

Physician Group Practice Demonstration Program  
Park Nicollet Health Services  
Demonstration Strategy and Learning  
Congestive Heart Failure/TeleAssurance Program

August 9, 2007

**Overview:** On April 1, 2005, Park Nicollet Health Services was one of 10 group practices across the country selected by CMS to begin implementation of the Physician Group Practice Demonstration program.

Under this demonstration program, group practices would become eligible for a bonus payment from CMS if they created savings for the Medicare program in excess of 2% compared to their comparison groups in any given performance year. Any savings in excess of 2% would be shared with the groups on an 80/20 basis. The 80% of savings would be paid to sites dependent on their meeting specific quality measures for each performance year.

**Park Nicollet Strategies:** Park Nicollet focused its energies in the demonstration on leveraging its knowledge in the “Lean Production System”, coupled with an electronic medical record that that made it possible to create patient disease registries and track on a real time basis progress within the demonstration.

Park Nicollet focused its energies and resources on Congestive Heart Failure care management. A 1999 Medicare Current Beneficiary Survey, indicated that individuals with CHF represent 14 percent of non-institutionalized FFS Medicare beneficiaries and account for 43 percent of Medicare expenditures, including treatment for all their health problems. Park Nicollet saw this as an area presenting the greatest opportunity to create savings. It did so by focusing on development of a daily telephonic care management program developed by Pharos Innovations. Under this program, patients provide daily telephonic updates of their condition. Nurse Practitioners monitor these updates and, operating under physician adopted standing orders change medications when a variance in the data indicates the need to do so.

In this program, nurse practitioners are empowered to provide care by changing medications as indicated by the patients’ reporting on 5 specific questions: shortness of breath, swelling, waking as a result of shortness of breath, sleeping upright in a chair in order to sleep at night, lightheadedness and dizziness and daily weight change. A 10% variance triggers a call from a nurse practitioner to the patient. If necessary, the nurse practitioner changes the patients’ medication.

The care management components of Park Nicollet’s interventions include:

- Population identification processes
- Evidence-based practice guidelines

- Collaborative practice models to include physician and support-service providers
- Patient self-management education
- Process and outcomes measurement, evaluation, and management
- Routine reporting/feedback loop (may include communication with patient, physician, health plan and ancillary providers, and practice profiling)
- Good evidence for improved quality; cost savings controversial

**Park Nicollet Performance on CHF:** Park Nicollet began to enroll patients with a diagnosis of Congestive Heart Failure in the TeleAssurance program in June of 2005. Initially 30 patients were enrolled in the program. By the end of the first performance year (March 31, 2006), 453 patients were enrolled in the program.

Park Nicollet's baseline measure for CHF admissions included all patients admitted for CHF. The charts below show Park Nicollet's success in averting admissions since inception of the program. Currently there are 625 patients enrolled in the program. For each patient with a CHF diagnosis enrolled in the program, Park Nicollet is averting one hospital admission per year. At a current average national cost of \$6,000 for each CHF admission (SG-2), avoiding one hospital admission per year for every CHF patient could save CMS \$5 billion per year. (As a staff person at OMB pointed out, that is real money even for CMS.)

Park Nicollet has achieved these results even though the number of patients with a diagnosis of CHF served by Park Nicollet increased by 14% .

While significantly improving quality and efficiencies, the program has not yet yielded a bonus payment to Park Nicollet. We are hopeful we will receive a bonus payment in the 2<sup>nd</sup> year of the demonstration program.

Park Nicollet's cost of implementing this initiative is approximately \$750,000 per year. These costs include the salaries of 4 nurse practitioners as well as the IT infrastructure cost to put the Pharos Innovations TeleAssurance program in place. (Each nurse practitioner is able to monitor 150 patients.) Additionally, Park Nicollet is foregoing about \$5 million in revenue as a result of averted hospital admissions. Under the current financial incentives, Park Nicollet is not able to recover the marginal cost of implementing this program even though it creates improved health outcomes and significant savings for CMS.

