PREMIER

National Bundled Payment Summit 2014

Clinical Reengineering

June 18th, 2014

Elizabeth Ireton RN, MS, Director,
Integrated Care Delivery

Questions

- What barriers to sustainable care redesign have you found in BPCI to date?
- In which areas of the clinical spectrum have you seen the most robust redesign? What are the most significant interventions?
- What are some examples of overall clinical goals and associated interventions?
- What are some examples of care management clinical innovations/practices, intended to sustain and scale a bundled payment program?

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Question 1:

- What barriers to sustainable care redesign have you found in BPCI to date?

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

That was then

Premier Response to Question 1-Barriers

- Culture change
- Physician compliance to bundled payment clinical protocol
- Coding
- Understanding inclusions and exclusions (especially with chronic bundle)
- Post-acute care management
- Technology, metrics and reporting

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Survey Results- During BPCI Application Process

- Confidence in their organization's ability to transform the care delivery model
  - **78%** "Agree" or "Strongly agree"

- Biggest organizational challenge
  - **59%** Redesigning care to support a new payment model
  - **23%** Experience, readiness, and leadership
  - **9%** Triple Aim care model
  - **9%** Measurement/ monitoring for improvement

- Biggest change management issue
  - **50%** Competing organizational priorities
  - **23%** New partnerships
  - **17%** Rapid improvement and diffusion
  - **11%** Standardization

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.
6

Survey Results-continued

- Where does your organization need the most help with improvement?
  - **67% Follow up and recovery,** 33% Inpatient stay

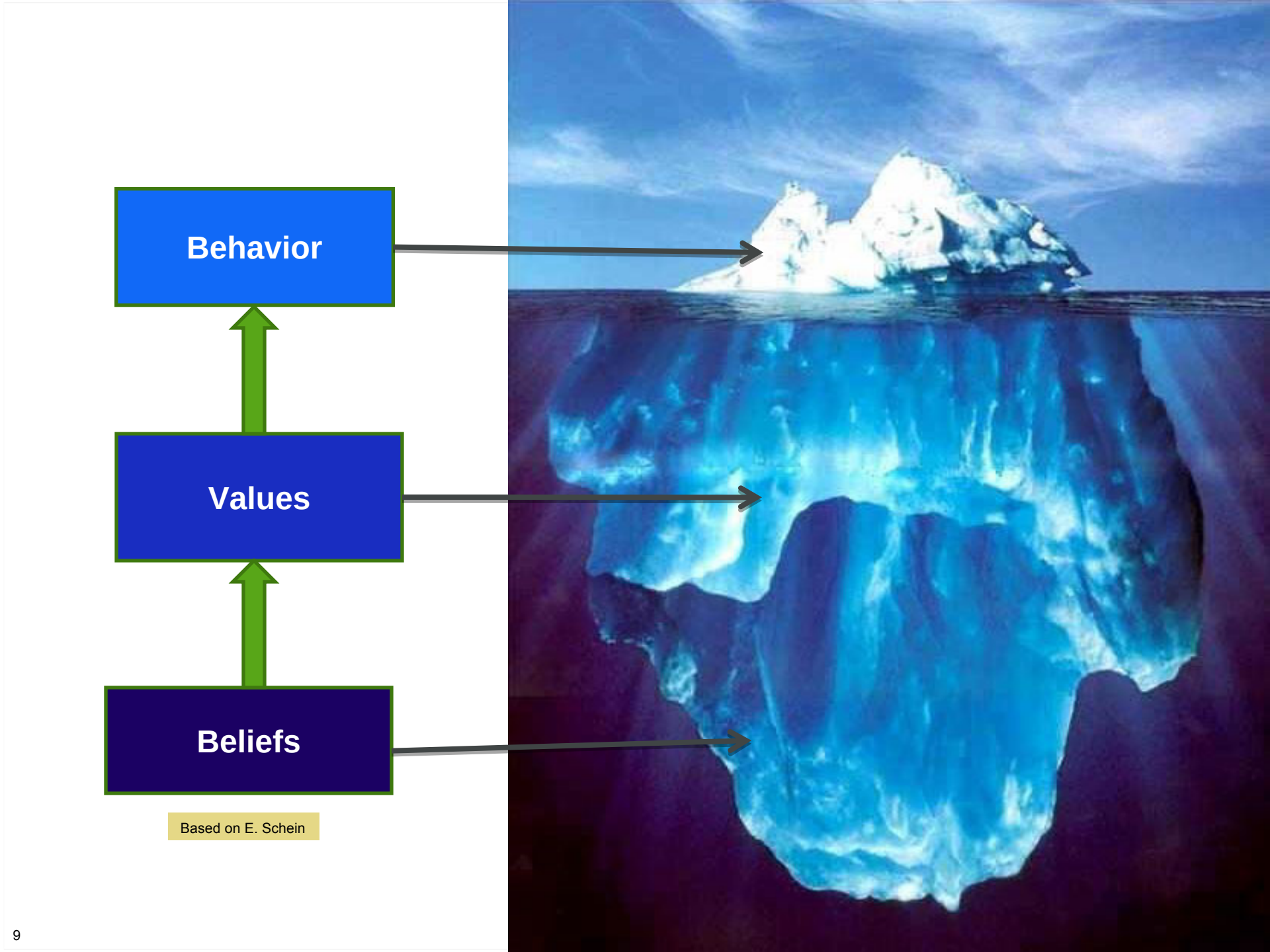
- In which improvement area does your organization need the most help with care redesign?
  - **73% Care Coordination,** 18% Best Practices, 9% Flow

