Population Health Management 2.0: *Rewarding Value Over Volume*

Christopher T. Olivia, MD, President
Michael Renzi, DO, Chief Medical Officer

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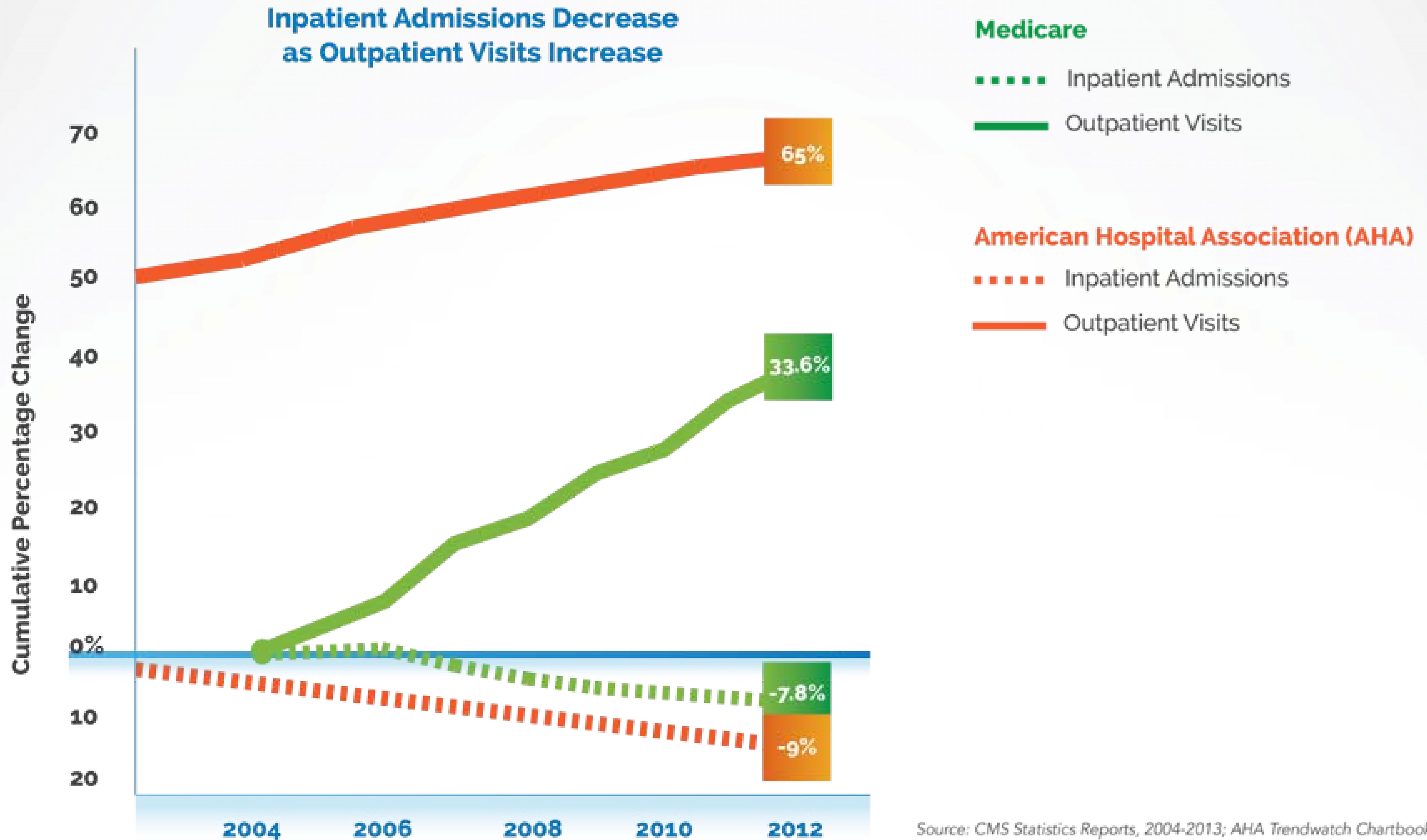
The Acute to Ambulatory Migration



