Integrated Health Partners

Presented by:

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Topics:

- ✓ IHP Network – current state
- ✓ IHP Network - opportunities
  - ✓ Partnership RFI
  - ✓ Path to risk
  - ✓ Network improvement
- ✓ IHP Network technology and informatics


Current State
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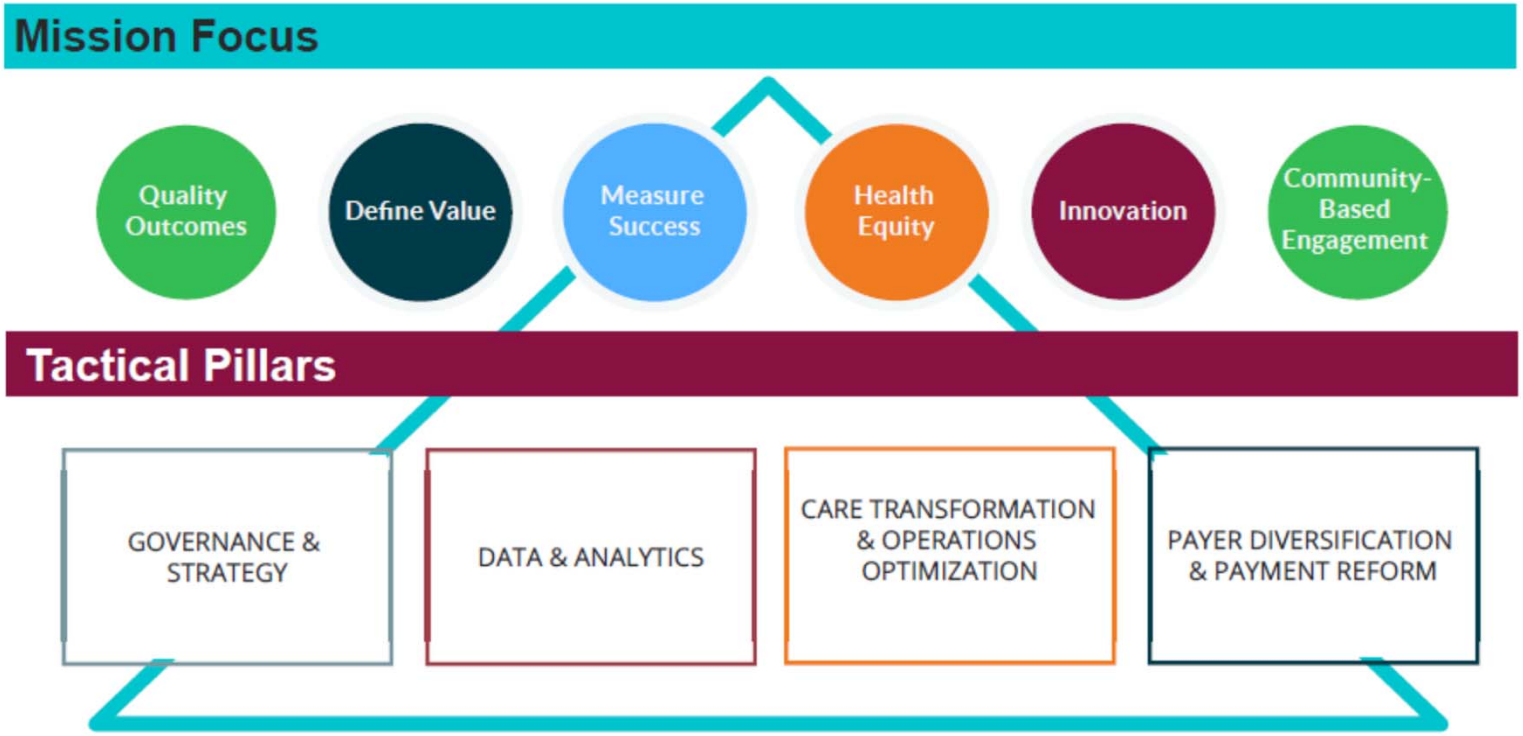
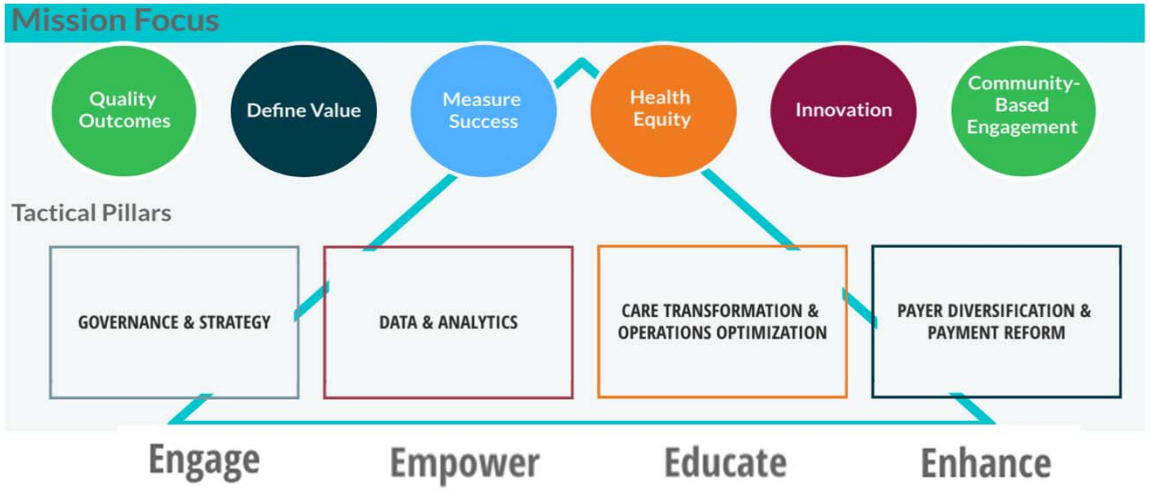
IHP Network Overview



IHP Committee Structure & Empowerment



Committee Success Focus

- Clear Network Vision & Goals (FY and Long-term)
- Proactive Population Health Management
- Physician leadership and engagement
- Structure for Continuous Improvement
- High-Value Culture
- Cross Synergies among Committees

