Cornerstone Health Care's ACO Playbook

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CORNERSTONE
YOUR MEDICAL HOME
health care

Mission:

To be your medical home

Vision:

To be the model for physician-led health care in America

Values:

As a physician owned and directed company, we are committed to ensuring that patient care is efficient, effective, equitable, patient centered, safe, and timely

Everyone has a Default Future

What is Our Default Future?

We can eliminate our default future by:

- Choosing to Re-write the Default Future
- Putting Language to our Alternative Future
- Creating a Vision of that Future
- Creating a Good Strategy to Get There

A Vision without a Good Strategy is a Hallucination

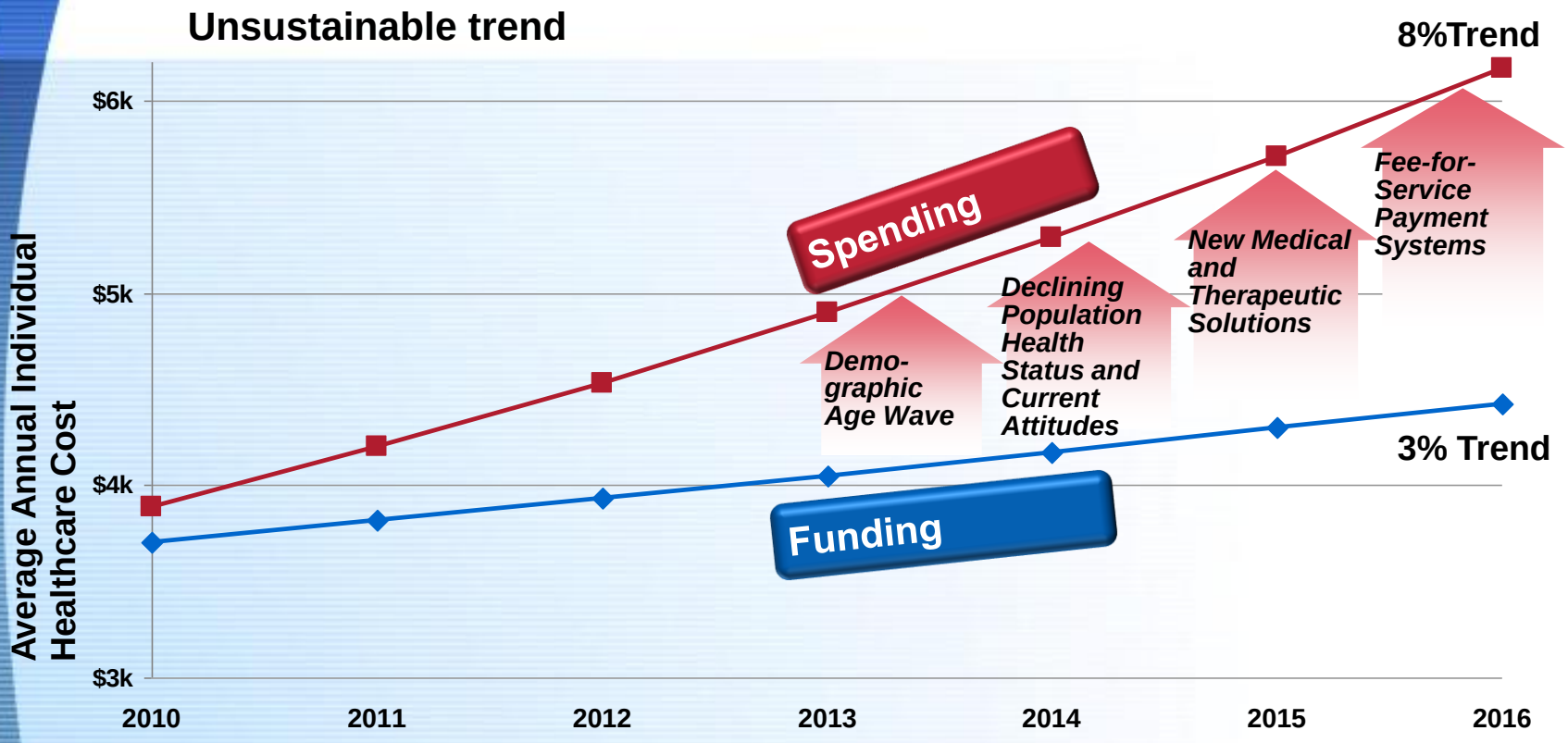
A Strategy is Not a Goal, Hope, or Aspiration

Strategies solve Real Problems

A good strategy

- Makes an accurate diagnosis
- Creates a guiding policy for problem solving
- Has a coherent administration of tactics
- Focuses on risks and how to mitigate them
- Understands competitive advantage

The US healthcare system is too expensive, wildly variable, with lower than desired quality and outcomes



Poor quality	
▪ 37th in WHO overall rankings ▪ 24th in life expectancy ▪ Last in preventable deaths	▪ 29th in infant mortality ▪ #1 in spending

Where will the money from?

Core funding sources are on a path to insolvency.

Healthcare Funding Source Pressures				
Medicaid	**Medicare**	**Commercial Payers**	**Employers**	**Consumers**
Virtually bankrupt—need tax reform or federal subsidies	Trust fund will be bankrupt between 2017 and 2024	Cost burden will become untenable as commercial market continues to contract	Continued bailout to prevent margin erosion	HC costs leading cause of personal bankruptcy

Trend is unsustainable and will continue to compress FFS reimbursement

Here is where we are headed:

- There will be continued downward pressure on health care providers to control costs while improving quality of care provided.

- Fee-for-service reimbursement will be continually subject to reductions in fees, external efforts to control utilization, and scrutiny of care provided.

