From Theory to Action.

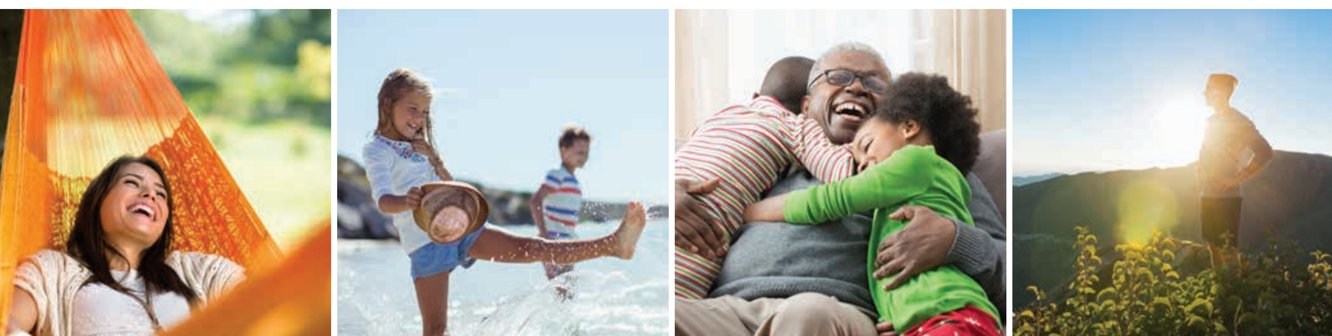
Executing on the Quadruple Aim

QUADRUPLE AIM 1: PATIENT EXPERIENCE

QUADRUPLE AIM 2: QUALITY

QUADRUPLE AIM 3: COST

QUADRUPLE AIM 4: PROVIDER EXPERIENCE



2018 Value Report for Physician Integration and Population Health Management

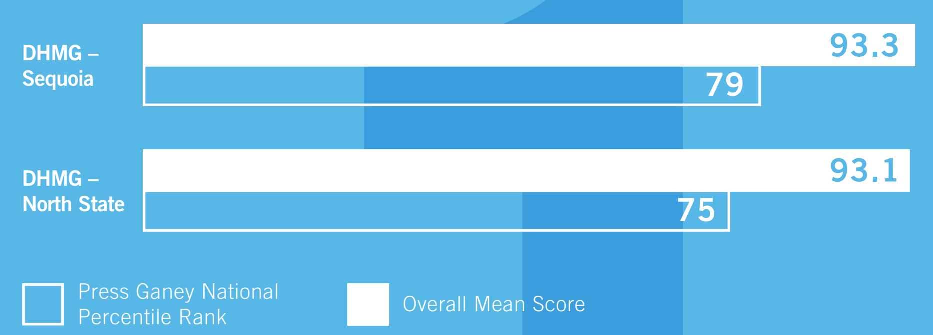
At the intersection of data, strategy and humankindness lies the Quadruple Aim.

At Dignity Health, we're putting theory and data into action to accomplish the Quadruple Aim and to transform health care for our patients. This year, we've built programs and services that support strategies aimed at executing on all four of these objectives — without losing sight of our distinctive brand of patient care, humankindness.

We're proud to share our extraordinary journey.

Improving the Patient Experience

After a clinic visit, patients receive a Press Ganey CG-CAHPS patient satisfaction survey. Dignity Health's commitment to humankindness is at the core of patient experience. We use the feedback to better understand and improve upon our patient experience.



DHMG-North State and DHMG-Sequoia were above the National Press Ganey 75th Percentile Ranking (over 1,000 facilities) for overall mean score for patient experience in 2017.

Ensuring Better Outcomes and Healthier Patients

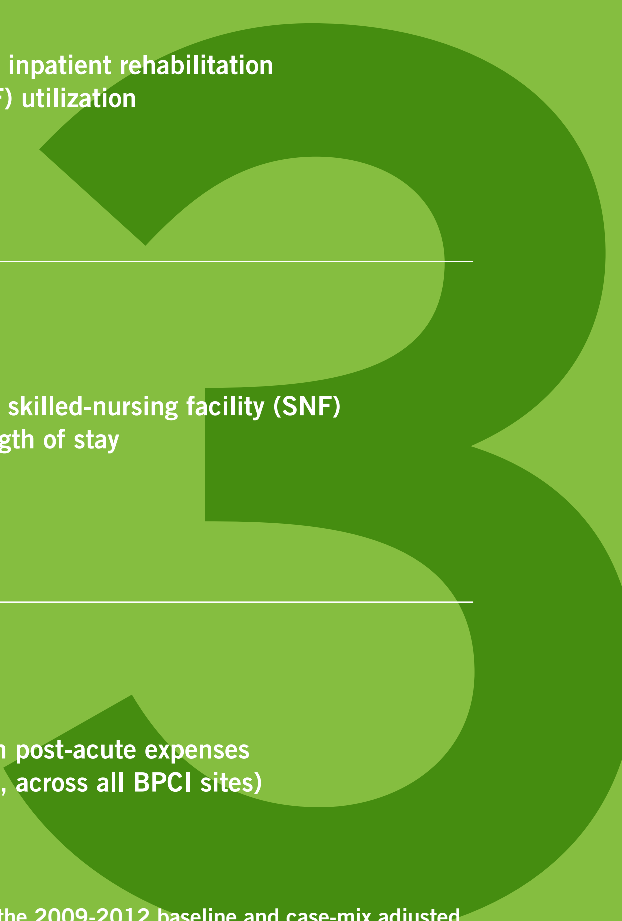
Health outcomes improve when providers and patients focus their efforts on key areas. Physicians in our clinically integrated networks are committed to following evidence-based quality measures to improve patient outcomes.

	Dignity Health ACO MSSP Average 2017 (Three ACOs in California)	National ACO MSSP Average 2017
Falls Screening	78%	74%
Breast Cancer Screening	72%	70%
Tobacco Screening and Follow-Up	93%	91%
Statin Therapy	81%	80%
DM A1c<9%	83%	83%
DM Eye Exam	46%	50%

SOURCE: GPRO survey data 2017

Lowering the Overall Cost of Care

Changes in the way we operate and provide care can lead to important shifts in measures like inpatient rehabilitation facility utilization and skilled-nursing facility length of stay. Those changes translate into improved care for patients and savings.



32% decrease in inpatient rehabilitation facility (IRF) utilization

4 days decrease in skilled-nursing facility (SNF) average length of stay

9% reduction in post-acute expenses (on average, across all BPCI sites)

Compared to the 2009-2012 baseline and case-mix adjusted

SOURCE: Bundled Payments for Care Improvement initiative

Improving the Provider Experience

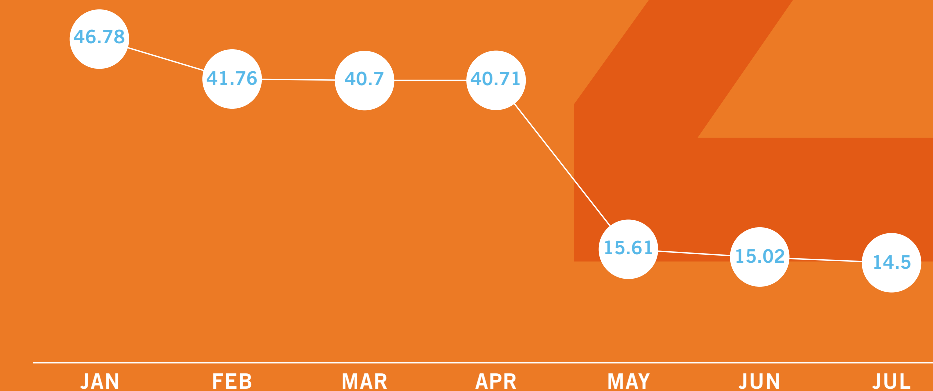
Our providers use par8o to efficiently manage referrals, making it easier to refer patients to specialists and community services — and increasing referral rates within our own system.

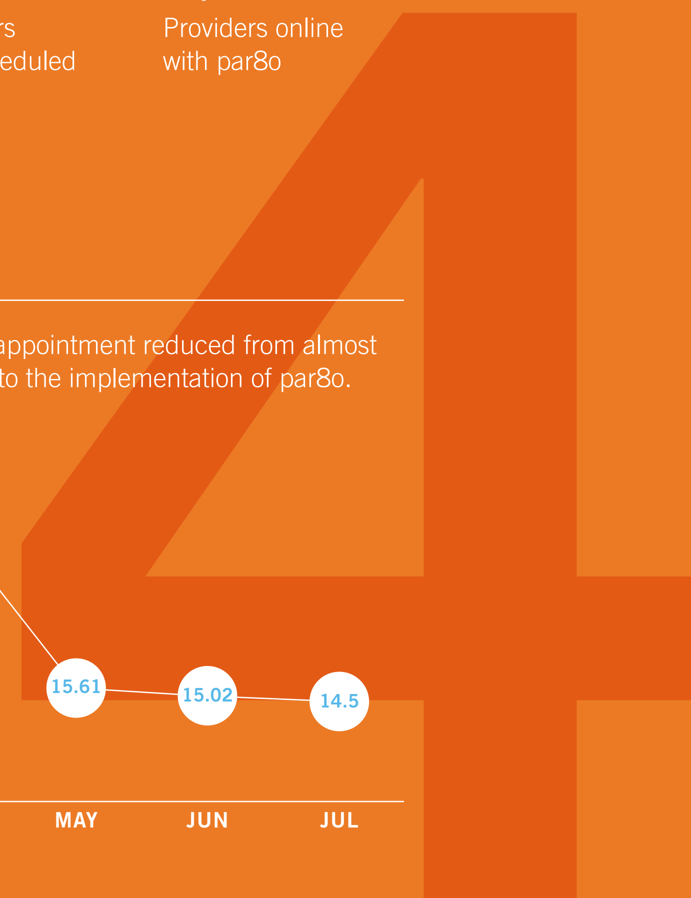
par8o at a Glance

1,618	2,367	4,287
Unique providers who sent or scheduled a referral from Jan-May 2017	Unique providers who sent or scheduled a referral from Jan-May 2018	Providers online with par8o

Time to Appointment in Days

At Arizona Care Network, the average time to appointment reduced from almost 47 days to 14.5 days over six months, thanks to the implementation of par8o.





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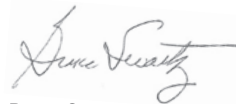
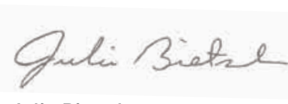
Welcome

Accomplishing the Quadruple Aim for health care is not a simple task. Healthier populations, a better overall patient experience, lower costs and more satisfied providers are the result of thoughtful planning, investments in various tools and resources, consistent data monitoring and analysis, innovation, commitment and teamwork across the enterprise.



Bruce Swartz
Senior Vice President
Physician Enterprise



Julie Bietsch
Vice President, Population Health
Physician Integration

Gary Greensweig
Vice President and Chief Physician
Executive for Physician Integration

Our Physician Integration and Population Health Management teams are committed to accomplishing the Quadruple Aim. During the past six years, our journey has been to better understand the health of our various populations and to improve their care by taking a different approach.

At the close of CY 2016, we published the first Dignity Health Value Report on our population health strategy, showcasing some of the tools we had implemented and the progress we had made. Today, we can report that we've executed on a variety of strategies and workflows (with more to come) aimed at enhancing the patient experience, improving health outcomes, reducing costs and improving the experience of our providers.

Dignity Health's Population Health Management program supports evolving health care payment models and enhanced value-based financial agreements that address the increased focus on patients' individual care needs. As of Sept. 30, 2018, we manage more than 1,146,417 members under value-based agreements (VBAs).

Providing excellent care means assuring that our patients receive the right care in the right place at the right time. By reducing out-migration, retaining referrals within Dignity Health provider networks and effectively managing care within risk-based agreements, we are able to better coordinate care and reduce fragmentation.

From a strategic perspective, part of what has empowered our success was the creation of a Clinical Steering Committee and its four subcommittees, which have been instrumental in driving our enterprise-wide clinical strategy and helping organize our processes.

We have enhanced our data collection and analytics processes to create actionable data that is now influencing our strategies for FY 2018 and beyond. In addition, we have developed analytics tools and chronic disease management strategies to support our work.

The pages ahead show how we are innovating throughout our hospitals, clinically integrated networks and physician practices — from our workflows, to how we provide care and use various technologies. These innovations are driving us closer toward the Quadruple Aim and toward better health for all of our populations.

We are excited to share with you our most recent progress.

Overview of Population Health Management

"Population health activities . . . connect prevention, wellness and behavioral health science with health care delivery, quality and safety, disease prevention/management and economic issues of value and risk — all in the service of specific populations, particularly at-risk populations and sub-populations." THE JEFFERSON COLLEGE OF POPULATION HEALTH

Dignity Health's Population Health Management program is dedicated to ensuring individual patients' needs are met with extraordinary care. At the same time, our Community Health team focuses its efforts on building strong partnerships to help address social behavioral and medical determinants of health. This includes such things as housing, access to healthy food, safe places to exercise and more. Where these two missions overlap, we see a distinct opportunity to enhance the overall health of the communities and populations that we are privileged to serve.

Payment reform, through Value Based Agreements (VBAs), has had a profound impact on our approach to supporting the health of our patients. Operating within the context of a growing number of VBAs will require an increasing reliance on clinical analytics and population health determinants to determine the best ways to meet the needs of our patients, both individually and collectively. We believe this model helps improve outcomes and promotes healthier populations.

"With Healthy Populations, we all win. A focus on healthy populations creates a backdrop for enhanced quality of life for those we serve. Dignity Health's focus is on extraordinary care for individual patients, and improving health outcomes in the broadest sense by focusing on access to care, health education, disease management and prevention, and the social determinants of health. We see Population Health Management and Healthy Populations as inextricably linked."

GARY GREENSWEIG, VICE PRESIDENT AND CHIEF PHYSICIAN EXECUTIVE FOR PHYSICIAN INTEGRATION

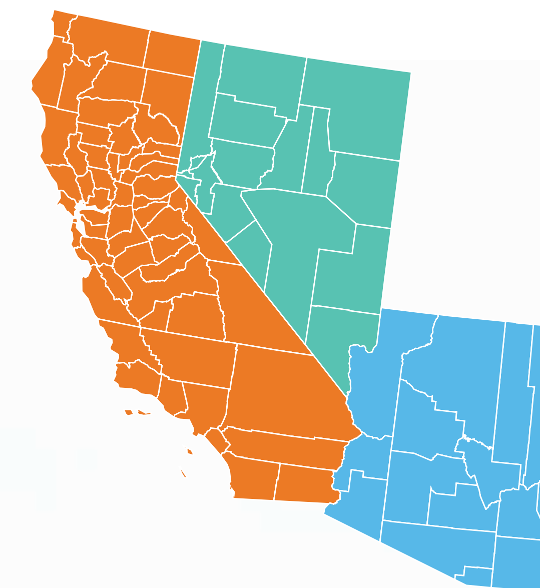
Total VBA Agreements

2018 VBA Agreements by Geography

California **986,283**
- GSSA **252,183**
- Central California **226,328**
- Southern California **282,277**
- Central Coast **136,296**
- Bay **59,644**
- North State **29,555**

Arizona **241,555**

Nevada **36,335**



Payment Innovation

The year 2013 marked the beginning of the Centers for Medicare and Medicaid Services initiative described as Bundled Payment for Care Improvement (BPCI). BPCI is one of several Medicare alternative payment models (APMs) — like accountable care organizations and the patient-centered medical home — that have been developed to preserve or improve quality of care, while reducing the total cost of care.

Since then, 25 Dignity Health hospitals and one affiliated hospital have enrolled in the program, covering 46 unique episodes of care and more than 41,000 Medicare patients.

The BPCI program promotes value-based care and operational efficiencies, while providing facilities and providers the opportunity to share in savings achieved by a more coordinated approach to care.

Dignity Health partners with naviHealth, a post-acute care services company that helps us to manage patients in the post-acute facilities environment. The collaborative efforts among hospitals, providers, post-acute facilities and naviHealth have yielded better outcomes and improved efficiency, which work in tandem to create more value-based care.

These results translate to savings for the participating hospitals, physicians, and naviHealth. Through Q2 2017 (the most recent quarter with fully reconciled data), Dignity Health achieved savings of $33 million. Additionally, we are projecting $53 million in savings through Q1 2018.

BPCI Savings Summary

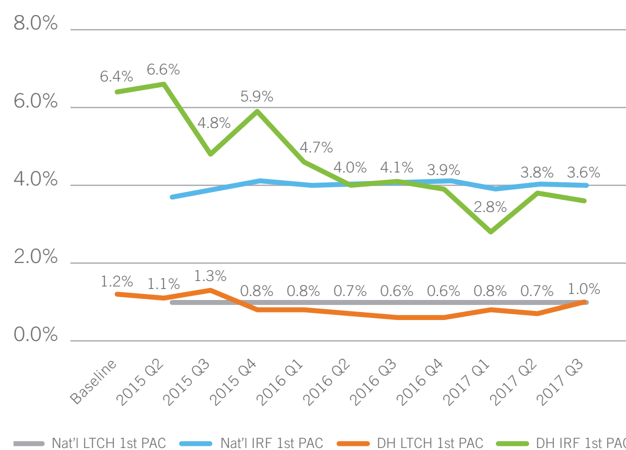
$33M

Reconciled data through Performance Year Q2 2017

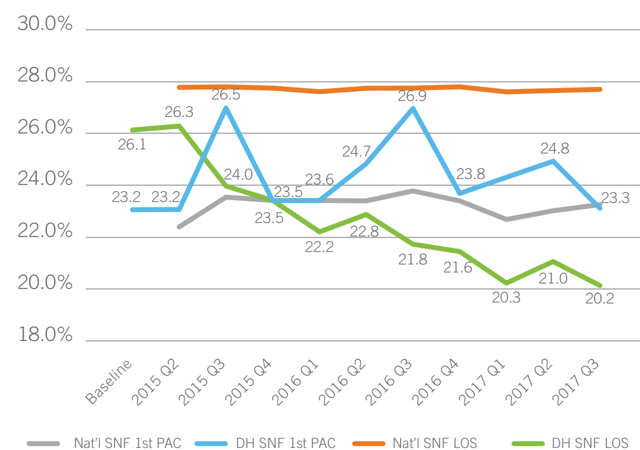
$53M

Projections through Performance Year Q1 2018

Utilization Summary – LTCH & IRF



Utilization Summary – SNF 1st PAC & LOS



Based on February 2018 monthly CMS claims filed for the BPCI bundled payment program.