Plan for Health Center Implementation of Recommendations

Updates versus Action

Lack of Member Engagement

Need for Clear Vision & Goals

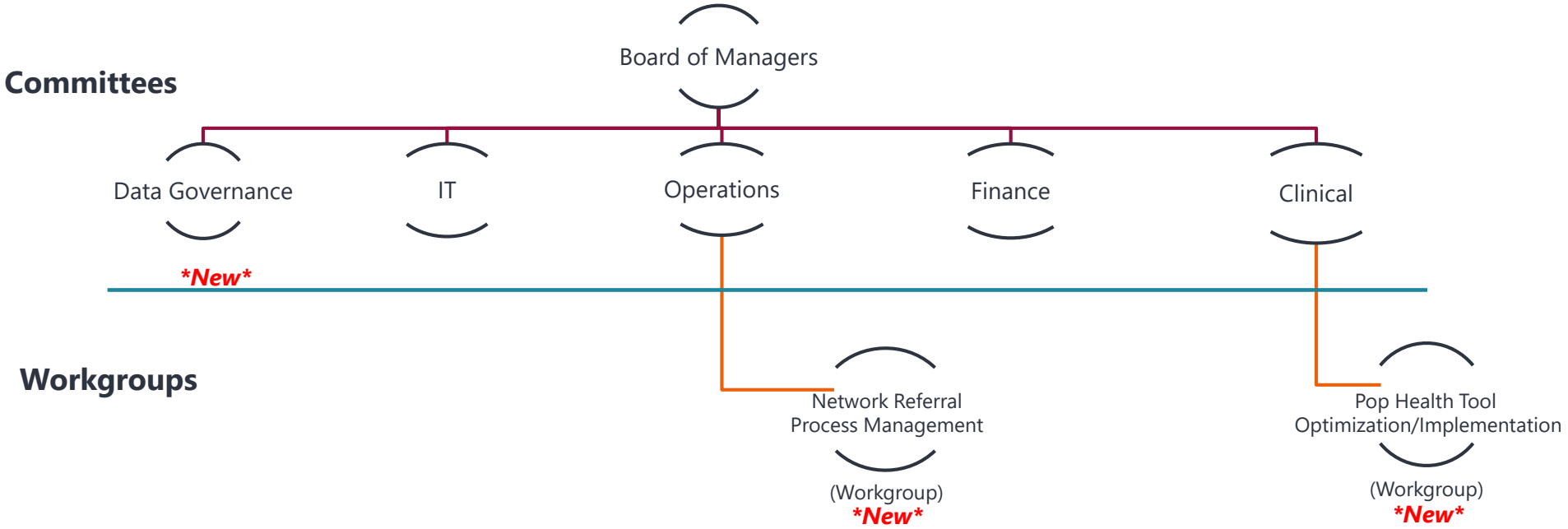
Chair/Vice Chair Empowerment

Need for Physician Voice & Involvement

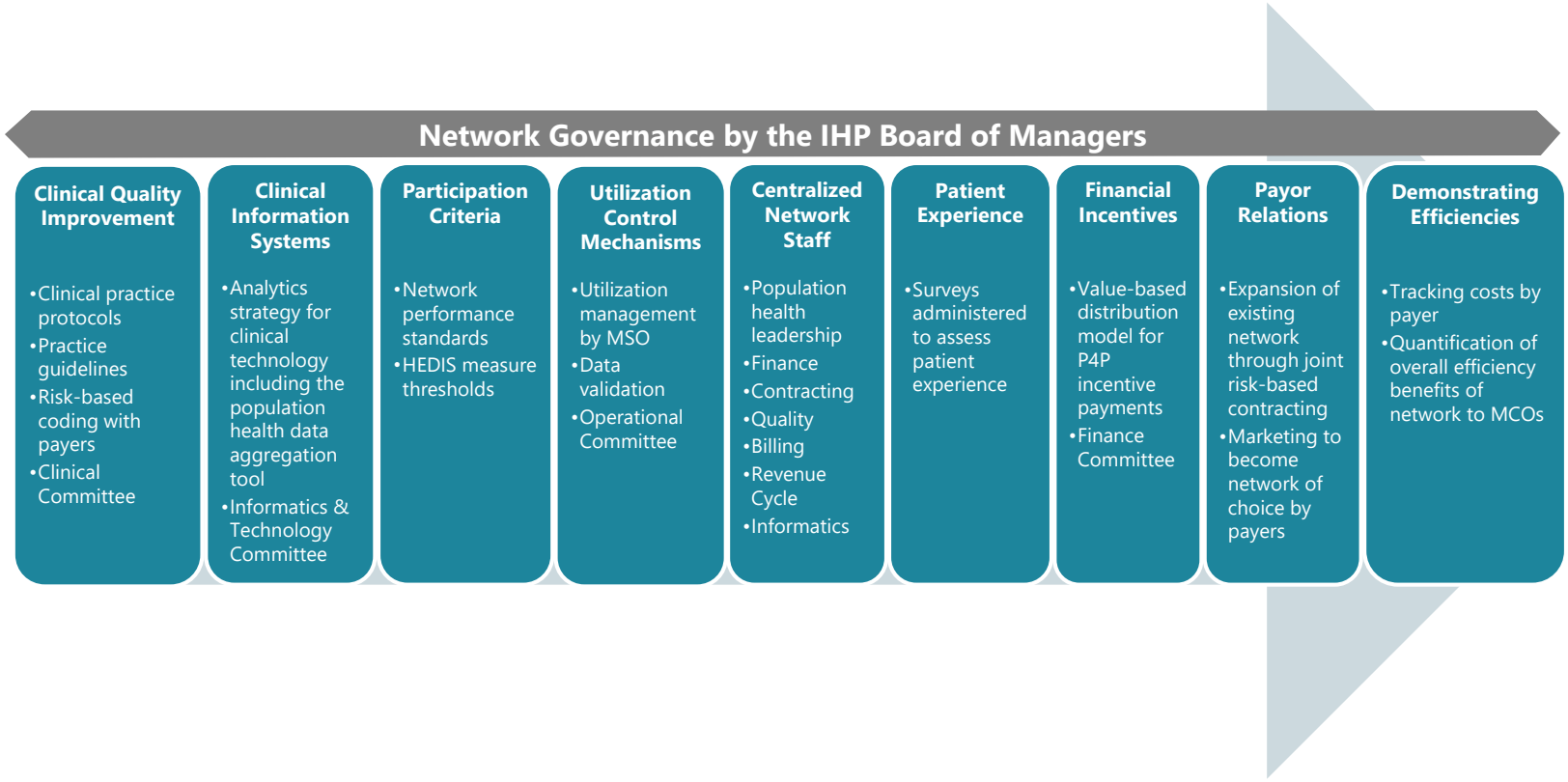
No Committee Synergies

Chair & Vice Chair Feedback

IHP Redesigned Committee Structure and Empowerment

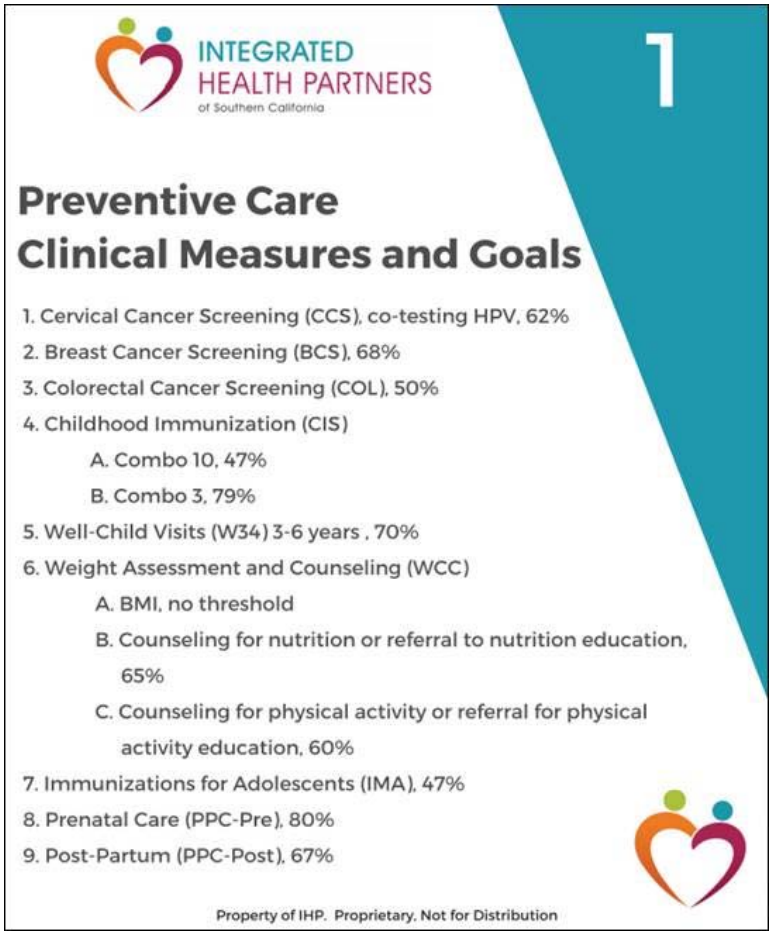


Core Elements of IHP's CIN



The IHP Experience

IHP Clinical Measures



CLINICAL INTEGRATION & QUALITY IMPROVEMENT

Goal: Clinical and Financial Integration: Produce evidence to satisfactorily qualify for clinical and financial integration.

