



Innovations in Hospital Relationships

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Cornerstone Health Care



Mission:

To be your medical home

Vision:

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

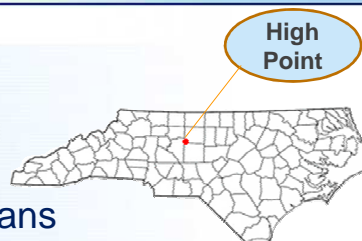
Values:

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

Who were we?

1995

- 221 employees
- 16 locations
- 8 specialties
- 42 shareholder physicians
- 2 mid-levels
- All on staff at High Point Regional Hospital
- Total net revenue: \$16M



Who are we now?

2011

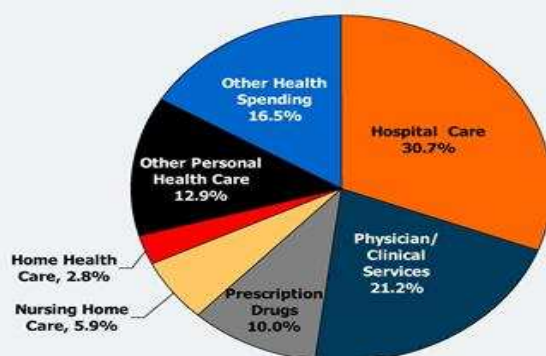
- 1,441 employees
- 192 physicians
- 75 locations
- 38 specialties
- 155 shareholder physicians
- 133 mid-levels
- Total net revenue: \$175,000,000
- 26th largest major employer in the Triad
- 6th largest employer in High Point
- Our physicians practice in 38 separate specialties in 75 locations and on staff at 8 different hospitals and 5 health systems
- Selected by The Business Journal as the fifth fastest growing company in the "Fast Fifty" in the Triad
- One of the fastest growing physician owned companies in the Southeast.

THE BUSINESS JOURNAL
SERVING THE GREATER TRIAD AREA

FAST **50**

The majority of health care costs are in physician and hospital services

Distribution of National Health Expenditures, by Type of Service, 2008



Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2008; file nhe2008.zip).



Market Context

- Health care cost and utilization trends are unsustainable
- Unexplained variation in practice accounts for 25% of total Medicare expenditures (Dartmouth-Atlas)

Market Context

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



Market Context

Value based health care necessitates a transformative shift in the clinical and business model

Absent change, all participants, should expect declining reimbursement

Physicians that are able to provide value (high quality at a low cost) will be successful

Physicians have traditionally been risk adverse

When Physicians Want Risk



Physicians Have Traditionally Been Risk Adverse Due To

- Minimal business training
- Competition from hospitals subsidized through the not-for-profit bond market
- Prolonged years of training necessitating a quicker return on investment
- High levels of personal indebtedness and low levels of savings

Innovation Changes How Services are Delivered



Clinical Integration: What Can You Offer

- Focus
 - Gap Assessments
 - Improvements
 - Quality
 - Outcomes
 - Cost control

Clinical Integration: What Can You Offer

- Competitive Differentiation (Secret Sauce)
 - What can you do to help the hospital be more competitive
 - NC has an estimated 20% excess of hospital beds
 - Establish goals related to quality, cost and outcomes
 - Create an experience that “compels” to other service lines

Clinical Integration: What Can You Offer

- Replicability
 - Make agreements and structure that are easily replicated to reduce variation and expense
- Scalability
 - Different specialties
 - Different organizations

Clinical Integration: What Can You Offer

- Clinical Transformation
 - Execute the plan
 - Grab the low hanging fruit
 - Move to team based approach with hospital
 - Catalyst to value based systems

Clinical Integration

Short Term Goals

- Align the goals of practice and hospitals
- Improve the quality and efficiency of patient care
- Improve profitability of mission critical service lines and practices

Long Term Goals

- Create service lines that are regionally recognized as the preferred destination for patients in the region
- Create a sustainable model that will meet the health care needs of the population of patients in the community



- ## Types of Agreements in Cornerstone Clinical Integration
- Assets Purchased
 - Nuclear
 - Echo
 - ETT
 - Employee Lease
 - Reception
 - Techs
 - Nurses
 - Pre-Cert

Agreements Continued. . .

- Facility Lease
 - Space used for testing
 - Reception space

- Cardiovascular Services Co-Management
 - Members
 - 3 Hospital
 - 3 Cardiologists

Agreements Continued. . .

- Responsibilities
 - Prepare budget
 - Develop operational plan
 - Personnel
 - Equipment
 - Supplies
 - Marketing
 - New services

Agreements Continued...

- Seven Task Force Subcommittees
 - Non-invasive Cardiology
 - Cath lab
 - Chest pain clinic
 - CCU and Coronary Observation Unit
 - Telemetry and Congestive Heart Failure
 - Outreach

Risk vs. Fixed

- 50/50 fixed vs. risk through first contract term
- Risk portion is to increase to 90%

Risk vs. Fixed

- Begin where you are today
 - Determine appropriate metrics
 - Ongoing review/adjustment
 - Set new metric once target is achieved and revisit as needed
 - Metrics must be:
 - Reasonable
 - Achievable
 - Verifiable

Problems. . .

- Number of committees proposed by hospital
- Unrealistic metrics at beginning
 - Too many
 - Not enough
 - Unrealistic targets

Problems. . .

- Initial decline in cash flow if risk portion is too high
- Time constraint on physicians
- Proper valuation

Problems. . .

