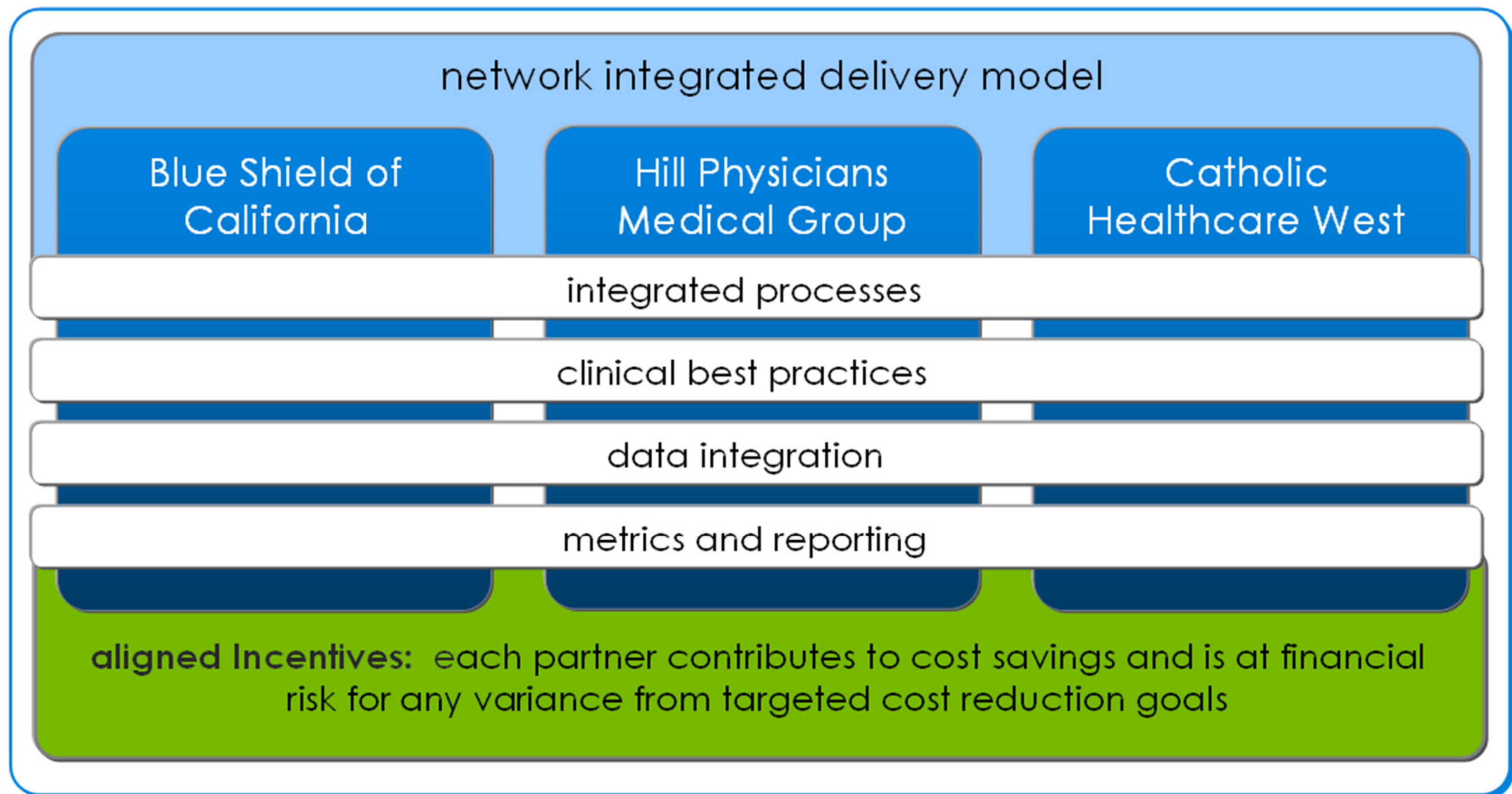
- provider costs are increasing and reducing the unit cost is not a long term sustainable approach for reducing costs and improving care

incentives do not promote long-term, system wide approach

- current health plan and employer incentives generally impact one component of healthcare delivery and do not reinforce a long-term, system wide approach
  - benefit changes impact member cost and behavior, but do not address the lack of efficiency between providers and the health plan
  - health plan incentives do not generally benefit hospitals for being more efficient
  - disease management and wellness programs are not well integrated into the delivery system

collaboration is required to…

- develop an integrated delivery model
- provide coordinated care
- improve quality outcomes
- drive out cost

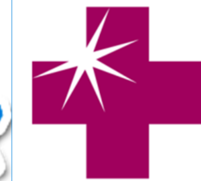


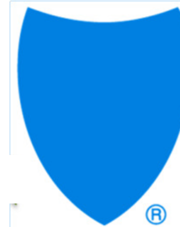
why Sacramento?

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.