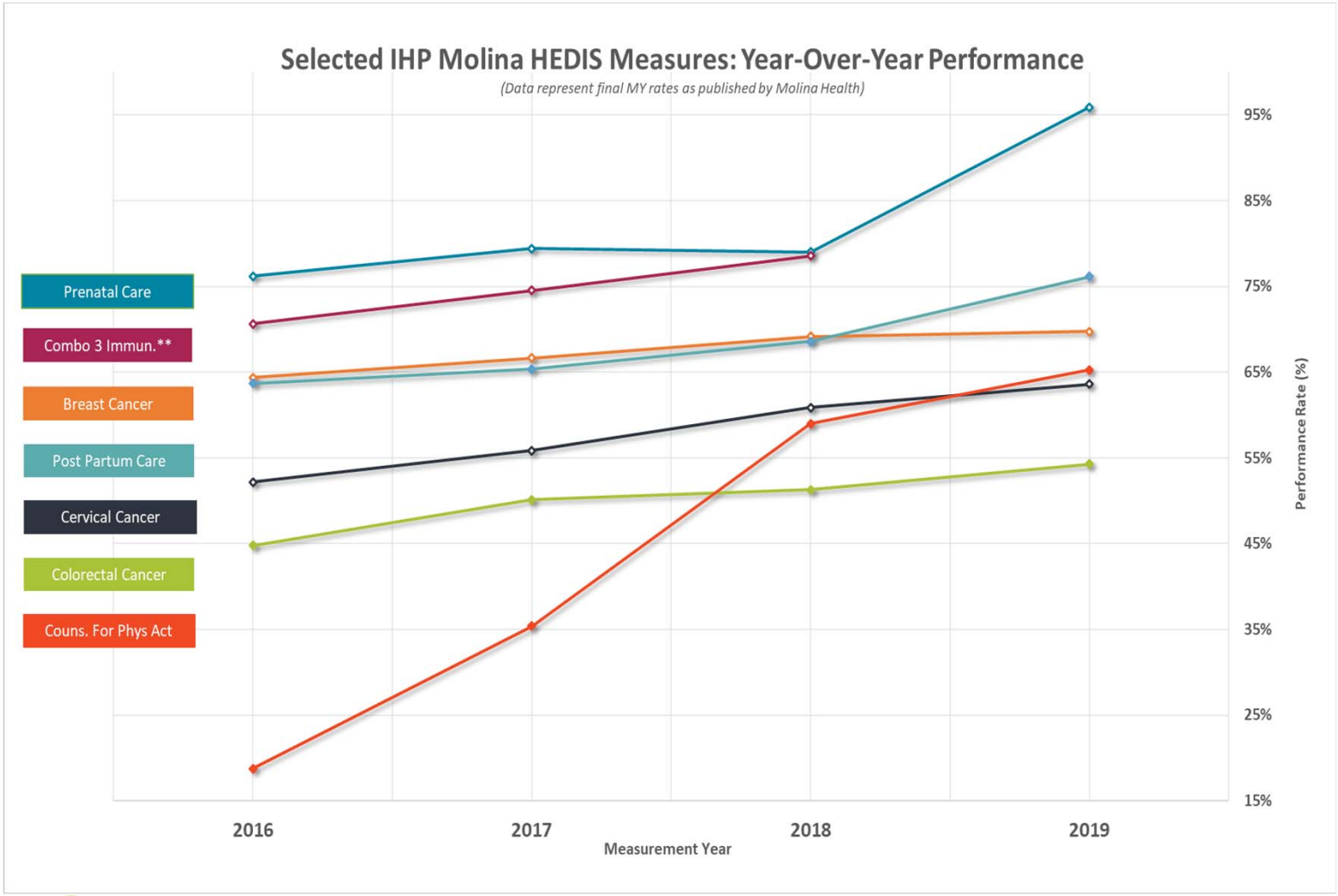
During fiscal 2019, IHP, driven by its clinicians committee, built upon previous successes in quality improvement and further improved upon quality scores across the network, demonstrating the positive impact of shared clinical protocols and accountability to each other and the network.

IHP produced a 2% year-over-year increase in HEDIS scores, overall, and exceeded established plan goals on each measure by between 2% and 38%. Overall, IHP exceeded established plan goals on focus measures by an average of 13%.

IHP HEDIS Scores

Acronym	HEDIS Measure	Final 2017 Y2	Final 2018 Y3	MPL
BCS	Breast Cancer Screening	66.64%	69.71%	51.78%
CCS	Cervical Cancer Screening	55.84%	61.11%	54.26%
PPC	Postpartum Care	65.36%	68.62%	59.61%
PPC	Timeliness of Prenatal Care	76.21%	79.01%	76.89%
CDC	HbA1c Adequate Control (<8)	55.33%	50.40%	44.44%
CDC	HbA1c Poor Control (>9)	35.62%	39.62%	47.20%
CDC	Eye Exam	63.28%	64.53%	50.85%
W34	Well Child Visits	73.91%	72.58%	67.15%
CIS	Combination 10 Immunizations	N/A*	50.82%	27.74%
IMA	Immunizations for Adolescents - Combo 2	N/A*	64.75%	26.28%

* New measure for 2018



From 2016 to 2017 IHP Health Centers:

- ✓ Became one of Molina's highest scoring provider organizations in California

During 2018 IHP Health Centers:

- ✓ Continued year-over-year improvement for 10 out of 12 of the IHP's priority HEDIS measures

During 2019 IHP Health Centers:

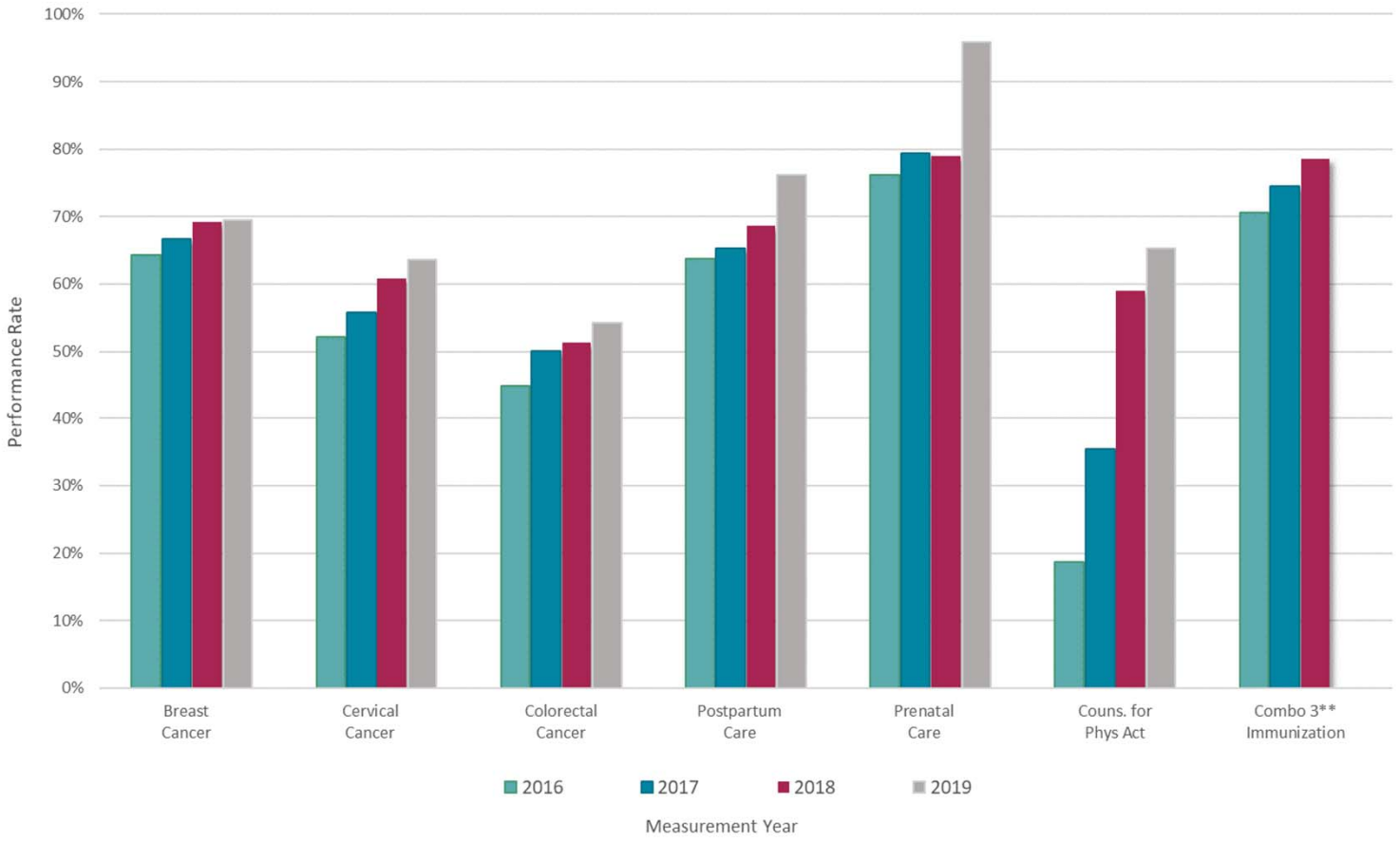
- ✓ Demonstrated a focused commitment to women's health, performing above HPL[2] thresholds for the following HEDIS measures:
  - Breast Cancer Screening
  - Post-Partum Care
  - Prenatal Care ***(7% above HPL)***

Health Plan no longer reported rates for Combo 3 Immunizations beginning 2019

[1] MPL = Minimum Performance Level; set by NCQA
[2] HPL = Highest Performance Level (90th %tile); set by NCQA