Source: CMS Statistics Reports, 2004-2013; AHA Trendwatch Chartbook, 2010

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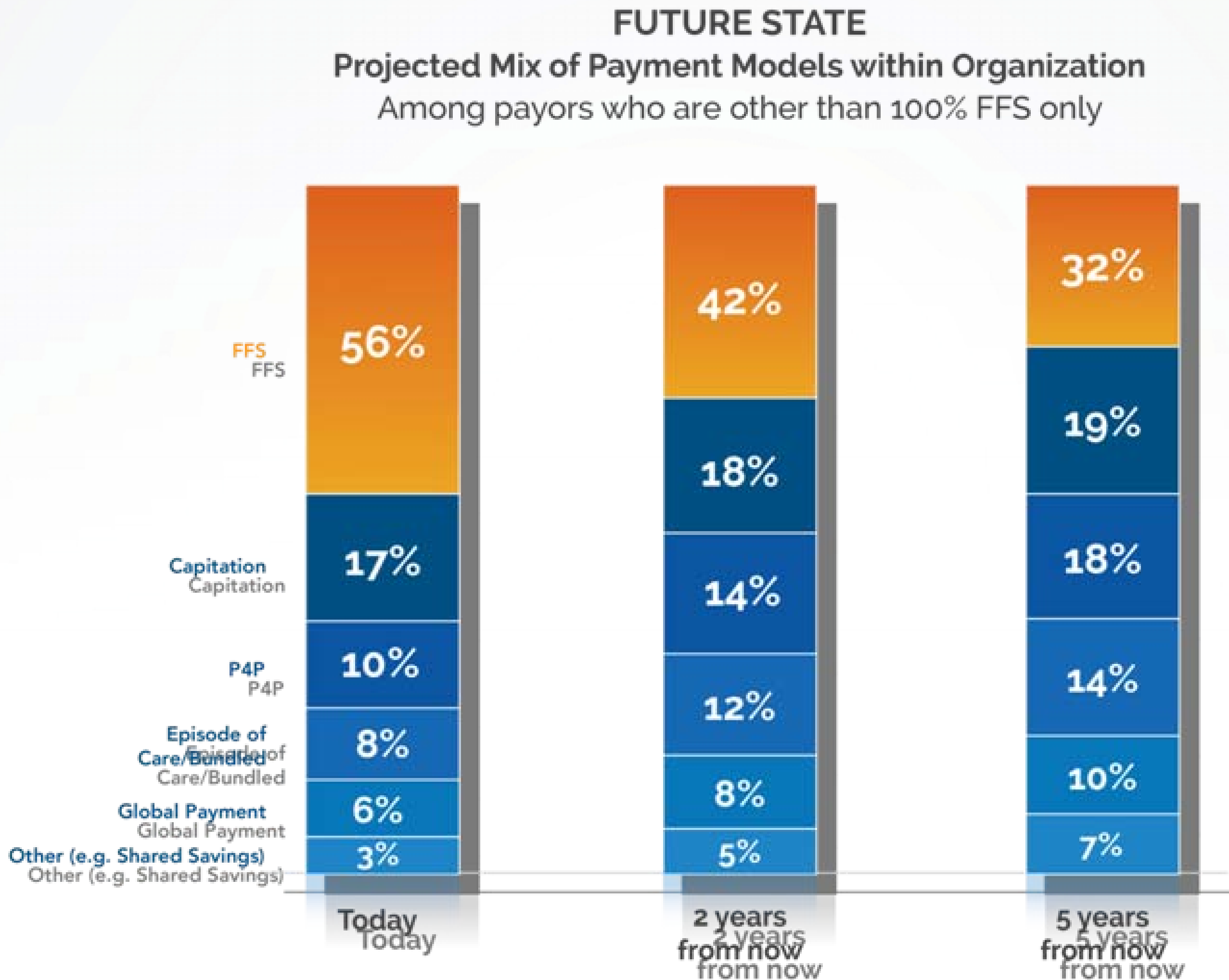
Transition from Volume to Value



