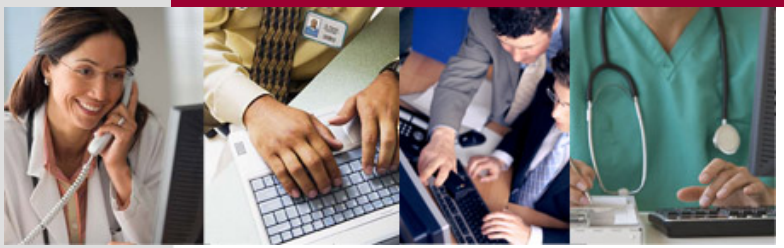
PHAROS INNOVATIONS

Better care coordination should be this simple.

Bridging from FFS to Accountable Care



Using the Medical Home

March 14, 2011

Randall Williams, MD, FACC; CEO, Pharos Innovations

Vince Kuraitis, JD, MBA; Principal, Better Health Technologies, LLC

A Metaphor

Agenda

1) Rationale for Transitional Strategies
2) Functional Elements of Transitional Strategies
   - Payment Reform
   - Health IT
   - Medical Home/Care Management
3) Example: Comprehensive Transitional Strategy
   - Where does the Medical Home “sit” on the path to Accountable Care?
   - What are the critical missing pieces?
   - Is there a “bridge strategy”?
   - CMS Innovation Center project: THE-CCDN