The collaborative efforts among hospitals, providers, post-acute facilities, and naviHealth (post-acute services partner) have yielded both operational improvements and financial savings, which work in tandem to improve patient outcomes. This has resulted in reduction in long-term care hospital (LTCH), inpatient rehab facility (IRF), and skilled-nursing facility (SNF) discharge and length of stay (LOS), shown above, paired with a stable risk-adjusted readmission rate.

Payment Innovation: Medicare Accountable Care Organizations (ACOs)

The Medicare Shared Savings Program (MSSP), a voluntary value-based program, encourages doctors, hospitals and other providers to create an accountable care organization (ACO) to provide well-coordinated, high-quality care to their Medicare patients.

Dignity Health's five Medicare ACOs include:

- Southern California Integrated Care Network MSSP (California)
- North State Quality Care Network MSSP (Northern California)
- St. Rose Quality Care Network MSSP (Las Vegas, Nevada)
- Arizona Care Network MSSP (a jointly owned clinical integration network between Dignity and Abrazo Health, Arizona)
- Arizona Care Network NextGen (a jointly owned clinical integration network between Dignity and Abrazo Health, Arizona)

Nearly 100,000 Medicare lives are attributed to these five Medicare ACOs. To share in savings generated, ACOs must demonstrate success as measured by 31 quality measures.

Dignity Health is planning to expand its participation even further in 2019 to include Bakersfield and communities in the Central Valley of California, Stockton and Merced.

MSSP By the Numbers 2018:

Estimated Number of Medicare Lives, by Geography

9,640	NSQCN
8,075	SRQCN
42,186	SCICN
8,687	ACN
27,312	ACN NextGen

As of Sept. 2018

Hello humankindness®

“Every single person with whom I interacted treated me not as a set of symptoms but as a fellow human being. Everyone was marvelously attentive and professional. This Dignity Health Medical Center is a beacon of hope for health care. Your organization has worked wonders in fostering an attitude of caring and respect, over and above the technical details of diagnosis and treatment.”

Clinical Steering Committee

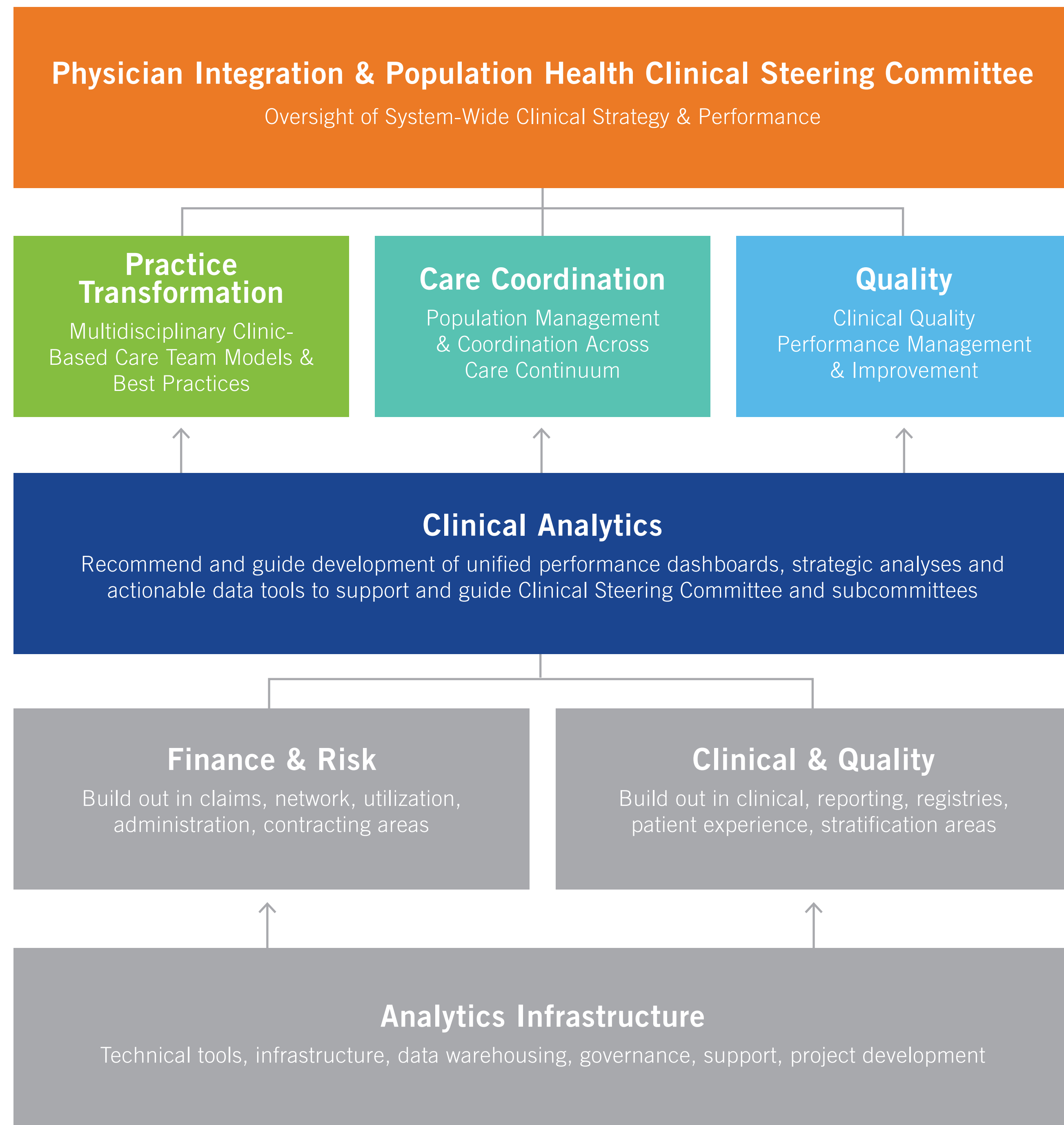
During the second half of 2017, we restructured the Clinical Steering Committee to govern our clinical direction for population health activities across the entire Dignity Health clinical enterprise.

The purpose and charter of the Clinical Steering Committee is to provide clinical governance and oversight to population health activities, such as guiding the clinical direction, priorities and focus of value-based care activities across Dignity Health.

The Clinical Steering Committee is supported by four subcommittees:

- Practice Transformation
- Care Coordination
- Quality and Chronic Disease Management
- Clinical Analytics (which also supports the other three subcommittees)

The Clinical Steering Committee focuses on enterprise-wide clinical direction for value-based enrollees. It is supported by the Practice Transformation, Care Coordination and Quality subcommittees. The Clinical Analytics Subcommittee supports the steering committee and all three subcommittees.



Value-Based Agreement (VBA) Council

With our focus on growing our value-based membership, Dignity Health has specific goals to improve performance in value-based agreements (VBAs). The VBA Council was established in April 2017 and collaboratively manages these goals for Dignity Health's value-based membership across the enterprise.

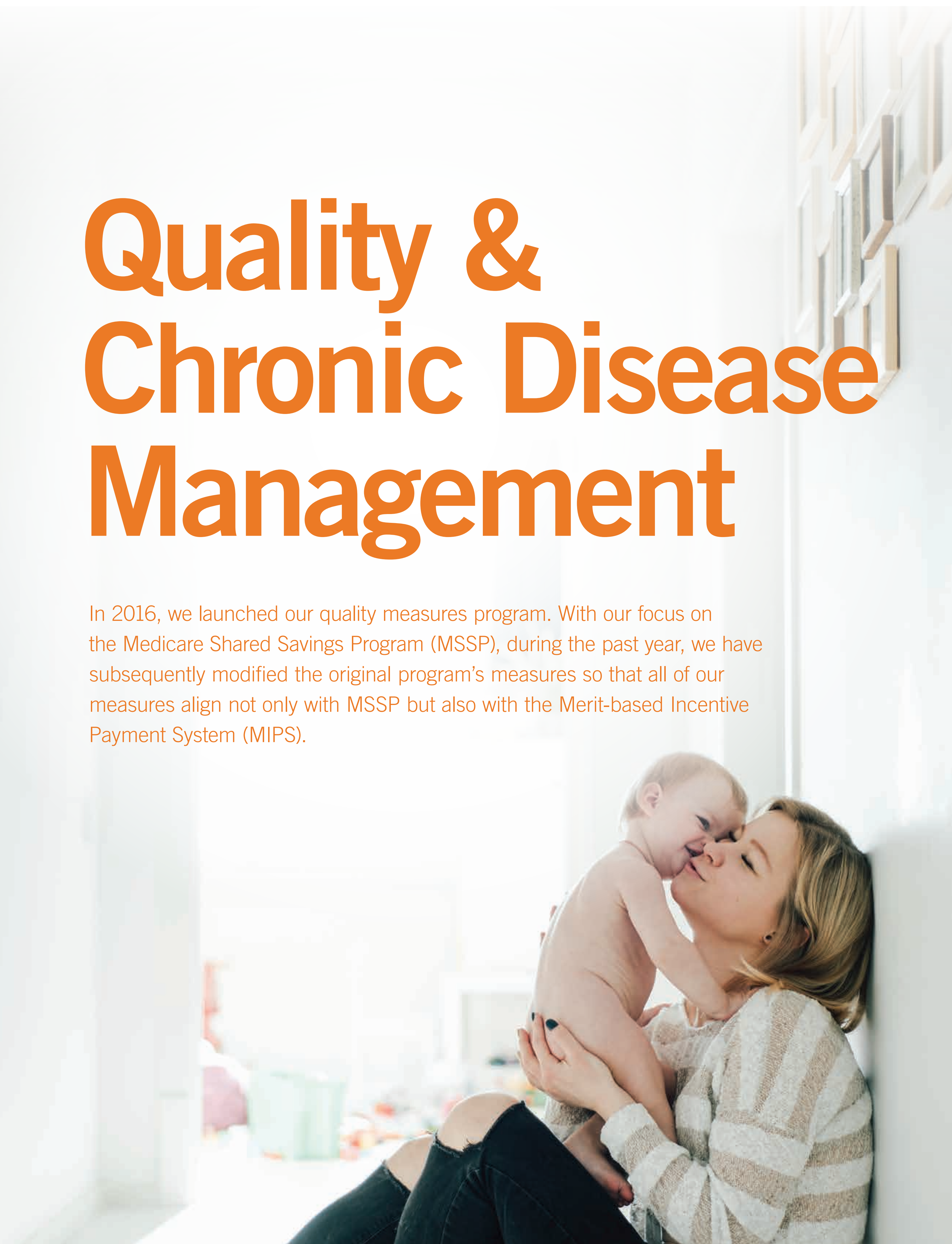
Key goals include:

- Clinical Steering: Complex care programs, disease management, clinical pathways
- Financial: Risk pool results, total medical expense
- Out-of-network (OON) and referral management

One area of focus included driving OON admissions back to Dignity Health facilities. Our various OON teams relied on certain levers, such as contracts, pricing controls and clinical factors to accomplish this goal.

$18.9M

For the 12 months ending on June 30, 2018, Dignity Health reduced fragmentation of care and improved in-network utilization, accomplishing a savings of $18.9 million in inpatient out-of-network cost.



Quality & Chronic Disease Management

In 2016, we launched our quality measures program. With our focus on the Medicare Shared Savings Program (MSSP), during the past year, we have subsequently modified the original program's measures so that all of our measures align not only with MSSP but also with the Merit-based Incentive Payment System (MIPS).

MSSP ACOs Report on 31 Quality Measures

	Patient/ Caregiver Experience	Care Coordination/ Patient Safety	Preventive Health	At-Risk Population
Total Points Possible	8	10	8	5
Number of Measures	16	22	16	8
Domain Weight	25%	25%	25%	25%

CMS also rewards ACOs for improvement within a domain by adding up to four points to each domain score.

About the Quality Subcommittee

Co-Chairs: Dr. Ann Marie Sun (ACN) and Dr. David Dahnke (Lassen)

The Quality Subcommittee exists to:

- Collaboratively create and regularly update physician-led clinically integrated standards of practice and clinical practice guidelines that support patients on their journey of health, wellness and healing
- Monitor the overall clinical quality and performance of the Dignity Health Physician Integration Clinical Enterprise

Based on the Quadruple Aim, the Quality Subcommittee set performance expectations across the service lines of our providers, which include emphasis on:

- prevention
- compliance with current standards of medical practice
- creation of a culture of clinical interdependence
- ensuring an enriched patient and provider experience and
- appropriate utilization of resources

Chronic Disease Management Task Force

The Chronic Disease Management Task Force, which is part of the Quality Subcommittee, has developed care pathways, protocols and toolkits, including:

- Hypertension
- Hyperlipidemia
- Diabetes
- COPD
- Annual Wellness Exam Toolkit
- Opioid Prescribing Toolkit
- Smoking Cessation

These evidence-based guidelines are based on well-vetted national standards and toolkits of care and serve as resources for physicians. Our physicians are encouraged to exercise their own judgment in caring for patients, but to refer to the pathways and protocols as a guide when needed.

MSSP Data Validation

Between Jan. 15 and March 15 of 2018, our five ACOs — ACN and ACN NextGen, SCICN, NSQCN and SRQCN — engaged in the Group Physician Reporting Option (GPRO), the process of abstracting and validating quality data for MSSP.

Once received, a team of 34 abstractors (including auditors) had eight weeks to manually abstract the required data from athenahealth, our platform for aggregating claims and other data from providers' various electronic health records (EHRs).

For each ACO in the program, we received a list of 616 attributed MSSP patients for each of the 15 reportable quality of care measures to pull data for, with the expectation that we report back — validating in each chart that certain measures were met — on a minimum of 248 consecutive beneficiaries for each measure (or 100 percent if we have fewer than 248 eligible beneficiaries).

GPRO By the Numbers

5 ACOs in MSSP	**34** Abstractors (including auditors)
13,400+ Man Hours*	**14,300+** Total Number of Beneficiaries Abstracted
41,901 Total Number of Measures Abstracted	**6 weeks** Time to Completion

*Does not include administrative duties

Reviews of the data show our participating networks exceeding the national MSSP average in many of the measures. Most importantly, through the abstraction and verification process, we now have reliable benchmark data to assess the performance of our networks, practices and providers. Moving forward, network leaders, as well as individual providers, will be able to view their quality data to determine where improvement is needed in processes or reporting.

Hello humankindness®

“Every nurse operated with the highest level of professionalism and care. Their dedication to their duties and to the tenets of excellent health care never wavered. Therapy staff gave me hope that I would someday be able to walk, talk and function in my world again. Your staff truly showed me that my tomorrows can be better than all my yesterdays.”

Practice Transformation

To improve the health of our population and to achieve our quality measure goals, we see value in helping our medical groups learn best practices and re-imagine their workflows to maximize their efficiency and value.

Co-chairs: Jennifer Brooks (ACN) and Dr. Mary Monroe-Rodman (Woodland)

About the Practice Transformation Subcommittee

The Practice Transformation Subcommittee was created to assist with operationalizing clinical pathways, enhancing practice workflows and deploying new technologies to better perform on the quality measures and other metrics that determine success in value-based arrangements.

The 12-member subcommittee, made up of physicians, operational leads and support staff from across Dignity Health, is responsible for assisting practices transforming to value-based care and practice by:

- Developing a standard format in which the Dignity Physician Integration team will create, distribute and revise any materials that will support the clinical guidelines from the Quality Subcommittee and other entities creating content to support success in VBA performance. These materials might include flow diagrams, toolkits and tip sheets.
- Defining standardized implementation timelines and milestones for subcommittee content, as well as leveraging change-management strategies to help the CINs implement any new programs, or to support any currently implemented programs.
- Identifying the need for additional technologies to solve clinical/operational challenges and working with IT and other entities to vet vendor solutions.

Key Practice Transformation Initiatives

The Practice Transformation Subcommittee has undertaken three primary initiatives to launch the effort. These include:

Annual Wellness Visits. Using the Population Health leadership team's Annual Wellness Visit guide, the Practice Transformation group devised an Annual Wellness Visit Toolkit for practice medical directors and operational leads. The toolkit helps practices understand what each person in the clinic should do before, during and after an Annual Wellness Visit.

Transitional Care Management. A *Journal of the American Medical Association* (JAMA) paper analyzed over 18 million TCM-eligible discharges over a three-year period to quantify the impact of compliant TCM services on post-discharge spend, mortality rate, and readmission rates. The post-discharge spend 31-60 days after eligible discharge decreased by 9.7 percent and decreased the post-discharge mortality rate by 0.6 percent.[1]

CMS offers a billing code for transitional care, which offers a higher reimbursement than a standard 99214 or 99215 visit. The Practice Transformation team sees an opportunity to educate providers on transitional care, helping them become more efficient, provide valuable evidence-based care to their patients and collect the appropriate CMS reimbursement.

Shared Decision-Making. There are opportunities to educate patients about their rights and responsibilities and to ensure end-of-life care conversations take place in the appropriate setting at the appropriate time.

[1]**SOURCE:** Bindman AB, Cox DF. Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries. JAMA Intern Med. 2018;178(9):1165–1171. doi:10.1001/jamainternmed.2018.2572

Facilitating In-Network Referrals Through par8o

Ensuring continuity of care requires providing more coordinated care for our patients and increasing our in-network referral rate. par8o helps us effectively and efficiently manage referrals and improve in-network referral rates.

