Controlling Volatility

Post Acute Trends and Their Implication for the Future Management of Costly and Medically Complex Cases

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Speakers:

Kevin Fleming, President, Paradigm Management Services

Dr. Gerben DeJong, Senior Fellow, National Rehabilitation Hospital

Dr. Nathan Cope, Chief Medical Officer, Paradigm Management Services

Welcome

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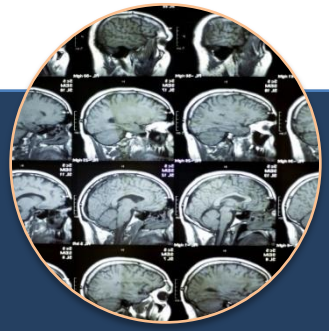
Kevin Fleming, President, Paradigm

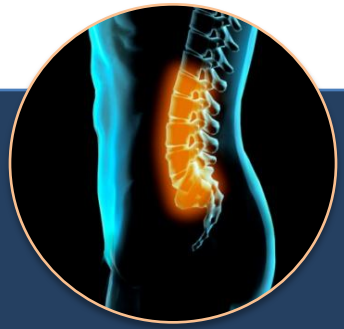
Thank you for joining us for our 2009 webinar series. Replays of past webinars are available for viewing at www.paradigmcorp.com/webinars.

Return to Work: Managing the Impossible



Managing Traumatic Brain Injuries

Taming Medical Cost Inflation



Spinal Cord Injuries: Planning for a Lifetime of Care and Expenses

Chronic Cases Causing Chronic Pain

Controlling Volatility

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First a few housekeeping points….

- Slides will advance automatically
- Question & Answer period at end
- You may submit questions at any time
  - Click the “Q&A” button in the upper right
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  - Ask All Panelists and be sure to click “Send”
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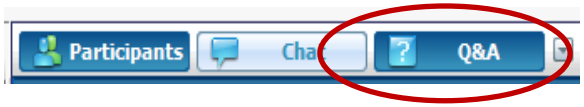

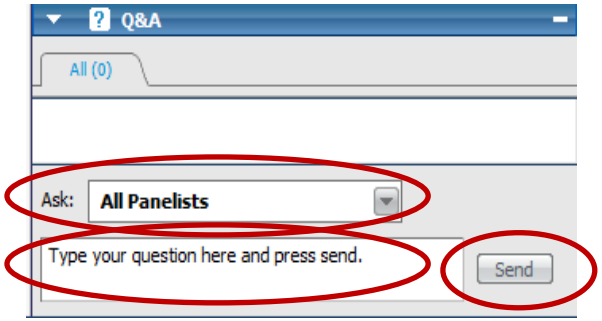

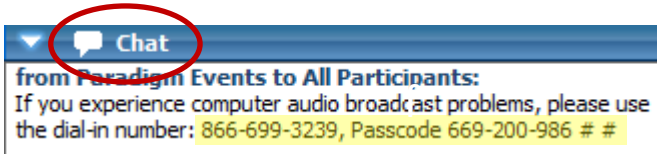

Alarming Rise of Medical Costs

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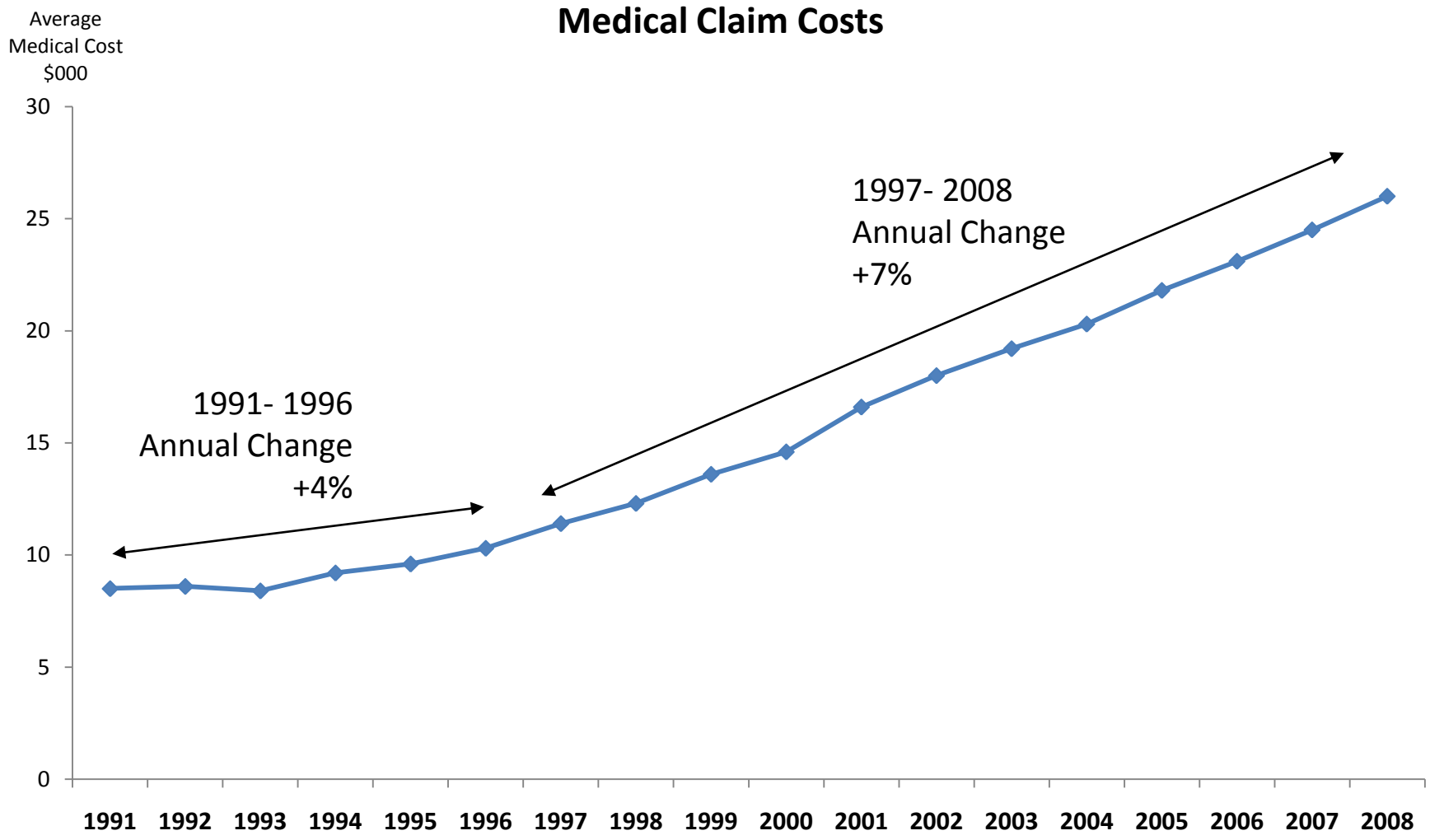
We all recognize the alarming rise of medical costs in Workers' Compensation.

