IHA 2020 Stakeholders Meeting will begin at 9:00 AM PST

Integrated Healthcare Association

Stakeholders 2020: Building Resilience Together

Integrated Healthcare ASSOCIATION

Welcome

Jeff Rideout, MD

President & Chief Executive Officer, IHA

Integrated Healthcare Association

Let's drive the

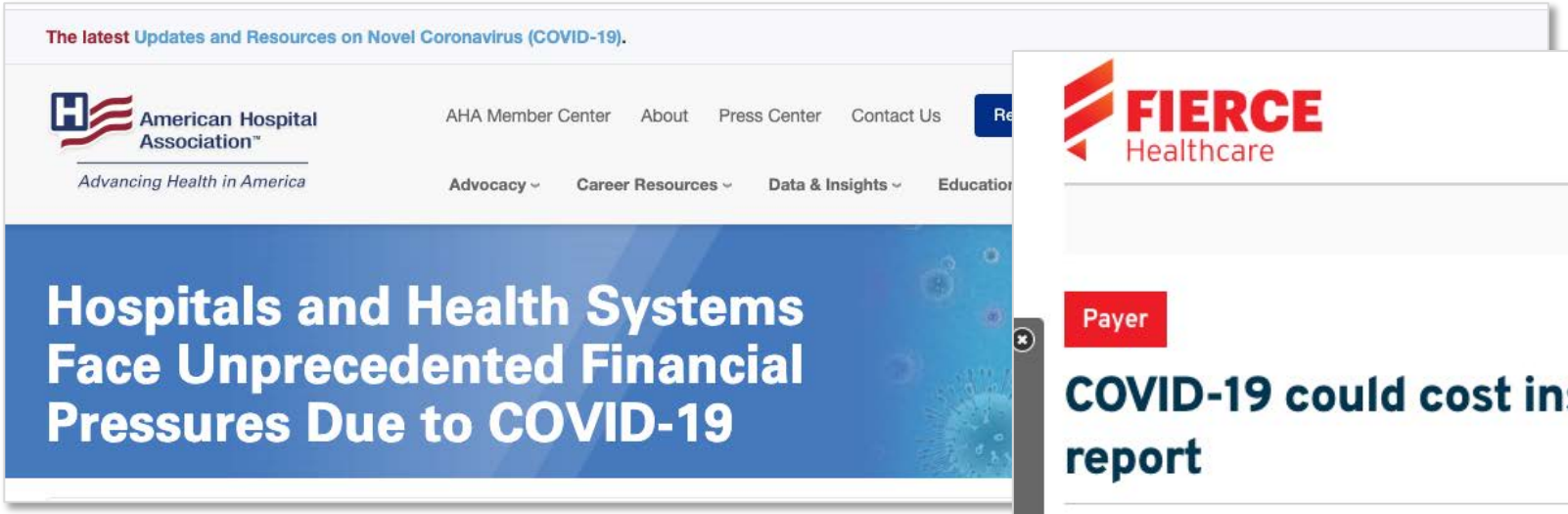
NEXT 25

2019 IHA STAKEHOLDERS CONFERENCE

We've been through a lot in 2020

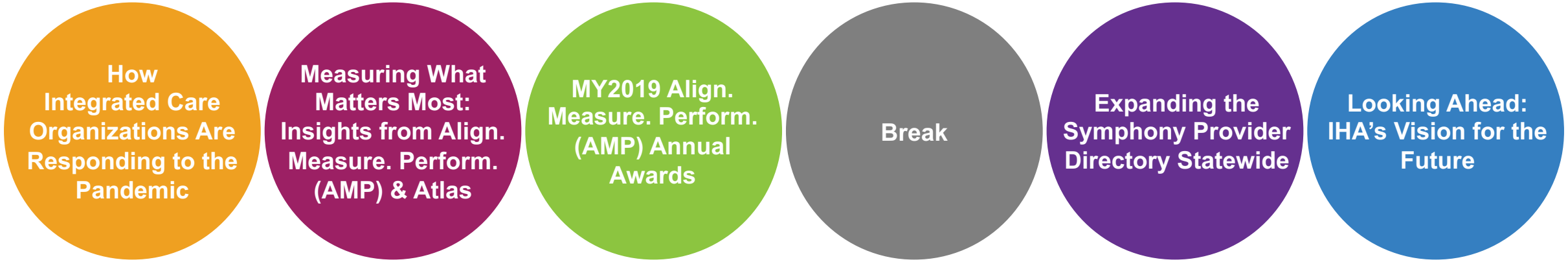
IHA

COVID-19 has impacted you meaningfully



IHA

Today's agenda — demonstrating resilience as a community



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Integrated Healthcare ASSOCIATION

How integrated care organizations are responding to the pandemic

Jeff Rideout, MD
Jamie Robinson, PhD, MPH
Martha Santana-Chin, MBA
Elizabeth Vilardo, MD, MBA

Welcome, panelists!

Jamie Robinson, PhD, MPH

Leonard D. Schaeffer Professor of Health Economics and Director, Berkeley Center for Health Technology

University of California at Berkeley

Elizabeth Vilardo, MD, MBA

Chief Executive Officer

Palo Alto Medical Foundation

Martha Santana, MBA

Government Programs Officer

Health Net

Berkeley School of Public Health

BCHT
BERKELEY CENTER FOR HEALTH TECHNOLOGY

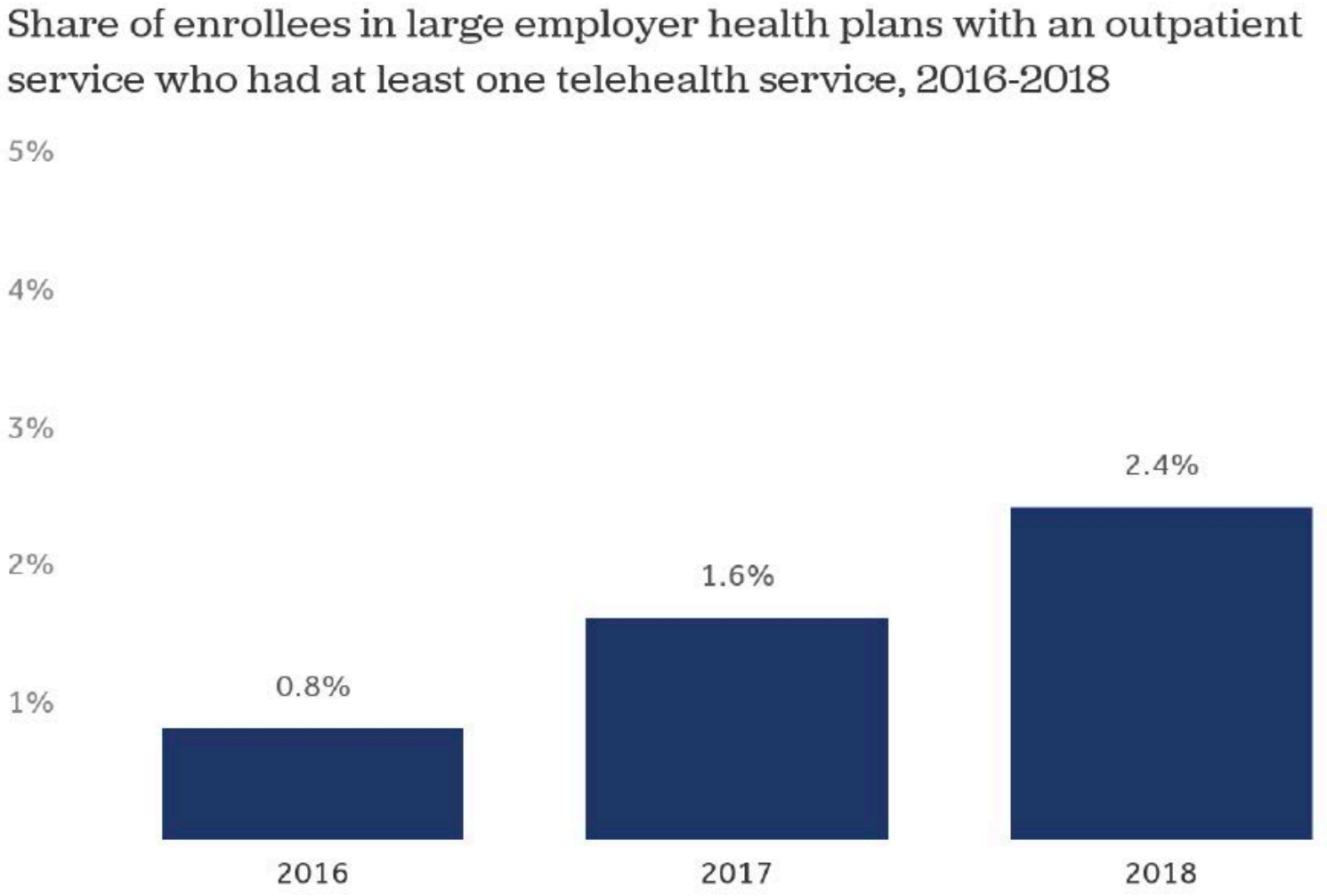
Accelerating Adoption of Virtual Care in the COVID-19 Era

James C. Robinson
Leonard D. Schaeffer Professor of Health Economics
University of California

Prior to the COVID Pandemic, Most Patients and Providers Had Used Few Virtual Services

Telemedicine was outsourced to independent entities not linked to the patient's usual caregivers

Most were not supported by, and did not contribute to, the patient's EMR



Source: KFF analysis of IBM MarketScan Commercial Claims and Encounters Database, 2016-2018.

When the pandemic hit, patient demand surged, insurers suddenly were willing to reimburse, but many providers lacked the capacity and range of modalities to respond effectively

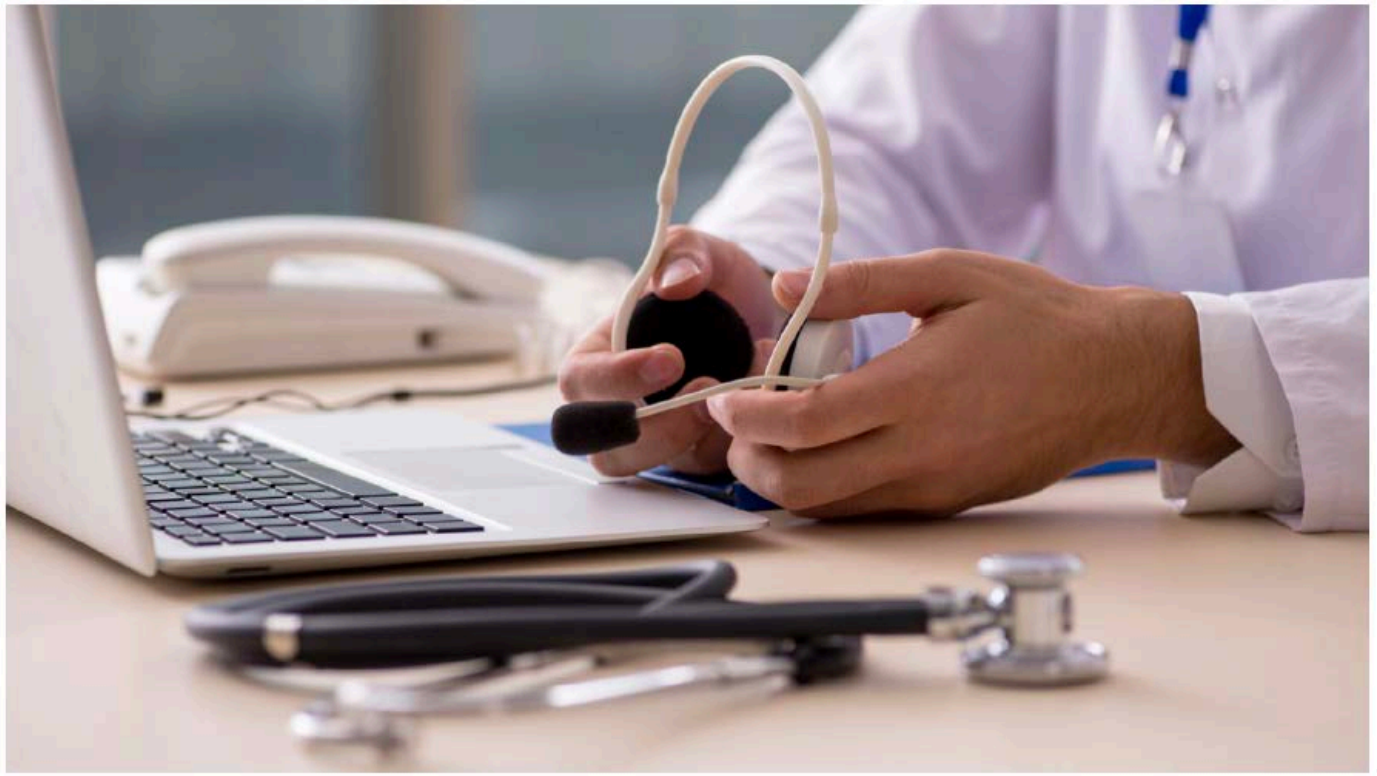
STAT[1]

Surge in patients overwhelms telehealth services amid coronavirus pandemic

By Erin Brodwin[2] @erbrod[3] *and* Casey Ross[4] @caseymross[5]

March 17, 2020

Reprints[6]



In contrast, as an integrated provider, Kaiser Permanente was able to adapt quickly to the shift towards virtual care when the pandemic hit

COMMENTARY

The Covid-19 Pandemic Accelerates the Transition to Virtual Care

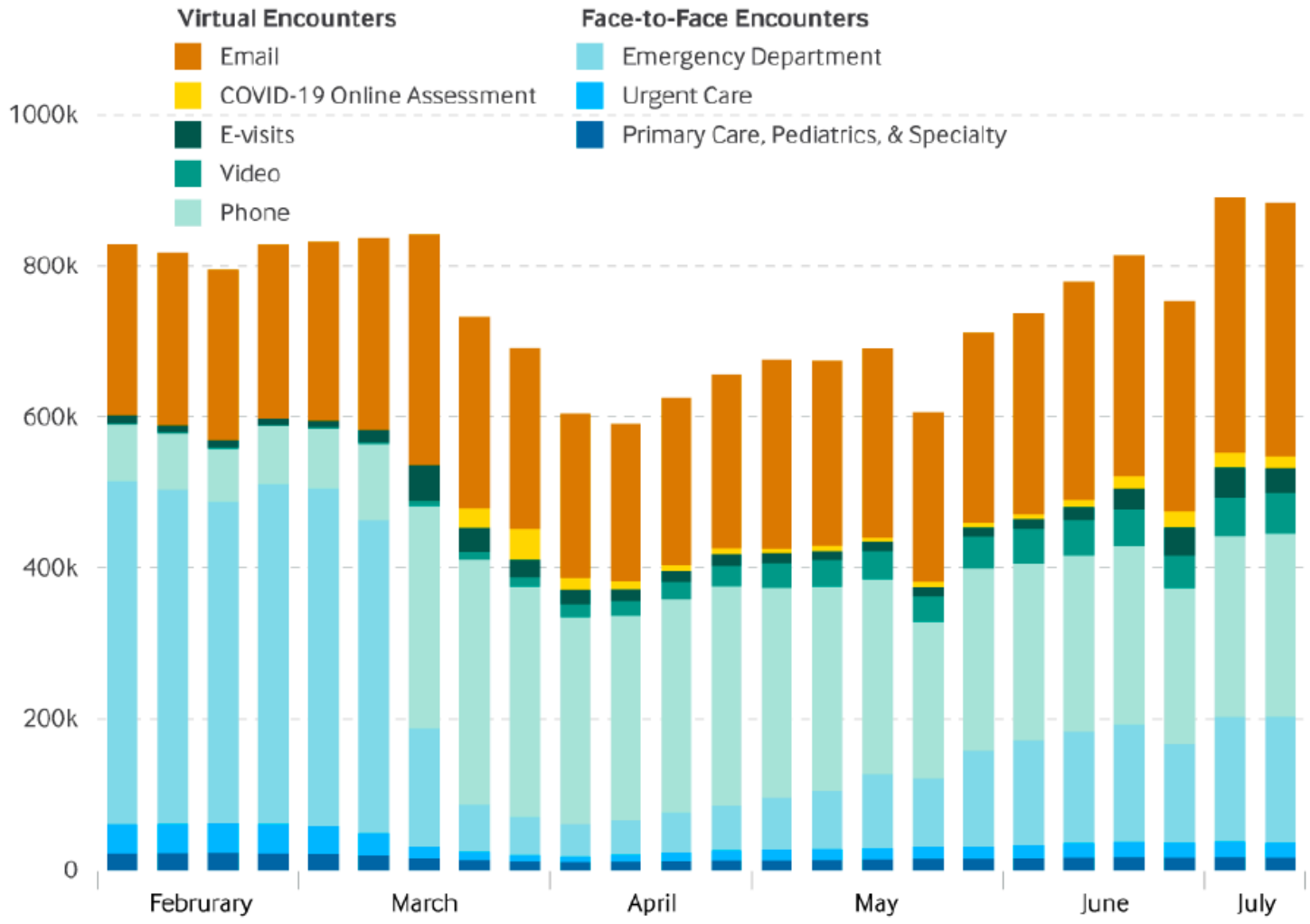
James Robinson, PhD, Lina Borgo, MPH, Kevin Fennell, MBA, Tadashi T. Funahashi, MD

