

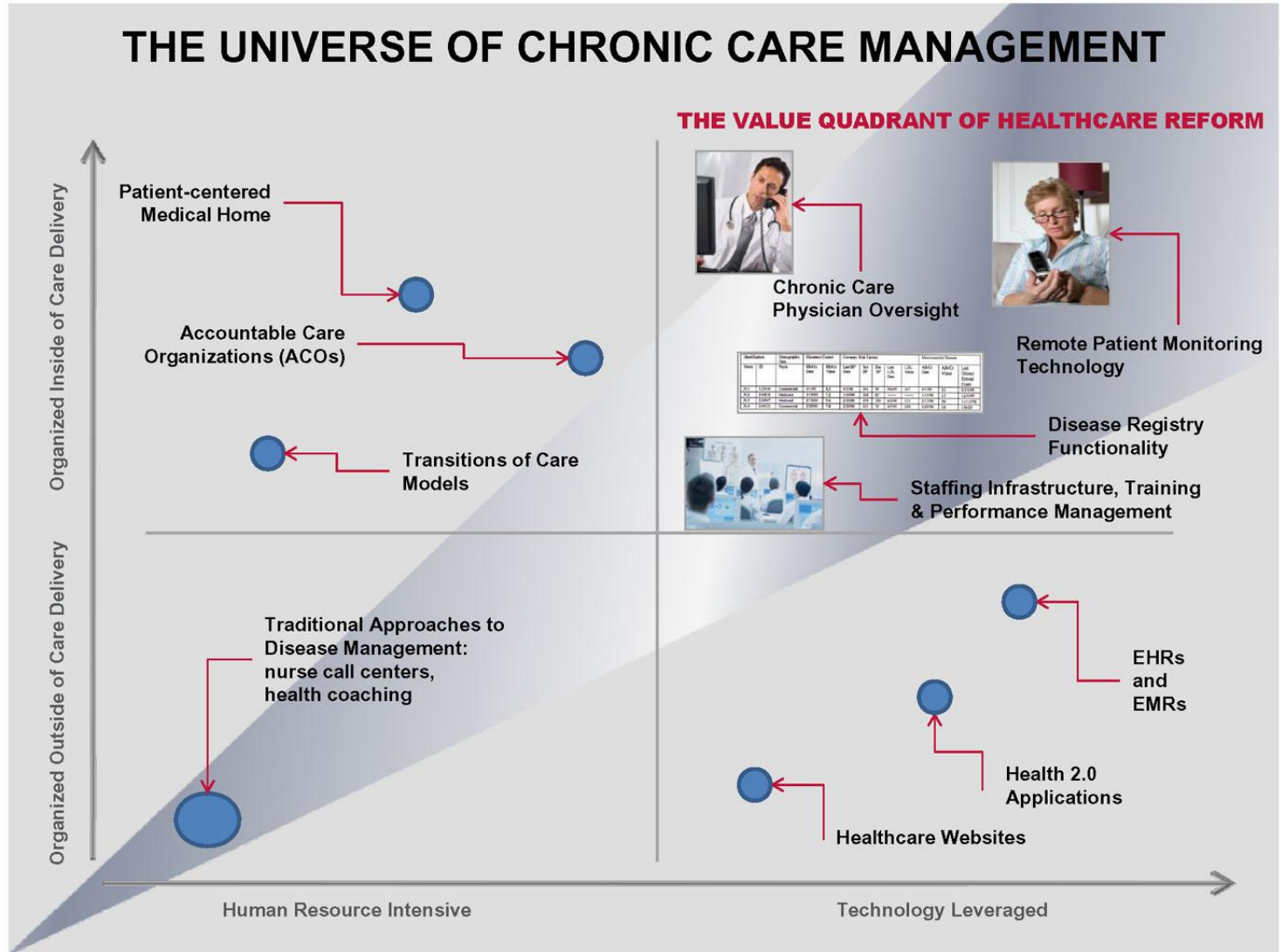


*Better care coordination
should be this simple.*

Overview

- 🚧 Role of Pharos Innovations in supporting Park Nicollet's successes
- 🚧 Strategic Vision
- 🚧 Operational Model
- 🚧 Implementation Approach
- 🚧 Impact and Results
- 🚧 Keys to Success

The Value Quadrant of Healthcare Reform





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Care Coordination Operational Model

<u>Entity</u>	<u>Function</u>	<u>Rationale</u>
Care Coordinators (RN's)	Deliver daily self-care support, patient monitoring and clinical care triage	This role supplements the physician and leads to improvement in quality and cost outcomes when following standard treatment protocols
Telehealth (Daily Remote Monitoring) and Disease Registry Technology	Monitor clinical and behavioral status of individuals and populations while allowing care coordinators to be maximally efficient	Proven to dramatically reduce admissions by identifying candidates for care coordination interventions; reinforces patient self-care regimen
Physician Care Coordination Oversight	Monitor and approve plan of treatment; adjust medications as needed	Prescriptive authority and treatment protocol approval
Provider Organization Leadership & Administration	Care Coordinator training, QA, Protocol approval, management of bonus payment model	Organizing entity for regional and local providers



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Implementation Approach

Establish Care Coordination Infrastructure-

- Hire, train, deploy care coordinators
- Initially centralized, then migrated to practice locations
- Design care protocols, manage quality assurance and reporting

Identify and Enroll Target Beneficiaries -

- Target enrollees identified using HCC grouper definition from claims
- Enrollee clinical data populates disease registry
- Design and roll-out beneficiary enrollment process

Track daily clinical and self-care status

- Triage to clinic visit if needed
- Optimize patient participation and stickiness

Track and document quality and hospitalization rates

- Trend all cause admissions, readmissions, condition specific admissions
- Review operational and outcomes metrics with senior leadership quarterly