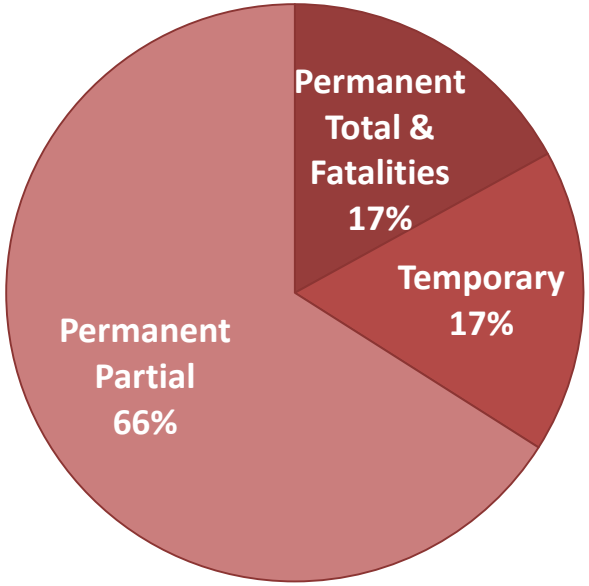


Source: NCCI; based on states where NCCI provides ratemaking services

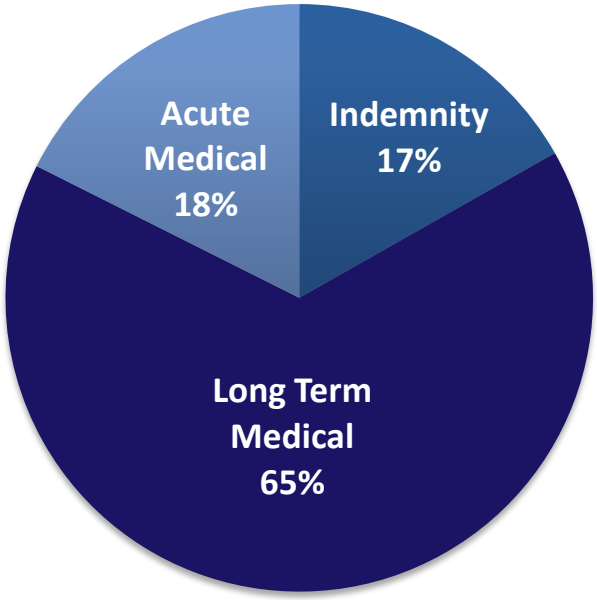
Major Cost Components

When we isolate the biggest components of those costs, we see that severe injuries with post-acute medical care account for a very large portion of the costs.

Distribution of WC Benefits Paid by Type of Disability



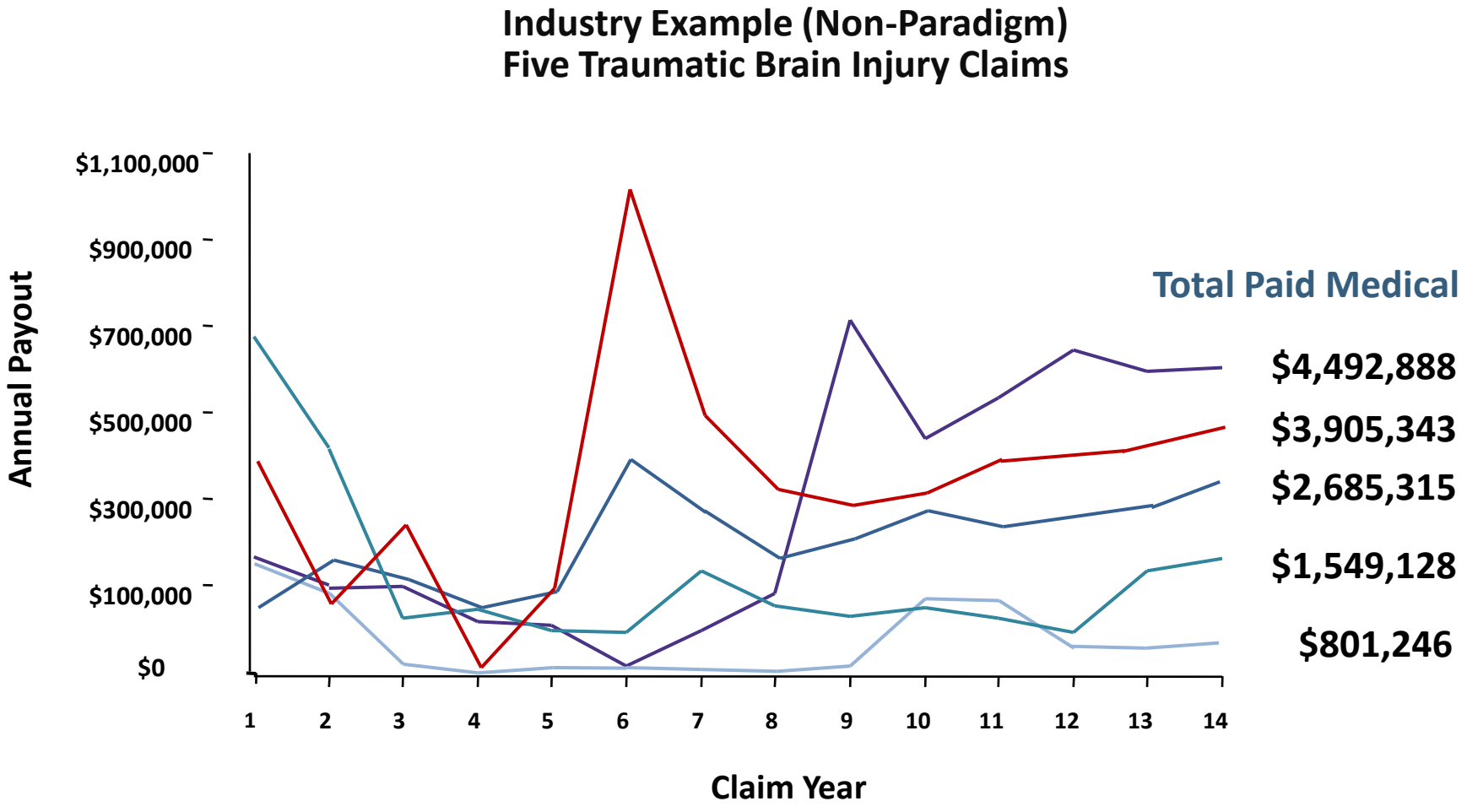
Industry-Wide Case-Related Catastrophic Claim Costs



