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# **Analytics, engagement and reimbursement**

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*Advancing Primary Care Delivery: Practical, Proven and Scalable Approaches*

Concurrent Session 1.5

10<sup>th</sup> National Pay for Performance Summit

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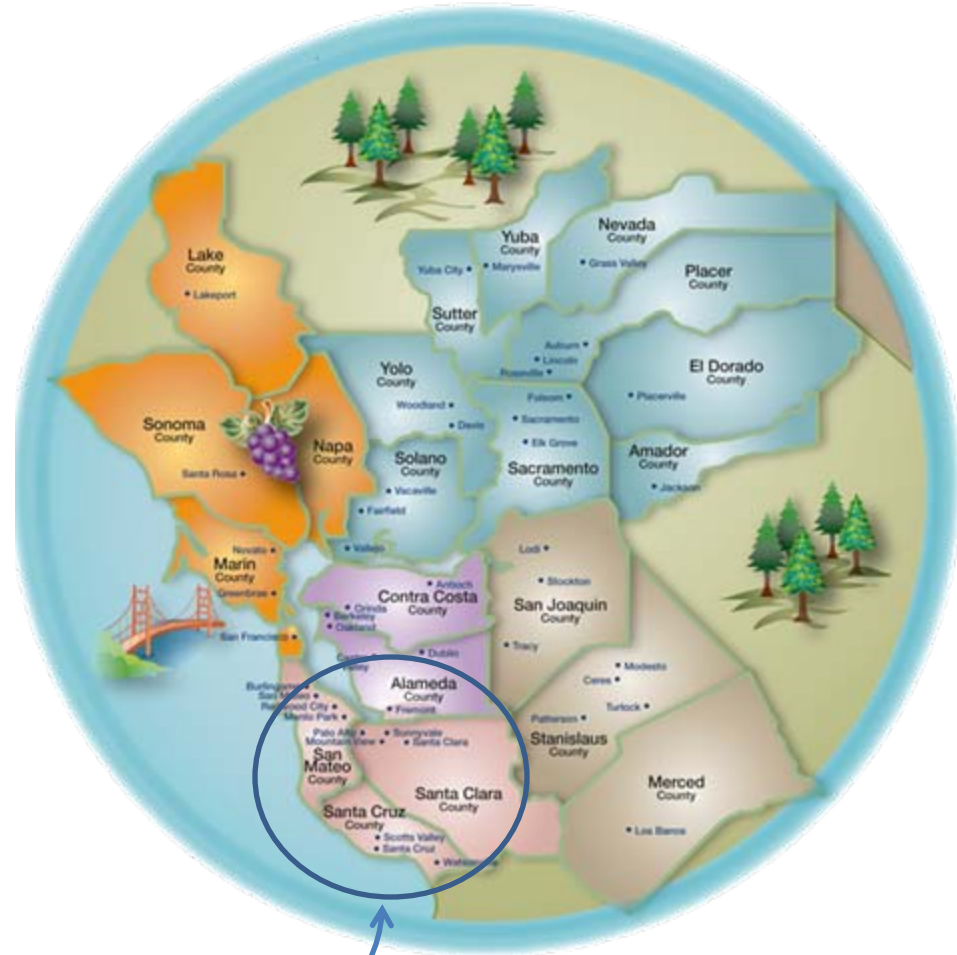
Chief Medical Officer, Sutter Health Peninsula-Coastal Region



- Sutter Health and the Palo Alto Medical Foundation
- Challenges for Primary Care
- Insurance industry response
- Innovator response



- A not-for-profit integrated delivery system serving Northern California
- 3 million active patients
- 50,000 employees
- 5,000 aligned physicians
- 24 acute care hospitals
- >200,000 inpatient discharges
- >35,000 births
- Sutter Health Plus (health plan)
- \$10B annual revenue
- MD and nurse training programs
- Medical research facilities
- Home health, hospice, ancillary

