INTERCEDE HEALTH

Pursuing the Triple Aim Together: Physicians and Executives Working in Collaboration

Joseph Jordan, MD, MBA
Chief Medical Officer
Intercede Health

So, what am I really talking about?

Using existing physician relationships to improve cost, quality, and patient satisfaction.

- Hospitalists
- Physician Managers
- Outpatient Physicians

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Consider employment, incentives to motivate inpatient physicians to work towards YOUR goals

- Lower cost per case
- Improved LOS
- Transitions
- Quality
- Citizenship

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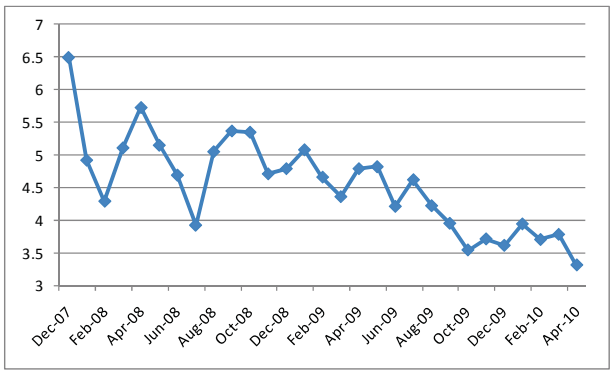

- Northern Virginia Hospital
- Hospitalist program in 2nd year – Intercede Health managed with employed physicians
- Focus on quality
  - Discharge audits
  - Elimination of unnecessary consults
  - Hiring of quality doctors
  - Hospitalist University training program
  - Incentive alignment

Focus on quality delivers lower cost and length of stay:

LOS=3.2
Annual savings of $5MM
Payback ratio of 3.5:1

Hospitalists & Quality

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Measure		Physician	Comparison	Cases	Adjustments
% 3 Day Readmissions (Any APR-DRG)	-0.87	1.48%	2.58%	24/1625	System Average | APR-DRG, Severity, Hospital-type
% 7 Day Readmissions (Any APR-DRG)	-0.94	3.14%	4.75%	51/1625	System Average | APR-DRG, Severity, Hospital-type
% 7 Day Readmissions (Same MS-DRG)	-0.39	0.37%	0.63%	6/1625	System Average | APR-DRG, Severity, Hospital-type
% 7 Day Readmissions (Same MDC)	-0.78	1.05%	1.91%	17/1625	System Average | APR-DRG, Severity, Hospital-type

Measure		Physician	Comparison	Cases	Adjustments
30 Day Readmission Observed/Expected Ratio		0.79	NA	192/1625	NA
Mortality Rate	-1.00	2.71%	4.06%	44/1625	System Average | APR-DRG, Risk of Mortality, Hospital-Type

Ensuring Quality, Satisfaction

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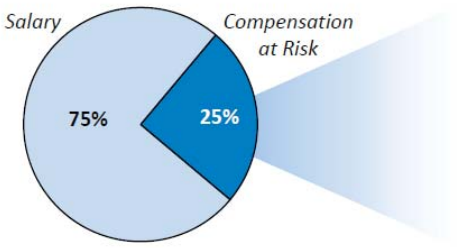
Compensation Structure



At-Risk Component

Previous Model
- Quality Metrics
- Chart Review

Current Model
- RVU Productivity
- Quality Metrics
- **Qualitative Assessment**

Study in Brief: Intercede Health
- Hospitalist management company based in Houston, Texas
- Altered structure of financial incentives to incorporate qualitative performance
- Developed standardized rating grid defining expectations across key performance areas

Source: Clinical Advisory Board interviews and analysis.

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Sample Hospitalist Performance Grid

Rating System Scale

1. Unacceptable
2. Needs Improvement
3. Meets Expectations
4. Exceeds Expectations
5. Outstanding

Excellence/ Quality of Care

- Medical knowledge
- Clinical skills
- Evidence-based practice

Communication Skills

- Written and communication skills
- Page responsiveness
- Documentation

Interpersonal Skills

- Collegiality, team-player
- Interactions with patients and staff

Reliability/ Accountability

- Shift coverage
- Problem solving

Hospital Citizenship

- Hospital governance, committee participation
- Quality initiative projects

Source: Clinical Advisory Board interviews and analysis.

