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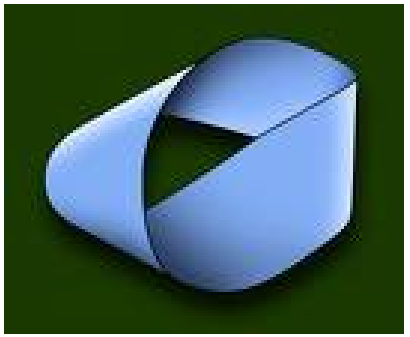
Park Nicollet Health Services Physician Group Practice (PGP) Demonstration Results

A Report From The Field



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David Abelson, M.D., Park Nicollet Health Services
Randall Williams, M.D., FACC CEO, Pharos Innovations

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Summary

- Compelling success of provider-based clinical model
  - 50 averted hospitalization stories/month
  - $6 cost savings for each $ invested
- “Secret sauce” provider based disease management integrated with care processes
- Lessons learned to replicate, scale and extend
  - Incentives need to overcome “tyranny of the visit”
  - Attribution model counts: incentives needed for condition specific processes; not payer specific processes
  - Structure of incentives need to scale across different organizational structures
  - Incentives by condition- not global population

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3 Year PGP Demo

- Create bonus pool
  - Rate of increase compared to service area
  - Share (max 80%) up to 5% after 2% threshold
- Share bonus pool based on efficiency & quality measures
  - Diabetes, congestive heart failure, coronary artery disease, hypertension, prevention

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PGP Sites

- Dartmouth-Hitchcock Clinic
- Billings Clinic
- Forsyth Medical Group
- Geisinger
- Integrated Resources for the Middlesex Area
- Marshfield Clinic
- Park Nicollet Health Services
- St. John's Health System
- The Everett Clinic
- University of Michigan Faculty Group Practice

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Park Nicollet Health Services

- Need to structure incentives to work across differing entity relationships (group practice, hospital, health plan)
- Integrated Delivery System
  - Primary hospital= Methodist
  - Multispecialty group practice 800 physicians or clinical professionals
  - 25 locations West metro Minneapolis
  - No health plan

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Park Nicollet PGP Strategy

- Avoid stratification of care quality by payer– long standing cultural value and necessary to manage complexity
- Continue ongoing care improvements for all PNHS patients using Lean Methodology
- Focus on Congestive Heart Failure (CHF) to create bonus pool
  - Most evidence for short term cost reduction with disease management
  - Primarily Medicare age population

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Congestive Heart Failure

- 620 patients (50% of eligible patients) enrolled in Tel-Assurance®
  - Patient initiated daily clinical monitoring
  - Uses Interactive Voice and Web technology
  - 4 RN case managers handle enrollment & 10% daily “variances”
- Secret sauce:
  - Follow protocols to “bump” or hold diuretics
  - Improved patient adherence
  - Use usual communication channels