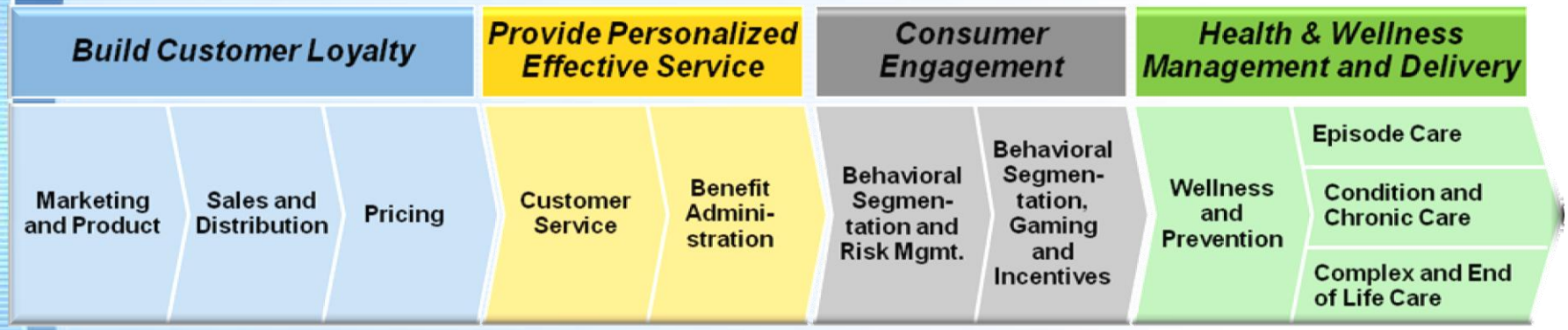
- Favorable reimbursement will be shifted to those providers able to demonstrate value through providing high quality care at the lowest cost.

The healthcare delivery system model will change across several key dimensions

	Volume Based	*Value Based*
Reimbursement	▪ FFS/DRGs ▪ No payment for readmits, never events, etc.	▪ Outcomes & Quality based ▪ Global payments
Organizational model	▪ Departmental	▪ Populations ▪ Conditions ▪ Focused factories
Value drivers	▪ Volume ▪ Efficiency (on a procedure level)	▪ Quality and low variability ▪ Efficiency (on a population level)
Profit pools	▪ Visits ▪ Surgery / Procedures ▪ Outpatient ancillary	▪ Wellness and prevention ▪ Population management ▪ Chronic condition management
Investments	▪ Capacity ▪ Revenue-producing assets ▪ Patient referrals	▪ Health IT ▪ Clinical integration ▪ Commercialization

Leading-edge hospital systems and large groups are repositioning as integrated healthcare companies—their product is better healthcare

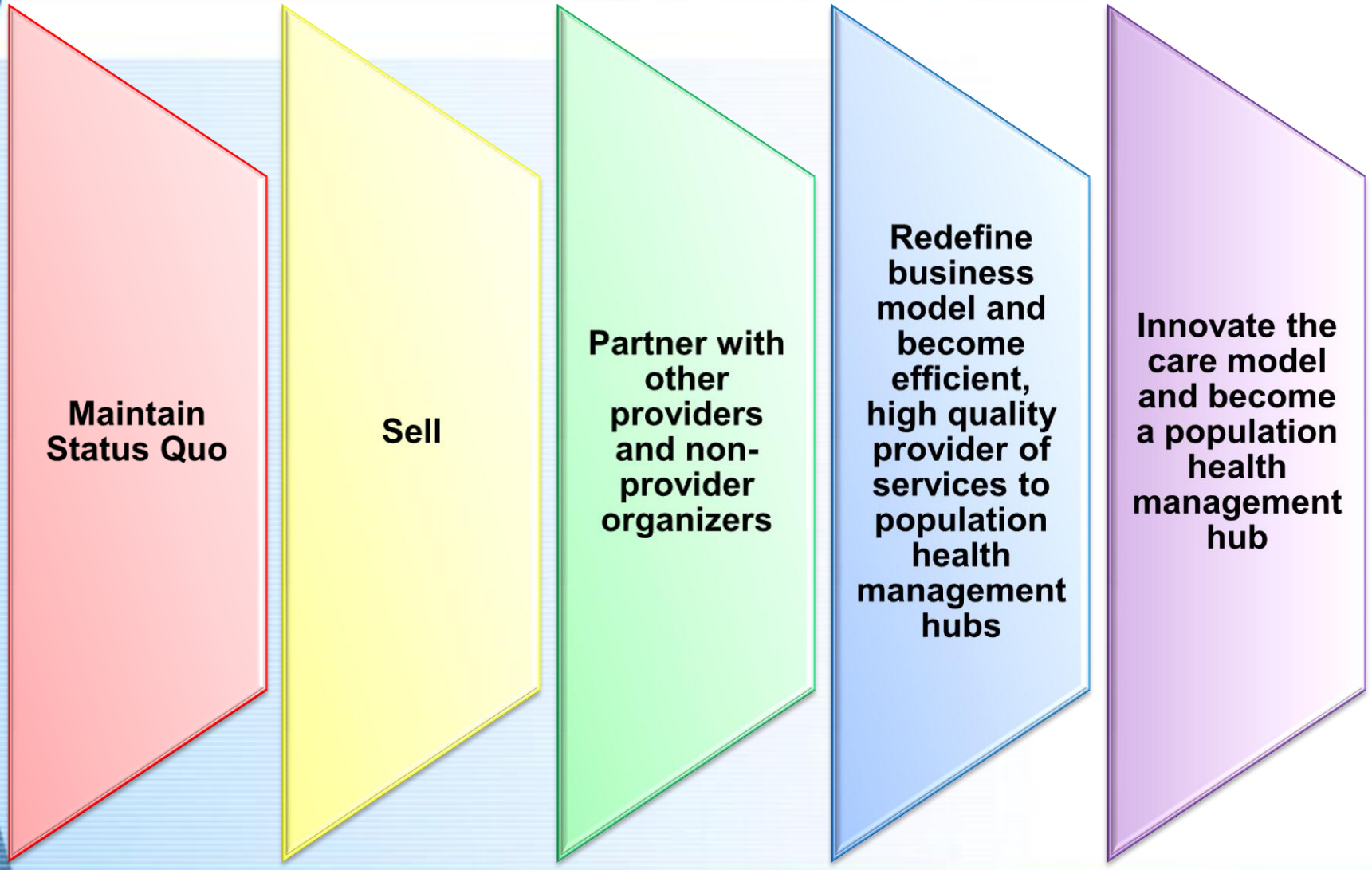
Integrated Healthcare Company Value Chain



What are Our Strategic Choices?

