The Next Era of Health Care: Improving Patient Satisfaction and Reducing Readmissions with Episode-Based Payment Models

National Bundled Payment Summit: 2016
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Disclosure

I have no actual or potential conflicts of interest in relation to this program and/or presentation.
About 54 million people – or nearly 17% of the U.S. population – live within a 60-mile radius of a CHI hospital.
OPERATIONS IN 19 STATES

102 HOSPITALS, INCLUDING:

4 ACADEMIC HEALTH CENTERS AND MAJOR TEACHING HOSPITALS
• 1,981 MEDICAL STUDENTS

30 CRITICAL ACCESS HOSPITALS

12 CLINICALLY INTEGRATED NETWORKS

10 INSURANCE PLANS
Population Health Management

Key Components
Announced by HHS: Expect Other Payers and Employers to Follow

Today
20% of Medicare FFS Payments Tied to Value

End of 2016
30% of Medicare FFS Payments Tied to Value

End of 2018
50% of Medicare FFS Payments Tied to Value

Acceleration of Value-Based Programs: The Future
Value Based Care Programs for Medicare

**Type of Model**
- Populations
  - PCP groups or small multi-specialty groups
  - Medium-sized multi-specialty groups
  - Large multi-specialty groups
  - Hospital-led

**Population**
- Providers can only participate in one of these programs

**Condition**
- Medicare FFS Beneficiaries
- <5,000
- 5,000-15,000
- 15,000+

**Episode**
- Multi-payer Advanced Primary Care Practice Demonstration
- Comprehensive Primary Care Initiative
- Medicare Shared Savings Program
- Advance Payment Model
- Pioneer ACO Model
- Bundled Payment for Care Improvement Initiative
- Comprehensive Care for Joint Replacements
- Accountable Health Communities
- Oncology Care Model

**Size**
- PCP groups or small multi-specialty groups
- Medium-sized multi-specialty groups
- Large multi-specialty groups
- Hospital-led
Defining Value-Based Payments

- Fee for Service
- Fee for Service with Quality Link
- Value-Based Payment
- Alternative Payment Models (ACO’s, BPCI and CJR, MSSP, PCMH, APII)
- Population Health Management (Full Risk)
**CHI’s Population Health Strategy**

**Who does Population Health impact?**

**Communities**
- Need care focused around value, not drive volume

**CHI Employees**
- Due to unsustainable healthcare cost trends

**Physicians**
- Clinically, this is the right thing to do for our patients

**CHI Inter-related Components**

**Clinically Integrated Network (CIN)** is a connection of providers (hospitals, PCPs, SCPs, home health, etc...) organized to meet the clinical needs of a population
- Focus on access
- Aligned incentives to address cost, quality and experience

**Care Management** is the approach to population health, working to support capabilities to improve total quality and cost of care
- New roles: RN Population Health Coaches, Population Health Coordinators (SW), RN Transition Coaches
- Focus is to follow the patient, not the provider
- Patient-centric motivation; understanding the patient’s goals

*CHI is committed to Population Health for our mission, ministry and legacy.*
Arkansas: Arkansas Health Network
Cincinnati: TriHealth
Chattanooga: Mission Health Care Network
Colorado: Colorado Health Network
Houston/E Texas: CHI St. Luke’s Health System
Iowa: Mercy Health Network
Kentucky: Kentucky One Health Partners
Nebraska: UniNet
Roseburg: Architrave
Tacoma: Rainier Health
W North Dakota: PrimeCare Select CIN
**Area of Focus**

- Prevention
- High Risk Individuals
- Transitions/Readmissions
- Acute Care

**Population Health Management Components**

- Utilization Management
- Acute Case Management
- Compliance
- LACE/ProjectRED
- Continuing Care Network/SNFists
- RN Transition Coaches
- Advanced Pop Health Analytics
- Coaches & Pop Health Care Coordinators
- Patient Centered Med Home
- Basic Analytics (such as registries)
- RN Pop Health Coaches
- Patient Centered Med Home
### CHI’s Participation in Population Health Programs