Selected IHP Molina HEDIS Measures: Year-Over-Year Performance

(Data represent final MY rates as published by Molina Health)



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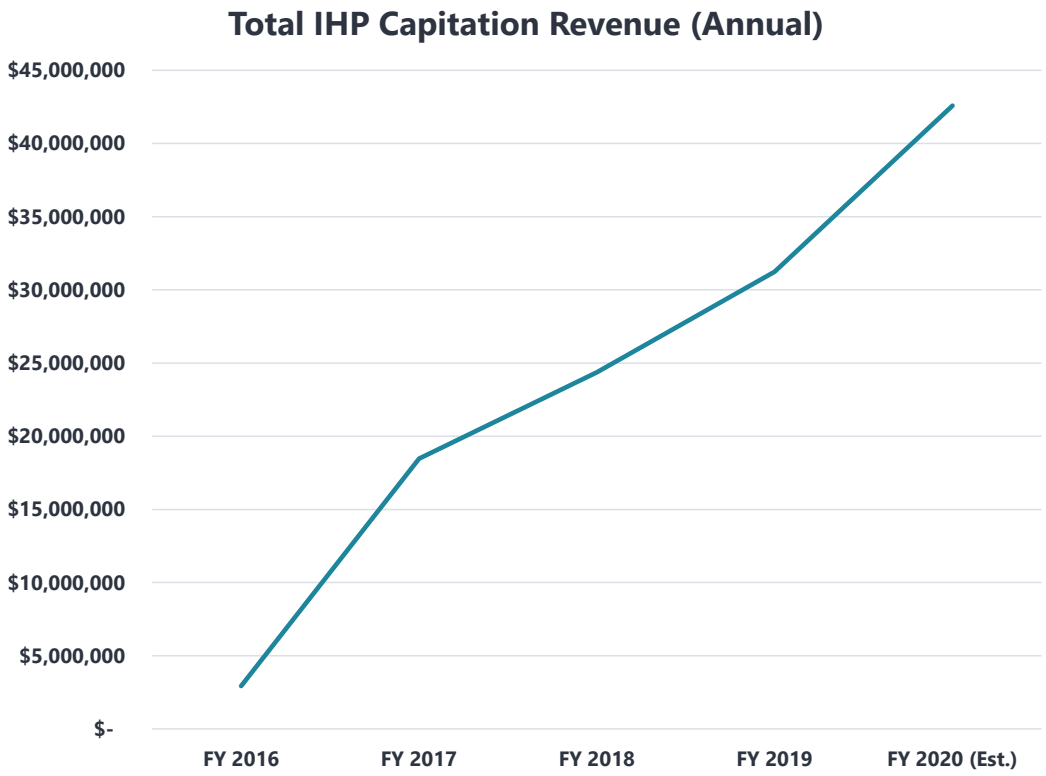
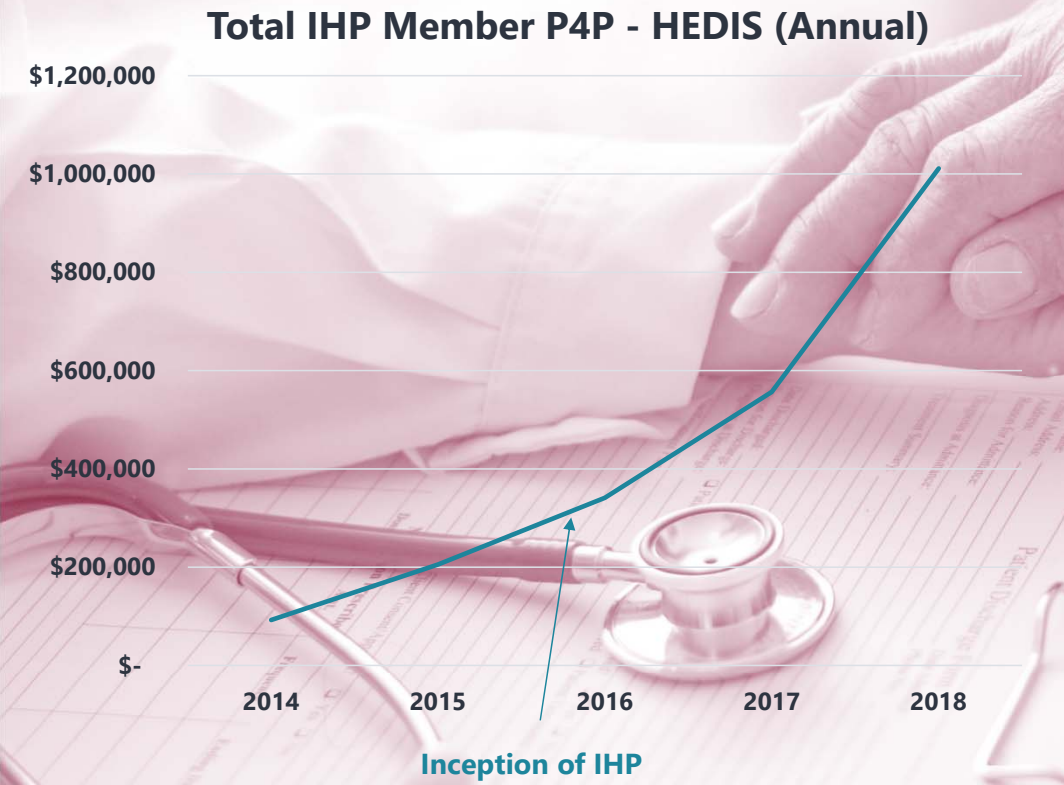
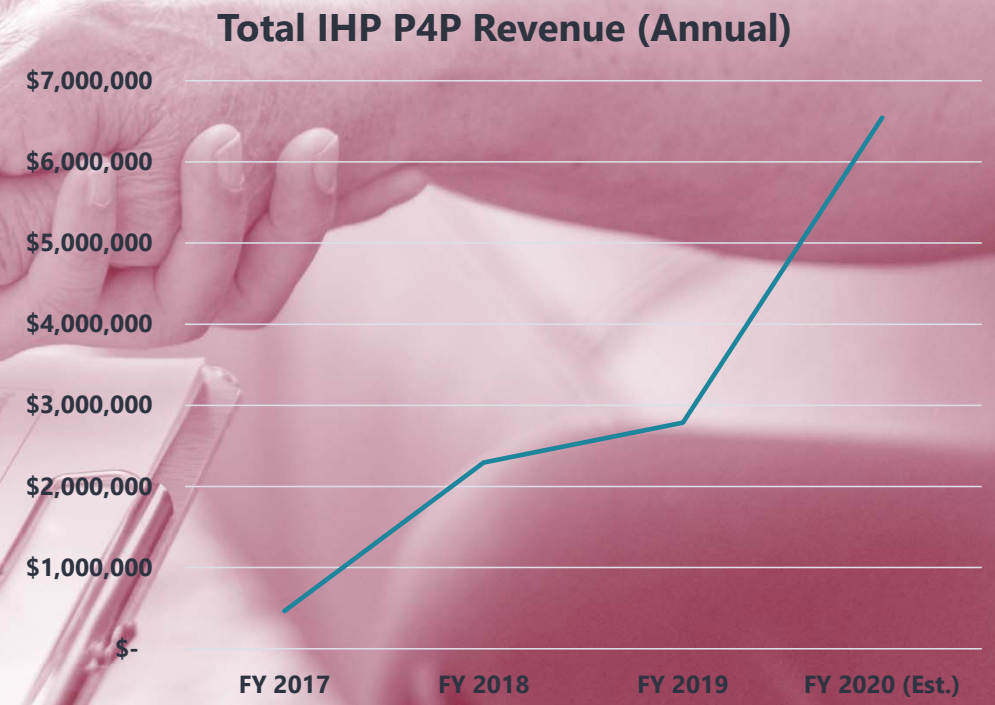


Total IHP Capitation Revenue (Annual)

IHP Performance Over Time





IHP Population Health Goals

- Provide a centralized data asset for IHP to use for **quality reporting, research functions and grant initiatives.**
- Develop an electronic infrastructure for **performance and utilization management** at the network level.
- Create a common set of population health management capabilities to **share and integrate best practice workflows** across the network.
- Produce a platform to **enhance care management and performance management capabilities** at the health center level.
- Utilize reporting and analytic capabilities of the platform to support **value-based contracting and total cost of care** initiatives in the future state.