1) The Rationale for Transition Strategies

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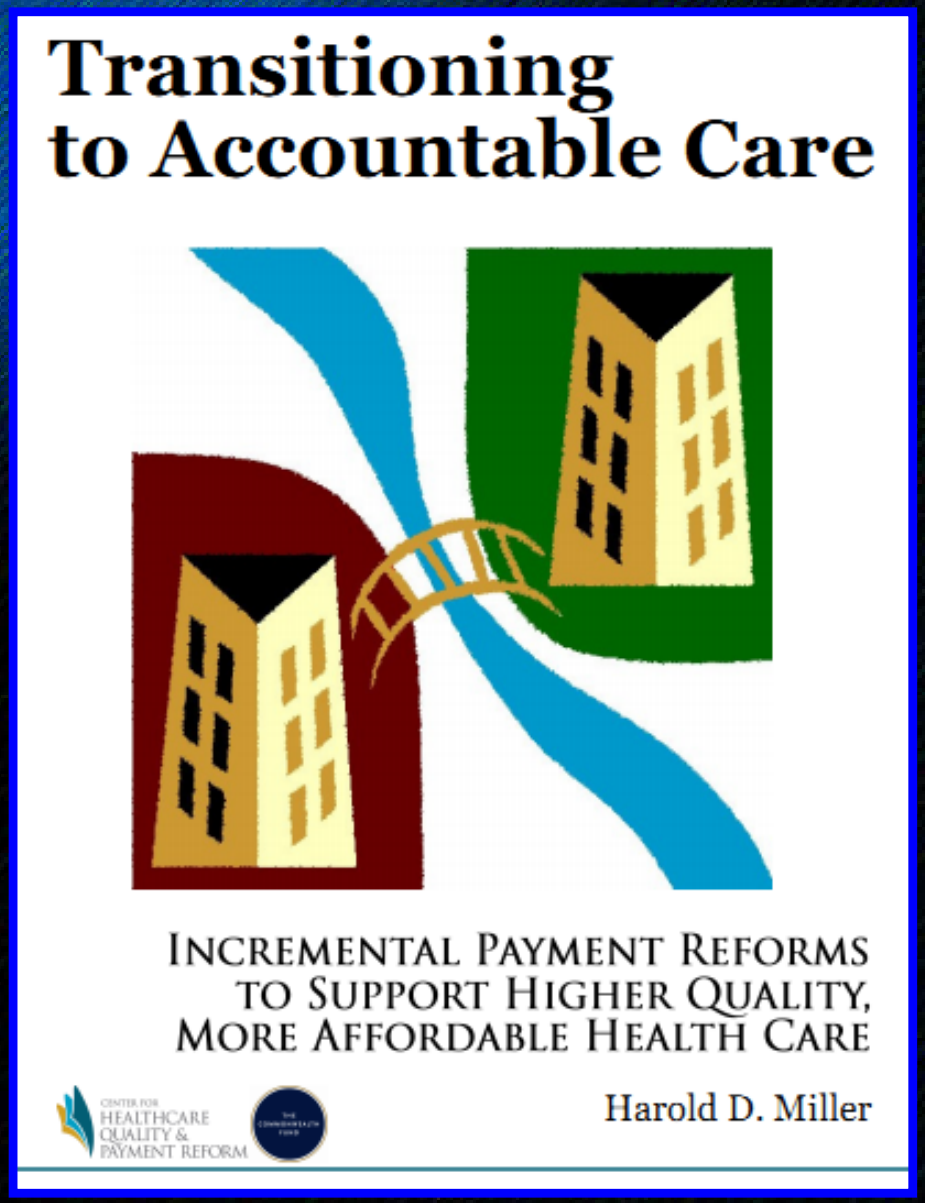
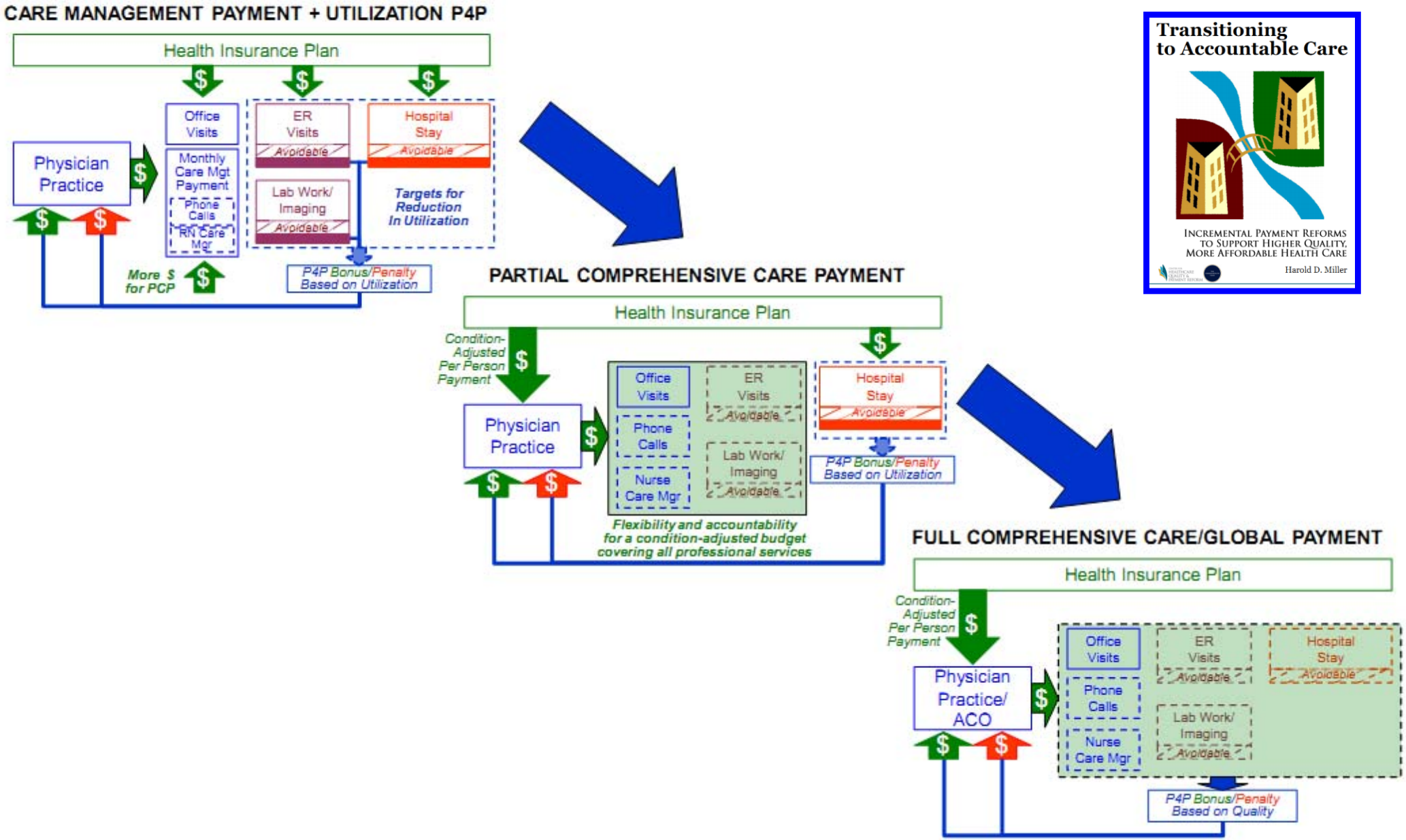
2) Functional Elements of Transitional Strategies