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### **The Success Paradox**

- Significant improvement in health and avoided heart damage, individual suffering and averted admissions. (Currently about 625 per year)
- Projected loss = @\$5 million/year (The current payment system does not provide for a rate of return on investments such as this, despite the demonstrated savings.)
  - Over \$750,000/year direct costs
  - Over \$4 million in lost revenue (Each admission pays about \$6500.)

- No payer pays for nurse practitioner services and infrastructure costs in the tele-assurance care management program.
- Benefits all payers for care provided to CHF patients. (We don't stratify care by payer.)

Over a year and a half into the program, no payer yet pays for these services that render significant savings. The financial incentives are not aligned to cover the marginal cost of doing the right thing.

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The market is not structured to allow rapid adaptation to creating financial incentives that reward efficient processes such as the CHF Tele-Assurance program. There currently exists economic risk for providers who “do the right thing” by coordinating care and services to patients. External disease management programs do not provide the same levels of improvement primarily because the person on the other end of the phone cannot provide care to the patient as the nurse practitioner can in this process.

We believe this problem could be alleviated with a care coordination fee payment to cover the incremental costs of putting the program in place.

**Trends**

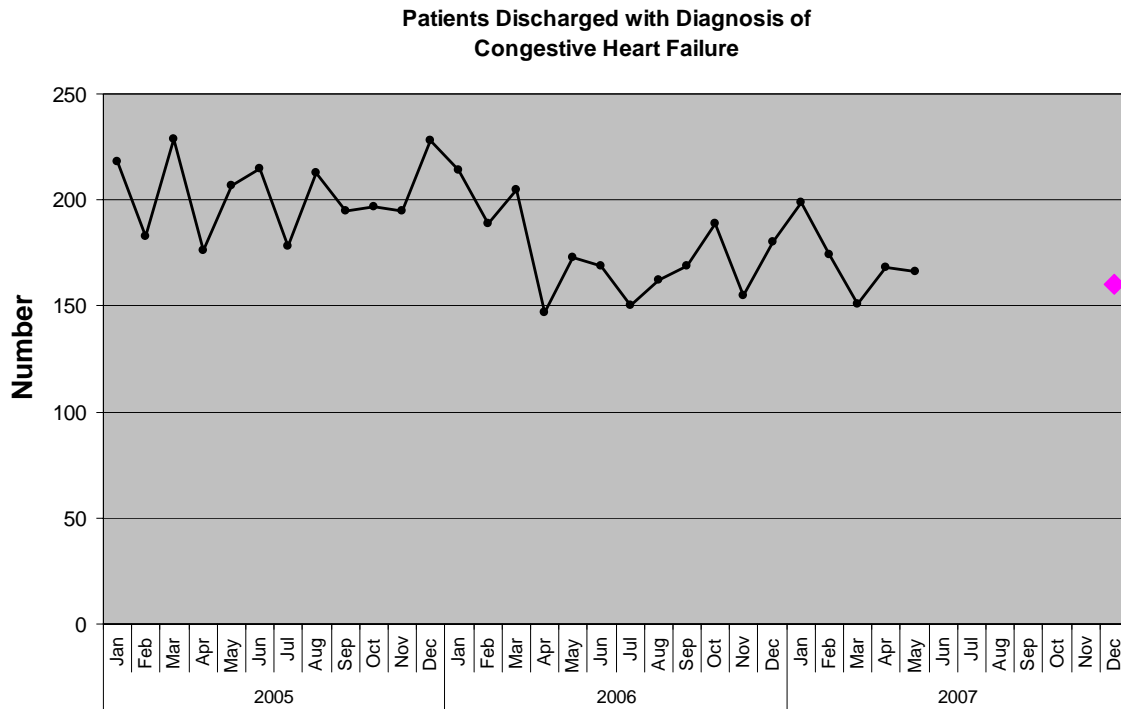
**Yet More Patients With CHF Codes**

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



Despite an upward trend in the number of patients served by Park Nicollet who have a diagnosis of Congestive Heart Failure, we have been able to consistently decrease the