Source: National Academy of Social Insurance (NASI) August 2009 –note cites: Cases classified as permanent partial include cases that are closed with lump sum settlements. Benefits paid in cases classified as permanent partial, permanent total and fatalities can include any temporary total disability benefits also paid in such cases. The data are from the first report from the NCCI *Annual Statistical Bulletin.* Source: *Annual Statistical Bulletin, NCCI 2008, Exhibits X and XII;* Industry-wide cost distribution Milliman, Inc. 2008

Post-Acute Volatility

One of the chief reasons for this is the severe volatility that takes place in this domain.



Source: Five traumatic brain injury claims from reinsurance data – claims received traditional medical management (i.e., not Paradigm medical management); numbers adjusted for inflation

Today's Topic

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Post-acute care is the most costly and volatile phase of care. Today we will look why it is so costly and what can be done about it.

35,000 ft View

Why costs are high, what is on the horizon relative to change

A view of integrated components that can significantly reduce the volatility and costs of post-acute care

Close Up & in Your Control

Guest Speaker: Dr. Gerben DeJong

PARADIGM®
Kevin Fleming, President, Paradigm

With us today is Dr. Gerben DeJong from the National Rehabilitation Hospital where he is a Senior Fellow providing leadership on issues shaping post-acute rehabilitation.

National Rehabilitation Hospital
MedStar Health

The Center for Post-Acute Studies

Dr. Gerben DeJong is the director of the Center for Post-acute Studies at the National Rehabilitation Hospital in Washington DC. Under his leadership the group provides national guidance on health policy issues shaping post-acute rehabilitation.

One-third of all patients discharged from acute care hospitals move on to post-acute care settings, including nearly all catastrophically injured workers.

Primary Post-Acute Care Settings

In-Patient (Hospital-Based) Rehab Facilities

Skilled Nursing Facilities

Long-term Care Hospitals

Home Health Agencies

Outpatient Facilities

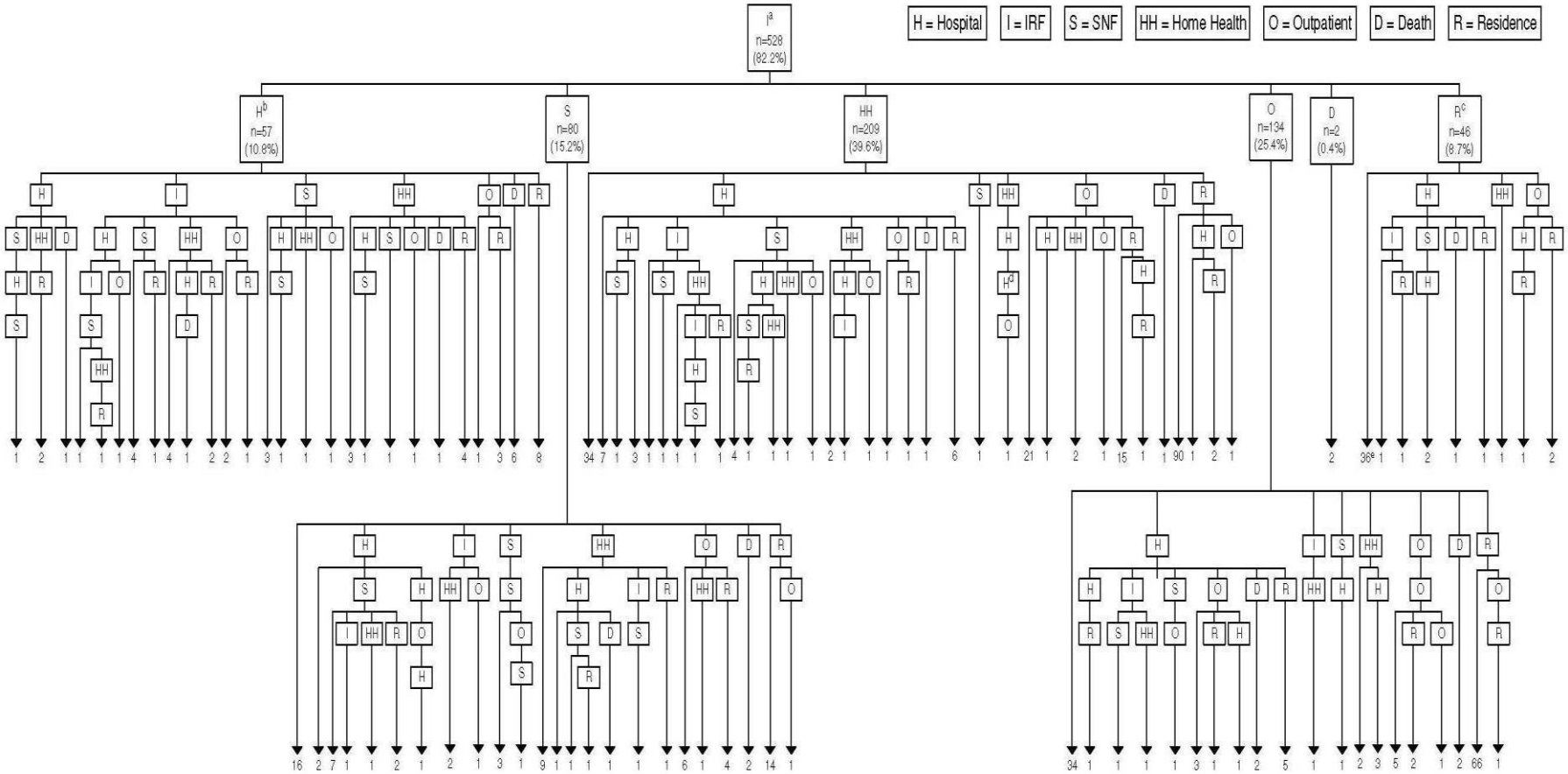
The post-acute payment system is a good example of how siloed the post-acute medical market has become.

