

Managing Patients for Performance under BPCI Total Hip and Knee Replacements

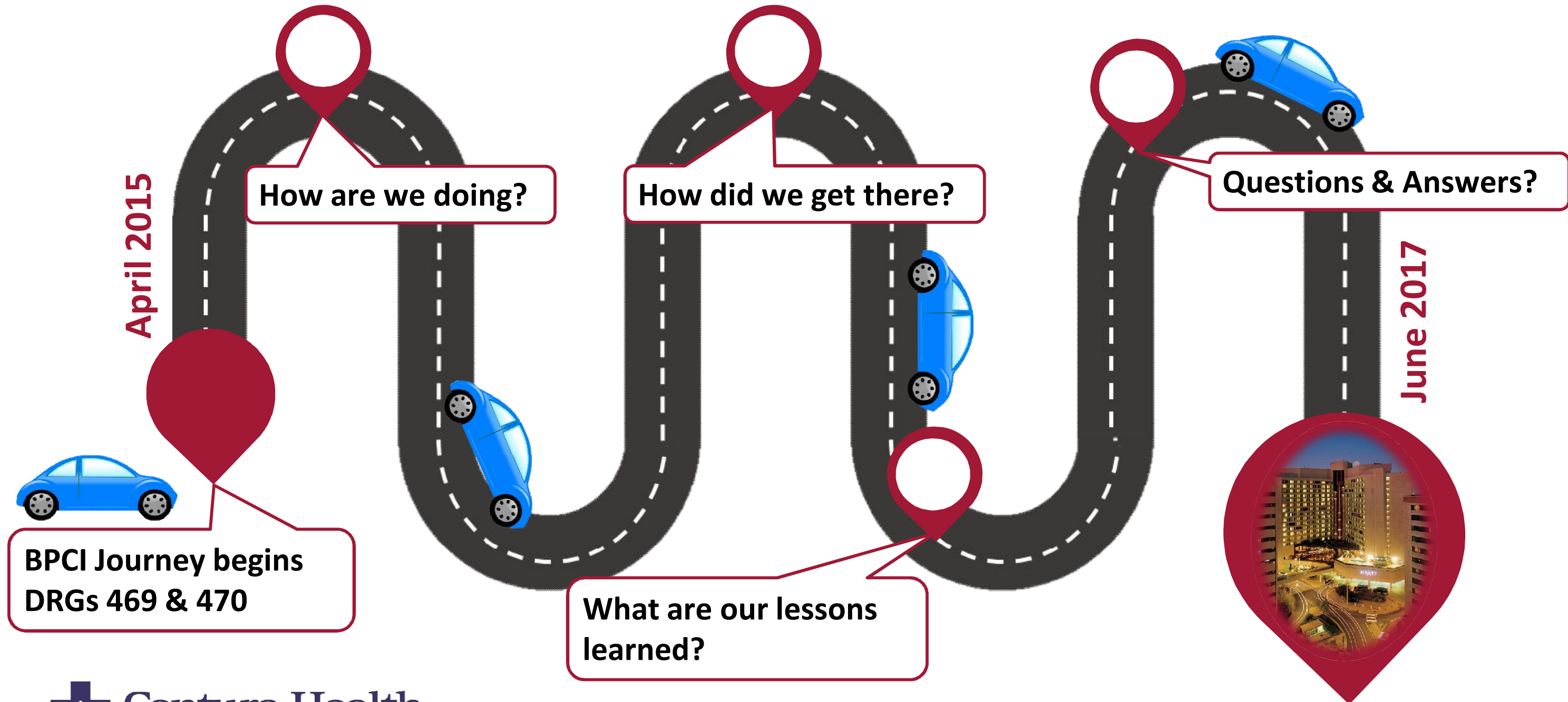
Kristen Daley, Group Director – Value Based Programs

Brenda Lewis, RN, MBA-HCM, CCM, ACM Group Manager – Care Coordination



Agenda

Our BPCI Program Roadmap...