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER INC.
7

Culture change-Survey of members, including applicants-2011

Focus Area	Culture Change Issues
Physician Network	• Developing new and different reimbursement models for physicians-how to convey this message to physicians • Sharing power with physicians • Focusing on people, not just patients • Shifting towards process-oriented thinking
Payor Partnerships	• A shift is needed in the fundamental relationship with health plans • How to communicate the need for transparency in the market • How to implement a new way of thinking, whereby an entire group needs to do well, not just an individual
Leadership	• The shift from a silo'ed approach of care to focusing on the continuum • Generational gaps among providers (how to communicate to providers stuck in the "old school" of thought)
Patients	• Empowering the patient to manage their care (knowing they understand how to manage their care) will effect both patient and provider • Facilitating communication among physicians to coordinate care • Dealing with the threat to physician autonomy (i.e. involving the patients in care decisions, use of care models) • Physicians working as part of a team (evolving the role of physicians)

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.



Based on E. Schein

Question 2

- In which areas of the clinical spectrum have you seen the most robust redesign? What are the most significant interventions?

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

This is now

Question 2- Robust Design

- Care management and navigation (acute to post-acute)
- Beneficiary identification
- Care pathway development with acute and ambulatory
- Post-acute determination and management of length-of-stay in SNF

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Clinical initiatives-in-process

Pre-Admission	Inpatient	Follow up/Recovery
• Post discharge recovery education • Family/patient classes • Clinical protocol • Risk Assessment	• Discharge Location and LOS • Care navigator • Post-discharge care prediction tool • EMR order sets	• Care navigator follow –up-Call or SNF visit • Post acute provider network/partnerships • RUG comparison
	• Care pathway • Care manager • Navigator • Transition Coach	• Care Manager • Navigator • Nurse Practitioner • Clinical Care Coordinators
		• After care checklist • Develop home care program
• Beneficiary identification	• Develop criteria for diagnosing condition • Set up observation unit for HF • Care management documentation software	• Post acute transition model –Coleman • Improved coding practices • Integrated pathways with clinics, SNFs and Home Health
• ED Evaluation	• EMR Order sets • Pharmacist • Nutritionist	• Focused medication management

