Healthcare System Innovators Discuss Early Investments and Harnessing the Power of Community

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KP’s Investments in ‘Total Health’
Bridging Social Care with Health Care

CIE Summit Workshop: Healthcare System Innovators Discuss Early Investments and Harnessing the Power of Community

Sarita A. Mohanty, MD, MPH
Vice President, Care Coordination for Medicaid and Vulnerable Populations
April 24, 2019
Our Mission

Kaiser Permanente is committed to providing high-quality, affordable health care services and to improving the health of our members and the communities we serve.
Kaiser Permanente – Over 12 million members

- Washington
- Northwest (Ore./Wash.)
- Northern California
- Southern California
- Colorado
- Georgia
- Hawaii
- Mid-Atlantic States

$72 B operating revenue
20,000+ physicians
216,199 employees
39 hospitals
684 medical offices
Many of Our KP Members are Struggling

While nearly all of our members will have an unmet social need at some point in their lives, those who struggle financially are at greatest risk.

Nearly **30% of members*** have incomes at or below 250% Federal Poverty Level
~ 3.4 million members
~ Over 50% are members in the commercial line of business
Challenges and Opportunities

**Challenges:** Unmet social needs including food, housing, transportation, are barriers to our members’ health and wellbeing

- **Food insecurity:** 29% of our KP high utilizers; 25% of elderly Medicaid members
- **Housing insecurity:** 11-23% of high utilizers
- **Transportation Needs:** 34% of ‘dual’ Medicare/Medicaid eligible

**Opportunities:**

- Enhanced care coordination and complex care management – meeting members and patients where they are
- Deployment of an enterprise-wide Social Services Resource Locator (SSRL)
Building Key Capabilities and Functions

1. **Assessment:**
   - Predict, assess and document social needs
   - Predictive Analytics
   - Standardized Screening

2. **Navigation:**
   - Connect members to the right resources
   - Community Resource Locator
   - Community-Based Workforce

3. **Partnership:**
   - Develop and maintain networks of community-based social service providers
   - Value-Based Contracting
   - Community Investment Policy Advocacy

4. **Accountability:**
   - Ensure closed-loop referral, system monitoring, and improvement
   - KP/CBO Data Exchange
   - Metrics and Reporting

Integrated clinical and social care, supported by data integration and partnership with community
Social Services Resource Locator (SSRL)

Connecting those with identified social needs to community resources and closing social needs gaps

- Resource Directory
- Development of ‘Community Partner Networks’
- Technology Platform

Integrated clinical and social care, supported by data integration and partnership with community
Dignity Health

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Community Information Exchange Summit 2019

Ji Im, Senior Director Community/Population Health
Healing is a team sport.

Hello humankindness®

Employees: 60,000
Active Physicians: 10,000
Affiliated Access Points: 400+
Acute Care Hospitals: 40
Community Benefit: $2.1B

As of June 30, 2018
Acute Care and Integrated Delivery Networks

40 Acute Care Hospitals
5 – AZ
3 – NV
32 - CA

400+ Affiliated Care Sites
Primary Care
Medical Foundation Clinics
Specialty Clinics
Ambulatory Surgery Centers
Micro Hospitals
Freestanding Emergency Departments
Urgent Care
Imaging
Home Health

8 Clinically Integrated Networks
Arizona
Nevada
Inland Empire, CA
Ventura, CA
Redwood City, CA
Bakersfield, CA
North State, CA
San Joaquin, CA

As of June 30, 2018
CommonSpirit Health

As of June 30, 2018 for all Operational and Financial Data

150 K Employees

25+ K Affiliated Physicians and APCs

93K Deliveries

$29.2 B Operating Revenue

$1.8 B EBITDA*

$12.1 B Unrestricted Cash

21 States**

*Normalized for various one time items
** 45 states through partnership with Concentra
Connected Community Network (CCN)

The goal is to create a smooth care and information flow amongst community service organizations allowing for improved coordination and management of a fragile population’s social needs.
Community members will have multiple access points to the community network

1. Patient being discharged from hospital
2. Patient leaving the doctor’s office
3. Caregiver helping a family member
4. Single individual searching for help
## Case Study: A look at Single and Dual Referral Patients

### Single Enrollments

**Case 1**
- **Better Breathers**
- **Rose de Lima**
- **Patient Visit Dates:**
  - 9/25/2017
  - 10/5/2017
  - 10/7/2017
  - 10/10/2017
  - 10/16/2017
  - 11/2/2017
  - 5/19/2018
- **Notes:** Patient showed 10 days or less between visits before enrollment and almost 200 after enrollment.