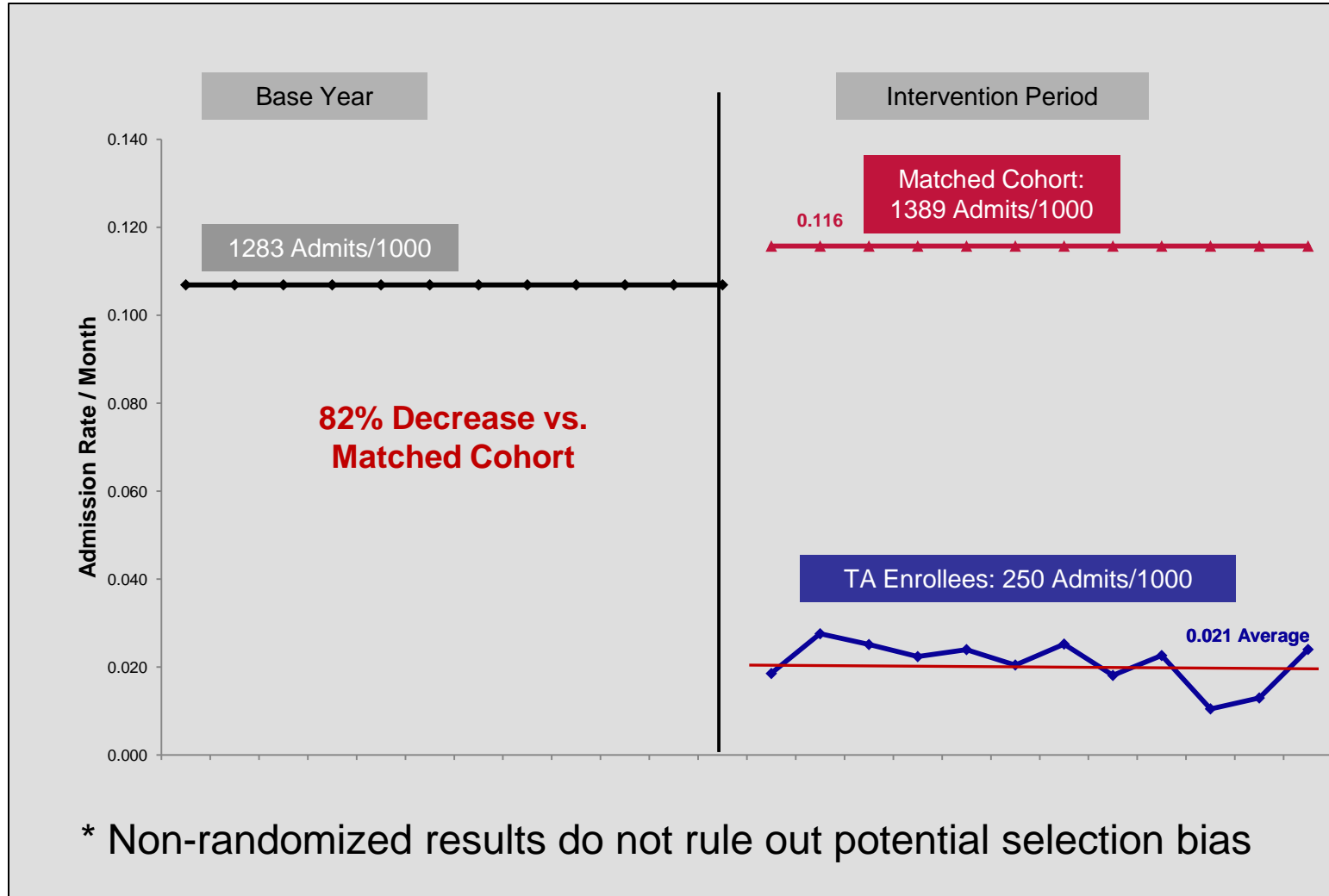


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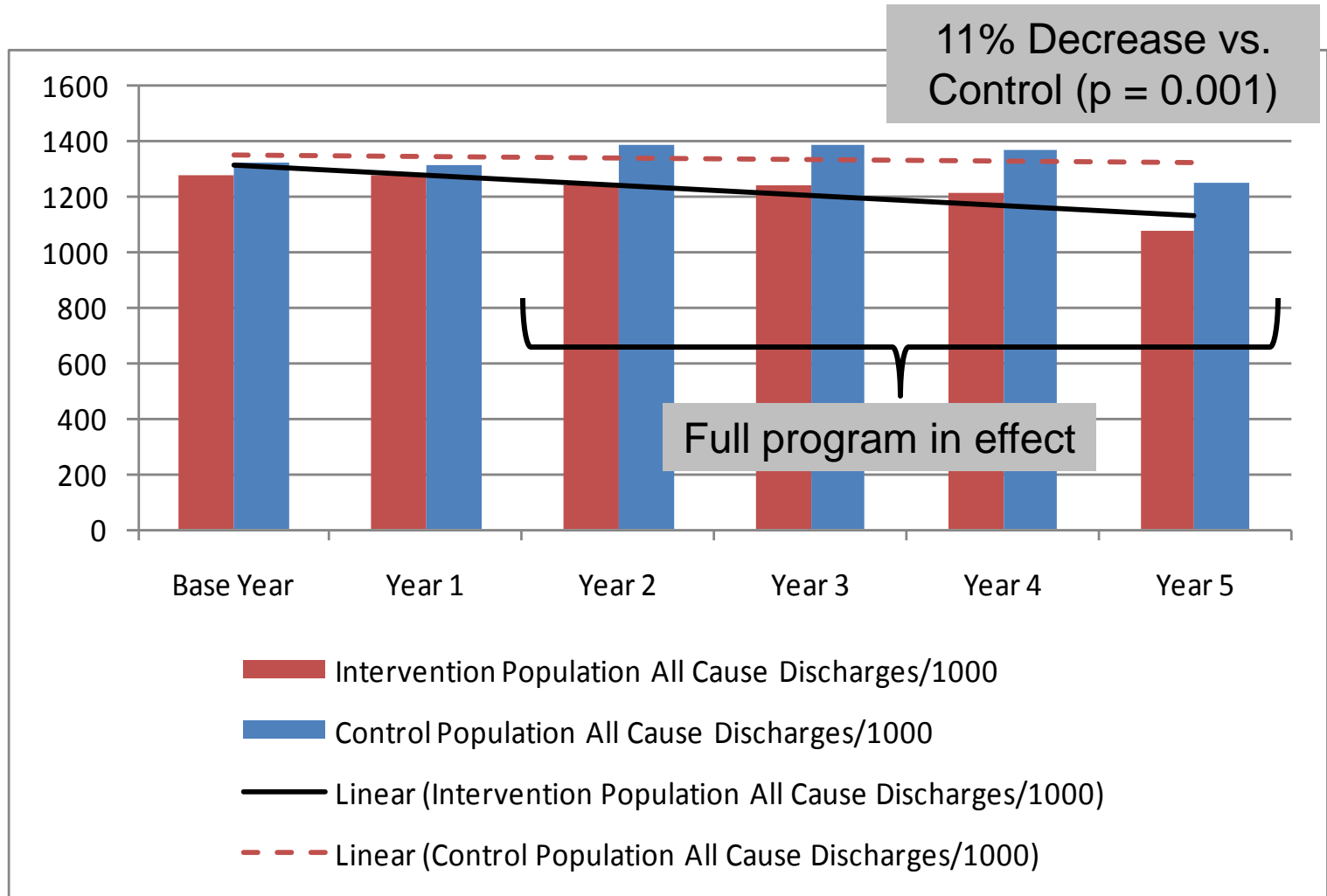
CMS Physician Group Practice Demonstration