Vol. No. | September 10, 2020
DOI: 10.1056/CAT.20.0399

Virtual Visits Replaced Face-to-Face Care, Sustained Overall Patient Access (to COVID and non-COVID care)

Virtual care visits increased from 38% of all ambulatory care visits in February to 77% in June and July

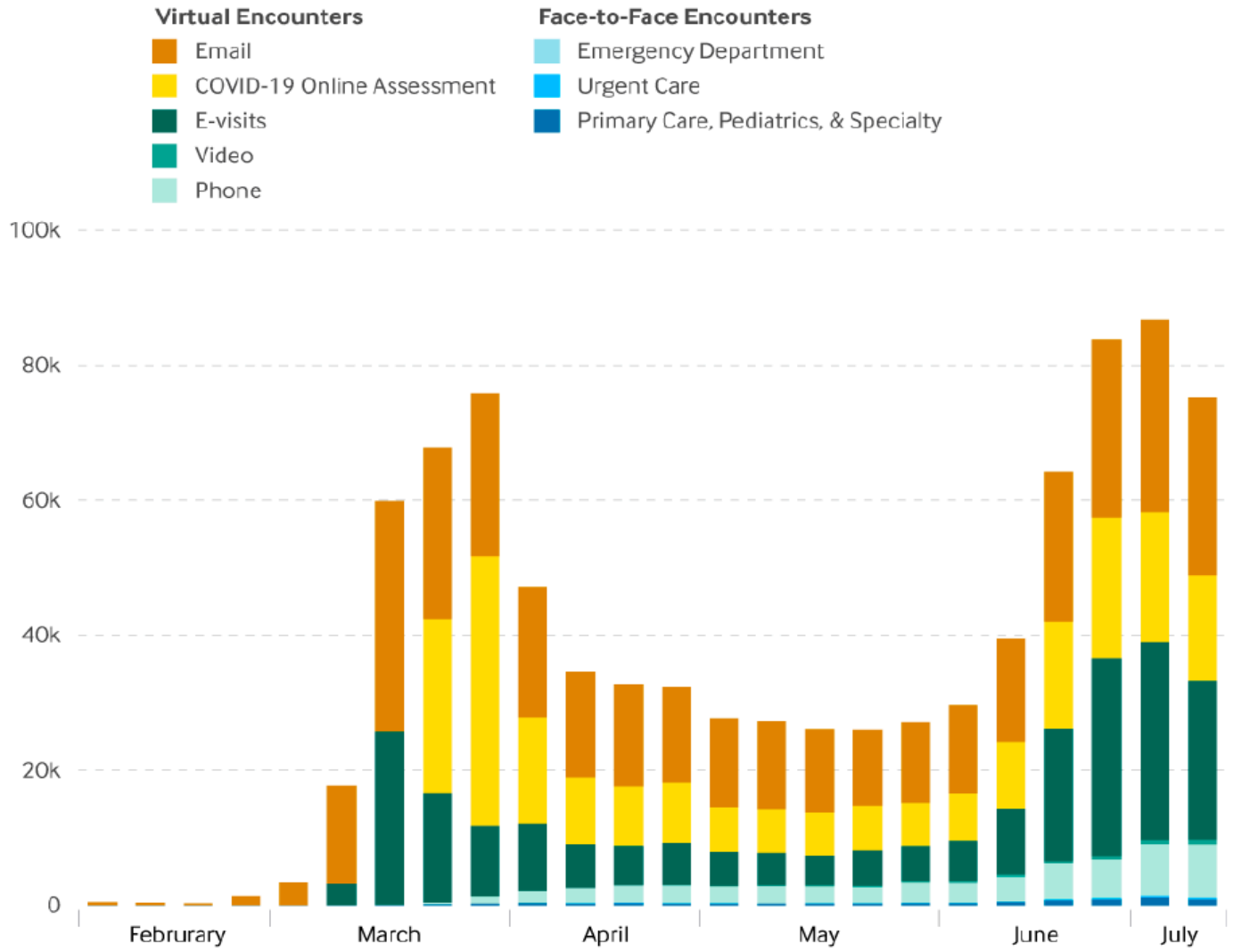
The most heavily used are phone and secure email (many concerning COVID testing)



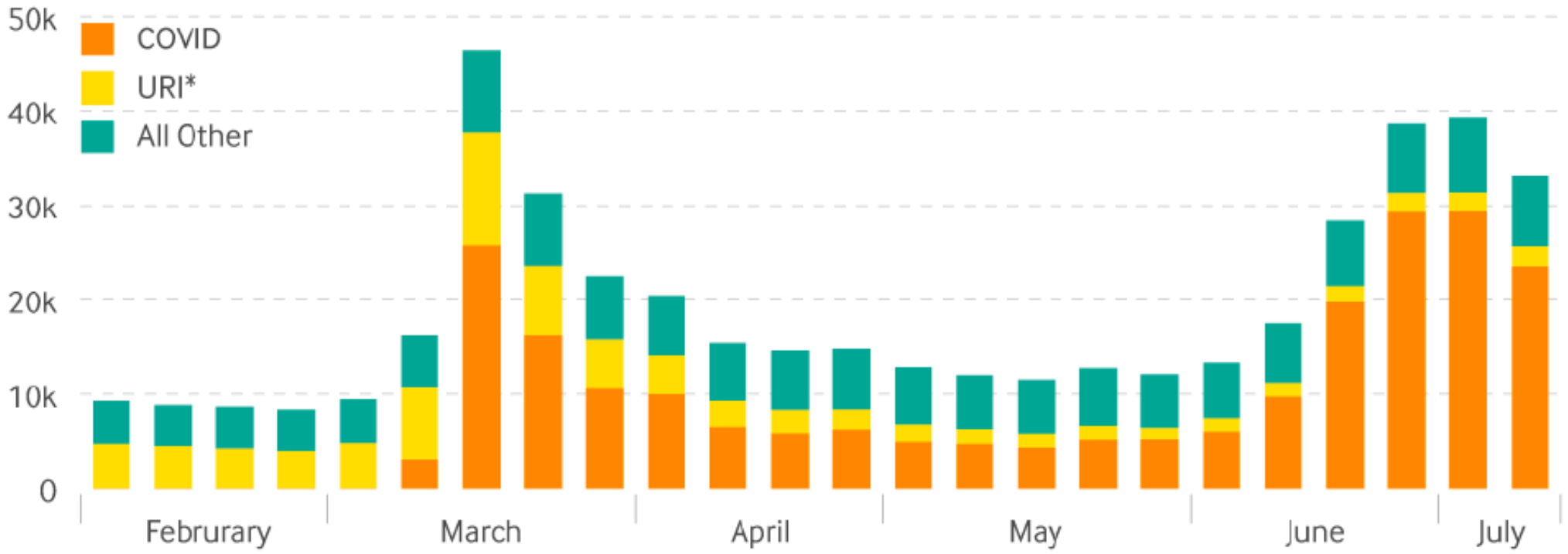
COVID-Related Ambulatory Visits

From the week of February 2 through the week of July 12, 99% of encounters for COVID-19 infections have been handled virtually

E-visits have increased strongly (and are preferred modality from the medical group perspective)



E-Visit Volume by Reason: COVID, Other Upper Respiratory Infection (URI), and All Other



Take-Away #1: Other Forms of Provider Organization Can and Should Invest in Virtual Care

- Kaiser Permanente is unique, but its lessons apply to others
- California is blessed with numerous organizations that can benefit enormously if they do not miss the opportunity and imperative of virtual care
  - Integrated health systems that combine hospitals, multispecialty medical groups, and independent caregivers
  - Delivery organizations based on safety net hospitals and/or county Medicaid managed care plans
  - Physician organizations, with both clinic and IPA components, that partner with multiple hospital facilities rather than being jointly owned
  - Health plans that own or invest in physician practices
- The fundamental take-away is that virtual care needs to be coordinated care

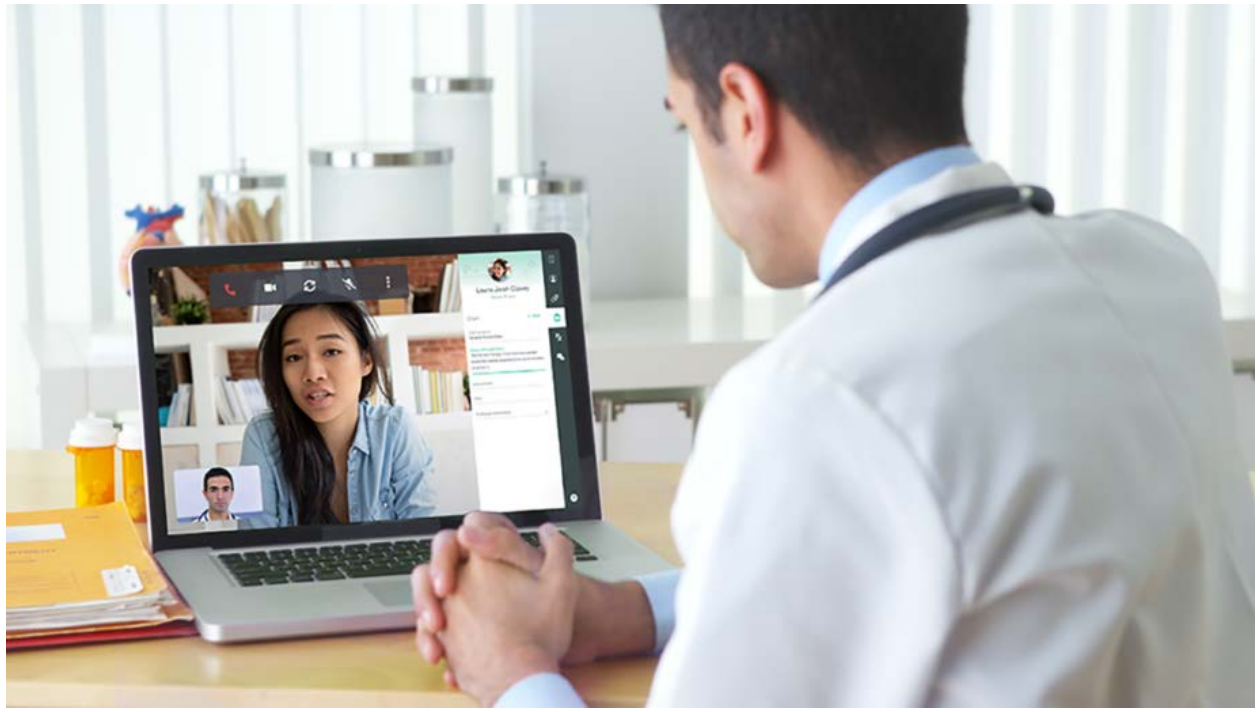
Take-Away #2: Virtual Care Should be Coordinated Care

- Virtual care requires sustained investment and commitment by the delivery system. Partnering with technology firms can be very valuable, but full outsourcing of virtual care to third party vendors leads to fragmentation
- Virtual care should be coordinated and (ideally) conducted by the patient's usual provider organization (not by anonymous clinicians in distant locales)
- Multiple modalities should be available: phone, video, secure email, e-visit
- More complex care increasingly can expand into virtual modalities: remote monitoring, cardiac rehab, musculoskeletal

Take-Away #3: Virtual Care Should be Connected to, and Supported by, the Patient's EMR

Virtual visits should be informed by information in the patient's EMR, and what happens in the virtual care visit should be entered into the EMR

Like all care, virtual care benefits from clinical guidelines and decision-support algorithms that take into consideration the patient's specific condition and health history

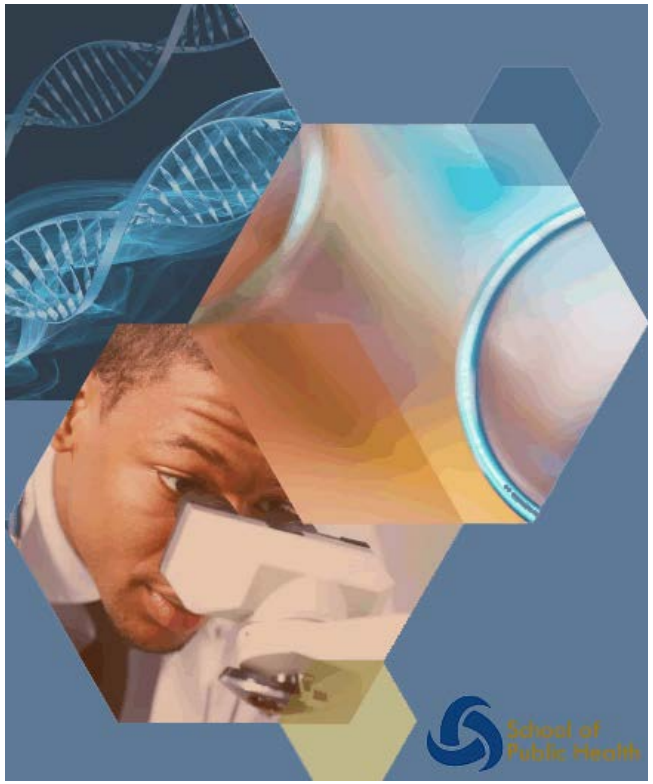


Thank you

The Berkeley Center for Health Technology (BCHT) promotes the efficiency and effectiveness of health care through research and education on the development, insurance coverage, payment, and appropriate use of medical technologies.

BCHT.Berkeley.Edu

BCHT
BERKELEY CENTER
FOR HEALTH TECHNOLOGY



Care in the time of Corona

Elizabeth Vilardo MD MBA President and CEO Sutter Bay Medical Foundation

WE DELIVER HEALTHCARE THAT IS...

