Care Redesign: Budgeted Episodes for Total Knee Replacement

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October 13, 2011

Agenda

CaroMont Health's Path to Accountable Care

Care Redesign

Lessons Learned

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CaroMont Health System Overview

CaroMont Health System

- Gaston Memorial Hospital, with 435 beds
- Courtland Terrace, a 96-bed skilled nursing community
- Gaston Hospice, includes the inpatient 12-bed
- Robin Johnson House
- CaroMont Medical Group, an extensive network of physician practices in 5 counties and 2 states with:
  - Nearly 200 employed physicians
  - 3,800 employees
  - Self-insured health plan

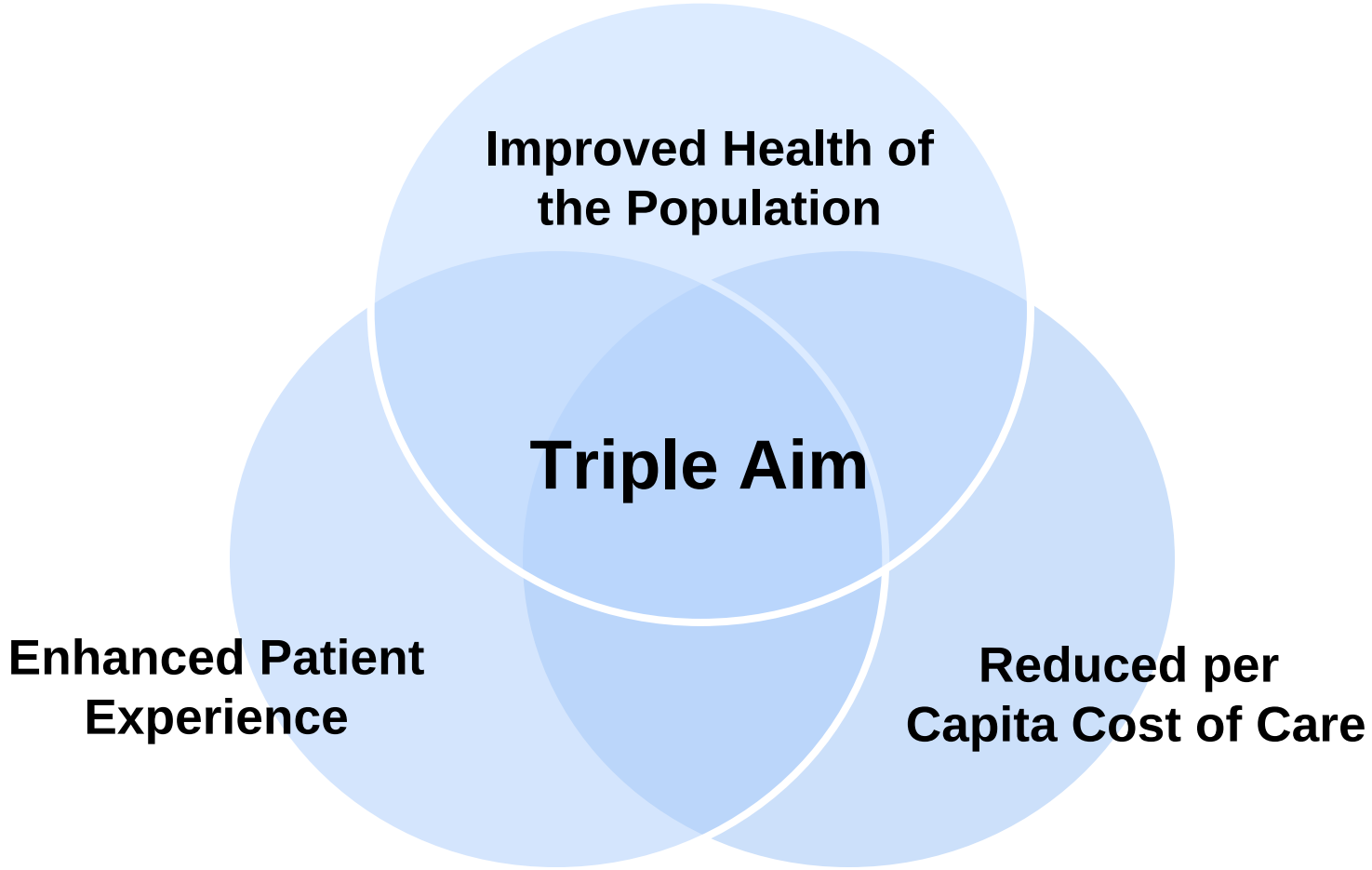
Vision

