

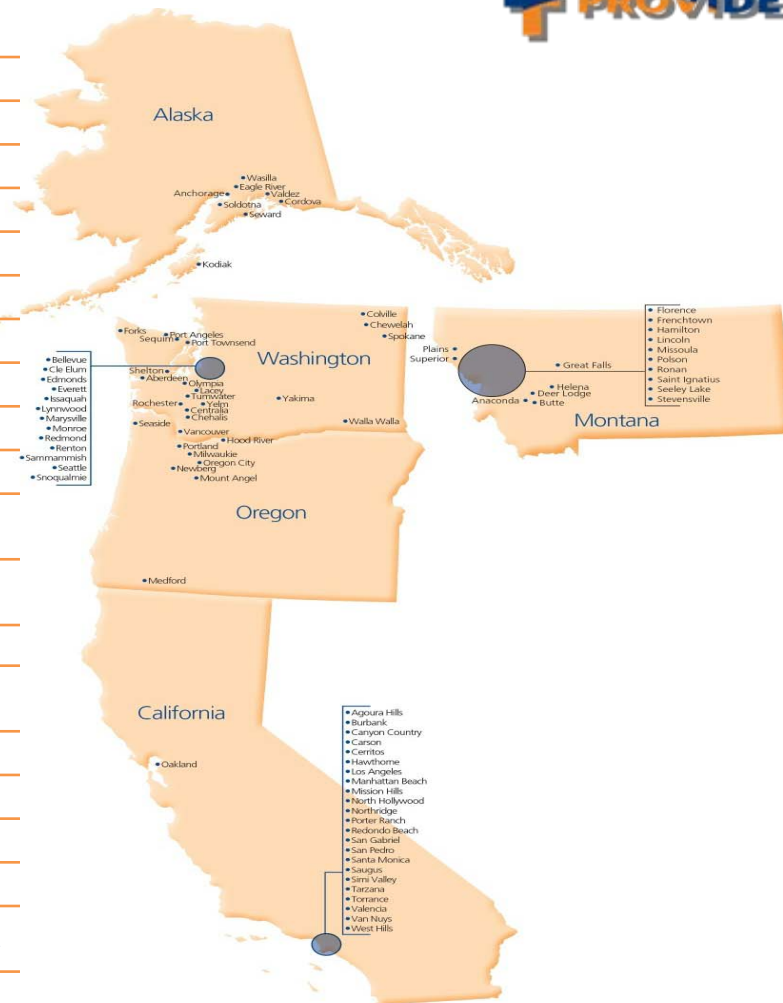
Capturing Triple Aim Value Across the Care Continuum in Cardiac Bundled Payments

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Program Manager, Cardiovascular Portfolio
Providence Health & Services

Snapshot of Providence



Employees	73,018
Employed physicians	3,389
Employed advance practice clinicians	923
Physician clinics	475
Acute care hospitals	34
Acute care beds (licensed)	7,932
Providence Health Plan members	390,596
Hospice and home health programs	19
Home health visits	633,364
Hospice days	640,409
Assisted living and long term care facilities (free standing and co-located)	22
Supportive housing	Facilities: 14 Units: 693
Unique patients served	2,483,462
Community benefit and charity care costs	\$951 million
Total net operating revenue	\$11.1 billion
Total net operating income	\$37.7 million
Total net income	\$253.3 million
Total net assets	\$7.3 billion
Long term bond ratings	Moody's Aa2; S&P AA; Fitch AA



Data is consolidated for Providence and its affiliates based on financial reporting.

Value-based Arrangements

Bundles



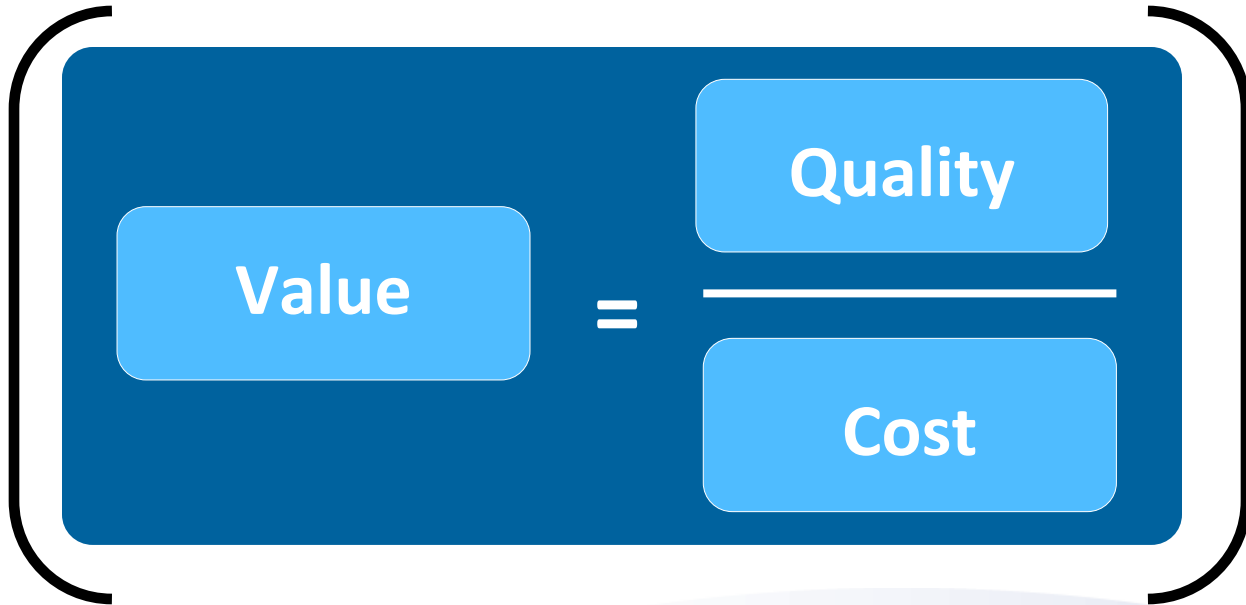
Risk-sharing/ CCO



Accountable Care



The Right Value Equation?