*Source: McKesson Health Solutions, 2014

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Value-Based Pain Points

- Hospitals hemorrhage cash on employed physicians
- MSSP/ACO model is unsustainable
- QI ≠ ROI
- Technology investments ≠ Value-based payment
- Risk modeling predicts 30% of future spend
- Hospital-based economic models drive utilization

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Pain Point: Hospitals Hemorrhage Cash on Employed Physicians

- Median loss per employed physician = $201,000 [1]
- Leakage rates unaffected by physician affiliation [2]
- Physician losses & patient leakage discourage ambulatory investment [2]

*Sources: 1. **Horizon Healthcare Innovations,** 2014*
*2. **MGMA.** 2013 Report*

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Pain Point: MSSP/ACO Model is Unsustainable

Case: Medicare's MSSP Experience with 220 ACOs in 2013 [1]

- Only 26% of MSSP ACOs earned shared savings
- Another 27% lowered global cost but did not qualify for shared savings
- 47% did not lower the cost of care

*Source: 1. **CMS,** September 2014*

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Pain Point: QI ≠ ROI

- Quality improvement does not lower the cost of care [1]
- ACO participants surpassed FFS providers' quality in 17 of 22 PQRS/GPRO measures [2]
- 74% did not receive shared savings payments [2]

Sources: ***1. Continuum Internal Data***
2. CMS, *September 2014*

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Pain Point: Technology Investments ≠ Value-Based Payment

- EHR deployment alone increases provider dissatisfaction & decreases provider productivity
- Promotes minimal transformation to value-based care
- Cumbersome user interface & screen toggling inhibits LEAN operations
- Metadata alone has limited usefulness in lowering cost of care