Population Health Informatics

Members acquired a population health solution to drive networked health centers to achieve the quadruple aim by:

- Establishing a collaborative system for reporting, analytics, and performance improvement.
- Demonstrating value of the CIN to payers and other customers.
- Moving to greater data acquisition, processing, and automated reporting.
- Provides a master patient index and longitudinal health record with a real time EHR pop-up.

*Source: Premier, Population Health Informatics & Technology Overview.


Opportunities
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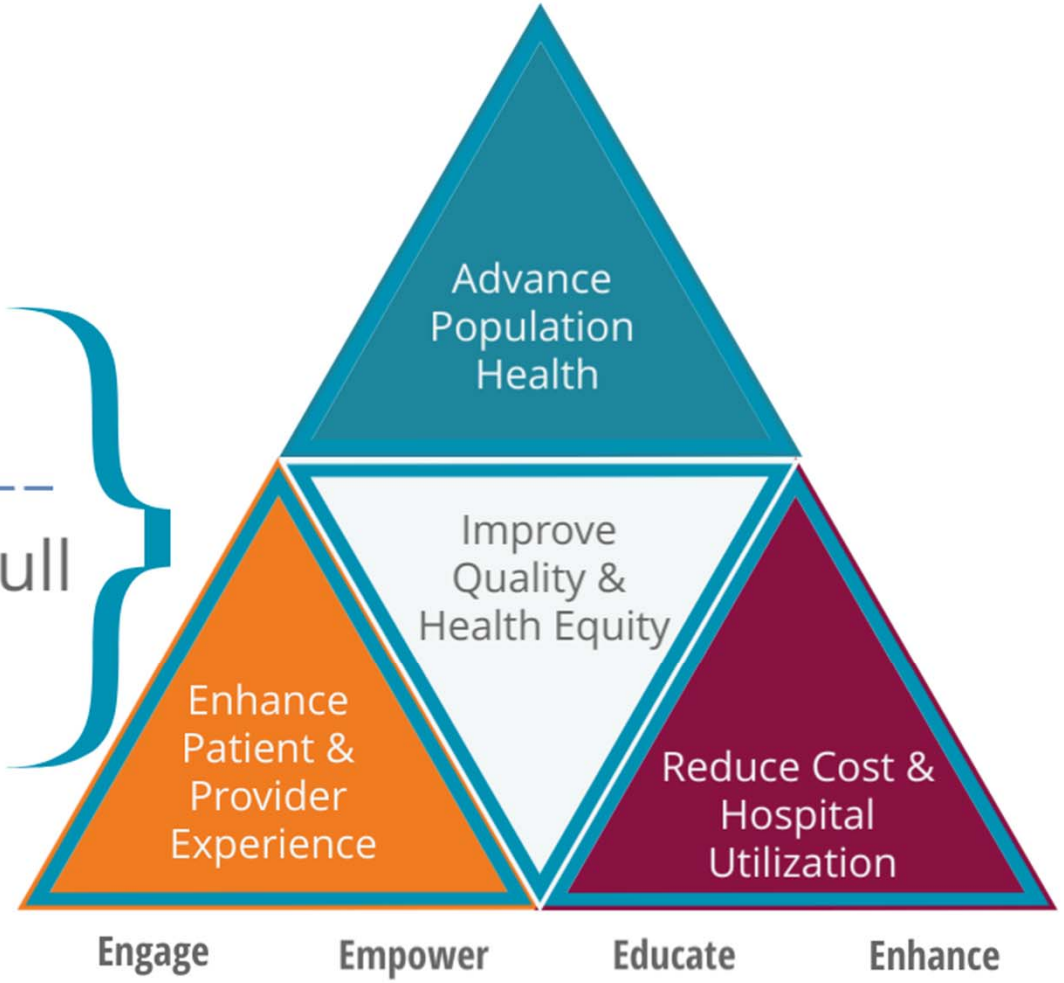
Integrated Health Partners CIN Model

PROOF OF CONCEPT ----› PROFESSIONAL RISK ----› TOTAL COST OF CARE

IHP Dual Path

Partnership / Affiliation

Network Optimization to Full Professional Risk



Value to Partners

- Management of uninsured & Medi-Cal patients
- Entrance into the Medi-Cal payer market
- Expansion of commercial & MA contracts
- Expansion of market footprint with additional ambulatory presence
- Care coordination (Medi-Cal/Uninsured) for reduction of facility utilization (ED)
- Reduce cost of care by ensuring patients are treated in the most cost-effective setting
- Payer negotiation – risk arrangements Medi-Cal
- Additional GME sites for programmatic growth
- Improvement of primary care-based quality outcome metrics & preventative screening metrics
- Focus to help improve CMS star rating

Option 1: Partnership Model

Partner with a health system to access payer contracts, specialty network, and MSO capabilities

- Ability to leverage size, scale, influence, and/or brand of health system partner.
- Health system partners may be willing to fund new clinical initiatives and programs.

RFI Process

- RFI Purpose – Identify partnership options for full professional risk/partnership strategies
- Counties: San Bernardino/Riverside, San Diego
  Release Date – August 27, 2020
- Response Date – October 9, 2020
- Distribution to 40 potential partners

Draft RFIs → Distribution List & Method Development → RFI Release & Response Gathering → Objective/ Subjective Response Grading → Present to BOM with Recommendation & Next Steps

RFI Partnership Goals

Goal	Goal	Goal	Goal	Goal
Identify partner organizations with similar interests and vision to improve health equity and the quality of community health which also seeks to customize partnership options to maximize the value of each organization	Develop partnership options that include efficient and effective business functions like care management structures, data warehousing and analytics, population health strategies, risk-based contract administration, social determinant of health screening and intervention and planning	Develop long-term clinical and operational strategies associated with and aging population's (Medicare and Medicare Advantage)	Identify a health care partner to enter into value-based risk agreements for the and Medicare Advantage communities in San Diego, Riverside and San Bernardino counties	Identify entities interested in partnering with primary care providers also seeking to expand their network to include high quality offerings and access to high quality specialty care network of providers

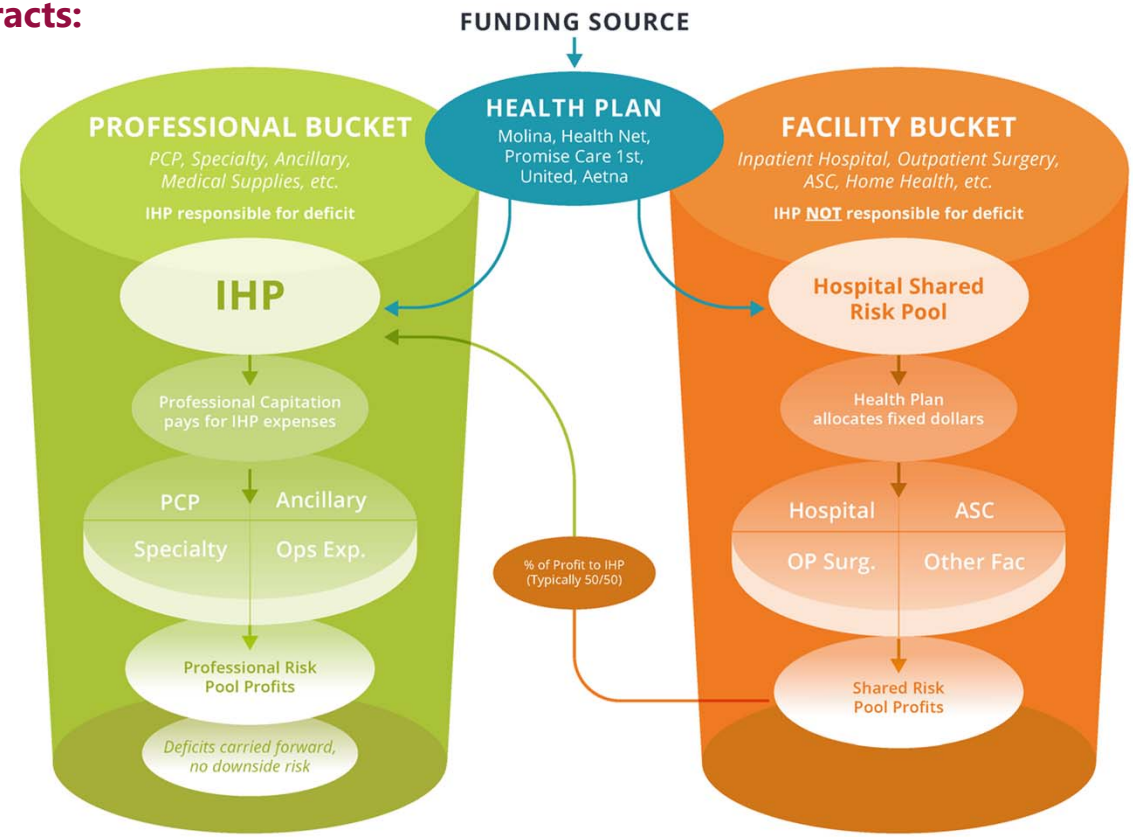
Organizational Competency Ratings

Category	Competence (1-10)
Population Health IT Analytics and Platform	
Network Development & Performance	
Care Management	
Referral/Utilization Management & Analytics	
Patient Engagement, Education & Outreach	
Payer Negotiations	
Payer Contract Performance	
Quality Outcomes – Ambulatory	
Quality Outcomes – Hospital Based	
Clinical Quality Process Improvement/Intervention Development	
Provider Engagement and Funds Flow	
Social Determinants of Health/Health Equity Screening and Interventions	

Option 2: IHP Professional Risk Model

Build specialty care network, determine MSO (partner, build in-house capabilities), negotiate payer contracts:

- Maintain control of the network and governance
- Provides direct control of clinical programs and operations.