To be a nationally recognized leader and valued partner in promoting individual health and vibrant communities.

Mission

To provide exceptional health care to the communities we serve

CaroMont's Transformation From Hospital- to Community-Centric Care



Bundled Knee Goals and Objectives

Develop a bundled payment program for primary total knee replacement to:

- Develop core competencies to implement community-wide Triple Aim
- Lay the framework for larger accountable care organization development
- Build the foundation for future performance-based product opportunities

Knee Replacement Episode

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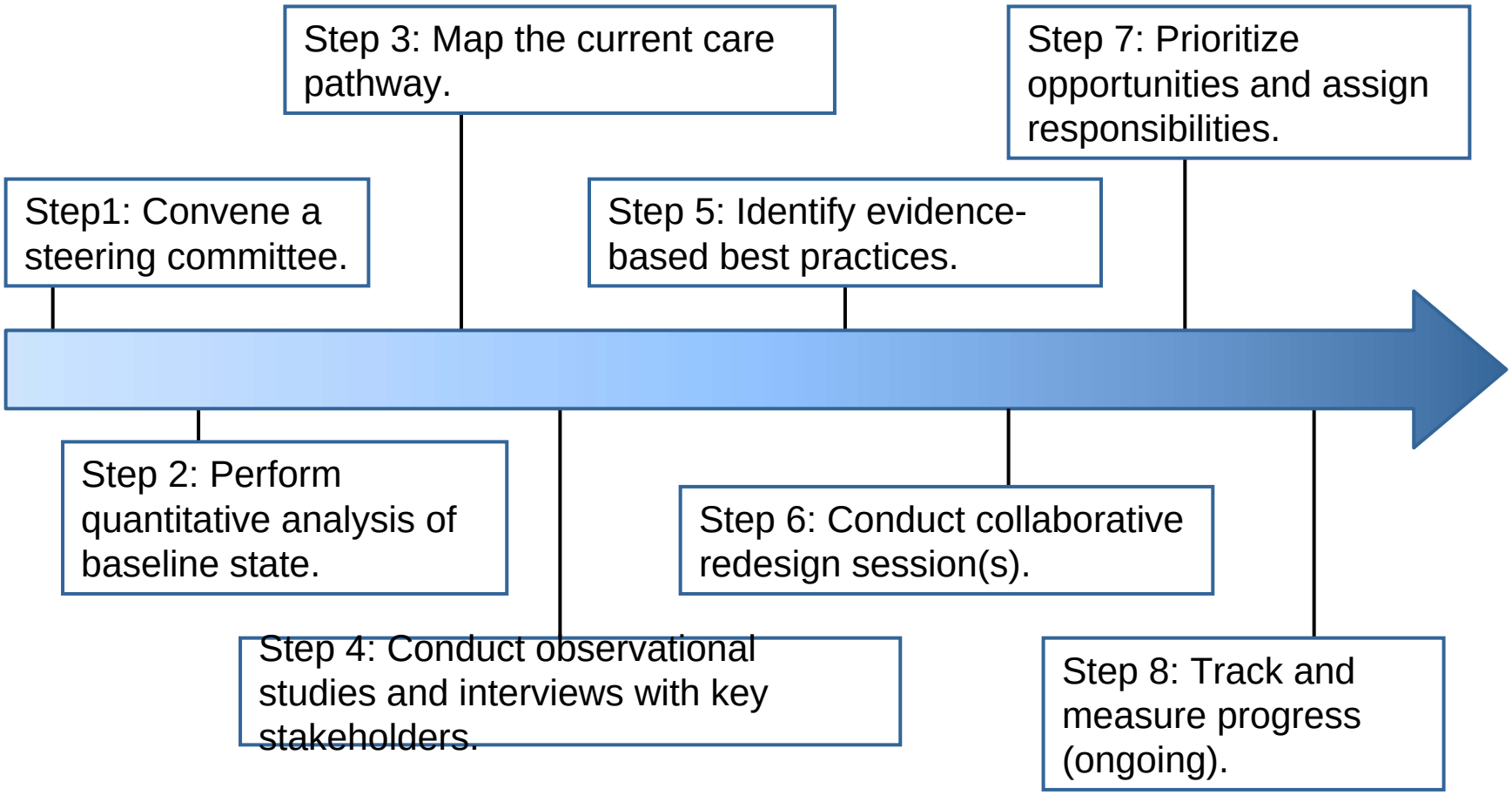
Key Steps and Milestones for Care Redesign



