Rethinking Post-Acute Care in the Context of Bundled Payment

Panel:

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THE VALLEY HOSPITAL: THE DECISION TO PARTICIPATE IN BUNDLED PAYMENT

- Highly competitive market with over 50 hospitals within a 25 mile radius
- Licensed for 431 beds and have a large active medical staff consisting of over 600 primary care and specialty care physicians
- Participated in the CMS sponsored Physician-Hospital demonstration project
- Participated in Model 1 of the Medicare Shared Savings Program

Primary Reasons the Valley Entered into the Bundled Payment Program:

- Bundled Payment program was complimentary to the quality improvement programs that the hospital had underway
  - Lack of data into patient recovery after discharge
  - Readmissions
  - Avoidable Emergency Room utilization
  - Need for increased visibility & referrals
- Financial opportunities
  - Also improve our Value Based Purchasing Scores and reduce readmission penalties
- Wanted to get ahead of the learning curve and be innovative
  - Allowed us the opportunity to partner with a strong team in order to gain experience, build infrastructure and position ourselves for future reforms.

CARDIAC INTENSIVE REHAB PROGRAM

Program Scope and Update

- Focused on patients in the Heart Failure Unit – Patients who would otherwise be offered care in a SNF
  - Established Criteria with hospital
    - MC and MCA population
    - Non-Palliative care , with > 6 months prognosis (not hospice eligible)
    - Not on VAD or Inotropic Therapy
    - 30-mile radius of Central Austin
- Weekly case review established with health system HF Floor CM, Hospitalist
- May 1st – Go Live Date

Current Metrics

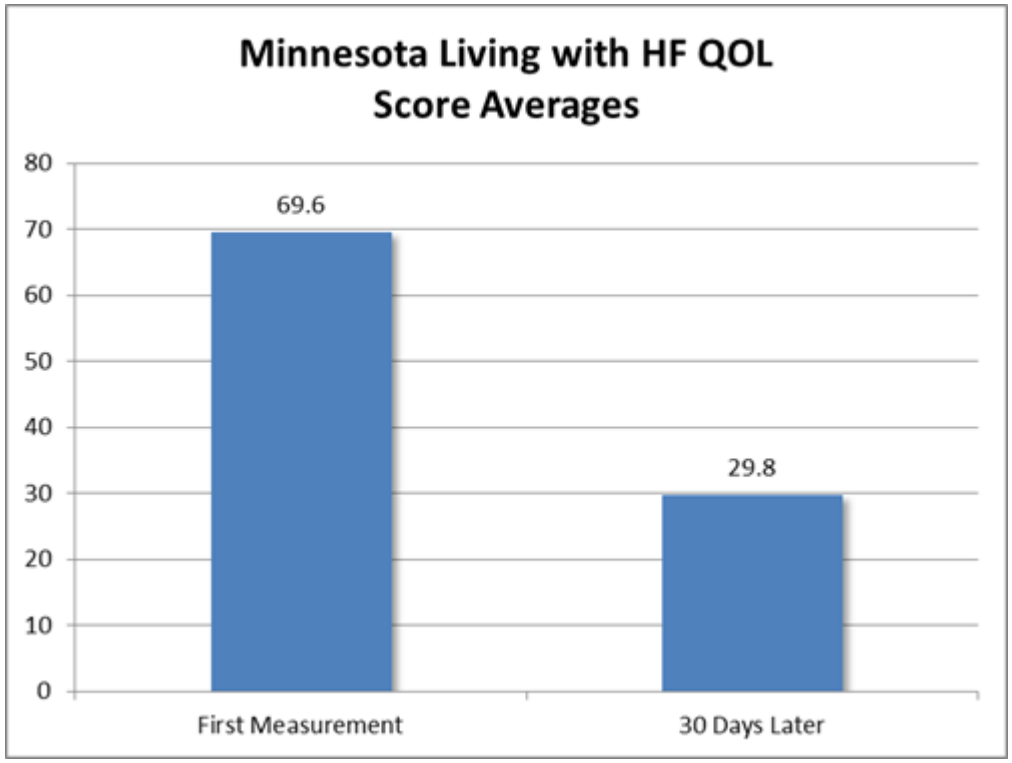
Metrics	Current Status
Referrals	19
Program Admissions	11
Pending Admission(s)	1
ER Diversions	10
ER Visits	2 – unrelated to HF 1 – HF related
Hospitalizations	1
Services provided	Skilled Nursing, Rehab, PCS, Coordination of NP services
Non-Program Referrals to HH	4*
Non-Program Admissions	5**