Zero Harm

Zero harm for our patients and workforce

Patient Experience

Providing **exceptional experiences** to the people we serve

Total Cost of Care

Delivering value for our patients and communities

Lives Touched

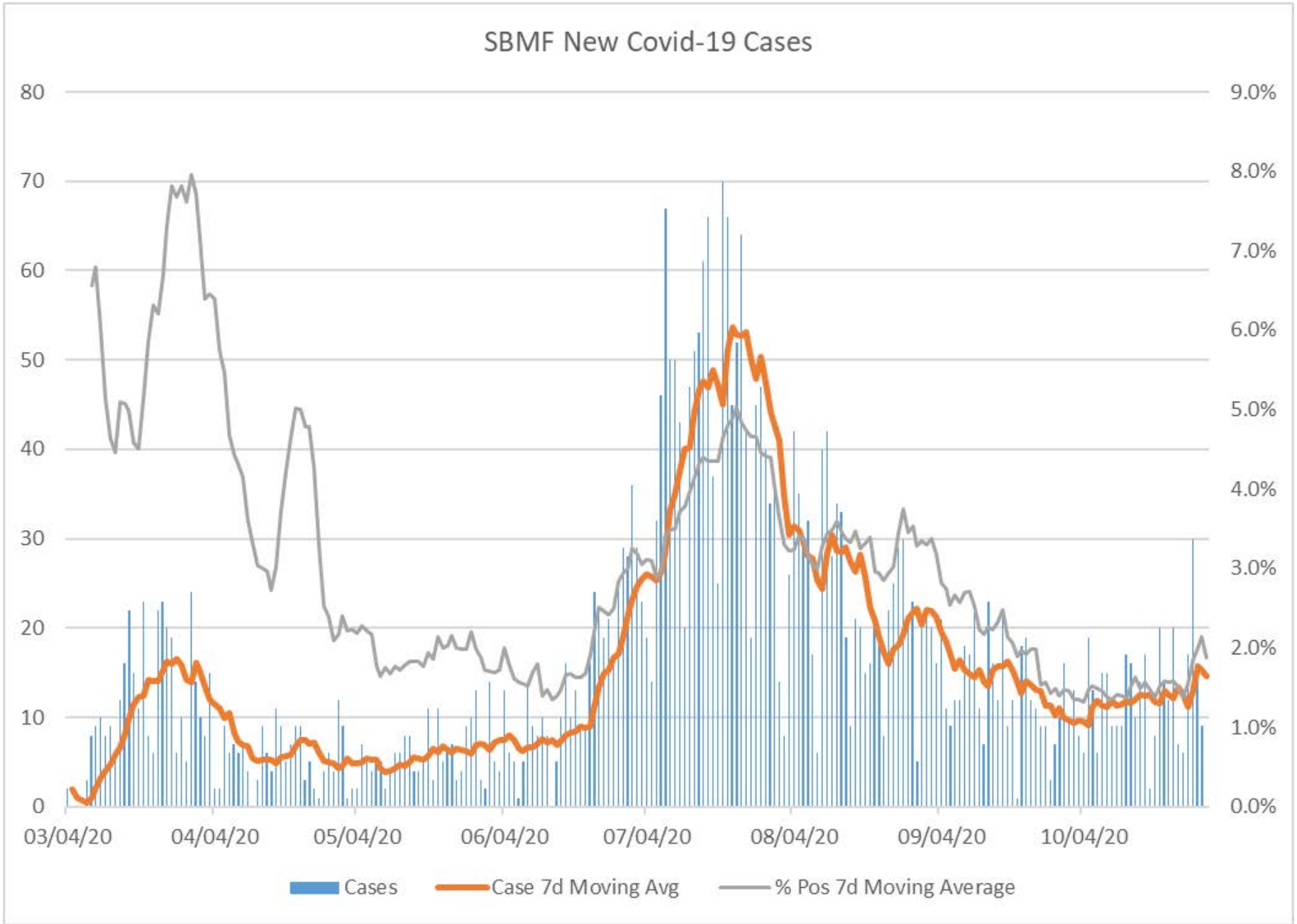
Intuitive and **human-centered**

Sutter Health Key Results

- Nearly 55,000 employees
- 5,000 physicians
- 250+ Medical Office Buildings
- 24 hospitals
- 37 Surgery centers
- Home health & hospice, and long-term care services
- Health care research, development and dissemination program
- Medical education/training
- 24 philanthropic organizations
- Epic EHR since 1990s in Bay

1/27/20 First Case in northern California- Los Gatos UCC

- Immediate activation of System wide SHEMS (Sutter Health Emergency Management system)
- Immediate implementation of screening questions, and quarantine of staff who had traveled
- Epic tools for Corona management implemented also implantation of supply pooling to ensure adequate PPE (2/3/20)
- Established 19 Outdoor drive-up respiratory clinics in tents and parking lots- all febrile patients were segregated to, evaluated in and treated in these sites clinics have lab, and x-ray capability. (3/1/20)
- Nurse and AI triage used to manage concerned or symptomatic patients.
- Daily metrics included febrile visits, respiratory clinic visits, PPE, supplies.

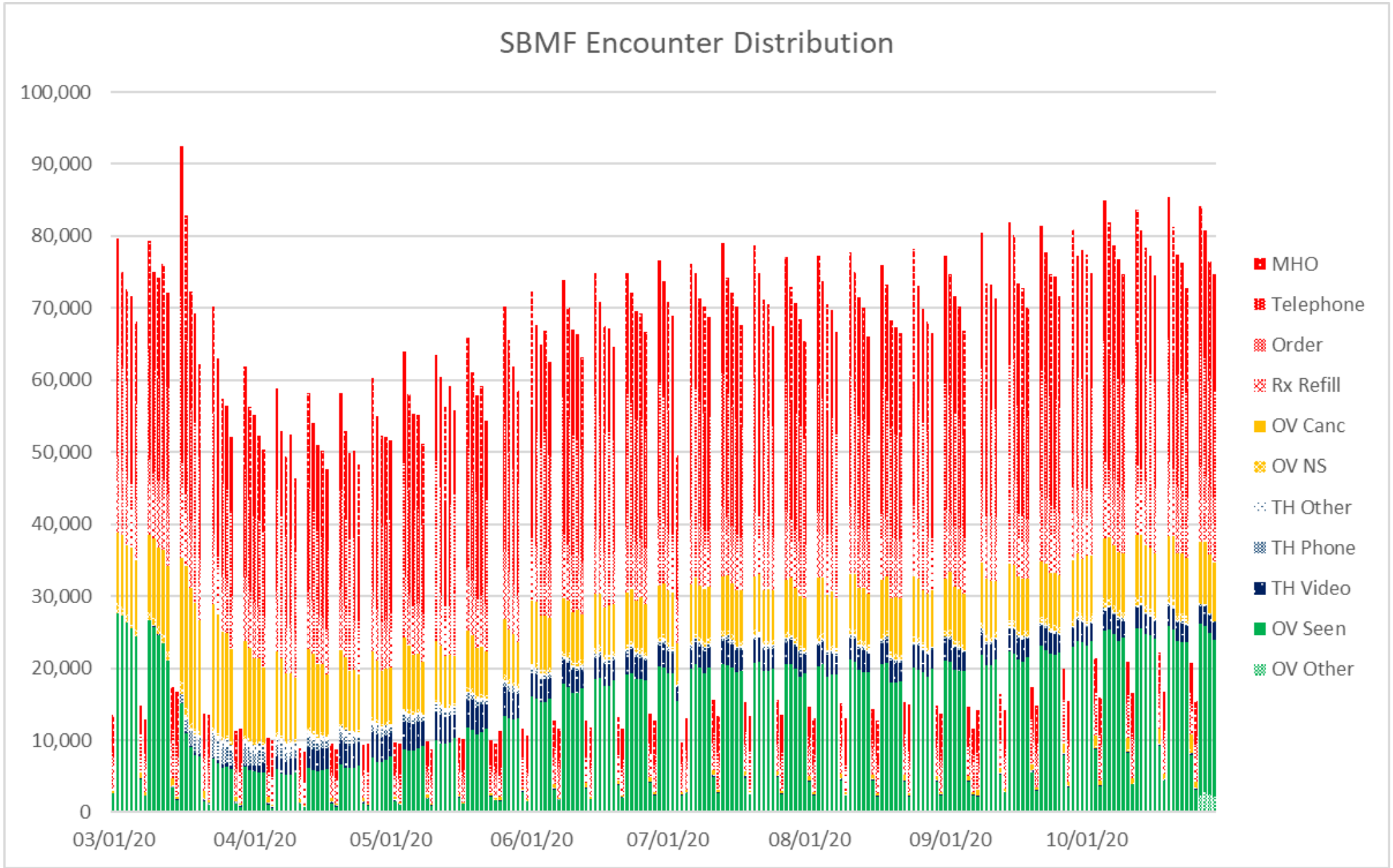

SBMF New Covid-19 Cases
80
70
60
50
40
30
20
10
0
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
03/04/20
04/04/20
05/04/20
06/04/20
07/04/20
08/04/20
09/04/20
10/04/20
Cases
Case 7d Moving Avg
% Pos 7d Moving Average

De-escalation

- March 14 in response to PPE supply uncertainty a decision was made to cease all non-urgent in person patient care. Until PPE supplies enabled and hospital capacity increased.
- Video visits rolled out over entire footprint. Providers trained in Canto (EPIC Telehealth Platform) and over 5000 cellular enabled iPads distributed to providers over 10 days.
- Jan- Feb Average weekly in-person visits 145K Tele visits 0

  March 15 56K in-person visits 0 Tele

  April 54k in-person 25K Tele
- Hospital side ICU capacity doubled including deploying additional e-ICU beds.


SBMF Encounter Distribution
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
03/01/20
04/01/20
05/01/20
06/01/20
07/01/20
08/01/20
09/01/20
10/01/20
MHO
Telephone
Order
Rx Refill
OV Canc
OV NS
TH Other
TH Phone
TH Video
OV Seen
OV Other

Clinician Voice:

"**Telemedicine is perhaps is the only silver lining** of this horrible pandemic. **It is transformative** — I don't think we'll ever go back – medicine BC (before coronavirus).... Over the next few weeks, each and every day will be shaping the way we practice medicine AC (after coronavirus). " ~ Aarti Srinivasan, M.D., internal medicine, PAFMG

Patient Voice:

"Because of the Covid-19 virus we did an online consultation. **The setup was simple** (I am 76) and the person working with me considerate and helpful. The call was on time and went better than I anticipated. I actually liked it and **hope we can make use of it in the future.** I did not have to drive 40 minutes and use gas etc. Good for me and good for the environment. Old dogs can learn new tricks. **Thank you for taking care** of all of us. Judy"

~ Patient, Auburn

Helping to Ensure Ongoing Access & Quality Care

The resiliency of Sutter Health's integrated system allows us to tap into and expand existing investments in key programs to respond to evolving patient needs throughout the pandemic – beyond the initial surge.

Driving Leadership on Core Issues

Addressing Health Equity

Sutter's Health Equity team conducted equity analyses early in the pandemic, revealing **Black COVID-19 patients are 2.7x more likely to be hospitalized**—in response Sutter Health's integrated network is driving outreach and education in at-risk communities.

Serving the Underserved

Sutter Health coordinated with the Governor's Office of Emergency Services to safely move and care for COVID-19 farm workers and prisoners from California's impacted Imperial Valley and San Quentin State Prison.

Developing Testing Solutions

Sutter Health's laboratory services team developed its own in-house testing and continues to gradually increase capacity while managing through national shortages in testing supplies.

Partnering in Crucial Research

Sutter Health partnered with public and private organizations, including Gilead Sciences and the Mayo Clinic, to participate in clinical trials testing new, investigational treatments for COVID-19.

Implementing a Phased Recovery

Protecting Sutter's Community & Visitors

Recognizing that some in-person care cannot and should not wait, we worked to adapt Sutter's protocols and facilities:

- Physical distancing
- Contactless patient check-in apps
- Limiting visitors
- Universal masking
- Symptom checks
- Remote work policies

Scaling Telehealth for the Long Term

Video visits became a crucial tool during shelter-in-place, providing convenient, accessible and seamless care—especially for patients who are hard to reach.

Telehealth Stats

- 5,000 clinicians trained
- 650,000+ video visits as of August 31
- High Patient Satisfaction

Getting Patients Home Faster

As the pandemic continues, Sutter Health is using the full breadth of our integrated network to develop targeted solutions. This work has helped reduce the length of stay for COVID patients from **an average of 20 days** at the start of the pandemic to just **8 days** today, and helped minimize the need for ventilator use in COVID-positive patients by utilizing other therapies.

While our work continues, this progress illustrates how our integrated network is delivering high-quality care that gets patients home faster – improving health outcomes and saving costs.

Sutter Health

COVID-19 RESPONSE:
RESILIENT INTEGRATED NETWORK PROTECTS PATIENTS, EMPLOYEES & COMMUNITY

This Pandemic has been devastating, and wonderful.
The pandemic has also brought attention to societal injustice and unconscionable gaps in public health. It has also launched us into the virtual care future.

We will be judged by our on going response to these challenges and opportunities.

Health Net of California

Health Net

1977
Year founded

6,900+
Employees in California

3 million
Californians covered
Individuals | Families | Medi-cal | Medicare | Business

85,000
Providers

ACCREDITED NCQA HEALTH PLAN

NCQA MULTICULTURAL HEALTH CARE DISTINCTION
Only national plan to achieve NCQA MHC distinction for all products

Pandemic Response

Members

Access to care
- Virtual care
- Digital Health Tools
- Physical Health & Mental Health

$500,000
Cell Phones + Minutes

Outreach and Community
- Education
- CBO COVID Response Programs

$325,000
Economic Recovery, Aging, Domestic Violence

Food Insecurity
- Feeding America – CalFresh

$120,000
5 Food banks

Providers

Enablement
- Maintain Provider Relationships
- Rural, Urban Underserved
- Technical Assistance
- Infrastructure (laptops, internet connectivity, etc)

$13.8 M
138 Grantees

Stabilize and Support
- Capitation
- Accelerate Incentives
- PPE – Independents, Nursing facilities

450,000
Units of PPE

Communication
- Capacity Monitoring and Coordination

Building on our Response

Enrollment Shifts
- Medi-Cal Roles
  - 3% - 5% increase, mostly from suspension of Re-determination
  - Managing adjustments post public health emergency
- Covered CA Growth
- Employer Sponsored Stability, at least initially

Removing Barriers
- Covered member cost shares for COVID screening, testing, treatment and telehealth
- Waived prior authorizations for screening, testing and treatment
- Extended open authorizations
- Refills and extended day supplies
- Extended timely filing for claims

Future State: Telehealth
- Reducing total cost of care
- Improving quality
- Measuring member and provider satisfaction
- Bridging disparities, recognizing the digital divide

Future State: Other Considerations
- Work force enablement
- Emergency Response Playbook
- Cross Sector Collaborations

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Questions & Answers

Matching market trends with performance assessment

2003
First AMP **quality measurement**

2009
Resource use measures added

2011
AMP **Medicare Advantage** launches

2012
Total Cost of Care added

2013
Atlas shows geographic variation by payer and product

2017
AMP **Medi-Cal** and **Commercial ACO** expansions

2019
Encounter data reports for Commercial and MA

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Thank you

Building Resilience Together

IHA 2020 Stakeholders Virtual Meeting

November 5, 2020

Measuring what matters most: insights from AMP and Atlas

Integrated Healthcare Association

Measurement Year 2019 Insights

Angela Czesnakowicz, MPH

Director of Data Operations, IHA

AMP is growing! ~1M lives added in Measurement Year (MY) 2019

Align. Measure. Perform.

Performance measurement by **physician organization**

13.1 Million Californians

- AMP Commercial HMO **9.7M lives**
- AMP Commercial ACO **1.1M lives**
- AMP Medicare Advantage **1.9M lives**
- AMP Medi-Cal Managed Care **330K lives**

Atlas

~ 30 million lives

75% of California's population

Thank you MY 2019 AMP program participants!