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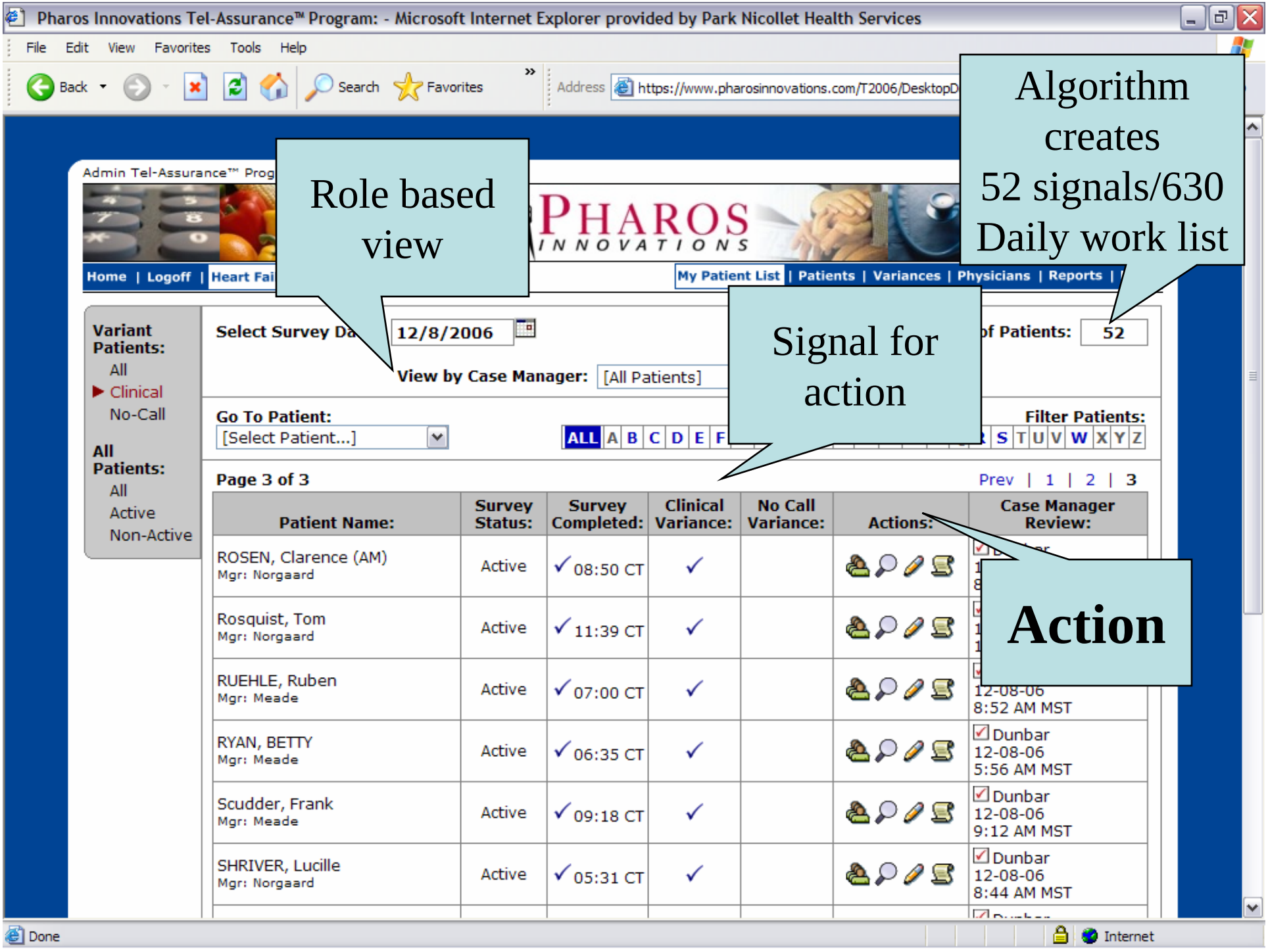
Pharos Innovations Tel-Assurance™ Program: - Microsoft Internet Explorer provided by Park Nicollet Health Services
File Edit View Favorites Tools Help
Back Search Favorites
Address https://www.pharosinnovations.com/T2006/DesktopD
Role based view
Algorithm creates 52 signals/630 Daily work list
Signal for action
Action
Admin Tel-Assurance™ Prog
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Variant Patients:
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Clinical
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52
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Page 3 of 3
Prev | 1 | 2 | 3
Patient Name:
Survey Status:
Survey Completed:
Clinical Variance:
No Call Variance:
Actions:
Case Manager Review:
ROSEN, Clarence (AM)
Mgr: Norgaard
Active
08:50 CT
Rosquist, Tom
Mgr: Norgaard
Active
11:39 CT
RUEHLE, Ruben
Mgr: Meade
Active
07:00 CT
12-08-06
8:52 AM MST
RYAN, BETTY
Mgr: Meade
Active
06:35 CT
Dunbar
12-08-06
5:56 AM MST
Scudder, Frank
Mgr: Meade
Active
09:18 CT
Dunbar
12-08-06
9:12 AM MST
SHRIVER, Lucille
Mgr: Norgaard
Active
05:31 CT
Dunbar
12-08-06
8:44 AM MST
Done
Internet

Secret Sauce: RN Intervention

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LASIX/FUROSEMIDE

Total Daily Dose	1 Increment Increase	2 Increments Increase
20mg QD	30mg QD or 20mg AM and 10mg PM	40mg QD or 20mg BID
40mg QD or 20mg BID	60mg QD or 40mg AM and 20mg PM	80mg QD or 40mg BID
60mg QD or 40mg qam and 20mg qpm	80mg QD or 40mg BID	120mg QD dosed at 80mg AM and 40mg PM
80mg QD or 40mg BID	120mg QD dosed at 80mg AM and 40mg PM	160mg QD dosed at 80mg BID
120mg QD or 80mg qam and 40mg qpm	160mg QD dosed at 80mg BID	200mg QD dosed at 120mg AM and 80mg PM
160mg QD or 80mg BID	200mg QD dosed at 120mg AM and 80mg PM	240mg QD dosed at 120mg BID
200mg QD or 120mg qam and 80mg qpm	240mg QD dosed at 120mg BID	CALL MD
240mg QD or 120mg BID	CALL MD	CALL MD

BUMEX/BUMETANIDE

Total Daily Dose	1 Increment Increase	2 Increments Increase
1mg QD	1.5mg QD	2mg QD
1.5mg QD	2mg QD	3mg QD
2mg QD	3mg QD	4mg QD dosed at 2mg BID
3mg QD	4mg QD dosed at 2mg BID	5mg QD dosed at 3mg AM and 2mg PM
4mg QD dosed at 2mg BID	5mg QD dosed at 3mg AM and 2mg PM	6mg QD dosed at 3mg BID
5mg QD dosed at 3mg qam and 2mg qpm	6mg QD dosed at 3mg BID	CALL MD
6mg QD dosed at	CALL MD	CALL MD