Target Population:	Medicare members with CHF Dx: all risk levels
Evaluation Setting:	Physician Group Practice setting, part of CMS PGP Demonstration Project
Intervention Duration:	4.5 Years for Enrollees (6 month ramp up)
Enrollment and Monitoring Duration:	1,132 unique individuals (57% of CHF population) <ul style="list-style-type: none"> • 62% of eligible individuals enrolled in program • Average time in program: 24 months
Measurement of Impact:	<ul style="list-style-type: none"> • All Cause Admits/1000 vs. base year • All Cause Admits vs. Matched Population • All Cause 30 day readmissions following CHF discharge
Control design:	Matched population from comparable geography, risk score and baseline utilization
Source of Analysis:	CMS Demonstration; CMS claims analysis

Hospitalizations for Monitored Individuals*

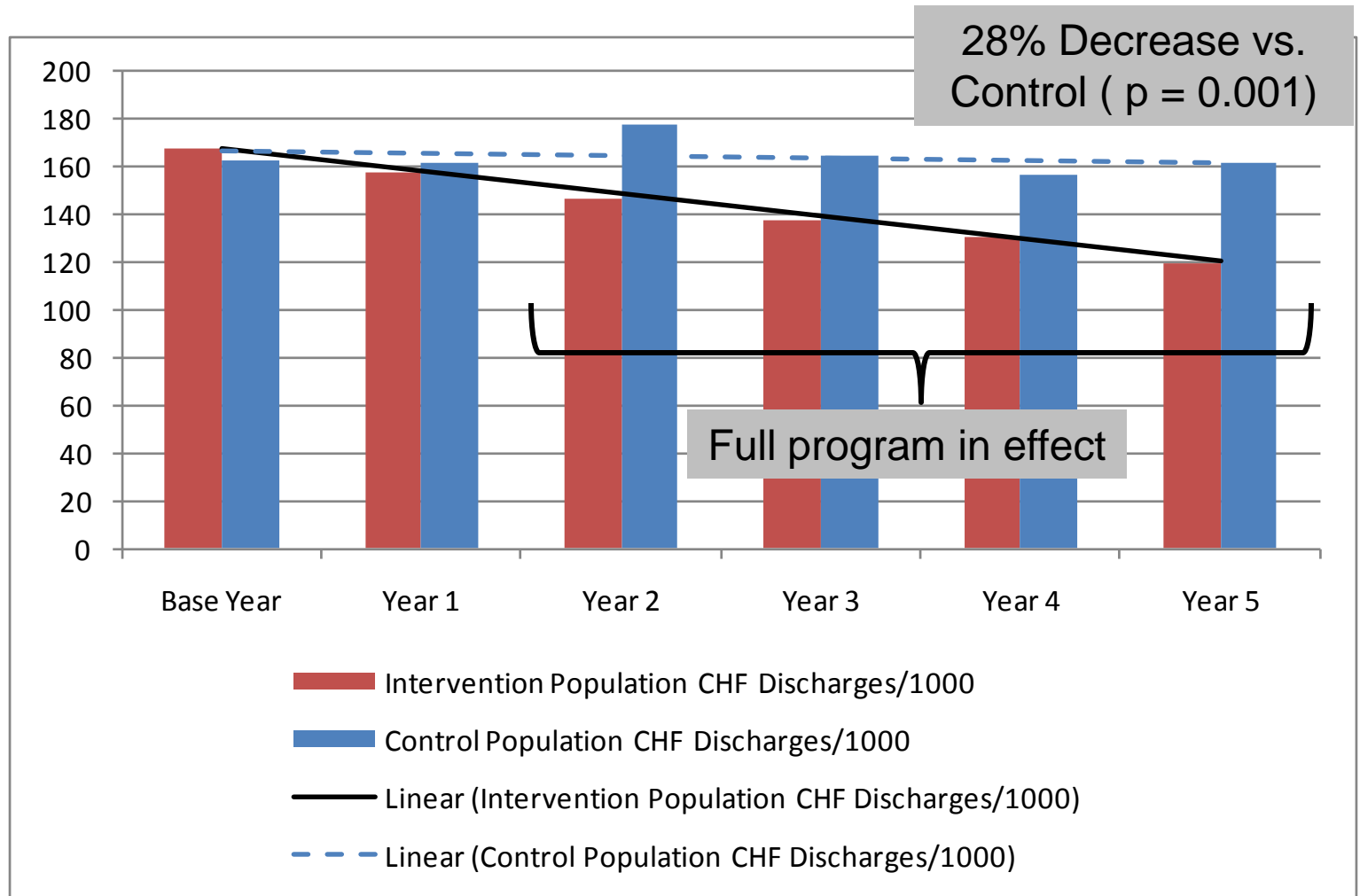


Population Level Impact of RPM/Care Coordination on All Cause Admits*



*Population level impact eliminated potential of selection bias

Population Level Impact of RPM/Care Coordination on Condition Admits*



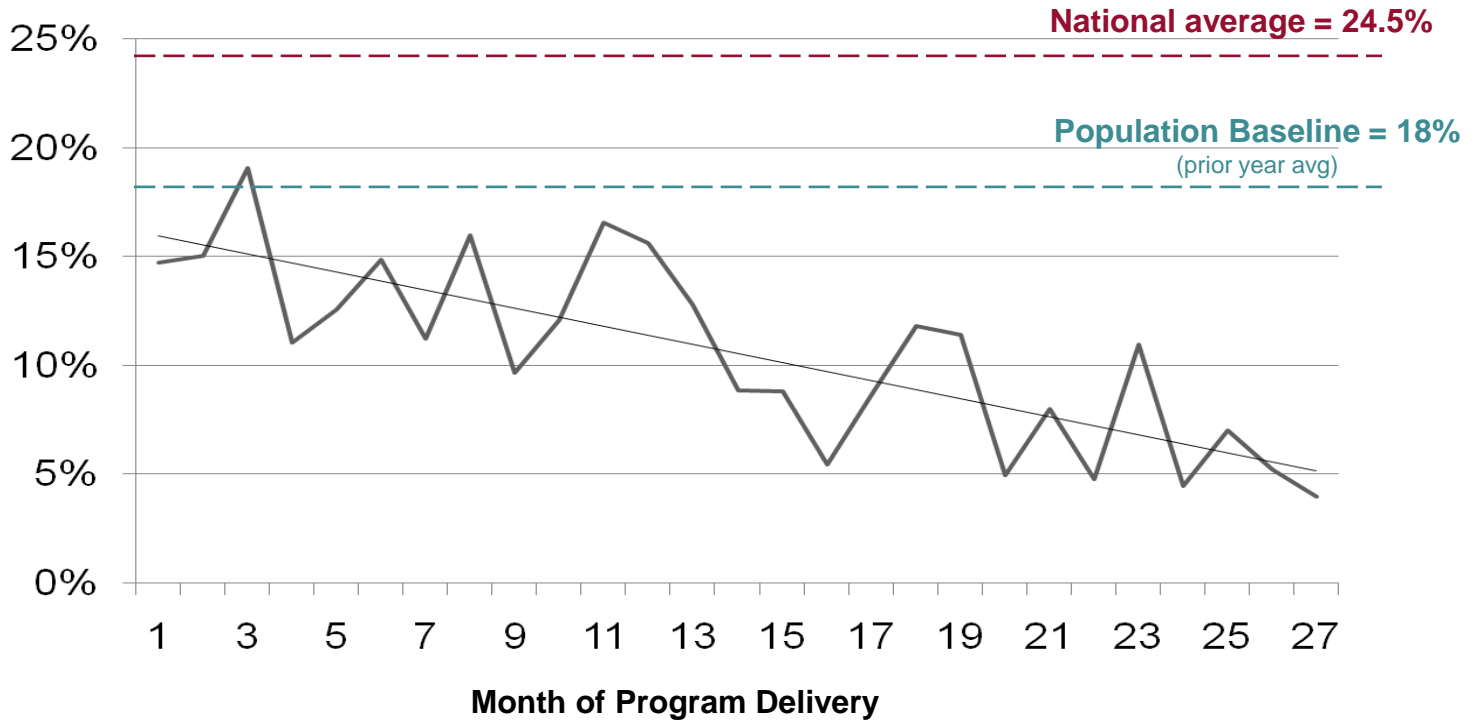
*Population level impact eliminated potential of selection bias



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Population Impact on 30 Day Readmissions*

All Cause 30-Day Readmission Rate Following Hospitalization for Heart Failure for ALL CHF Patients

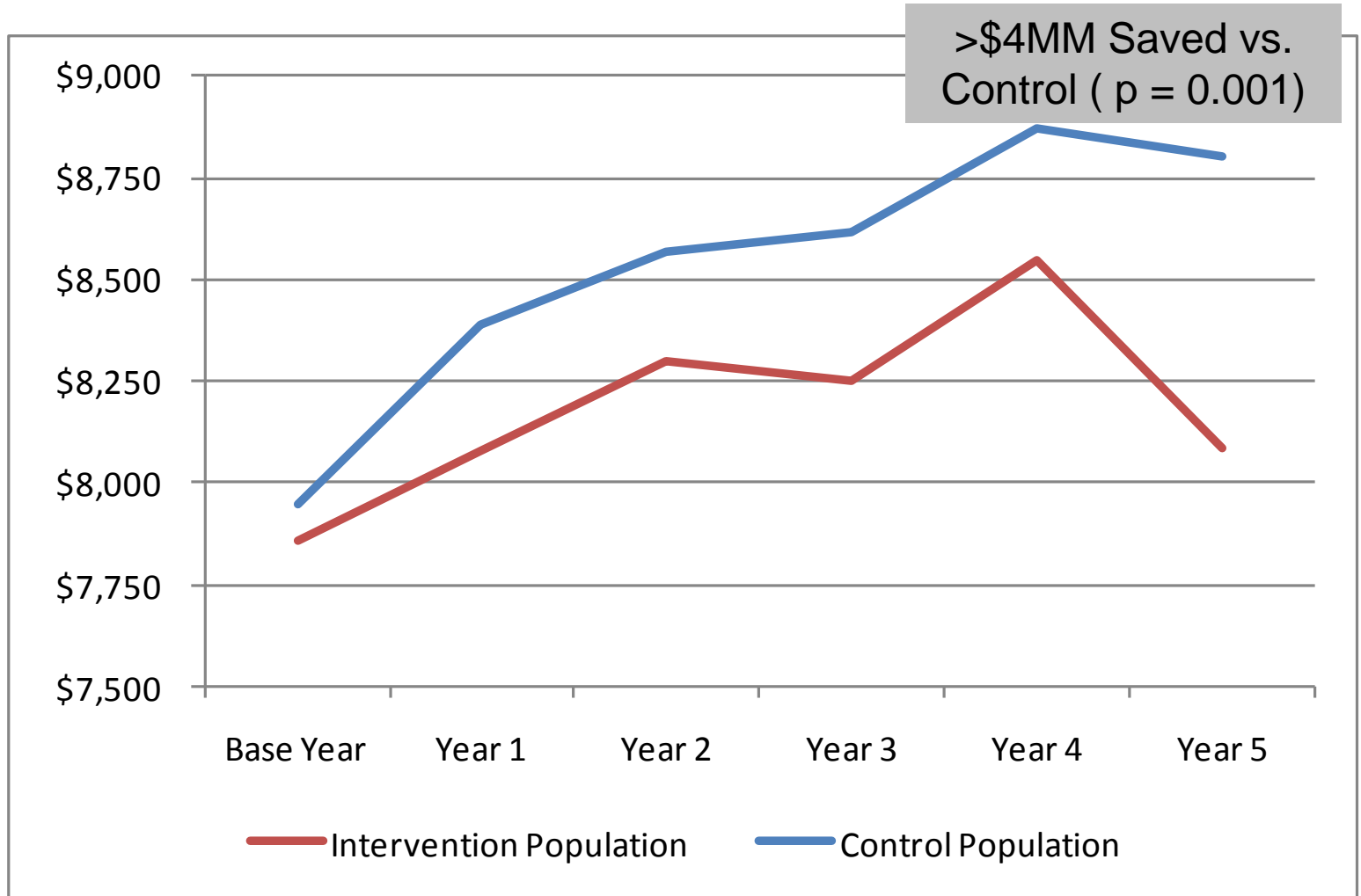


*Population level impact eliminated potential of selection bias



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Population Impact on Costs* per CHF Member (Part A and B)