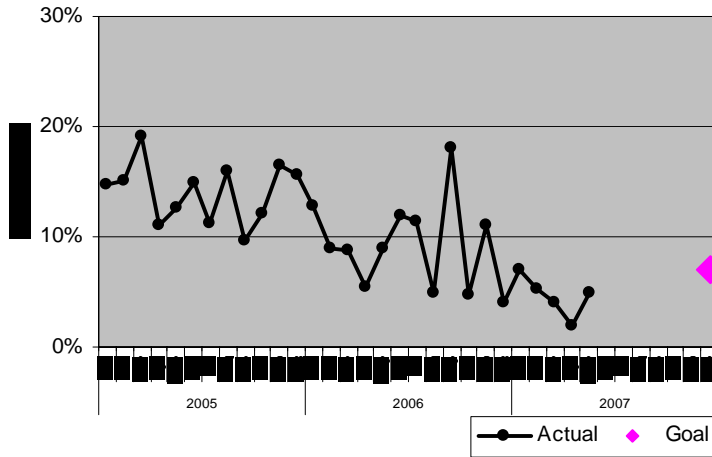
number of discharges for CHF over time. The chart below describes our trend from baseline admissions despite a growing population of patients with CHF.



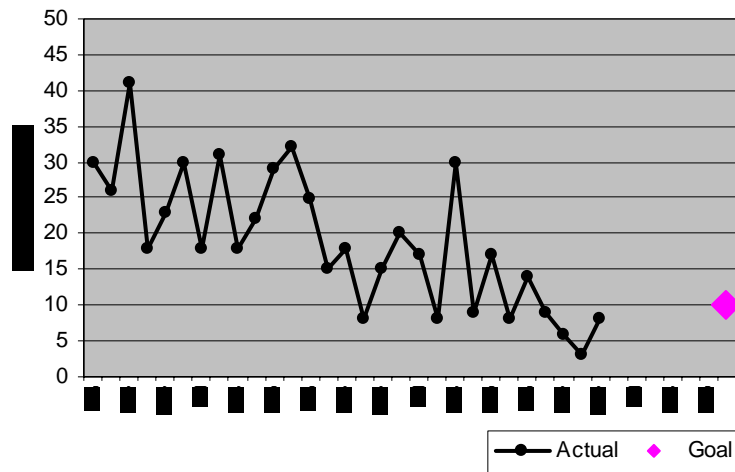
**Date Prepared:** 07/06/07  
**Report Contact:** Amy Sticha/Barb Sundquist 31700/QR  
**Source:** Brio  
**Refresh Cycle:** 30 days after the month ends  
**Operational Def:** Premier ICD-9 definition of Heart Failure used for purposes of this query--primary, secondary or tertiary code on discharge (Goal=yearly avg <50%)

—●— Actual    ◆ Goal

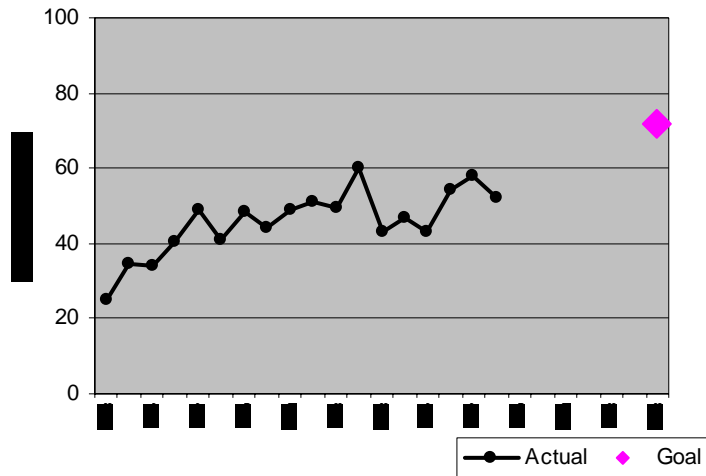
**Percent of CHF\* Patients  
Readmitted within 30 days for CHF**



**Total number of CHF Patients  
Readmitted within 30 days for CHF**



### Number of Averted CHF Admissions\*



### Implications and Opportunities:

Even though Park Nicollet is avoiding about 600 admissions per year for patients in the Medicare Program, we are only able to get the credit for about half the avoided admissions due to the attribution model for the PGP demonstration program.