Step 1: Convene a Steering Committee

- Should include representation from:
  - Clinical staff
  - Decision support
  - Quality improvement
  - Administrative leadership
  - Legal counsel
- Provide education and develop buy-in.
  - Clear goals
  - What's in it for the patient, family, physicians, facility, etc

Step 2: Perform Quantitative Analysis of Baseline State

- Look for unwarranted variation and “outliers” in episode cost and/or quality measures.
- Conduct chart audits where questions arise.
- What are the common characteristics and other diagnoses?
  - Eg, BMI>40, drug/alcohol abuse, sleep apnea, diabetes, hypercoagulable state
- Can high-risk patients be screened for and given additional support?

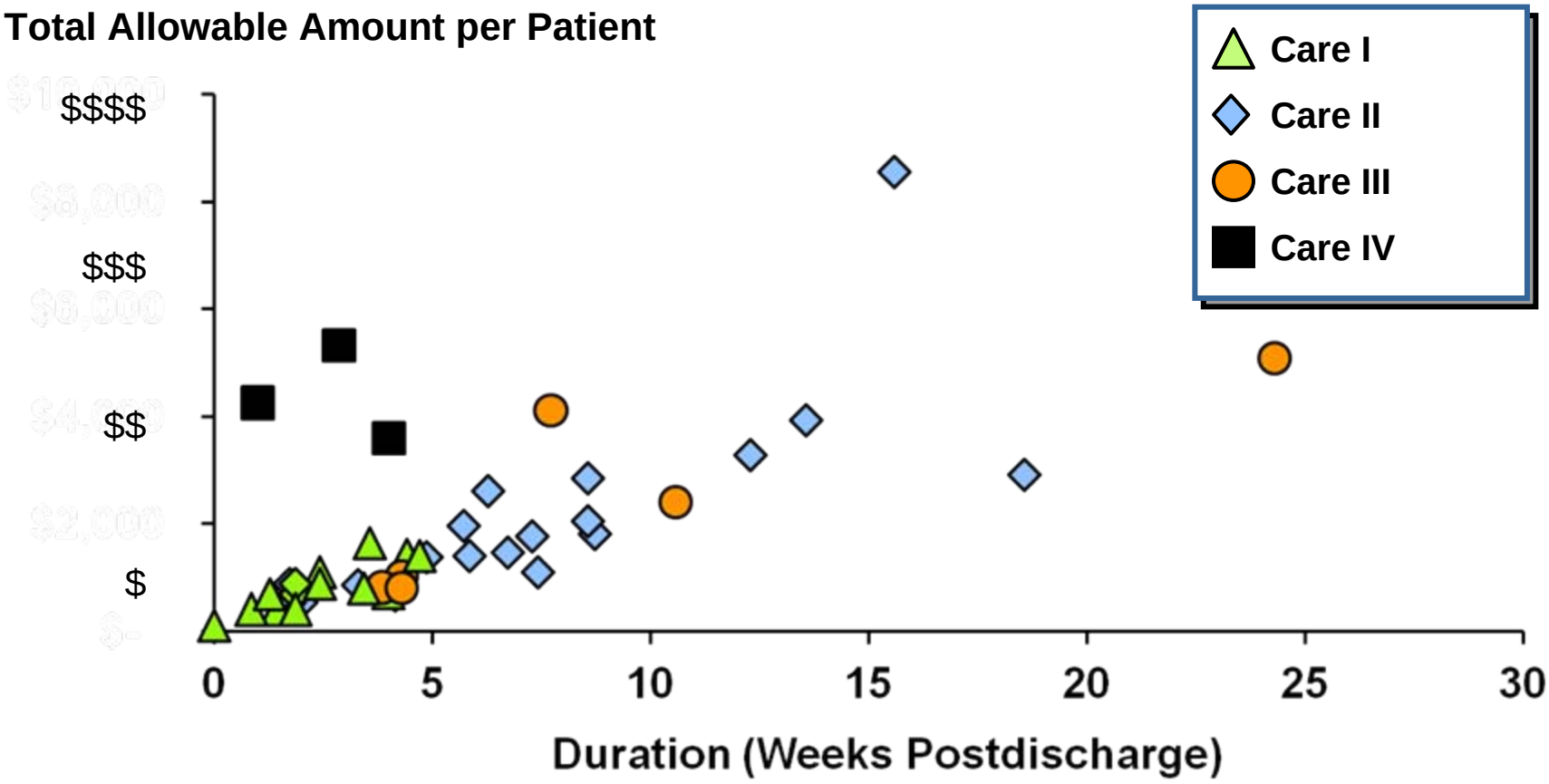
BMI = body mass index.