Latency...
And to whom does it go?

Strong CMMI Alignment



"The Centers for Medicare and Medicaid Services should be given, and be willing to exercise, more flexibility and authority to make broader and quicker decisions about identifying, implementing, monitoring, and modifying promising payment strategies."

Our CABG Care Package

- ✓ Covers all admit types
- ✓ No diagnosis exclusions
- ✓ Longer episode duration
- ✓ Broad scope of covered post-operative services
- ✓ Inclusive readmission DRGs
- ✓ Incorporates key outcome and patient satisfaction measures

Understanding Continuum Cost

Coronary Artery Bypass Graft Procedure Episode Group PHP Commercial & Medicare Advantage -Portland Service Area

Billed Charges per Episode by Phase of Care (Jan-Dec 2011)

PRE-ADMIT
7%

Episode Start through the day prior to admission

DURING-ADMIT
86%

During the Hospital Stay

30 Day Post-Discharge
7%

Post-Discharge through the episode end date

TT Roll Up	#Claims	Tot Cost	Avg per Claim	Cost per Episode
AlternativeCare Total				
DME Total				
ECG Total				
Lab Total				
OPFacility Total				
PrimaryAncillary Total				
PrimaryE&M Total				
PrimaryProf Total				
Radiology Total				
SpecAncilla Total				
SpecE&M Total				
SpecProf Total				
Therapy Total				
Grand Total				

Preliminary

TT Roll Up	#Cases	Total Cost	Avg per Case	% of Grand Total
Room and Board	344	\$3,344,313	\$9,721.84	38%
Surgery	344	\$1,672,777.00	\$4,862.72	19%
Pharmacy	344	\$952,583.00	\$2,769.14	11%
Supply	344	\$1,539,281.00	\$4,474.65	17%
Imaging	344	\$92,021.00	\$267.50	1%
Lab	344	\$427,067.00	\$1,241.47	5%
Other	344	\$848,842.00	\$2,467.56	10%
Grand Total	344	\$8,876,883.96	\$25,804.90	100%

Data Source: DSS 2011 Isolated CABG, All Payors

ALOS=8 Days

Coronary Artery Bypass Graft

TT Roll Up	#Claims	Tot Cost	Avg per Claim	Cost per Episode
AcuteInpatient Total				
AlternativeCare Total				
DME Total				
Home Health Total				
Lab Total				
OPFacility Total				
PrimaryE&M Total				
Radiology Total				
SNF/Skilled Reh				
SpecAncillary Total				
SpecE&M Total				
SpecProf Total				
Therapy Total				
Grand Total				

Preliminary

Episode Start to Day Prior to Admit

Post-Discharge Through the Episode End Date

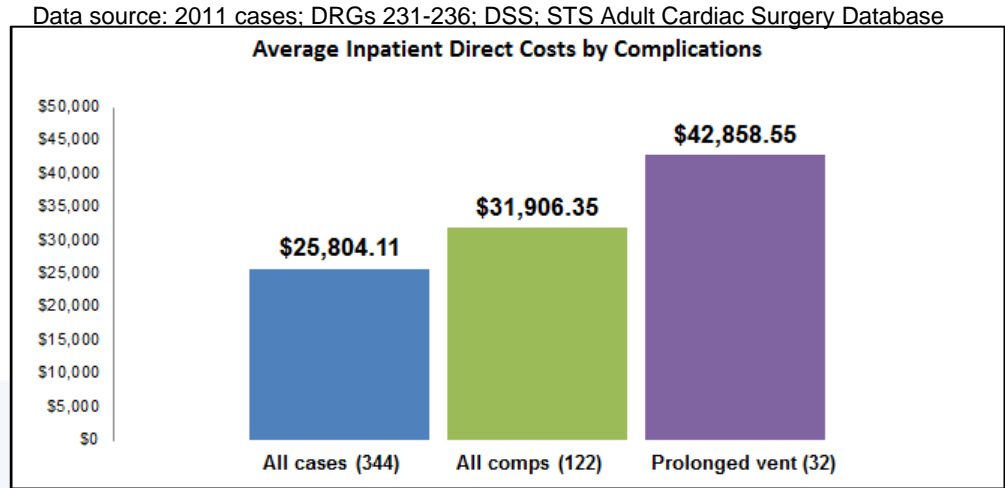
**CABG Care Package - DRG Sensitivity Analysis
DRG'S 231 - 236**