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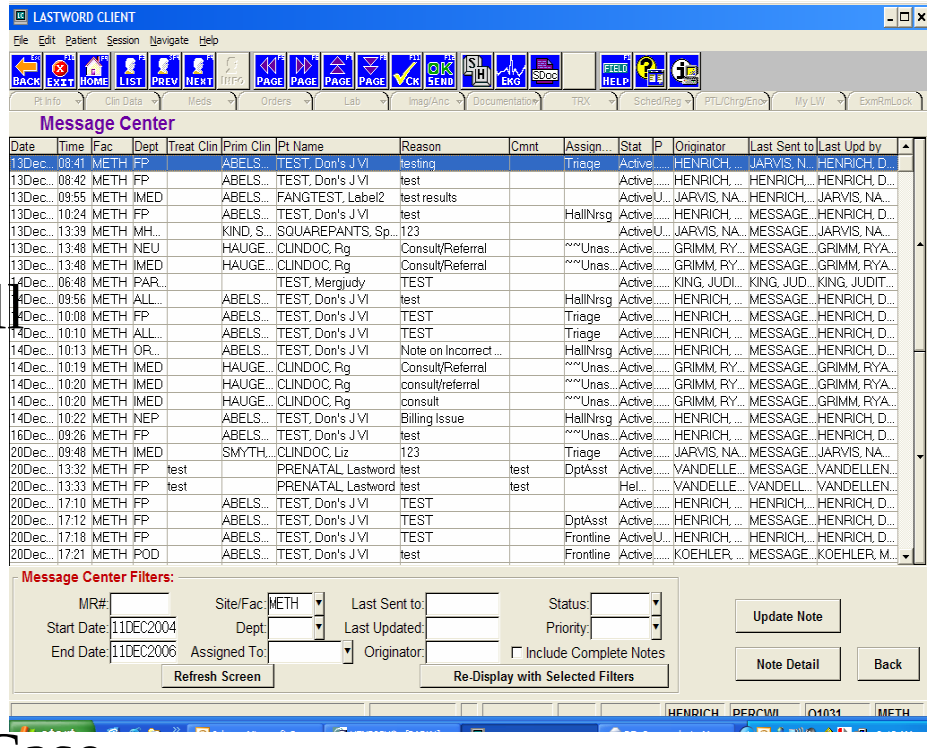
Secret Sauce: Usual Communication and Relationships

“Phone Messaging”

Rx Refill

Patients Online

CHF Case Management



Inbox 1

Inbox 2

Inbox 3

Inbox n

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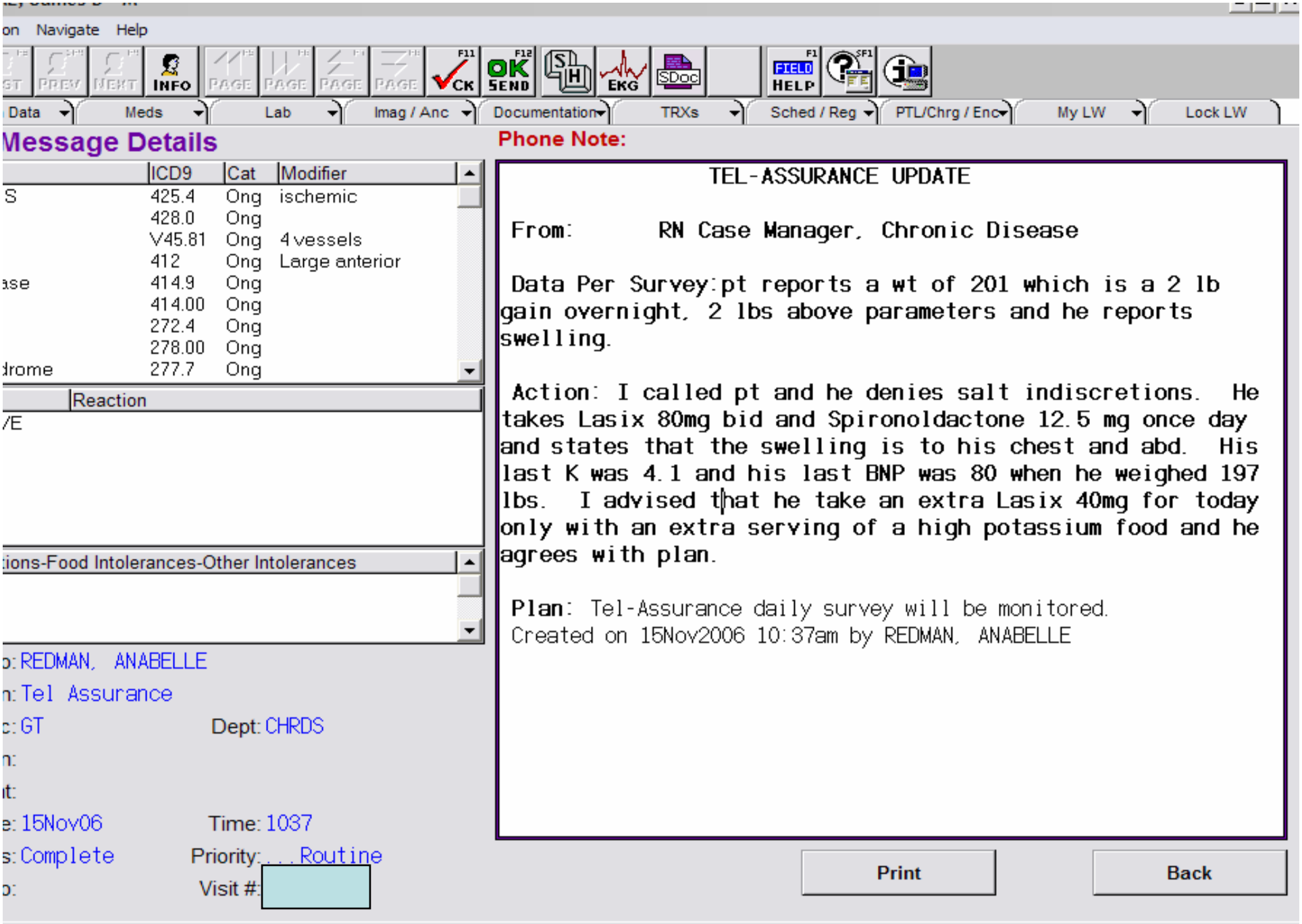
on Navigate Help
INFO
F11 CK
F12 OK SEND
EKG
SDoc
F1 FIELD HELP
Data
Meds
Lab
Imag / Anc
Documentation
TRXs
Sched / Reg
PTL/Chrg / Enc
My LW
Lock LW
Message Details
Phone Note:
ICD9 Cat Modifier
425.4 Ong ischemic
428.0 Ong
V45.81 Ong 4 vessels
412 Ong Large anterior
414.9 Ong
414.00 Ong
272.4 Ong
278.00 Ong
277.7 Ong
Reaction
TEL-ASSURANCE UPDATE
From: RN Case Manager, Chronic Disease
Data Per Survey:pt reports a wt of 201 which is a 2 lb gain overnight, 2 lbs above parameters and he reports swelling.
Action: I called pt and he denies salt indiscretions. He takes Lasix 80mg bid and Spironoldactone 12.5 mg once day and states that the swelling is to his chest and abd. His last K was 4.1 and his last BNP was 80 when he weighed 197 lbs. I advised that he take an extra Lasix 40mg for today only with an extra serving of a high potassium food and he agrees with plan.
Plan: Tel-Assurance daily survey will be monitored.
Created on 15Nov2006 10:37am by REDMAN, ANABELLE
REDMAN, ANABELLE
Tel Assurance
GT
Dept: CHRDS
15Nov06
Time: 1037
Complete
Priority: Routine
Visit #:
Print
Back