**Case 2**
- **Better Breathers**
- **Siena**
- **Patient Visit Dates:**
  - 8/17/2017
  - 12/22/2017
  - 1/9/2018
  - 1/11/2018
  - 1/13/2018
  - 1/15/2018
  - 1/17/2018
- **Notes:** Referral only after 3 visits, then unknown follow up with patient.

**Case 3**
- **Better Breathers**
- **Siena**
- **Patient Visit Dates:**
  - 9/6/2017
  - 10/26/2017
  - 11/15/2017
  - 11/27/2017
  - 11/28/2017
  - 12/17/2017
  - 3/12/2018
  - 6/4/2018
  - 6/6/2018
  - 6/11/2018
  - 7/5/2018
- **Notes:** 8 visits before referral was made with an average of 39 days between each visit. After referral, no additional visits.

### Dual Enrollments

**Case 4**
- **NV Health Link & SNAP**
- **Rose de Lima**
- **Patient Visit Dates:**
  - 3/13/2018
  - 3/14/2018
  - 3/15/2018
  - 3/16/2018
  - 3/18/2018
  - 3/22/2018
  - 3/23/2018
  - 3/27/2018
  - 3/28/2018
  - 6/9/2018
- **Notes:** Patient had 2 weeks between referral and program enrollment, during which they had 4 visits. After enrollment, only 1 visit in 73 days.

**Case 5**
- **NV Health Link & Stanford Diabetes**
- **Rose de Lima**
- **Patient Visit Dates:**
  - 7/26/2017
  - 7/30/2017
  - 8/16/2017
  - 3/22/2018
  - 4/14/2018
  - 4/17/2018
  - 4/19/2018
  - 4/20/2018
  - 4/23/2018
- **Notes:** Patient had 5 visits before dual referral was made. After referral, no visits occurred. Patient may have benefited from earlier intervention.

**Case 6**
- **Better Breathers & Stanford Diabetes**
- **San Martin**
- **Patient Visit Dates:**
  - 4/25/2018
  - 4/30/2018
  - 5/2/2018
  - 5/3/2018
- **Notes:** Fast referral process and good contact information allowed for rapid enrollment of patient in program, no return visit after enrollment.

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Whether early or late intervention, the positive impact on decreasing repeat visits remains.

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Data Source: nH Reports & Cerner / Logic: Days between Admits before and after NaviHealth
EVOLUTION OF THE CCN

- Partnership: United Way Worldwide / 2-1-1
- Technology: Sophisticated outcomes-based digital solution
- Sustainability: Multi-payer funding model
- Community Building: Strengthening existing infrastructure
- Payment innovation
- Outcomes evaluation
COMMUNITY PARTNERS
Thank you.

Ji.Im@dignityhealth.org
Hong Truong
Innovation Fund
California
Health Care Foundation

April 25, 2019
The California Health Care Foundation is dedicated to **advancing meaningful, measurable improvements** in the way the health care delivery system provides care to the people of California, particularly those with **low incomes and those whose needs are not well served by the status quo**. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.
Data Exchange

Structures for data exchange are especially important for safety-net providers because patients tend to:

- **Receive care and services from FQHCs and small physician practices** that do not use the major EHR vendors with built-in data-sharing capabilities
- **Be more itinerant in seeking/receiving care**, creating enhanced need for regional data sharing with broad-based provider participation
- **Have more frequent ED visits**, creating a greater need for providers and payers to be promptly notified of ED admissions, share clinical details of ED encounters, and have access to longitudinal patient data at the point of contact
- **Have more mental health and substance abuse treatment needs**, creating a need to include specialized MH and SA providers among the integrated participants
- **Need more coordination with non-medical social services**, which most health systems and EHRs do not have integrated into systems
Grants

- **Delivery system interventions (HIOs):** $90M of HITECH funding is available to onboard EMS, hospitals, and ambulatory providers onto health information exchange organizations (HIOs) in California. CHCF is supporting DHCS in the application and planning for the disbursement of these grants.

- **Payment/Financing:** States that have strong data exchange have used policy mandates and group purchasing structures to incentivize participation, lower costs and coordinate data exchange efforts across the state. CHCF has commissioned research to learn other states’ experiences and identify what policy levers, if any, are viable in California.

- **Evaluation and learning:** CHCF has commissioned a series of papers to inform policy makers, care delivery system partners about HIOs, lessons learned from WPC, EHR transitions.