Current Post-Acute Payment System

Feature	Skilled Nursing Facilities (SNF-PPS)	Inpatient Rehabilitation Facilities (IRF-PPS)	Long-term Care Hospitals (LTCH-PPS)	Home Health Agencies (HHA-PPS)
Unit basis	Per diem	Per case/ per hospitalization	Per Case/ per hospitalization	Per 60-day episode of care
Case-mix adjuster	Resource Utilization Groups III (RUGs III)	Function-related groups (FRGs) or case-mix groups (CMGs)	Diagnosis-related groups (DRGs) specific to LTCH patients	Home Health Resource Groups (HHRCs)
No. of case-mix groups	53	92 CMGs X 4 comorbidity subgroups/CMG = 368 groups	540	153
Input document/ information Source	Minimum Data Set (MDS)	Patient Assessment Instrument (IRF-PAI)	ICD-9-CM codes recorded on pt claims	Outcome & Assessment Information Set (OASIS)
Effective dates & phase-in period	1999 25% 2000 50% 2001 75% 2002 100%	Jan 2002 67% or 100% Oct 2002 100%	Oct 2002 20% Oct 2003 40% Oct 2004 60% Oct 2005 80% Oct 2006 100%	Oct 2000 100% (no phase-in period)

However, there is a great deal of variation in how patients move through the medical system.

Patterns of Post-acute Care for Stroke Survivors Following Discharge from Acute Hospital and Admission to IRF (n=528)



Source: U Colorado report to ASPE, 2006

The variation has led to a "hardening of the silos."

- Distinct historic traditions
- Distinct organizational and professional cultures
- Own patient assessment tool and clinical information system
- Own manuals, guidelines, staff training
- Own industry-based databases
- Own trade associations
- Each has made a sizable infrastructure investment associated with its payment systems

What Can Be Done

The costly nature of the system, difficulty coordinating care, and payment systems which lead to unnecessary utilization have all prompted reform discussions.

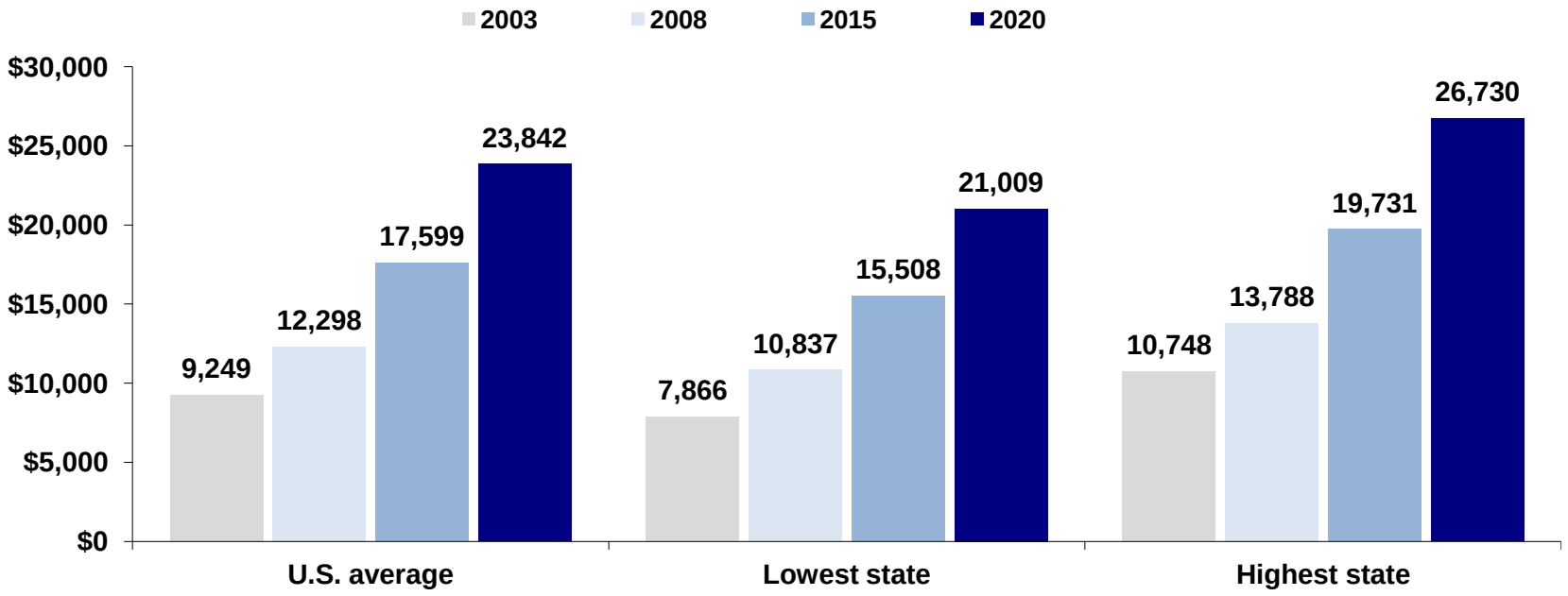
Common Reform "Buckets"

1. **Senate Finance Committee (S 1761)**
2. **Senate HELP Committee (S 1679)**
3. **House Tri-Committee (HR 3200)**
4. **House Democratic merged bill (HR 3962)**
5. **Senate Bill (HR 3590)**

Motivation for Health Care Reform

However, it is important to remember that reform is trying to solve for a multitude of issues at the same time.

- Uninsured—47 million at any one time
- "Market Failure" -- competition on risk and prestige
- Horrible inefficiencies in organization, delivery, and financing
- Expenditures increasing faster than CPI
- Premiums for family coverage causing consumer demand for change



[1] 2003: Lowest is North Dakota; highest is District of Columbia. 2008, 2015, and 2020: Lowest is Idaho; highest is Massachusetts.
Data sources: Medical Expenditure Panel Survey–Insurance Component (for 2003 and 2008 premiums); Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, national health expenditures per capita annual growth rate (for premium estimates for 2015 and 2020).

Bundling as an Answer

Bundling is being looked at as a way to achieve the cost savings needed to finance other parts of the health care reform agenda.