- Payment Reform
- Health IT
- Medical Home/Care Management

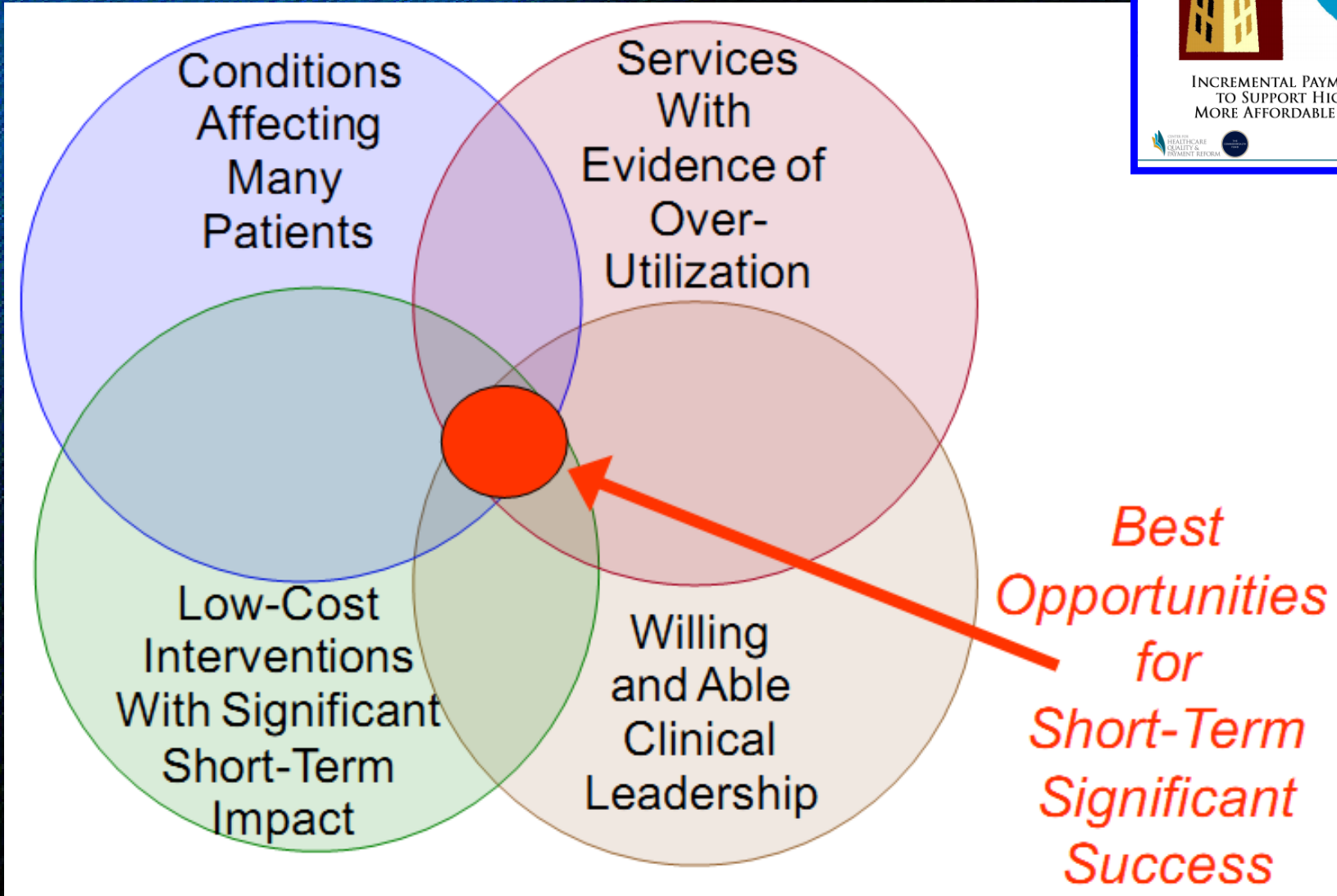
Payment Reform



TRANSITIONING TO ACCOUNTABLE CARE PAYMENT




Transitioning
to Accountable Care
Incremental Payment Reforms
to Support Higher Quality,
More Affordable Health Care
Harold D. Miller


Conditions Affecting Many Patients
Services With Evidence of Over-Utilization
Low-Cost Interventions With Significant Short-Term Impact
Willing and Able Clinical Leadership
Best Opportunities for Short-Term Significant Success