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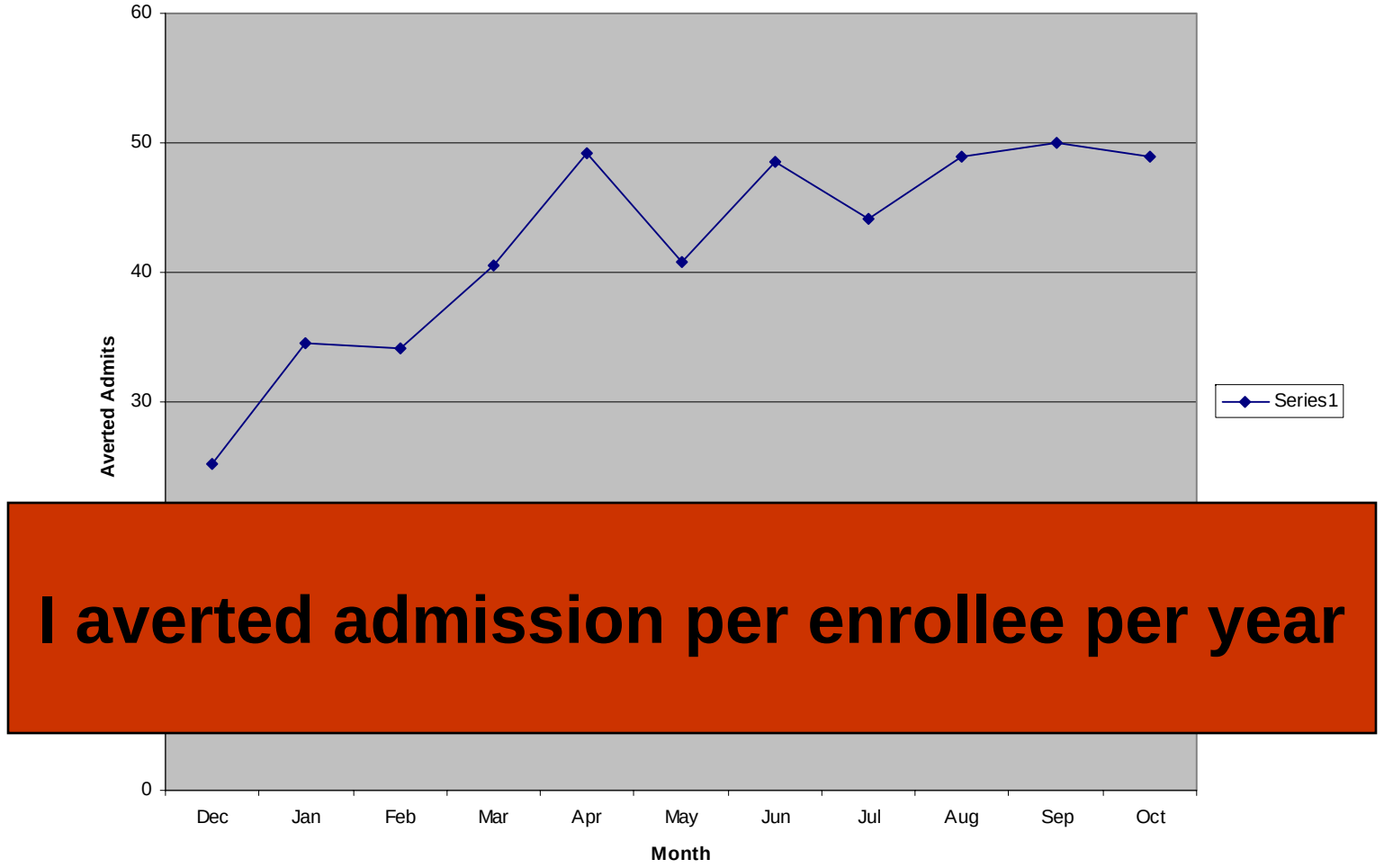
Calculated Averted CHF Admissions