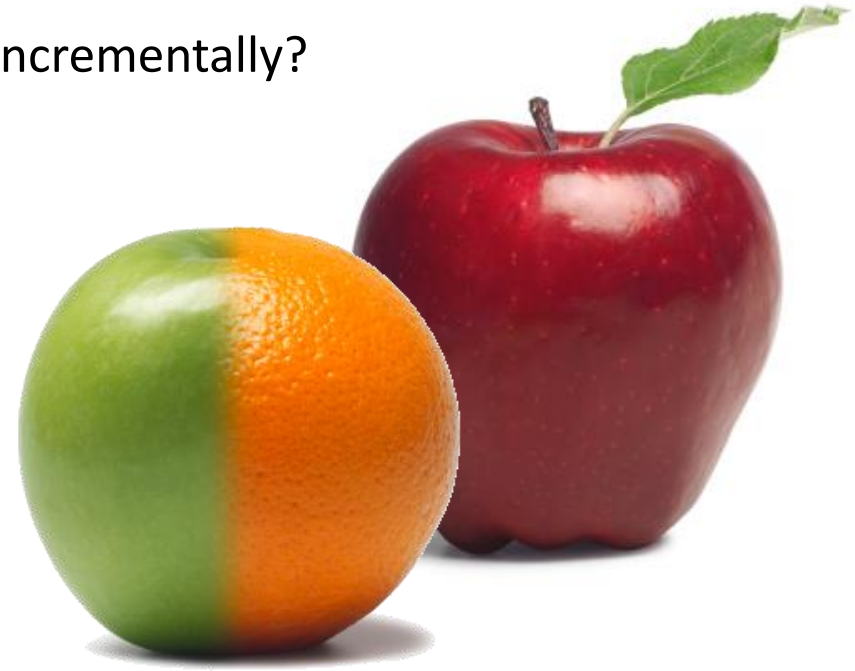
Bundling post-acute payment is the single largest issue for post-acute care providers. Bundling is . . . .

1. **Service bundle**
2. **Episode duration**
3. **Patient assessment method**
4. **Payment method**
5. **Bundler or accountable entity**
6. **Risk or case-mix adjustment method**
7. **Quality and outcome metrics**

- Feature of nearly every health care reform proposal in the 111th Congress
- Initially perceived as a fairly simple and straightforward solution that would quickly lead to cost savings
- Anything but simple – and getting it right is critical

There are a number of ways that services can be bundled.

- Post-acute only
- Acute + post-acute
- Acute + physician
- Acute + physician + post-acute
- Should these be bundled in stages? Incrementally?



Building Block 4—Payment method

Relative to bundling of payments, there are two distinct approaches.

More 'static' approach

- Builds on current payment systems—starting with what we have
- More certainty, more predictable, less risk

More 'dynamic' approach

- Example, providers bid on patients and go at risk for both price and outcome
- Less certainty, more disruptive

Other key elements

- Pay for performance (P4P)
- Some payment based on outcome
- Mitigate stinting

Building Block 5—Accountable entity

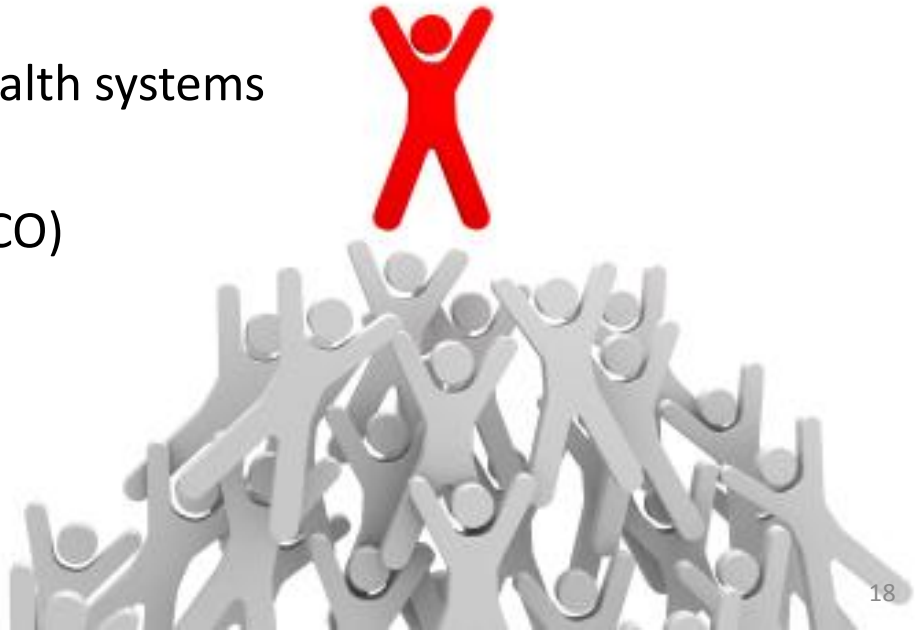
In looking for an accountable entity, a few candidates rise to the forefront.

Acute care hospital

- Worries post-acute providers
- As downstream providers, post-acute providers fear they will be short-changed

Other Accountable Candidates

- A post-acute provider network
- Loosely affiliated
- Subsidiaries of a larger integrated health systems
- Joint ventures
- An accountable care organization (ACO)
- Existing companies that diversify their portfolios



Building Block 6—Risk/case-mix adjustment

In order to ensure the right incentives in the payment structure, provisions must be made relative to the patient's risk variables.

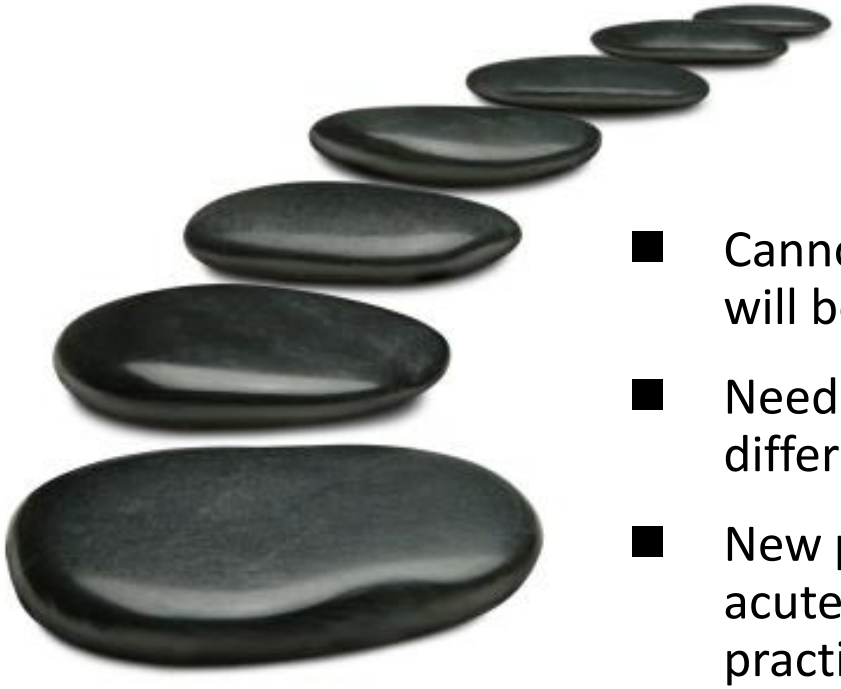
- Needed to create a level playing field:
  - Need to risk adjust payment based on how patients present at time of admission to post-acute care
  - Need to case-mix adjust outcome measures

Likewise, we need an appropriate mechanism for measuring quality.