Our vision is to be the model for physician-led health care in America

Cornerstone's Strategic Choices

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POINT A
POINT B
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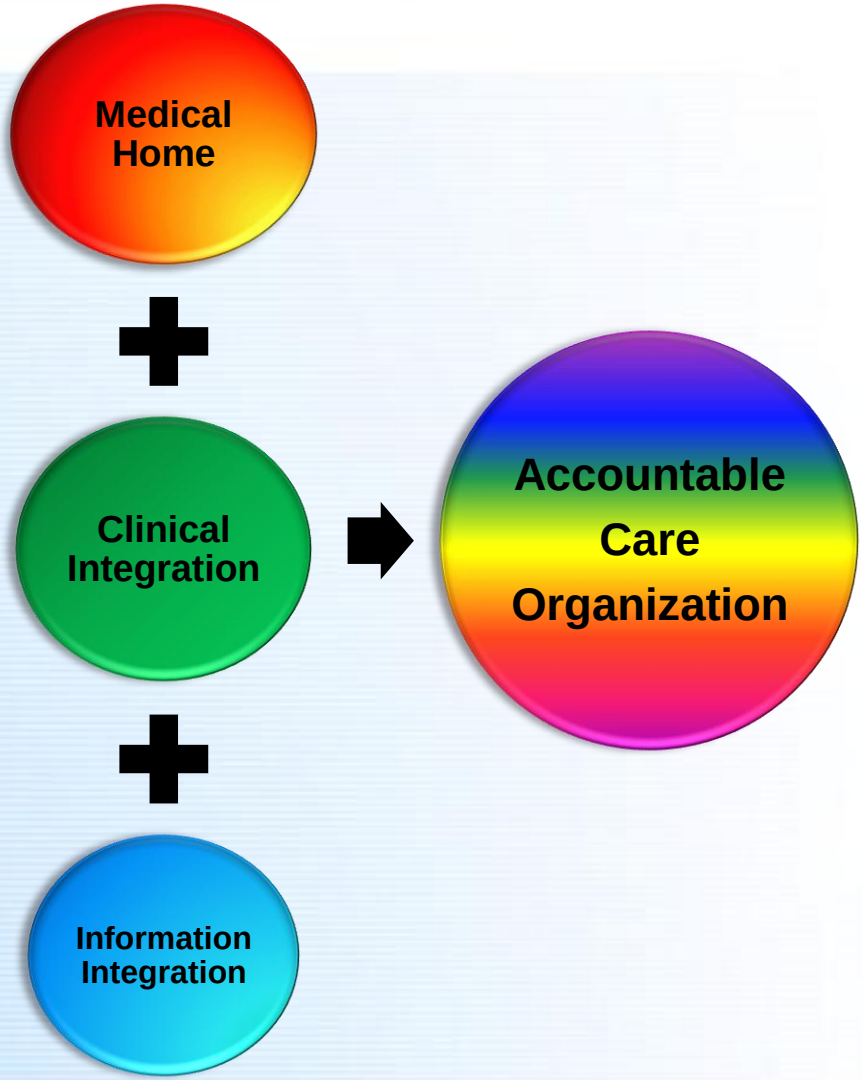
Here is what we've done so far:



Our Steps to a Medical Home Model

Clinical Pharmacy Services

- Coumadin Management
- Diabetes Management
- Polypharmacy Management

Extended and Weekend Hours

- Ancillary Services Care
- Primary Care
- Some Specialty
- Multiple Locations

Medical Home Professional

- All 1500 Employees completed intranet video training in medical home concepts
- After completion of coursework received certificate of recognition
- Required part of orientation for new hires