Isolated CABG - All Admit Types - All Payers

2011 Average Direct Costs per Case by DRG													Total DRG Direct Cost
DRG	Cases	Avg LOS	Room	CRU/CCU	Surgery	Supplies	Implants	Lab/RX	Rehab	Imaging	ED	Other	
231	2	12.5	\$4,280	\$12,848	\$6,430	\$6,261	\$2,090	\$23,998	\$707	\$667	\$490	\$2,378	\$60,150
232	5	5.2	\$1,207	\$5,299	\$5,857	\$5,928	\$2,028	\$5,916	\$181	\$226	\$352	\$1,096	\$28,091
233	52	12.8	\$3,038	\$12,613	\$5,850	\$4,878	\$358	\$6,328	\$610	\$494	\$294	\$3,537	\$38,000
234	127	8.4	\$2,535	\$6,707	\$5,421	\$4,537	\$162	\$3,824	\$204	\$217	\$265	\$1,616	\$25,490
235	36	10.2	\$2,355	\$10,064	\$4,446	\$4,664	\$167	\$4,769	\$470	\$389	\$34	\$2,269	\$29,627
236	122	6.1	\$1,800	\$5,108	\$3,916	\$4,094	\$134	\$2,587	\$236	\$182	\$17	\$1,075	\$19,149
TOTAL	344		\$2,536	\$8,773	\$5,320	\$5,060	\$823	\$7,904	\$401	\$363	\$242	\$1,995	
			7.6%	26.3%	15.9%	15.1%	2.5%	23.7%	1.2%	1.1%	0.7%	6.0%	
Percentage Goal for Reduction in Direct Costs per Case													Total DRG Expected Value Percentage
DRG	Cases	Avg LOS	Room	CRU/CCU	Surgery	Supplies	Implants	Lab/RX	Rehab	Imaging	ED	Other	
231	2		6.0%	3.9%	0.2%	0.5%	0.0%	1.5%	0.0%	0.5%	0.0%	0.0%	1.9%
232	5		14.4%	11.7%	0.2%	0.5%	0.0%	1.5%	0.0%	0.5%	0.0%	0.0%	3.3%
233	52		5.9%	6.4%	4.0%	0.5%	0.0%	5.0%	0.0%	5.0%	0.0%	2.5%	4.4%
234	127		8.9%	11.7%	4.0%	0.5%	0.0%	6.0%	0.0%	15.0%	0.0%	2.5%	6.1%
235	36		7.3%	6.5%	0.5%	0.5%	0.0%	5.0%	0.0%	5.0%	0.0%	2.5%	4.0%
236	122		12.3%	11.7%	4.0%	0.5%	0.0%	6.0%	0.0%	15.0%	0.0%	2.5%	6.3%
TOTAL	344												
Expected Value - Savings in Total Direct Costs by DRG													Total Value of Direct Cost Savings
DRG	Cases	Avg LOS	Room	CRU/CCU	Surgery	Supplies	Implants	Lab/RX	Rehab	Imaging	ED	Other	
231	2		\$514	\$1,007	\$26	\$63	\$0	\$720	\$0	\$7	\$0	\$0	\$2,335
232	5		\$870	\$3,100	\$59	\$148	\$0	\$444	\$0	\$6	\$0	\$0	\$4,627
233	52		\$9,293	\$42,227	\$12,169	\$1,268	\$0	\$16,454	\$0	\$1,284	\$0	\$4,599	\$87,294
234	127		\$28,637	\$99,754	\$27,540	\$2,881	\$0	\$29,142	\$0	\$4,138	\$0	\$5,131	\$197,222
235	36		\$6,221	\$23,601	\$800	\$840	\$0	\$8,583	\$0	\$700	\$0	\$2,042	\$42,787
236	122		\$27,012	\$72,867	\$19,108	\$2,497	\$0	\$18,936	\$0	\$3,324	\$0	\$3,280	\$147,025
TOTAL	344		\$72,546	\$242,557	\$59,702	\$7,697	\$0	\$74,279	\$0	\$9,459	\$0	\$15,051	\$481,290

Delivering predictable, high quality care is the best strategy to reduce cost and improve patient experience.

- Traditional cost-reduction strategies:
 - Contracting and utilization (supplies/tests/Rx)
 - Readmission
 - Procedure time
 - Staffing
 - Throughput/ LOS
- Value-based cost-reduction strategies:
 - Prospective case review
 - Evidence-based care steps
 - Reduction in complications and major morbidities
 - Data-driven strategies using clinical registries



The average direct cost of a case where a complication occurred is **24% higher** than the average direct cost of all cases.

Patient Interviews

“I went from being someone who took a daily multi-vitamin and some fish oil to a being heart patient. I remember getting home from the hospital and sitting at my kitchen table looking at a pile of pills I had to take. I just put my head in my hands and started to cry.”

-Gail, CABG patient



“I grew up in the days of the Marlboro Man and Joe Camel- smoking was perfectly acceptable. I haven’t quit smoking yet, but I’m working on it. I still eat at Carl’s Jr. because it tastes so good. I don’t like fish and I can’t be vegan. Except for the heart attack and my stroke I am in good health.”

-John, PCI patient





Care Package Key Features

- **Bundled payment:** One price covers related services 30 days pre-admission through 30 days post-discharge.
- **Evidence-based:** Provider-driven adherence to gold standards of cardiac surgery and post-operative care.
- **Patient-centric:** Shared decision-making and patient engagement tools are hardwired into the care design.
- **Appropriateness:** Multidisciplinary review process that considers the risks and benefits of surgery vs. alternative treatments.