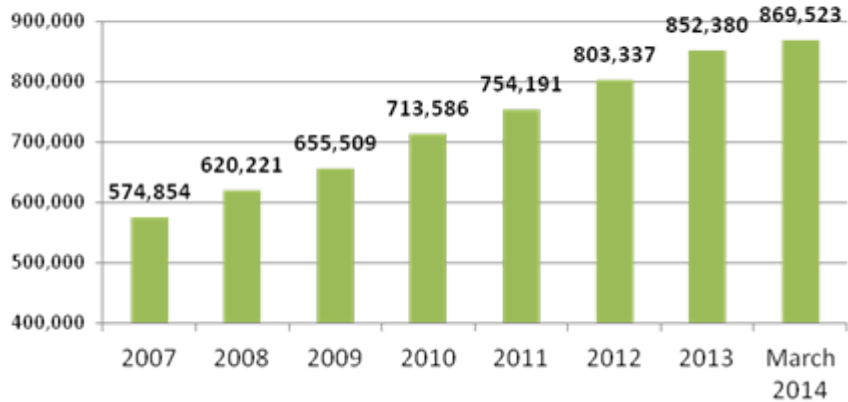


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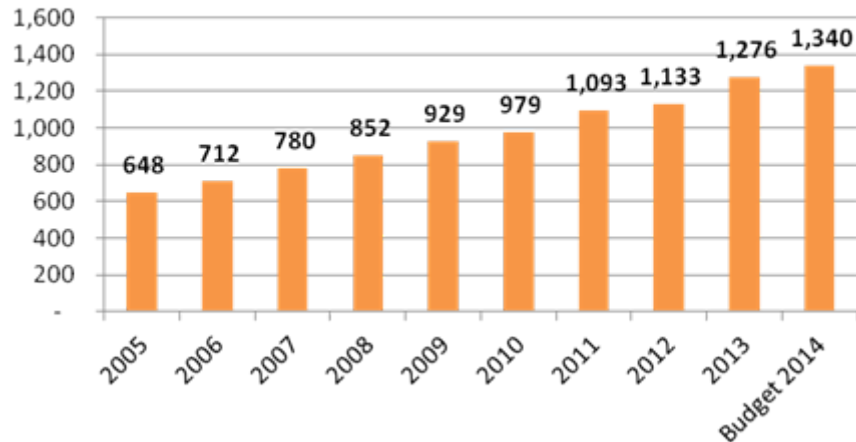
# Palo Alto Medical Foundation Growth



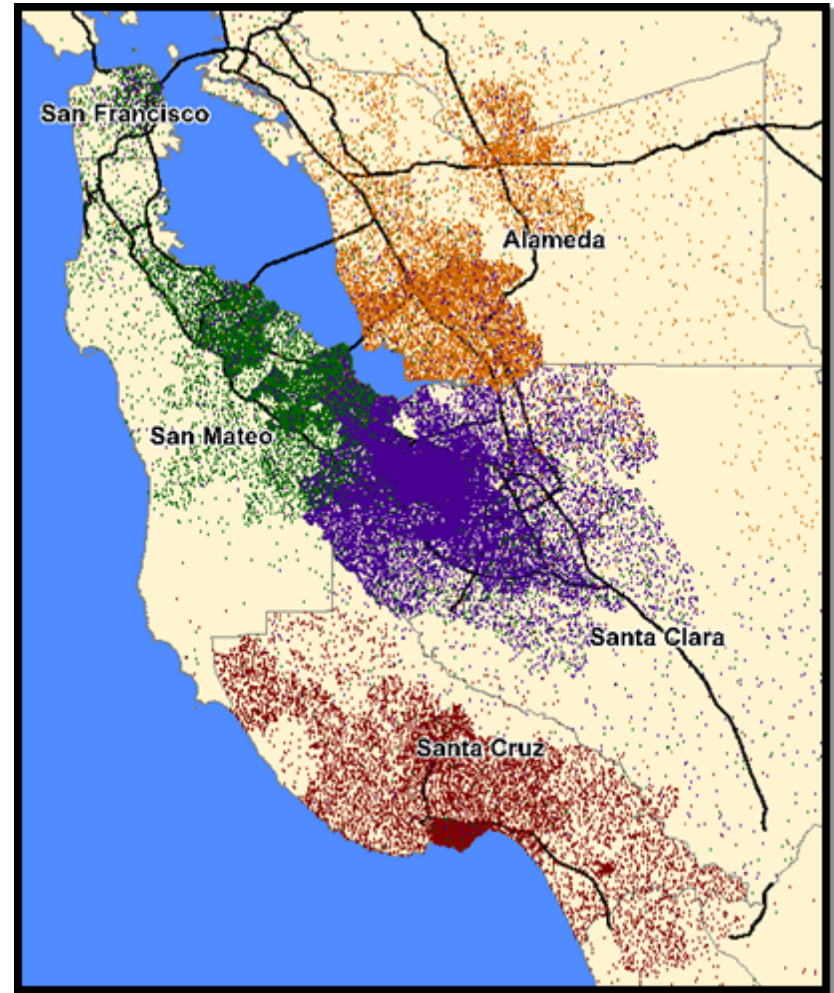
## Unique Patient Lives



## MD Headcount



\$000s	2010	2011	2012	2013
<b>Revenue</b>	\$1,356,431	\$1,516,039	\$1,624,477	\$1,733,920
<b>Income</b>	\$103,395	\$159,293	\$216,991	\$210,904
<b>EBITDA</b>	\$160,239	\$219,388	\$278,674	\$287,542