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	1 Unacceptable	2 Needs Improvement	3 Meets Expectations	4 Exceeds Expectations	5 Outstanding
Excellence/ Quality of Care	Noted gaps in medical knowledge and clinical skills. Fails to follow evidence based guidelines. Medical judgment questioned by peers.	Medical knowledge and clinical skills adequate. Occasionally misses evidence based diagnostics and therapeutics when appropriate. May have episodes of near misses.	Solid fund of medical knowledge and clinical skills. Generally used evidence based diagnostics and therapeutic where appropriate.	Strong fund of medial knowledge and clinical skills. Consistently uses evidence based diagnostics and therapeutics where appropriate. Is a group leader in clinical practice.	Excellent fund of medical knowledge and clinical skills. Always uses evidence based diagnostics and therapeutics where appropriate. Role model for others.
Communication Skills	Communication style an issue with others. Often misunderstood or the source of conflict. Consistently needs to be reminded about clinical charting. Known for not returning pages.	Communication sometimes effective with occasional instances of misinterpretation. Needs reminders about clinical charting. Discharge summaries not always done within 24 hours. Pages often not returned.	Effective communicator in both written and verbal. Rarely in need of refinement of message or reminders about clinical charting. Returns pages.	Strong communicator, both verbally and written. Clearly communicates with clinical staff. Generally returns pages promptly. Discharge summaries complete and done within 24 hours.	Written and verbal communications a role model for others. Clearly communicates with clinical staff at all times. Always returns pages promptly. Discharge summaries always complete and done within 24 hours.

Source: Clinical Advisory Board interviews and analysis.

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	1 Unacceptable	2 Needs Improvement	3 Meets Expectations	4 Exceeds Expectations	5 Outstanding
Interpersonal Skills	Is a constant source of friction for the team. Never assists for extra work. Constantly having poor interactions with patients and staff.	Often has conflict with other members of team. Will begrudgingly assist for extra work when asked. Often has poor interactions with patients and staff.	Gets along with other members of team. Will step in to help for extra work when asked. Has no consistent issues with patient and staff interactions.	Works well in team environment. Generally steps in if extra help needed. Generally pleasant with patients and staff.	Consummate team player. Always can be counted to step in for extra work without complaint. Always pleasant in interactions with patients and staff.
Reliability/ Accountability	Frequently misses assigned shifts and does not arrange own coverage in emergencies. Never attempts to solve problems on own.	Occasionally calls out for assigned shifts and does not arrange own coverage. Rarely makes first attempt to solve problems.	Shows up when scheduled and generally arranges own coverage in emergencies. Often makes first attempt to solve problems.	Rarely is unavailable when scheduled and usually arranges own coverage in emergencies. Generally makes first attempt to solve problems.	Always is available when scheduled and always arranges own coverage for emergencies. Always makes first attempt to solve problems.
Hospital Citizenship	Has no involvement with hospital governance and is a source of hindrance to hospital improvements.	Has limited involvement in hospital committees and generally does not participate in hospital performance improvements.	Attends hospital committees and occasionally participates in improvement projects.	Fully participates on hospital committees and performance improvement projects. Takes initiative in improving hospital function and quality.	Works on multiple committees and is integral for hospital improvement projects. Recognized as a change leader.

Source: Clinical Advisory Board interviews and analysis.