Source: ***Continuum Internal Data***

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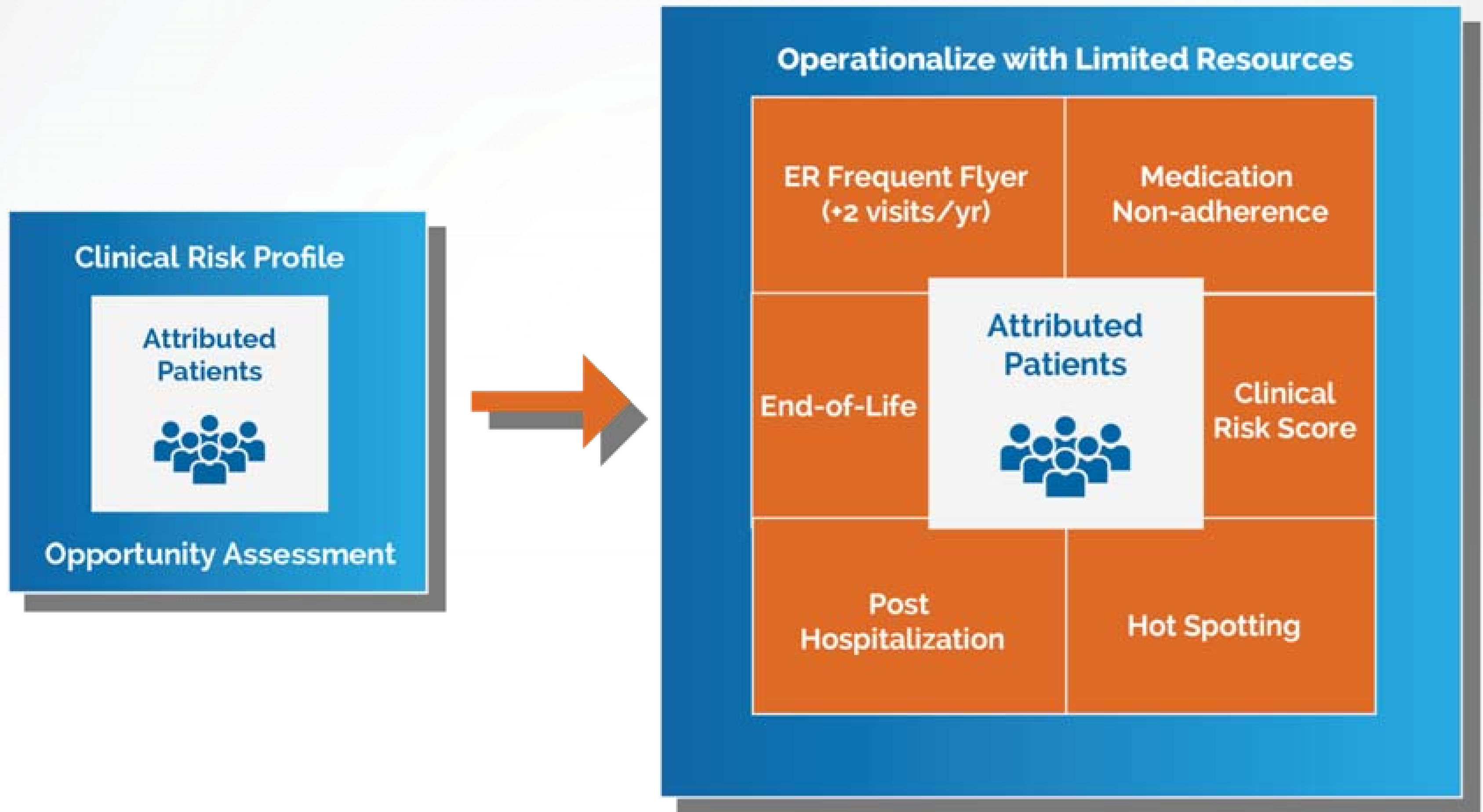
Pain Point: Risk Modeling Predicts 30% of Future Spend



Source: ***Managed Care*****, *More Data in Health Care Will Enable Predictive Modeling Advances,*** *February 2013*