COMMON MEASUREMENT LED BY

200+
Medical Groups & IPAs, ACOs & FQHCs

14 Health Plans

aetna™ · Anthem BlueCross · blue california · blue california Promise Health Plan · Cigna · Health Net · KAISER PERMANENTE · L.A. Care HEALTH PLAN · oscar · scan HEALTH PLAN · SHARP · Sutter Health Plus Your Health Plan · UnitedHealthcare · Western Health Advantage

Integrated Healthcare Association · TransUnion · PBGH Pacific Business Group on Health · NCQA Measuring quality. Improving health care. · ONPOINT Health Data · OPA Office of the Patient Advocate

3 Purchasers

CalPERS · Covered California · University of California

IMPACTING

13.1 Million Californians

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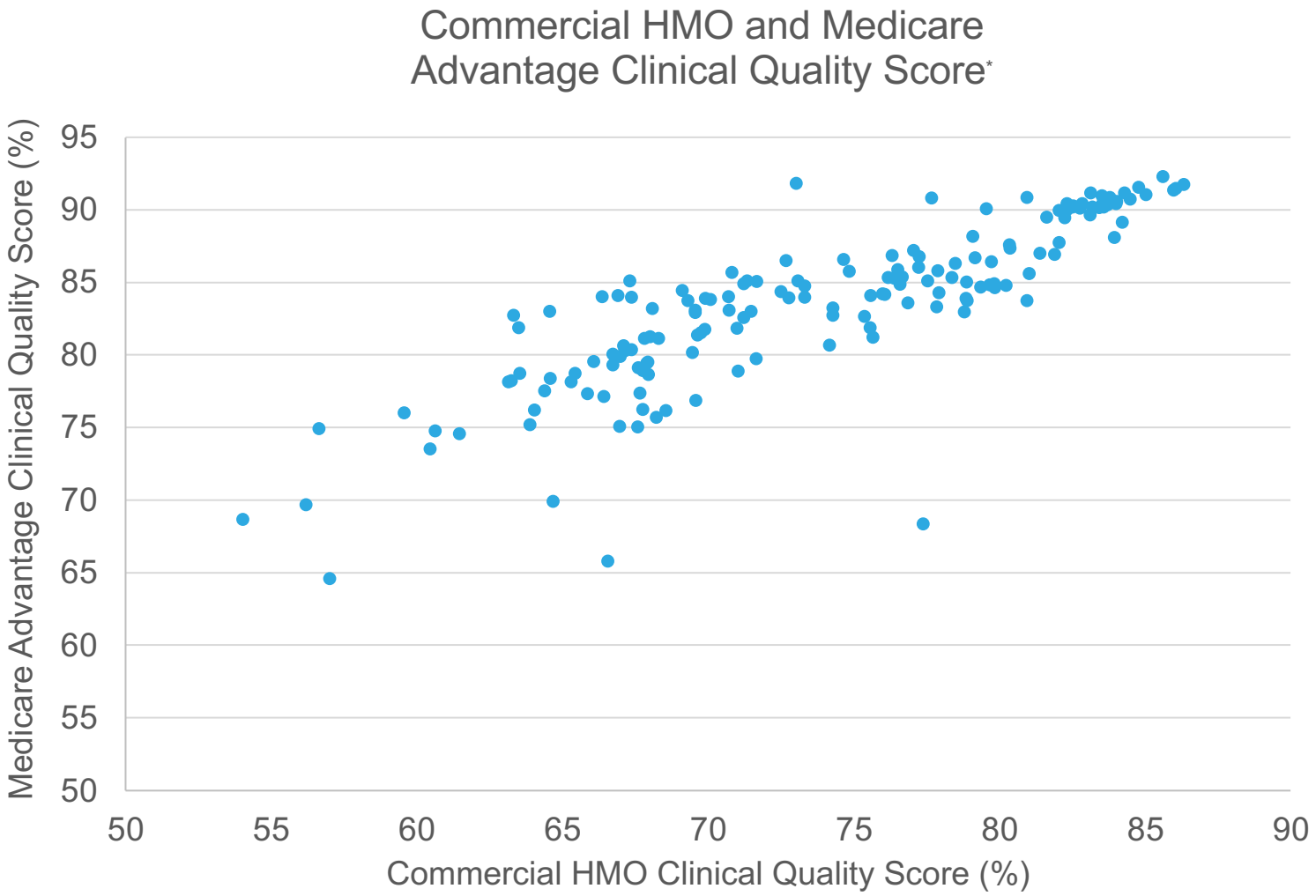
Results Highlights

High performing POs tend to perform similarly across products



- PO performance for Commercial HMO and Medicare Advantage is correlated
- Pattern persists with Commercial HMO and ACO; Commercial HMO and Medi-Cal Managed Care

*MY 2019 Quality Achievement Score Across 13 Clinical Quality Measures

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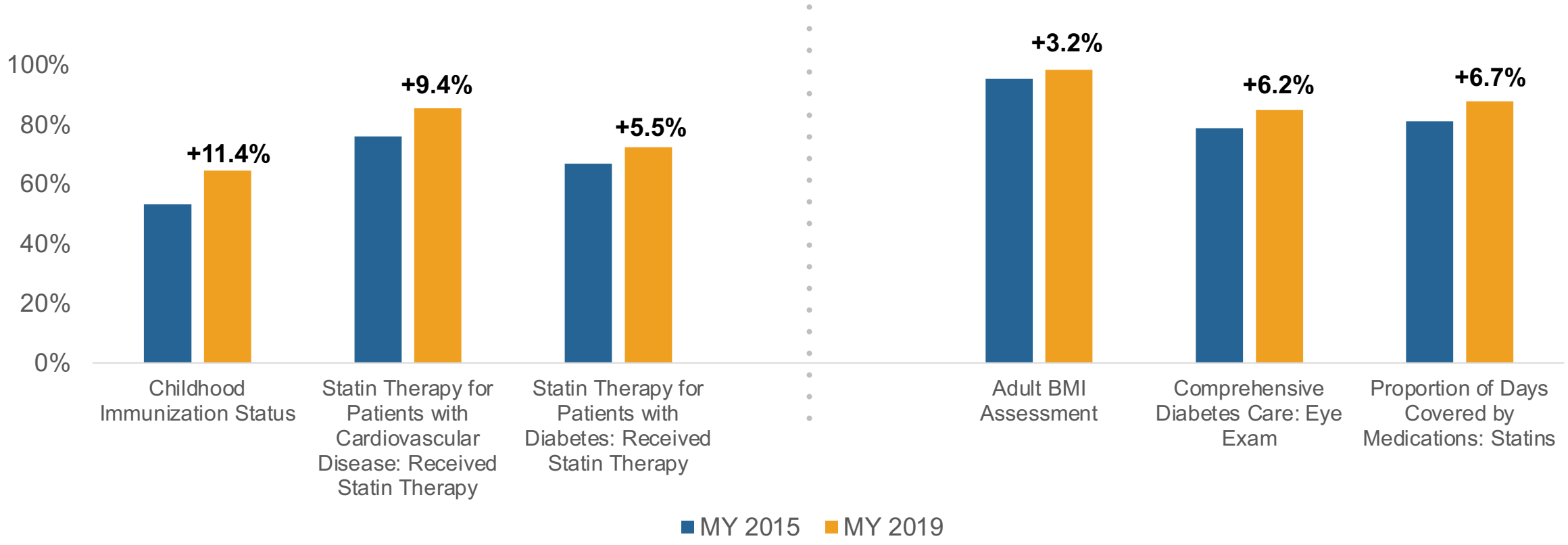
Your dedication to quality improvement has made a difference in California!

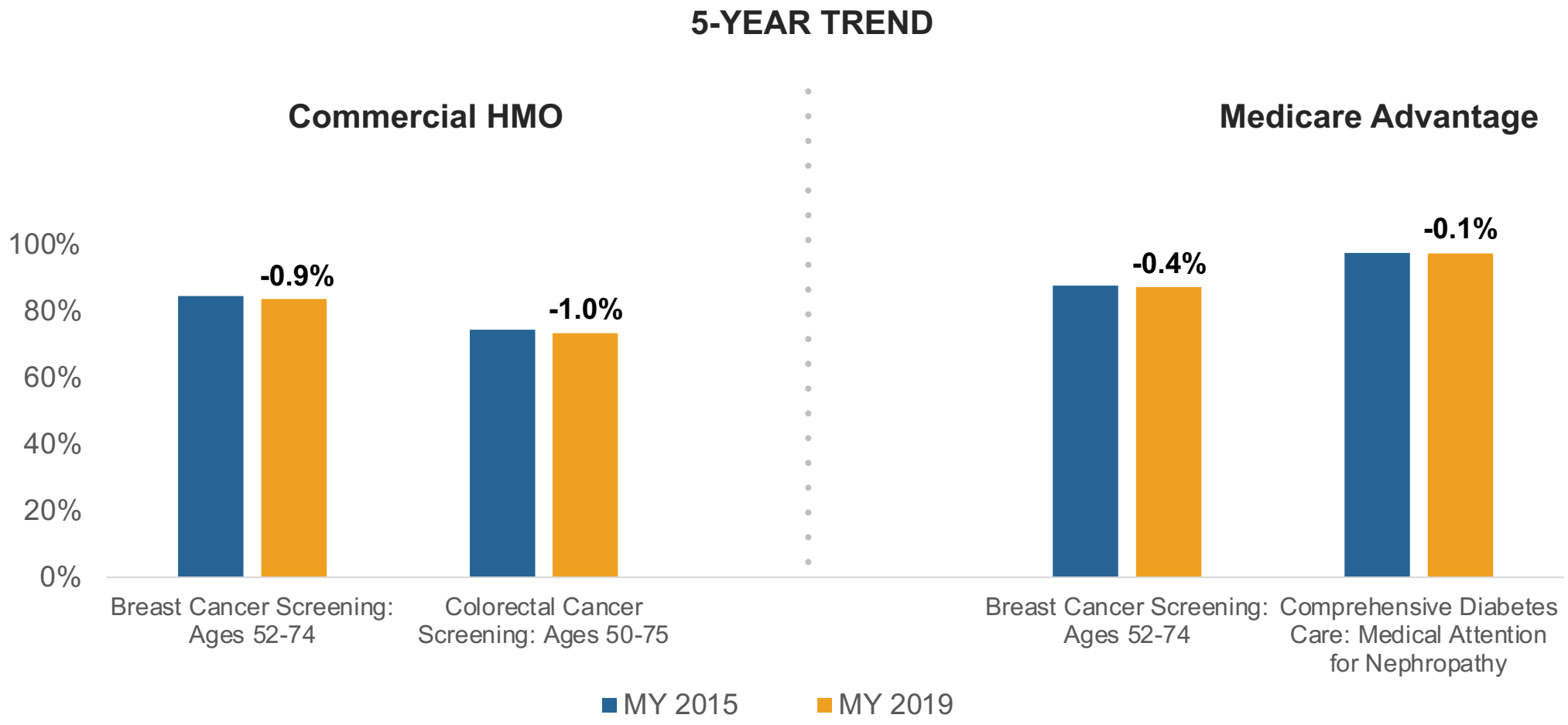
Most Improved: Commercial HMO

Most Improved: Medicare Advantage



>75% of AMP measures improved over 5 years!

Even measures that held steady or slightly declined still surpass NCQA PPO averages & HMO national averages



And that translates into better patient care

HMO Patient Population

8,900
more children were immunized for the 10 most pressing diseases

9,200
more patients with acute bronchitis did not inappropriately receive an antibiotic

20,200
more patients received statin therapy for diabetes

3,200
more patients received statin therapy for cardiovascular disease

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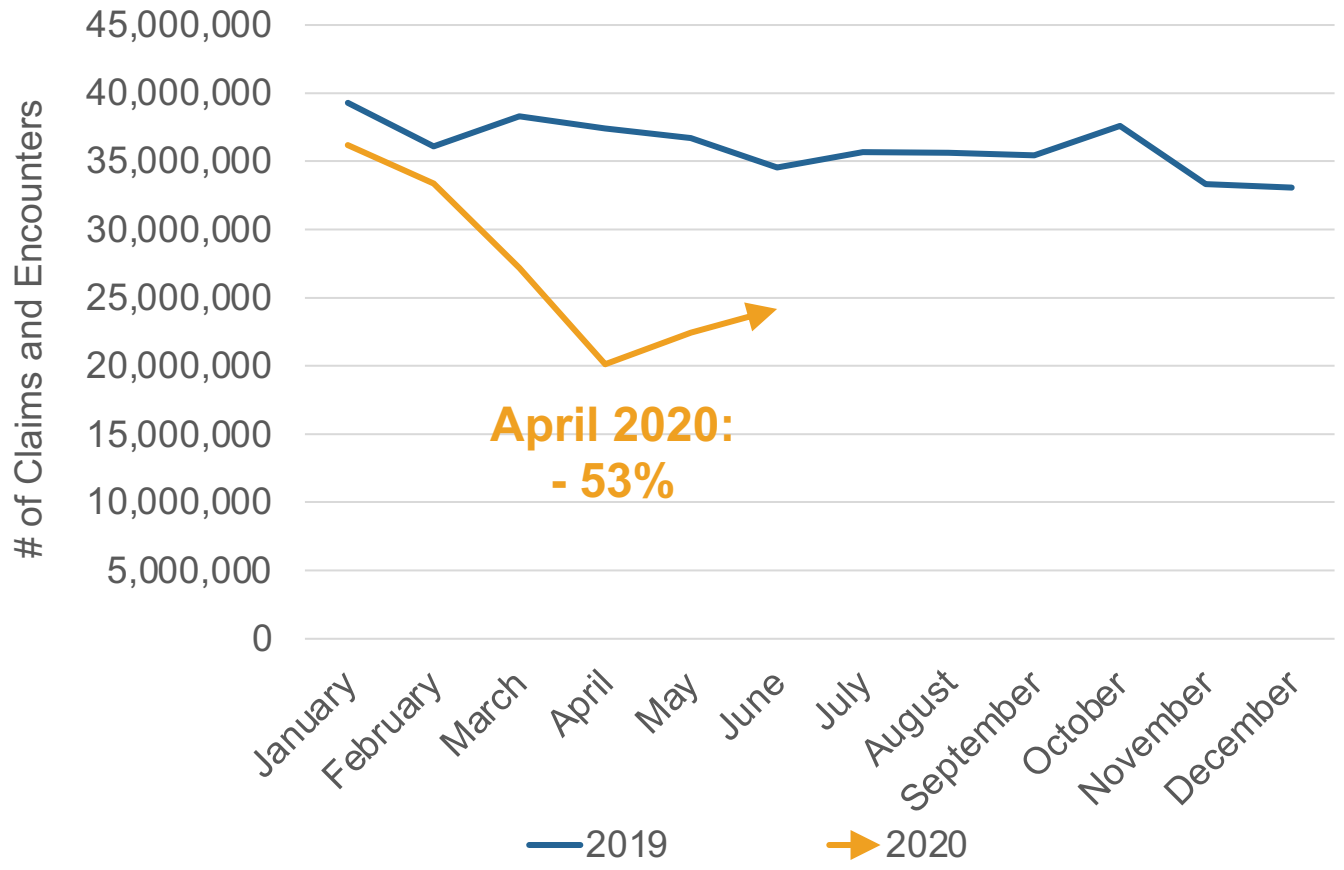
MY 2020 preview: The industry has adapted quickly and the trend is improving steadily since April

Due to the pandemic, we saw a decrease in number of claims in quarterly AMP submissions



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November 5, 2020

Measuring what matters most: MY 2020 AMP program response to COVID-19

Thien Nguyen, MPH, IHA

Ray Chicoine, MBA, Monarch Healthcare

Anil Keswani, MD, Scripps Health

Ed Yu, MD, FAAFP, CMQ, CPPS, CPE, Sutter Health - Palo Alto Medical Foundation

Welcome, panelists!

Thien Nguyen, MPH

Director of Data Strategy

IHA

Ray Chicoine, MBA

IHA Governance Committee Chair

President at Monarch Healthcare, Part of OptumCare

Anil Keswani, MD

IHA Technical Payment Committee Chair

Corporate Senior Vice President,

Chief Medical Officer Ambulatory & Accountable Care

Scripps Health

Ed Yu, MD, FAAFP, CMQ, CPPS, CPE

IHA Technical Measurement Committee Representative

Chief Quality Officer

Sutter Health - Palo Alto Medical Foundation

Measurement Year (MY) 2020 Program Updates

MY 2020 Data Collection & Reporting

IHA intends to collect and report all normally submitted data for MY 2020 to continue to provide insights from 2020 results including those related to COVID-19.

MY 2020 AMP Accountability Measure Set – *"Pandemic Priority"*

The committee members voted to keep 27 of the 38 measures across clinical quality, ACI, patient experience, resource use and cost domains to be used for awards, public reporting and incentive design.

MY 2020 AMP Incentive Design Approach

The committee members agreed with Technical Payment Committee recommended incentive approach to use the current Attainment Incentive pathway with updated/relaxed performance targets.

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MY 2020 Updated Accountability Measure Set

The committee members voted to keep 27 of the 38 measures across clinical quality, advance care information, patient experience, resource use and cost domains to be used for **awards, public reporting and incentive design**.