* Risk Adjusted using HCC methodology



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Keys to Success

-  **Pick the right partners**
-  Focus on the right patients
-  Develop the right operational infrastructure
-  Monitor, monitor, monitor
-  Optimize, optimize, optimize

Great Partnerships – Share Common Goals



- Organizational leadership commitment
- Vision and passion for transforming healthcare delivery
- Culture of developing and disseminating best practices



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Keys to Success

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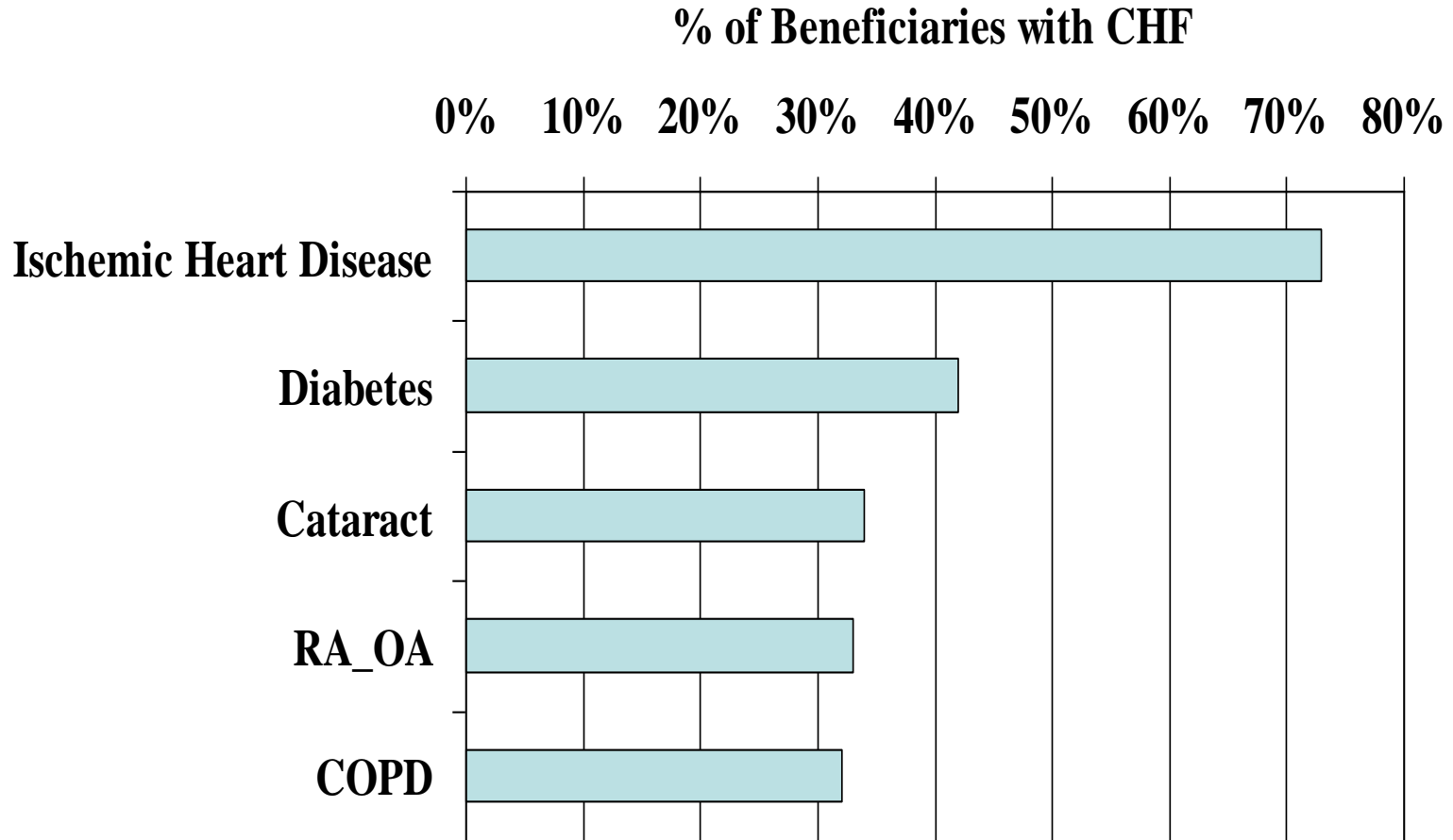
Chronic Condition: Congestive Heart Failure (CHF)

- 🚧 20% of Medicare Beneficiaries have CHF
- 🚧 Beneficiaries with CHF account for 48% of Medicare Spending
- 🚧 Medicare spends on average \$17,700 per beneficiary with CHF annually
- 🚧 98% of those with CHF have at least 1 other chronic condition



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Common Comorbid Conditions Associated with CHF





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Keys to Success

- 🚧 Pick the right partners
- 🚧 Focus on the right patients
- 🚧 **Develop the right operational infrastructure**
 - **Mine available data**
 - **Staff deployment strategy**
 - **Divide the responsibilities effectively**
- 🚧 Monitor, monitor, monitor
- 🚧 Optimization, optimize, optimize



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Keys to Success

- 🚧 Pick the right partners
- 🚧 Focus on the right patients
- 🚧 Develop the right operational infrastructure
- 🚧 **Monitor, monitor, monitor**
 - **Patients: daily**
 - **Staff: monthly**
 - **Results: quarterly**
- 🚧 **Optimize, optimize, optimize**
 - ***AT LEAST* a 12-18 month process**



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Key Considerations for Potential ACO Leaders

- 🚧 Can we afford to ignore the ACO movement?
- 🚧 Should we participate in the ACO movement?
- 🚧 What core competencies do we bring?
- 🚧 How do we find the right partners?
- 🚧 Where would we start?
- 🚧 How does an ACO strategy create competitive advantage in our market?



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Questions



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The Physician Group Practice Demonstration

Lessons Learned

**Mark Skubic, Vice President Government Relations
Park Nicollet Health Services**

Sept. 7, 2011

Care Continuum Alliance Symposium

“We always overestimate the change that will occur in the next two years and underestimate the change that will occur in the next ten.”

Bill Gates Jr.