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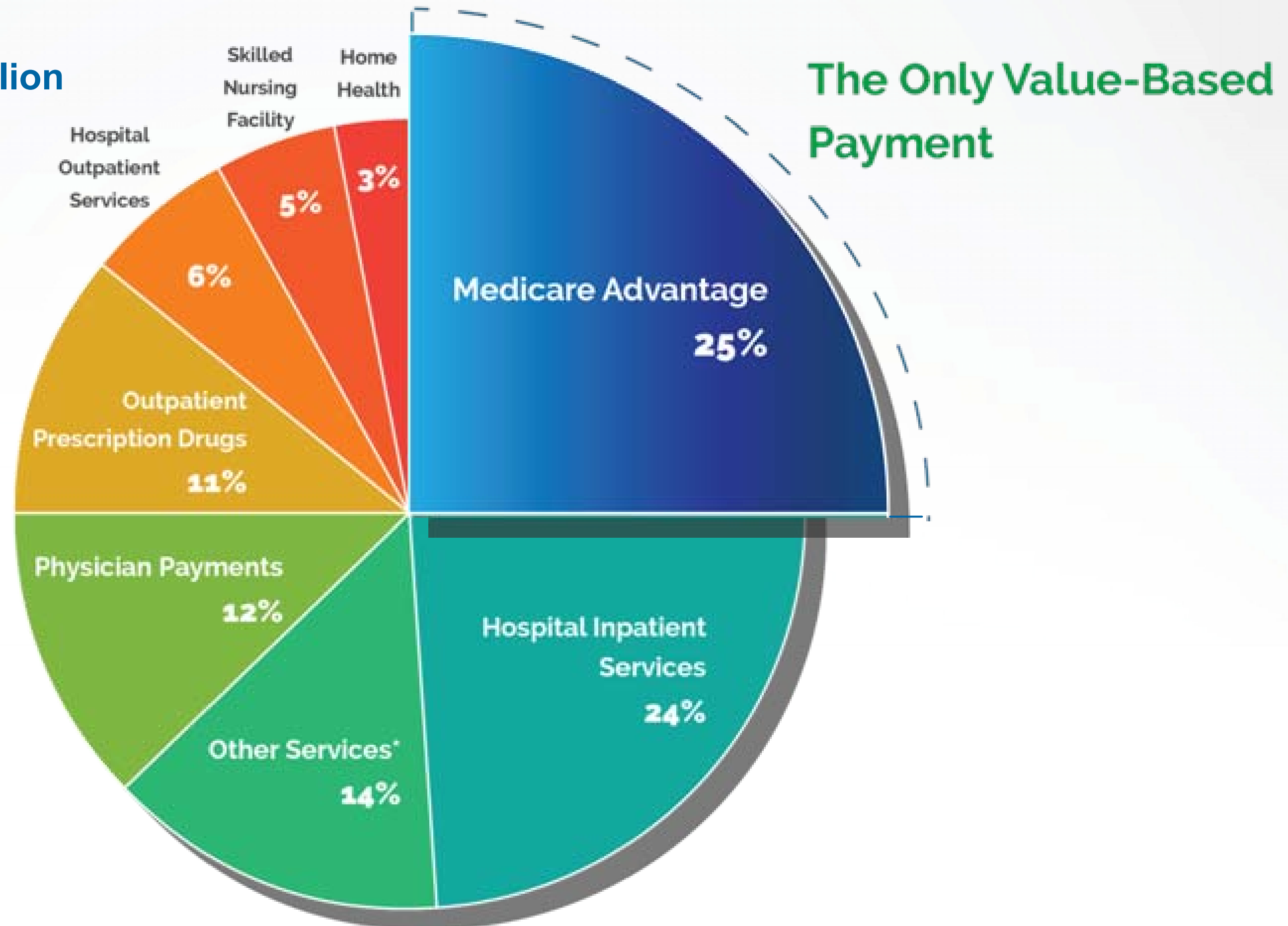
Pain Point: Hospital-Based Economic Models Drive Utilization

Total Medicare
Benefit Payments = $583 Billion



*NOTE: **'Other Services'** includes hospice, durable medical equipment, Part B drugs, outpatient dialysis, etc.

Sources: ***1. Congressional Budget Office, 2014 Medicare Baseline,*** *April 2014*
2. The Henry J. Kaiser Family Foundation, The Facts on Medicare Spending and Financing, *July 2014*

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Alleviate the Pain: Transform the Hospital/Physician Model

- Expand ambulatory access for patients
- Direct CIN patient flow
- Manage site-of-service

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Value-Based Reality: Case Study

New ACO: 18,500 Commercial & 1,500 Medicare Advantage

- Overview: 30 sites, 107 primary care providers
- At Start-Up:
  - No prior value-based infrastructure
  - No value-based strategy
  - No Medical Home implementation or workflows
  - No care coordination resources
  - Never used a care plan
  - No disease registry
  - No quality strategy
- Currently in Year 3