Measure Domain	Status Quo	MY 2020 "Pandemic Priority"
Clinical Quality • **Prevention & Screening**: childhood and adolescent immunizations • **Diabetes**: statin therapy for patients with diabetes; HbA1c control; medication adherence • **Cardiovascular**: controlling blood pressure; statin therapy; medication adherence • **Respiratory**: appropriate antibiotic use; appropriate testing for pharyngitis; asthma medication ratio	24	16
Advancing Care Information	2	2
Patient Experience	5	4
Appropriate Resource Use • All-Cause Readmissions (PCR); Acute Hospital Utilization (AHU); Emergency Department Utilization (EDU); Generic Prescribing – Overall (GRX)	5	4
Cost	1	1
Data Quality	1	0
TOTAL	**38**	**27**

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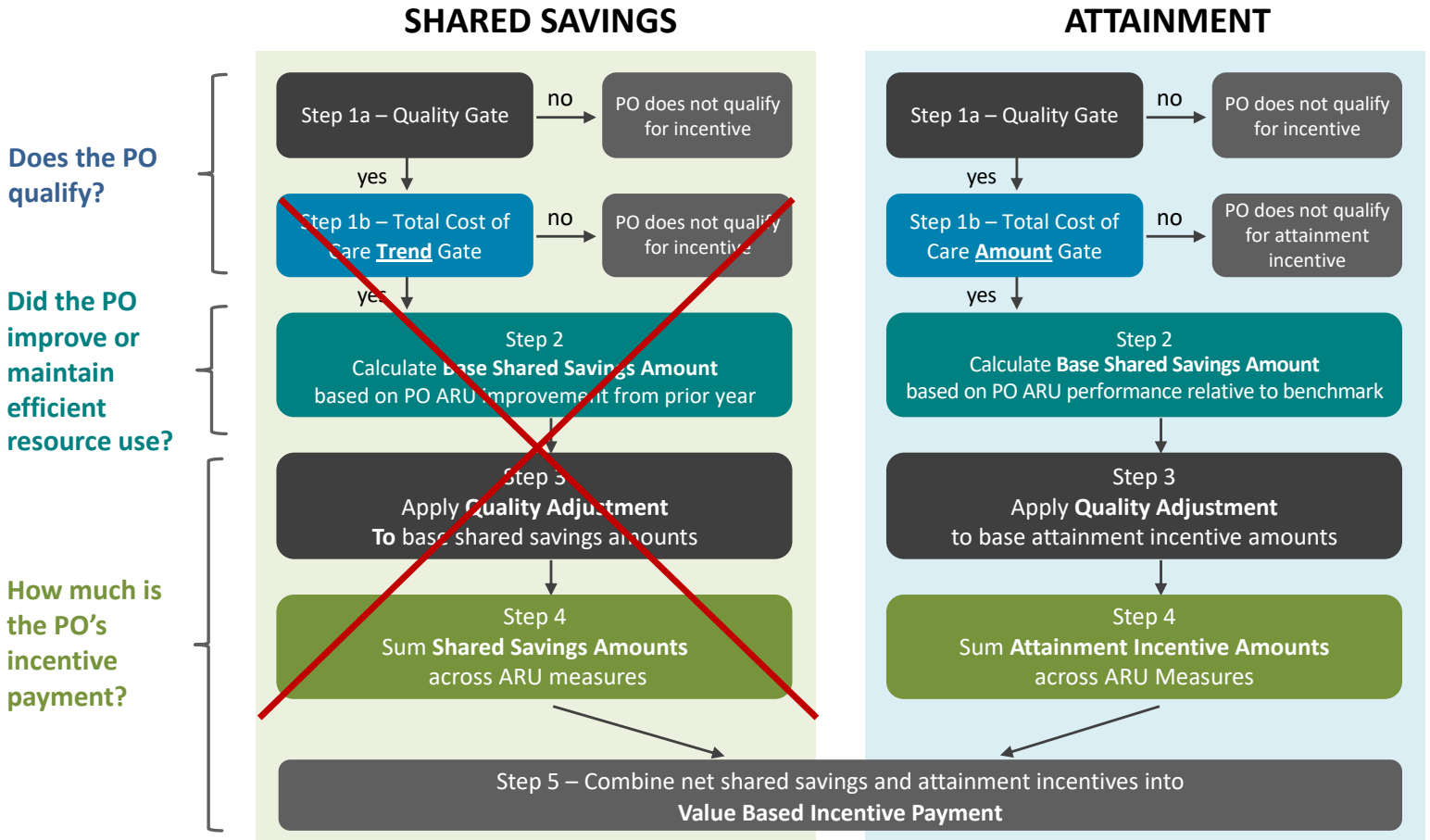
MY 2020 Incentive Design Approach



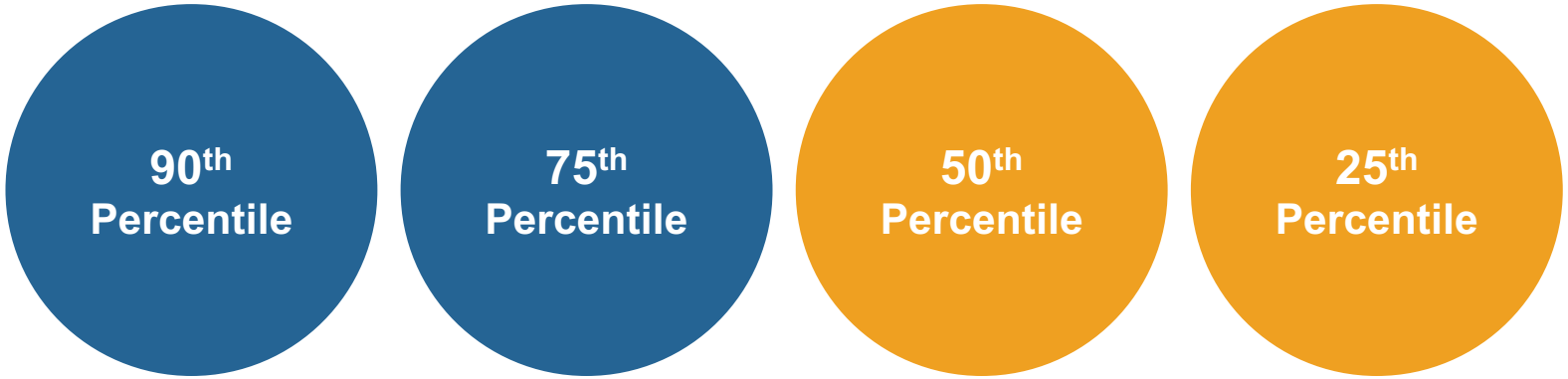
The committee members agreed with the Technical Payment Committee recommended incentive approach to use the current Attainment Incentive pathway with updated/relaxed performance targets.

Attainment Incentive Pathway

Expanded Performance Targets

Attainment benchmarks would reflect percentiles of performances for all POs in the population. The higher benchmark earns a larger incentive.

Performance target example
for each Appropriate Resource Use measure ($ PMPY)



Understanding primary care spend: insights from IHA's data infrastructure

Dolores Yanagihara, MPH

Vice President, Strategic Initiatives, IHA

Understanding Primary Care Spending – overview

Analysis

Percent of total cost that is spent on primary care services

Partners:

- Covered CA
- Onpoint Health Data
- RAND

Study question

Does higher proportion of primary care investment have better health outcomes and lower utilization/cost?

(based on all Commercial data in IHA's data infrastructure)

Potential uses

- Statewide benchmarks to inform Covered CA targets for QHPs in Attachment 7 refresh
- Advanced primary care initiatives
- Adopt as AMP measure

Considerations:

- There is not a standard definition of primary care services or primary care providers
- Many (but not all) studies have shown overall better outcomes and lower costs in geographic markets or delivery systems with greater emphasis on primary care

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Primary Care Spend – methodology selected

Methodology selected based on:

- Onpoint inventory and crosswalk of provider specialty taxonomy codes and procedure codes used in other studies
- Concurrent review with NESCSO (New England States Consortium Systems Organization) study team
- Clinical consultation
- Guidance from RAND (Cheryl Damberg, PhD and Rachel Reid, MD) based on their work with Milbank

Decisions made:

- Limited specialties, including IM, GP, FP, Peds, NPs, PAs
  - Anchored in IOM definition of primary care
  - Include adolescent, adult, and geriatric health sub-specialties
  - Include hospice and palliative care sub-specialties, limited to home health and hospice procedure codes
- Comprehensive procedure types, including all services provided by above specialties (except as noted)
- Medical and pharmacy costs, with member cost sharing, included in total cost denominator

IOM definition of primary care: “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.”

Primary Care Spend – how our results compare to others

Other Primary Care Spend work – commercial plans

Analysis year	Sponsor	Average	Range	Notes
2014	Milbank	7.6%	3.1 - 12.1%	Includes Rx costs in denominator
2011-2016	Graham Center – All States	10.2%		Based on MEPS
2017	Covered CA		5.4 - 10.9%	Covered CA population only
2018	Maine	10.5%		Plan paid only
2018	Oregon	13.0%		Plan paid + non-claims payments
2018	Rhode Island	12.3%		Claims + non-claims payments
2018	Vermont	9.2%		Plan paid + non-claims payments
2018	Washington	5.7%		Includes Rx costs in denominator
2018	Covered CA/IHA	9.1%	4.2 - 14.1%	Includes Rx costs in denominator
2019	PBGH	7.7%	5.1 - 12%	Milbank methodology; for purchasers

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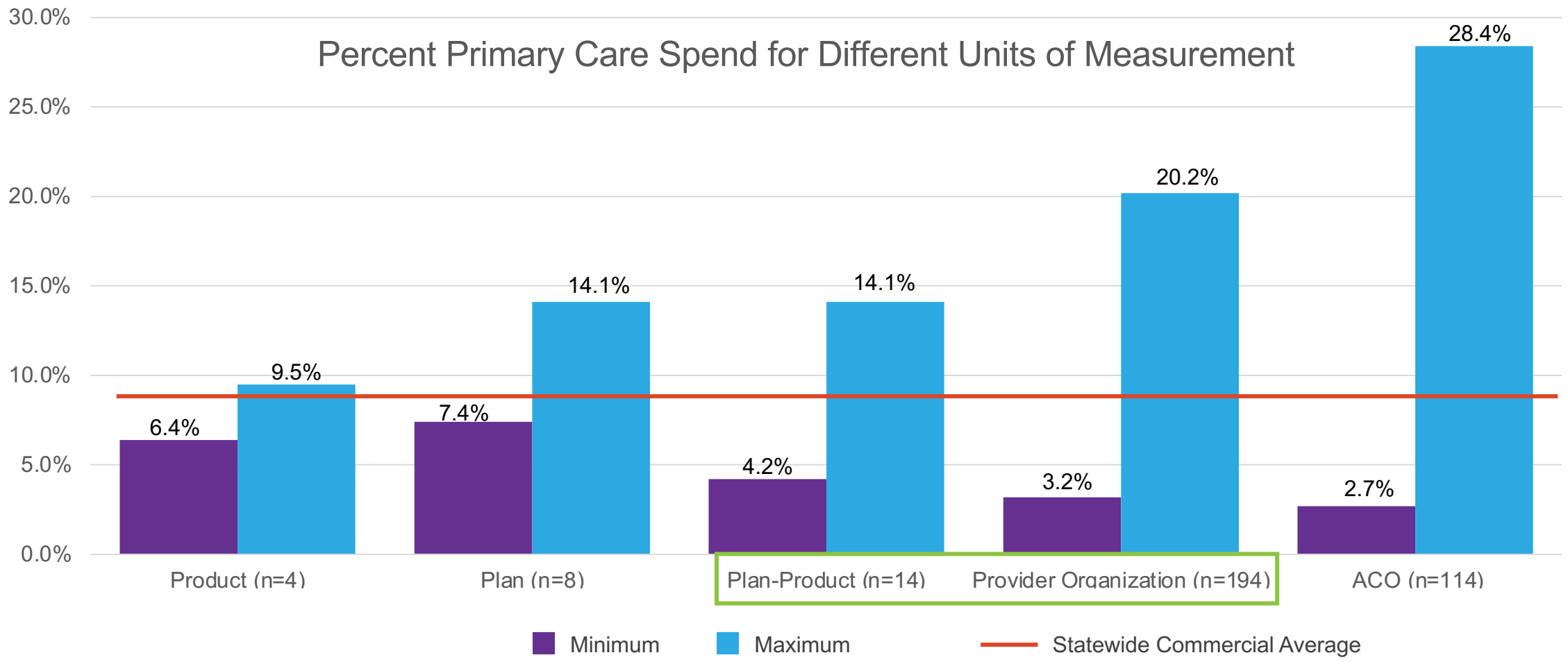
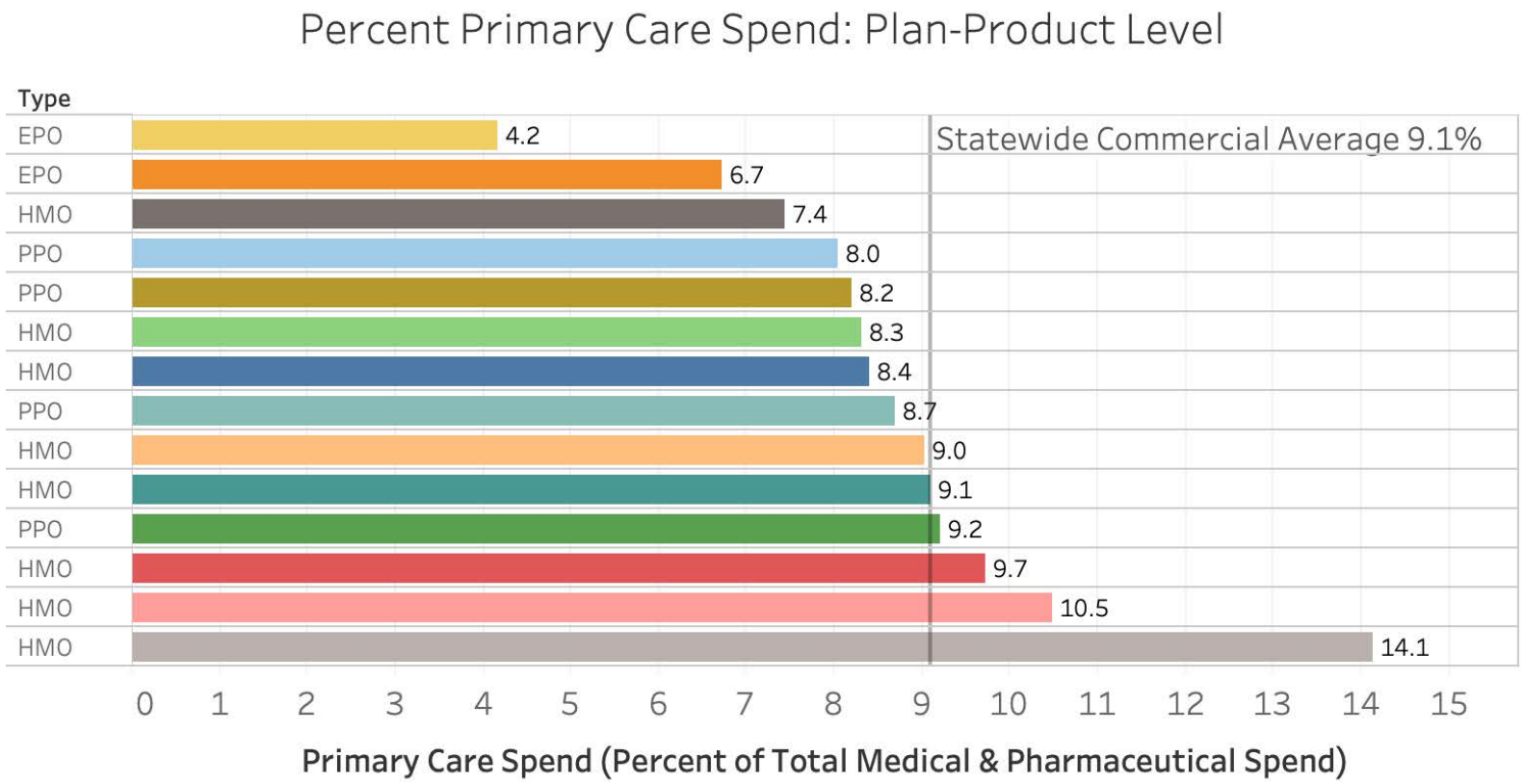
Primary Care Spend – variation results

Amount of variation increases as size of unit of measurement decreases



* Plan-product is a combination of a particular plan and a particular product, e.g., Anthem EPO, Anthem HMO, Anthem PPO