#### Medicare Shared Savings Program (MSSP)
- Added 6th program 1/1/14
- 4 Additional programs started 1/1/15
- Current Total of 10 MSSP Programs

#### Bundled Payment for Care Improvement (BPCI)
- 29 hospitals started Phase 1 (no financial risk)
- 14 entered Phase 2 (up/down financial risk)
- 12 total joint replacement
- 4 CHF
- 1 Non-Cervical Spinal Fusion
- 1 Sepsis

#### CHI Medical Plan
- 3 markets started 1/1/14
- 4 additional markets started 1/1/15

#### Health Connections Initiative
- For high-utilizers that live in poverty: Multiple states now with program
- Sponsored by CHI Mission and Ministry
- Education, accountability and support: Home-based team focus on “total” need of patients/families

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Total Managed Membership with financial risk rapidly expanding
**CHI’s BPCI Journey**

**July 1, 2015**
- 14 Hospitals in Phase 2 (up/down financial risk)
- Ortho, Spine and Cardiac Service Lines
  - 12 Total Joint Replacement
  - 2 CHF
  - 1 Non-Cervical Spinal Fusion
  - **15 Total Bundles at CHI**

**October 1, 2015**
- 14 Hospitals in Phase 2
- Ortho, Spine, Cardiac, and Medical Service Lines
  - 12 Total Joint Replacement
  - 1 Non-Cervical Spinal Fusion
  - 4 CHF
  - 1 Sepsis
  - **18 Total Bundles at CHI**

**April 1, 2016**
- Launch of Comprehensive Care for Joint Replacement (CJR)
- An additional 21 CHI facilities at risk (17 not in BPCI now)
  - 29 Total Joint Replacement
  - 1 Non-Cervical Spinal Fusion
  - 4 CHF
  - 1 Sepsis
  - **35 Total Bundles at CHI**

**Next Mandatory CMS Bundle for 2017? Cardiac Focus**
Ortho Care Model Redesign
Traditional cost center approaches generate silos.
Redesigning care has required strong collaboration across CHI teams

Development of CHI Care Model for Transformation in Joint Care

- Care Redesign developed for the identification and documentation of joint replacement best practices
  - Performance assessment tool and metrics have been developed for teams to identify needs for improvement

- Population Health team have built successful tools and training that have been instrumental current participants in the bundled payment programs

- A partnership among these groups will allow us to create, design, and implement tools and processes and provide support to aid in the implementation of the (CJR)
We are charged with understanding the patient’s full experience in order to impact overall quality of care
Care Redesign Model Overview

1 – Design
• Select DRG, condition or process by opportunity, need and consensus
• Review data
• Develop CR Design Team and dyad/triad leadership
• Establish “100 Day” Improvement Cycle Plan

2 – Model Development
• Engage EBC, Service Lines, campuses, entities, PACs, CHI for continuum view and development
• Gather best practices
• Develop gap analysis and patient care tools

3 – CR Plan (Pilot)
• Determine pilot site
• Define implementation, communication and coaching plans
• Develop CR Design Team and dyad/triad leadership
• Establish “100 Day” Improvement Cycle Plan

4 – Evaluate
• Implement at pilot site
• Complete Gap Analysis (all sites)
• Evaluate metrics/outcomes and stakeholders’ feedback

5 – Refine
• Address pilot site recommendations
• Revise plans
• Revise Gap Analysis

6 – Standard Set
• Define draft practices, processes and patient care tools with all pilot and Care Redesign Stakeholders
• Review and finalize metrics

7 – Functional Review
• Identify learnings
• Share and get feedback, all stakeholders
• Finalize approval
• Define Install Plan and Timeline

8 – Implement
• Launch implementation, communication and coaching plans to all sites
• Commence ownership and accountability

9 – Operationalize
• Hardwired, system-wide solutions
• Dyad/triad leadership maintaining ownership and accountability
• Looking for improvement opportunities