Non-Program Admissions:
**4 patient admitted to routine HH - outside program service area*
***4 patient/family elected service at SNF – long-term placement decision, 1 d/c to HH of choice*

Key Learnings to Date

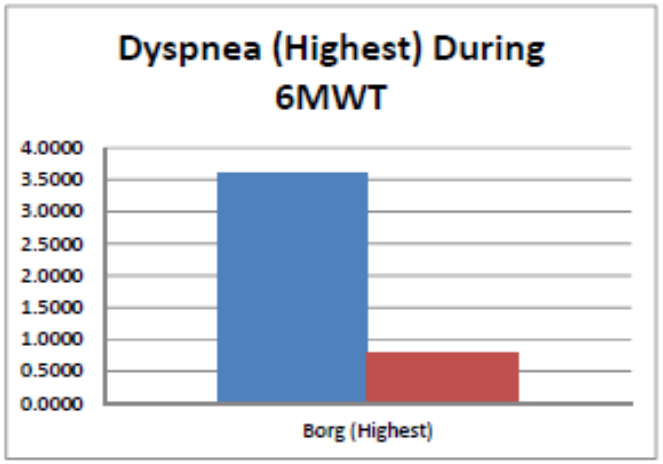
- Many patients have a HH provider of choice; extensive explanation of the program differences is necessary
- Communication with the treating physician is key; visiting practitioners are helpful with this

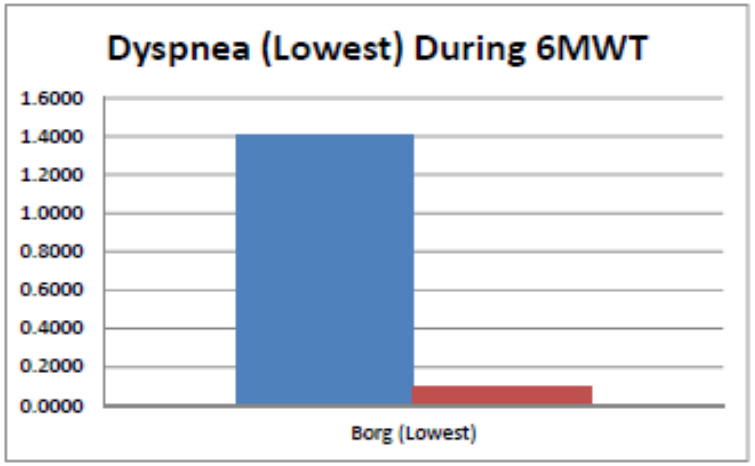
SUMMARY – MLWHF SCORES FROM SOC TO DAY 30