This web-based referral management platform allows physicians to easily refer patients to providers who accept their insurance. It has also been designated as the main referral processing system for all Medicare Shared Savings patients.

In addition, par8o enables a deeper understanding of the health care markets Dignity Health serves by providing data that can strategically pinpoint areas where additional providers may be needed, enabling improved patient care and recruitment efforts.

par8o implementation began in 2017 and has gone live in:

- Arizona Care Network (ACN)
- Dignity Health Arizona Hospital and 10 associated emergency departments
- Mercy Medical Group (MMG) in Sacramento
- Santa Cruz Dignity Health Medical Network
- St. Rose Quality Care Network in Las Vegas
- Woodland Clinic Medical Group in Woodland

In early 2017, Arizona launched the par8o tool. They showed exponential growth in the number of referrals over the first three quarters of 2017. During that span, the in-network referral percentage averaged 78 percent and continued around 80 percent for the first three quarters of 2018.

During the launch year of 2017, the number of ACN sending providers increased by 30 percent, and the number of receiving providers almost doubled. Further, the total number of referrals sent in the first three quarters of 2018 turned out to be roughly 75 percent more than the number of referrals sent in the first three quarters of 2017.

Similar growth was seen in Mercy Medical Group (MMG), which went live in March 2018. In the first three quarters, MMG had exponential growth in the number of referrals. The in-network referral percentage averaged 87 percent for the three quarters, and the number of sending providers increased by over 30 percent.

The tool will be rolled out to the remaining CINs and Dignity Health markets by early FY20.

Improved Clinician Experience: Caring for the Care Providers

Part of ensuring a better experience for clinicians at Dignity Health requires a focus on the prevention and management of provider burnout — among physicians and nurses.

In 2016, Dignity Health's Arizona Service Area sponsored the pilot of a commercially available self-assessment tool, WELL-BEING INDEX by MedEd Solutions, to gain individualized feedback on physician wellness, job satisfaction and burnout. The confidential, web-based tool was co-developed by and deployed at the Mayo Clinic and is now used by more than 40 major health systems across the U.S. Dignity Health has adopted this tool for our clinical providers, giving them access to valuable supportive resources.

Following the pilot, chief physician executives in additional service areas — including Nevada, Southern California, GSSA and the California GME programs — have deployed this tool and analyzed their regional results. In addition, local events have been held to discuss physician well-being and address some of the key contributors.

Dignity Health nurse research leaders and Dr. Keith Frey, Chief Physician Executive for Dignity Health Arizona, have also launched research studies, in partnership with Arizona State University, to further examine key drivers for bedside nurse burnout. The research will be expanded to include other clinicians as preliminary results are reviewed.

Care Coordination

In 2017, Dignity Health sought to improve and standardize its care coordination efforts by creating an enterprise-wide approach to care coordination. We worked with ambulatory physicians, nurses, care coordinators and other stakeholders across Dignity Health and employed various tools and evidence-based research to design a standardized structure and approach to care coordination.

The goal of care coordination is to help the patient regain or maintain optimum health or improved functional capability that best serves the patient.

Co-Chairs: Gail Daly (System), Gail Moxley (System), Jamie Davis (System)

About the Program

Under Dignity Health's new care coordination model, patients are evaluated and then placed into one of four categories based on a specific set of qualifying parameters. Each category includes corresponding services and best practices that care coordinators can use to provide care for each individual.

Category 4
Palliative Care

Category 3
Complex Care

Category 2
Rising Risk

Category 1
Wellness/Stable

The athenahealth Population Health platform assists with risk stratification of Dignity Health's patient population. This helps our care coordinators to identify potential candidates, access social determinants of health, enroll patients in disease management programs and document patient interactions. It also helps them make evidence-based medical care decisions while concentrating resources where they can do the most good for the overall population.

Humankindness lives here. From Hope to Home

When Sandra* was sent to short-term rehabilitation after surgery for a hip fracture, her world fell apart: During her stay, her husband passed away and her daughter committed suicide. As a result, she became depressed, stopped participating in therapy and "just wanted to die." At the request of the rehab facility's administrator, Dignity Health's Care Coordination team worked to find resources to offer her support during a time of crisis for the purpose of healing mind, body and spirit. They were able to connect with a local hospice partner who provided a licensed clinical social worker for support. The licensed clinical social worker made medication recommendations to the attending physician, met with Sandra and encouraged her to ease back into therapy, after which she was eventually able to return home.

*Name has been changed to protect patient privacy.

Dignity Health Transfer Center

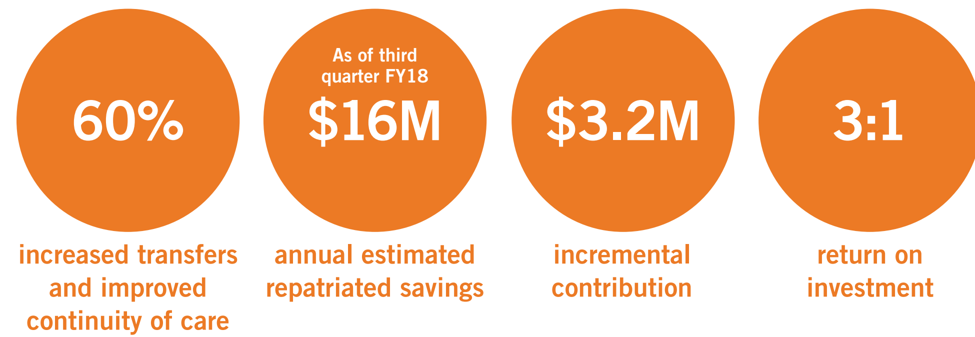
Though its physical location is in Sacramento, the Transfer Center is able to advance a coordinated, systematic, and customizable approach to serving those with acute, chronic and complex conditions by providing leading transfer and consult services. These services help create coordinated and continuous patient journeys and maximize access to the best care available. The ranges of services include: Acute transfer and consults, System telemedicine, Patient placement, Post-discharge placement.

In October 2017, the Dignity Health Transfer Center began its system standardization process, operationalizing all of its markets. The Transfer Center's reach now includes the service areas of Sacramento, Southern California, Arizona, North State and the Bay, as well as three pending service areas: Bakersfield/Central California, Central Coast and Nevada.

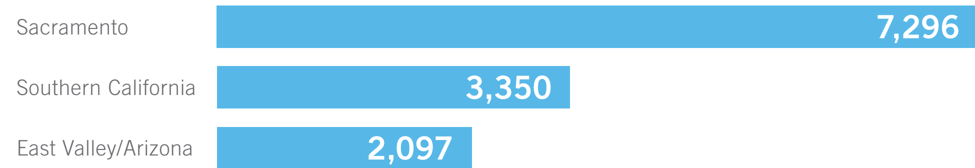
The Transfer Center adds value by:

1. Improving continuity of care and reducing leakage for outbound transfers
2. Enabling rapid in-network reintroduction at preferred Dignity Health providers
3. Increasing new patient volume

Achievements



Large-market completed transfers by service area in FY18



Hello humankindness®

“My husband underwent back surgery at Dignity Health. We are still talking about the amazing care. Communication from all members of your staff was beyond anything we could have expected, and kept us calm. Housekeeping staff tiptoed into the room; nursing and support staff greeted our questions and concerns with a smile. We never felt that they were rushed and they showed genuine concern.”

Clinical Analytics

The key to understanding where we are and how we're progressing lies in our data and our commitment to clinical analytics. Demonstrating our success in overall quality and outcomes, measures of resource utilization, and practice transformation and care coordination requires an ambitious approach to data collection and a strong clinical analytics function.

Co-Chairs: Dr. Nicholas Stine (System) and Lisa Perko (System)

About the Clinical Analytics Subcommittee

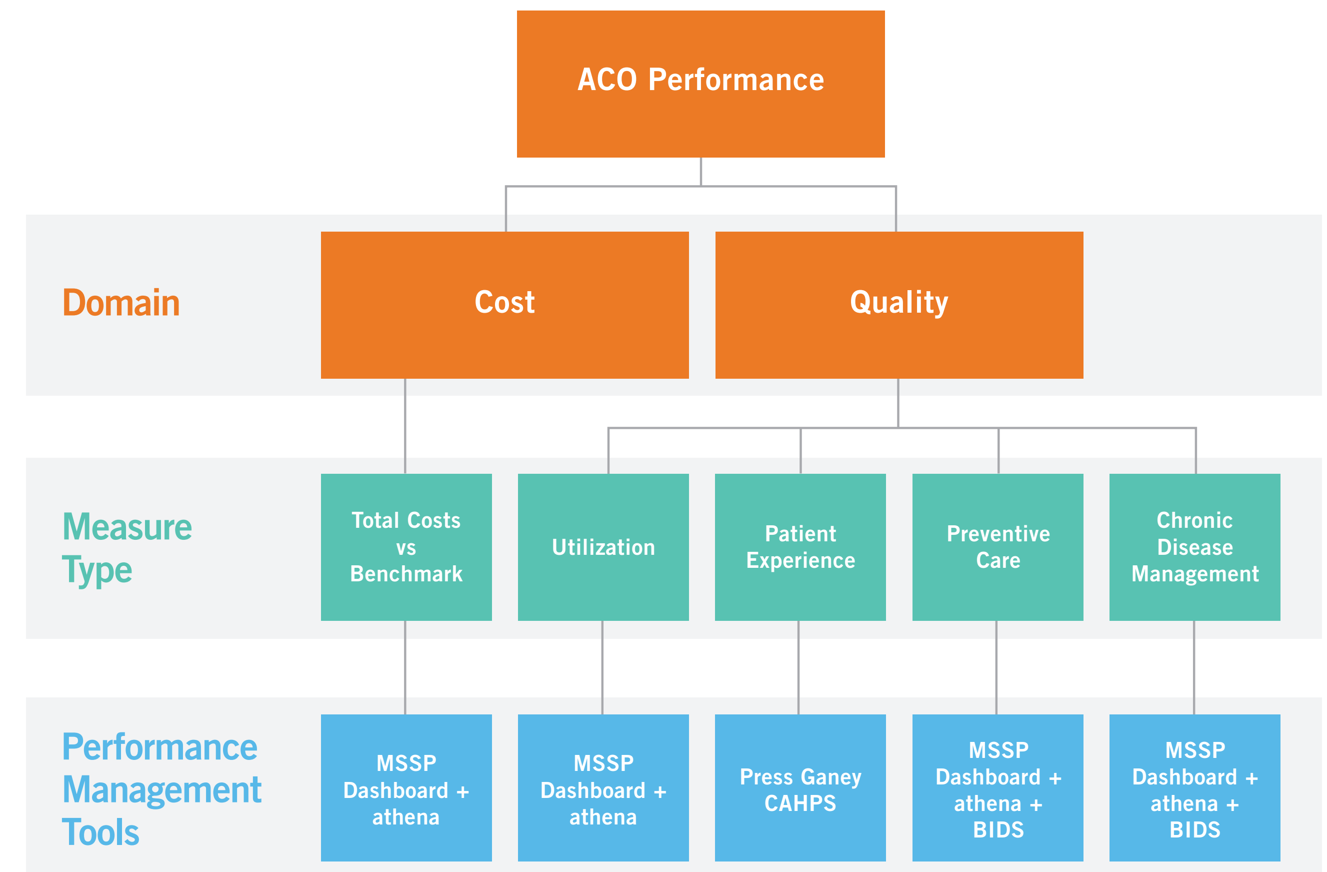
The Clinical Analytics Subcommittee is responsible for identifying and reporting on key clinical, quality, risk, and financial drivers. The subcommittee ensures that analytics development strategies and capabilities align with enterprise clinical, quality, risk and financial performance goals. It also sets the vision and direction of the strategies to be implemented while monitoring the status of the identified initiatives and projects and providing oversight on deliverables.

The subcommittee's main goals are to:

- Recommend and guide development of unified performance dashboards, strategic analyses and actionable data tools to support the Quadruple Aim for health care and guide the Clinical Steering Committee and work groups
- Formulate strategies for establishing, defining and developing capabilities for clinical, risk, financial and quality performance targets of Population Health programs
- Enact and solidify analytics strategies to drive how organizational goals and health care transformation are achieved

MSSP Performance Management: How We Measure Cost and Quality

Our view of MSSP performance combines measures of both quality and cost.



Dignity Health MSSP ACOs Priority Metrics

After analyzing our performance measures, we have identified — at the network and practice level — the areas that each group needs to focus on to improve performance.

North State MSSP

1. Part B – Macular Degeneration
2. SNF Utilization
3. Inpatient Admission Rate

St. Rose MSSP

1. IRF Utilization
2. Part B
3. CHF Admission Rate

California MSSP

ACO Overall
1. Inpatient Admission Rate
2. ED Visit Rate

MMG
1. Inpatient Admission Rate
2. Part B – Macular Degeneration

FPMG
1. Inpatient Admission Rate
2. SNF Utilization

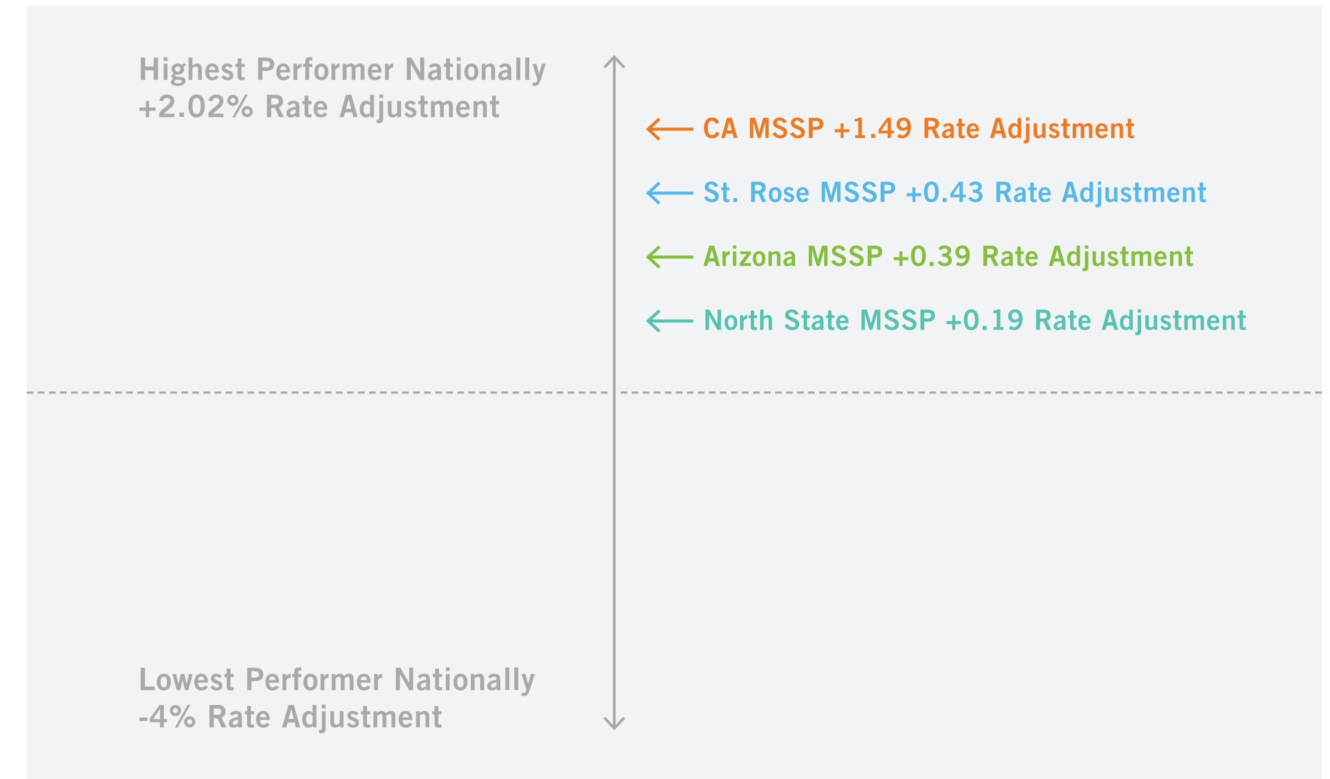
SCICN
1. Inpatient Admission Rate
2. SNF Utilization
3. Part B – Macular Degeneration

MMG
1. Part B – Macular Degeneration
2. ED Visit Rate

FPMG
1. SNF Utilization
2. Inpatient Admission Rate

2017 MIPS Performance — 2019 Rate Adjustments

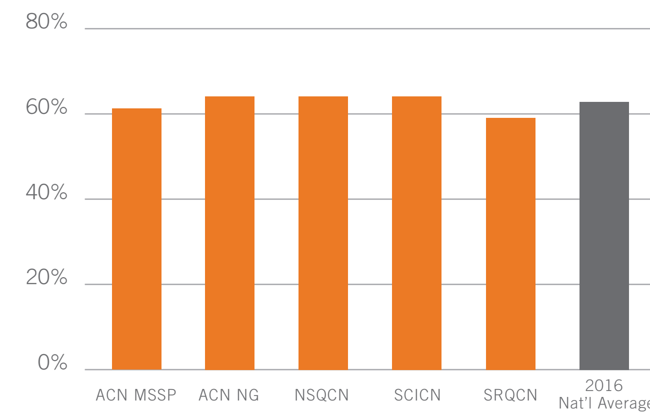
The table below outlines our ACOs' total MIPS payment adjustments for 2019 (based on 2017 performance).



2017 GPRO Results Summary

Each year, we submit quality measure data to CMS as part of our participation in the MSSP ACO program. The charts below show the results of our various networks, which, in general, performed better than the previous year's national average.