Why Take More Risk?

- ✓ Control over a robust specialty care network of high-quality performers and the continuum of care for better patient and provider engagement and satisfaction

- ✓ Control over data quality for improved decision support
  - Encounter data
  - Clinical efficiencies
  - Data aggregation and analytics

Care Model Redesign

The transition to a **professional risk model** will mean IHP members need to have core managed care principles in practice:

- Preventive care – medical home is key!
  - Access and availability
  - Anchor patients
  - After hours availability
- Patient Education – appropriate use of ED
- Radiology – direct to free standing facilities
- Primary Care providers – practicing up to the full extent of their license
- Maximize performance for Health Plan P4P measures

TRANSITION FROM PROVIDING PRIMARY CARE TO MANAGING THE CARE OF OUR PATIENTS

Network Improvement Framework

Future Planning with Measurable Goals — **Transparency & Accountability** — **Aligned Incentives & Improvement Efforts** — **Value-Add to Network, Providers, Patients & Community**

Tactical Pillars of Success

GOVERNANCE & STRATEGY

- Define Vision & Measurable Expectations
- Partnership / Affiliations
- Create Value Proposition
- Align Committee Focus & Deliverables
- High-Value Network

DATA & ANALYTICS

- Population Health Tool
- Prioritize Quality & Operational Metrics to Maximize Impact & Return
- Payer Data Set Utilization
- Dashboard Development with Benchmarks & Goals

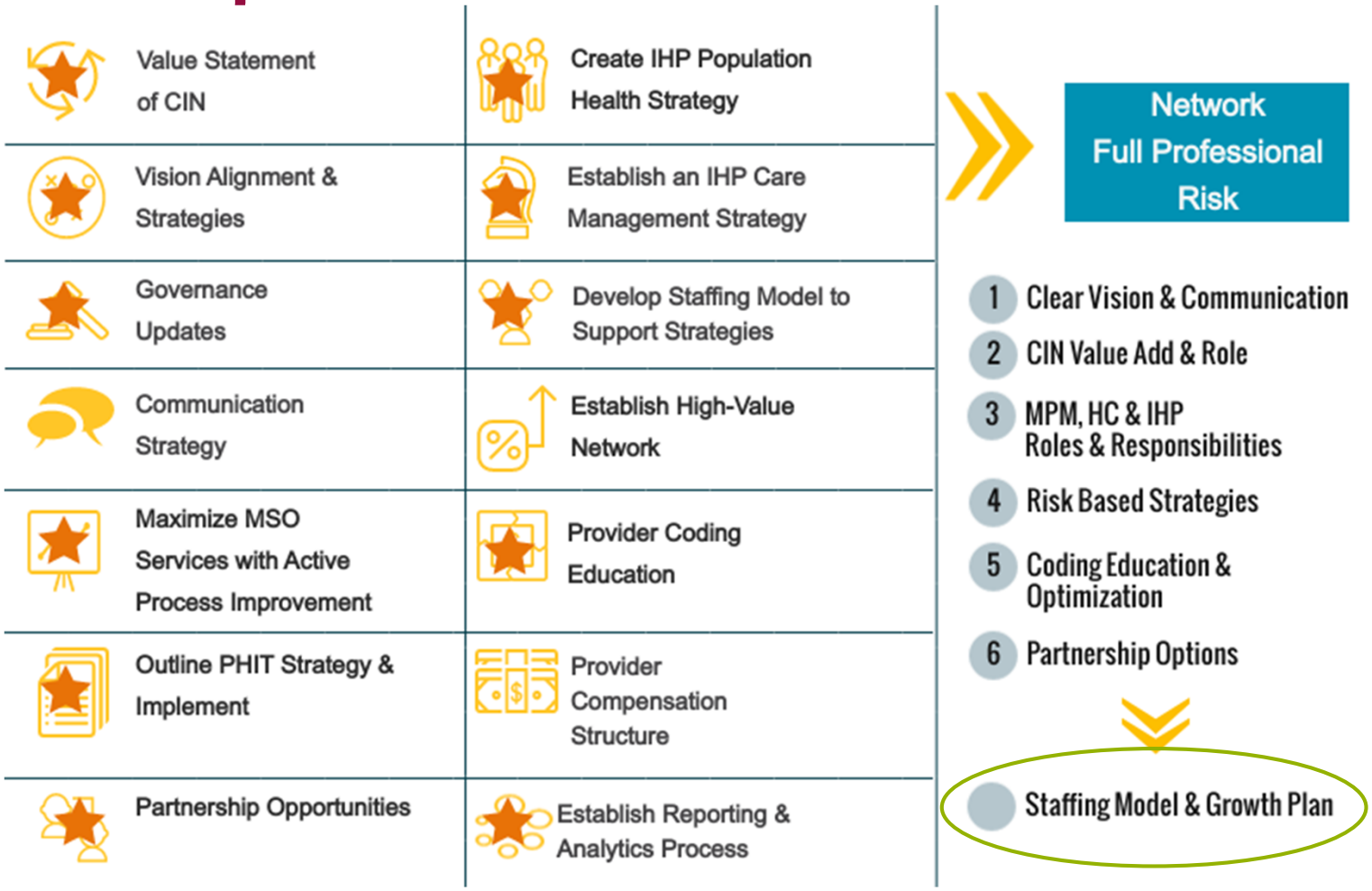
CARE TRANSFORMATION & OPERATIONS OPTIMIZATION

- Population Health Strategies
- Evidence Based Medicine
- Community-Based Partnerships
- SDoH / Health Equity
- MSO Performance Improvement