I averted admission per enrollee per year

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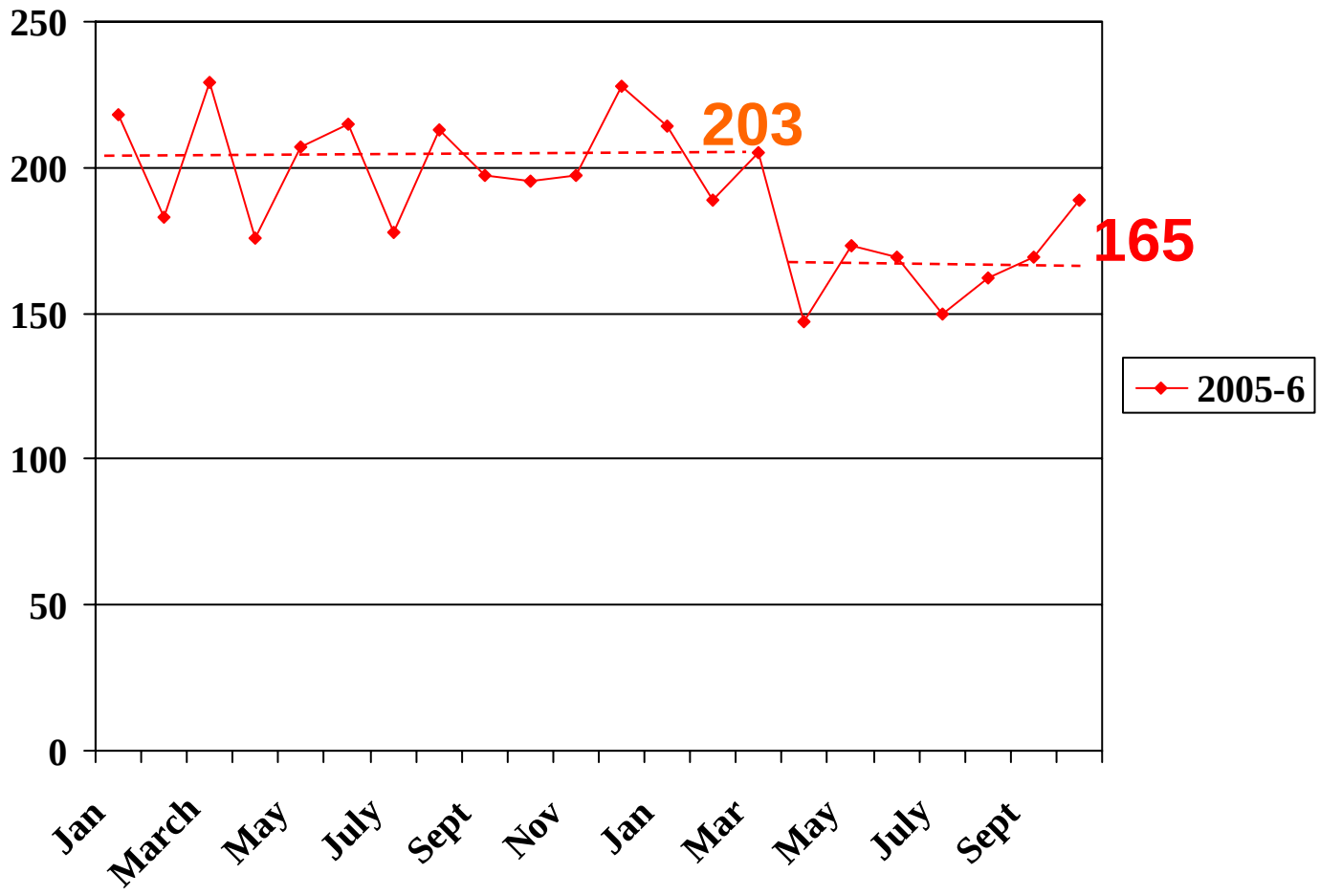
CHF Discharges (1° & 2°)