Outpatient Infusion Center

- Antibiotics, other meds
- IV Fluids
- 7 days a week

Patient Care Advocates

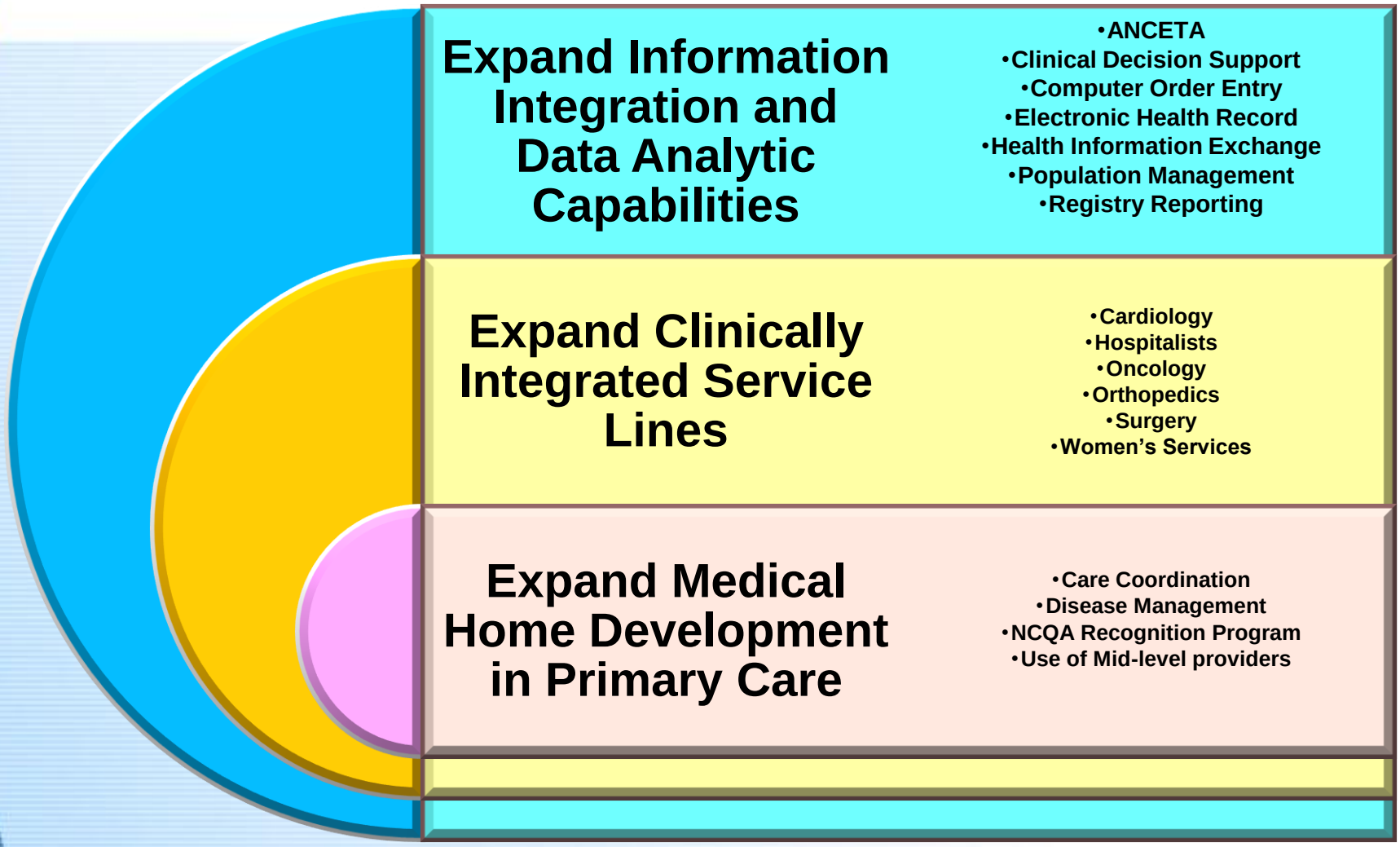
- Improve the overall patient experience in the PCMH model
- Disease Education
- Service Recovery