ACO challenges

what are the challenges

- limited electronic connectivity based on existing, individually-operated, IT infrastructure
- legal and regulatory barriers make data sharing difficult
- lack of centralized management can lead to slower consensus decision-making
- limited member incentives to "do the right thing" through plan design
- efforts may result in fewer bed days which is a challenge for hospitals

how to address them

- required on-going involvement of senior leaders across all organizations
- agreed to achieve cost reduction through service initiatives
- acknowledged the need to make upfront investments in resources
- key to creating an equal partnership – creation of a risk-sharing agreement operational data sharing was instrumental to success

strategy development is all about data

compiled datasets

- 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 5% patients accounting for 75% of total pilot population spend
  - identified opportunities to expand care program and develop additional programs

identified utilization outliers

- 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 outcomes

strategy	outcomes
integrate IT	•enable a strong technological framework to automate processes
reduce drug costs	•reduce drug costs
reduce physician variation	•narrow practice patterns •address inappropriate and over or under utilization of key services •reduce unnecessary length of stay, admissions and readmissions
implement CalPERS-specific utilization management	•reduce length of stay, admissions, readmissions, out-of-network spend
implement population management	• get more CalPERs members actively managed in a disease management / care management program • improve coordination and hand-off between programs • reduce the number of members "falling through the cracks"

key accomplishments

discharge planning

- implemented industry best practice discharge planning process including hospital teach back, follow-up visit within 8-10 days, welcome home calls and sharing of discharge plan with PCP

expanded Health Information Exchange (HIE)

- clinical results (lab, rad)
- hospital discharge summary and patient discharge summary to IPA EMR and/or physician portal
- IPA continuity of care (CCD) data into the hospital EMR
- re-admission discharge plan into hospital portal

benchmarking

- benchmarked acute care admissions/LOS and implemented changes by service line including physician variability, hospital variability and clinical practices (i.e. knee replacement and hysterectomies)

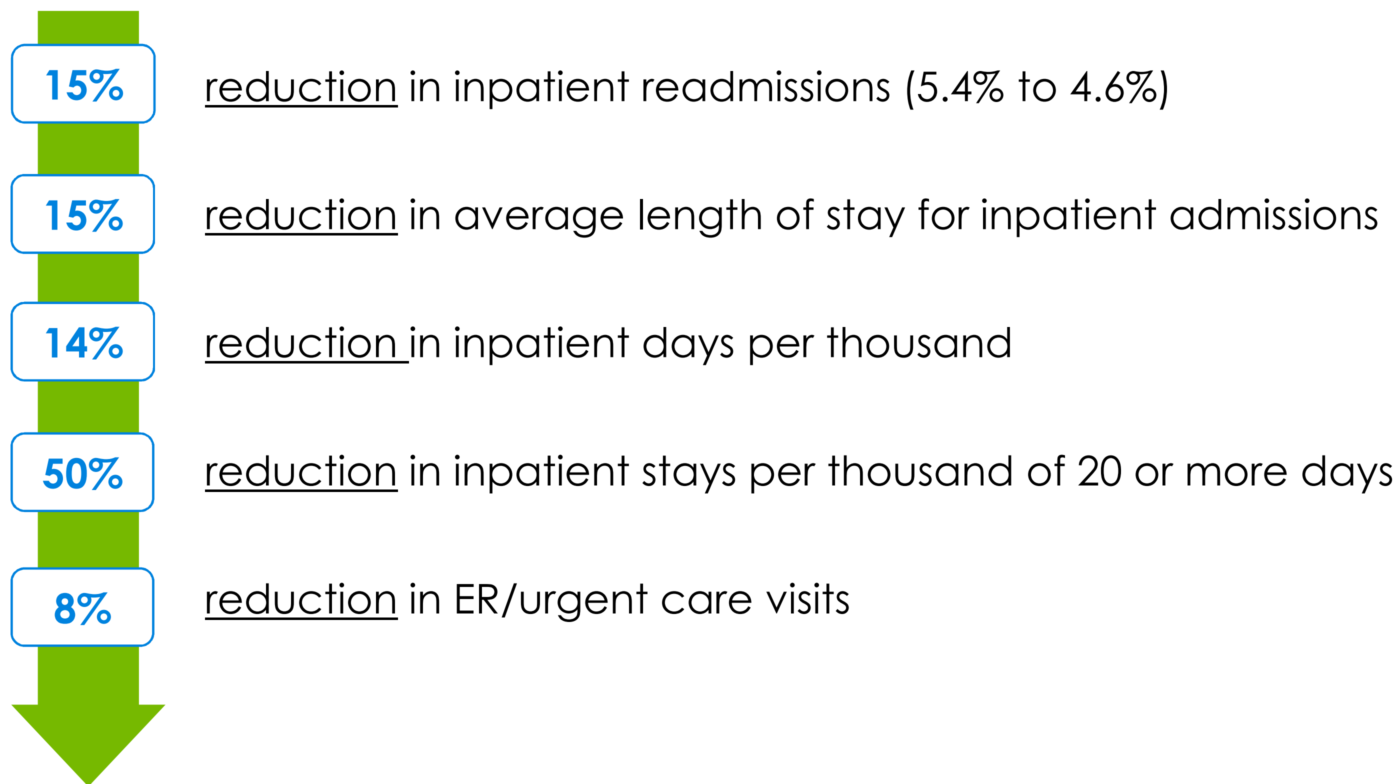
tracking and measuring

- in-house development of a high-risk patient tracking and stratification tool integrating health plan and IPA risk scores and dm enrollment status

2010 results exceeded targets

- exceeded 2010 target of **$15.5M** healthcare cost savings for the 42,000 member pilot population
- new membership grew by 2,200 reversing market erosion

"Positive improvement in our CalPERS members' lives"-- Ann Boynton, CalPERS



lessons learned

- implement changes in small increments as soon as they are ready
- establish clear targets at the project level and hold team accountable for results
- resources are scarce…don't be afraid to pull resources and reassign if an initiative is not driving results
- have a clear mechanism for prioritization of initiatives and prioritize frequently
- financial integration promotes clinical integration and accountability
- initial stress on hospitals comes from reduced inpatient use; patriation from out-of-network is key
- the medical group must expect heavy lifting coordinating among providers
  and facilities
- managing success requires a continual balance: lower pricing vs. profit taking

questions?