Premier ACO Health IT Maturity Model

Premier Coordinated Care HIT Capability Maturity Model™

Enabling technology for accountable care organizations

	LEVEL 1 "Transaction"	LEVEL 2 "Interaction"	LEVEL 3 "Integration"	LEVEL 4 "Collaboration"	LEVEL 5 "Transformation"
	IT supports individual providers in delivering care and measuring outcomes	*Basic care coordination capabilities emerge with initial population-based metrics*	*Care coordination capabilities improve and health status measurement is possible*	*Seamless care coordination with demonstrable improvement in population health status*	*Triple Aim™ goals realized across the population*
	POPULATION-BASED ANALYTIC REQUIREMENTS				
Care management	Provider-centric quality reporting Harm index	Population-based quality reporting	Health status analytics using self-reported outcomes Patient profiling	Predictive models for disease prevalence services required, cost, outcomes, etc.	Real-time feedback loops on outcomes analytics between providers and patients
Performance management	Shared savings tracking Physician profiling	PMPM-based reimbursement and cost modeling Comprehensive practitioner profiling	Population-based performance measurement	Population health improvement benchmarking and modeling	Revenue and incentive modeling – scenario planning Population-based performance forecasting
	Resource utilization benchmarking Productivity	Demand forecasting and modeling	Risk adjustment Population pool definitions	Venue comparison Patient experience profiling	
	POPULATION MANAGEMENT TRANSACTION SYSTEM REQUIREMENTS				
	EHR (certified) Patient portal (self-service) Registration and scheduling	Personal health record Case management Health assessments	Patient health and experience self-reporting Decision support embedded in workflow Disease management Remote patient monitoring	Wellness management Remote patient intervention	Personalized self-management health improvement programs
	POPULATION INTEGRATION INFRASTRUCTURE REQUIREMENTS				
	EMPI Enterprise-wide interoperability	Standards-based connectivity to key stakeholders Standard clinical vocabulary mapping	HIE connectivity to state-based and other exchanges Semantic interoperability	Real-time connectivity of evidence-based best practice to clinical systems	Ubiquitous access to health and wellness information
	SHARED SAVINGS		**SHARED RISK**		**PERSONALIZED CARE MODELS**

Medical Home Transition Model

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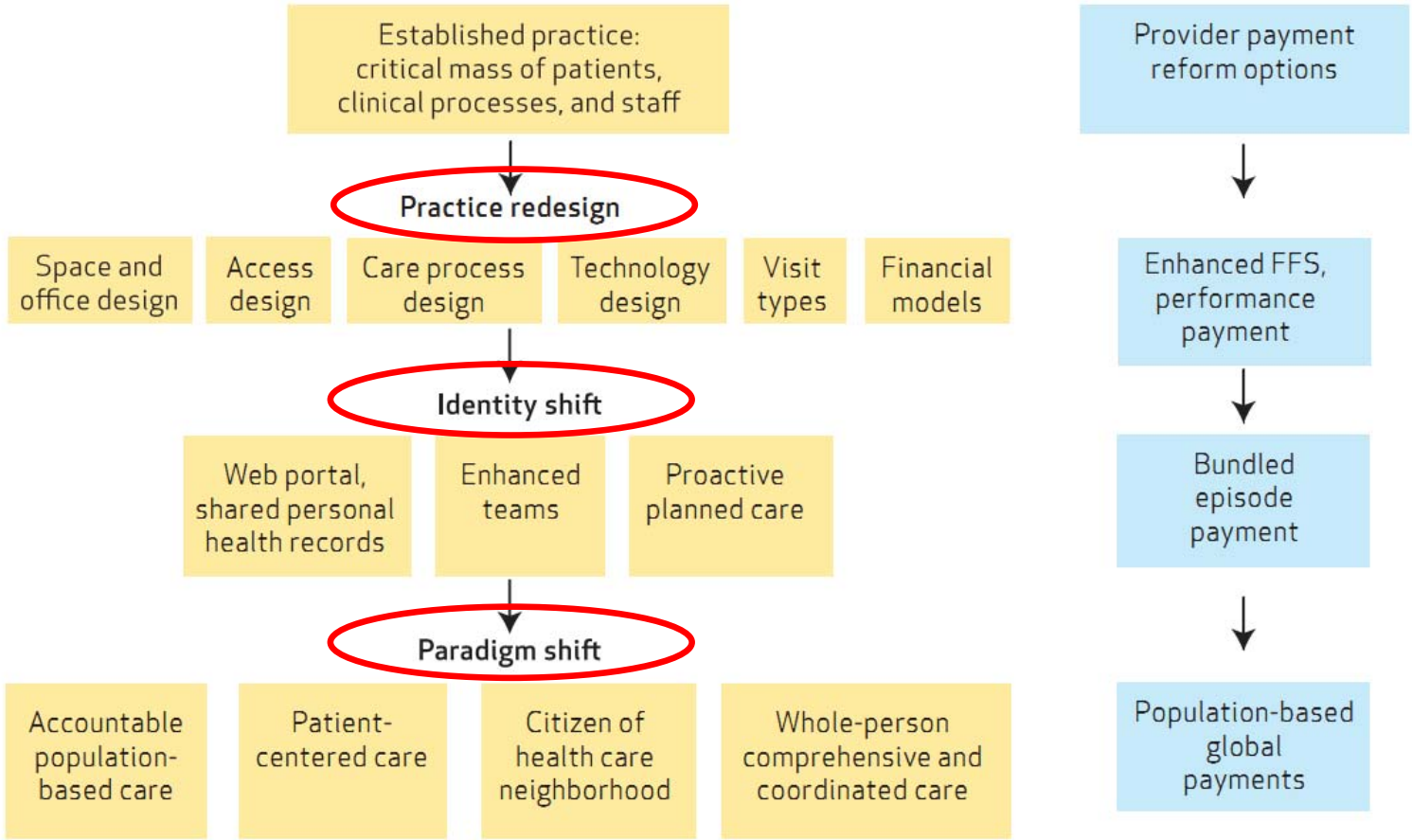
Transforming Physician Practices To Patient-Centered Medical Homes: Lessons From The National Demonstration Project

