The Heart of Care Redesign; Care Protocols

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Lancaster General Health - *By the Numbers (Fiscal Year 2012)*

- **Beds:** 631 in service at both campuses
- **Physicians:** More than 900
  - Includes 245 health system-employed in medical group
- **Operating Rooms:** 39
- **Surgeries:** 41,503
- **Emergency visits:** 107,914
- **Inpatient discharges:** 37,166 (includes 4,315 births)
- **Outpatient registrations:** 903,145
- **LG Health physician office visits:** 572,783
### CMMI Bundled Payment for Care Improvement

<table>
<thead>
<tr>
<th>Payment of Bundle</th>
<th>Acute Care Hospital Stay Only</th>
<th>Acute Care Hospital Stay plus Post-acute Care</th>
<th>Post-acute Care Only</th>
<th>Chronic Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Retrospective” (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)</td>
<td>Model #1</td>
<td>Model #2</td>
<td>Model #3</td>
<td>Model #7</td>
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<tr>
<td>“Prospective” (Single prospective payment for an episode in lieu of traditional FFS payment)</td>
<td>Model #4</td>
<td>Model #5</td>
<td>Model #6</td>
<td>Model #8</td>
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</table>

- **Model #4**: (Joint replacement, Hip fracture, Cardiac surgery, Coronary stents, Pacemakers, ICDs, Spine surgery)

*Current* | *Future*
CMMI Bundled Payment for Care Improvement

• Lancaster General Health – potential opportunities:
  • Supply costs (variation in supplies utilized)
  • Length of stay
  • ED utilization/Readmissions
  • Diagnostic testing
  • Number of providers per case
  • Services/testing performed – unrelated to reason for admission
Care Redesign - Lancaster General Health

• Clinical Effectiveness Committees
  • Care Management Teams
  • Service Lines
  • Surgical/Medical Workgroups
  • System-wide Approach
Care Management Team
Multidisciplinary Membership

• Medical Director/Physician Leader
• Executive Sponsor
• Physicians/Surgeons
• Nursing Director
• Nurse Manager(s)
• Staff Nurse(s)
• Performance Improvement Coordinator
• Data Analyst
• Care Management (case manager, social work)
• Specialty Department Manager/Staff
  • Nutrition
  • Pharmacy
  • Rehab
  • Research
  • Laboratories
  • Therapy
Care Redesign - Hip Fracture

- 350,000 annually & number of hip fracture repairs predicted to increase
- Fracture risk doubles every decade after age 50
- One year mortality rate 14-36%
- 50% fail to regain pre-fracture mobility
- 25% who previously lived independently, require long term nursing care
- 35-65% hip fracture patients are affected by delirium
Care Redesign - Hip Fracture

- Greatest share of adverse events among orthopedic procedures
- Account for more hospital days than any other musculoskeletal injury
- Early operative treatment is associated with improved ability to return to independent living, reduction in risk for pressure ulcers and shortened LOS
Care Redesign - Hip Fracture

- Co-Management (Friedman, et al., Arch. Int Med, 2009)
- Early Surgical Intervention (Al-Ani, et al., JBJS, 2008)
- Delirium Assessment (Inouye, NEJM, 2006)
- Pain Management (Ickowicz, JAGS, 2009)
- PM&R (Koval & Cooley, Disability & Rehab, 2005)
- Cardiac Pre op Assessment (Salerno, et al., Am. Journal of Med, 2007)
Care Redesign - Hip Fracture

- Clear Coordination: ED, Medicine, Surgery, Nursing
- Timeliness to surgical intervention
- Standard orders: ED, Pre and Post op
- INR reversal
- Reduction in the use of narcotics /blood transfusions
- Delirium prevention, assessment and treatment
- Rheumatology integration to assess and understand root cause
- Physical Rehabilitation and Medicine evaluation – early ambulation
Care Redesign - Hip Fracture

- Nursing Specialization
- Community and Family Education
- Daily Discharge rounds
- Outreach to Extended Care Facility
Where we are today

- Average length of stay
- Surgical intervention in 24 hours
- Pre-op cardiac evaluation
- Delirium management
- Early ambulation
Care Connections Team

- Extensivist, or clinical leader and “quarterback” for the member’s care
- Advanced Practice Provider (NP)
- Navigators
  - Clinical or Lay Health Worker
  - Community Paramedics
- Social worker/Case manager
- Clinical pharmacist
- County Social Services Liaison

The core care team is responsible for coordination (gets what is needed, when it is needed, where it is needed)

LG Health Care Transformation Model

Patient Centered Medical Home

- Data/claims analytics
- Enrollment

Communication
- Support Services
- Coordination
- Acute Episodes
- Place of Residence

Enablement
- Transition Plan Development
- Graduation Assessment
- Home Visits

End-of-life care

Virtual care
At the Care Center
At home / institution

Repatiate
Member
Benefits of CTM: Care Connections

• **Team care**, that crosses traditional boundaries and functions, to provide better access, better care and lower costs
• Dedicated **Care Center** to provide high-risk track for CTM participants; including
  – Coordination of critical resources
  – Boundary spanning: care at home, nursing facility, community centers and hospitals
• **Scalable and Replicable**: Pilot approach with staging to include ‘second tier’ of individuals
• **Incorporation of protocols and early identification of individuals at risk** of becoming Care Connections participant (multiple comorbidities, psycho-social, etc.)
  • Standardizing definitions of superutilizers
  • Standardizing care management process