Primary Care Spend – plan-product results



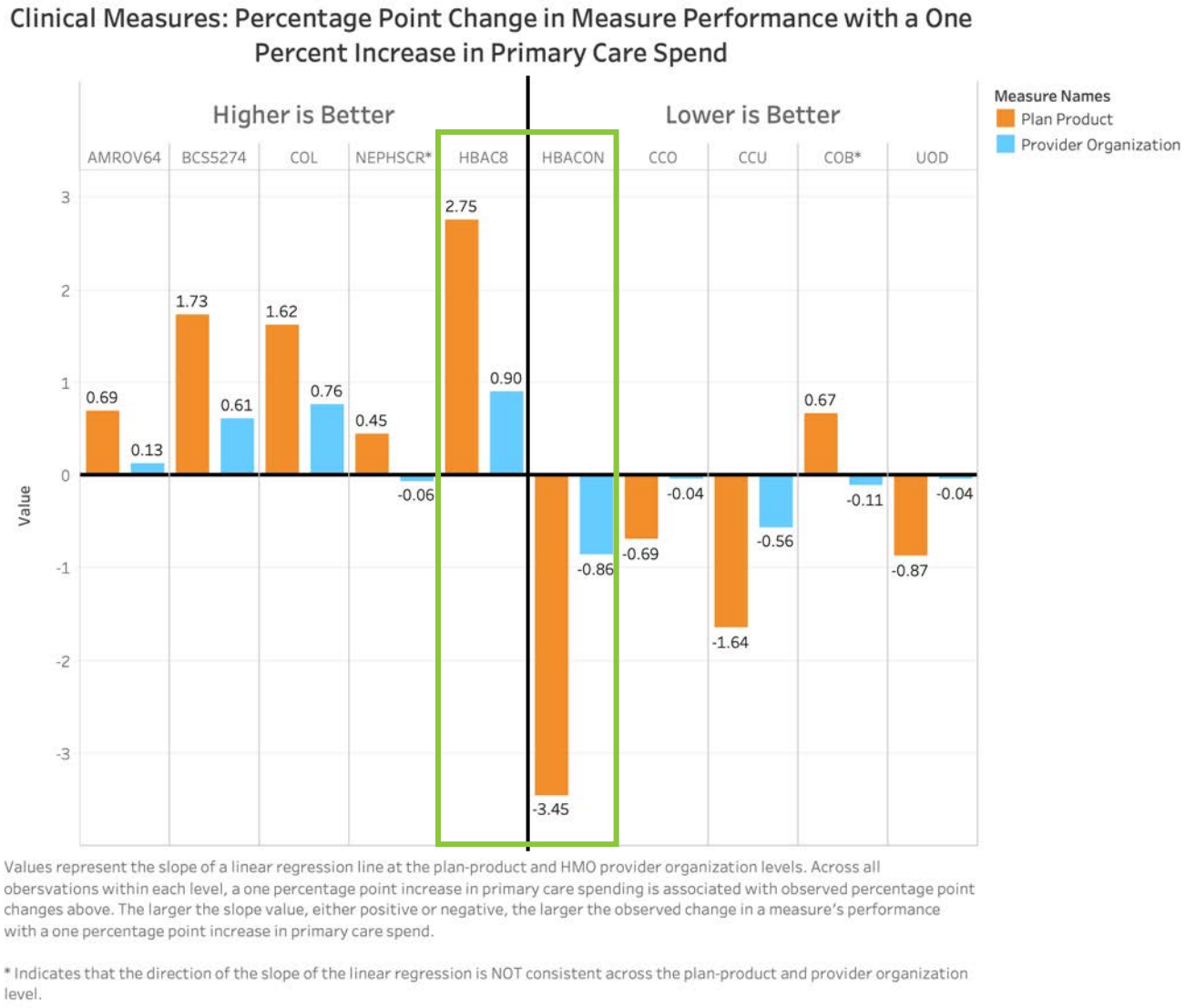
- On average, 9.1% of Commercial total medical and pharmaceutical spend went towards primary care
- At the plan-product* level Primary Care Spend ranges from 4.2 to 14.1%
  - 3 lowest: 2 EPO and 1 HMO plan-product
  - 3 highest: 3 HMO plan-products

* Plan-product is a combination of a particular plan and a particular product, e.g., Anthem EPO, Anthem HMO, Anthem PPO

Associations between Primary Care Spend and Performance

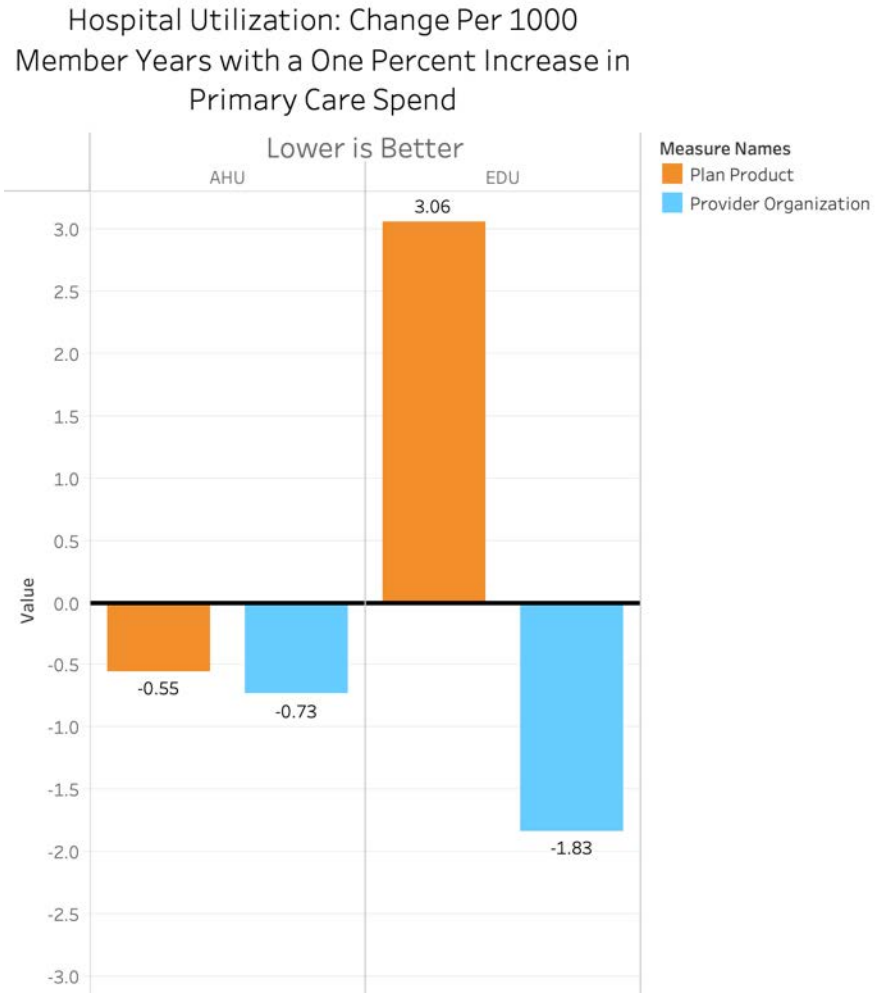
Higher Primary Care Spend is associated with better clinical quality

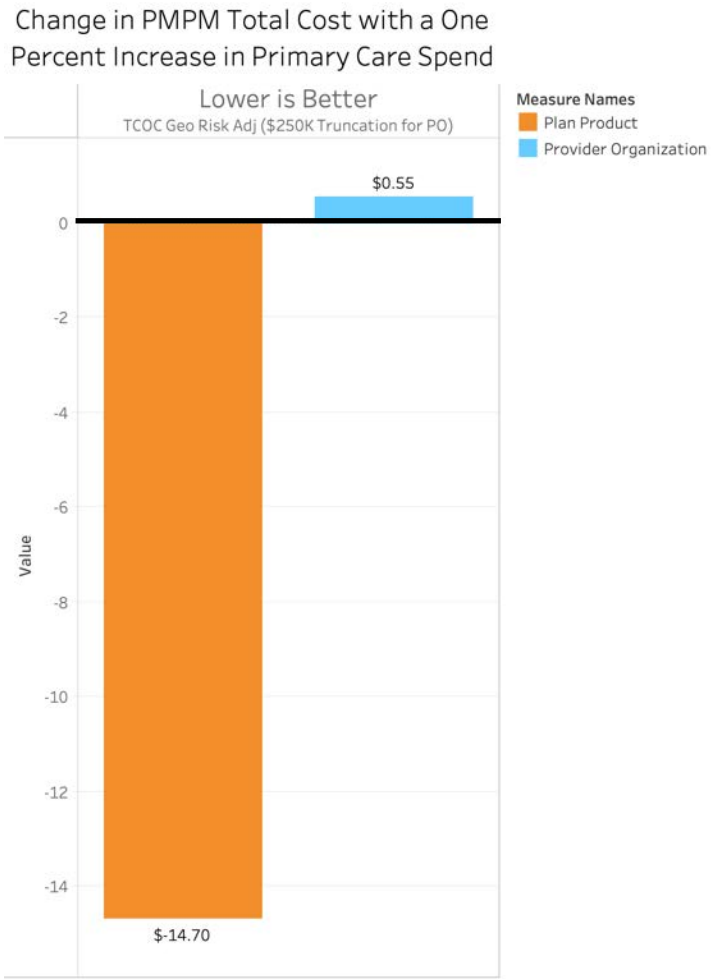
- The greatest associations are seen in the diabetes blood sugar control measures, where 1 percentage point increase in Primary Care Spend is associated with:
  - 2.75 percentage point higher HbA1c good control by for plan-product
  - 3.45 percentage point lower HbA1c poor control by for plan-product
- Overall, 1 percentage point increase in Primary Care Spend is associated with better performance in 9 of 10 clinical quality measures at plan-product level and at provider organization level



* Plan-product is a combination of a particular plan and a particular product, e.g., Anthem EPO, Anthem HMO, Anthem PPO

Higher Primary Care Spend is associated with lower utilization & cost

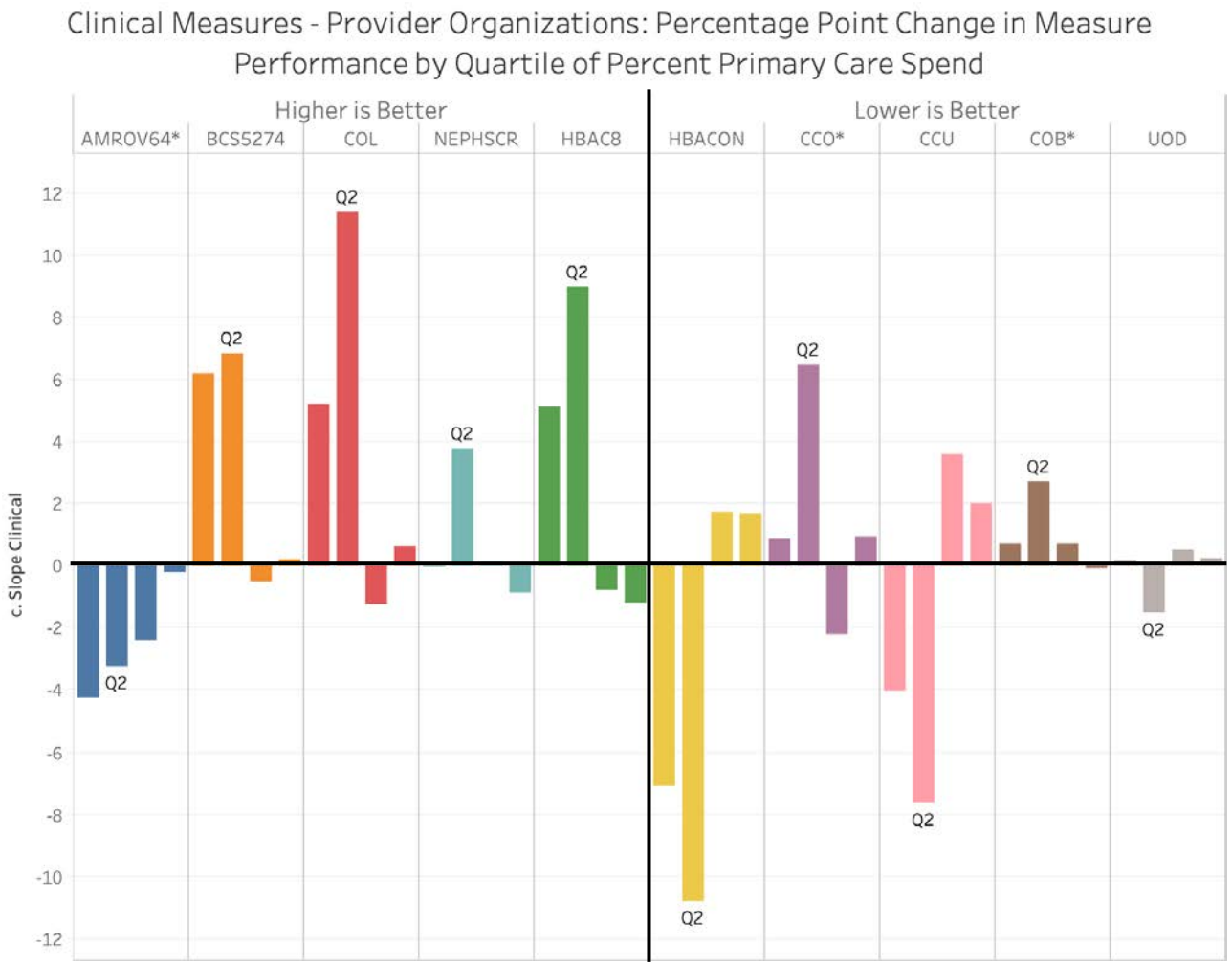




One percentage point increase in Primary Care Spend is associated with:

- lower acute hospital discharges for plan-product and provider organization levels
- lower geography and risk adjusted total cost at plan-product level
- inconsistent association with ED utilization at different levels
- no association with total cost at provider organization level

Increasing Primary Care Spend may have differential impact, depending on starting point



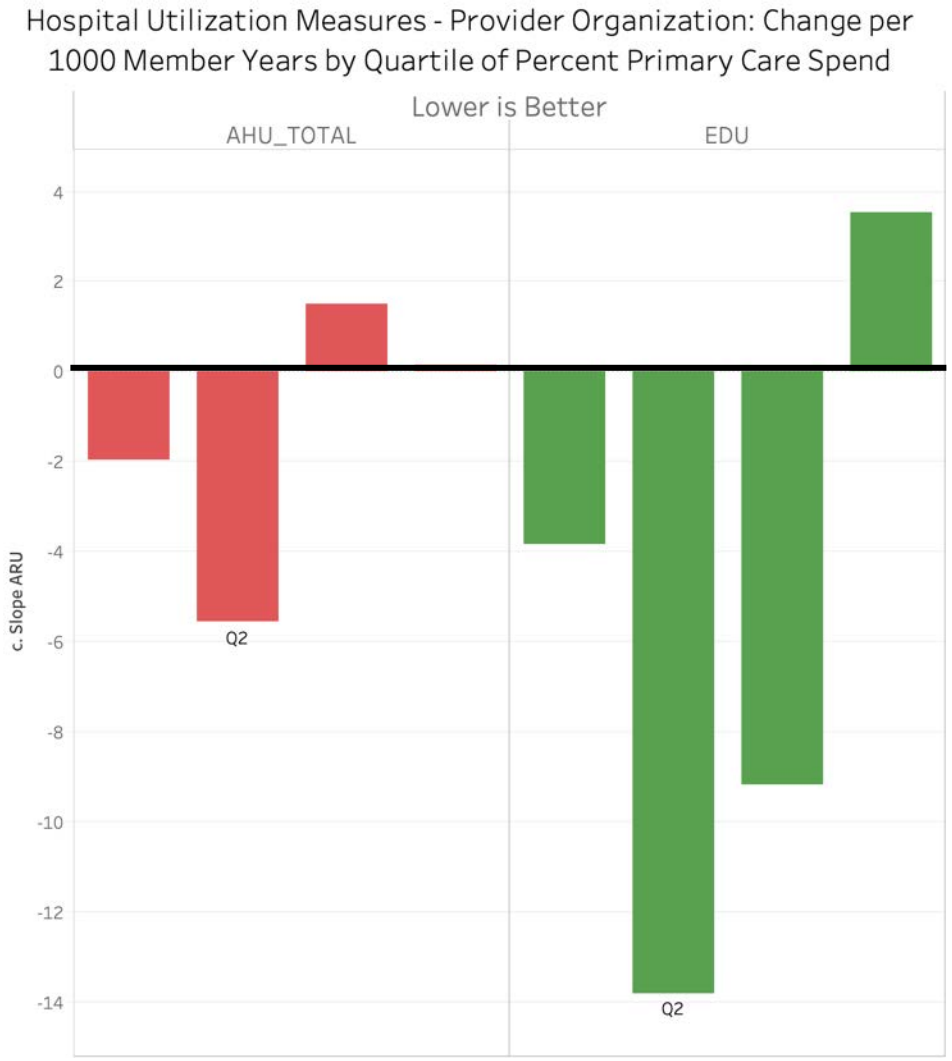
* Indicates Quartiles 1 and 2 are opposite direction than desired