Objectives

- ◆ **What does it mean to be an Accountable Care Organization**
- ◆ **Park Nicollet's Medicare Physician Group Practice Demonstration Project Experience**
 - ◆ **FFS→PGP→PGP-TD→?Pioneer ACO**
- ◆ **Other aligned payment models**
 - ◆ Commercial Shared Savings and Pay For Performance
- ◆ **Park Nicollet Quality Strategic Focus**
 - ◆ Hot Spotting
 - ◆ Elimination of Unnecessary Variation
 - ◆ Developing Cross Departmental Protocols

Health Care Reform Alphabet Soup

ACO: Accountable Care Organization

MNCM: Minnesota Community Measures

VBPP: Value Based Purchasing Program

P4P: Quality Pay For Performance

PQRI: Physician Quality Reporting Initiative

SS: Shared Savings

FFS: Fee For Service

TJC: The Joint Commission (JCAHO)

SCIP: Surgical Care Improvement Project

PGP: Physician Group Practice Demonstration

GPRO: Group Practice Reporting Option

MU: Meaningful Use

NCDR: National Cardiovascular Data Registry



Accountable Care Organizations (Accountable for Quality and Cost of Care)

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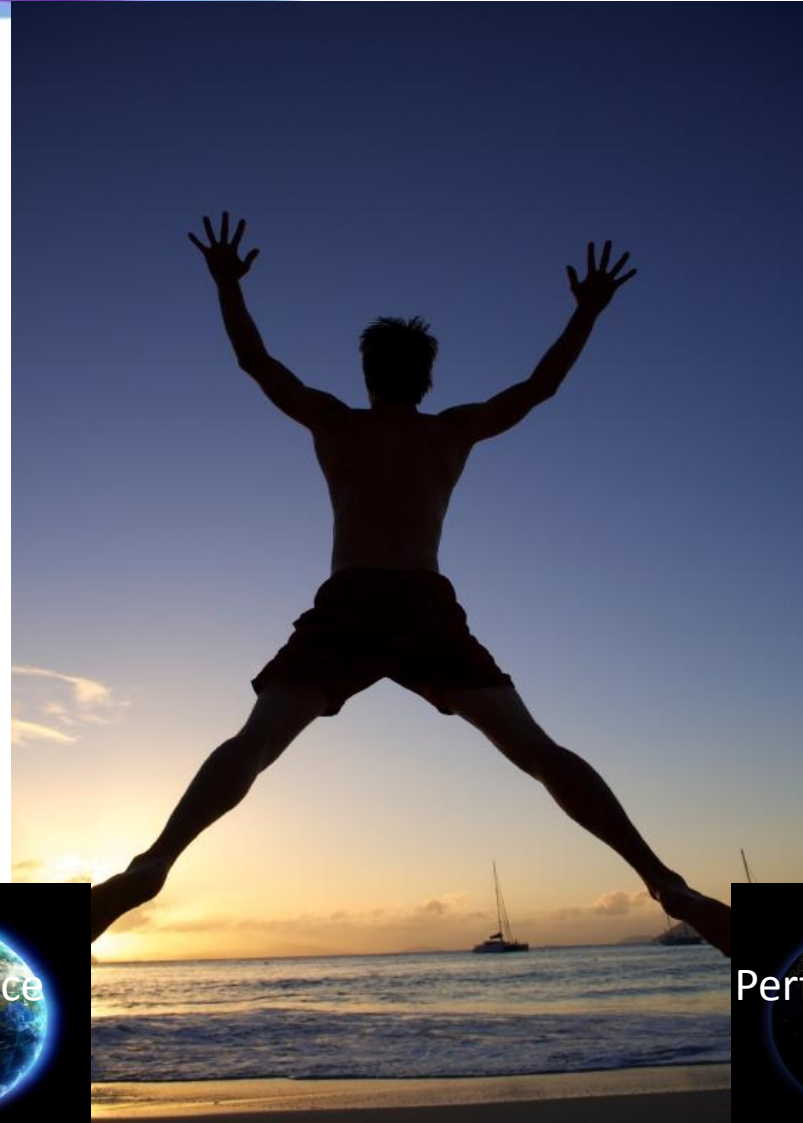
NCDR: National Cardiovascular Data Registry

Why Did PNHS Apply?

- ◆ Ability to get paid without care limitations (Ability to innovate).
- ◆ No down-side risk.
- ◆ Minnesota was a Medicare Cost Contract market, not Medicare + Choice
- ◆ Aligned with PN Vision and Objectives
- ◆ We thought we could win if we could throw away the broken business model of Fee for Service.

A foot in two worlds

Fee for Service payment with capitation incentives



Fee for Service

Performance risk

We thought we could succeed because:

- ◆ We already had an integrated delivery system.
- ◆ Our adoption of Lean gave us an advantage to eliminate waste.
- ◆ Focus on Continuous Quality Improvement.
- ◆ Experience in our employer market around total cost of care payment models.

But we soon realized we didn't have:

- ◆ Exquisite Focus across all service lines.
 - ◆ For complex patients (individuals) needing care coordination.
- ◆ Sufficient FTEs for care coordinators (No payment with reduced hospital revenue).
- ◆ Technology to identify and track these patients.
- ◆ Data.
- ◆ Analytic capabilities on the complex metrics of the payment model and patient flow.
- ◆ Ability to Hot Spot patients.

Park Nicollet hit 100% of quality Goals in Years 3,4 and 5

Park Nicollet hit 100% Quality Goals.

PY1	-	95.45%	30% of Payment
PY2	-	97.78%	40% of Payment
PY3	-	100%	50% of Payment
PY4	-	100%	50% of Payment
PY5	-	100%	50% of Payment

Note: Quality Targets met also applied to PQRI payments for which PGP sites were eligible to receive in Demonstration.

Park Nicollet Performance PY -1 to PY 5

	<u>Savings</u>	<u>2% Threshold</u>	<u>Bonus Pool</u>	<u>CMS</u>	<u>PNHS</u>
PY 1	- 656,929	2,559,899	\$0	0	0
PY2	- 1,468,439	2,654,538	0	0	0
PY3	- 695,207	2,819,621	0	0	0
PY4	- (562,752)	(2,858,335)	0	0	0
PY5	- \$10,049,998	\$2,958,526	\$7,091,472	\$1.41	\$5.67

Intervention Focus Mattered

Sites that achieved larger savings had more initiatives focused on patients with greatest need for care coordination.

- ◆ PNHS focused on CHF, CQI, Palliative Care.
- ◆ Other groups focused on more initiatives including:
 - ◆ Coumadin Clinics
 - ◆ Post discharge follow-up
 - ◆ Hospital admissions
 - ◆ Hospital readmissions

How did we do?