Project Structure

Stage Gate Council

Core Team

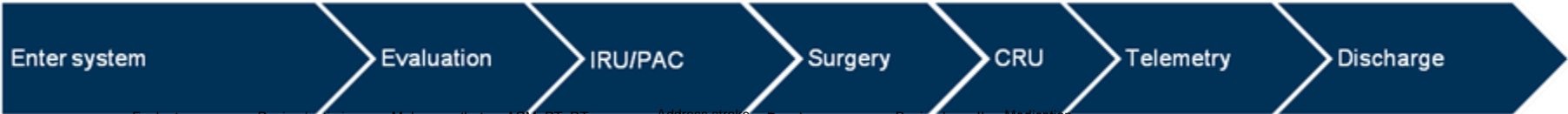
Clinical Workgroup

- Goals
 - Clinical optimization along the care path.
 - Recommend improvements to provider group.
- 22 clinical and support services

Provider Workgroup

- Goals
 - Develop and approve provider-driven best practices (care steps).
 - Review care package scope and key features.
- Physicians and PAs/NPs

Workout Session #1: Patient Care Path



Enter system	Evaluation	IRU/PAC	Surgery	CRU	Telemetry	Discharge		
<p>Prepare for discharge (teaching, discharge planning) prior to admission</p> <p>Develop optimization pre-op: Nutrition, OT/PT, smoking, medical care coordinator pre-op to provide consistency from pre-admit to discharge communication: interdisciplinary and staff to indicate whether the service will be bundled pre-operatively. Schedule as far ahead of time as possible to work with ins. Company to develop inpatient protocol followed and incorporated into EPIC. Use during rounding to ensure consistency. Should start at outpatient care.</p> <p>Evaluate timeliness of pre-op education, labs, surgical scheduling (same day vs. delay)</p> <p>Collect and enter history, medication, labs, and ECG into EMR in the cardiologist/surgeon office to minimize PAC apt. and surgical apt. made for the week ahead and the results communicated to surgeons 1 week prior to surgery to capture elective anemic patients, heparin allergies, etc. Provide online, interactive Q&A for patients to work through at home. Any questions could be directed to an online forum/clinic nurse at the Home Health pre-op home visit and labs moved to a home model or facility away from the hospital</p> <p>Encourage more cg education, family involvement for improved carryover of instruction and motivation to</p>	<p>Review/optimize patient meds pre-op</p> <p>Medication review pre-op</p> <p>Collect and enter history, medication, labs, and ECG into EMR in the cardiologist/surgeon office to minimize PAC apt. and surgical apt. made for the week ahead and the results communicated to surgeons 1 week prior to surgery to capture elective anemic patients, heparin allergies, etc. Provide online, interactive Q&A for patients to work through at home. Any questions could be directed to an online forum/clinic nurse at the Home Health pre-op home visit and labs moved to a home model or facility away from the hospital</p> <p>Encourage more cg education, family involvement for improved carryover of instruction and motivation to</p>	<p>Make sure that patient's home meds or devices (CPAP) are ordered for</p> <p>Provide admission of-town patients who have PAC the prior day or have a delay before surgery rather than the patient and family pre/post-op education tours or videos of facility. Send patients home pre-surgery to wear from meds rather than keep in teaching. Discharge begun earlier in pt stay and reinforced through multidisciplinary teaching and family on medications. Initiate decision for SNF placement early in process</p> <p>Evaluate by PT/OT or other therapists pre-op rounding with team approach</p> <p>Develop comprehensive pre/intra/post-op care: Video to take home, book to take home, book to take home, questions for other rehab staff earlier</p> <p>Present to CRU nurses if any patient issues are</p>	<p>ACM, PT, RT, PAC eval meeting</p> <p>Disposition plan should be known on admission & treatment team should be working toward that goal with the patient and family</p> <p>pre/post-op education tours or videos of facility. Send patients home pre-surgery to wear from meds rather than keep in teaching. Discharge begun earlier in pt stay and reinforced through multidisciplinary teaching and family on medications. Initiate decision for SNF placement early in process</p> <p>Evaluation by PT/OT or other therapists pre-op rounding with team approach</p> <p>Develop comprehensive pre/intra/post-op care: Video to take home, book to take home, book to take home, questions for other rehab staff earlier</p> <p>Present to CRU nurses if any patient issues are</p>	<p>Address stroke rate issues</p> <p>Evidence based review of OT practice to decrease OR time. Apply best practice to coordinate choice of surgery/ sedation medications for cost and efficiency. Standardization of surgical supplies among surgeons.</p> <p>Begin cardiac rehab pre-op</p> <p>Assign a patient advocate to help family navigate the complexity of the insurance process. Meet with someone in the process so they are more comfortable with the inpatient stay. Create a patient and family in formal rounding</p> <p>Standardize discharge protocol for CRU</p> <p>Develop comprehensive pre/intra/post-op care: Video to take home, book to take home, book to take home, questions for other rehab staff earlier</p> <p>Present to CRU nurses if any patient issues are</p>	<p>Develop a communication tool for hand-offs. Explore documenting in Epic to coordinate hand-off from IRU to CRU.</p> <p>Assign a person who follows a patient from IRU until 6 hrs post-surgery: don't let lunches and reports interfere with this. Check extubation times. Implement daily interdisciplinary rounds post-op. Formal postop interdisciplinary rounding process on all CABG pts- include patient and family in formal rounding</p> <p>Standardize discharge protocol for CRU</p> <p>Develop comprehensive pre/intra/post-op care: Video to take home, book to take home, book to take home, questions for other rehab staff earlier</p> <p>Present to CRU nurses if any patient issues are</p>	<p>Begin phase II cardiac rehab inpatient versus outpatient</p> <p>Have cardiac rehab staff meet with patient during CRU finalization</p> <p>improve MD/PA availability to develop an interdisciplinary rounding process that incorporates a specific time/day and includes all disciplines. Develop a rounding checklist to ensure best practice and that nothing is missed (Always available) present during rounds</p> <p>Create an early transfer protocol so patients can be transferred in a more timely manner without a specific surgeon leader at the time of discussion with the patient regarding expected progression of activity and ADLS to facilitate participation in cardiac rehab rounds on all MDs. Prioritize rounds on patients who are ready to be discharged</p> <p>More communication between surgery and cardiology with plans, orders, discharge</p>	<p>Medication review at discharge</p> <p>Interdisciplinary communication re: hospital discharge between rehab, care management, nursing, surgical rounds post-op</p> <p>Liberalization of diet order: is heart healthy really necessary. Want to encourage PO post-op. Post-op heart healthy diet education: heart to heart book vs. consult to RD, referral to outpatient dietician, calculate primary rounding: better and more frequent PT/OT involvement specific to cardiac rehab services and frequent mobilization to be able to transfer patients to telemetry earlier. This is in response to surgeons keeping patients in CRU longer because they are too sedated. Increase rounding on patients who are ready to be discharged</p> <p>Reduce pharmacy costs by using the patients own oral meds that are continued. Create a standardized protocol for team in CRU for transfer to next unit</p> <p>Make sure that the patient knows when and where to go for cardiac rehab (create a handout with info). Use EPIC to facilitate follow-up visits- standardize clarity of the information. Implement a scheduled call to the patient to set up follow-up visits. Contact the facility early. Create an order set/checklist of discharge medications</p> <p>Involve PA + others in the discharge process to clarify post-op scheduling/plan for patients. Better coordination between cardiology and CVS RNs in both inpatient and outpatient care</p>	<p>Follow-up call to patients post-discharge</p> <p>Transportation system: patients wait for hours for wheelchairs for discharge. Homecare instructions that emphasize daily cleaning of wounds: soap and water, pat dry. Use the Heart strong program (outpatient PT) as prep for patients who aren't quite ready for cardiac rehab. Create a standardized discharge plan. Schedule post-op/post-hospital MD appointment at discharge. At discharge try to fill scripts in-house</p> <p>Perform a regular review of readmission data for specific conditions to address problems that may be addressed for prevention.</p>