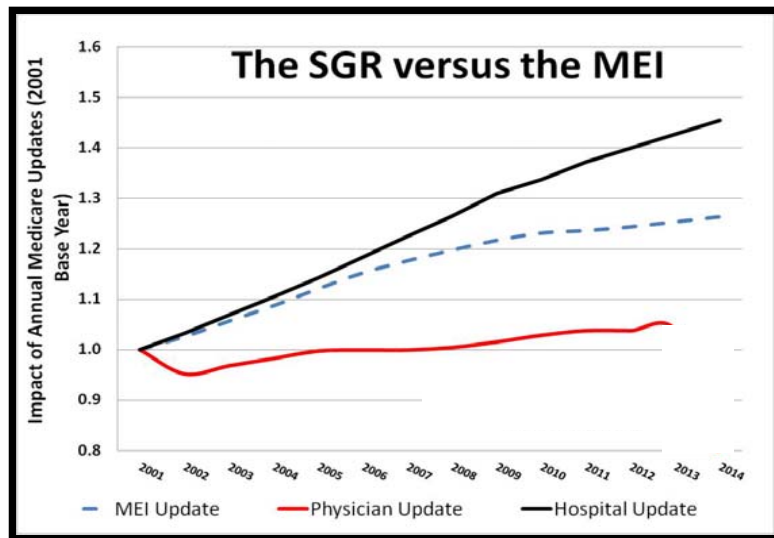
- IHA Value-based P4P “Quality Performer” award winner
- CMS Medicare Advantage 5-star rating (for 2012)
- CMS GPRO Quality Composite Score top rating
- CAPG Elite Status
  - Standards of Excellence for Coordinated Care
- Consumer Reports top score for physician groups in Northern California (based on patient experience)





## Business Model

- PCP compensation/RVU hasn't kept up with inflation (since 2001)



- Because of increasing cost-share, patients perceive value as decreasing

## Operating Model

- Demand for primary care services is increasing faster than supply
- The in-office, in-person, one-visit-at-a-time model prevails
- Technology is not leveraged
- PCP burnout (dissatisfaction) is high