Paul A. Nutting[1,*], Benjamin F. Crabtree[2], William L. Miller[3], Kurt C. Stange[4], Elizabeth Stewart[5] and Carlos Jaén[6]

EXHIBIT 1

Provider Payment Reform Options To Support Change And Transformation To A Medical Home Model



SOURCE Authors' analysis. **NOTE** FFS is fee-for-service.

3) Example: Comprehensive Transitional Strategy

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Better care coordination should be this simple.

Presentation Overview

- Where does the Medical Home "sit" on the path to Accountable Care?
- What are the critical missing pieces?
- Is there a "bridge strategy"?
- CMS Innovation Center project: THE-CCDN

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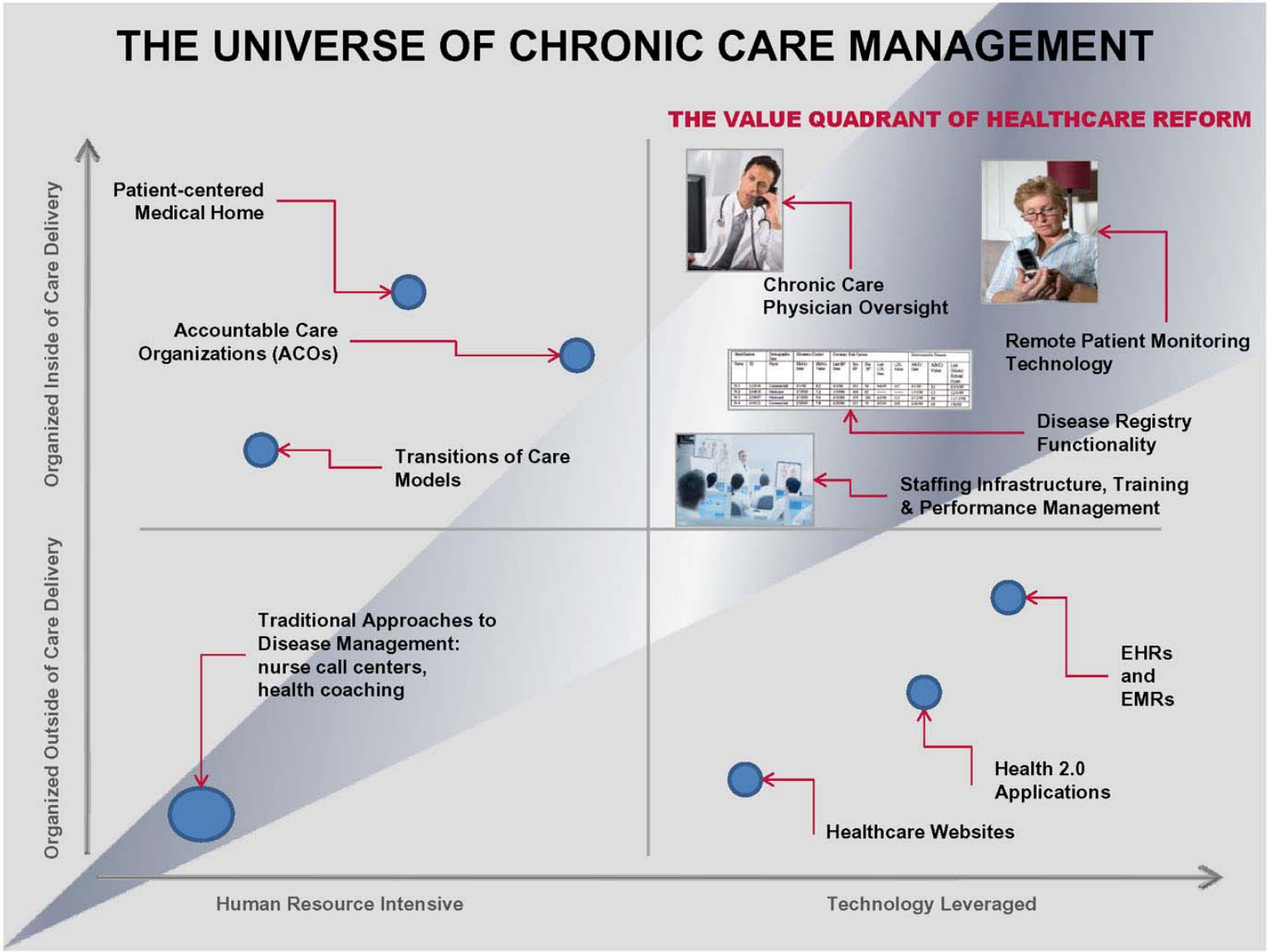
The Value Quadrant of Healthcare Reform