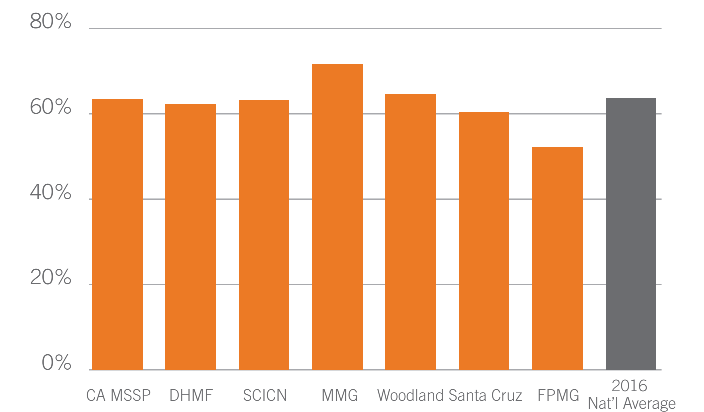
Average of 2017 GPRO Results



A Closer Look at California

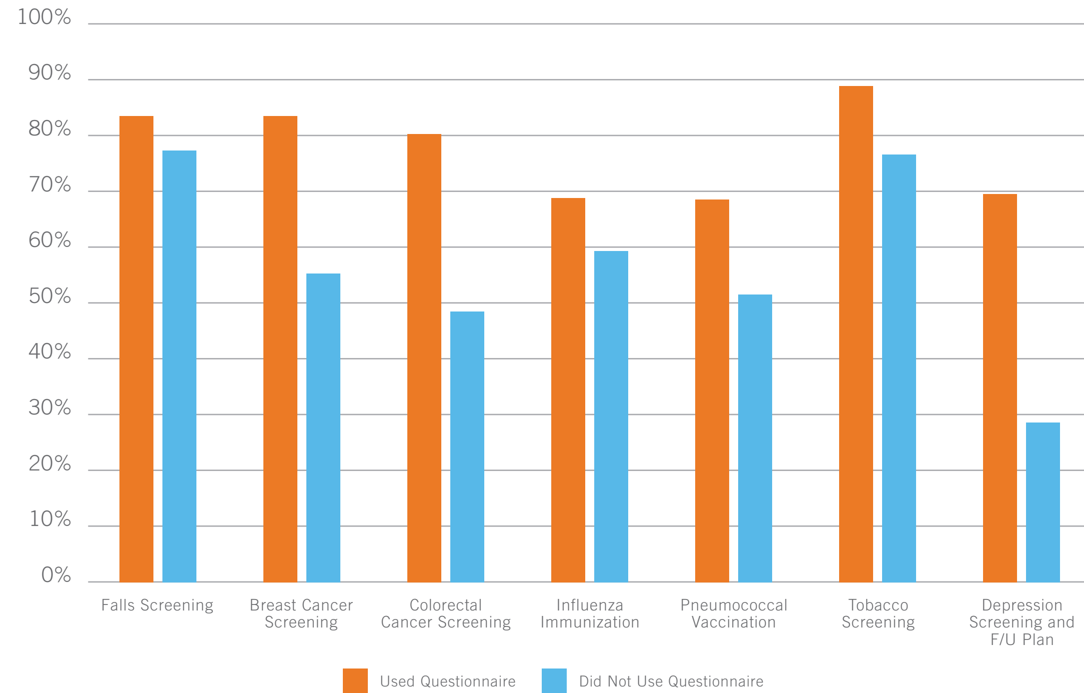
Within California, there are two key stakeholders — SCICN and the Dignity Health Medical Foundation. Under the umbrella of the Foundation are four groups: MMG, Woodland, Santa Cruz and FPMG.

Average of 2017 Reported Quality Measures



Use of Patient Questionnaire & Practice Performance within St. Rose MSSP

In SRQCN, the Nevada CIN did a pilot study looking at the value of a Medicare patient questionnaire. We found the presence of critical data to be higher when the questionnaire is used. These results were the catalyst to implement the questionnaire as a tool more widely across our networks.



MSSP Dashboard: Core Performance Management Tool Developed by the Data & Analytics Subcommittee at Dignity Health

Using the athena platform, we are able to view various key data points via a clinical dashboard. Analysis of this data helps us determine our performance priorities.

Key 2017-18 Accomplishments

In less than a year, the Clinical Analytics Subcommittee has achieved a few important accomplishments:

- Established an enterprise-wide scope, strategy and governance of the Population Health analytics function. The subcommittee has been central to developing a lens through which we can view the full picture of Population Health and Clinical Integration
- Established a comprehensive and enterprise-wide approach to how patients are attributed to primary care physicians in our various tools, enhancing the accuracy and usefulness of our reporting and analyses
- Created a PMPM Dashboard with established targets for both quality and value-based care goals at enterprise/regional and local levels
- Established a standard reporting tool-set using data available in the athena Sandbox, including monthly reporting and distribution of the following reports:
  - – Annual Wellness Visits
  - – Attributed Members
  - – Disease-State Registry
    - - Coronary Artery Disease (CAD)
    - - Congestive Heart Failure (CHF)
    - - Chronic Obstructive Pulmonary Disease (COPD)
    - - Diabetes
    - - Hypertension
  - – High-Cost Members ($50K or more in the last 12 months)
  - – High-Risk Members
  - – Inpatient Frequent Utilization
  - – ED Frequent Utilization
  - – MSSP Quality Measure Tracking
  - – Part B Drug Utilization – Macular Degeneration
  - – Part B Drug Utilization – Osteoarthritis
  - – Part B Drug Utilization – Osteoporosis
  - – Inpatient Admissions for CHF
  - – Inpatient Admissions for COPD
  - – Bi-Weekly MSSP Tracking Report: tracks care coordination activities
  - – Weekly CCE Dashboard: provides counts of each CCE enrollment statuses by market
  - – Care Coordination Activity Detail: individual PCP report includes patients enrolled in care coordination and detailed activity for each patient

The Role of athenahealth

athenahealth, a population health solution, is a cloud-based tool for managing patient populations. Within Population Health, athenahealth is used to manage care coordination activities, value-based care activities and quality measures reports.

The implementation of athenahealth has allowed us to standardize the processes and criteria for identifying high-risk members, coordinating care and managing services available. The athena platform empowers us to report on care coordination productivity across the enterprise, including referrals and member touchpoints. This solution allows us to better assess our outcomes and successes and to identify areas that might need additional clinical resources.

athena aggregates data from multiple sources to deliver a complete picture of care

Payers

Aetna (3)
BlueCross BlueShield (15)
Bright Health (1)
CareMore Health (1)
Cigna (4)
CMS (5)
Express Scripts (1)
GemCare (1)
Health Net (8)
MercyCare Health Plans (1)
QualCare (1)
UnitedHealthcare (4)
Western Healthcare Alliance (1)

Labs

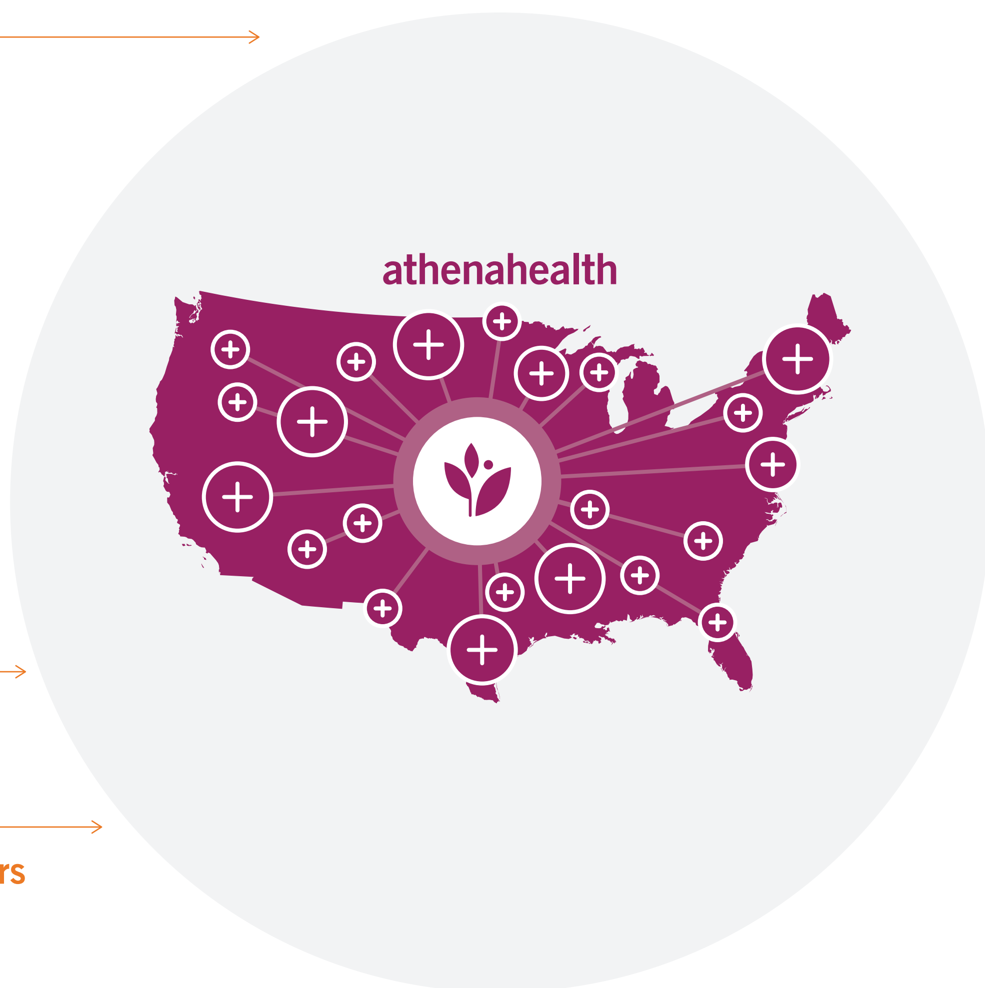
Cerner (10)
LabCorp (6)
Meditech (2)
Quest Diagnostics (9)

EMRs

Allscripts (5)
Cerner (10)
athenaOne (15)

Admissions/ Discharges/Transfers

Cerner (10)
Health Current (1)
Meditech (2)

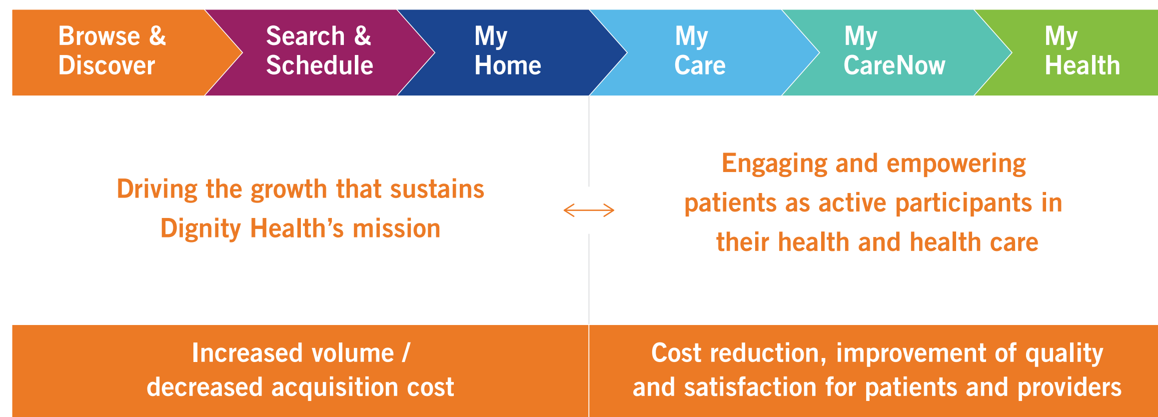


The athenahealth Quality Measurement tool tracks members, documents information and generates reports to allow us to track gaps in care and helps quantify our overall progress in quality measure management. Beyond the requisite reporting, we are able to use the quality data we collect to assess where we need to invest resources, expand programs and explore opportunities for cost efficiencies.

During our initial year in the MSSP Program, we developed regular reports to assist our CINs and clinics. Monthly dashboards and specific reporting tools help medical directors and other leaders identify where they are excelling, as well as areas that need improvement.

Technology & Digital

The Dignity Health Office of Digital seeks to create an intensely positive and personalized patient and consumer digital experience, driving growth that sustains our mission by engaging and empowering patients as active participants in their health and health care.



Web Presence Enhancements

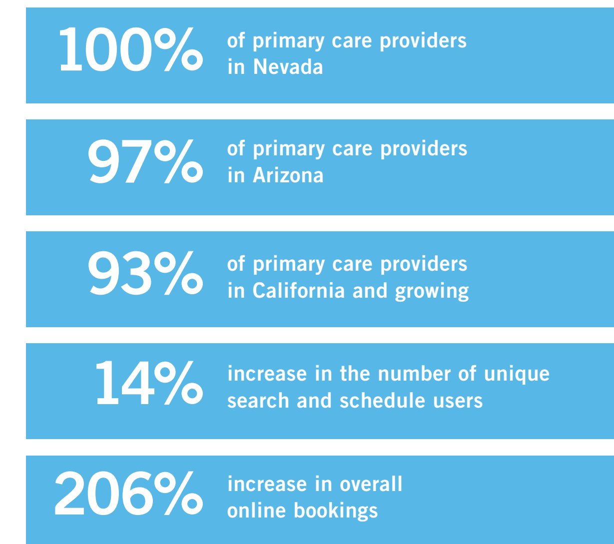
Throughout FY17 and into FY18, the DignityHealth.org website underwent extraordinary transformation with enhancements that included:

- Personalized marketing landing pages for all Dignity Health service lines, with key enhancements such as form integration to assist with lead generation and marketing automation
- A re-optimized urgent care and emergency services scheduling environment with enhanced features such as an integrated registration form, advanced search filters, mobile-ready enablement, an interactive Google map integration that includes location pins with facility images, location details and hours of operation
- Continued search engine optimization (SEO) enhancements that ensure patients and consumers get timely and always up-to-date information about each facility and clinic

Search and Schedule

The Find-a-Doctor tool continues to receive consumer-friendly features that make it easier for consumers and patients to find a Dignity Health provider suited to their needs. This includes the expansion of our online booking feature.

And the tool is catching on. In the past year, we experienced 50 percent growth in participating physicians, with current provider participation at:



My Home

My Home guides patients to resources and fosters long-term relationships by bridging Dignity Health clinical services and digital tools. My Home also serves as a springboard into other digital offerings, including paying bills online, accessing medical records and securely messaging with providers.

The My Home app has already won two national awards: the 2018 Digital Edge Award for digital transformation and the 2018 Mobile Web Award as the best-in-class health care mobile application. Since its release in April 2017, My Home enrollments have shown a steady upward trend, with a total of more than 24,600 individual accounts registered as of July 2018.

Telehealth

Patients can not only search, find and engage with us, but can also receive online care via telehealth, all from the convenience of their homes. Patients invited to participate in telehealth enjoy a seamless care delivery experience from within the Dignity Health My Home app.

Digital Care Transformation

Dignity Health provides patients with tools to enhance their care experience and to improve their self-care for various conditions. In collaboration with the Population Health and Care Coordination programs, we have implemented tools to assist with patient management between visits, decreasing the likelihood of unexpected emergency department/urgent care visits or hospitalizations.

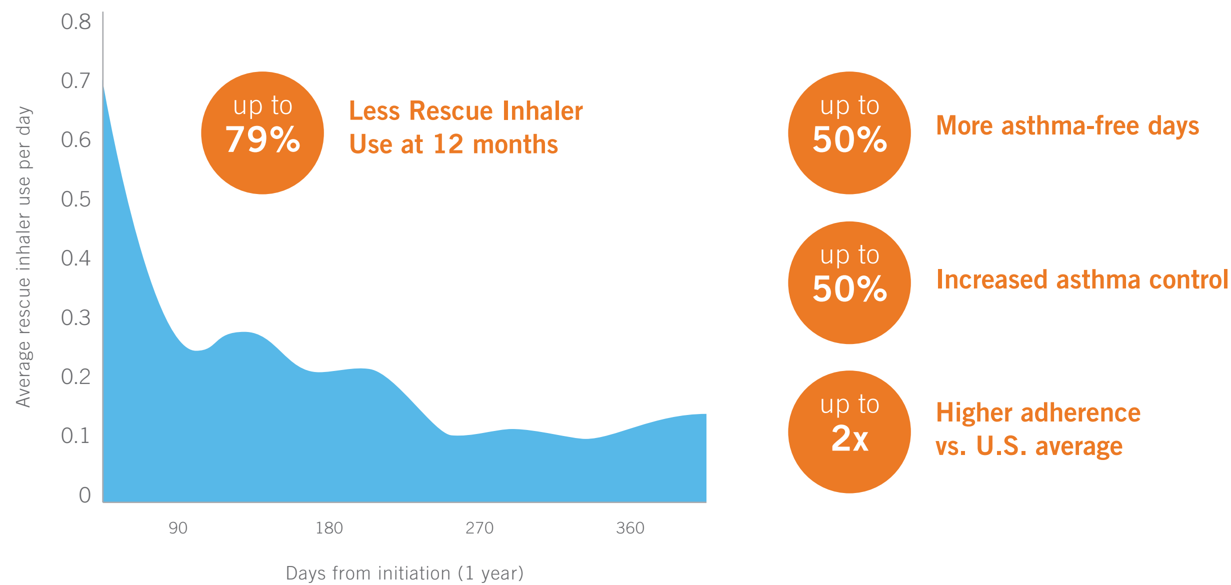
These projects include:

- **Livongo Healthcare,** which allows Dignity Health to provide our patients with diabetes access to a data-enabled glucose meter, supplies, coaching and other products and services.
- **The MyBaby app,** which helps expectant mothers have a healthier pregnancy through information and connecting them to nurse support.
- **An Apple partnership** that allows Dignity Health patients who are iPhone users to access and visualize their health records via the phone's Health app.
- **The Propeller Health Asthma Platform,** which provides detailed information about patterns of medication use and notifies providers about patients with worsening asthma control. A randomized controlled study conducted at Dignity Health's Woodland Clinic Medical Group and recently published in the *Journal of Allergy and Clinical Immunology: In Practice* demonstrated that it improved asthma control.