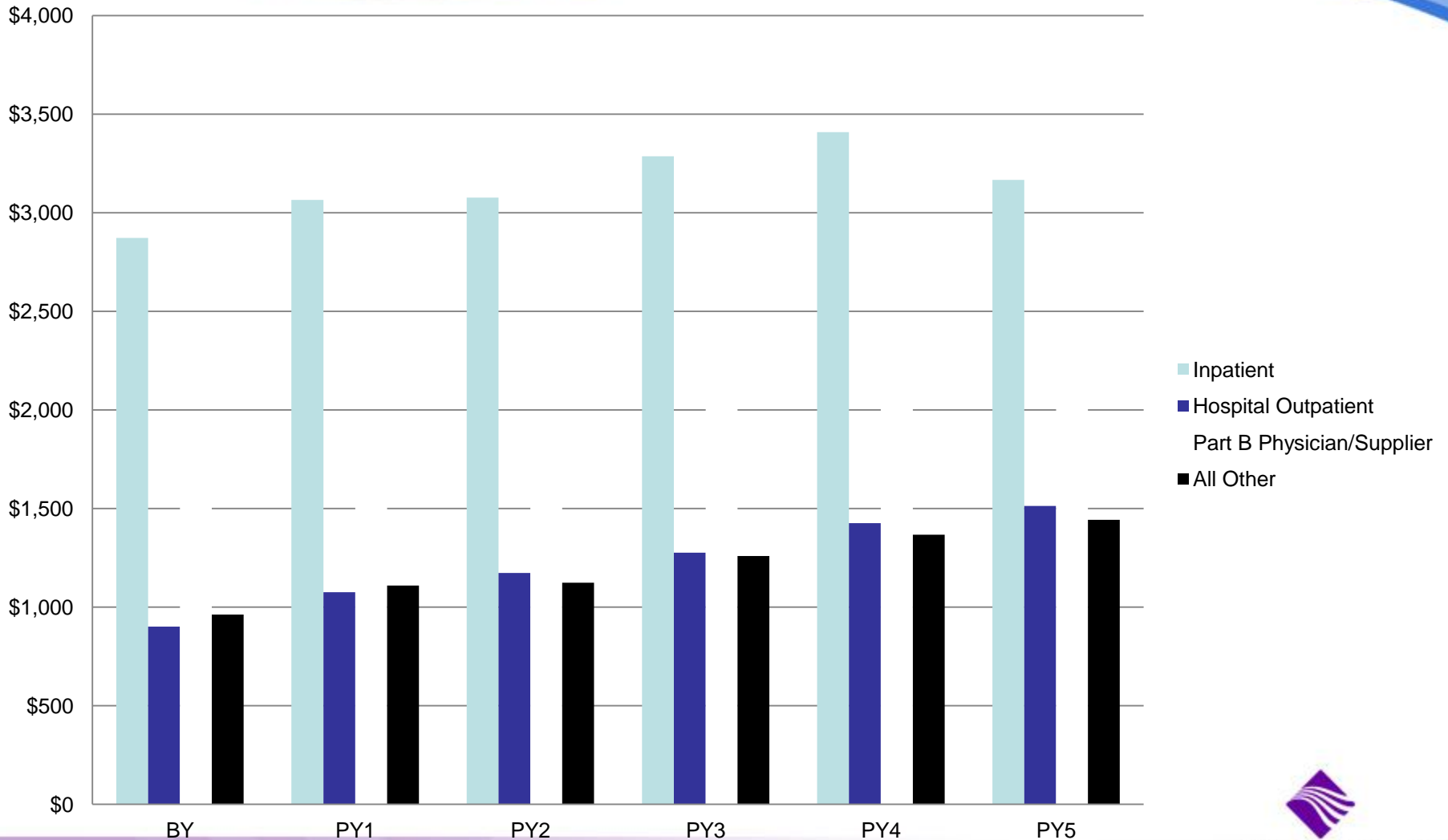
1. We Reduced Hospital Admissions.

PGP Results

Discharges Per 10k Patients with Select Conditions			
Condition	PY4	PY5	Percent
All Discharges	3,599	3,273	-9%
CHF	12,134	10,756	-11%
CAD	13,228	10,811	-18%
Diabetes	6,362	5,621	-12%
COPD	9,981	9,209	-8%
Heart Arrhythmia	9,675	8,599	-11%
High Risk Patients (90 th %)	20,573	17,786	-14%
Hypertension	5,003	4,535	-9%
At Least 1 Discharge	16,788	16,102	-4%

PGP Results

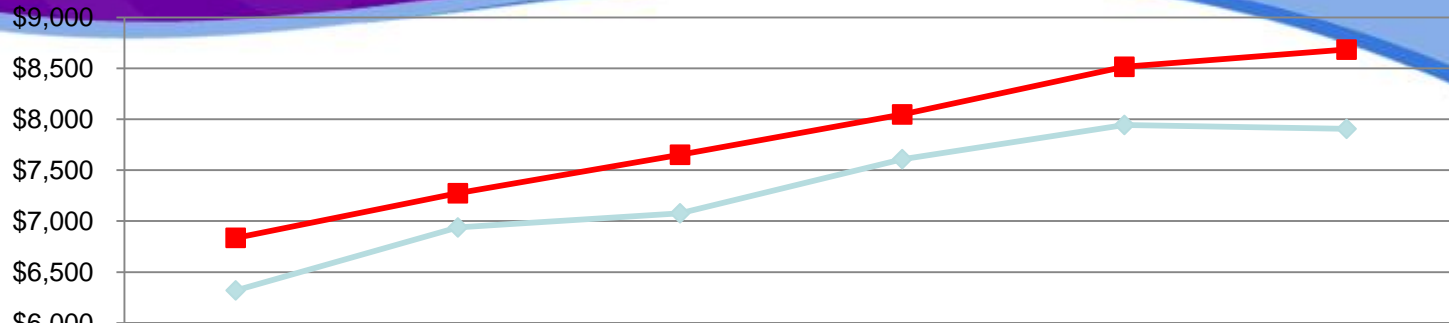
PNHS PGP Per Member Per Year Expenditures by Category - Base Year Through PY5



