

I. Background:

There are sweeping changes happening in the health care environment. At the federal level, CMS has declared its intent to have 90% of Medicare fee-for-service payments tied to quality or value by 2018. Initiatives like hospital readmission penalties and the Value Based Purchasing program, as well as alternative payment models like advanced primary care medical homes and bundled payments are forcing the US healthcare system to move away from a reactive focus on being paid for the volume of services to being clinically and financially accountable for a defined population of patients (i.e. accountable care).

For safety net systems like SFHN, Medicaid payment policy has a greater financial impact than Medicare. In California, the last three 1115 Medicaid waivers, along with the Affordable Care Act, represent a stepwise progression from volume to value-driven payment and from individual to population health. Relevant initiatives have included Healthy San Francisco, which provided a population level understanding of the City's uninsured residents, mandatory enrollment of SPDs and Medicaid expansion patients into Medi-Cal managed care, and Medi-Cal's first pay-for-performance program (DSRIP). The current waiver includes an ambitious pay-for-performance program with 57 measures (PRIME, \$35 million annually) and a new methodology for supporting uncompensated care that incentivizes public hospital systems to shift from emergency and inpatient care to providing more primary, preventive, and nontraditional services (GPP, \$95 million annually). The state has indicated that its goal is to leverage PRIME to transition Medi-Cal payments from fee-for-service to value-based payments by 2020.

SFHN is in a fairly unique position of having the majority of its Medi-Cal revenue – approaching \$300 million annually – in near fully capitated arrangements, a payment model that is highly aligned with the goals of GPP. However, we do not actively manage the utilization and cost of these patients against capitation revenue, nor are these payments tied to outcome measures. In addition, because of capitation as well as other non-FFS funding streams (DSH, FQHC, general fund) we have not prioritized documentation and billing practices that are now being used to track utilization and determine capitation rates. Finally, we have not developed the capacity to recruit and retain capitated patients. PRIME and GPP represent a significant opportunity – and challenge – for SFHN to evolve into a safety-net healthcare delivery system that can thrive in the new era of value-based payments.

- V. Proposed Countermeasures**
- Analytics: trends, risk adjustment, predictive analytics
 - partner with SFHP to obtain utilization data outside of SFHN (OOMG use)
 - Population management: registries, member outreach and engagement
 - Care model standardization and spread: focus on transitions in care, chronic disease management, medication management
 - Culture of data driven improvement: LEAN and True North measures
 - IT infrastructure: EMR, registries, reporting (Tableau)
 - Finance: ODB and financial dashboards
 - PRIME: programmatic workgroups focused on linking care processes to measurement for rapid improvement
 - GPP: development of standard work for documentation of traditional and nontraditional ambulatory services

II. Current Conditions

- SFHN has all the key components of an integrated delivery system (primary care, behavioral health, specialty care, acute care, long term care), but these are historically separate institutions with separate budgets and care models.
- While our Medicaid managed care patient population has grown from less than 40K to over 65K over a two year period, our disenrollment rates remain high.
- Our patient population utilization data is primarily limited to SFHP patients, rudimentary, and not risk adjusted (and therefore difficult to interpret).
- We do not have mechanisms to measure and manage the utilization or cost of individual or defined populations of patients in real time.
- The availability of timely, relevant, actionable clinical and process data to drive improvement is limited.
- The culture of data driven improvement is variable across SFHN.
- Centralized population-focused quality improvement efforts vary across primary care clinics.
- Our care management infrastructure is limited to subsets of high risk groups, with little coordination across programs.
- Provider compensation in our system is not tied to quality or cost.
- We are currently participating in four Medicare value based payment programs (VBP, re-admissions, HAC, bundled payments) with variable success.
- \$130 million of our annual budget is at risk based on our performance on PRIME quality measures and standardized documentation practices for GPP.

VI. Plan

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Problem Statement (Gap)

We do not have the right infrastructure, processes and culture to effectively manage financial risk, clinical utilization and outcomes for our patients.

III. Goals & Targets

Infrastructure/Capacity	Current State	1 year goal	3 year goal
Enterprise EHR			
Proactive outreach for ENYS			
Actionable population utilization data			
Actionable population cost data			
Actionable population outcomes data			

- IV. Analysis**
- We lack an enterprise EHR, which is a foundational element of being able to measure and manage care.
 - We have not developed the capacity to engage members who are assigned but not yet seen (ENYS).
 - We have not made investments in predictive analytics that would guide targeted programmatic investment and/or systematic patient case management (models of care).
 - Clinical revenues have not been tied to outcomes, but volume of patients seen or assigned.
 - Documentation and billing have not been a priority, and are seen by some as not congruent with mission.
 - Financial management has occurred at the executive rather than unit level.
 - We lack standard work around documentation of both traditional and nontraditional services (for GPP).

- VII. Follow-Up**
- When and how you will know if plans have been followed & the actions have had the impact needed?
 - What related issues or unintended consequences do you anticipated & what are your contingencies?
 - What processes will you use to enable, assure & sustain success?