- Quartile 2 shows the greatest opportunity for improvement in clinical quality; 1 percentage point increase in Primary Care Spend is associated with:
  - Nearly 12 percentage point better performance for colorectal cancer screening
  - 9-11 percentage point better performance for diabetes HbA1c control
- Quartile 1 also shows consistent but lower magnitude of opportunity for improvement

Quartile	Primary Care Spend Range
1 (lowest)	< 6.5%
2	6.5 – 8.1%
3	8.1 – 11.5%
4 (top)	> 11.5%

Increasing Primary Care Spend may have differential impact, depending on starting point

- Quartile 2 shows the greatest opportunity for improvement in hospital utilization; 1 percentage point increase in Primary Care Spend is associated with:
  - Nearly 6 fewer acute hospital discharges per 1000 member years
  - About 14 fewer ED visits per 1000 member years
- Quartile 1 also shows opportunity for improvement



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Primary Care Spend – potential next steps

- Work with plans to improve data gaps
- Share methodology and results more broadly for input and buy-in
- Consider methodology refinements
- Conduct additional related analyses to further understand results

Primary Care Spend – key takeaways

- Our results are comparable to results from other studies, with overall 2018 statewide commercial Primary Care Spend of 9.1%
- Higher Primary Care Spend is associated with better performance at multiple levels, including plan-product and provider organization levels
- Among provider organizations, performance improvement opportunity is greatest for provider organizations spending less on primary care
- Performance improvement opportunity is most pronounced as a provider organization nears 8.1% in Primary Care Spend

Number of measures where Primary Care Spend associated with Performance

Measure Domain	Plan-Product Level (n=14)	Provider Organization Level (n=194)
Clinical	9 of 10 measures	9 of 10 measures
Utilization	1 of 2 measures	2 of 2 measures
Cost	1 of 1 measure	0 of 1 measure

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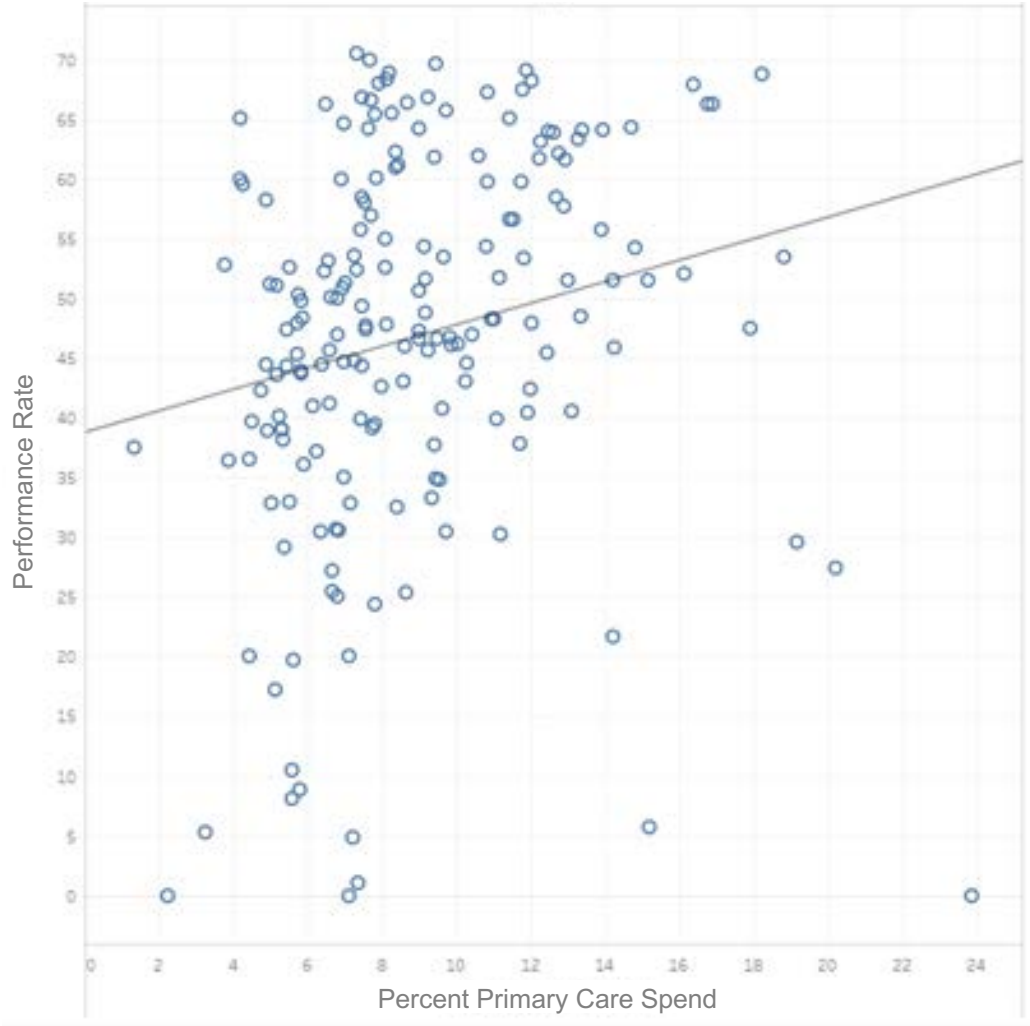
Technical Appendix

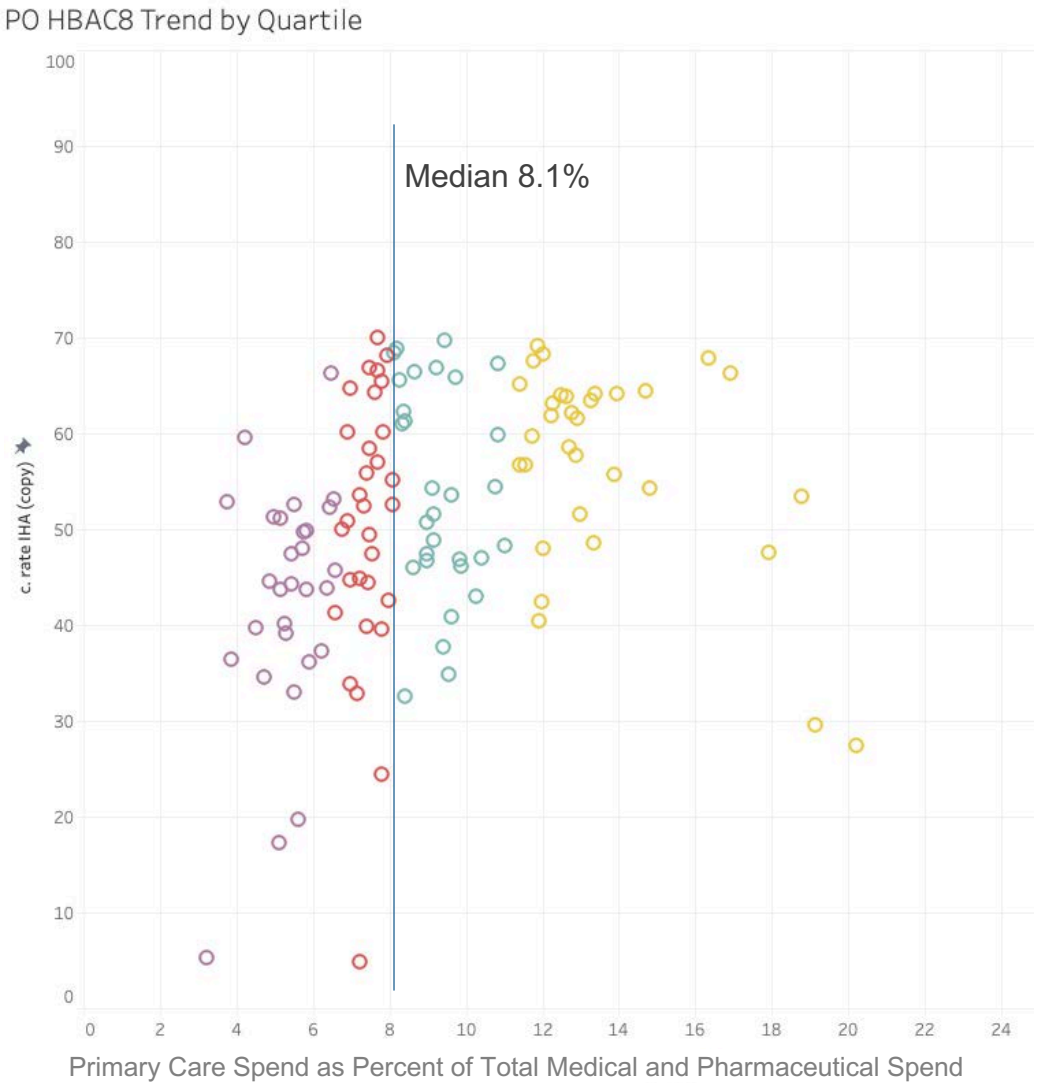
Assessing opportunity for improvement overall

- slope of line = average number of units change in y given a one unit change in x
- x axis is percent Primary Care Spend
- y axis is performance rate of a particular measure
- When we increase Primary Care Spend by 1 percentage point, how much change do we see in the performance measure results?



Assessing opportunity for improvement by quartile of Primary Care Spend

- Opportunity for improvement likely dependent on starting point
- Divide provider organizations into quartiles based on amount of Primary Care Spend
  - Purple = lowest quartile = < 6.5%
  - Red = second quartile = 6.5-8.1%
  - Green = third quartile = 8.1-11.5%
  - Yellow = top quartile = > 11.5%
- Median Primary Care Spend = 8.1%
  - 97 provider organizations have Primary Care Spend < 8.1%
- Assess by quartile:
  - current performance
  - magnitude of performance improvement opportunity



Integrated Healthcare ASSOCIATION

Questions & Answers

Integrated Healthcare ASSOCIATION

MY2019 Align. Measure. Perform. Annual Awards

Jeff Rideout, MD, President & Chief Executive Officer, IHA

Mary Watanabe, Acting Director, California Department of Managed Health Care

Welcome, panelists!

Jeff Rideout, MD

President &
Chief Executive Officer

IHA

Mary Watanabe

Acting Director

California Department of
Managed Health Care

AMP Commercial HMO Recognition

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Ronald P. Bangasser Award for Quality Improvement

This Year's Ronald P. Bangasser Award Winners

Accelerating the pace of healthcare quality improvement – 7.1x higher than average!

Bay Area
Kaiser Permanente Northern California Permanente Medical Group — South San Francisco Medical Center

Central Coast
Physicians Choice Medical Group of San Luis Obispo

Central Valley
Dignity Health Medical Network — Central California

Inland Empire
Redlands Yucaipa Medical Group

Los Angeles
Saint John's Physician Partners

Orange County
AMVI Medical Group

Sacramento/Northern California
Sutter Independent Physicians

San Diego
Sharp Community Medical Group

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Top 10% Quality, Patient Experience and Total Cost of Care

This Year's Top 10% – Quality

Setting the bar for high quality clinical care – 26% higher performance

Edinger Medical Group

Kaiser Permanente Northern California Permanente Medical Group

- Fremont/San Leandro Medical Centers
- Redwood City Medical Center
- San Francisco Medical Center
- San Jose Medical Center
- San Rafael Medical Center
- Santa Clara Medical Center
- South San Francisco Medical Center

Kaiser Permanente Southern California Permanente Medical Group

- Baldwin Park
- Downey
- Orange County
- Panorama City
- San Diego
- South Bay
- Woodland Hills

Sutter Palo Alto Medical Foundation — Mills-Peninsula Division/Mills-Peninsula Medical Group

Sutter Palo Alto Medical Foundation — Palo Alto Foundation Medical Group

UC San Diego Health

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This Year's Top 10% – Patient Experience

Delivering care that meets patient's needs – 11% better performance

Cedars-Sinai Health Associates

Cedars-Sinai Medical Group

Kaiser Permanente Northern California Permanente Medical Group — South San Francisco Medical Center

MemorialCare Medical Group

Mercy Medical Group/Dignity Health Medical Foundation

Rady Children's Health Network

Scripps Clinic Medical Group

Scripps Coastal Medical Center

Sharp Rees-Stealy Medical Group

Sutter East Bay Medical Group

Sutter Gould Medical Foundation — Gould Medical Group

Sutter Medical Foundation — Sutter Medical Group

Sutter Palo Alto Medical Foundation — Mills-Peninsula Division/Mills-Peninsula Medical Group

Sutter Palo Alto Medical Foundation — Palo Alto Foundation Medical Group

UCLA Medical Group — Santa Monica Bay Physicians

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This Year's Top 10% – Total Cost of Care

Solving for affordable care is critical to addressing healthcare access – 33% lower costs

Advantage Health Network

Allied Pacific of California IPA

AltaMed Health Services

Angeles IPA

AppleCare Medical Group

Associated Hispanic Physicians of Southern CA

Brookshire IPA

Crown City Medical Group

Family Care Specialists IPA

Family Health Alliance

Global Care Medical Group

Health Care L.A., IPA

Korean-American Medical Group

Loma Linda University Health Care

Nuestra Familia Medical Group, Inc.

Preferred IPA of California

Premier Healthcare

Seoul Medical Group

St. Vincent IPA

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Excellence in Healthcare Award

Excellence in Healthcare Award Winners Drive Value

Quality

12%
higher than average

Patient Experience

5%
higher than average

Total Cost of Care

$408
lower annual costs per member

Let's find out who they are…

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Excellence in Healthcare Award Winners

ARCH HEALTH Medical Group

JOHN MUIR HEALTH

PIH HEALTH

St. Joseph Health
Mission Heritage Medical Group

Mercy Medical Group
A Service of Dignity Health Medical Foundation

hoag
Medical Group

UCDAVIS HEALTH

St. Joseph Health
St. Joseph Heritage Medical Group

EDINGER MEDICAL GROUP

AXMINSTER MEDICAL GROUP, INC.

KAISER PERMANENTE®
Antelope Valley

Providence

KAISER PERMANENTE®
Kern County

LOMA LINDA UNIVERSITY HEALTH CARE

SHARP Community Medical Group

NORTHBAY™ HEALTHCARE

FACEY MEDICAL GROUP
An affiliate of PROVIDENCE Health & Services

UCLA Health
UCLA Medical Group

Sutter Medical Group
Affiliated with Sutter Medical Foundation

Scripps Coastal Medical Center

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Congratulations to all!

Break

Integrated Healthcare ASSOCIATION

Expanding the Symphony Provider Directory Statewide

Jacqui Darcy, VP Client Operations, IHA

Eyal Gurion, MBA, Chief Operating Officer, IHA

Mary Watanabe, Acting Director, California Department of Managed Health Care

Welcome, panelists!