- Legal representation that does not understand the process or valuation method
- Trust by both parties
- Hold back % by hospital on risk portion

Clinical Integration Results

Performance Metrics	Measurement	Target set at Contracting	Hospital Jan-Mar 2011 Performance*	Hospital Apr-Jun 2011 Performance*	Comments	
Clinical Outcome Metrics						
Patients with Systolic Heart Failure:						
<small>Systolic heart failure definition (ICD-9 Codes 428.20, 428.21, 428.22, 428.23)</small>						
1	LV Function Assessed- Cardiology Attending only	% of Patients	> 80%	100%	100%	HPM Core Measures
	Patients Given ACE inhibitor or ARB at discharge	% of Patients	> 80%	100%	100%	HPM Core Measures
	Received beta blockers	% of Patients	> 80%	96.6% (112/116)	99.1% (221/223)	Chart Review/HF Database
	Utilizing HPRHS standing orders - for Systolic Heart Failure- Cardiology Attending only	% of Patients	≥ 80%	23.3% (27/116)	23.3% (52/223)	Orders New March 14, 2011 - granted phase in
	Readmissions within 30 days for Systolic Heart Failure - Cardiology Attending only	% of Patients	< 10%	7.8% (5)	Calc. after Aug 15	HPM/Premier - granted phase in
2	Patients with Atrial Fibrillation receiving thromboembolic risk assessment (CHA2DS score)	% of Patients	> 50%	51.5% (51/99)	62.8% (59/94)	Chart Review/HPM
3	Patient discharged on a statin drug after acute MI (STEMI), unless contraindicated (does not include transfers)	% of Patients	≥ 95%	100% (25/25)	100% (27/27)	Chart Review/Discharge Summary
Complications and Patient Safety metrics						
1	TIMI(Thrombosis in Myocardial Infarction) major bleeding (hemoglobin drop of >5g/dL with or without an identified site) post Cath Lab Procedure	% of patients	< 3%	0.2% (1/444)	0% (0/459)	HPM- possibly look for transfusion post Cath or Other labs
2	Risk Assessment for patients admitted with chest pain	% of patients	> 50%	65.2% (182/279)	72.9% (234/321)	Chart Review/MIDAS/HPM
3	Post-PCI Death In Hospital (PCI Mortality)	% of patients	< 2%	0.6% (1/179)	0.6% (1/178)	HPM/Premier
Process and Efficiency Metrics						
1	Door to Balloon time for STEMI patients undergoing PCI	> 50% of cases	< 60 Min	100% (49 min)	Dr. Daniel to email	Cath Lab: Median 028 Time
2	Median Time for MD to be present in lab for nonemergent procedures	Minutes	< 10 minutes	2 minutes	0 minutes	Cath Lab: Median Time in minutes
3	Average # of stents per coronary lesion treated	Stents per Case	1.3	1.04	1.08	Cath Lab: Average stents per lesion
Satisfaction Metrics						
1	Cath Lab patient satisfaction percentile score IP or OP?? HCAHPS or AII -Current Measure is HCAHPS Top Box %	Press Ganey Rank Bed size/AAA region 3	80%	Not evaluated	Not evaluated	
2	Cath Lab staff satisfaction-Physicians respect staff	Staff Survey	90%	Not evaluated	Not evaluated	

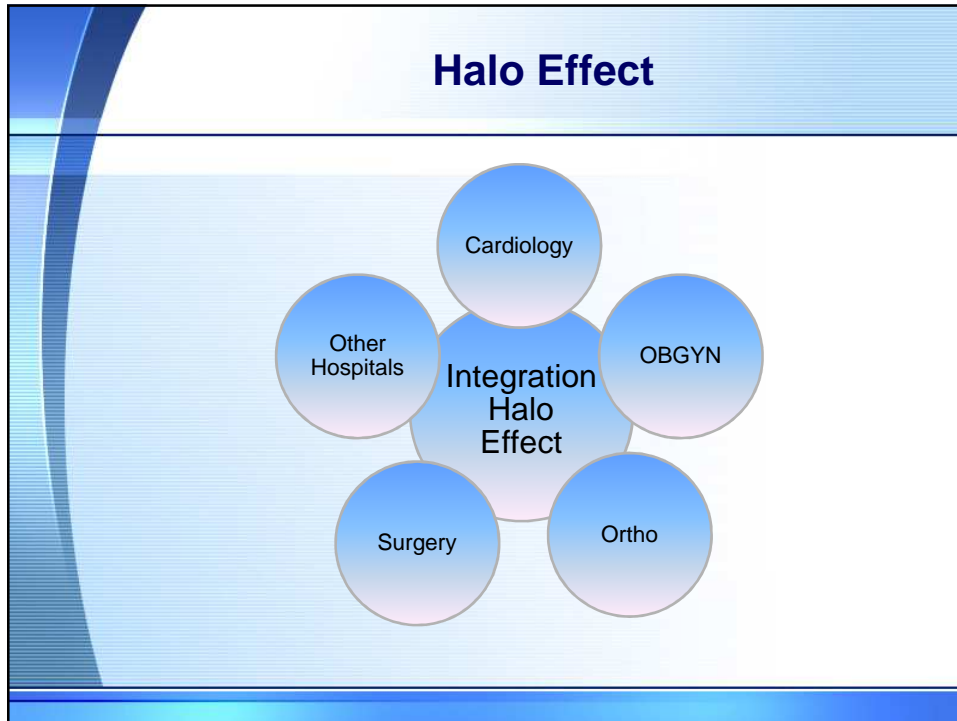
Complete the Cycle

Is there a better way?

What are we doing?

Is it accomplishing what it should?

Why are we doing it?



CORNERSTONE
YOUR MEDICAL HOME *health care*

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