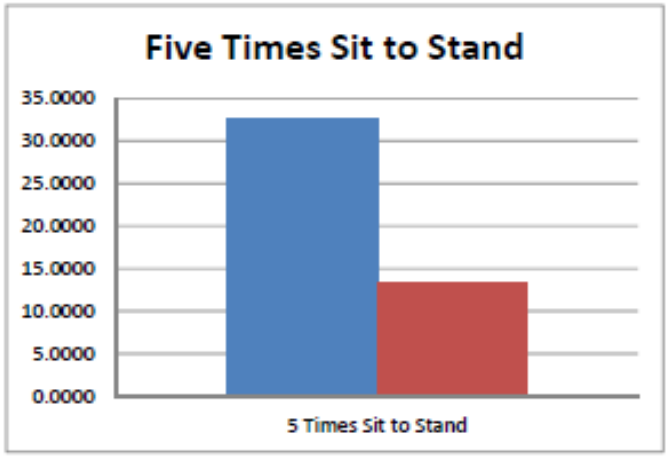


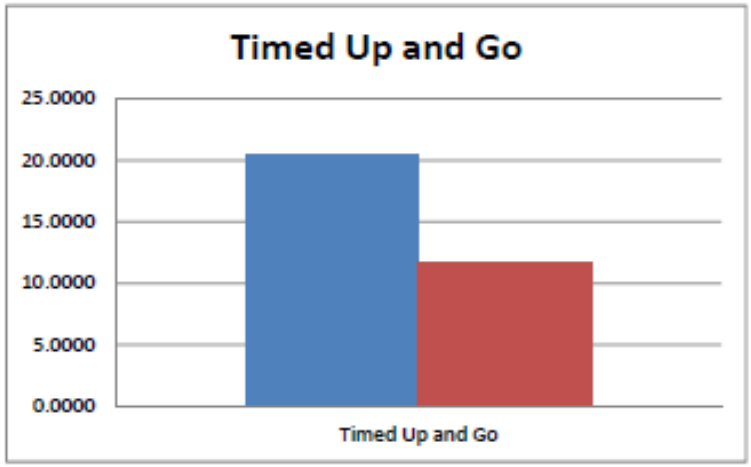
INTENSIVE REHAB AT HOME THERAPY FUNCTIONAL MEASURES SUMMARY

Therapy Outcome Measures - RightPath® Intensive Rehab Program at Home









TEXAS ORTHOPEDIC REHAB PROGRAM

Program Scope and Update

- Focused on patients of Orthopedic Patients scheduled for surgery
  - Established Criteria with Texas Orthopedics
    - All payers contracted with Texas Home Health (TXHH)
    - Patients living within TXHH service area
- Dedicated TXHH Clinical Liaison, focused on managing care for the patients from initial referral (typically received at the same time as surgery scheduled) through recovery
- Clinical Liaison responsible for coordinating:
  - Outpatient physical therapy evaluation prior to surgery
  - Durable Medical equipment to be delivered before or on day of surgery
  - Home health to ensure admission completed within 24 hours of hospital discharge
  - Discharge disposition – assisting discharge planners in eliminating barriers which cause patients to utilize skilled nursing facilities (SNF) and inpatient rehabilitation (IRF)

Current Metrics 8/28/14 - present

Metrics	Current Status
Referrals	168
Program Admissions	97
Pending Admission(s)	25
ER Visits	3
Hospitalizations	3 (1 fall, 1 CHF exacerbation, 1 Myocardial Infarction)
Services provided	PT, OT, Skilled Nursing
Non-Admissions	45**

** Non-admissions due to out of network payer sources

Key Learnings to Date

- Must begin instructing expectation for return home after surgery (vs. SNF/IRF)
- Immediate communication with surgeon for any complications to avoid ER
- Patient education of complications and process to address

CLINICAL OASIS OUTCOMES

	Timely Initiation Of Care	Emergent Care	Hospital Admission w/in 30 Days of SOC	Hospital Admission w/in 60 Days of SOC	Discharged To Community
	86%	3%	2%	3%	96%
Clinical Outcomes	Stabilization and Improvement in Transferring	Stabilization and Improvement in Toileting Hygiene	Stabilization and Improvement in Management of Oral	Stabilization and Improvement in Dyspnea	Stabilization and Improvement in Ambulation/Locomotion
	100%	100%	100%	96%	100%
	30 Day Re-Hospitalization	Stabilization and Improvement in Grooming	Stabilization and Improvement in Dress Upper Body	Stabilization and Improvement in Dress Lower Body	Stabilization and Improvement in Bathing
	0%	100%	100%	100%	100%

TOTAL KNEE REPLACEMENT – HOME HEALTH OUTCOMES

Therapy Assessment Item Description	Average Assessment at Initial Visit	Average Assessment at Discharge	
ASSISTIVE DEVICE	Rolling Walker	CANE/SINGLE SUPPORT	
DISTANCE AMBULATED (FEET)	51 - 100	101 - 250	
PAIN (LOWEST IN PREVIOUS 24 HOUR PERIOD) - KNEE	3	2	
PAIN (WORST IN PREVIOUS 24 HOUR PERIOD) - KNEE	7	5	
PERCENTAGE OF WEIGHT BEARING	70 - 99	100	
ROM - KNEE EXTENSION	-6	-2	
ROM - KNEE FLEXION	85	105	
STRENGTH - KNEE EXTENSION	3-/FAIR-	4/GOOD	
STRENGTH - KNEE FLEXION	3-/FAIR-	4/GOOD	

KEY POINTS FOR SUCCESS

- Streamlined communication process in order to quickly escalate emergent issues to the surgeon
- Coordination of care beginning prior to surgery in order to eliminate potential barriers to effective recovery following hospital discharge
- Specially trained therapists able to provide effective therapy and identify any potential complications immediately
- Optimal short-term home health focused on regaining patient independence as soon as possible

BUNDLED PAYMENT CARE RE-DESIGN

eviCore healthcare's Care Re-design Plan for The Valley Hospital

- Certified Care Management RNs
- Qualified patients into program via timely concurrent DRG coding
- Engaged patients during acute stay
- Worked closely with the intra-disciplinary care team at hospital
  - Attending Physicians, Hospitalists, Hospital Care Managers, and Discharge Planners
- Assessed patient needs, assets, and psycho-social environment
- Developed individualized plans of care:
  - Leveraged evidence-based guidelines and patient clinical data
- Performed medication review and/or reconciliation at transitions between sites of care
- Employed a transitional model of care to improve outcomes across the post-acute continuum