Physician managers

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Maximizing the effectiveness of physicians in non-clinical roles

- Reviewers (bed status)
- Physician Advisors
- Chief Medical Officer
- Case Management Physicians

Physician Managers should drive results

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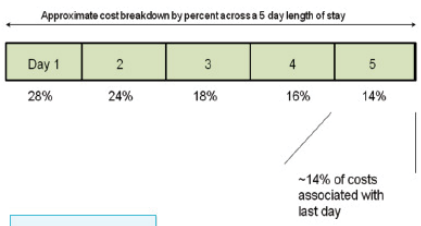
Incremental margin possibility

	Supporting Metrics							Potential Dollars
	Total Beds	Revenue per Case	Cost per Case	Contribution Margin per Case	Medicine LOS	Potential LOS	Potential Reduction LOS	Incremental Contribution Margin Opportunity
Anonymous Name		B	C	D (C-B)	F	G	H (F-G)	(365 days/F) - (365 days/G)*D*A
Hospital A	300	$7,449	$4,501	$2,948	4.8	4.0	0.8	$13,450,250
Hospital B	194	$9,187	$4,793	$4,394	4.8	4.0	0.8	$12,964,131
Hospital C	227	$4,551	$1,854	$2,697	3.4	3.2	0.2	$4,107,719
Hospital D	204	$10,864	$4,587	$6,277	4.3	4.0	0.3	$8,152,071
Hospital E	227	$6,043	$2,229	$3,814	5.7	4.5	1.2	$14,784,045
	230	$7,619	$3,593	$4,026	4.6	3.9	0.7	$12,329,316

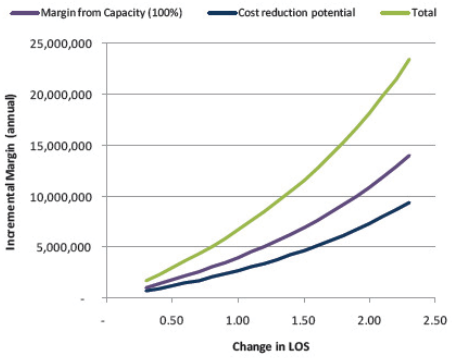
Capacity has to be used to get benefit

Cost reduction breakdown



Strong and Compelling Payback

Financial benefit of LOS reduction for a 100 bed facility (DRG)



Physician Managers should drive results

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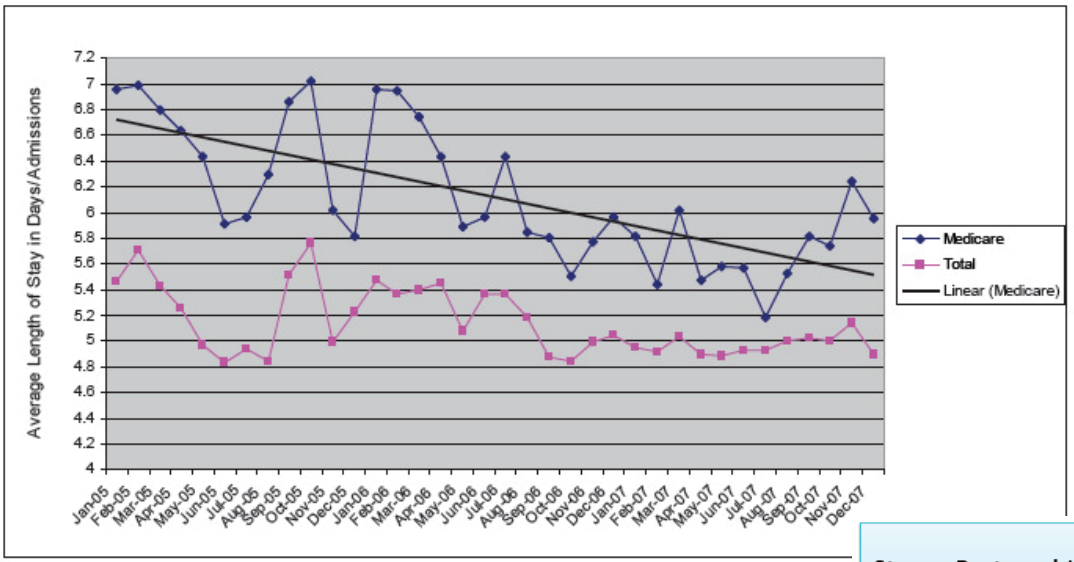