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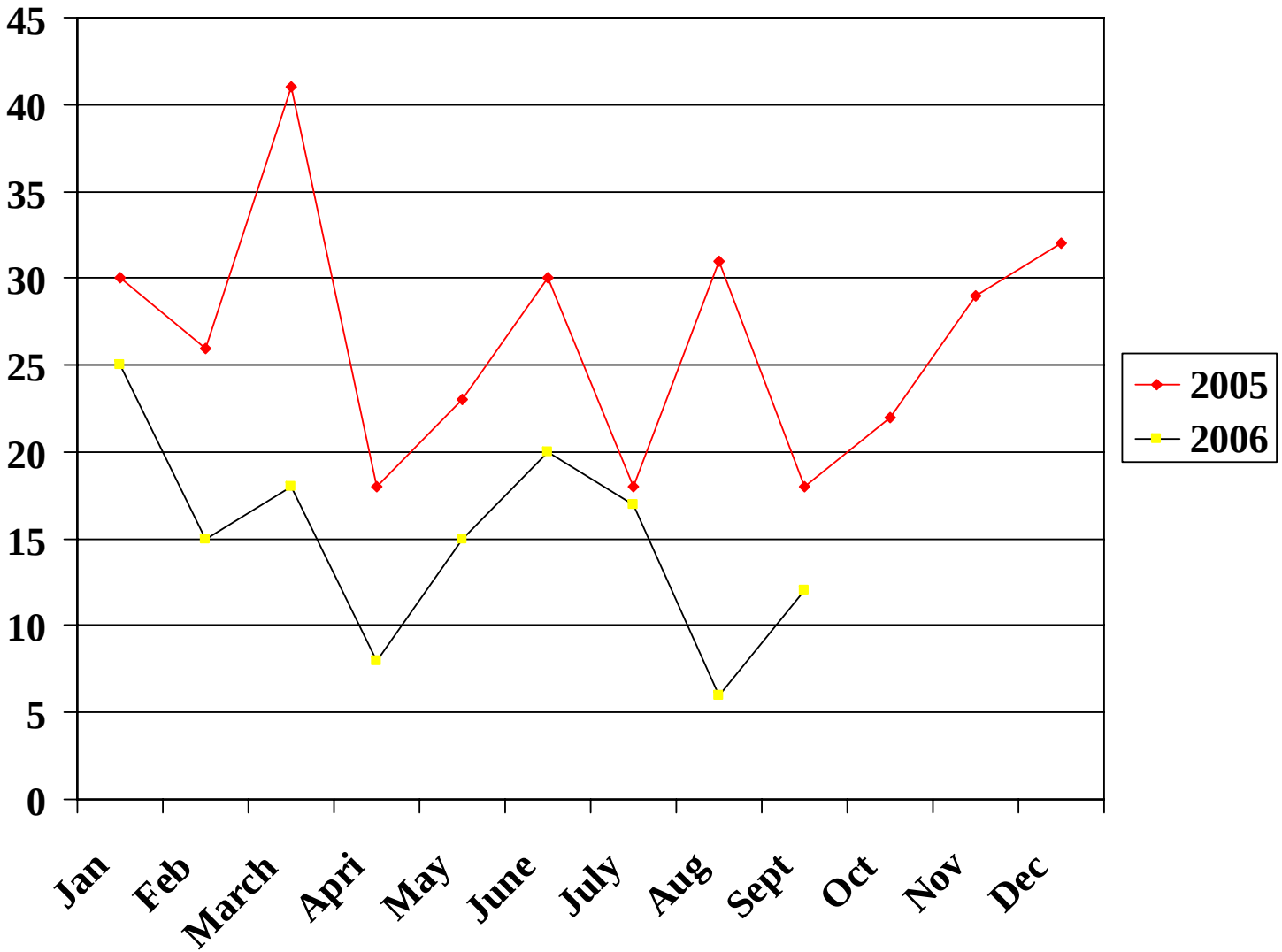
30 Day Readmission (all cause)