Littleton Adventist



Centura Health®

Parker Adventist



St. Mary Corwin



Porter Adventist



Ortho Colorado



St. Thomas More



Avista



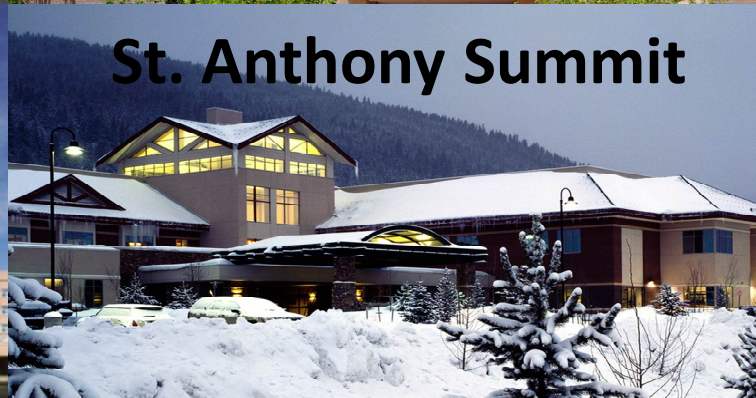
Penrose/St. Francis



Longmont United



St. Anthony Summit



St. Anthony North



St. Anthony



Castle Rock Adventist



St. Catherine



Mercy Regional



St. Anthony Mountain Clinics

Keystone Medical Clinic
Copper Mountain Clinic
Granby Medical Center
Breckenridge Community Clinic

Porter Adventist Hospital



- Located in Denver, Colorado
- Founded in 1930 (87 years)
- 368-Bed Hospital Facility
- Magnet Recognition
- Level-3 Trauma

Employed Total Joint Replacement Practice

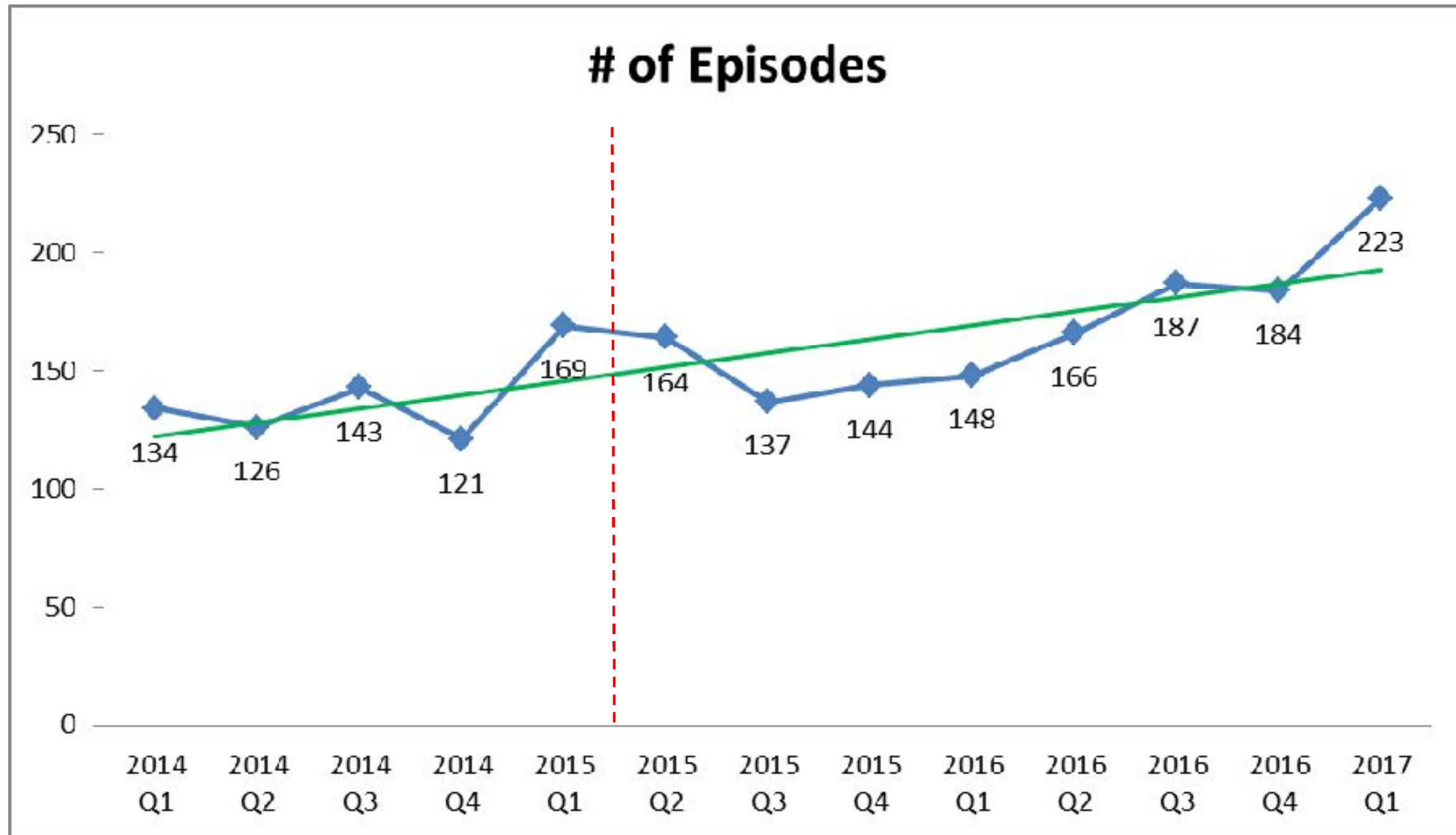
- Dr Doug Dennis, Dr Todd Miner, Dr Raymond Kim, Dr Charlie Yang, Dr Jason Jennings
- 2,200 Total Joint Replacement Cases per Year
- 85% Primary, 15% Revision