Clinical Integration

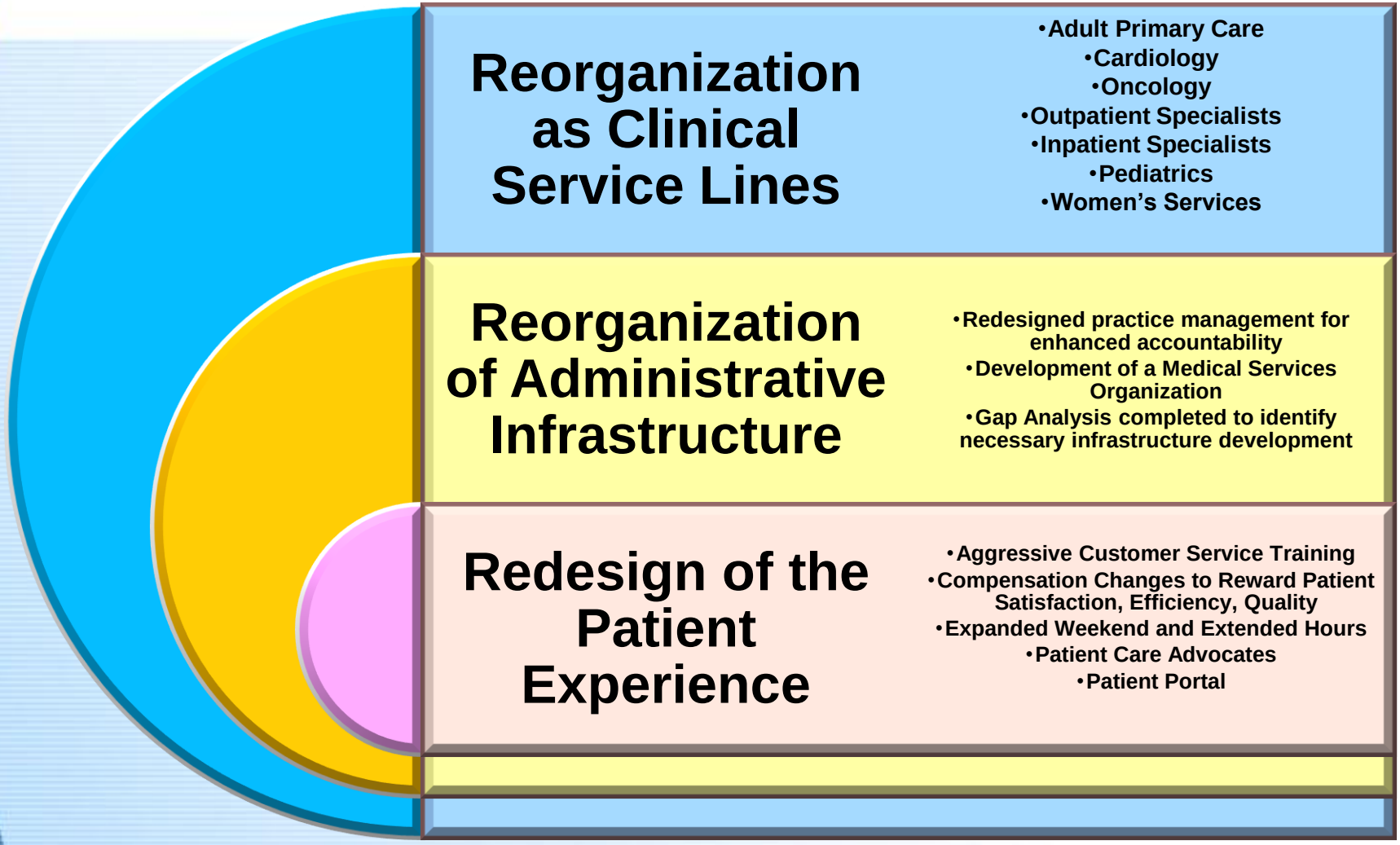
Our Information Integration Projects

- Electronic Health Record
- QBM (Clinical Decision Support Tool)
- Practice Financial Benchmarking
- Practice Clinical Benchmarking
- Meaningful Use
- Medicare Registry
- Patient Portal
- ANCETA Collaborative
- NCHEX

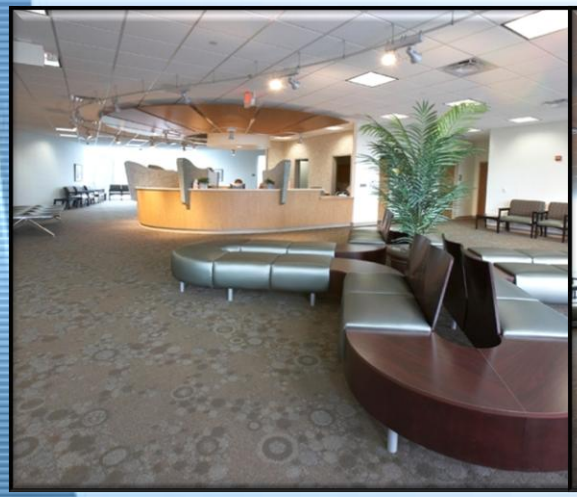
Early Strategic Initiatives



Current Strategic Initiatives



Now Here Is Where We Are Going:

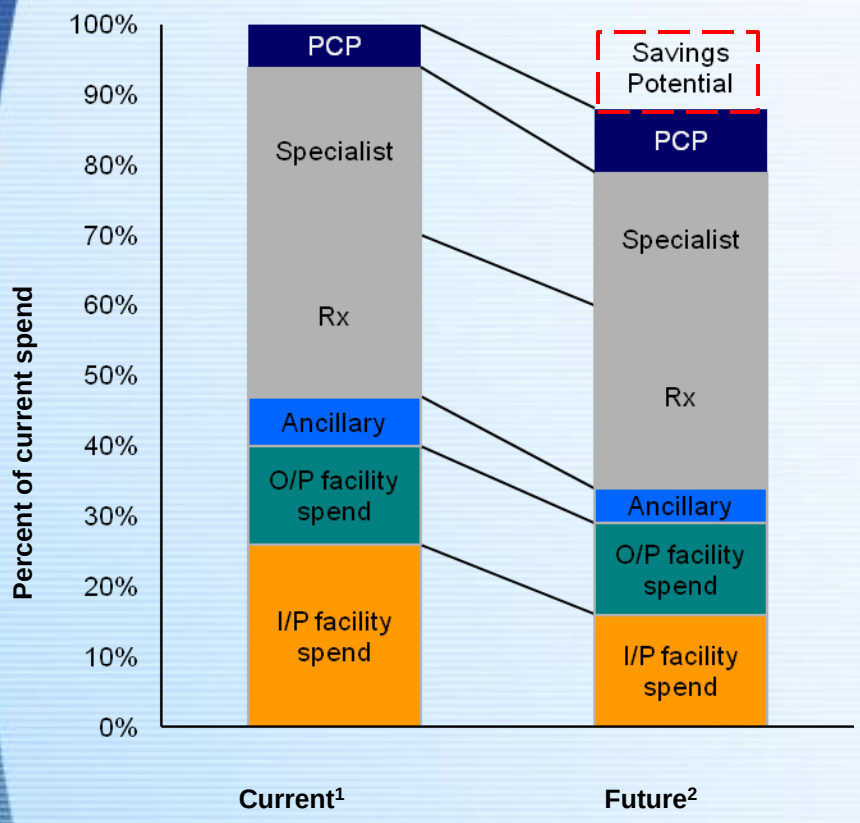


Population Health Management

New care models focus on reducing excess medical spend and lowering year-over-year increases in the cost of care

Total system spend:

Illustrative

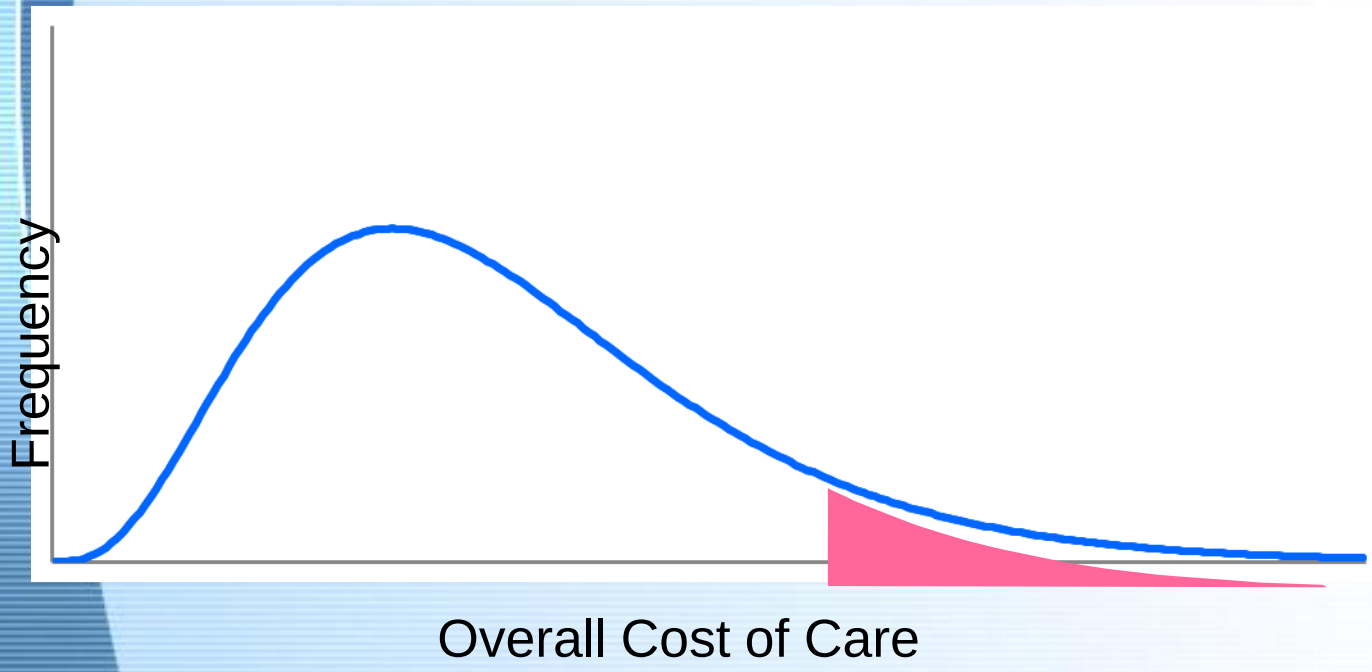


- **The FFV reimbursement model better aligns incentives to promote team-based, coordinated care**
- **New care models that focus on reduced practice variation, care coordination, and improved clinical support systems promise to reduce spend in key areas**

Source: Blinded payer data, Cornerstone patient data, OW Analysis. 1. Based on blinded benchmark payer data with blended Commercial/Medicare population. 2. Based on OW analysis surrounding impact of care models on various cost drivers.

Improvement: Two Components

1. **Exception management**
   a. Identify potential physician or patient “outliers”
      - Clinical intuition—view in “context”
      - Population analytics—patterns of risk/cost
   b. Enables individualized attention