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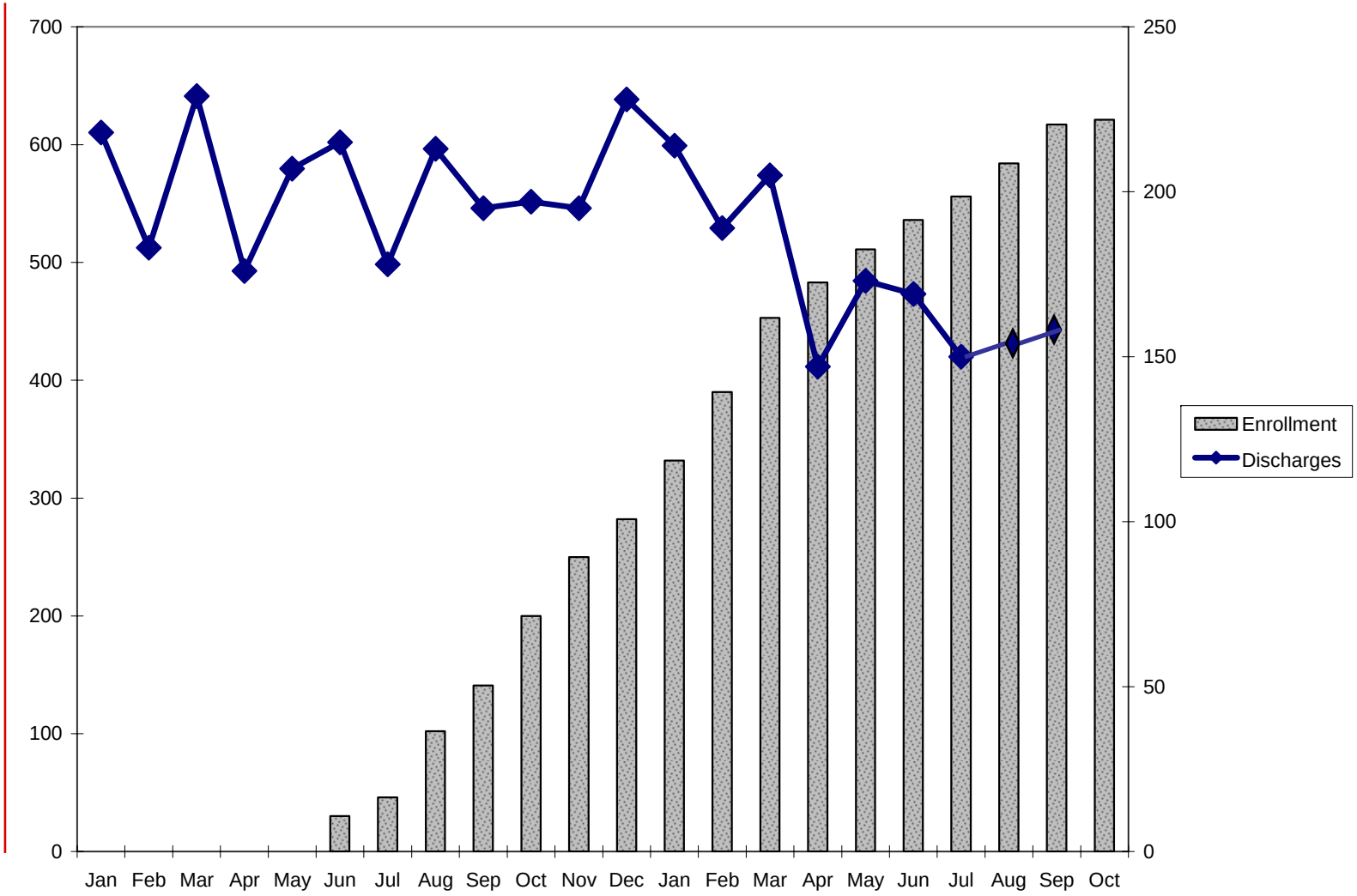
CHF Discharges Versus Enrollment



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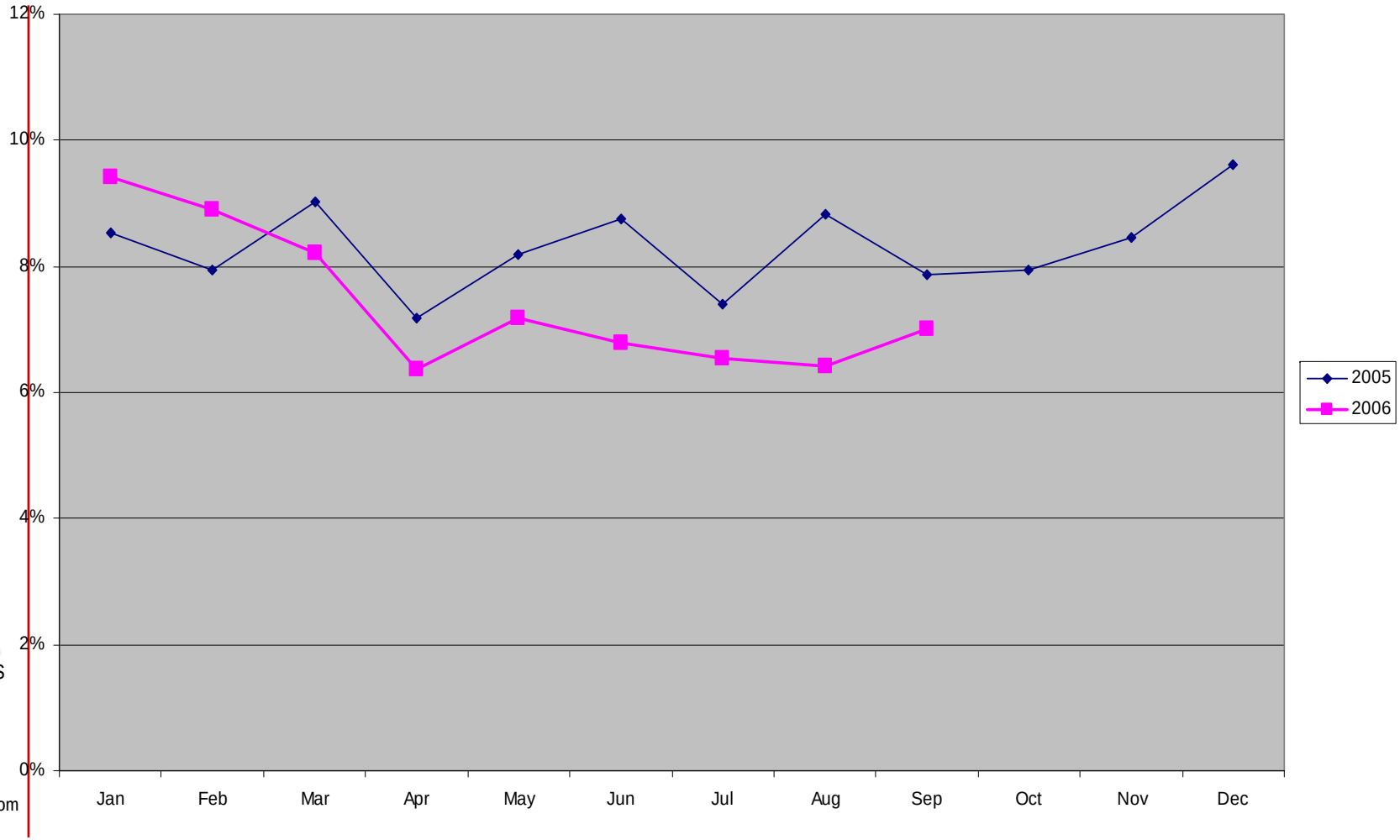
% Total Inpatient Discharges With CHF