- 17.5% reduction in Medicare LOS
- 10.3% reduction in all payer LOS
- 11, 735 bed days saved
- 12.9 Million in estimated savings

Strong Partnership with Administration and Case Management yielded solid results

Physician Managers: Quality & Satisfaction

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- Right level of care, at the right time
- Appropriate length of stay
- Post-discharge planning & communication
- **Physicians talking to physicians**

Outpatient physicians

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Rethinking high-risk patient care to meet the demands of the new healthcare environment

- ACOs
- Readmission Penalties
- Living on Medicare margins

Different populations = different outpatient needs

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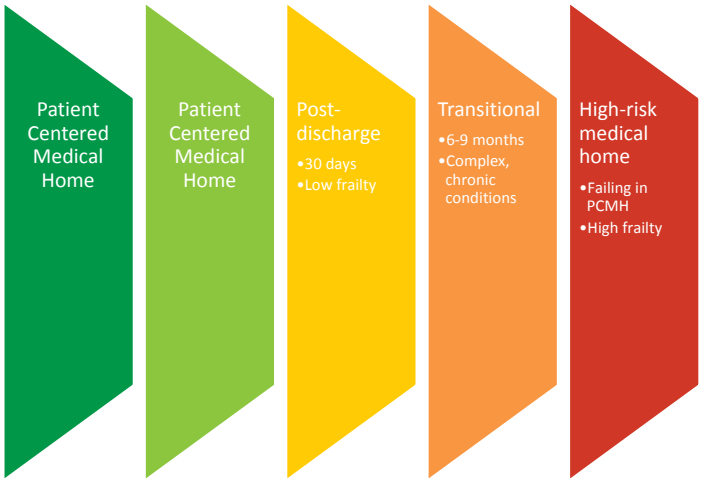

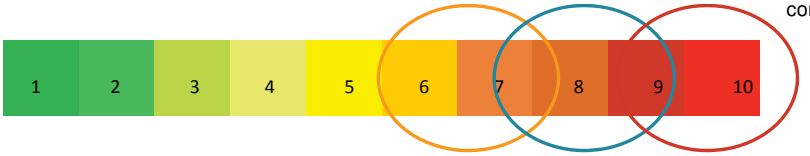

1 = Independent, mobile, healthy.

4 = Independent, mobile (will usually get to clinic appointment), family support,

6= Lives alone or with limited support, chronic disease mostly under control, but recent acute exacerbation/acute care episode, new medication

8= Chronic disease with co-morbidities. Confusion about medication, diet, little family support, new diagnosis

10= Chronic disease with co-morbidities. Little or no family support, poly-pharmacy, mental confusion. Needs intensive care and constant follow-up

Rethink care delivery for high-risk patients

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- Post-discharge
  - 30-day
  - PCP access an issue
- Transitional
  - Moving from "generally well" to "generally sick"
  - 7-9 months' average
  - New onset
  - Major life change
  - End of life
- High-Risk Medical Home
  - Unstable, unmanaged
  - Complex, chronic conditions
  - Frail
  - COPD, CHF, Diabetes, HTN, CAD, Renal

Extensivists, High-Risk Medical Homes

Care Team & Coordination

Medication Reconciliation

Telephonic Management

Coaching & Education

HRAs, Stars, Screenings &sments

High-Risk Medical Home compared to PCMH

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	PCP Medical Home	High-Risk Medical Home
Patients	•Generally well •0-3 chronic conditions	•Generally sick •5+ chronic, complex conditions
Volumes	•2000 patients per provider	•250 patients per provider
Care Plans	•Population Based •Self-management •Prevention	•Individual, patient based •Care coordination •Condition stabilization
Visits	•2-3 per year •15 minutes average	•1-2 per month •30 minutes -1 hour average

Designed for the patients who "fail" in a typical PCP environment
These patients need MORE time, MORE coordination, MORE care