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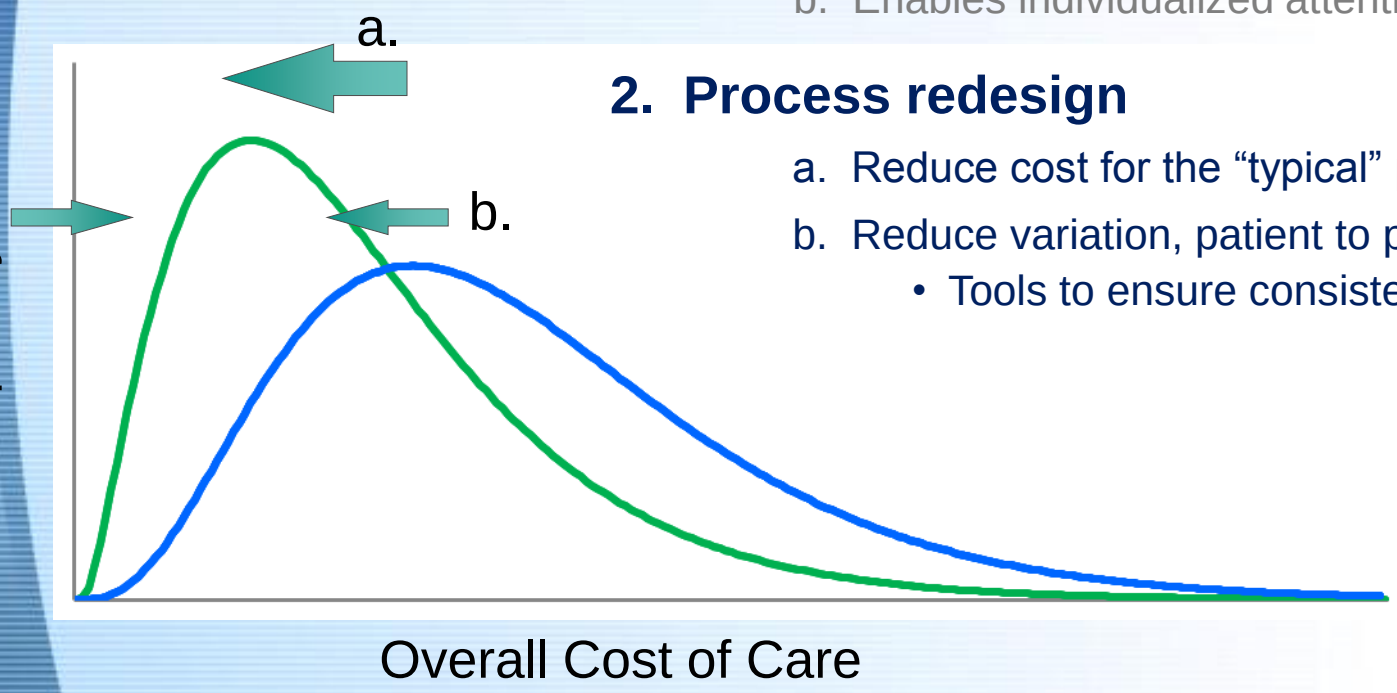
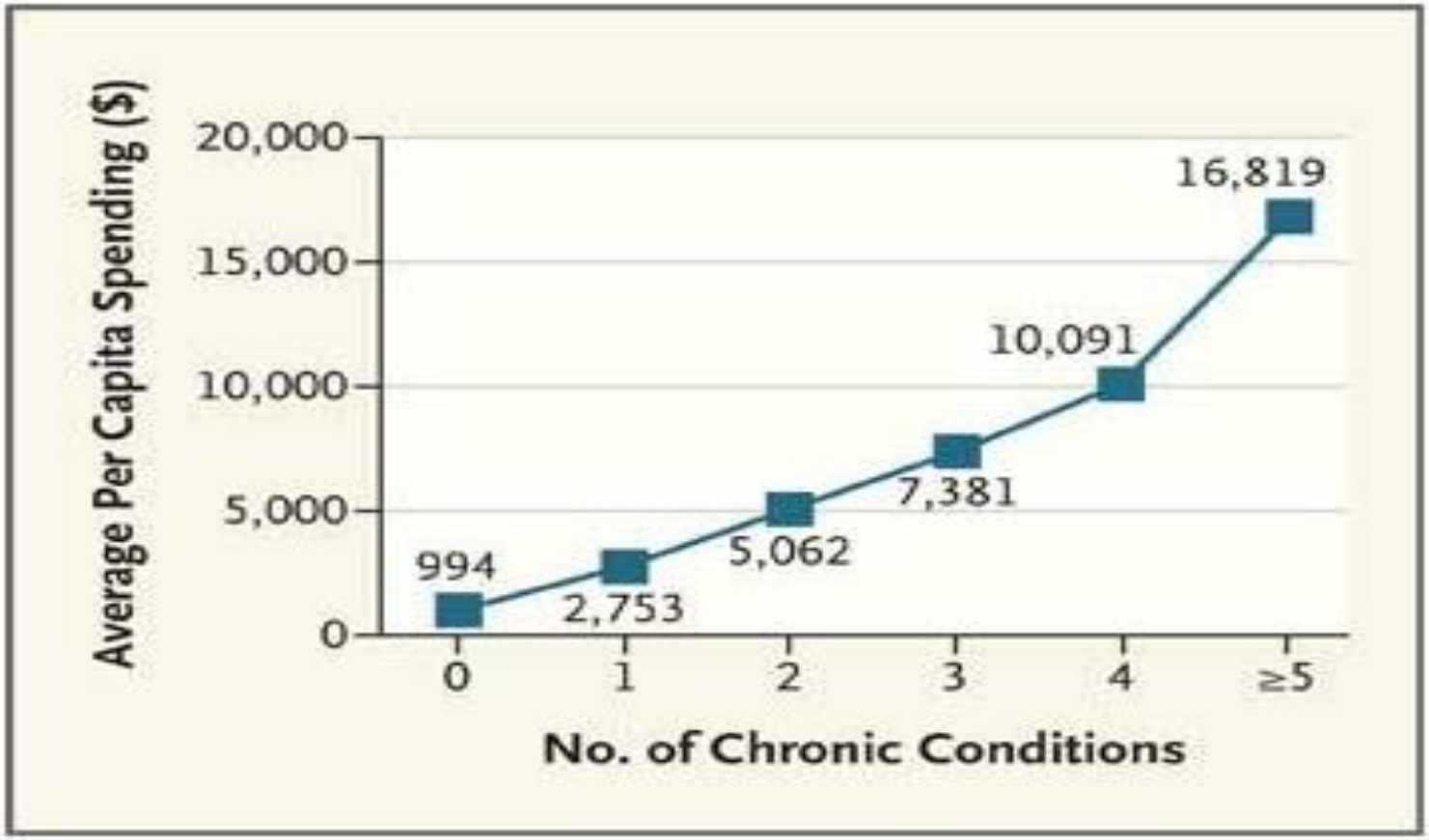


2. **Process redesign**
   a. Reduce cost for the "typical" patient
   b. Reduce variation, patient to patient
      - Tools to ensure consistent execution

Controlling Population Expenses By Improving Care For Patients Need in Costly Services