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The Bucket List

Develop	**Operational capacity for coordinated population care**
Improve	**Patient accountability and self-care capacity**
Reduce	**Avoidable costs of care: unnecessary hospitalizations**
Continue to Reduce	**Variability in processes of care**
Create Visibility	**Manage populations with real time "actionable" information**

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What are the missing pieces?

- Patient Focus
  - The “right” patient groups where cost savings exists today and can be capture quickly
- Operational Excellence
  - Organizing to do “a few things well”
  - Defining and managing “processes of care”
  - Hardwire a Customer-centric QA/CQI culture
- Actionable Information
  - Clinical AND financial
  - Clinical AND self-care
  - Process AND outcomes

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CMS Innovation Center – Telehealth And Hit Enabled Chronic Care Delivery Network (THE-CCDN)

PPACA Section III establishing CMS Innovation Center; Model V, as implemented by Pharos Innovations within CMS PGP Demo's and Iowa Medicaid Demonstration

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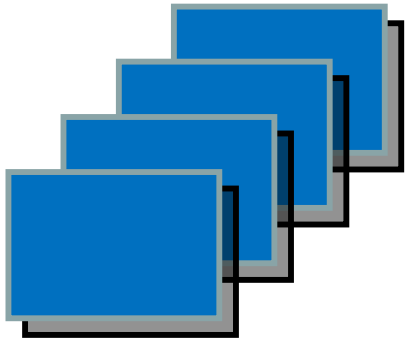
THE-CCDN
Telehealth and HIT Enabled Chronic Care Delivery Network

Medical Home Model

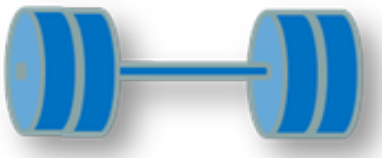


Accountable Care Organizations

Focus:
CHF, COPD, Diabetes

Common Goals

- Enhance care coordination
- Align incentive for value
- Constrain cost growth



Bundled Payment Model

Unique Attributes

- Near-term cost savings
- Simple model, rapidly scalable
- Proven in multiple settings and populations

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THE-CCDN Operational Model

Entity	Function	Rationale
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
Network Administration	Care Coordinator training, QA, Protocol approval, provider contracting, management of bonus payment model	Organizing entity for regional and local providers

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Target Population and Payment Model

Target Population:
- CHF 1.23MM x 30% enrollment x 40% reduction in admissions = $1.097B annual savings
- COPD 1.06 MM x 30% enrollment x 40% reduction in admissions = $739MM annual savings
- Diabetes 1.5MM x 30% enrollment x 40% reduction in admissions = $666MM
- **Total annual savings = $2.5B**

CPT Code based monthly PMPM:
- $35 Care Coordinator (200 cases per FTE)
- $12 Physician Oversight
- $50 Telehealth and IT
- $4.88 Administration
- **Total = $102 PMPM**

Performance Pool Model:
- 20% of savings accrues to provider network (thru administrative entities)
- **Approx $200 per enrollee per year**

CMS Savings Potential:
- 3 year averted cost = $8.9B
- 3 year program cost (before bonus) = $4.7B
- 3 year CMS savings (after bonus