Identified Priorities:

Develop recommendations that include:

- 1) Establish transfer protocols from CICU to telemetry.
- 2) Establish extubation protocol and procedures.
- 3) Better communication of expectations, orders, and post-op plans.
- 4) Utilize Epic to support standardization and communication.
- 5) Increase the rate of cardiac rehab referral AND enrollment in the phase II rehab program.

Building CABG 50 Care Steps

1

Review

2

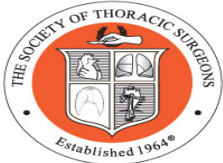
Translate

3

Examine

4

Deliver



Gold Standard
and Evidence
Based Guidelines

- 1 Preoperative
- 2 Intra-Operative
- 3 Post-Operative
- 4. Discharge
- 5. Post-Discharge

Actionable Care
Steps across
Episode
(56 proposed)



Review evidence
and vote:
31 unanimous yes
19 adopted after
discussion



Outline provider
behavior, modify
physician orders,
add Epic smart
phrases

Navigators and EPIC Optimization



Discharge Checklist:

1. **Aspirin is being given at discharge at ≥ 100 mg/day:** {Blank single:19197::"Yes.,"No, because of allergy, hypersensitivity, or intolerance. Clopidogrel (75 mg daily) is being given at discharge instead.,"No, because of active bleeding.,"No because of significant thrombocytopenia.,"No. The dose dose has been lowered to 81 mg/day because of concomitant use of other antithrombotic therapy.,"No, because ***."}
2. **A beta blocker is being given at discharge:** {Blank single:19197::"Yes.,"No, because of allergy, hypersensitivity, or intolerance.,"No because of hypotension.,"No, because of bradycardia/conduction block.,"No, because of reactive airway disease.,"No, because ***."}
3. **A statin is being given at discharge to achieve at least a 30% reduction in LDL-C and/or a level <100 mg/dL:** {Blank single:19197::"Yes.,"No, because of allergy, hypersensitivity, or intolerance. An alternative LDL-cholesterol lowering agent is being given instead.,"No, because ***."}
4. **An ACE inhibitor or ARB is being given at discharge:** {Blank single:19197::"Yes.,"No, because of allergy, hypersensitivity, or intolerance.,"No because of hypotension.,"No, because of renal insufficiency.,"No, because of hyperkalemia.,"No, because ***."}
5. **Warfarin is being given at discharge and will be managed by:** {Blank single:19197::"The hospital anticoagulation clinic (ACC).,"Cardiology.,"The primary care physician (PCP).,"Other: ***"}
6. **A referral to phase 2 of cardiac rehabilitation has been placed:** {Blank single:19197::"Yes.,"No, because ***."}
7. **Follow up with CT surgery has been arranged and is documented in the after visit summary:** {Blank single:19197::"Yes.,"No, follow up has not been arranged because ***."}
8. **Follow up with Cardiology has been arranged and is documented in the after visit summary:** {Blank single:19197::"Yes.,"No, follow up has not been arranged because ***."}
9. **Follow up with the PCP has been arranged and is documented in the after visit summary:** {Blank single:19197::"Yes.,"No, follow up has not been arranged because ***."}
10. **The patient has symptoms suggestive of postoperative depression:** {Blank single:19197::"Yes, and the patient has been referred to their primary care physician (PCP) for further evaluation and treatment.,"Yes, and the patient has been referred to a behavioral health specialist for further evaluation and treatment.,"No."}