Jacqui Darcy

Vice President, Client Operations

IHA

Eyal Gurion, MBA

Chief Operating Officer

IHA

Mary Watanabe

Acting Director

California Department of Managed Health Care

Agenda

- Introduction and 2020 progress update
- Insights from our second year
- DMHC Update
- Looking towards the future
- Q & A

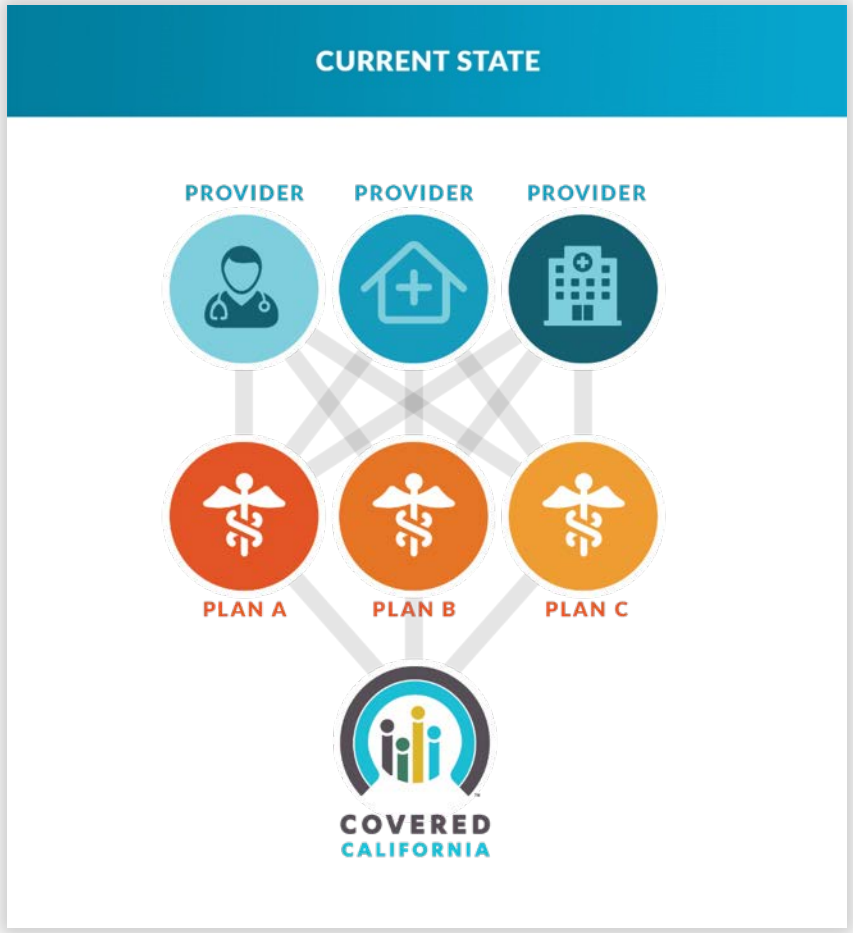
Integrated Healthcare ASSOCIATION

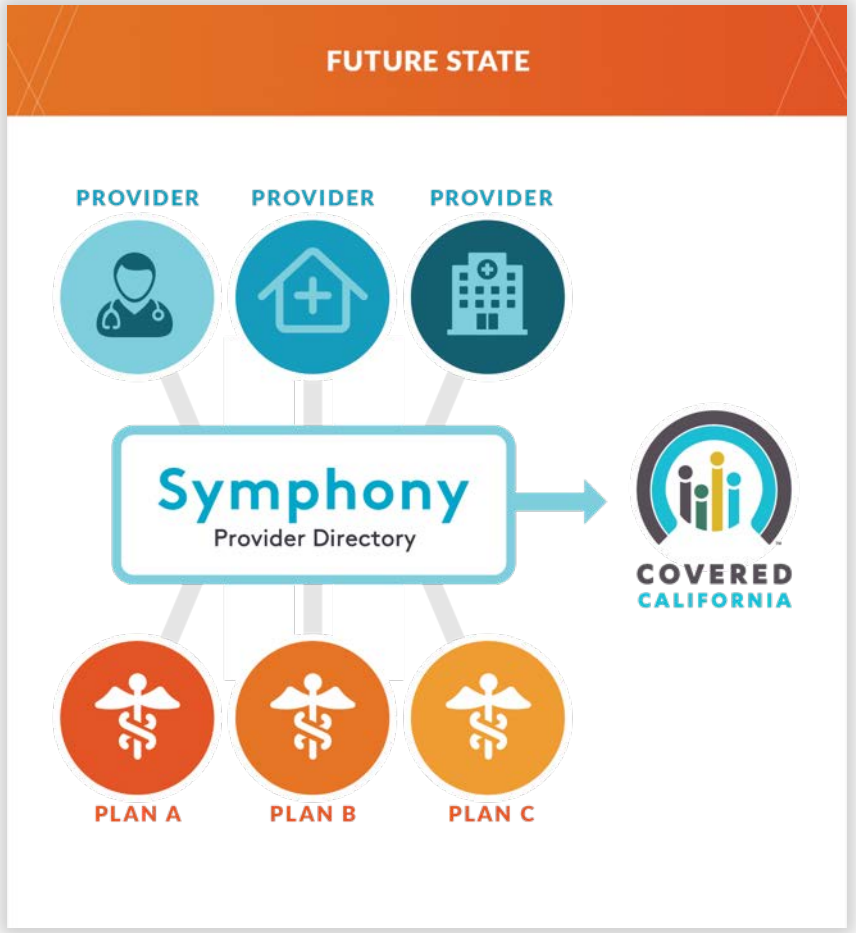
2020 Symphony progress update

Eyal Gurion

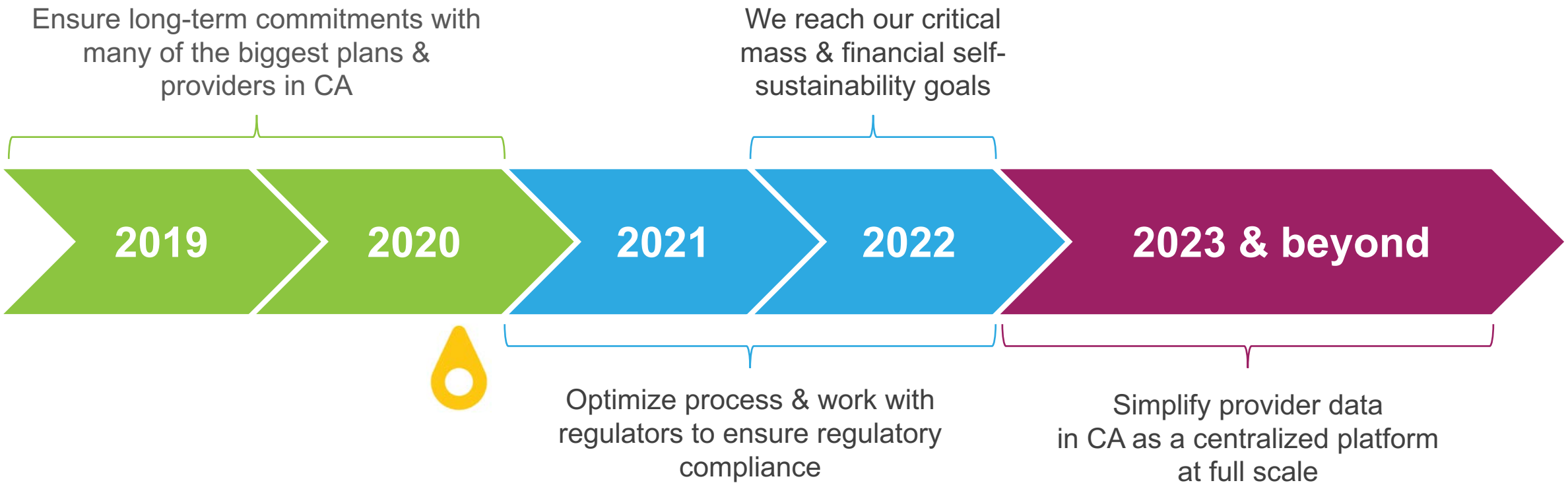
Chief Operating Officer

The vision: centralized provider data in California





Our path to a state-wide solution



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What has Symphony been up to this year?

Developing provider directory data standards

Preparing our clients to exchange data

Implementing the Symphony-Availity integration

Working with regulators such as the DMHC

Measuring our progress

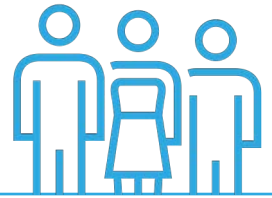
14 health plan participants

98 provider organization participants

567,723
provider records

250
provider data elements captured by Symphony

100%
clients believe Symphony is committed to the client relationship*



82% clients satisfied or higher with Symphony experience*

85% clients satisfied or higher with onboarding experience*

- Percentage of clients who responded to surveys
- Note: participant, provider record, and provider element numbers as of October 2020

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Insights from our second year

Jacqui Darcy

Vice President, Client Operations

Data exchange
is a conversation
so we need to speak
the same language

What makes a client successful?

Resources

Time

Process

Getting the right people to the table

- Executive sponsor
- Project lead
- Business process owner
- IT and technical staff

Investing in Symphony onboarding leads to success

Milestones	Planning	Discovery	BPR (optional)	Design	Testing	Data Exchange
Health plans	4-8 weeks	15 weeks	TBD	8-12 weeks	8-12 weeks	**Total: 1 year +**
Provider organizations	3 weeks	4-8 weeks	TBD	4-8 weeks	8-12 weeks	**Total: 6-9 months +**

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Aligning processes with new industry-wide standardization

How does Symphony support internal process improvements?

Symphony	Symphony	Symphony + Client	Client	Client
Educates and sets expectations	Assesses client readiness to change	Identify impacted processes Technical Integration Optional business process review	Documents process updates	Updates processes

What else makes a client successful?

6 habits of successful clients

1
Submit data frequently on a scheduled cadence

2
Ensure data is complete before submitting

3
Ingest Symphony data responsively

4
Trust Symphony to address updates

5
Actively engage with Client Success Manager

6
Proactively notify Symphony of updates

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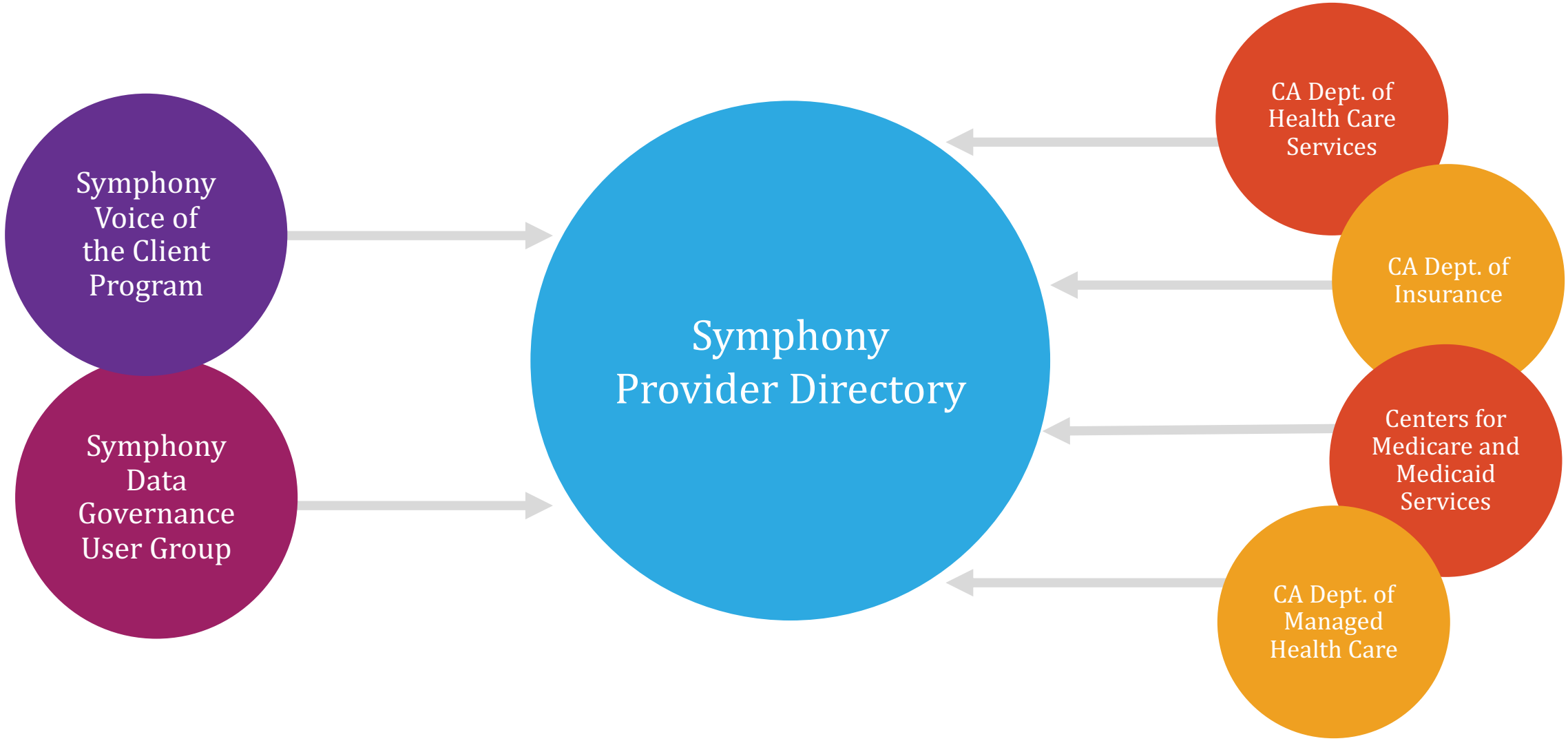
Scaling Symphony with industry collaboration



DMHC Update

November 5, 2020

Mary Watanabe, Acting Director

DMHC Compliance Update

- Annual Compliance Filings
- Review of Symphony Provider Directory Utility Contracts
- SB 137 Provider Directory Standards Regulation
- Impact of COVID-19

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Looking ahead: 2021 and beyond

Eyal Gurion

Chief Operating Officer

What does the future hold for Symphony Provider Directory?

2021

1. Optimizing data exchange with a standard extract and other process improvements
2. Expanding the Symphony-Availity integration to other plans and providers
3. Adding ancillary providers as Symphony grows

Possibilities for 2022 and beyond

1. Credentialing functionality
2. Consumer-facing directory
3. Integration with IHA's AMP Programs and Cost & Quality Atlas

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Panel Q & A

Integrated Healthcare Association

Thank you

Building Resilience Together

IHA 2020 Stakeholders Virtual Meeting

November 5, 2020

Integrated Healthcare Association

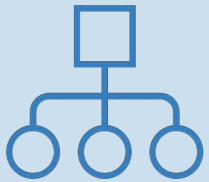
Looking Ahead: Our Vision for the Future

Jeff Rideout, MD

President & Chief Executive Officer, IHA

Who we are today…

Supporting role to industry



California-focused

Trusted source of truth for members

Consensus builder

Data & technology provider

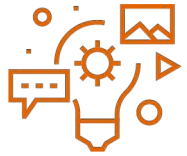
Connector & Convener

IHA

… and where we are going

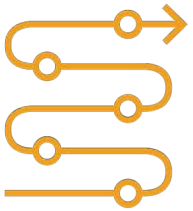
Driver of industry change

CA & National thought leader



Sought-after insight generator

Consensus driver & ***problem solver***



Solution provider & consultant

Catalyst

IHA

Who we are and what we believe in

Values Purpose Vision Mission Brand Pillars

Integrated Healthcare ASSOCIATION

Our core values guide us…

Collaboration

We leave our egos at the door

Candor

We embrace the tough conversations and hard work

Impact

We never lose sight of driving results

...our Purpose, Vision and Mission show us the way

Purpose

Describes IHA's desired impact on those we serve, ideally from their point of view

Vision

Describes what IHA wishes to be like in some years' time

Mission

Describes what business IHA is in (and what it isn't) both now and projecting into the future

Definitions from the HBR, G. Kenney Sept 2014

IHA

Together, we can make the healthcare system work better for everyone.

The Purpose

Because at IHA, we envision a more integrated healthcare system that delivers high-quality, affordable care.

The Vision

We bring healthcare together to make better care a reality.

The Mission

Finally, our brand pillars direct our work

We align healthcare around shared goals – and new possibilities.

We use data and insights to help everyone improve.

We build what's needed to drive lasting change.

Thank you

Questions? Get in touch at events@iha.org!

Building Resilience Together

IHA 2020 Stakeholders Virtual Meeting

November 5, 2020