- Criteria (A Jette)
  - Relevant to diversity of patients and health conditions
  - Adequate validity and reliability
  - Measurement precision at all levels of functionality
  - Feasible in a busy clinical setting
- Focus on outcome measures, not process measures
- Common language ➜ common culture across providers, health plans
  - "A common language is extremely powerful in shaping organizational culture and behavior" (Reg Warren, SeniorMetrix)
- Outcome metrics important to pay for performance (P4P)

Bundling—Going Forward

The components of bundling provide a pathway for addressing costs and volatility in today's health care system, but achieving the right solution will take time.

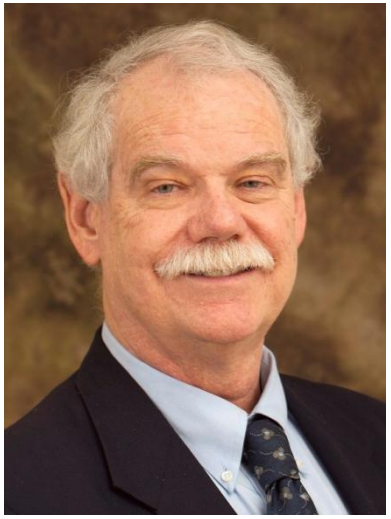


- Cannot get to bundling in a single bound; it will be an incremental process
- Need a period to experiment and test different models
- New payment systems should encourage a post-acute culture that emphasizes innovation and best practice rather than a culture of compliance
- Congress should not over legislate until we learn more

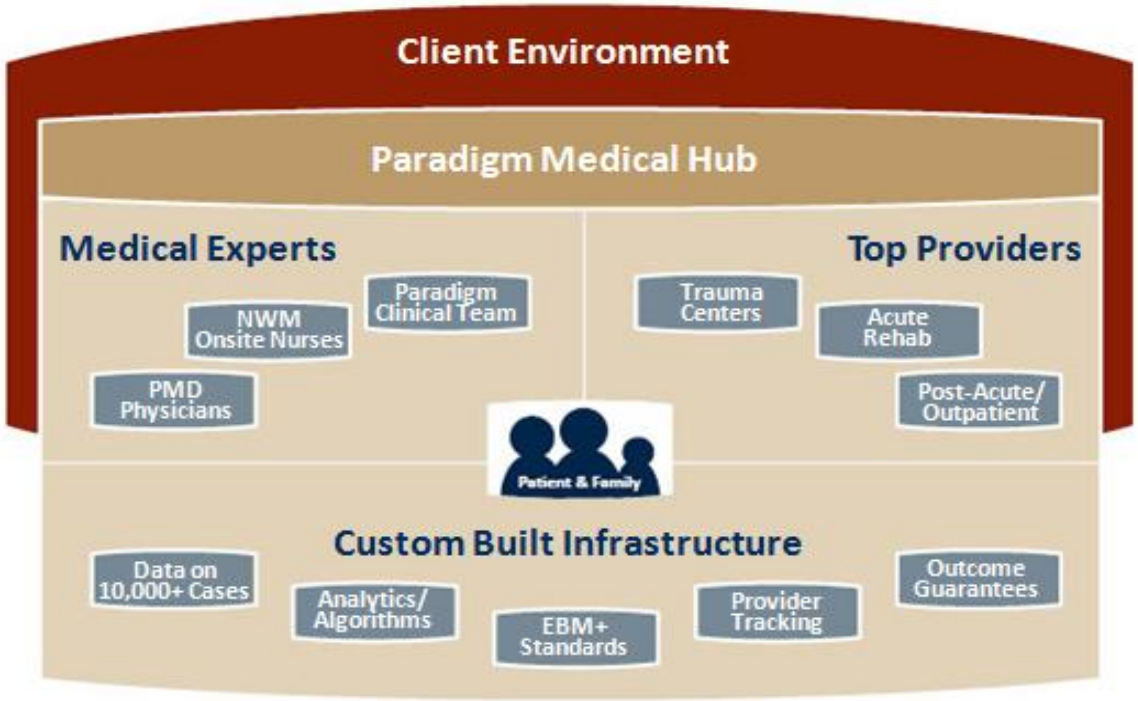
Fundamentally, the shift that needs to occur is a focus on outcome and price.

Living the Experiment

Recently recognized as Risk Innovator of the Year by Business Insurance magazine, Paradigm's Chief Medical Officer Dr. Nathan Cope conceived of a bundled system nearly 20 years ago.



Paradigm's Systematic Care Management SM



Bundling in Action

Dr. Nathan Cope, Chief Medical Officer, Paradigm

Systematic Care Management℠ ties together the acute and post-acute services needed to bring a patient to the best medical outcome attainable.