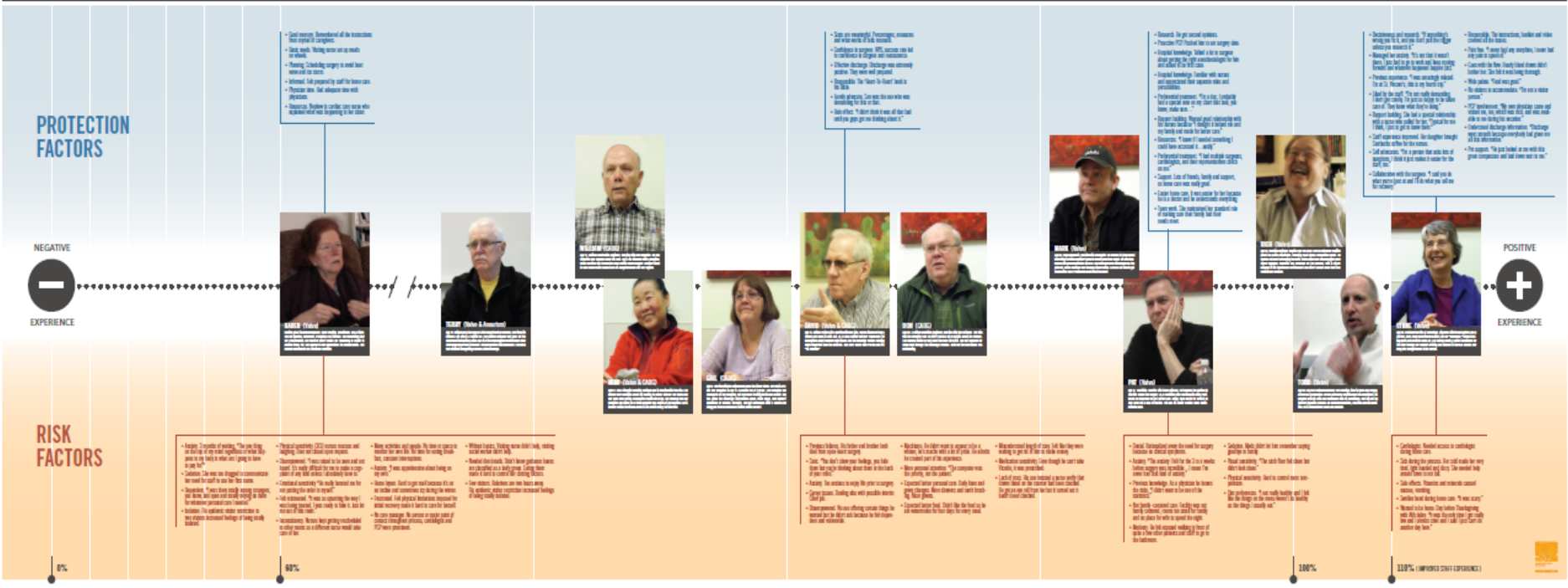
Human Centered Design

PSVMC CABG / Valve Patient Experience Spectrum

The risk and protection factors highlight patient attributes that could positively or negatively affect their experience. These factors interact with the others that can be creating their unique patient experience.

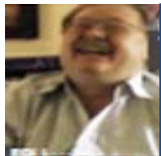
EXPERIENCE CRITERIA:

- 1. Access to care
- 2. Patient and family engagement
- 3. Patient and family education
- 4. Patient and family support
- 5. Patient and family information
- 6. Patient and family involvement
- 7. Patient and family participation
- 8. Patient and family collaboration
- 9. Patient and family partnership
- 10. Patient and family leadership