CHANGE IN UTILIZATION PATTERNS & IMPACT TO OUTCOMES

- In the first 3 months of the care redesign, we have seen a 14% reduction in discharges to SNFs and a 10% reduction in discharges to IRF. For some bundles, results are even better
- In the sepsis bundle, for example, we have seen a 26% reduction in discharges to SNF and in pneumonia a 21% reduction in discharges to SNF

Impact to Outcomes

	CY2013	Oct2014 & Nov 2014
Total Readmit Encounters LT 30 Days	970	139
Total Anchor Episodes	5,796	907
Percent	16.7%	15.3%

- We have seen a 9.2% reduction in 30 Day readmission rates on the first two months of the program
- We expect that we will see improvements in this metric as our experience has shown that the Care Management model becomes more effective over time as hospitals, physicians, and post-acute facilities become accustomed to the care re-design

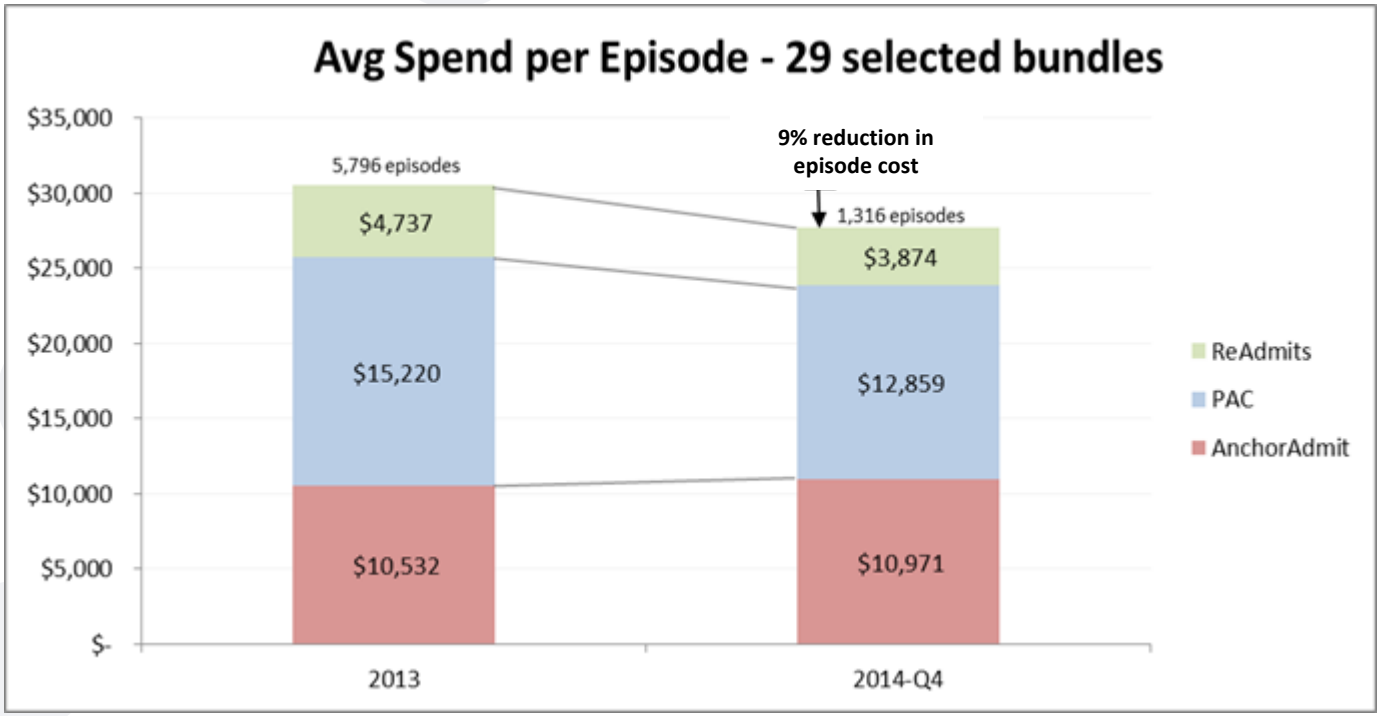
READMISSION REDUCTIONS

- Specifically, and more importantly, we have seen significant reduction in some of the common causes of avoidable readmissions. Readmissions due to Simple Pneumonia for instance are down by 27.6% and readmissions from Urinary Tract Infections are down by 58.1%