Cost Outliers Emphasize Importance of Optimization and Selection

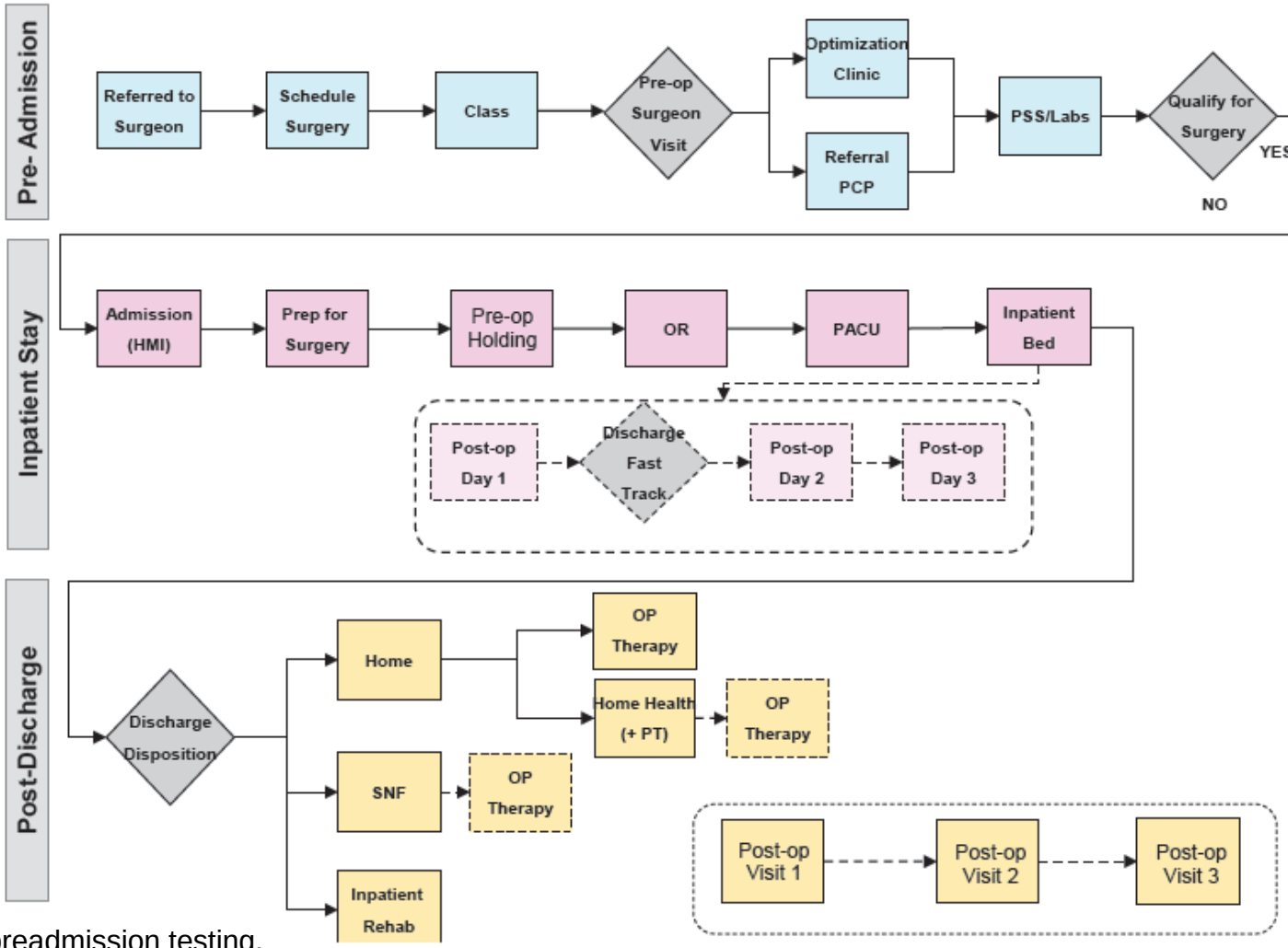
Patient #	Cost Driver	Other Diagnoses
1	Hospital Stay	BMI >40, COPD, Drug Abuse, Chronic Airway Obstruction, Cardiac Arrest, Sleep Apnea, Posttraumatic Respiratory Insufficiency
2	OP PT	Osteoarthritis, Pain in Joint
3	HH, OP PT	Asthma, Hypertension, Hyperlipidemia, Post-hemorrhagic Anemia, Pneumonia
4	ED Visit for Hemorrhage	Diabetes, Hypertension, Primary Hypercoagulable State, Long-Term Use of Anticoagulant, Post-Hemorrhagic Anemia
5	Hospital Services for Gastritis, Colonic Polyps, Melena	Long-term Antiplatelet Use, Anemia
6	Hospital Stay, Readmission for VTE	Diabetes, Hypertension, Atrial Fibrillation, Drug-Induced Delirium, Hypercholesterol

Variation in Post-Discharge Care Was Identified as a Key Opportunity

Post-Discharge Rehabilitation Costs/Duration per Patient



Step 3: Map the Current Care Pathway



PAT = preadmission testing.

Step 4: Conduct Observational Studies and Interviews With Key Stakeholders

- Use data to inform your line of questioning.
- Conduct observational exercises.
- Move beyond the hospital's walls.

Key Findings

- Expectations and education are critical to overall patient satisfaction.
- Optimization clinic is not consistently utilized.
- Earlier mobilization, discharge and rehabilitation may be possible, but post-op nausea and fatigue may be impediments.
- Socioeconomic barriers may prevent more patients from being discharged directly to home.