Our BPCI Program Roadmap...

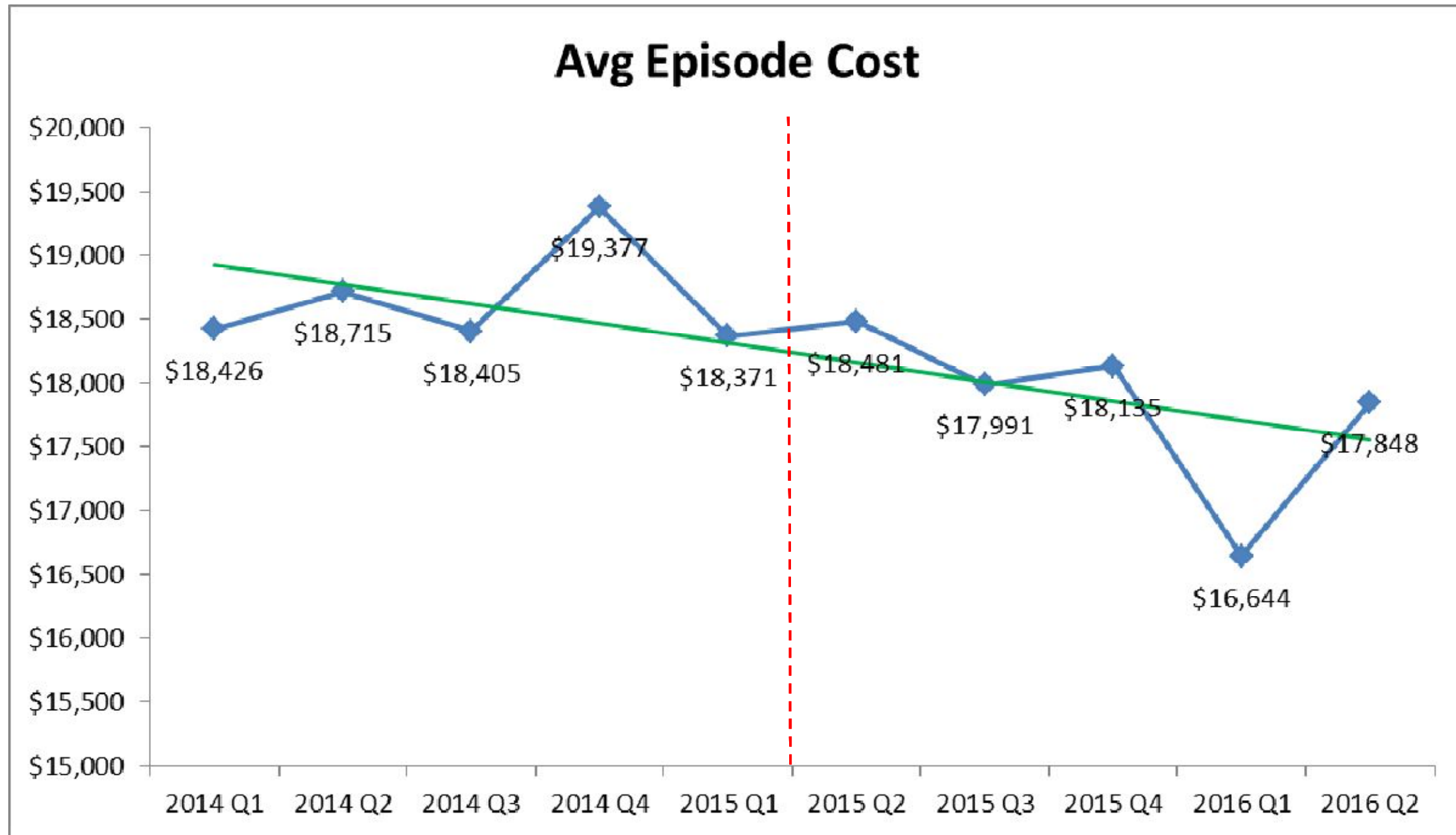


Volume



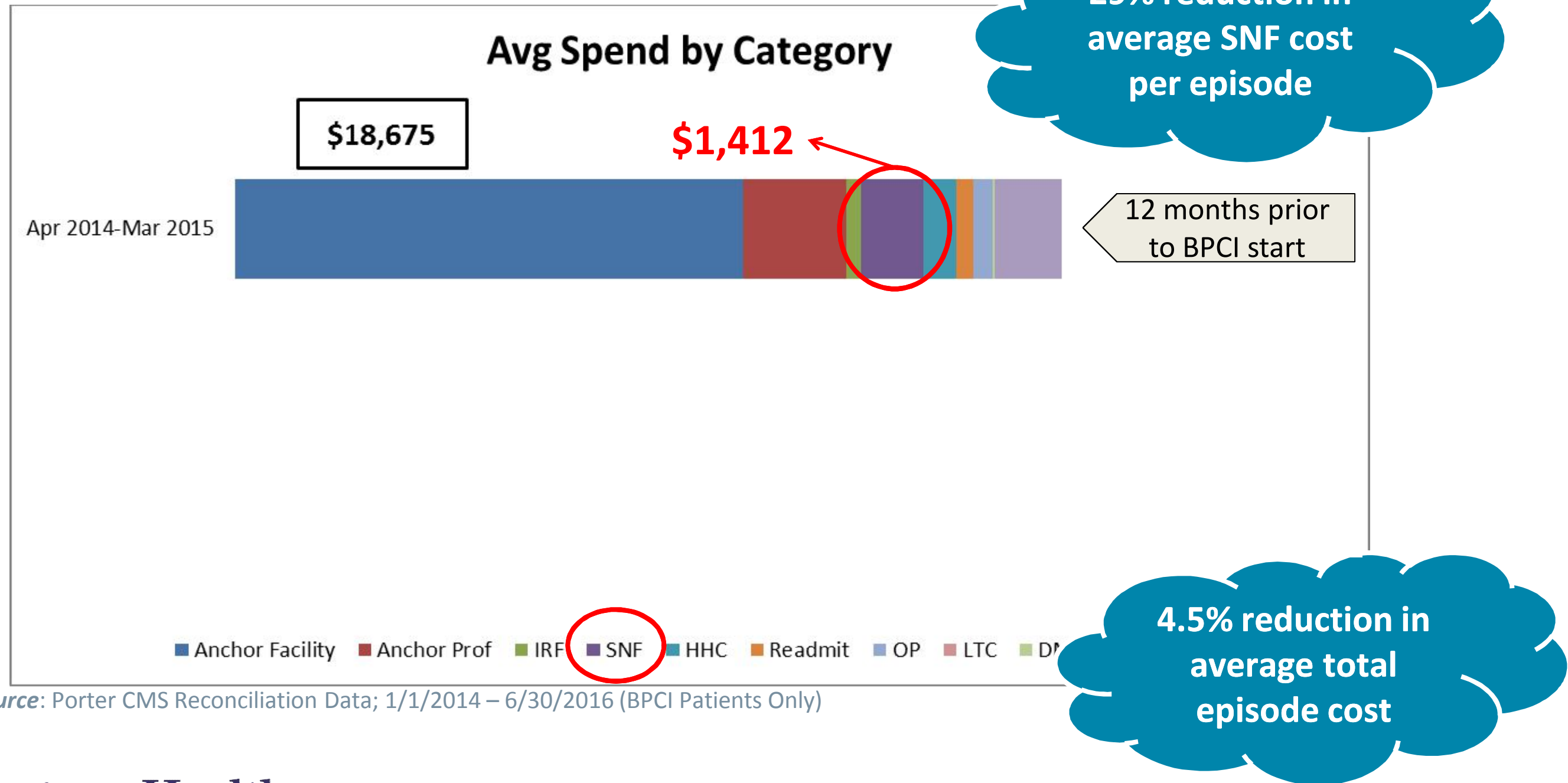
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016; Internally Collected Data; 7/1/2016 – 3/31/2017 (BPCI Patients Only)