Example cost & utilization savings

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- Admissions-Acute
  - Prior 12 months: 1,574 admits/k
  - HRMH: 1,034 admits/k (34% reduction)
- Admissions-ER
  - Prior 12 months: 851 admits/k
  - HRMH: 542 admits/k (36% reduction)
- PMPM-Inpatient
  - Prior 12 months: $1,438
  - HRMH: 1,017 ($421-29% reduction)
- Medical Loss Ratio
  - Prior 12 months: 132%
  - HRMH: 108% (23% reduction)

Metrics: Sample Quality/HEDIS Dashboard

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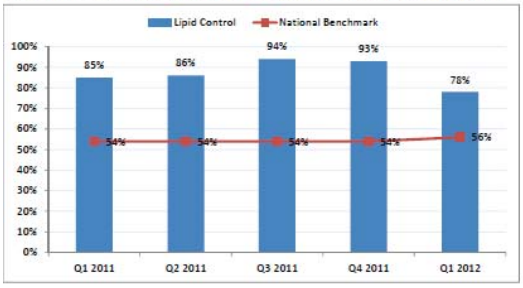
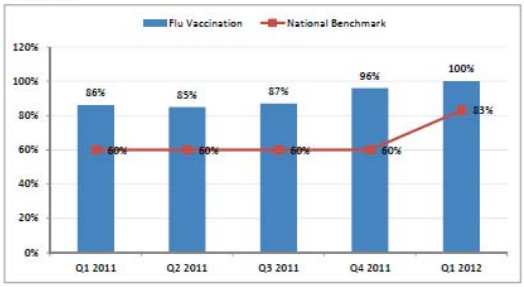
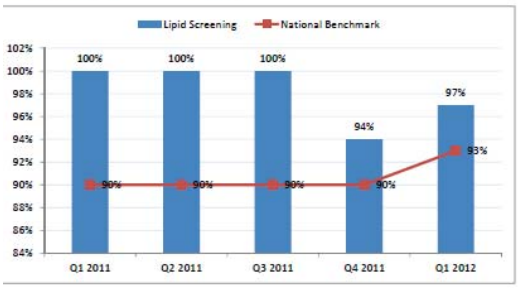
Measurement of all patients >18 with dx of diabetes who received at least an annual LDL-C screening and whose LDL-C level was controlled to <100 mg/dL



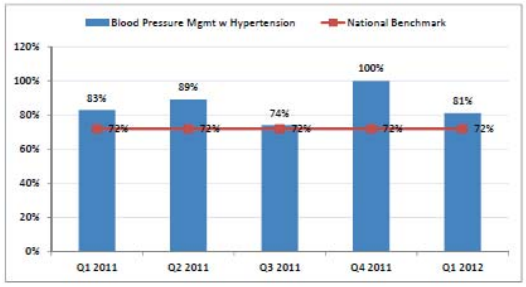
Percentage of clinic patients who receive, and do not refuse, an annual flu vaccination



Assess the percentage of patients >18 years of age with a dx of CAD who received an annual LDL-C screening



Measure of the members >18 years of age who had a dx of hypertension and whose blood pressure was adequately controlled to <140/90 mmhg during the measurement year



High Patient Satisfaction

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- Experienced Clinicians—"Extensivist"
- Time with Providers
  - Initial visit and first follow-up scheduled for 1 to 1 ½ hours, follow ups 30 min or more
  - Frequent scheduled clinic visits
  - In-between visit calls
  - 24/7 access to physician
- Convenience of in-office procedures & treatments
  - IV Lasix, IM/IV steroids, IV Saline, Neb treatments, Insulin initiation
- Reduced Barriers to Care
  - No office-visit copays
  - Transportation coordination
- Management & Coordination of all health services
  - Prescriptions and refills
  - As-needed specialist referrals (for complex problems/specific procedures)
  - As-needed home health, rehab
- Participation in Care
  - Information about condition and treatment choices
  - Development of long-term care plan
  - Self-management tools and education

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Questions & Discussion