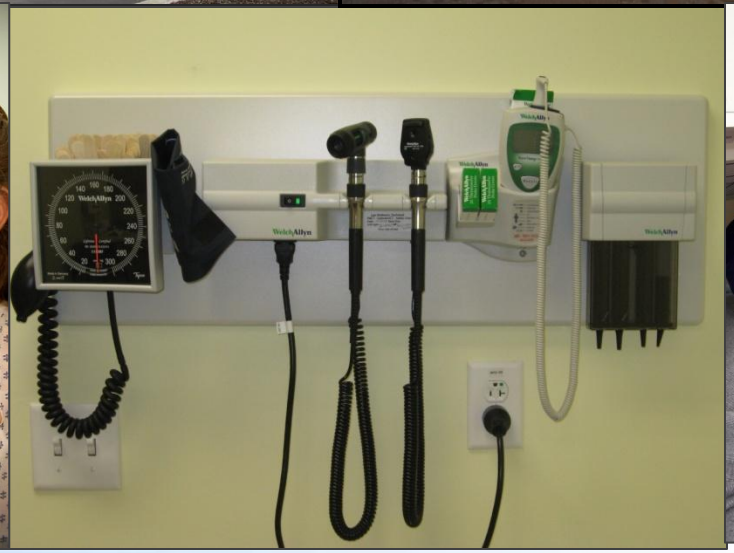


NEJM Oct 2009 (Medicare data): T. Bodenheimer, R. Berry-Millett

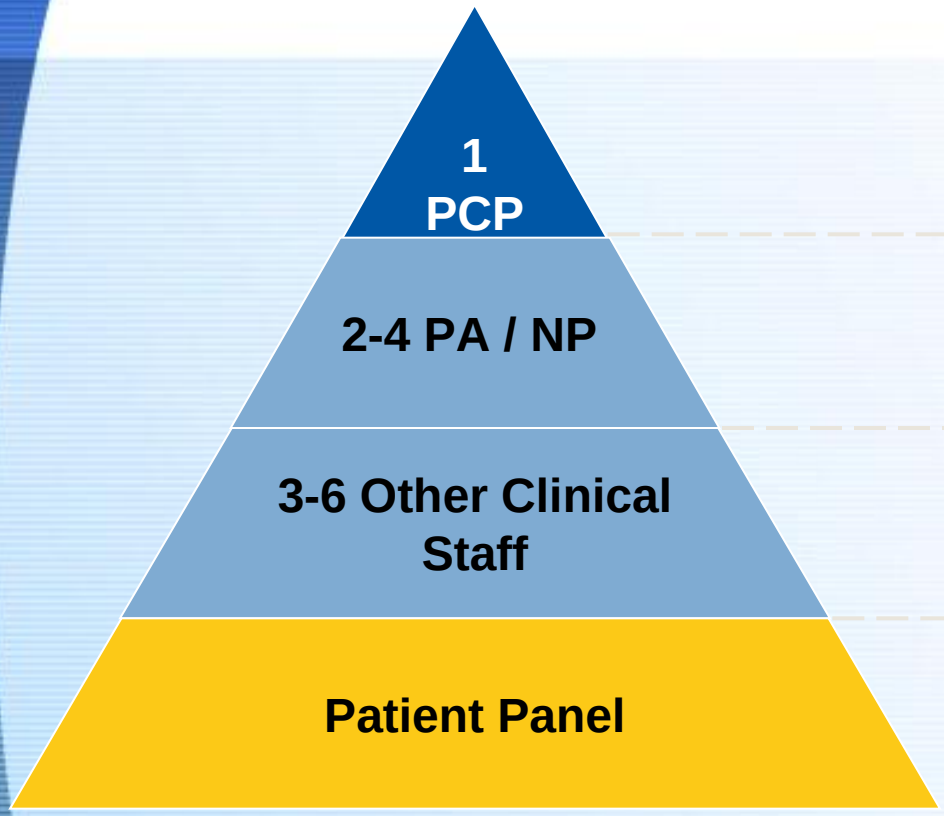
Our Transformation Process

- Care Redesign
- Contract Redesign
- Financing
- Governance Redesign
- Growth Plan
- Infrastructure Development

Patient Care Redesign



A shift to a higher leverage model across all key coordinating physicians (PCPs and many specialists) will be critical to successfully managing population health



Patient-Centered Medical Home Teamlet

A primary care physician (PCP) will oversee the extender staff and a dedicated panel of patients

Physician Assistants and Nurse Practitioners act as the main extenders to support the PCP

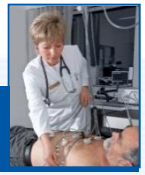
Other clinical staff such as RN Care Managers, clinical associates and clerks will act as extenders depending on the makeup of the panel

The number of patients in a panel will depend on the population's health status; varying from 5000 for Healthy Independents and 800 for polychronic

Source: United States Department of Veteran Affairs, VA Healthcare VISN 4, Patient-Centered Medical Homes: Patient-Aligned Care Teams, 2010; Oliver Wyman Analysis

Cornerstone will need to execute on key changes to successfully support patients across the continuum of care and drive cost of care savings

High-Impact Care Models:



Cardiology

- Improve collaboration among cardiologists, cardiovascular surgeons and other specialists around treatment planning and care management
- Reduce unnecessary and potentially harmful interventions
- Improve patient experience through quicker access to services (e.g., cardiovascular rehab, home care, etc.) and lifestyle planning (e.g., diet, nutrition, exercise)

Oncology

- Improve patient experience through end-to-end care navigation and integration of other care providers/ key support services (behavioral health, home health, etc.)
- Increase collaboration around treatment planning and care management with an oncology care team coordinating with a PCP
- Reduce practice/ pathway variation

Orthopedics

- Reduce supply costs via standardizing medical devices and supplies to reduce variability and increase buying power
- Reduce excess surgical costs by better utilizing implants, shortening the length of inpatient stays following surgery, and shifting the location of surgeries to lower cost settings
- Quality programs to reduce surgical complications

Patient Centered Medical Home

- Reduce practice variation, increase care coordination, and improve access to clinical support systems
- Heavily manage chronic conditions to optimize treatment plans, drive care coordination, and ensure patient compliance
- Incentivize patients to engage through empowered decision making and participation in wellness/ prevention programs

Building team-based care models and properly aligning physician incentives will be key drivers of success

Contract Redesign

Financing

- Debt
- Equity
- Grants

Governance Redesign

- Board of Directors to include Medicare Beneficiary
- Income Distribution Formula being tweaked to account for revenues from gain-sharing, P4P, risk contracts.
- Development of a separate MSO

We have an aggressive five year growth plan.

- Geographic expansion
- Integration across the continuum of care leveraging existing relationships.
- MSO development

  -Care Coordination

  -Contracting

  -Health Enablement
- Recruit new executives and delegate leadership responsibilities.

Infrastructure Development

- Facilities
- Information Technology
- People

Cornerstone's Early Results

- All 22 of our Family Medicine, Internal Medicine, and Pediatric Practices have Level 3 NCQA PCMH Recognition
- $1,347,000 in PQRS and e-Prescribe incentive bonuses in 2009 and 2010
- Improved Commercial and Medicare Contracts
- Meaningful Use attestation completed for >145 providers

There are several key risks to Cornerstone that may affect the move to population health management

- Waiting too long to make the shift
- Competitors outperform on cost and quality
- Inability to wrestle risk away from payers
- Mispricing risk
- Dependency on payers to quickly operationalize a FFV claim system
- Failure to change clinical models, wring out excess spending and create value
  - Clinical culture change and unwillingness of physicians to shift to a team-based model
  - Clinical integration across continuum of care
- Limited investment in key capabilities and infrastructure
- Consolidation of hospital systems and other physician groups

Thank You!