Enabling this type of innovation within an organization of Dignity Health's size and complexity requires a commitment to wholesale organizational change. Through a culture dedicated to continual releases, versions and improvements, the Office of Digital will be able to continue to accomplish and surpass its aims.

Clinical Outcomes: Aggregated with Other Health Systems

Using predictive analytics tools to look at various parameters such as air pollution, temperature, humidity and others to predict the likelihood of an asthma event, the Propeller platform showed the following results compared with baseline numbers, demonstrating the tool's effectiveness.



100% elimination of hospitalization

64% reduction of emergency department visits

61% increase in ambulatory visits

Dignity Health Insights Analytics

Population Health's thirst for data to power the athena platform is at the core of Dignity Health Insights (DHI) Analytics. Serving to directly enable Population Health objectives, DHI Analytics has evolved into a data hub for athena Population Health. The team's mission is to enhance the quality of care and to reduce costs by aggregating internal and external data sources into a hub to predict, manage and deliver unique insights. Beyond being able to aggregate information for use with the Population Health program, the DHI team of physician informaticists, data scientists, clinical analysts, IT programmers and developers has been able to uniquely deliver insights back into operational workflow that extends across the continuum of care.

In 2017, the team built and deployed several inpatient tools including:

SMART Care Transition (SCT). Proper discharge planning has proven to reduce readmissions and decrease the cost of health care. The SCT app provides unique, thought-out management insights, real-time length-of-stay (LOS) management and readmission-risk scoring that enhances the care coordination team's ability to manage risk for at-risk patients.

Antibiotic Stewardship. This application enables rapid lookup of the inpatient antibiotic provider and facility utilization of all high-cost antibiotics. Integrating basic information from clinical, financial and quality data systems to support further analysis, this app creates opportunities to identify high-cost, high-utilization drugs and their days of therapy, and to recommend potential alternatives to reduce utilization. In addition, utilization trends in drugs of interest can be tracked by service area, facility and more.

Global Patient Search (GPS). This product enables the rapid lookup of inpatient encounters by any condition (using ICD-10 and DRG codes) or demographic attribute of a custom cohort of patients. This provides the chance to identify areas of opportunity for various outcome parameters by generating and comparing cohorts, and offers an avenue to request encounter-level cohort information for further analysis.

Sepsis Dashboard. The Sepsis Dashboard was created to monitor outcomes and key performance indicators (KPIs) of the Dignity Health sepsis program in near real time and apply an accountability model for program performance. Current calculations show that 317 lives were saved in 2017 due to the combined efforts of the sepsis program tools, processes and people dedicated to identifying and responding to sepsis. The program has resulted in a $28 million savings from length of stay and ICU stay reductions from FY16-FY18.

Health Information Exchange

Using technology to share patient information across the system — and even beyond Dignity Health — breaks down the traditional silos of care and enhances our providers' ability to coordinate care across the spectrum while empowering patients to participate in their own health care solutions.

Cerner Health Information Exchange (HIE) is our HIE platform, which allows us to share clinical information with more than 10,000 affiliated and community physicians and our 39 hospitals across three states. The technology is foundational to our clinical integration strategy.

As of December 2018, 69 percent of participating clinical staff in Dignity Health's clinically integrated networks are provisioned on the Cerner HIE provider portal.

In addition, Dignity Health providers that use Cerner's EHR in their practices are connected to Cerner Community View, a solution that links many large health systems, including but not limited to Kaiser Permanente, Stanford Health Care, Department Veterans Affairs, UCSF, CVS Minute Clinic, UC Davis, Sutter Health, Providence Health & Services, and more. Community View also offers the ability to view data via various regional and state HIEs.

Dignity Health providers access Community View more than 3,000 times (patient encounters) a day. Through our participation in local and state HIEs, as well as national networks that are connected to Community View, our clinicians are empowered with the information they need to give the most accurate diagnoses and to provide the best care. This means physicians have a clearer picture of a patient's recent medical history.

Moving forward in FY 2018 and beyond, our IT team will continue to work with our providers and clinics to deploy EHR systems that integrate smoothly into their workflows, help address gaps in care and make it easy for them to access the records they need when they need them to provide the highest-quality care.

> "Community View is a real game changer. Many patients I am caring for traverse in and out of the Dignity Health system, and now having the ability to see the patient in a larger context and view previous clinical notes, labs and reports makes for a better handoff and facilitates care that is higher quality, more efficient and less costly. Providers and patients both win!"

DR. FRANCISCO RHEIN, HOSPITALIST
CMIO BAY AREA SERVICE AREA

Augmedix

Augmedix is a patient-charting solution that uses wearable technology to help providers spend less time charting and more time with their patients.

With Augmedix, patient notes are completed in real time by remote, professionally trained scribes working in HIPAA-secure environments. The provider wears a Google Glass device during the patient visit, and a live, audiovisual feed is streamed securely to the scribe. These streams are not recorded, but simply used by the scribes, who access the patient's electronic medical record remotely and create a patient note in real time.

It's worth noting:

- As of October 2018, we had 83 providers using Augmedix.
- Physicians utilizing Augmedix spend less time charting and more time with patients than their non-Augmedix counterparts. They save about an hour a day charting and see 1.4 patients more per day.
- There is a more than 98 percent acceptance rate among patients.

The improvements in documentation and productivity with the use of Augmedix have resulted in a return on investment that more than funds the additional cost of the technology. Patients also benefit because they find that their physician spends more time in conversation during their visit. The overall quality of clinical documentation for the patient's record has also improved.

Because of these positive results, an oversight committee formed to govern the expansion of Augmedix across Dignity Health operations has recommended a gradual and incremental rollout in selected sites across Dignity Health, with physicians in five of Dignity Health's eight service areas currently using Augmedix.

We anticipate an increase of up to 100 Dignity Health providers utilizing Augmedix by the end of FY 2019.

Humankindness lives here. Community View in Action

Don* arrived at Dominican Hospital in Santa Cruz complaining of chest pain. He told doctors he had heart disease and needed high-dose opioids. His doctor, Dr. Steven Magee, wasn't convinced. And he wanted to gain a better understanding of what was happening so he could help Don.

Using Cerner Community View, Dr. Magee saw that Don had 19 encounters during the previous several months at various health systems. Each time he had presented with a similar story, but never disclosed his visits to other facilities. Each admission had resulted in an extensive workup, difficulty trying to control his reported pain, and eventually a release from the facility after all testing came back negative. Often he would start the process all over at a new facility within one to two days.

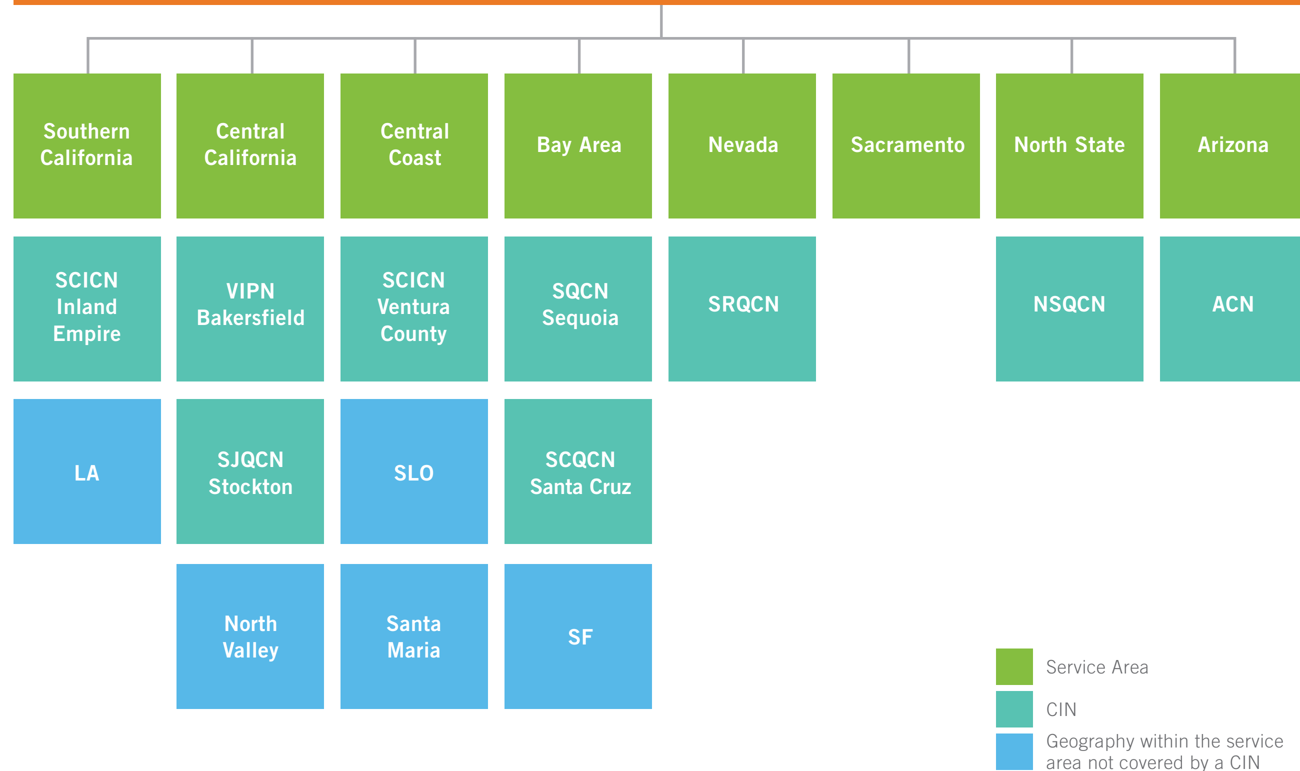
Seeing everything together helped Dr. Magee begin to see the bigger picture of Don's medical story. Don was ultimately diagnosed with factitious disorder (Munchausen syndrome) and substance abuse issues and was connected with the right community resources, rather than admitted to the hospital for another costly and futile workup.

*Name has been changed to protect patient privacy.

Hello humankindness®

"The doctors were careful and took time explaining what was going on with me; the nurses were always letting me know they were available and made me feel very comfortable. The nursing assistants were kind; the staff who gave me breathing treatments educated me. The phlebotomist didn't hurt me. The cleaning staff even brought me flowers. Dignity Health did just that — they treated me with dignity and kindness."

A Look at Dignity Health's CINs



There are 7,144 clinical integration providers

- **370 employed physicians**
- **5,278 independent physicians**
- **1,496 AHPs**

Across all of Dignity Health's clinically integrated networks (CINs), clinical and operations leaders engage in a variety of initiatives to enhance care quality, better coordinate patient care and lower costs.

Our networks worked with Population Health/Clinical Integration leadership to produce and distribute MACRA playbooks to help providers meet the MIPS requirements for reporting quality measures. The CINs also offered on-site sessions for physicians and office staff to prepare them for the reporting process.

The CINs are also taking advantage of the revamped Care Coordination program, working to identify patients for rising- and high-risk conditions and ensuring those patients get access to the preventive and other services they need to maintain good health.

In addition, CINs completed a Press Ganey Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CGCAHPS) survey based on claims encounters to measure patient perceptions of care delivered by providers and to identify patients who may need care management so they can be enrolled.

As a result of the population health strategy we have built, Dignity Health successfully negotiated annual increases for the next five years with certain payers for network physicians in California. Many of our networks saw payouts for the Bundled Payment for Care Improvement participation.

Arizona Care Network

Arizona Care Network (ACN) is jointly owned by Dignity Health and Abrazo Community Health Network. Located in the metro Phoenix region, Arizona Care Network continues to expand, adding new primary care providers to the network as well as several value-based contracts with commercial payers, and the network's first direct-to-employer arrangement for Intel Corp.

Arizona Care Network Value-Based Contracts

Model	Covered Lives	Results 2016–2017*
Medicare Shared Savings Program (MSSP)	8,781	Reduced total medical spend 2 percent below target benchmark for 2016 contract year. Trend indicates continued year-over-year performance improvement.
Next Generation ACO (NGACC)	28,000	One of only 37 in the country. Saved $756,000 and earned gain share in the first year.
Medicaid (Acute & ALTCS)	117,000	$15.7 million savings over two years based on total medical cost benchmarks.
Medicare Advantage	9,284	Various payer partners; new Bright Health and Arizona Care Network launched in 2018 with ACN as its exclusive provider network.
Commercial – Group	133,650	Shared savings generated for four of five commercial contracts.
Direct to Employer, Intel Corp., Arizona	6,500	In year three of full risk contract for ConnectedCare ACN, an employee concierge services health plan.
TOTAL	**303,215**	**$40.5 million savings against contract benchmark.**

*Contract years vary and CMS data lags 18 months.
All data is accurate as of 10/1/18 for 2016–2017 performance years.

While the savings are impressive, clinical quality serves as the gateway to shared savings, and driving quality improvements requires a 360-degree approach, surrounding both providers and patients with the tools and resources needed to achieve improved health care outcomes and reduced cost of care.

Mercy Care Plan and Mercy Maricopa Integrated Care

Integration of state medical and behavioral health programs better serves the Arizona residents with behavioral health conditions. Mercy Care Plan and Mercy Maricopa Integrated Care (MMIC) contracted with ACN to manage a portion of their attributed population, approximately 100,000 patients, more than 8,000 of whom were determined to have serious mental illness.

ACN behavioral health coaches attend medical and behavioral health appointments with the patients, partnering with their providers to support collaboration, remove roadblocks that could jeopardize patient progress, source and connect them with social services, and support their families in helping to manage their ongoing needs.

In 2018, ACN opened three Mercy Care Clinics throughout the area to support the complex needs of the Mercy Care population. ACN will staff these clinics with a social worker, population health medical assistant, behavioral health coach, RN care coordinator and a navigator.

EXPANDED LEADERSHIP

- ACN expanded its clinical leadership team, adding Dr. Ann Marie Sun, Medical Director of Population Health; Dr. Mark Schippits, Chief Medical Informatics Officer; and Jennifer Brooks, RN, Executive Director of Clinical Services.
- The network also added new leadership in essential functions such as Analytics, Care Coordination, Information Technology, Marketing and Communications and Practice Transformation.

AWARDS AND RECOGNITION

- ACN was named "One of 110 ACOs to Know in 2017" by the industry's premier business publication.
- ACN met the criteria for high-performing ACOs in a recent report by the U.S. Office of the Inspector General. The report noted that a small subset of high-performing ACOs showed substantial reductions in Medicare spending for key services and made cost-effective changes in utilization while providing high-quality care.

TRANSITIONAL CARE PROGRAMS

- To help prevent readmissions and improve continuity of care, ACN launched a transitional program where navigators monitor patients and work with hospital staff, the patient, and the patient's PCP to ensure patients are seen within seven days of discharge.
- The network is also building a SNF to Home program, where "transitionalists" will visit recently discharged patients in their homes as well as provide a warm hand-off back to the PCP for continuing care.

ACN continues to mature and is realizing the promise of its potential to improve the health of our patients while reducing the total cost of care.

North State Quality Care Network

North State Quality Care Network (NSQCN) has continued to grow its network while completing its first year of MSSP participation and engaging in the Group Physician Reporting Option (GPRO), the process of abstracting and validating quality data for MSSP. Meanwhile, the network remains committed to assisting its non-MSSP providers with MIPS participation. The following initiatives are also noteworthy.

CHF CLINIC

With a greater proportion of elderly patients than other regions, NSQCN sees a high number of chronic heart failure (CHF) admissions. So, NSQCN partnered with the inpatient team, pharmacy and community cardiologists to create an outpatient CHF clinic to address the needs of the population. The clinic was soon restructured to ensure this vulnerable population is seen within seven days of hospital discharge and provided useful education to help them manage their condition.

PATIENT AND PROVIDER EDUCATION

The network has also done extensive work to standardize guidelines around hypertension and diabetes for physicians.

For patients, the network has rolled out its Know Where to Go campaign, which is designed to help patients determine where to go to receive the appropriate level of care at the appropriate time. And with classes, communication materials and personal engagement, the NSQCN ongoing advance care planning awareness campaign has served to educate patients on the importance of advance care planning and how to complete their advance directives.

In addition, NSQCN has expanded its care coordination team to better assist physicians in the management of their patients and to help keep patients safe, healthy and out of the hospital.

St. Rose Quality Care Network

St. Rose Quality Care Network (SRQCN), located in southern Nevada, has been focused on implementing tools that assist with the interaction between acute care coordination and patients. SRQCN also added a medical director, Dr. Teresa Hong, who is managing quality and resource utilization initiatives for the network. Some of these initiatives include:

PROVIDER PERFORMANCE

To educate SRQCN providers on their performance data, the network's quality nurse manager meets every six weeks with each practice to review their data and discuss how and where to improve.

UTILIZATION MANAGEMENT

SRQCN's utilization management committee looked at inpatient and outpatient utilization, from length of stay (LOS) to resource use such as MRI, and acute and ambulatory use to help decrease readmissions and to improve communications in acute and ambulatory settings.

REDUCING READMISSIONS

On the network side, the Readmission Reduction Committee conducted a 2017 skilled-nursing facility analysis in the Las Vegas Valley, examining quality, access and rates of readmission. The results were used to rank all of the skilled-nursing facilities in the area and to create a top-tier list of partners to let patients know SRQCN's preference. In 2018, SRQCN conducted a similar analysis of local home health services.

SRQCN: Making Progress

Inpatient rehabilitation facility (IRF) utilization

Average length of stay for skilled-nursing facilities

Sequoia Quality Care Network

Sequoia Quality Care Network (SQCN), which serves both independent and Dignity Health Medical Foundation physicians throughout San Mateo County, has targeted its efforts to improve the patient experience on care coordination and quality measures.

DIABETES CARE

Since launching its diabetes initiative in 2016, SQCN has identified a significant number of diabetic patients at risk and rising risk. Care paths for diabetes and pre-diabetes have been established and implemented under the guidance of SQCN's medical director and the diabetes champion, a local primary care physician.