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Yet More Patients With CHF Codes

2004	10/05-9/30/06	
4,399	5,030	14.3% increase

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Barriers To Sustainability

- Attribution model
  - Care designed for condition, not payer
  - 80% CHF patients Medicare aged
  - Only 50% of Medicare aged patients FFS and count in bonus pool (effort benefits local plans)
- 2% threshold rather than condition specific
  - Impossible to manage with unknowns of service area despite making gains
- “Pits” physician group against hospital– does not work for IDN
- “Placing bet” rather than predictable incentive to overcome tyranny of the visit

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Success Not Sustainable

- Projected loss= $6.25 million ($2.65 million marginal loss)
  - 750 k direct costs
  - $5.5 million lost revenue ($1.9 million marginal loss)
- With 2% threshold need to lose $3.25 million ($2.5 million threshold plus 750k costs) before qualify for first penny assuming 100% Medicare FFS
- Unfortunately, with attribution model 50% Medicare replacement product need to lose $5.75 million before qualify for 1st penny

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Recommendations: The Devil In The Details

- P4P amounts to “backend” reconciliation to overcome front end perverse incentives of ***tyranny of visit***.
- Provider groups positioned to integrate interventions with DM monitoring; carve-out DM vendors unable to link interventions and communication
  - RN’s following med titration protocols linked to usual communication and relationships
  - Reimburse directly for more effective and less costly care (e.g. CHF case managers)
  - Or at minimum P4P needs to be large enough to incent process redesign
- Attribution model must enable condition specific rather than payer specific processes (avoid cost of complexity)
- Create condition specific incentives without thresholds
  - Global savings with threshold a bet that cannot be managed

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CMS P4P – Implementation Lessons Learned

- Efficiencies of care
- Organizational capacities and culture
- Role of IT and Data infrastructure
- Challenges of claims vs. clinical diagnosis
- Improving the “system” vs. Improving the “patient”
- Aligning internal stakeholders
- Role of payers
- Comments on the “economics”

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Efficiencies of Care

- Focusing on the demographic characteristics
- Examples of “following the money”
- Knowing what conditions can’t be impacted
- Knowing whose “ox gets gored”
- Roles of care delivery: physician, mid-levels, staff, and patient/ caregivers
- Role of technology as driver of efficiency

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Organizational Capacities and Culture

- Importance of senior leadership
- Critical workflow considerations
- Role of care manager and physicians
- Desire to organize in multi-disciplinary teams
- New challenges of chronic care focus

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Role of IT and Data Infrastructure

- Patient identification
- Tracking of clinical and performance metrics
- Automating a flawed process vs. designing the right processes, then automating them
- The role of the patient as data entry coordinator
- Focusing IT on the goal: disease registries and patient communications/ monitoring technologies

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Challenges of Claims vs. Clinical Data

- Patient identification is flawed when claims only are used
- Location/ setting of care also needed
  - Nursing home
  - SNF
  - Independent living, etc.
- Requires mass communications attempts
  - Not something most provider organizations have the time or infrastructure to do well

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Improving the System vs. the Patient

- P4P has traditionally been about improving delivery of care processes
- Yet, patients control the vast majority of improvement metrics that have true clinical and financial relevance
  - Adherence
  - Self-care
  - Visit and testing timeliness
- Does P4P properly align incentives of patients and the system of care?

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Aligning Internal Stakeholders

- Unless physicians support a change at both the system and patient level, it will be a long road to success
- Unless the clinical staff support a change at both the system and patient level, it will never succeed
- Unless the organization's leadership supports a change at the system level, it will not be sustainable

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The Role of Payers

- Focusing on what to incent can only be done by the payers
  - Quality
  - Process
  - Infrastructure
  - Organizational alignment
  - Patient populations
  - Efficiencies
- Allaying fears about “the flavor of the month”

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Comments on Economics of P4P

- Incenting care that is not currently done means focusing on Chronic Care services
- Getting healthcare systems to do chronic care services will require payment for time and infrastructure first, improvement second, and results third
- Financial losses (eg, decreased fees for hospitalizations and visits) resulting from more efficient care must be accounted for
- Quality will come from process redesign; Efficiency will have to come from technology implementation
- There is plenty of waste in the system to more than make up for payment of any new services, processes or technologies that are “proven” to be efficient

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Conclusion

- Compelling evidence for success
  - 1 averted hospitalization per enrollee/yr
- Provider groups, linking DM with care interventions positioned for effectiveness
- But
  - Address up front care redesign costs
  - Enable by eliminating “tyranny of the visit”
  - Enable care design by condition, not payer
  - Create predictable incentive by condition, not bet on global performance

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