PGP Results

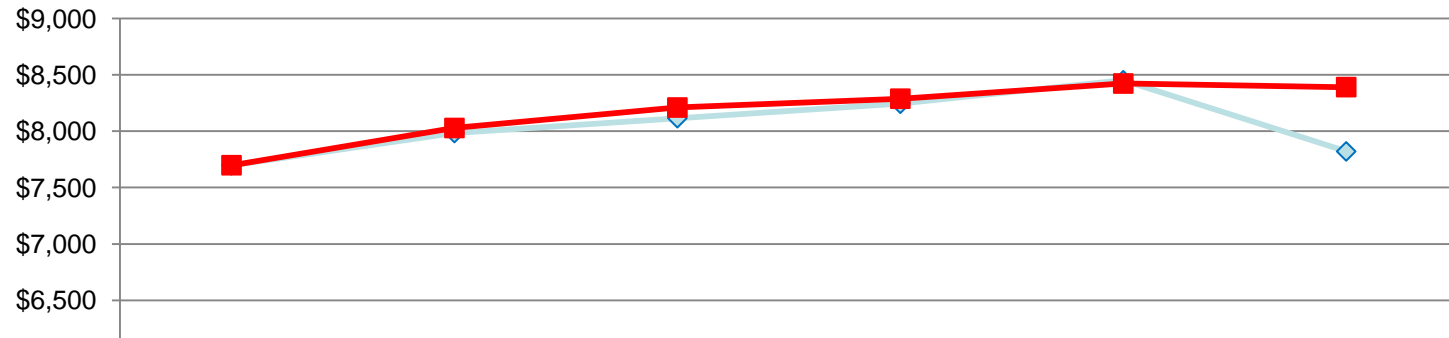
Summary of PGP Expenditure Rates PY1 – PY5 (2004-2010)

Non Risk Adjusted Expenditures



	Base Year (2004)	PY1 (Ending Q1 06)	PY2 (Ending Q1 07)	PY3 (Ending Q1 08)	PY4 (Ending Q1 09)	PY5 (Ending Q1 10)
PN \$100k Cap Expenditures	\$6,320	\$6,938	\$7,077	\$7,609	\$7,945	\$7,907
CG \$100k Cap Expenditures	\$6,836	\$7,274	\$7,652	\$8,048	\$8,516	\$8,685

Risk Adjusted Expenditures



	Base Year (2004)	PY1 (Ending Q1 06)	PY2 (Ending Q1 07)	PY3 (Ending Q1 08)	PY4 (Ending Q1 09)	PY5 (Ending Q1 10)
PN Risk Adjusted Expenditures (1.0)	\$7,698	\$7,984	\$8,116	\$8,244	\$8,452	\$7,821
PN Risk Score	0.821	0.869	0.872	0.923	0.940	1.011
CG Risk Adjusted Expenditures (1.0)	\$7,698	\$8,029	\$8,210	\$8,288	\$8,423	\$8,391
CG Risk Score	0.888	0.906	0.932	0.971	1.011	1.035



Summary Results of the Physician Group Practice Demonstration, Performance Years 1–4.*

Physician Group Practice	Percentage of Quality Goals Attained				Shared Savings Payments (\$)			
	Year 1	Year 2	Year 3	Year 4	Year 1	Year 2	Year 3	Year 4
Billings Clinic, Billings, MT	90.91	97.78	98.11	92.45	0	0	0	0
Dartmouth–Hitchcock Clinic, Lebanon, NH	95.45	97.78	92.45	94.34	0	6,689,879	3,570,173	328,798
Everett Clinic, Everett, WA	86.36	95.56	94.34	94.34	0	129,268	0	0
Forsyth Medical Group, Winston-Salem, NC	100.00	100.00	96.23	96.23	0	0	0	0
Geisinger Clinic, Danville, PA	72.73	100.00	100.00	100.00	0	0	1,950,649	1,788,196
Marshfield Clinic, Marshfield, WI	81.82	100.00	98.11	100.00	4,565,327	5,781,573	13,816,922	16,154,242
Middlesex Health System, Middletown, CT	86.36	95.56	92.45	94.34	0	0	0	0
Park Nicollet Clinic, St. Louis Park, MN	95.45	97.78	100.00	100.00	0	0	0	0
St. John's Clinic, Springfield, MO	100.00	100.00	96.23	98.11	0	0	3,143,044	8,185,757
University of Michigan Faculty Group Practice, Ann Arbor	95.45	100.00	94.34	96.23	2,758,370	1,239,294	2,798,006	5,222,852

* Because the CMS applied different weights to each of the quality measures, the agency calculated the quality goals attained as percentages, rather than absolute numbers of measures. Data are from RTI International.

<http://www.nejm.org/doi/pdf/10.1056/NEJMp1013896>

Everyone caring, every day



Park Nicollet

What We Learned

- ◆ Critical Mass in new Payment Model necessary.
 - ◆ Achievements benefit all, but all don't pay to reward the benefit.
- ◆ Coding Accuracy in a risk adjusted world is critical.
- ◆ Exquisite focus initiatives to hot spot and track.
 - ◆ Need to know prospectively individual patients and need.
- ◆ Timely data and ability to model new methods.
- ◆ With a focus on subpopulations presenting greatest opportunities for improvement.

Accountable Care Organization Timeline

2006-10
PGP

- Shared Savings
- Quality P4P
- 32 Measures

2011-12
PGP-TD

- Shared Savings
- Quality P4P
- 41 Measures

2012-13
ACO?

- Shared Savings
- Quality P4P
- 65 Measures

2014+
?

- Partial Global Payment (50/50)
- Quality P4P
- 65 Measures



Park Nicollet 2011 Commercial P4P & Shared Savings (Total \$26.7 Million)

- ◆ DM (\$2.26M)
- ◆ OVC (\$1.25M)
- ◆ HTN (\$696K)
- ◆ Depression (\$795K)
- ◆ Advanced Care Directives (\$243K)
- ◆ Meaningful Use
 - Colon CA Screen (\$496K)
 - Tobacco Cessation (\$486K)
 - BMI (\$486K)
 - VTE Prophylaxis (\$243K)
- ◆ Potentially Avoidable Admissions/Readmission/Complications (\$729K)
 - Lead (\$61K)
 - Patient Experience—Access (\$1.01M)
 - ER Utilization (\$61K)
 - Total Cost of Care Shared Savings (Total \$17.54M)
 - PGP
 - Medica
 - BCBS
 - HP
 - Pref One
 - UCARE

The Tectonic Plates of Reform Move Slowly

To achieve the objectives, must replace the broken fee for service payment model with a new model that:

Allows our physicians to do well by doing right.



Everyone carin