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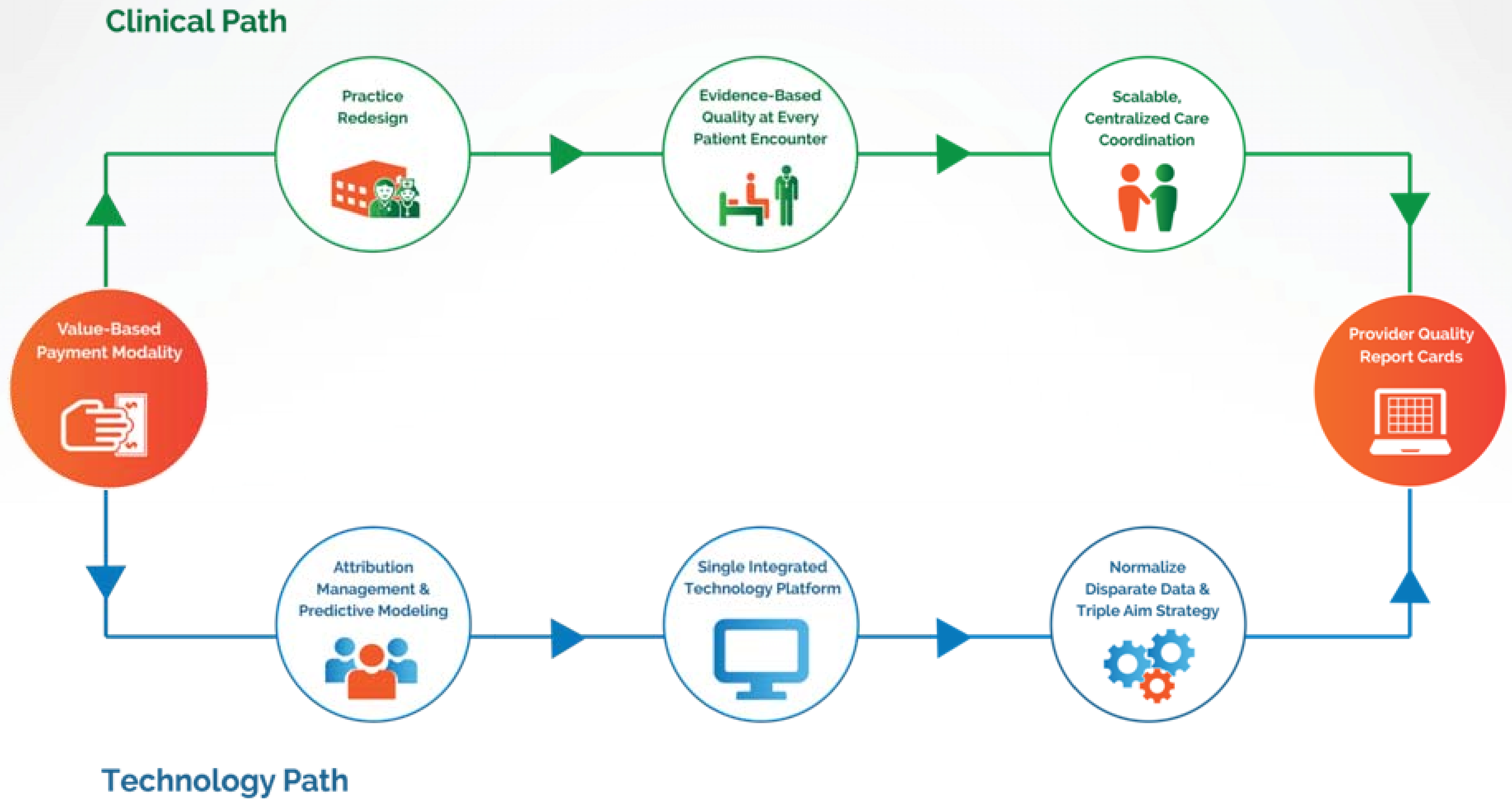
How To Win



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Value-Based Payment Modality: Start Here

- Value-Based Payment Program Basics:
  - Driven by Triple Aim
  - Shared savings model
  - Payor investment ($PMPM)
  - Provider utilizes investment to enable value transformation

Key Principals of Practice Redesign

- Strong practice management foundation
  - Robust RCM collections (FFS & VBP)
  - Meaningfully-Structured & Meaningfully-Used EHR
- Engaged leadership
- Patient panel management (attribution)
- Practice roles for strong team-based care
  - The care team includes the patient
- Enhanced access
- Quality improvement strategy