Only patients who are straight fee for service beneficiaries are counted in our assigned beneficiary pool for the demonstration. Since Park Nicollet does not stratify care by payer type, half of the patients in the TeleAssurance program are Medicare Cost Contract Enrollees. In a Medicare Cost Contract health plans take the risk for Part B (clinic) services and pay us claims for physician services. CMS however is at risk for Part A (hospital) services. Even though CMS gets the benefit of avoided hospital admissions for patients in the Medicare Cost Contract served by Park Nicollet, the savings for these patients are not included in our bonus pool calculations.

CMS has expressed interest in pursuing a continuation of this demonstration beyond the initial 3 year period, with the potential for creating a “care management fee” for patients enrolled in a care management program. However, they do not have resources at this time to implement this change until perhaps 2009. (Slow adaptation)

We believe that under the following criteria and monthly care management fee arrangement, CMS could replicate this program nation-wide and save potentially \$5 billion:

- Care Management Fee covers non-reimbursable management costs for CHF patients, e.g. equipment, patient outreach, registries, oversight, assessment and interpretation of data, nurse practitioner conducting daily monitoring, etc.

- Paid periodically for eligible patients using agreed upon CPT or HCPCs code, not based on encounters or time
- Applied only to patients with specific conditions meeting defined criteria
- Available only to providers with demonstrated capacity to supply appropriate interventions

The financials of such an arrangement could work as follows:

- CMS agrees to Care Management Fee (CMF) for CHF patients of \$125 per eligible patient per month. Annually this would result in a payment per year of \$1500. With the average national payment for a CHF admit being \$6000 per year, a savings could be created at a rate of \$4500 per patient admit averted.

These savings could be achieved immediately if implemented.

Yet these changes won't happen if the financial incentives are not changed to reward the added value created by such an initiative. In the current payment system providers are unlikely to migrate to a care management program that does not pay for the services of the nurse practitioner providing the daily monitoring of the patient. This results in what we view as the "tyranny of the office visit", where the only way to get paid is to have the patient schedule appointments in the office with the physician. More importantly, smaller provider groups that don't have the resources of larger organizations are unlikely to be able to adopt a care management program without payment to cover the marginal costs of implementing such a program.

### **Adaptable to Other Chronic Conditions**

Similar results can be achieved in other areas of chronic illness, although the potential for improvement and savings will be variable depending on the condition. Park Nicollet is developing a strategy for CMS to apply these processes to other chronic conditions with savings potential. The following describes some of the criteria.

- Can apply to principle physician of any specialty
- Other chronic conditions can be added in the future
  - COPD
  - Diabetes
  - Renal Failure
  - Other?
- Performance metrics, CMF baseline value, and billing frequency would be specific for each identified condition
- Condition specific

- Provider eligibility criteria includes willingness and ability to collect and report clinical measures
- Examples of possible measures for other conditions
  - Diabetes: HgA1c level, HDL/LDL levels, BP levels, tobacco use, admission rates, complication rates, cost per patient per year
  - COPD: admit rates, pulmonary function, ADLs
  - Renal failure: diagnosis to dialysis time span, rate of transplant/dialysis, cost per risk adjusted patient per year

**Conclusion:**

The economic incentives in the current market do not create rewards or incentives for improved health and savings created by care coordination by providers for chronically ill patients. Nor do the incentives change quickly enough to sustain and increase the potential gains under such care coordination arrangements.

CHF is only one example of the potential for improved health and efficiencies through provider based care coordination programs. To achieve these savings the market must create incentives that avoid the “tyranny of the visit”, and rapidly adapt to these innovative programs.