Step 5: Identify Evidence-Based Best Practices

Step 6: Conduct Collaborative Redesign Session(s)

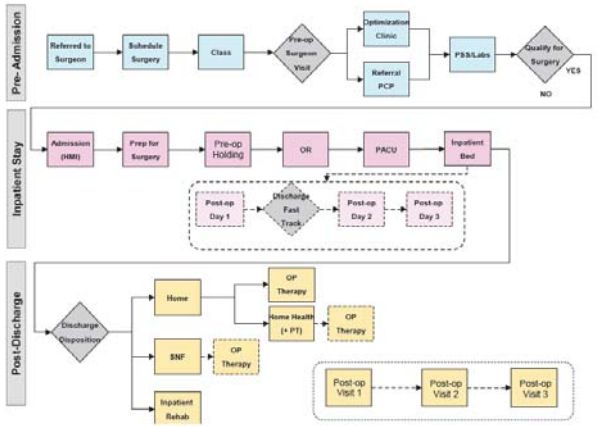
"Ground Rules" for Collaborative Redesign

- There is no standard model for the idealized bundled care pathway; we are dependent on your input, clinical insight and judgment as to what constitutes the optimal provision of care.
- Today's exercise is about brainstorming outside the box and creating a comparative ranking of the opportunities.
- The only "bad idea" is the one that you keep to yourself and are afraid to share with the group.
- Respect others' contributions and hear them out first, even if you initially disagree with their point of view.
- Forthcoming sessions will address: a) resourcing, b) timing, c) governance, d) accountability and incentives and e) continued performance management to established metrics.

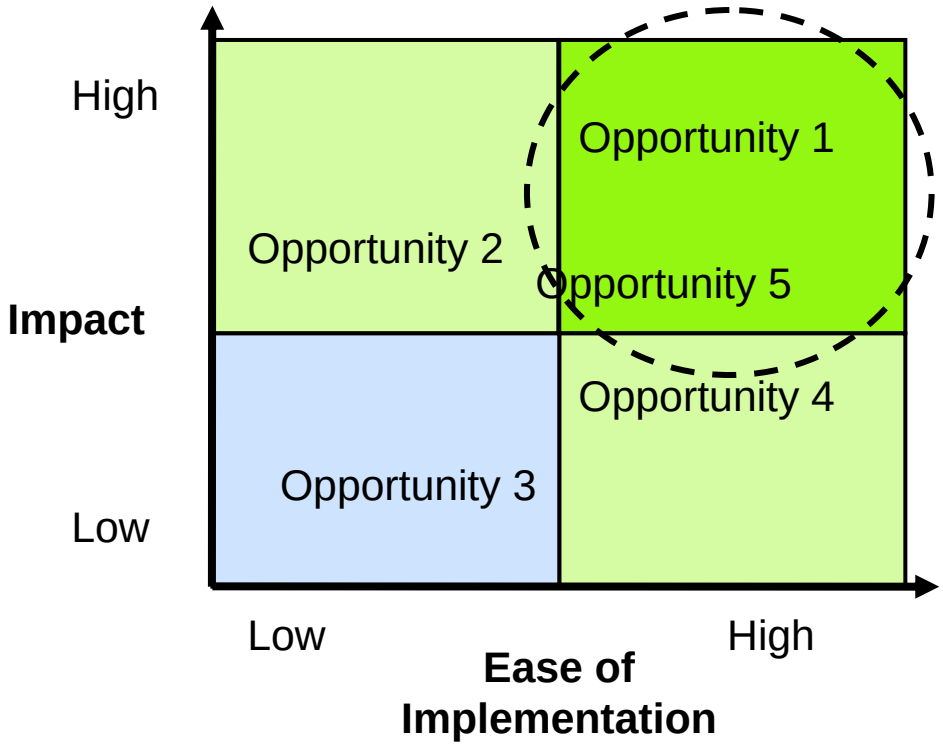
Five Improvement Initiatives Were Identified

1. Patient Engagement and Patient Contract
2. Risk Screening and Optimization
3. Acceleration of Return to Wellness
4. Reduce Variable Supply Costs
5. Increase Discharge to Outpatient Physical Therapy