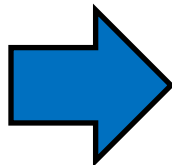
Patient engagement features

Meaningful innovations will require us to know our users well



Human Centered Design

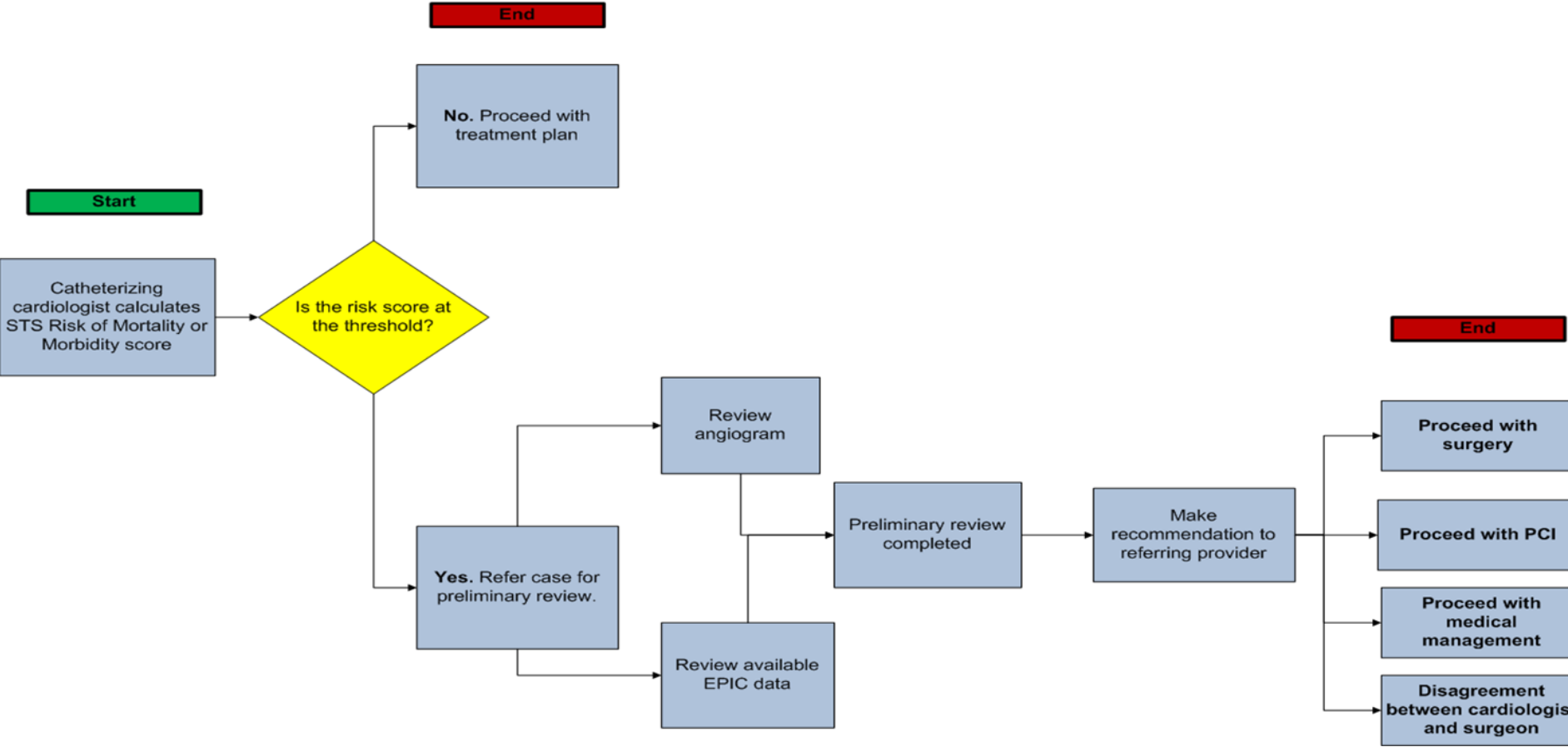
- Observation
- Patient interviews
- Clinical workgroups
- Planning
- Care integration



Care Package Features

- **Patient Compact**
- Shared decision-making
- **Pre-admission planning checklist**
- Medication education
- Follow-up appointments
- Manage home recovery and establish healthy lifestyle

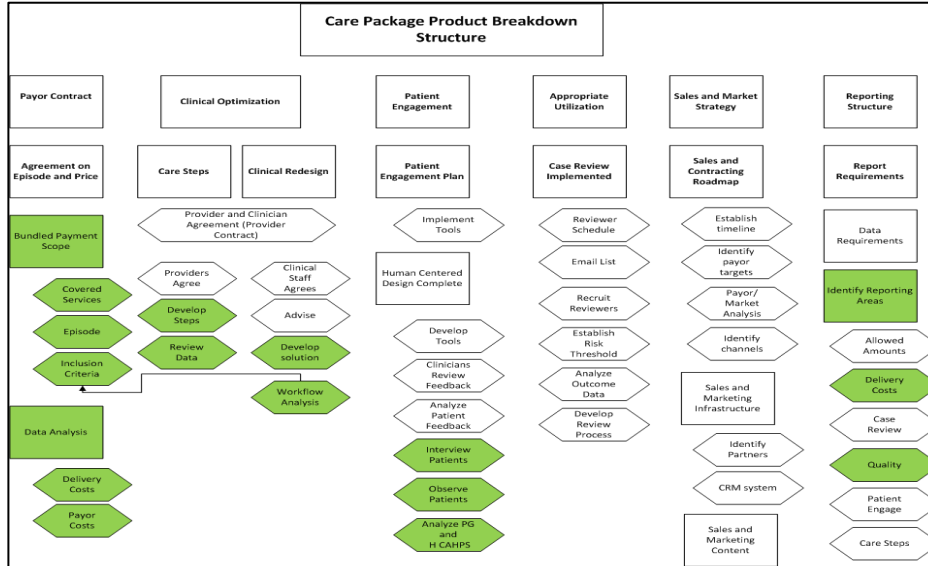
Prospective Case Review



Pilot Results

“However beautiful the strategy, you should occasionally look at the results.”