QUALITY REPORTING & PERFORMANCE

In addition, SQCN has utilized athenahealth to generate data and perform chart reviews of the approved quality metrics for primary care physicians. Performance reports have been reviewed and shared with providers to identify gaps in care, assist in workflow processes and improve the quality of care. And the network has collaborated with providers to focus on increasing compliance rates for colorectal cancer screening and depression screening for quality improvement.

CARE MANAGEMENT

The number of patients enrolled in care management has more than doubled since the beginning of the year under guidelines of the Care Coordination Enterprise. The network provides care coordination services to patients of contracted payers as well as MSSP patients.

SHARED SAVINGS

Shared savings were achieved under the Blue Shield IFP PPO ACO program for the performance year 2016; savings were distributed to physicians in 2018.

Southern California Integrated Care Network

Dignity Health created the SCICN Accountable Care Organization, which includes two SCICN chapters — Inland Empire and Venture County — as well as the Dignity Health Medical Foundation in California. The MSSP ACO has more than 44,000 total enrollees; SCICN Ventura has 8,500 of those lives and SCICN Inland Empire has 976. Additionally, SCICN has over 4,500 Blue Shield lives (Ventura has 3,900 of those), and SCICN Ventura has 3,600 Employer Relation lives. Both chapters expect to have additional lives in 2019 through contracts with United and Anthem.

SCICN-IE

Southern California Integrated Care Network – Inland Empire continues to expand, while maintaining a strong focus on quality improvements. As part of SCICN-IE's diabetes initiative to support network physicians in addressing the high incidence of patients with uncontrolled diabetes in the area, the network:

- Hosted a monthly chronic disease management meeting to review all patients with diabetes (controlled vs. uncontrolled) and to develop a pathway that ensures follow-up for patients with rising A1Cs.
- Increased patient/PCP engagement with care coordination and provided educational resources to patients. The MSSP population experienced a 7 percent decrease in uncontrolled A1Cs, while IEHP Dual patients saw a 5 percent decrease.
- In 2018, a formalized care coordination program deployed, increasing patient engagement from 26.5 percent in 2017 to 32.4 percent at the end of the second quarter of 2018. Care coordination received a 99.1 percent positive experience reported through patient satisfaction surveys.

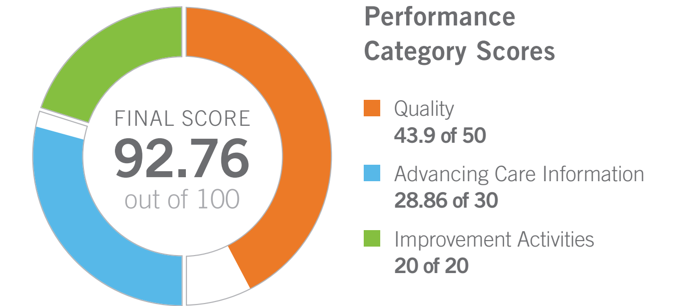
SCICN-VC

Southern California Integrated Care Network – Ventura County has continued to grow, significantly increasing the number of ob/gyn physicians, hospitalists and physical therapists. The network also closed gaps in the specialty areas of rheumatology, ophthalmology, neurosurgery and pain medicine. Overall, the network has grown more than 25 percent since January of 2017.

SCICN-VC has contracted a part-time medical director to assist in the oversight of the quality program's objectives, goals and strategies. The medical director developed a proposal for a Quality Committee alliance across all Dignity Health CINs/ACOs, led efforts to develop new lipid guidelines and steered the network toward an improvement in its quality measures scores for blood pressure control and diabetes.

QUALITY

Overall MIPS performance for the SCICN accountable care organization (ACO) participants was positive. The final score of 92.76 will result in a positive payment adjustment of 1.49 percent for SCICN ACO participants.



In addition, SCICN completed its first year of MSSP participation. The ACO's MSSP Quality performance was in line with 2016 national averages, and the ACO scored above the national average in the following categories: BMI, Tobacco Screening and Follow-Up, Statin Therapy and Diabetes A1C control.

SHARED SAVINGS

SCICN shared news of its first Shared Savings distribution in 2018. The network had entered into a Shared Savings Agreement with Dignity Health in 2015 to be the exclusive Tier 1 network for the employees of St. John's Regional and Pleasant Valley hospitals. The program's intent is to improve the health of the patient population, improve the patient experience and reduce the members' overall cost of health care.

CARE COORDINATION

SCICN-VC's Care Coordination team continues to make a positive impact on patients' quality of life. In fact, one of the SCICN-VC Care Coordination team's patient success stories was featured on a major statewide health plan's website, showcasing the program's value.

SCICN-VC currently has 108 members enrolled in the Care Coordination program. SCICN-VC averages an additional 250 patient outreach calls per month for transitional care and wellness.

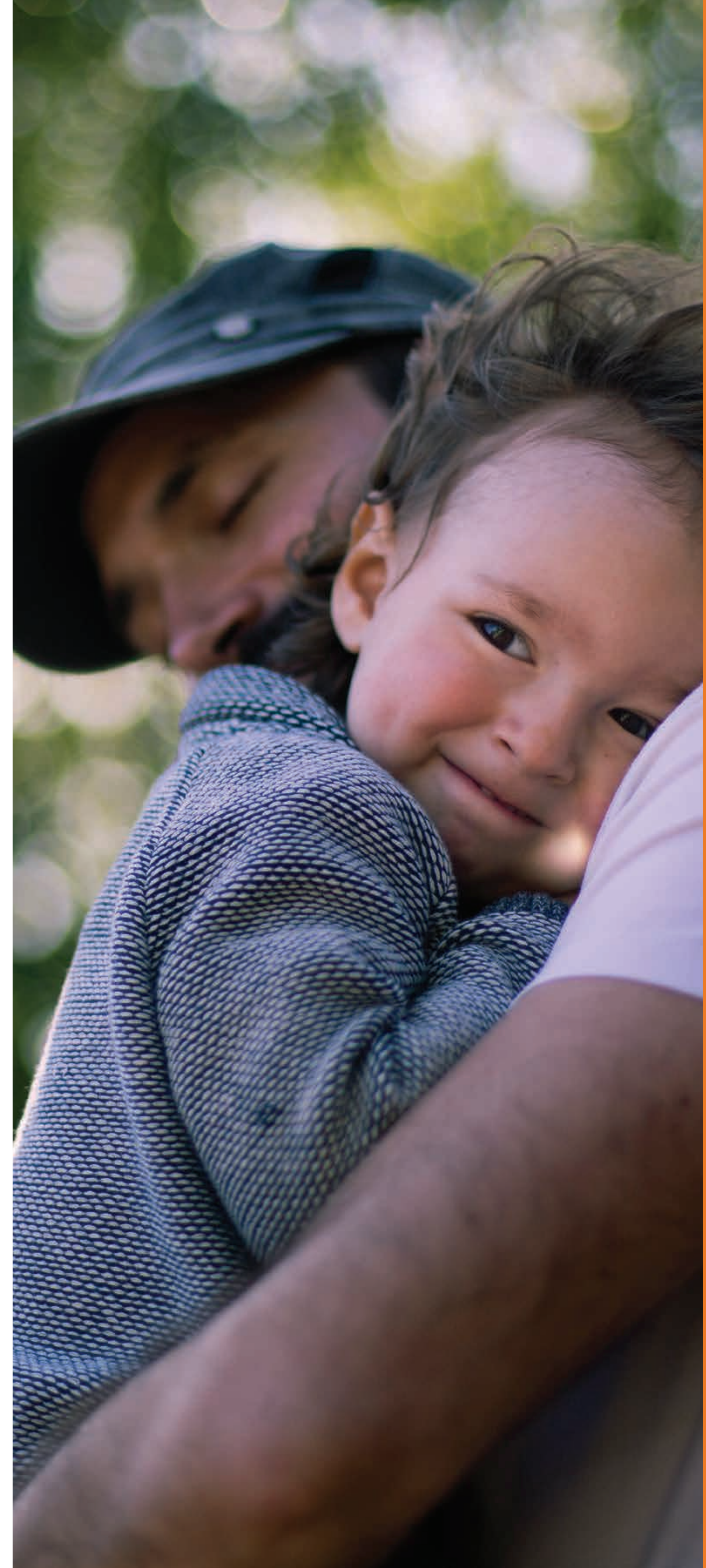
Valley Integrated Provider Network

Located in Bakersfield, Calif., Valley Integrated Provider Network (VIPN) has experienced significant growth, adding new providers and ramping up their care coordination efforts. In 2018, VIPN added four additional members to the Board of Managers, five additional members to the Payer Committee, and three additional members to the Quality Committee and continues to obtain new employer relationships. The network is well-positioned for its MSSP application in 2019.

CARE COORDINATION

In 2017, enrollment in Care Coordination was primarily based on multiple ER visits/admits, multiple co-morbidities and noncompliance with treatment. This work set the stage for more robust reporting in 2018. As a result, VIPN will be able to leverage the athena platform to identify high-risk patients and to enhance disease management in 2019 and beyond.

Average Attributed Member Counts	3,360
Average Attributed Members Reviewed for Care Management	2,807
Average Percentage of Attributed Members Reviewed for Care Management	83.61%
Average Number of Members Targeted for Care Management	207
Average Percentage of Members Targeted for Care Management	6.35%
Total Members Enrolled in Care Management Since Project Start	2,092



Humankindness lives here. Vitals Are Vital

No matter the reason for a patient visit, it's Dignity Health policy to check vital signs. And our doctors don't just record the numbers in a chart — they are empowered to follow their clinical instincts and take action. Ophthalmologist Robert Bellinoff, MD, notes that numerous times in his department, doctors have identified conditions including hypertension, heart block and other health problems.

Recently, a 92-year-old man was in for his routine eye exam. His oxygen saturation was 85 percent, and he said he was somewhat short of breath.

"After I evaluated him, I decided to call 911 and have him taken to Mercy General. He was found to have a pneumothorax, was admitted and had a chest tube placed," Dr. Bellinoff says. "I continue to be grateful that these policies are not in place just for us, but for our patients. I think we just saved a life today."

Dignity Health Medical Foundation

Dignity Health Medical Foundation (DHMF) supports physician medical groups, independent physician associations (IPAs), and network providers, and plays an integral part in the effort to build integrated delivery networks that manage patient care across the health care continuum.

Dignity Health Medical Network supports **3** IPAs

Multiple joint ventures and partnerships, including **GoHealth** Urgent Care and **UCSF**

125 locations and growing

500k+ unique patients per year

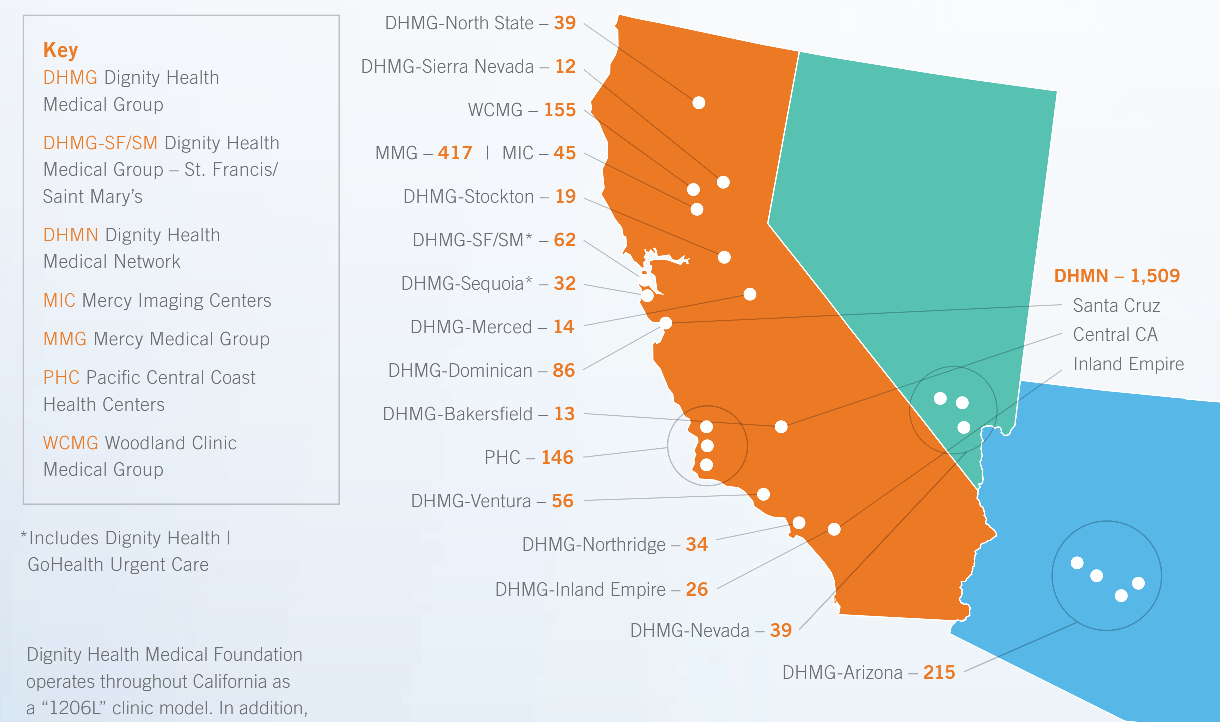
2.3M+ yearly office visits

2,800+ employees

Foundation, Employed and Affiliated Medical Group Models

As of October 2018, there are 1,410 physicians and allied health providers in employed practice models across Dignity Health

Key
DHMG Dignity Health Medical Group
DHMG-SF/SM Dignity Health Medical Group – St. Francis/ Saint Mary's
DHMN Dignity Health Medical Network
MIC Mercy Imaging Centers
MMG Mercy Medical Group
PHC Pacific Central Coast Health Centers
WCMG Woodland Clinic Medical Group



*Includes Dignity Health | GoHealth Urgent Care

Dignity Health Medical Foundation operates throughout California as a "1206L" clinic model. In addition, it operates the Dignity Health Medical Network.

There is one additional clinic model in California, Pacific Central Coast Health Centers, which operates as a "1204a" community clinic. Dignity Health also operates the Dignity Health Medical Group Arizona and the Dignity Health Medical Group Nevada.

MEDICAL GROUPS

DHMF's affiliated medical groups serve as the primary physician employment model for Dignity Health in California, with more than 950 providers delivering care in 125 clinic locations across the state.

INDEPENDENT PHYSICIAN ASSOCIATIONS

Launched in 2017, Dignity Health Medical Network (DHMN), DHMF's managed care health plan contracting entity for IPAs in California, provides the support and resources to help them better serve their managed care patients. DHMN is already expanding across the state and currently supports independent practices in Santa Cruz, Inland Empire and Bakersfield, representing more than 1,500 independent providers.

GROWING TO MEET THE NEEDS OF OUR COMMUNITIES

Dignity Health Medical Foundation continues on a growth trajectory, including new building construction, facility expansion and hiring more than 100 new providers. Plus, in 2018, Identity Medical Group joined Dignity Health to provide services in Ventura County as Dignity Health Medical Group. With the addition of Identity Medical Group, the footprint has grown in Ventura to more than 50 providers and 15 convenient locations.

JOINT VENTURES AND PARTNERSHIPS

- Dignity Health and UCSF Health formed an affiliation to expand access to care, integrating community-based care with the best of academic medicine and creating a stronger physician network throughout the Bay Area.
- Dignity Health | GoHealth Urgent Care is a joint venture established to bring a new model of high-quality, patient-focused urgent care centers to the Bay Area. The clinics offer seamless referrals to specialists; they are open seven days a week with extended evening hours and welcome walk-in patients.

PAYER PARTNERSHIPS AND DIRECT-TO-EMPLOYER PLANS

Our ACO partnership with Blue Shield, a collaboration that began in 2010 in Northern California, is now available throughout the state with a focus on collaboration among physician groups and hospitals to arrange coordinated care across the care continuum, thereby improving care quality and achieving cost savings. DHMF also collaborated with medical groups and IPAs to create a high-quality network of services for a large employer, putting their employees' health and well-being at the forefront and meeting all quality measures within the first year.

AWARD-WINNING CARE

- Mercy Medical Group was recognized by the American Heart Association and American Medical Association for the Inaugural Target: BP Recognition Program awards for their commitment to reducing the number of Americans who have heart attacks and strokes each year.
- Mercy Medical Group also received "Most Improved by a Large Group" for achievements in diabetes care by the AMGA.
- Integrated Healthcare Association (IHA) recognized Woodland Clinic Medical Group (WCMG) and Dignity Health Medical Group – Inland Empire for providing high-quality care to Medicare Advantage patients.
- Mercy Medical Group and Woodland Clinic Medical Group earned Elite Status from the America's Physician Groups (APG), the nation's leading professional association for accountable physician groups. Mercy Medical Group and Woodland Clinic are two of just 87 organizations nationally to achieve Elite Status (the highest recognition) in 2018.

A MULTIDISCIPLINARY APPROACH TO CARE

The Foundation continues to embrace a multidisciplinary model with a team-focused approach.

Preventive Clinical Measures: Mercy Medical Group surpassed the 90th percentile for Chlamydia Screening, Asthma Medication Ratio, Persistent Medications and HbA1c Control. Woodland Clinic Medical Group surpassed the 90th percentile for Childhood and Adolescent Immunizations, Asthma Medication Ratio, Proportion Days Covered by Meds and HbA1c Control.

Patient-Centered Medical Homes: Mercy Medical Group and Woodland Clinic Medical Group both recently achieved National Committee for Quality Assurance (NCQA) Level 3 Patient-Centered Medical Home (PCMH) recognition for all of their primary care sites, the highest level of achievement recognized by the NCQA.

GRADUATE MEDICAL EDUCATION

In 2017, Dignity Health acquired the Northridge Hospital Medical Group including the faculty of the Dignity Health Family Medicine Residency at Northridge. The program trains 24 resident physicians at Northridge Hospital for three years under board-certified family physicians. They also have a Sports Medicine Fellowship program. So far, it has graduated more than 200 family physicians — many of whom stay to serve the local community.