1. **Service bundle –** all in: acute + post acute + physician
2. **Episode duration –** as long as it takes to reach the best medical outcome

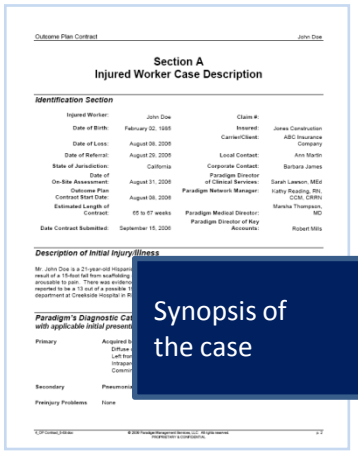
Bundling in Action

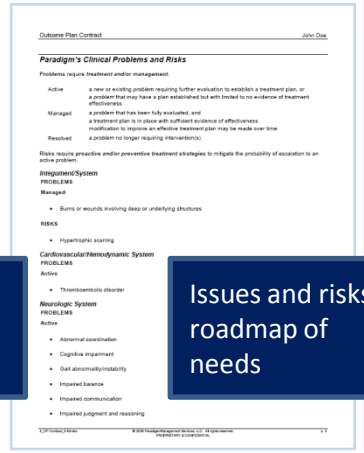
PARADIGM®

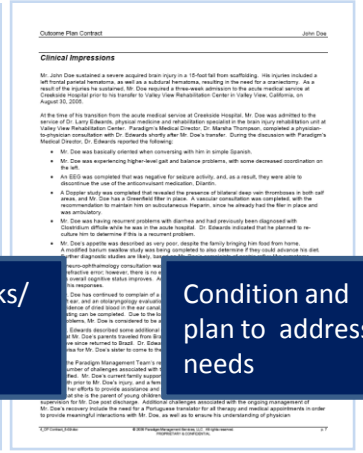
Dr. Nathan Cope, Chief Medical Officer, Paradigm

The method of assessing the patient is very involved and includes a thorough review of all aspects of the patient's condition.

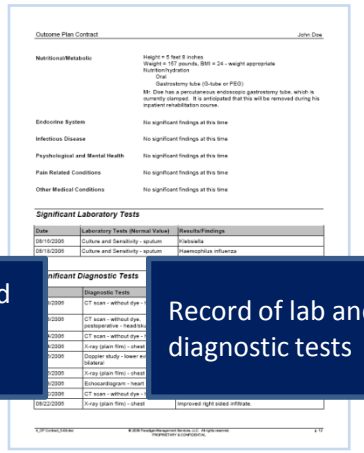
3. Patient assessment method – doctor, onsite nurse, intense data collection


Synopsis of the case

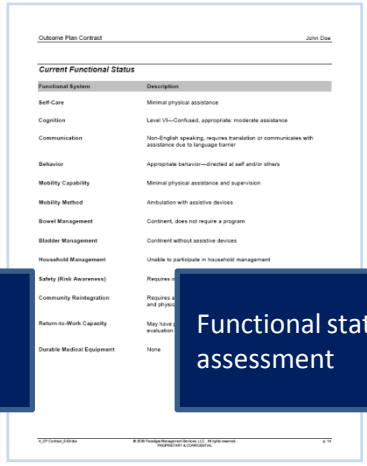

Issues and risks/ roadmap of needs

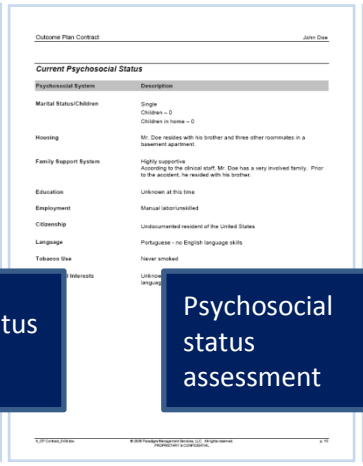

Condition and plan to address needs

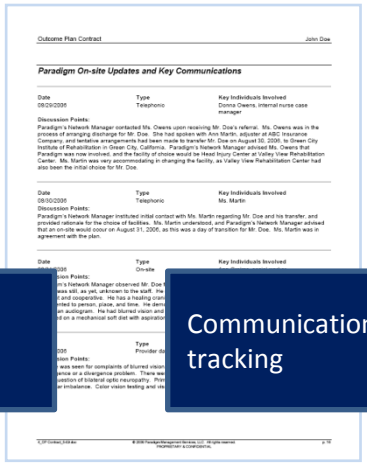

Injury detail and past medical history

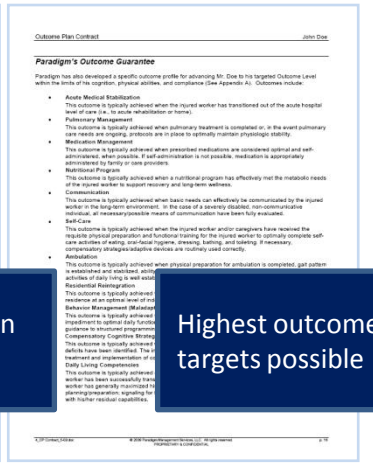

Record of lab and diagnostic tests


Details on surgeries and medications


Functional status assessment


Psychosocial status assessment


Communication tracking


Highest outcome targets possible

Bundling in Action

PARADIGM®
Dr. Nathan Cope, Chief Medical Officer, Paradigm

Paradigm is paid for delivering outcomes.

4. **Payment method –** pay for performance
5. **Bundler or accountable entity –** Paradigm Management Services
6. **Risk or case-mix adjustment method –** multi-variable data modeling

collect data

- Assignment variables from Paradigm Medical Director
- 500+ variables
  - Demographic
  - Procedural
  - Complications
  - Psychological
  - Financial
  - Etc.

target outcome level

The target outcome level is the best outcome that can be foreseen for the injured worker at the injury outset

- 0 **Physiologic Instability**
- I **Physiologic Stability**
- II **Physiologic Maintenance**
- III **Residential Integration**
- IV **Community Integration**
- V **Capacity for Return to Work**

run through proprietary algorithms

Weighted variable formula derived from Paradigm's nearly 20 years of practice

determine clinical complexity

The Clinical Complexity Indicator reflects the anticipated resource consumption (cost) required to take an injured worker to a designated Paradigm Outcome Level

- 1 **Minimal Treatment**
- 2 **Routine Treatment**
- 3 **Low-Intensity Treatment**
- 4 **High-Intensity Treatment**
- 5 **Severe**
- 6 **Extremely Severe**

Example of Paradigm Typology/ Nomenclature

- SCI **Major Diagnostic Category**
- 5 **Clinical Complexity Indicator**
- 0 **Initial Outcome Level**
- V **Targeted Outcome Level**

Finally, it is critical to ensure that the right outcomes are reached.