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Quality Strategy

- Every patient contact is an opportunity to drive quality
- Quality is recorded in one place & every provider must use that place, at every encounter

Centricity EMR - Susan Scanlin @ Advocare Heights Primary Care (emr) - 6/18/2014 11:27 AM - [Chart]

Go Actions Options Help
Desktop Chart Appts

ZZTEST, HORACE
86 Years Old Male (DOB: 10/24/1927)

Find Pt. Protocols Graph Handouts
Summary History Problems
Doc ID: 397 Properties: Office Visit at
Summary:

Inserted
CareManager Co
HPI-ROS-CCC-2
Entry-CCC
Entry-2-CCC
Preventive Care
Prob-Meds-Aller
PMH-PSH-CCC
FH-SH-CCC
ROS-CCC
Vital Signs-4-CC
PE-CCC
Problems-CCC
Test Manageme
CPOE A&P-CCC
Patient Instructio
Blank image

[CareManager Co
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Allergies:
1) Penicillin G Po
[Vital Signs-4-CC
[PE-CCC]

CareManager Control Panel: HORACE ZZTEST

PS-DM-CHD-HF | Airway-Stroke-Osteo

CareManager Control Panel Version 4.3.1 (May 2014)

Multiple Providers | PROBLEMS | MEDICATIONS | ORDERS | ALLERGIES

Preventive Services

Cancer Screening	Colorectal: Due: 03/2021										CA Dashboard
Other Screening	Chol	DM	Tob	BMI	AAA	Depr					PS Dashboard / Tobacco Screen
Immunizations *Contraindication	Flu	TDAP	Pneu	Zost*	HPV	MGC	MMR*	Var*	HepA	HepB	
Diabetes Mgmt	LDL	Statins	BP	A1c (DUE)	Urn Alb	Eye	Foot				Diab Dashboard
CHD/CHD Risk Mgmt	LDL	Statins	BP	A1c (DUE)	APT	Beta	ACE				CHD Dashboard
Heart Failure Mgmt	LVEF	NYHA	BP	AF HR	Meds	Creat (DUE)	K+ (DUE)	Dig	ICD	EOL (DUE)	HF Dashboard

If red, a module on 'Airway-Stroke-Osteo' tab requires attention: AW-Stroke-Ost | De-Identify

Prev Form (Ctrl+PgUp) | Next Form (Ctrl+PgDn) | Close

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Scalable, Centralized Care Coordination (CC)

- Why?
  - Manage utilization according to lower cost of care
  - Use CC to control CIN leakage
  - Reduces management burden for providers if it is centralized
    - 5,000:1 per CC

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Does it Work? – Aggregate Results

Continuum Client Case Study*

20,000 Members
(90% Commercial/10% Medicare Advantage)

Delivered **17%** Lower Overall Cost of Care

Reduced Inpatient Admissions by **18.8%**

Achieved **90th** Percentile of Care Quality

Increased Ambulatory Volume by **8-9%**

Reduced Hospital 30-Day Readmissions to **12%**
(National Industry Average is 18%)

Reduced Emergency Department Visits by **3.2%**

Increased Generic Drug Dispensing to Medicare Patients by **11.3%**

Increased Provider Revenue by **5-10%** Through Value-Based Rewards

**Outlier Product Mix Adjusted Global Cost of Care vs. Peers. Results from 24-month period.*

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Provider Quality Report Cards: Public Acclaim or Shame

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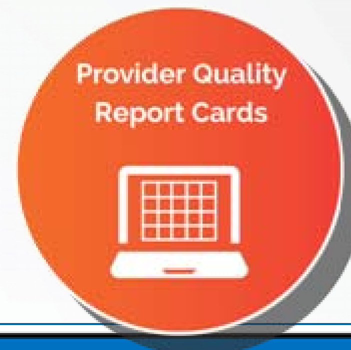
Provider Quality Report Cards: Public Acclaim or Shame