CREATING BETTER PATIENT EXPERIENCES

DHMF tracks patients' experiences through Press Ganey surveys that offer patient feedback about providers, clinic team members and other departments.

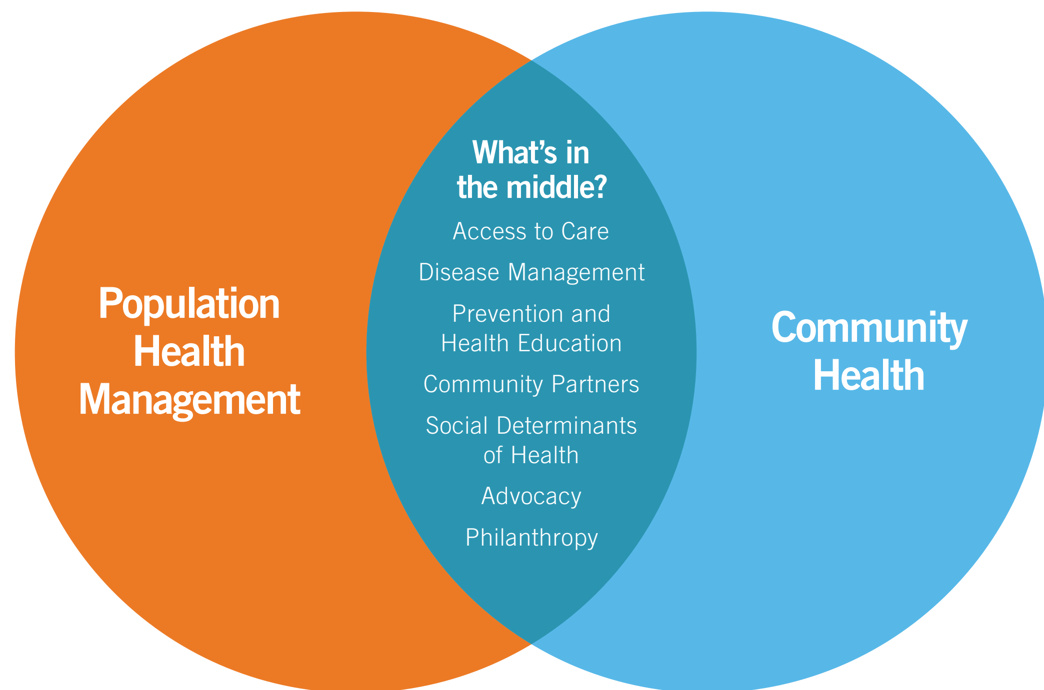
Dignity Health Medical Foundation Mean Overall Score for Patient Experience

Group Factor	Number of Responses	DHMF Group Score	25 Percentile	50 Percentile	75 Percentile
Overall Mean Score	79.7K	91.0	90.1	92.0	93.1

Community Health

Community Health helps put Dignity Health's mission into practice through health programs, grants and investments, and sustainability initiatives.

The Intersection of Population Health Management and Community Health



Legacy Programs

Within population health management, there is a natural relationship with our legacy community health programs, including a focus on:

- Access to care
- Mental health
- Housing and housing insecurity
- Chronic disease
- Safety and violence
- Cancer
- Community partners and coalitions
- Advocacy
- Philanthropy

Connected Community Network

Dignity Health has launched the Connected Community Network (CCN) to optimize the transition of patients from the hospital to supportive resources that meet their health and social needs in community settings. Supported by a referral technology and agreements with community providers of health and social services both inside and outside of Dignity Health, the CCN works to identify and meet the ongoing medical and health-related social needs of patients following a clinical episode. By focusing first on our most vulnerable patients, we're able to act where we can make the biggest difference in the lives of patients. Currently CCN is located in Arizona, California, and Nevada.

Since its initial launch and expansion, more than 7,500 referrals were sent to more than 380 programs across 19 Dignity Health hospitals. The programs range from smoking cessation, substance abuse treatment, shelter referrals and homeless services to diabetes management, Women, Infants, and Children (WIC), the Supplemental Nutrition Assistance Program (SNAP), and elder adult day health care, as well as various support groups.

CCN Phase 1: Referrals to Dignity Health Programs

Phase 1 involves referrals made to Dignity Health Community Health Programs. The baseline number of referrals prior to CCN in most sites is zero.

P1 Dashboard

Service Area	Hospital	# of Programs	# of Referrals	Go-Live Date
Nevada	St. Rose Dominican Hospitals – San Martin St. Rose Dominican Hospitals – Rose de Lima St. Rose Dominican Hospitals – Siena	25	2,387	Mar-16
Bay Area	Dominican Hospital Santa Cruz	25	225	Jun-17
Bay Area	Sequoia Hospital	4	206	Jun-17
Arizona	St. Joseph's Hospital and Medical Center	7	294	Jun-17
Arizona	Mercy Gilbert Medical Center Chandler Regional Medical Center	29	288	Jun-17
Southern California	Community Hospital San Bernardino St. Bernardine Medical Center	25	495	Jun-17
Southern California	Northridge Hospital Medical Center	4	87	Jun-17
Southern California	St. Mary Medical Center Long Beach	3	12	Jun-17
Southern California	California Hospital Medical Center	18	67	Jun-18
	Total	140	4,061	

With the go-live of the CCN and electronic referral system we have rapidly increased the number of referrals to both Dignity Health and external community resources.

CCN Phase 2: Referrals to External Community Resources

Phase 2 involves an electronic referral to a community partner for specific community-based resources (for example, meals on wheels, medication-assisted treatment programs and so on).

P2 Dashboard

Service Area	Hospital	# of Partners	# of Programs	# of Referrals	Go-Live Date
Nevada	St. Rose Dominican Hospitals – San Martin St. Rose Dominican Hospitals – Rose de Lima St. Rose Dominican Hospitals – Siena	7	12	56	May-18
Bay Area	Dominican Hospital Santa Cruz	11	38	602	Dec-17
Bay Area	Sequoia Hospital	7	10	139	Jan-18
Arizona	St. Joseph's Hospital and Medical Center	8	31	474	Feb-18
Arizona	Mercy Gilbert Medical Center Chandler Regional Medical Center	11	46	82	Feb-18
Southern California	Community Hospital San Bernardino St. Bernardine Medical Center	7	21	13	Mar-18
Southern California	Northridge	9	23	14	Apr-18
Southern California	St. Mary Medical Center – Long Beach	5	10	44	May-18
	Total	65	191	1,424	

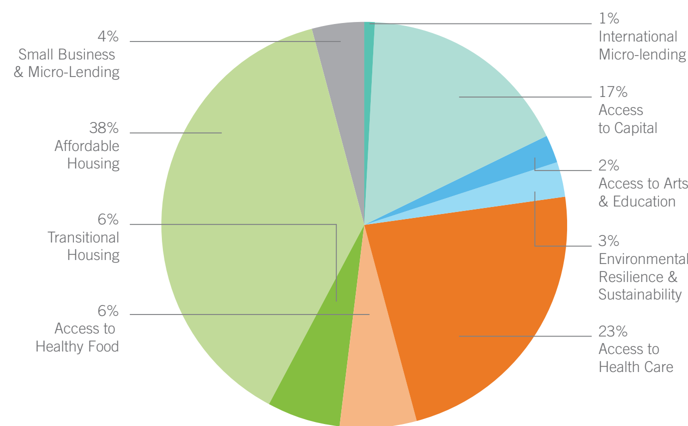
Passport 2 Health

In 2017, Dignity Health launched the Passport 2 Health (P2H) initiative in collaboration with local community clinics and service providers in Santa Cruz County. The initiative identified 350 high utilizers and designed interventions for intensive case management and holistic care, developed an evaluation plan and created outcome metrics to strengthen linkages with community-based resources for high-need, high-cost patients.

Through the P2H initiative, multiple community partners collaborate in addressing housing, mental health, substance abuse and other health-related social needs, in addition to working hand in hand to collectively provide holistic care. Regular tracking of how these patients use health care services, coupled with intensive case management at the clinics where they receive care, can help reduce expensive visits to the emergency department and encourage more consistent visits with primary care physicians, thereby improving overall health and reducing health care expenses.

Community Investment Program

As of May 2018, the Community Economic-Investment Program (CEIP) has a portfolio that includes 72 loans to 62 organizations for a total approved amount of more than $94 million and more than $72 million in outstanding loans. Housing and access to health care are the program's two major focuses, but the program also invests in other sectors affecting health. The breakdown is as follows:



Humankindness lives here. Housed and Healing

Monica* first engaged in the Passport 2 Health Case Management program while staying at a temporary shelter searching for affordable housing. She had been homeless for over eight years and had worked with multiple case management programs and peer-run mental health advocacy groups in Santa Cruz.

Now in her 60s, Monica was also navigating appointments with specialists for her complex medical concerns and behavioral health needs. Her P2H case manager provided advocacy at her various specialists, met with her while she was in the hospital, helped her navigate social service systems, and played a key role in collaborating with all the members on Monica's team to support her overall wellness.

After being enrolled in P2H for over a year, she notes this is one of the longest periods she's gone without a psychiatric hospitalization, and that her depression symptoms are better managed and she's able to focus on healing. She also moved into her own permanent room and is creating a safe space to call home.

*Name has been changed to protect patient privacy

The Following Highlights from the Community Economic Investment Program (CEIP) Showcase the Work Supported by Dignity Health in FY 2018

JOSHUA HOUSE – LOS ANGELES, CALIFORNIA

Operated by the Los Angeles Christian Health Centers (LACHC), Joshua House is a former hotel built in 1913 that is currently providing comprehensive medical, dental, optometry and mental health care to 3,300 patients in the Skid Row district annually, which has one of the largest homeless populations in the country.

In partnership with Nonprofit Finance Fund, Dignity Health has invested $4.7 million to help LACHC expand into a new, 26,000-square-foot location down the street that will feature similar health services as well as 55 units of permanent supportive housing for homeless individuals on the upper floors, developed and managed by Skid Row Housing Trust.

TIPPING POINT – SAN FRANCISCO, CALIFORNIA

Tipping Point Community is a 501(c) (3) nonprofit organization established in 2005 with a mission to break the cycle of poverty through investments in nonprofit organizations that serve individuals and families experiencing poverty in the six Bay Area counties. A major part of Tipping Point's strategy is finding housing for the city's 2,100 chronically homeless individuals, and they're currently implementing their first pilot affordable housing project. In 2017, Dignity Health made a $5 million loan to Tipping Point for the purchase of a site on which they intend to build 118 modular units of new supportive housing.

During the next year, CEIP proposes to expand its impact further into mitigation of the housing crisis affecting all of Dignity Health's service areas. The program will also broaden its investment to include for-profit "B" corporations — or private companies involved in social impact/public benefit enterprises — thereby leveraging greater capital resources toward the promotion of social justice.

Recuperative Care

A substantial amount of health care research shows that at least 80 percent of what affects outcomes happens beyond the scope of clinical care — including social, behavioral and environment factors such as housing. The most important aspect of Recuperative Care is that the patient is with a service who understands their needs and can connect them to permanent housing, in most cases saving their lives.

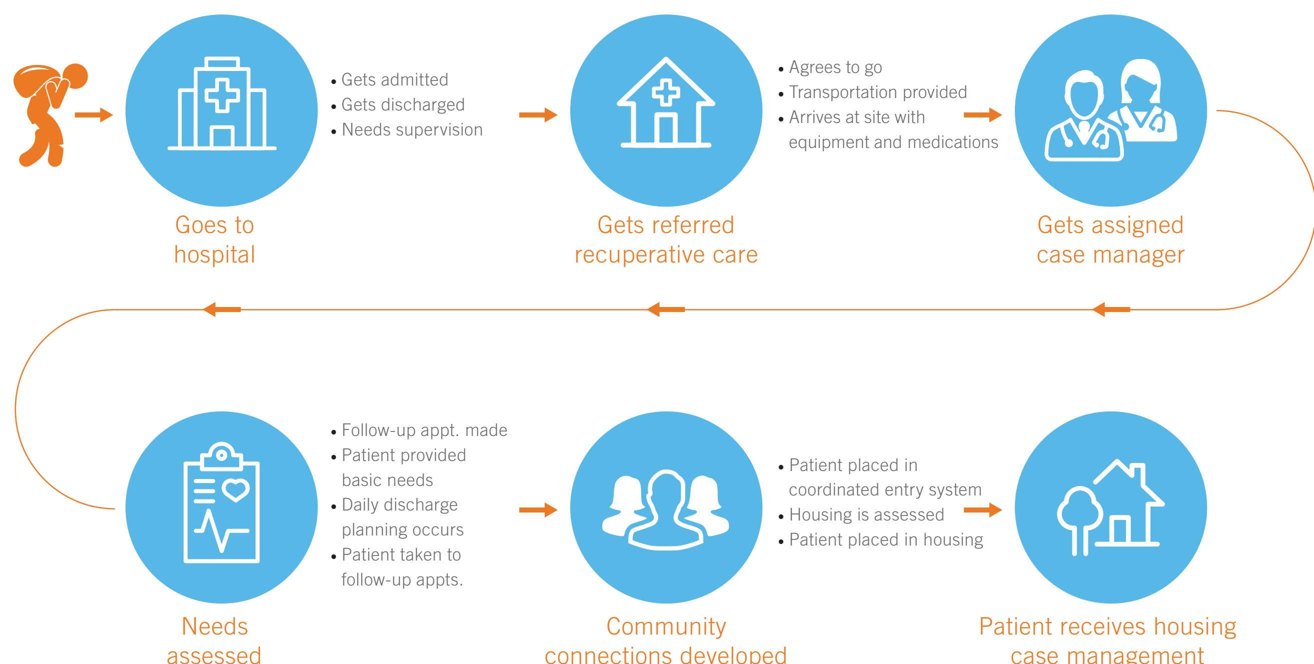
Dignity Health's participation in supporting Recuperative Care Programs works to help address the issue of homelessness in this equation by providing short-term medical care and case management to homeless individuals recovering from acute illness or injury, with the help of our Recuperative Care providers:

- Harbor Care (formerly Hope of the Valley) – Mission Hills, Calif.
- Illumination Foundation – Irvine, Calif.
- Pathways Recuperative Care – Los Angeles, Calif.

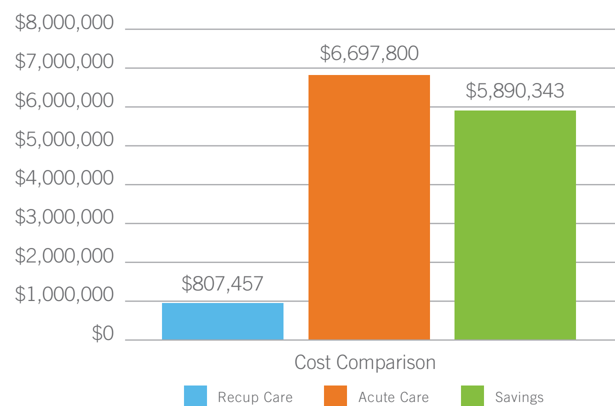
HOUSING IS HEALTH CARE

Dignity Health recognizes the complexity of both the mental and physical health of our homeless patients and has invested $1.2 million in recuperative care services. From 2010 to May 2017, Dignity Health hospitals in Los Angeles and the Inland Empire utilized 6,129 bed days.

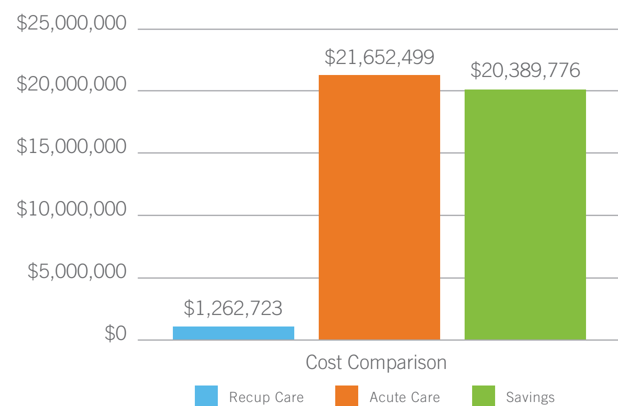
Recuperative care reduces the cost to hospitals by providing a safe discharge. While the inpatient acute cost of a typical Medi-Cal hospital stay is $1,800 per day, at a recuperative care provider, it's $217 per day. From June to December 2017, this translated into approximately $5.9 million in hospital savings and $20.4 million in savings for CY 2017.



Acute Care v. Recuperative Care Jun–Dec 2017



Acute Care v. Recuperative Care CY 2017



Recuperative care costs a fraction of acute care at a hospital, saving Dignity Health more than $20 million in 2017.

Addressing High Utilizers and Chronic Care Needs

Managing patients who struggle with many social determinants of health, especially housing, is challenging for the Care Coordination staff. In 2018, Dignity Health partnered with the Illumination Foundation to implement the Chronic Care Plus Program. This program accepts patients from all the Dignity Health Southern California hospitals who are homeless, have several comorbidities and are high utilizers of emergency services. They provide immediate housing upon discharge for these patients and manage them for up to two years until they can get permanent housing and support services.

255 patients referred by hospitals to recuperative care from June to December 2017

3,721 total number of bed days

82 of the patients received referrals for housing in the process

Readmission Rate Drops

Using admissions data from our recuperative care partners, each patient is reviewed to determine if they have been readmitted to any of the six Dignity Health hospitals in Southern California. In 2016, 5 percent were readmitted, and in 2017 readmissions were down to just 1 percent.

42% of Dignity Health's homeless patients have been placed in permanent or temporary housing arrangements by our recuperative care partners

Humankindness lives here. Home at Last

Sherolyn Scott, 60, had been living on the streets of Los Angeles for two years when she was treated at California Hospital for injuries she received as the result of an incidence of domestic violence.

"I was rushed to California Hospital where they saved me because I could've almost died," she says. The hospital worked with their partner, Pathways Recuperative Care, to locate a place for Scott to rest and recover and to work to find permanent housing.