7. Quality and outcome metrics – clearly defined and functional in nature

Functional Outcome Examples:

- Acute Medical Stabilization – transition out of the acute hospital level of care
- Pulmonary Management –establishment of protocols to maintain physiologic stability
- Musculoskeletal and Orthopedic Trauma Management – formal therapy completed followed by transition to maintenance level care
- Wound Management – primary wounds are healed, plan in place to address chronic wounds
- Skin Maintenance and Protection – breakdowns healed and a plan in place to maintain current skin integrity
- Pain Management – acute pain resolved and long-term plan for chronic pain established
- Medication Management – ongoing medication plan (medications and plan for self/family administration)
- Bladder Management – return of routine bladder function and/or bladder management protocol implemented
- Bowel Management – return of routine bowel function and/or bowel management protocol implemented
- Nutritional Program –the appropriate nutritional program established which is able to meet the metabolic needs
- Communication – an effective system of communication has been established or all necessary/possible means of communication have been fully evaluated
- Self-Care – requisite physical preparation and functional training for the injured worker and/or care to complete self-care activities
- Wheelchair Mobility – definitive equipment has been provided, training has been completed, and functional use in residential and community environments has been successfully demonstrated
- Transfers – injured worker can perform transfers to/from the applicable surfaces necessary for engaging in routine activities of daily living at an acceptable level of independence

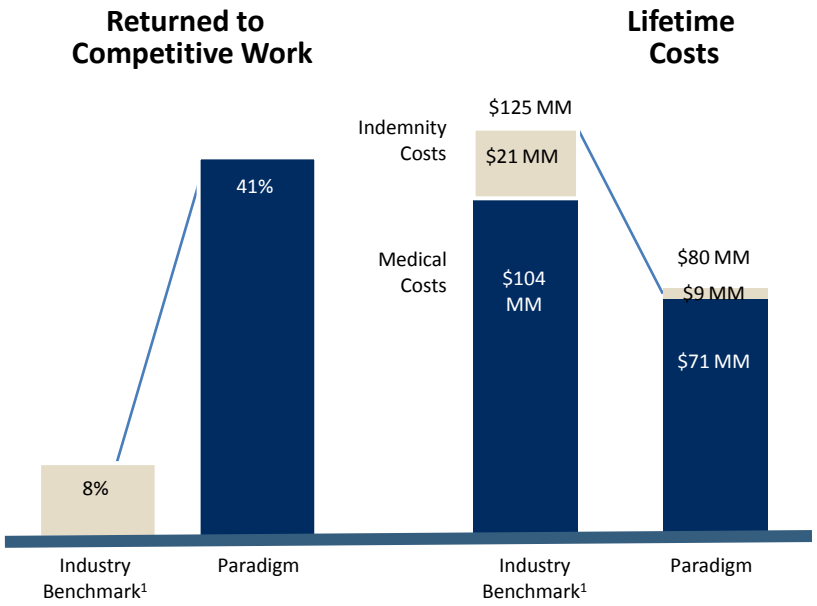
Medical and Financial Results

Dr. Nathan Cope, Chief Medical Officer, Paradigm

Our bundled system achieves better medical outcomes and lower costs.

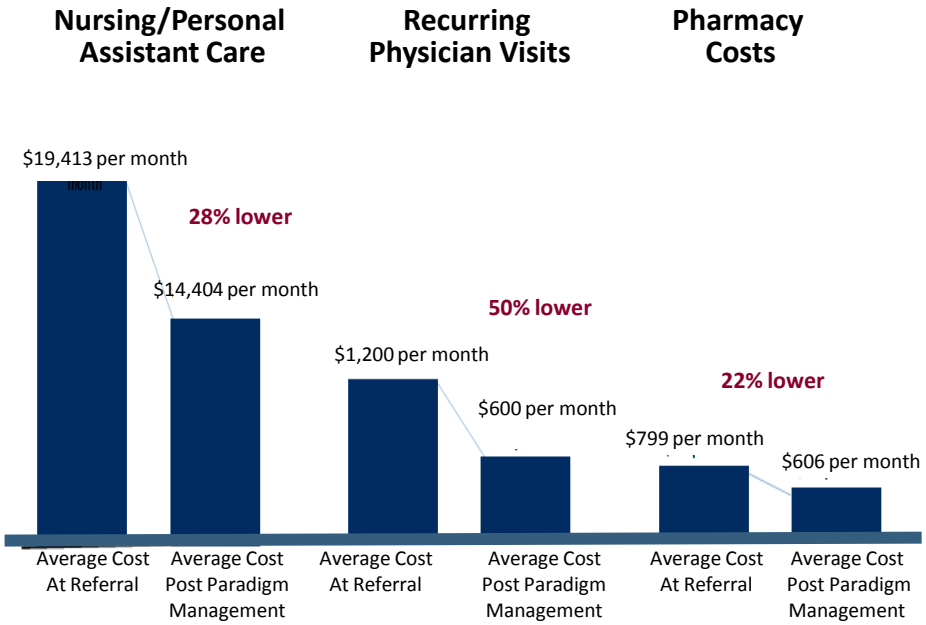
Catastrophic Management Results

5x Better Medical Outcomes **36% Cost Savings**



Complex Large Loss Results

29% lower lifetime reserves



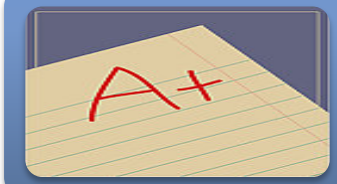
Source: Based on a an independent comparison by Milliman, Inc, the nation's leading actuarial and consulting firm, to their proprietary database of similar Workers' Compensation claims; Return to Work classification based on attending physician's judgment (not Paradigm's); Complex Large Loss cases are defined as at least three months post injury. The large loss cases on which this data is based were new cases that had not been managed by Paradigm during the acute phase of injury. Lifetime savings calculated for a 50 year life span from date of injury.

Summary

We hope you will join us for future webinars, and leave knowing the following.

Post-acute care is the most costly phase of care

The future will likely bring new models



Workers comp may be leading the way

PARADIGM®

Paradigm has successfully proven the value of the “new” models during the past 20 years

Questions

Question and Answer Session

Please submit your questions for our panelists in the Q&A window on the right.

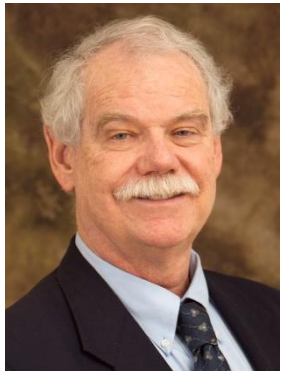
Today's speakers:

Kevin Fleming

President
Paradigm Management Services

Dr. Gerben DeJong

Senior Fellow
National Rehabilitation Hospital



Dr. Nathan Cope
Chief Medical Officer
Paradigm Management Services

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