- **Data:** California lacks transparency and a common language around what we mean by meaningful data exchange. CHCF is working with UCSF to develop a common set of metrics for HIOs to measure and report their activities.
Program Related Investments

- CHCF can accelerate adoption and spread of innovations that improve access to care by offering mission-aligned, for-profit companies favorable investment terms to enter and serve safety-net markets.

- Companies (vs. grantees) are well positioned for broad impact because they are naturally organized to scale and tap incremental sources of talent and capital.

- Impact investments can be capital-efficient relative to grants because investees are positioned (and contractually obligated) to return CHCF’s money, creating more opportunity for further mission investment.

- Grant funding for evaluation of these solutions supports broad access to lessons learned.
Read more about our work in data exchange on our website:
https://www.chcf.org/topic/data-exchange/

Catalyzing Coordination: Technology’s role in California’s Whole Person Care Pilots
https://www.chcf.org/publication/catalyzing-coordination-technologys-whole-person-care/

Promise and Pitfalls: A look at California’s Health Information Exchange Organizations
https://www.chcf.org/publication/promise-pitfalls-californias-regional-health-information-organizations/

Thank you!

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htruong@chcf.org
Investors Speak! Healthcare System Innovators Discuss Early Investments and Harnessing the Power of Data Exchange

Wednesday, April 24, 2019
OPENING REMARKS

ELIZABETH DREICER
Interim Executive Director
Alliance Healthcare Foundation
ALLIANCE HEALTHCARE FOUNDATION
ADVANCING HEALTH AND WELLNESS FOR THOSE IN NEED
OUR HISTORY

The San Diego Community Healthcare Alliance (Alliance) created the first Preferred Provider Organization / Network (PPO) in the United States.

The Alliance funded Alliance Healthcare Foundation (AHF) through profits from its Community Care Network (CCN) operations.

Alliance sold CCN to Value Health, Inc. a national healthcare company, and channeled the proceeds from CCN’s sale into an endowment of $83M.

Our endowment holds approximately $80 million in assets today, with funding for programs and operations derived from endowment investment earnings enabling ~$64M in direct funding + leveraging ~$41M from national and local funding partners.
OUR EVOLUTION...
FROM HEALTHCARE TO WELLNESS
Wellness

is a state of complete physical, mental, spiritual, economic and social well-being and not merely the absence of disease or infirmity. Society, community, neighborhood, and family are collectively responsible for creating an environment of health and wellness. Wellness is personal and is not the same for everyone. Individuals need information and support to make positive choices for a more successful existence.
Wellness is a state of complete physical, mental, spiritual, economic and social well-being and not merely the absence of disease or infirmity.

Society, community, neighborhood, and family are collectively responsible for creating an environment of health and wellness.

Wellness is personal and is not the same for everyone. Individuals need information and support to make positive choices for a more successful existence.
DESIGN CHALLENGE

DO THE MOST GOOD FOR THE MOST PEOPLE
Innovation is needed as we cannot spend more.

Coordination is better in that it can unlock better quality, more access and lower cost.

Trust individuals + those closest to needs.
HOW

ADVOCACY

FUNDING

CONVENING
## 5 FUNDING PROGRAMS

<table>
<thead>
<tr>
<th></th>
<th>Program</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>i2 INNOVATION INITIATIVE</td>
<td>~$1M annually</td>
</tr>
<tr>
<td>2</td>
<td>MISSION SUPPORT</td>
<td>~$1M annually</td>
</tr>
<tr>
<td>3</td>
<td>RESPONSIVE</td>
<td>~250k annually</td>
</tr>
<tr>
<td>4</td>
<td>INVEST UP</td>
<td>No set amount; could be entire portfolio</td>
</tr>
<tr>
<td>5</td>
<td>PROGRAM RELATED INVESTMENTS</td>
<td>10% (~8M total)</td>
</tr>
</tbody>
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HISTORICAL PERFORMANCE

- Asset Value
- Cumulative Total Payout
- Cumulative Funding

- $109 M
- $77 M
- $64 M

ALLIANCE HEALTHCARE FOUNDATION
ADVANCING HEALTH AND WELLNESS FOR THOSE IN NEED
INNOVATION INITIATIVE
PORTFOLIO
INVEST UP
PORTFOLIO
WELLNESS IMPERIAL COUNTY
Valley Wellness Foundation
Started 2018
$7.8M Challenge

WELLNESS SAN DIEGO
San Diego Healthcare Collaborative
Started 2017
~$500K

2-1-1 SAN DIEGO
Community Information Exchange
2011 – Current
$4.5M+
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