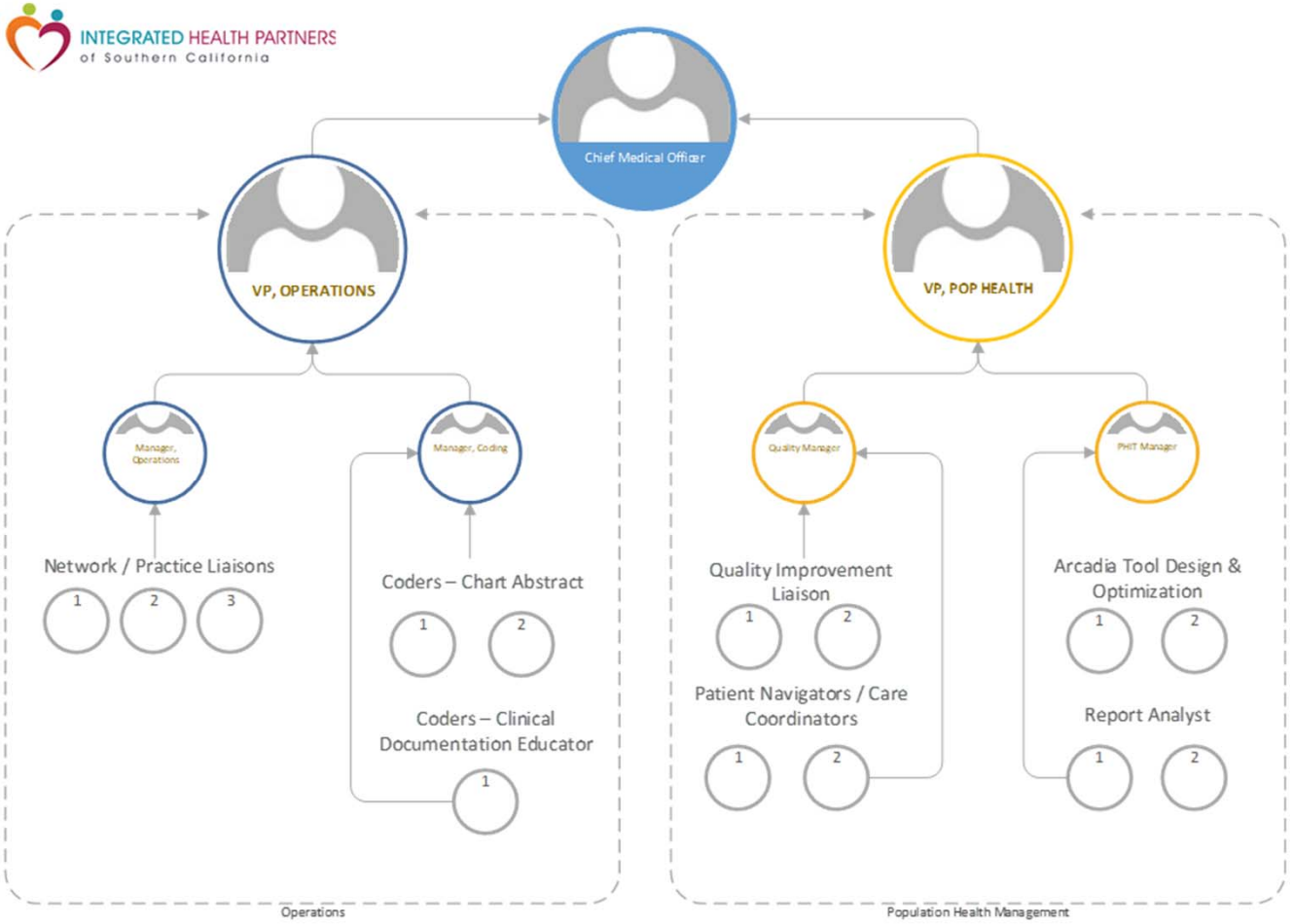
PAYER DIVERSIFICATION & PAYMENT REFORM

- Senior Strategy
- Full Professional Risk
- Cost of Care
- Maximizing Existing MCO Contract Incentives

Network Improvement Framework

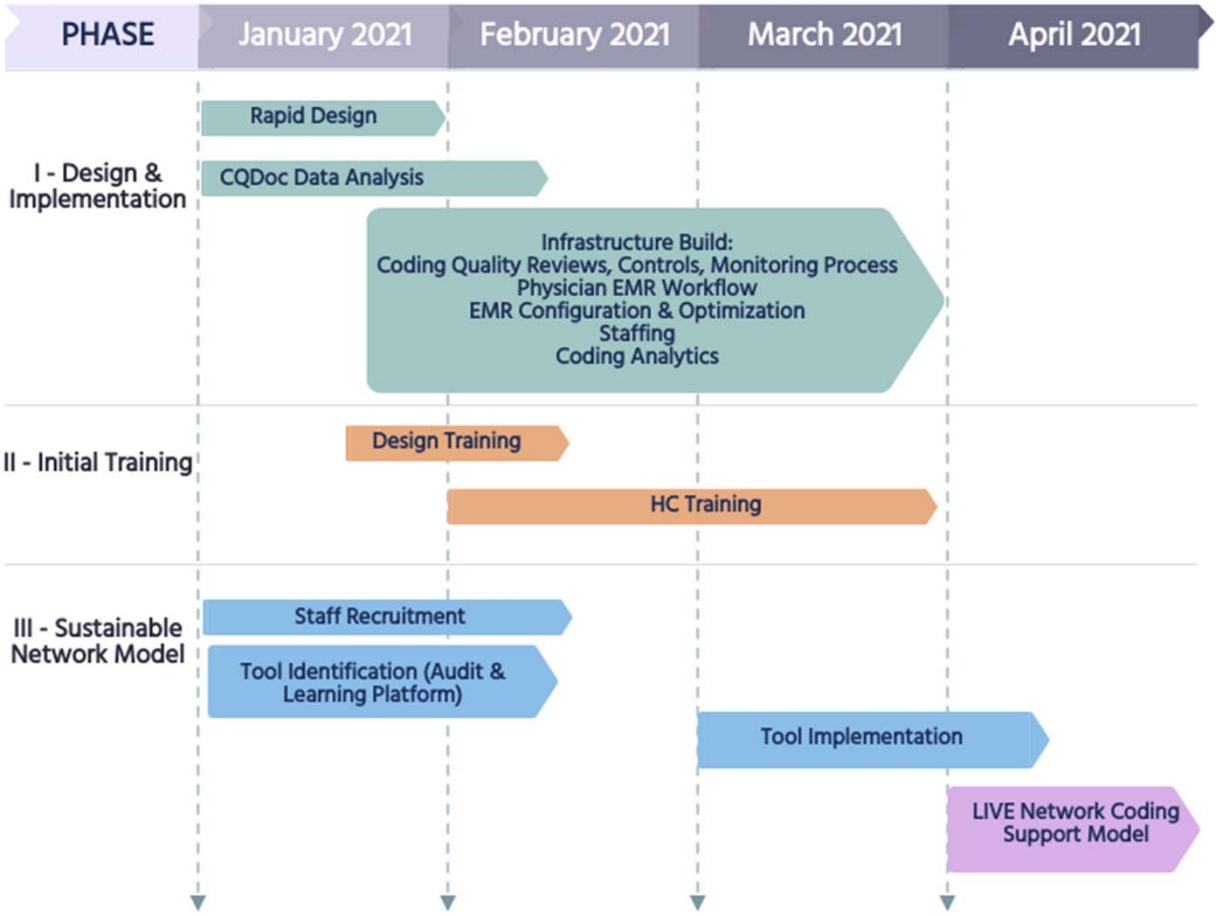


Network Improvement Staffing Model



Network Improvement Framework

Estimate of timing – Updates Pending Contract Execution & Planning




Population Health
Technology and Informatics
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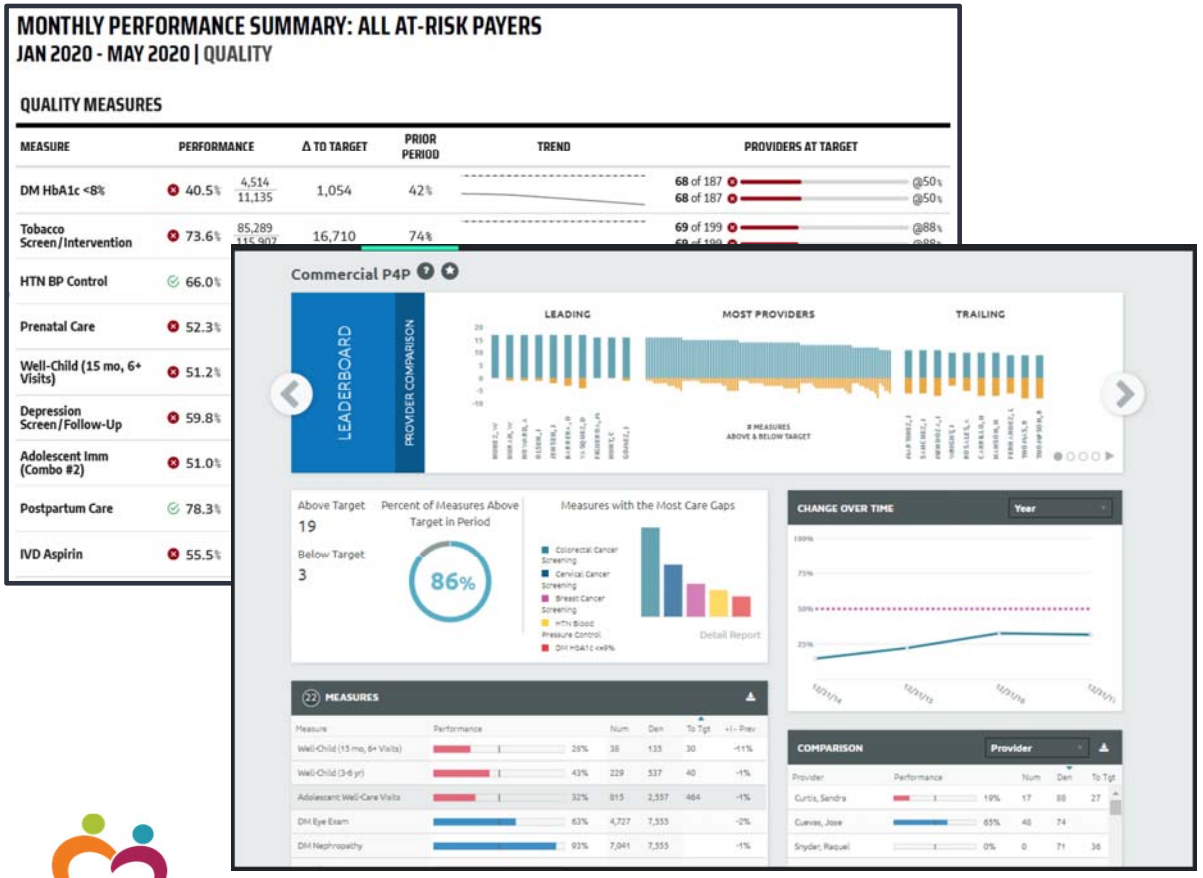
Our PHIT Journey

- In 2017, IHP embarked on the development and execution of its population health informatics & technology (PHIT) strategy to support the value-based reporting and analytic needs of the clinically integrated network.