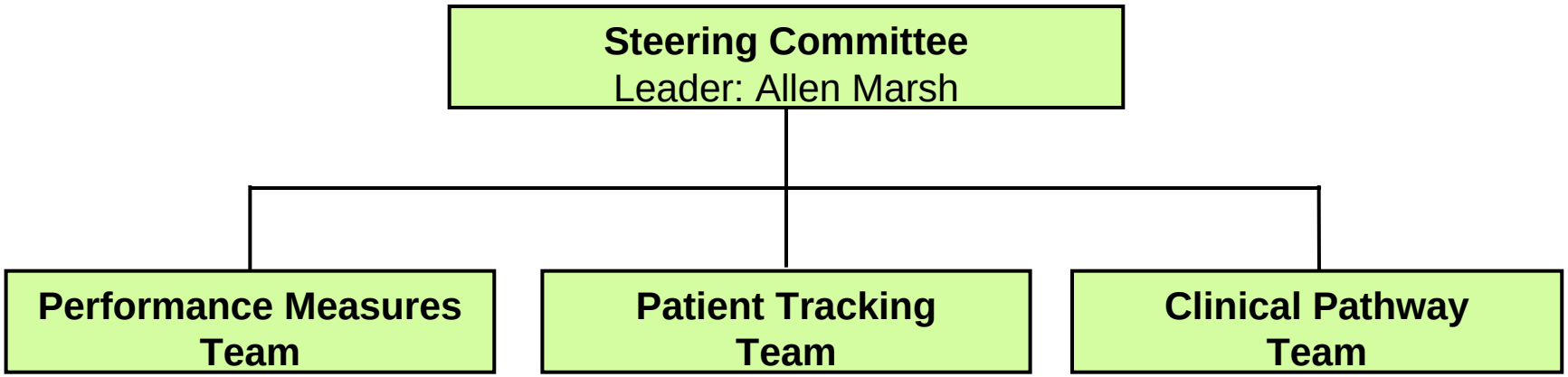
Step 7: Prioritize Opportunities and Assign Responsibilities



- Opportunity 1
- Opportunity 2
- Opportunity 3
- Opportunity 4
- Opportunity 5



Workgroups Are Responsible for Implementation



Leader:
AVP, Quality Management

Leader:
Director of Patient Financial Services

Co-Leader:
Orthopedic Practice Administrator

Leader:
Director Medical Surgical Services

Co-Leader:
Director & Service Line Manager

Step 8: Track and Measure Progress (Ongoing)

New metrics (including cost, quality and patient experience) will be needed to support management across an episode of care.

Sample Measures for a Joint Replacement Episode of Care

Measure	Rationale/Goal	Source/Frequency
% of new patients who attend and complete education class	Attendance at the education class is a critical step in setting correct patient expectations and preparing the patient for surgery and recovery.	Total joint coordinator, quarterly
% of patients discharged to home with outpatient physical therapy	Increasing % discharge to OP PT would reflect more active involvement of coaches and better social preparation needed to facilitate routine discharge to home.	Health information system, quarterly
% of patients with episode cost >budget	Reduce costs by minimizing complications and readmissions and managing the episode.	Payer data feed, quarterly