Return on Program Cost (Inclusive of Bonus)

1.6 : 1

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On-Going Goal Alignment with Stakeholders

Joint Operations Committee

- Promotes ongoing alignment
- Key leaders from stakeholder organizations
- Focus Areas: Quality, Productivity, Utilization, Cost
- Key executive reporting

30-day readmission reduction
ALOS reduction
Cost per admit/day/reductions
All-cause admissions

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Stepping the Bridge

1. Focus operational efforts on realities of payment today under DRG system (Length of stay)
2. Build transitions of care approaches for high volume readmission conditions
3. Establish primary care networks in partnership with hospital systems
4. Develop programs to track and improve continuum of care services for chronic conditions

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…But how

- Three chronic conditions: CHF, COPD, Diabetes
- Repurpose nursing infrastructure for "care coordination":
  - Cardiac and pulmonary rehab; diabetes educators
  - Case managers and discharge planners
  - Home health
  - Outpatient "health coaches"

PHAROS INNOVATIONS

Better care coordination should be this simple.

…But how

- IT infrastructure requirements
  - Disease registry functionality; allows clinical and financial view of population continuum
  - Telehealth and remote monitoring; leverages staffing resources to increase outcomes
  - Analytics environment; clinical and business process optimization

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Phased Approach to the Business Model

- Initial emphasis on approaches that decrease ALOS and 30 day readmissions
- Then look for targeted payer relationships (likely not CMS initially)
- Develop robust proof source
- Prepare for demos, pilots, and CMS Innovation Center opportunities by 2011-2012

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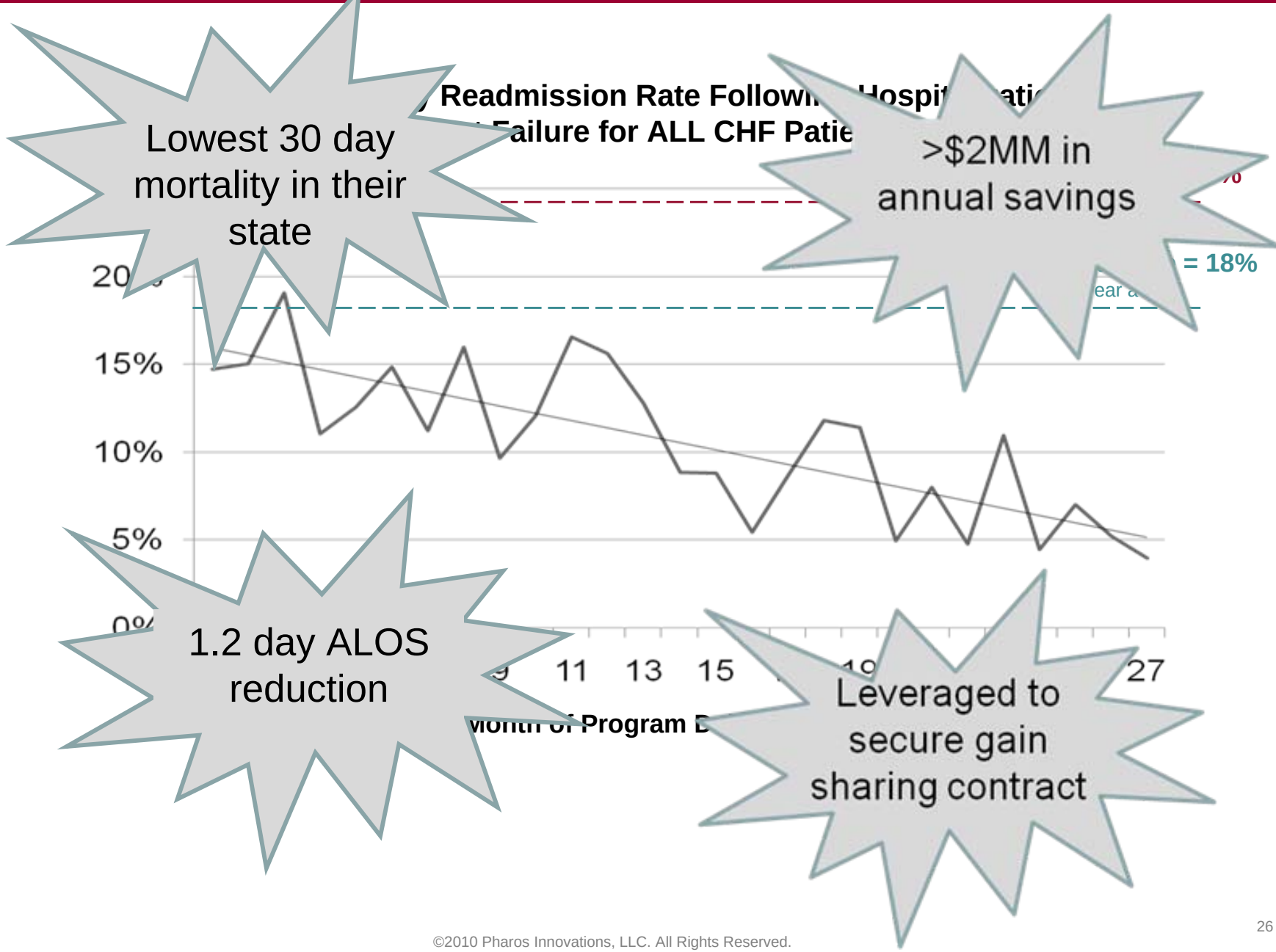
Impact on Outcomes- PGP Demo