Initial 100 Days
Episode-Based Payment Models: Key Components for Success in Program
## Patient Engagement Tactics: Critical Interventions

### Pre-Operative
- Physician Office Activity
- Patient Contract
- Joint Academy Education
  - Coach Identification
  - Recovery and Expectations
  - Patient Optimization Assessments and Clearance
  - Increase patient self-management skills
- Discharge Planning, SNF Education

### Acute
- Hospitalist Protocol
- Physician Therapy Protocol
- Post-Op Pain Management
- Coordination with Post-Acute Providers
- Discharge Transition Plan
- Med Reconciliation
- 7-10 Day Follow Up Plans
- Development of Continuing Care Network

### Post-Acute
- 24/7 Access Line
- Navigator coordination with ED, Hospitalist, Coach, Home Health or other Post-Acute providers as necessary
- Follow Up Plans for 30-, 60-, 90- and 120-Day post surgery
- Readmission Contact Plan
Critical Factors for Success

The most successful CHI bundled payment programs chose to focus on the post-acute platform, decreasing readmissions and post-acute spend.

Bending the Cost Curve

- Acute admission—ICS opportunities; Focused planning
- Decreasing Readmissions
- Decreasing Post-Acute Spend
- Need for Pre-Op Education/Optimization/Coordination
- Aggressive post-op LOS/post-acute utilization management
- Nurse Navigators: Starting at acute care with follow-up to 120 post-episode; 24 hour call back available
- Integrated Care Management model
- Workflow management tool
- Post-Acute: CCN network/relationships critical to succeed
- Engaged Physician Leadership/ Active Steering Committee
- Patient Engagement

Key Learnings

- Engaged physician leadership is key to success—physicians must change their practice patterns for success in this model
- Decreased utilization of post-acute services was largest revenue reduction for the programs
- Data/Information must be paired with staff – data without staff (or vice versa) won’t work
- Care Management/Navigation beginning at pre-op and continuing through entire episode of care is required; Patients must have access to providers 24/7 to prevent ED use and hospital readmissions
- Robust patient optimization/education program to identify issues/set expectations early was critical to early identification of potential
**CHI’s BPCI Experience: Year 1**

### CHI St. Vincent Infirmary Medical Center
- **Location:** Little Rock, AR
- **Phase:** Phase 2
- **Launch Date:** October 1, 2013
- **Procedure(s):** Total Knee/Hip Replacement

### CHI Health, Alegent Mercy Council Bluffs
- **Location:** Council Bluffs, IA
- **Phase:** Phase 2
- **Launch Date:** January 1, 2014
- **Procedure(s):** Total Knee/Hip Replacement

### CHI Health, St. Elizabeth Regional Medical Center
- **Location:** Lincoln, NE
- **Phase:** Phase 2
- **Launch Date:** January 1, 2014
- **Procedure(s):** Total Knee/Hip Replacement

### CHI Health, Good Samaritan Hospital
- **Location:** Kearney, NE
- **Phase:** Phase 2
- **Launch Date:** January 1, 2014
- **Procedure(s):** Total Knee/Hip Replacement

**CHI Results:**
- **Achieved CMS Savings**
- **Achieved Internal Cost Savings**
- **Improved Patient Satisfaction by 9%**
- **Decreased Readmissions by 46%**
- **Decreased SNF Utilization by 45%**
**Physician Success Factors**

- Value-Based Care Models **Require** Physician Collaboration
  - Must be able to demonstrate collaboration
  - Verification of collaboration is likely (on all sides)

- Partner with high quality hospitals and ACO’s
  - High Quality = High Value (Financial Impacts)
  - Labor required in these models

- Coordination of Care Across the Entire Care Continuum
  - Acute, Post-Acute, and ACO Partners Impact YOUR success in these models
  - Sharing of Tools and Lessons Learned
Questions?
Ask Tamara
Is There Any Research on the Effectiveness of the Episode-Based Payment Model that CHI is currently utilizing?

2016