"They found me a place," Scott says. "California Hospital sent me to Pathway Recuperative Care and my miracle really started there."

She says she received support and counseling and was able to secure permanent housing.

"I'm so grateful for a hospital that cared enough . . . This is a miracle. I can't believe it. I can't believe I'm in my house like a normal person."

SOURCE: Story courtesy of Pathway Recuperative Care (a Dignity Health recuperative care partner) and the National Health Foundation.

Hello humankindness®

> “From the beginning to the end of my appointment, the staff worked together very well . . . each doing their job and preparing me for each step along the way. It was the best organized medical office I had ever been in.”

Employer Relations

The Dignity Health Employer Relations Program has worked to deepen our partnerships with local employers and to address their vital health plan challenges: an increased demand among employers for higher-quality, value-based health care options and affordable integrated care management.

Our Employer Relations Program now has approximately 13,500 lives under management in the following geographies:

ARIZONA CARE NETWORK – METRO PHOENIX

Arizona Care Network (ACN), a Dignity Health joint venture CIN, is the delivery system partner for Intel, offering Connected Care AZ to Intel's Arizona employee population. This customized plan delivers a high-touch, highly coordinated health care experience.

Since its launch in 2016, this collaborative employer relations model has achieved:

- Improved quality performance year over year with outcomes better than Intel's non-Connected Care employees
- Year-over-year plan growth greater than 10 percent, with 7,100 enrolled for 2019
- Using ACN's active referral management technology, 80 percent of referrals stay in the network, which supports care collaboration
- Improved cost efficiency over other Intel plan options
- High member satisfaction with their access to timely, high-quality health care: 97 percent would recommend an ACN provider

CENTRAL COAST SERVICE AREA

In 2015, the Employer Relations Program initiated a pilot in partnership with SCICN-VC and Dignity Health's Employee Plan at St. John's Regional Medical Center and St. John's Pleasant Valley Hospital.

The pilot began with 860 members supported by a network of 290 providers in 2015 and has grown to 3,600 members supported by a network of 375 providers in 2018. The pilot has transitioned to a formal contractual arrangement to include quality measures and shared savings.

Throughout the second year, in-network utilization and reduced high-cost claimants as a percentage of costs improved. In 2018, we also added 6,200 members from Dignity Health's Employee Plan and Pacific Central Coast Health Centers Plan in the North Central Coast.

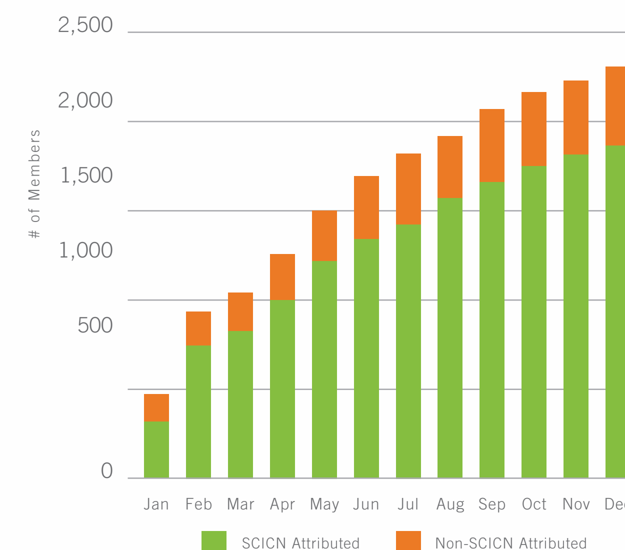
GREATER SACRAMENTO SERVICE AREA

The Employer Relations Program facilitated a strategic collaboration between Dignity Health, Dignity Health Medical Foundation, Mercy Medical Group, Inc. and Hill Physicians Medical Group to serve as a Delivery Service Provider (DSP) for a corporate health care benefit program.

This collaboration establishes a preferred network of select Mercy Medical Group and Hill Physicians Medical Group providers, along with Mercy Imaging Centers and Dignity Health hospitals, that will provide patient care and population health management services to the company's employees and their dependents in the Sacramento area. For 2018, approximately 3,700 members were enrolled. These members received concierge-level service, interconnectivity between providers and facilities, and enhanced clinical coordination with a Patient-Centered Medical Home (PCMH) team focused on preventive care.

Central Coast Market – Ventura

Managed Claimants



For the majority of our members, their care is being managed by their primary care physician, who is looking after their overall health and can address chronic illnesses, annual wellness checks and other preventive health needs.

By contrast, an unmanaged member may see a specialist to address symptoms or illnesses as they arise, but the lack of regular and preventive care tends to lead to a higher risk of disease and complications.

Approximately 64 percent of our member population is under the care of a PCP with the majority attributed to SCICN providers, reflecting that our growing SCICN provider network is more robust and able to meet the needs of the majority of members.

Incurred Medical Claims: Total Cost – High-Cost Claimants as a Percentage of Total Lives

Plan	2015	2016	2017
EPO	25%	20%	14%

Through our care coordination and integrated care management efforts over the past few years, we have helped reduce the overall cost incurred by high-cost claimants (those claimants >$100k) from 25 percent in 2015 to 14 percent in 2017.

Graduate Medical Education

Dignity Health operates 39 hospitals, 11 of which are teaching hospital sites that, in addition to patient care, educate post-medical school graduate physicians in real-world environments.

About Graduate Medical Education (GME)

There are approximately 400 resident physicians and 30 fellows who train each year in the 11 Dignity Health GME hospitals. The hospitals that host graduate programs are, in order of initiation dates:

- St. Mary's San Francisco
- St. Joseph's Phoenix
- St. Mary's Long Beach
- Mercy Merced
- Mercy Redding
- Dignity Health Northridge
- California Hospital Medical Center
- Methodist Sacramento
- Marian Regional
- St. Bernadine's San Bernardino
- St. Joseph's Medical Center Stockton

Recruitment/Retention

For the past three years, Dignity Health has been able to improve the post-graduate retention rates of residents who have finished residency programs. Of the 129 total residents who finished residency programs from across Dignity Health in 2018, 35 residents chose to continue their employment within a Dignity Health Catchment area, meaning they accepted a position in a Dignity Health service area. The number of physicians retained increased from 26 to 35 between 2016 and 2018, which represents a 34 percent increase.

New Programs

St. Joseph's Medical Center in Stockton, Calif., started two new programs in 2018, for Emergency Medicine and Family Medicine. Marian Regional Medical Center in Santa Maria, Calif., has a new Ob/Gyn program starting this year as well.

The GME programs at St. Joseph's Medical Center in Phoenix, Ariz., have joined the Creighton-Arizona Health Education Alliance between Dignity Health, Maricopa Integrated Health System and Creighton University. This will improve and expand Graduate Medical Education and create a four-year Creighton University Medical School on the Phoenix Campus, beginning in fall 2021.

Creighton-Arizona Health Education Alliance				
A joint venture between:	**St. Joseph's Hospital and Medical Center** **Mission:** High-quality, affordable care for all **Core Values:** Justice, Collaboration, Dignity, Excellence, Stewardship **Founding:** 1895, Sisters of Mercy	**Creighton University School of Medicine** **Mission:** Teaching, patient care, research **Core Values:** Service, Care for the Whole Person, Sacred Calling, Reflection **Founding:** 1892, Society of Jesus	**Maricopa Integrated Health System** **Mission:** To provide exceptional care, without exception **Core Values:** Accountability, Compassion, Excellence, Safety **Founding:** 1864 (Howell Code of 1864)	**District Medical Group** **Mission:** Integrated practice of patient care, education, research and community service **Core Values:** Quality, Professionalism, Partnership, Physician-Patient Relationship **Founding:** Academic multi-specialty practice formed in 1992
Medical Education				
Undergraduate Medical Ed	• 84 FTE medical students • 225 visiting student rotations/year	• 614 FTE medical students (fall 2016)	• 778 medical student monthly rotations/year	
Graduate Medical Ed	• 178 residents • 24 clinical fellows	• 180 residents • 32 clinical fellows	• 338 residents, 1 clinical fellow • 169 residents from various institutions competed 198 rotations in 2015-2016	
GME Residency Programs	Family Medicine, Internal Medicine, Neurology, Neurosurgery, Diagnostic Radiology, General Surgery	Family Medicine, Internal Medicine, Obstetrics & Gynecology, Pathology, Psychiatry, Radiology, Surgery, Urology	Emergency Medicine, Dental (adult), Dental (pediatric), Child Psychiatry, Internal Medicine, Ob/Gyn, Pediatrics, Podiatry, Pharmacy, Psychiatry, Radiology, Surgery	
GME Joint Programs	Ob/Gyn with MIHS	Pediatrics, Orthopedics, Neurology (with Nebraska Medical Center)	Ob/Gyn (with St. Joseph's Hospital and Medical Center), Pediatrics (with Phoenix Children's Hospital), Adult and Pediatric Dental (with Lutheran Medical Center in New York)	
GME Fellowship Programs	Cardiovascular Disease, Minimally Invasive Gynecological Surgery, Neuroradiology, Clinical Neurophysiology, Epilepsy, Movement Disorders, Sports Neurology, Neuro-Otology, Endovascular Surgical Neuroradiology, Gastroenterology	Allergy/Immunology, Cardiology, Child Psychiatry, Colon Rectal Surgery, Endocrinology, Family Medicine-Obstetrics, Gastroenterology, Infectious Disease, Interventional Cardiology, Pulmonary/Critical Care	Surgical Critical Care	
Faculty	• 160 GMA teaching faculty • 325 Creighton faculty in the Phoenix-metro area for the Phoenix Regional Campus • 212 FTE research staff • 18 post-doctoral fellows	• 241 FTE clinical employed faculty (May 2009) • 66 FTE basic scientists • 14 FTE post-doctoral research fellows	• Active (full-time) 259 • Courtesy (part-time) 246 • Total = 505	• Largest integrated faculty practice in Maricopa County, poised and practicing value-based purchasing • 411 full time • 184 part time • 25 different specialties

International Medical Residency Rotation in Rural North and Northeast India Started September 2018

Dignity Health is partnering with a network of nonprofit hospitals in the rural parts of north and northeast India to expand health care access for the poor. Dignity Health is pursuing this work as an extension of our mission and our commitment to address human trafficking locally and globally. We will be supporting efforts to prevent trafficking that often results from unpaid health care debt.

In India many vulnerable families who don't have access to affordable health care end up in bonded labor when they can't pay their medical bills. We will contribute to the important work of prevention by increasing the capacity of our partners in health care delivery. Through the involvement of residents, our Indian partners will be able to expand the services at their nonprofit clinics and hospitals so that more vulnerable families will have access to affordable health care.

The program will provide residents an opportunity to work directly with patients at the rural hospitals and experience what life is like for a physician serving in these remote regions. As resources are limited in these areas, residents will need to find creative ways to use their skills and assess when new medical advances can be implemented. Under the guidance and supervision of an experienced Indian physician, they will work side-by-side with other health care workers and come back with a new perspective on the challenges and opportunities in global health.

There are currently eight Graduate Medical Education residents with Dignity Health who have signed up to participate in the month-long international rotation program. The residents will be going to one of three sites with our Indian partner agency, Emmanuel Hospital Association, and the first resident went in September 2018.

In preparation for this program, one of the GME residency program directors, Dr. Ron Chambers from Methodist Hospital, and a resident from Methodist Hospital, Dr. Tamar Stokelman, visited one of the rural hospital sites to view patient care and discuss the program with the medical director and staff physicians. Dr. Chambers and Dr. Stokelman were also part of a volunteer team from Dignity Health that provided training on human trafficking to health care personnel in India.

The training, which focused on trauma-informed care and the collection of forensic evidence to support survivors, was very well received, and participants made plans to immediately implement what they had learned. Additional volunteer teams are being formed as there was a great need expressed for future training opportunities.

Planning for the Future

Health care is on a new trajectory — with important discoveries, new collaborations and partnerships, exciting research and clinical trials, new technologies and techniques. As we look toward the future, we must think beyond the instruments and the therapies and continually evaluate how we provide care. At Dignity Health, we know this process of evaluation and iteration is essential to the way we develop medical office space and our ability to capitalize on technology.

Care of the Future

In the ambulatory health care setting, consumers are moving from traditional primary care delivery models to urgent care, virtual video visits and online chats with doctors and mid-level practitioners. Dignity Health has been proactively incorporating these extended primary care access points into our ambulatory strategy. With our Care of the Future initiative, we are building a next-generation platform to be able to rapidly test and implement positive changes for how our patients, providers and team members experience ambulatory care.

The Care of the Future team has a simple vision: Exceptional Health Care, Exceptional Experience.

This ambitious initiative is designed to achieve breakthrough performance for clinical measures, operations and the patient experience by taking a quantum leap in the modernization of care team structure, workflow and physical space to meet and exceed the needs of the changing health care landscape. This enterprise-wide initiative impacts the more than 200 ambulatory sites.

The team includes more than 50 members, representing ambulatory front-line staff, patients, providers, operations, real estate, IT, materials management and the Offices of Digital and Innovation. While standard measures of patient satisfaction, quality and financial impact are tracked, this effort is also identifying how to make more time for meaningful human interaction, which is a key driver for patient, provider and staff engagement.

Early Successes

The team first convened in March 2017 to create a new paradigm of ambulatory delivery, and today, seven new sites follow the design principles of Care of the Future, with more slated to go online in 2019.

A Care of the Future site takes into account apps for scheduling and registration/sign-in kiosks, minimizes the traditional waiting area, and focuses on efficiency — ensuring that providers have optimal time and human contact with the patient.

The redesign eliminates unnecessary steps for patients, staff and providers. At one location, medical assistants were previously walking an average of 1,000 steps per patient. Following the Care of the Future workflows, it is now 250 steps per patient, saving 3.5 hours of walking time per medical assistant per week. Through the process, the Care of the Future team also found that providers need less physical space, which translates into less real estate per provider and lower overall costs.

By capitalizing on these workflows, the Care of the Future model strives to have providers working at their maximum clinical level. And that means an enhanced provider — and patient — experience.

Increased Capacity

- Calls to the clinic reduced by 25 percent
- Patient waiting (non-value added) time reduced by 50 percent
- Room-utilization rate doubled

Improved Engagement

- Average provider EHR “tasks” reduced by 50 percent
- Time between patient and caregiver increased by 30 percent

Ambulatory Care Transformation

To help ensure our ambulatory care sites are as efficient as possible with a common approach to technology, we established the Ambulatory Care Transformation (ACT) committee. Clinical, business, population health, digital/technology and other areas — as well as all geographies — are represented.

ACT, an advisory committee that makes recommendations to Dignity Health leadership, held its inaugural meeting in the fall of 2017. The committee has four subcommittees:

- Ambulatory Revenue Cycle
- Ambulatory Refinement
- Ambulatory Prioritization
- Ambulatory Best Practices

ACT and its subcommittees are tasked with making recommendations related to an array of technology solutions, including EMRs, collecting MSSP data points consistently across the enterprise, scheduling and billing systems, Augmedix, par8o and more.

One key success in the committee’s first year was aiding in the transition to the Cerner EMR solution. To improve the platform’s efficiency, the committee made changes within the system, and tackled a 150-plus-item backlog of issues. Their countless hours of work enabled recent go-lives in three markets, laying the foundation for other sites.

As the committee matures and hones its goals and metrics, ACT is serving a vision of optimizing current technology while keeping the future in mind.

Ambulatory Care Transformation (ACT)

Ambulatory Initiatives

Examples
- MACRA/MIPS
- Clinic of the future
- Physician, patient digital initiatives
- Interoperability
- Implementation activities

Ambulatory IT Strategy and Solutions

- Clinical technology solutions
- Rev cycle technology solutions
- Pop health (CIN) technology solutions

Ambulatory EHR Transformation

- Optimization of:
  - Cerner build
  - User proficiency
  - Documentation
  - User experience

A Final Word

As we progress, Dignity Health continues to learn and iterate new lessons and ways to improve the Quadruple Aim for health care.

Key to our progress between 2017 and 2018 was our Clinical Steering Committee, which has helped drive our organization's clinical path forward. Our Practice Transformation, Quality and Care Coordination subcommittees, and the Risk Council — empowered by our Clinical Analytics function — embarked on exciting, new initiatives and projects. Our mission was further supported by our Community Health efforts and digital innovations.

Throughout Dignity Health's hospitals, as well as our medical groups, clinically integrated networks and accountable care organizations, we are focused on collecting actionable data and on setting targets that empower us to achieve the Quadruple Aim. Indeed, in 2017 and 2018, we saw our strategies take shape as we arrived at key benchmarks.

We are optimistic about the opportunities we see on the horizon — and all that we can achieve. We look forward to updating the community on these endeavors in the months and years to come. We thank you for joining us on this journey to a healthier population.

VIEW ONLINE REPORT

dignityhealthvaluereport.org

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Editorial and Design Team
Jessica Dixon
Dr. Gary Greensweig
John Kniesche

Additional Contributors
Julie Bietsch
Kelly Bitonio
Brent Blzik
Pablo Bravo
Jennifer Brooks
Brooke Burgess
Marie Angelica Chanco
Diwen Chen
Dr. Joseph Colorafi
Tiffany Combs
Gail Daly
Dr. Keith Frey
Tri Ho
Dr. Teresa Hong
Kim Hurley
Ana Igoa
Ji Im
Natasha Jivani
Joe Kim
Judy Hallada
Dr. Davin Lundquist
Dr. Steven Magee
Dr. David Mescher
Elizabeth Mestas
Barbara Minnery
Gail Moxley
Amanda Nims
Dr. Shez Partovi
Kristine Penza
Lisa Perko
Gopi Polavarapu
Kristin Rosemond
Samantha Ross
Jennifer Schaab
Michael Seagraves
Julie Sprengel
Debra Stevens
Dr. Nicholas Stine
Bruce Swartz
Dennis Sweeney
Sean Turner
Rosa Vicente-Soito
Jane Weldon

Dignity Health®

185 Berry Street #300, San Francisco, CA 94107

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