CY2013			Oct2014 & Nov 2014 (Annualized)	
OTHER - NON BUNDLE	269		OTHER - NON BUNDLE	186
CONGESTIVE HEART FAILURE	76		CONGESTIVE HEART FAILURE	126
SEPSIS	66		OTHER RESPIRATORY	90
SIMPLE PNEUMONIA AND RESPIRATORY INFECTIONS	58		SEPSIS	66
CHRONIC OBSTRUCTIVE PULMONARY DISEASE, BRONC	43		CARDIAC ARRHYTHMIA	48
GASTROINTESTINAL HEMORRHAGE	43		SIMPLE PNEUMONIA AND RESPIRATORY INFECTIONS	42
URINARY TRACT INFECTION	43		NUTRITIONAL AND METABOLIC DISORDERS	42
CARDIAC ARRHYTHIMIA	34		GASTROINTESTINAL HEMORRHAGE	24
OTHER RESPIRATORY	30		RENAL FAILURE	24
RENAL FAILURE	28		URINARY TRACT INFECTION	18
All Other DRGS	280		All Other DRGS	168
	970			834

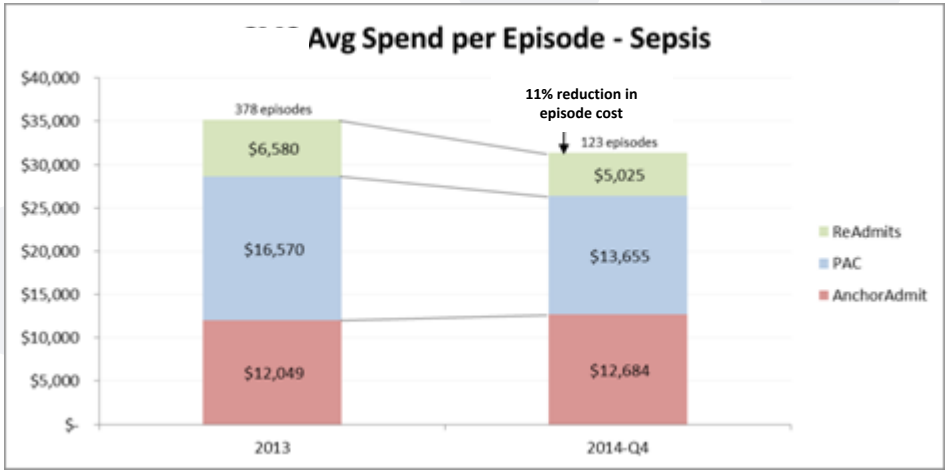
REDUCTION IN OVERALL COST OF EPISODES

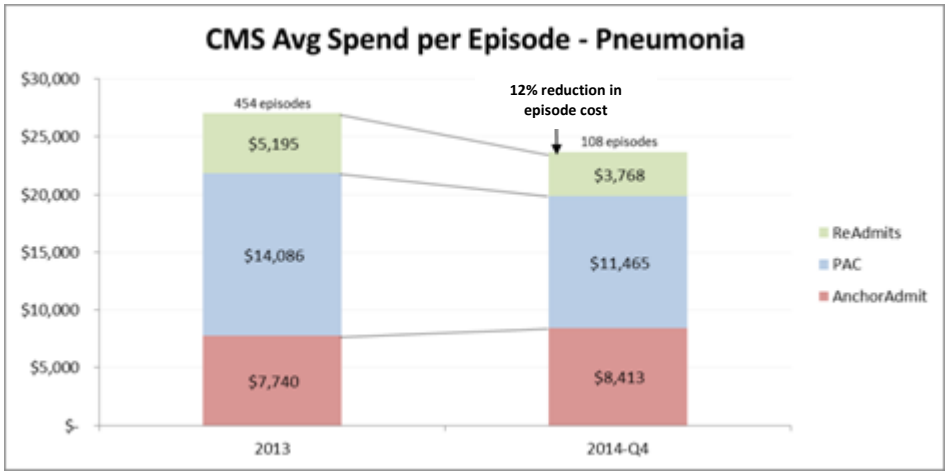
- Both the reduction in the overutilization of PAC services and the reductions in readmissions have had an impact on the overall cost of the episodes. For all 29 bundles under the care redesign, we have seen average cost reduction of 9% per episode.



REDUCTION IN OVERALL COST OF EPISODES

- For some bundles, results were even better. Sepsis for instance showed an 11% reduction and Pneumonia showed 12%.





CONCLUSION

- Our suggestion is not that all differences in costs are attributable the care redesign.
- Early indicators are positive and this is true for both surgical and medical bundles.

- **We believe these kinds of results are achievable where**:
  - Post-acute costs make up a significant portion of the episode cost
  - Readmissions rates are high
  - And, volume of episodes is high enough to establish a meaningful baseline

- **To succeed in reducing episodic costs, a program must:**
  - Have a focused, quality based care redesign
  - Be patient-centric
  - Leverage evidence-based guidelines
  - Be supported by a transitional model of care