- Winston Churchill



Cost reduction and halo effect

CABG Care Package Inpatient Value Proposition Calculation	Projected	Actual
Isolated CABG Cases	235	209
(Weighted) Average Direct Cost Percent Savings	5.40%	7.9%
Value Proposition Per Case	\$1,400	\$2063
Total CABG Care Package Inpatient Value Proposition	\$329,000	\$431,063

HALO EFFECT- Applied to all Inpatient Cardiac Surgery Cases	Projected	Actual
All Other Inpatient Cardiac Surgery Cases	336	373
Value Proposition Per Case	\$1,400	\$1,775
Halo Effect- Total Estimated Value for Inpatient Cost Savings	\$470,400	\$763,718

OVERALL CARDIAC SURGERY INPATIENT VALUE PROPOSITION	\$799,400	\$1,194,781
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Calculations based on 2011 inpatient direct costs per case of \$26,030 for PSVMC. Actual savings based on R4Q (Q4 2012- Q3 2013).

Physician Dashboard

TRIPLE AIM			
Affordable Services			
Avg Total LOS (days)	● 8.05	● 7.70	● 7.90
Avg Total CICU Stay (hours)	● 53.5	● 45.1	● 49.5
Improving Population Health			
% Readmission within 30 days	● 7.6%	● 5.7%	● 4.9%
% Any Blood Products	● 31.7%	● 27.8%	● 29.0%
% Extubated <6 hours	● 68.7%	● 81.5%	● 85.5%
Avg Postop Vent (initial hours)	● 11.6	● 9.1	● 9.8
PROCESS MEASURES			
SCIP (SCIP Definitions)			
% Antibiotic Selection	● 100.0%	● 100.0%	● 100.0%
% Antibiotic Timing	● 99.6%	● 100.0%	● 100.0%
% Antibiotic Discontinued	● 100.0%	● 100.0%	● 100.0%
% Glycemic Control Day 1	#N/A	#N/A	● 96.8%
% Glycemic Control Day 2	#N/A	#N/A	● 100.0%
STS NQF (STS Definitions)			
% Preop Beta Blocker	● 96.8%	● 100.0%	● 92.6%
% IMA Use	● 95.5%	● 94.1%	● 93.2%
% Discharge Antiplatelets	● 98.7%	● 100.0%	● 100.0%
% Discharge Beta Blocker	● 98.6%	● 100.0%	● 100.0%
% Discharge Lipid Lowering	● 99.1%	● 100.0%	● 100.0%
STS Quality			
% Cardiac Rehab Referral	● 91.5%	● 100.0%	● 100.0%
Avg Predicted Risk Mortality	2.54%	2.61%	2.28%
Avg Predicted Risk M&M	16.6%	16.9%	15.9%
Median Total LOS (days)	● 6.0	● 6.0	● 6.0
Median Total CICU Stay (hours)	● 37.1	● 29.0	● 40.2
Median Postop Vent (initial hours)	● 5.1	● 4.6	● 4.5

Formatting Rules		
7.60		7.70
63.3		63.4
5.3%	5.4%	10.0%
43.6%	43.7%	51.8%
43.1%	43.0%	42.9%
14.6	14.7	14.8
100.0%		99.9%
100.0%		99.9%
100.0%		99.9%
100.0%		99.9%
100.0%		99.9%
NQF avg		
100.0%	92.0%	91.9%
100.0%	98.1%	98.0%
100.0%	98.3%	98.2%
100.0%	97.6%	97.5%
100.0%	96.7%	96.6%
target		
100.0%	95.0%	94.9%

KEY - Target source	
	Program target
	PSVMC Overall 2012
	STS avg 1Q-4Q 2012
	STS mdn 1Q-4Q 2012
	NQF avg 1Q-4Q 2012
	(+/- 0.1) of Yellow

8.0
47.0
6.7

Data Source: PATS STS Adult Cardiac registry, STS-defined Isolated CABG cases only.

Produced by Regional Heart and Vascular Data Services

Patient Satisfaction

Metric	2014	2012
Likely to recommend	92%	88.2%
Physician overall (percentile)	97th	78th
Home care instructions (percentile)	99th	90th

Data source: Press Ganey/ H CAHPS database; 1/1/2011- 6/30/2014; DRGs 231-236; PSVMC; 2014 n= 30; 2012 n=66

Case Review

**119 cases sent to review 2014
(31.7% of 375 cases)**

Receive PCI: 20 cases
(17%)

Proceed to CABG:
82 cases (69 %)

Medical Management:
17 cases (14%)



What does it take?

- Massive care coordination
- Redesigned processes
- Set performance standards
- Expertise in claims and pricing
- Engage the patient/family
- Rigorous accountability
 - ✓ Primary care
 - ✓ Cardiologist
 - ✓ Surgeon
 - ✓ Inpatient care team
 - ✓ Patient and Family



Lessons Learned

- ✓ Identify a strong physician champion and protect his/her time.
- ✓ Engage physicians around the data, especially their own.
- ✓ Merged cost and quality data is powerful but difficult to get.
- ✓ Don't forget about Nursing!
- ✓ There will be unintended consequences, both good and bad.
- ✓ This approach works for value based reimbursement.
- ✓ Partnerships are critical and should start early in the process.
- ✓ The price of this work is eternal vigilance.

Vigilance

n. alert watchfulness; the fact, quality, or condition of being vigilant