- Implementation of the selected PHIT platform began in 2019 with EHR connectors for all member health centers and network-level enrollment and payer gap file feeds.
- Post user acceptance testing (UAT), the network is working with member health centers to optimize the suite of products for clinical quality performance monitoring, patient outreach for gap closures, management of patient panels, and risk and coding assessment tools.

Clinical Quality Performance Monitoring

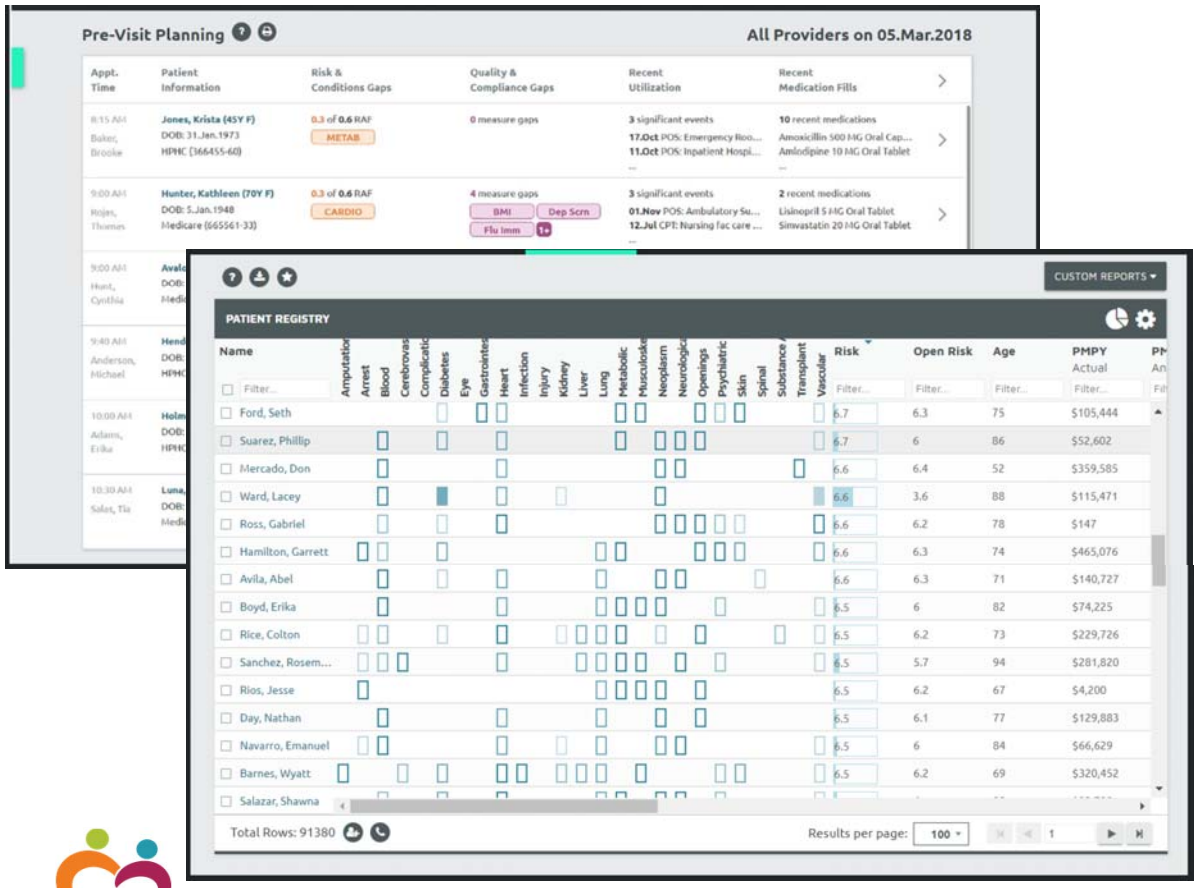


Platform Highlights:

- Library of 400+ national quality metrics routinely updated with new specifications
- Performance based on integration of EHR data refreshed nightly
- Compare across providers and practices and generate outreach lists
- Measure sets include: HEDIS, HRSA UDS, Regional P4P, PCMH, CMS ACO
- Ability to publish and distribute scorecards with secure interactive links to patient-level content

*Screenshots display test data for demonstration purposes only

Patient Panel Management

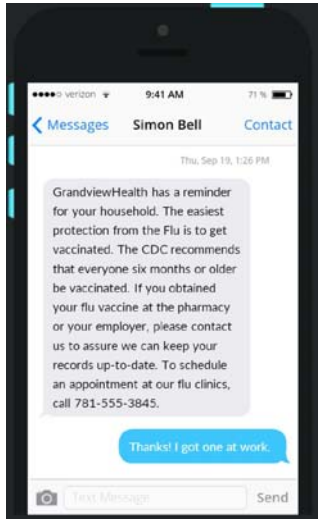


Platform Highlights:

- Unified patient registry presents patient complexity across 85 condition categories
- Track patient risk and identifies documentation gaps for under-represented acuity
- Pre-built decision support rules and alerts to highlight quality gaps
- Integration with scheduling data from the EHR for pre-visit planning reports
- Customizable lists to share with care team members

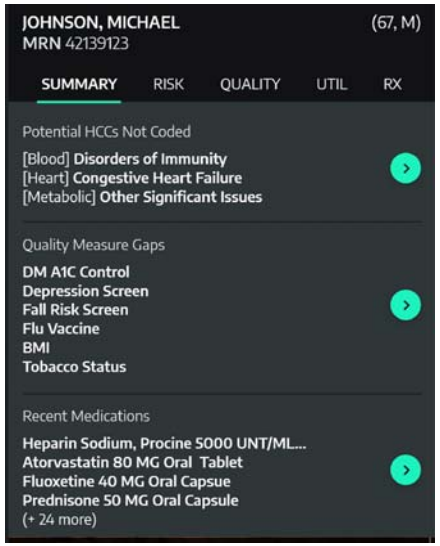
**Screenshots display test data for demonstration purposes only*

Patient Outreach for Gap Closures



Desktop Application:

- EHR pop-up automatically displays patient risk and quality gaps at the point-of-care without additional clicks
- Makes analytic insights actionable within existing workflows
- Providers can review utilization history and medication list to address comprehensive patient care during actual visit



Patient Outreach Campaigns:

- Configure and enable dozens of passive patient engagement messages to close gaps and trigger volume
- Library of hundreds of rules for messages based on contracted quality measures and risk/coding needs

**Screenshots display test data for demonstration purposes only*

Risk and Coding Assessment Tools

Platform Highlights:

- Workflow tools to support collaboration between admins, coders and practices targeted to improve performance on risk-based contracts
- Documentation and annotation of existing coding gaps feed clinical workflows downstream

*Screenshots display test data for demonstration purposes only

Progression of PHIT Strategy

- Roll-out new platform functionalities in alignment with the network's care management program
- Centralized business intelligence development:
  - Informatics support for custom analytics and data visualization
  - Data governance for data integrity and stewardship
  - Tool optimization for ongoing and/or changing needs of the network and member health centers
  - Peer learning groups to share best practices and continuous education
- Greater data acquisition across the care continuum for population health management initiatives with new data feeds: HIE, lab vendors, claims for risk-based contracts


Questions?
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