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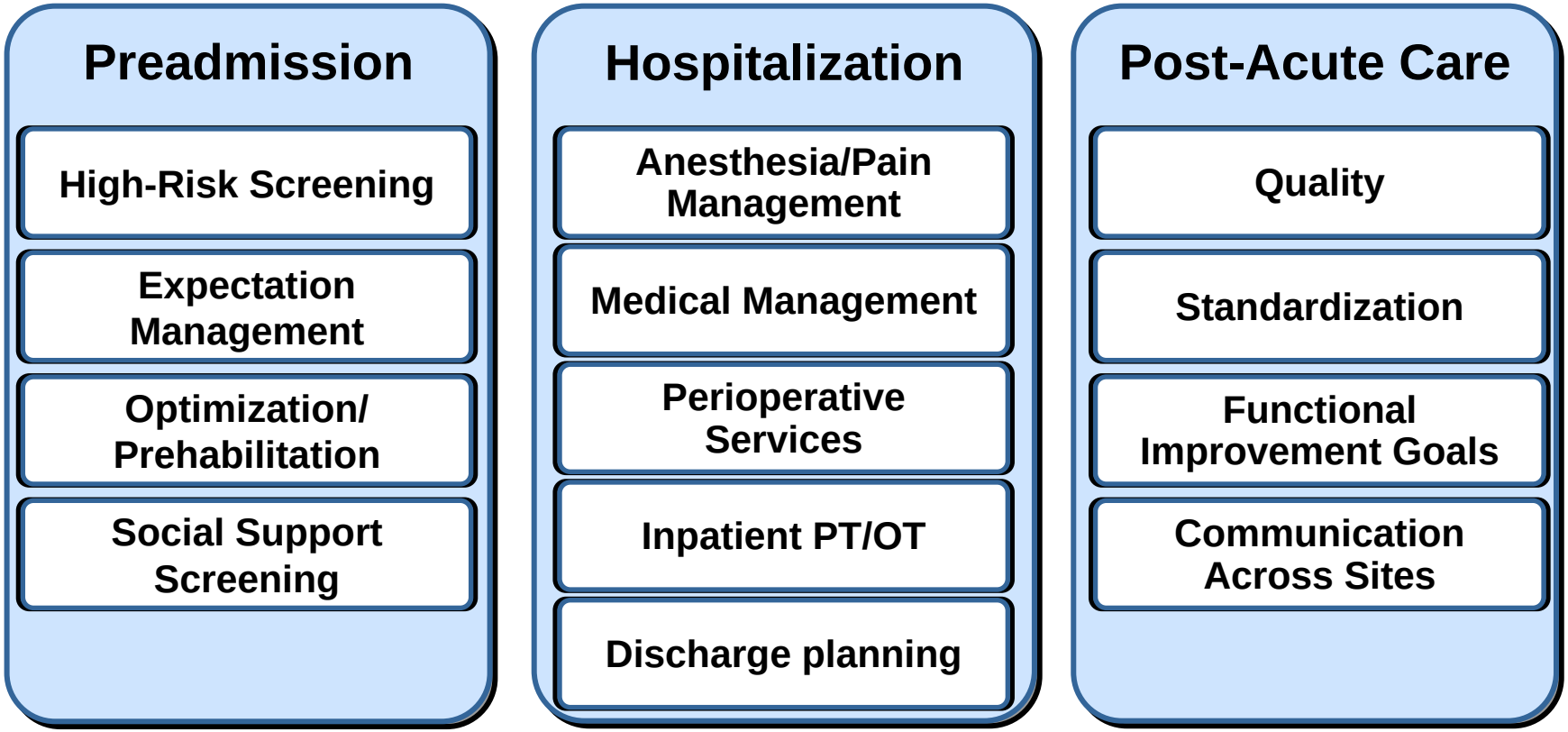
Critical Success Factors, Risks and Barriers

- Payers and providers must act as true partners.
- Leadership and collaboration from clinical staff across the care continuum
- Care redesign across the continuum must occur simultaneous to payment redesign.
- Elevating quality while managing to a budget may require a departure from care as usual (and standardization).
- Identification and real-time tracking of patients will be challenged by lack of IT integration across provider sites.
- Completion of performance scorecard will require tracking of non-traditional/additional process/outcome elements.
- Program optimization is iterative.

Care Redesign Will Require Coordination and Partnerships Across the Continuum



OT = occupational therapy.

Questions for Discussion and Homework

- **How does your organization coordinate with post-acute facilities?**
  - What are the major challenges to coordinating post-acute care?
  - How does your organization overcome these barriers?
- **How does your organization engage patients in their care and cultivate patient loyalty?**
  - Which patients will benefit most from these strategies?
  - How will you know if these strategies are working?
- **How does your organization cultivate innovation in care redesign?**
  - How will you prioritize service lines, patient populations and sites of care for care redesign initiatives?
  - What is the role of administration in care redesign meetings and working sessions?

Thank You

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Sg2 provides business analytics for health care.

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