Key Targets
Does Not Meet Performance
50th %ile
75th %ile
90th %ile



Physician Report Card				
Clinical Metric	Compliance Rate	Potential $'s	Lost $'s	Total Earned
Adult BMI Assessment	98.94%	$ 50,711.71	$ 536.37	$ 50,175.34
Appropriate Low Back Pain Imaging	100.00%	$ 877.70	$ -	$ 877.70
Breast Cancer Screening	75.32%	$ 22,527.70	$ 5,558.78	$ 16,968.92
Colorectal Cancer Screening	71.45%	$ 30,231.98	$ 8,630.74	$ 21,601.24
Diabetes: BP Control (<140/90 mm Hg)	69.31%	$ 4,924.89	$ 1,511.60	$ 3,413.29
Diabetes: HbA1c Control (<8%)	67.33%	$ 4,924.89	$ 1,609.12	$ 3,315.77
Diabetes: Medical Attention for Nephropathy	93.07%	$ 4,924.89	$ 341.33	$ 4,583.56
High Blood Pressure Control (<140/90 mm Hg)	77.25%	$ 12,434.12	$ 2,828.15	$ 9,605.97
LDL-C Control (<100)	72.22%	$ 877.70	$ 243.81	$ 633.90
Pneumonia Vaccination Status for Older Adults	81.19%	$ 10,629.95	$ 1,999.21	$ 8,630.74
Tobacco Cessation Intervention	98.09%	$ 7,655.52	$ 146.28	$ 7,509.23
Total	84.47%	$ 150,721.05	$ 23,405.40	$ 127,315.65

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Behavior Follows Payment

Driving Transformation

Care Center	Year 1		Year 2		% Change
Practice G	$	1,545.46	$	19,202.95	1142.54%
Practice Q	$	19,620.16	$	86,818.60	342.50%
Practice O	$	3,848.00	$	14,299.22	271.60%
Practice B	$	24,504.00	$	85,363.43	248.37%
Practice C	$	7,024.00	$	22,498.68	220.31%
Practice E	$	49,300.00	$	153,530.58	211.42%
Practice F	$	19,402.00	$	58,904.55	203.60%
Practice R	$	6,666.00	$	19,661.43	194.95%
Practice D	$	130,560.58	$	149,490.65	14.50%
Practice M	$	55,869.42	$	63,436.18	13.54%
Practice A	$	40,911.53	$	44,831.25	9.58%
Practice L	$	90,013.45	$	96,280.54	6.96%
Practice H	$	46,024.74	$	48,545.59	5.48%
Practice S	$	24,698.46	$	26,000.40	5.27%
Practice I	$	127,315.65	$	131,769.45	3.50%
Practice J	$	39,916.65	$	40,704.94	1.97%
Practice K	$	37,776.50	$	37,362.70	(1.10%)
Practice P	$	10,781.72	$	10,458.63	(3.00%)
Practice N	$	29,221.69	$	26,658.21	(8.77%)
Advocare - All Care Centers	**$**	**765,000.00**	**$**	**1,135,817.98**	**48.47%**

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Path Forward

Value-Based Pain Points	Value-Based Solutions
Hospitals hemorrhage cash on employed physicians	Solvent physician networks
MSSP/ACO model is unsustainable	Practice redesign & CIN development
QI ≠ ROI	Triple Aim
Technology investments ≠ Value-based payment	Technology drives cost reduction strategy
Risk modeling predicts 30% of future spend	Target rising risk
Hospital-based economic models drive utilization	Distribute non-FFS funds/payments

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Value-Based Payment Progression

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Continuum: A Physician Enablement Company

- 15-year track record of success
- Serving over 1,000 providers
- Supports clinical treatment of 2 million patients
- Processes ~$1B practice management fees annually
- Proven success managing value-based purchasing/risk-based contracts

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Thank you.

Questions & Discussion

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402 Lippincott Drive | Marlton, NJ 08053
Phone: 856.782.3300 | Fax: 856.762.1785
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