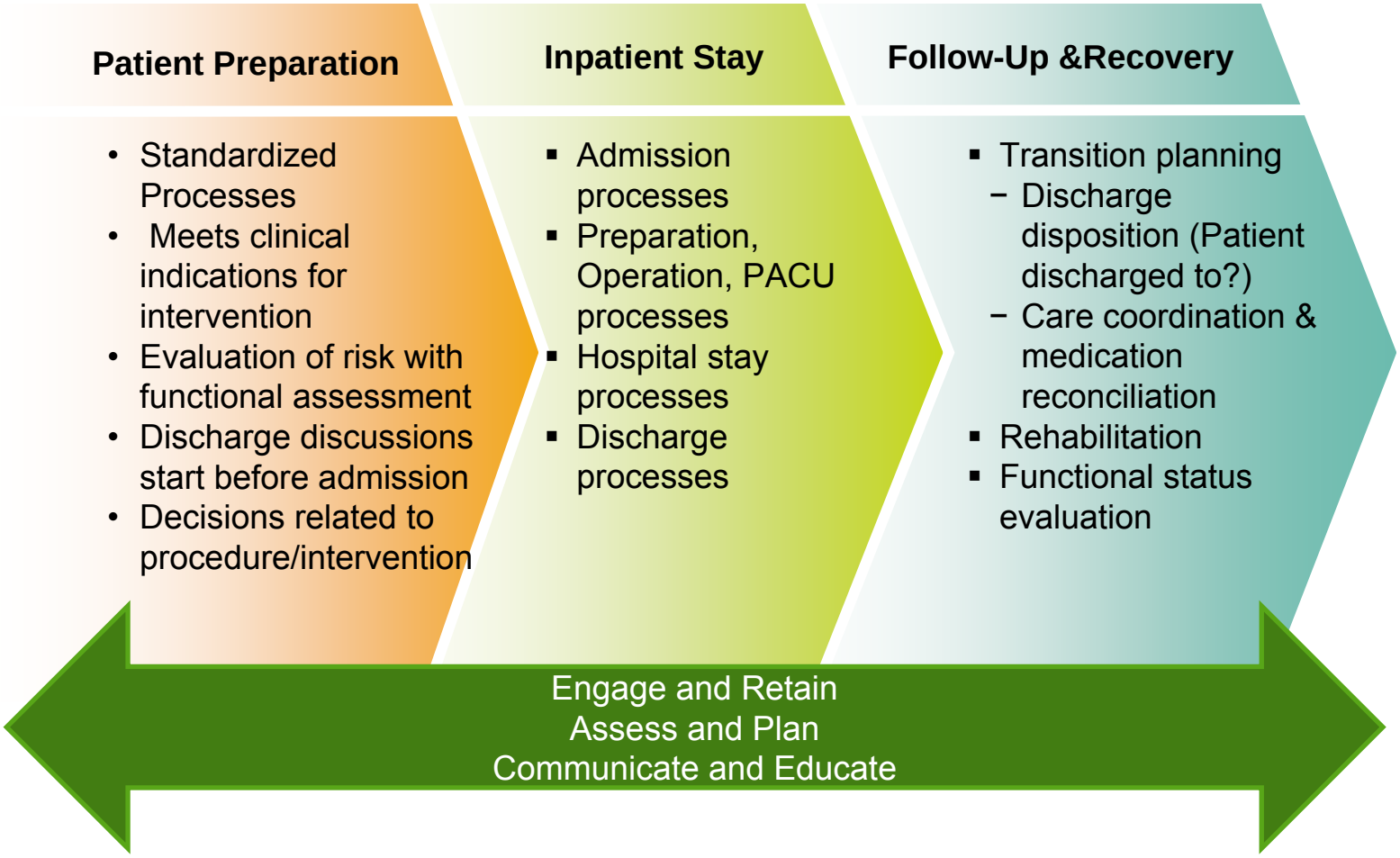
PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Question 3

- What are some examples of overall clinical goals and associated interventions?

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Redesigning patient connections



PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Clinical Goals and Interventions

Excellent Patient Preparation

- Improved pre-op/admission workflows
- Risk-stratification
- Improve prediction and discussions about PAC setting and LOS
- Standardized order sets (all locations)
- Patient educational materials (all locations)
- Enhanced patient discharge teaching including teach back and adoption of system-wide patient education approach
- Cost reduction: labs, imaging, therapies, specialist,

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Clinical Goals and Interventions

Quality
Inpatient Stay

- Identification of who is in the bundle
- Beneficiary communication
- Assignment of care manager/navigator/advanced practice nurse to follow patient from admission through post-acute period
- Improved workflows and processes to reduce wait times and patient throughput
- Improved coding practices
- Cost reduction practices (supplies, blood, imaging)

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Clinical Goals and Interventions

Excellence in Follow Up and Recovery

- Developing post-acute provider partnerships
- Tightening up care pathways to include specialty clinics i.e. cardiac, orthopedic, GI clinic
- Development of common assessments- used in acute and post-acute (manual or included in EMRs and post-acute)
- Implementation of care management tools for use across continuum
- Enhance home health programs-Advance Practice Nurses make home visits
- EMR enhancements- add icon indicating bundle patient
- Enhance palliative care
- RUGs comparison process

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Question 4-

What are some examples of care management clinical innovations/practices intended to sustain and scale a bundled payment program?

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.

Question 4-Response

- Care redesign program that is stable, ongoing and represents all stakeholders (including primary care)
- Technology to support the following is essential:
  - Care management documentation
  - Post –acute levels of care and LOS
  - Order sets and support for clinical protocols
  - Access to acute care clinical record and visa versa in between acute and post acute
  - Support for processing post acute claims for reporting purposes
  - Outcome measures scorecard/dashboard reporting

PROPRIETARY & CONFIDENTIAL – © 2014 PREMIER, INC.