# Insurance Industry Response – “ACOs”

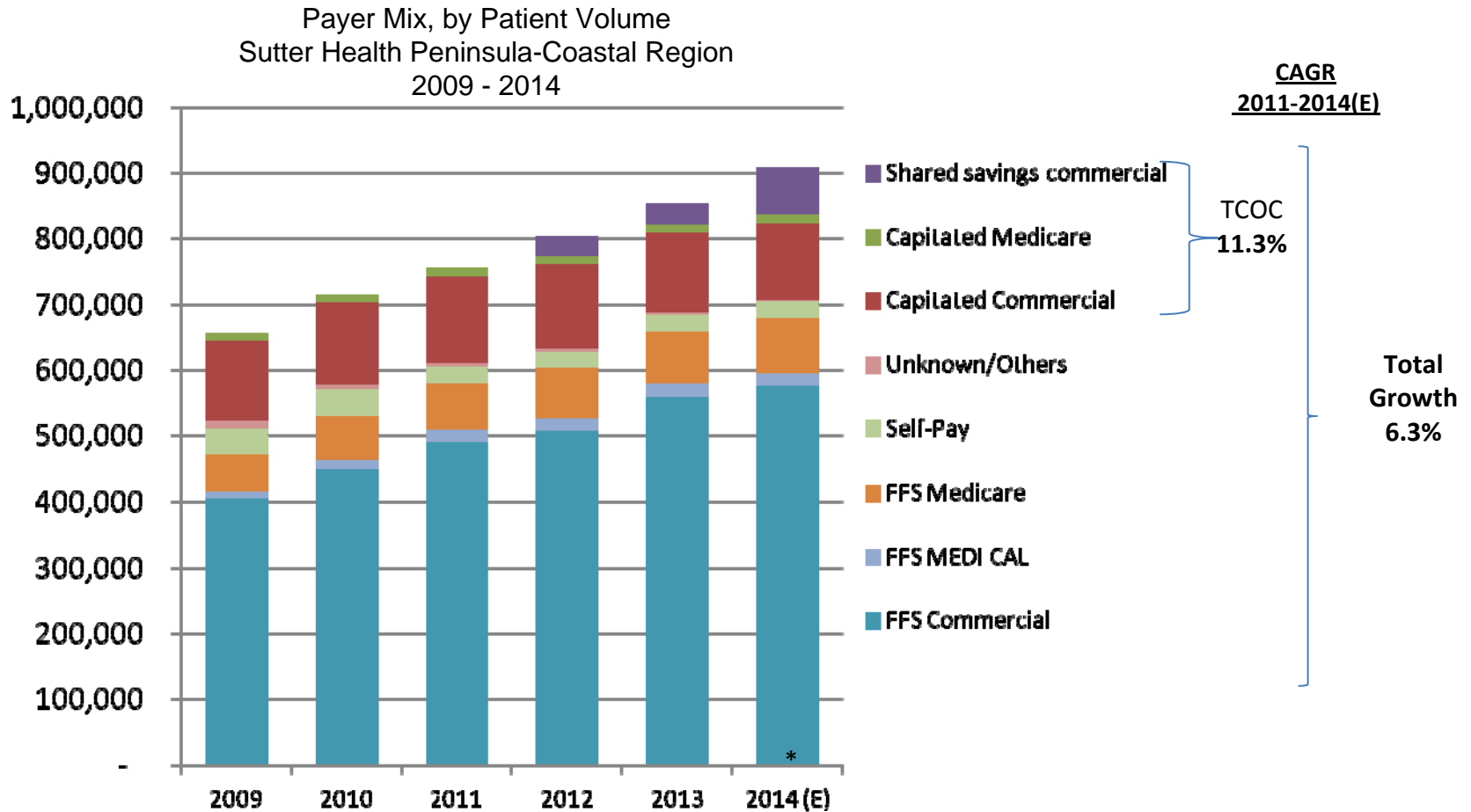


	HMO (professional cap only)	HMO (dual or global cap)	ACO (PPO)
<b>Revenue Model</b>			
- cap	Yes	Yes	No
- case management fee	Typically not	Typically not	Sometimes
- TCOC shared savings	Sometimes	No	Yes
<b>% of Premium opportunity</b>	Small	Significant	Small
<b>Provider Payment Model</b>	Variable	Variable	Variable
<b>Quality gate</b>	Typically not	Typically not	Yes
<b>Care model objectives</b>	Prevent leakage	Prevent leakage Prevent IP admits	Prevent leakage Prevent IP admits Measurable quality
<b>Operating Model</b>	Care coordination  Downstream contracting	Care coordination Case management Downstream contracting	Care coordination Case management
<b>Identification of assigned (attributed) pts</b>	Concurrent	Concurrent	Retrospective (3-6 mos.)

# Total Cost of Care (TCOC) Population Growth



TCOC population is the fastest growing group and represents ~25% of patients.



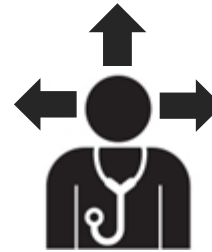
\* 2014 Estimated patient count assumes overall growth at 2012-2013 rate for all categories and shift of additional 35K lives into Shared savings (Anthem)



# The Problem:



## Too Much To Do, Too Little Time



### The Data Problem

- A lot to ask
- Poorly documented Hx
- Miscommunication
- Not enough time

### The Knowledge Problem

- Knowledge advances
- Learning does not
- Knowledge is not accessible or operational

### The Decision Problem

- Knowledge is dated
- Knowledge is not used
- Data are incomplete
- Patient is left out

### The Documentation Problem

- Takes time
- Done after-the-fact
- Inadequate for billing & quality

Gather  
data

Visit  
Start

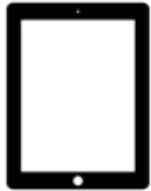
Apply evidence

Make a decision

Visit  
End

Document  
& code

# The Solution



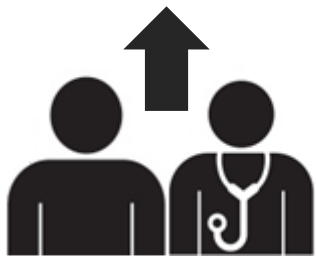
**The Data Solution**  
Collect data prior to visit

**Gather data**      **Visit Start**



**The Knowledge Solution**  
Make data easy for the doctor and patient to see and understand

**Apply evidence**      **Make a decision**



**The Decision Solution**  
Create visual displays that encourage shared decision-making conversations



**The Documentation Solution**  
Structure the encounter and automate as much as possible

**Visit End**      **Document & code**



## In-office efficiency tools

- On-line scheduling
- Patient clinical data-capture (before/after arrival)
- Automated arrival/registration
- Scribes (in-person, virtual; documentation & real-time prompts)
- Specialty-specific desktop displays/workflows



## Leveraging staffing/overhead

- virtual encounters (synch/asynch; secure email and video)
- Non-physician providers
- Inter-disciplinary teams working at top-of-license
- Case management (clinical) and Care coordination (logistical)
- Go-to-the-customer (e.g., in-home)

## “Anywhere”/In-home status monitoring & decision support

- Biometric/activity monitoring
- App-based decision support (suggesting, alerting, triaging)
- Engagement (cohorting; 7x24 connection; rapid feedback)
- Self-diagnosis (rules-based; smartphone image capture and pattern-matching)

## Partnering

- w/ retail and employer-based clinics