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END

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Better care coordination should be this simple.

Who We Are, What We Do

Why We Exist	**To transform chronic care**
Our Beginning	**Physician founded; refined over 15 years**
Belief	**Better self-care = improved quality & cost**
Model	**Elegantly simple, rapidly scalable**
Conditions	**Heart failure, diabetes, asthma, COPD + high risk pregnancy & Care Transitions**

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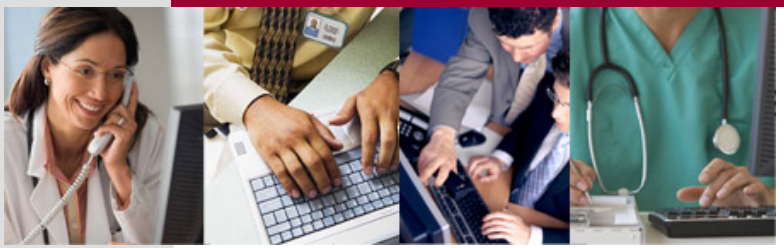
Contact Information



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Brief Bio – Vince Kuraitis

- Vince Kuraitis JD, MBA is Principal and founder of Better Health Technologies, LLC (http://e-CareManagement.com). BHT consults to companies in developing strategy, partnerships and business models for clinical care and care management platforms/applications delivered in homes, workplaces, and communities.
- BHT's clients -- both established organizations and early-stage companies -- include: Intel Digital Health Group, Philips Electronics, Amedisys, Joslin Diabetes Center, Ascension Health System, Samsung Electronics, Siemens Medical Solutions, Medtronic, Varian Medical Systems, Disease Management Association of America, and many others.
- Vince brings 25 years health care experience in multiple roles: President, VP Corporate Development, VP operations, management consultant, and marketing executive. His consulting and work projects span 100+ different health care organizations, including hospitals, physician groups, medical devices, pharma, health plans, disease management, e-Health, IT, and others.
- Vince speaks frequently at industry conferences and corporate events. He has been the opening keynote speaker at the Healthcare Unbound conferences between 2004 and 2010 and has spoken at about 35 conferences in the past 3 years. He has experience leading strategic planning retreats for Boards and physicians.
- Vince's experience includes: Principal, Better Health Technologies; President, Health Choice (medical call center), VP Corporate Development and VP Specialty Operations, Saint Alphonsus Regional Medical Center; Regional Director of Marketing, National Medical Enterprises (hospital chain with 100 facilities); Senior Consultant, Amherst Associates, national health care management consulting company.
- His education includes MBA and JD degrees from UCLA, and a BS degree in business administration from USC.
- Contact: vincek@bhtinfo.com, 208-395-1197

BHT Clients

Pre-IPO Companies

RMD Networks
HealthPost
Cardiobeat
EZWeb
Sensitron
Life Navigator
Medical Peace
Stress Less
DiabetesManager.com
CogniMed
Caresoft
Benchmark Oncology
SOS Wireless
Click4Care
eCare Technologies
The Healan Group
Fitsense
Elite Care Technologies

Established organizations

Intel Digital Health Group
Samsung Electronics, South Korea
-- Global Research Group
-- Samsung Advanced Institute of Technology
-- Digital Solution Center
Amedisys
Ascension Health System
Midmark
Medtronic
-- Neurological Disease Management
-- Cardiac Rhythm Patient Management
Siemens Medical Solutions
Philips Electronics
Joslin Diabetes Center
GSK
Disease Management Association of America
PCS Health Systems
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VRI
Washoe Health System
S2 Systems
CorpHealth
Physician IPA
Centocor
Clinical Groupware Collaborative