Average Episode Cost



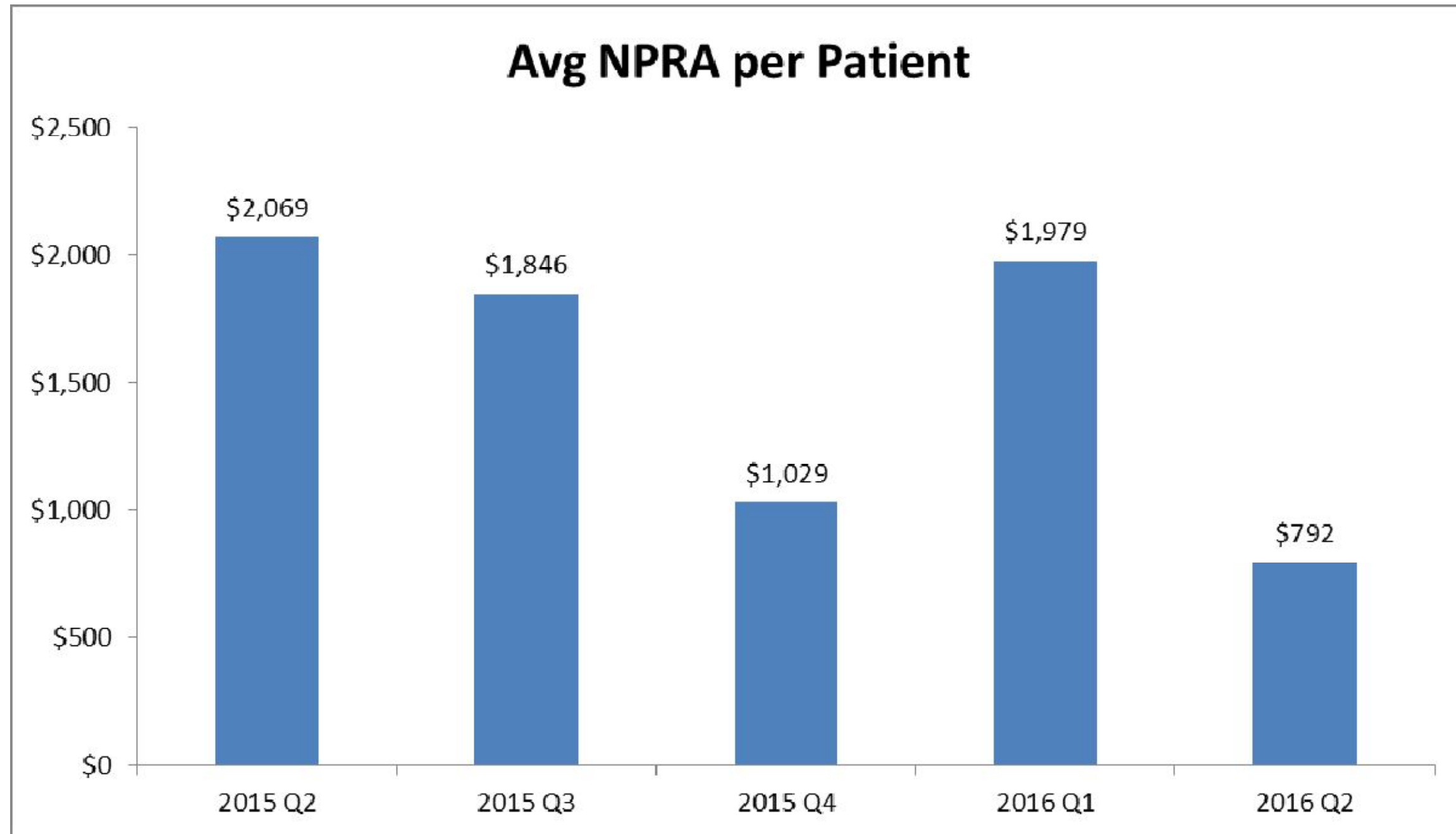
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Average Episode Cost



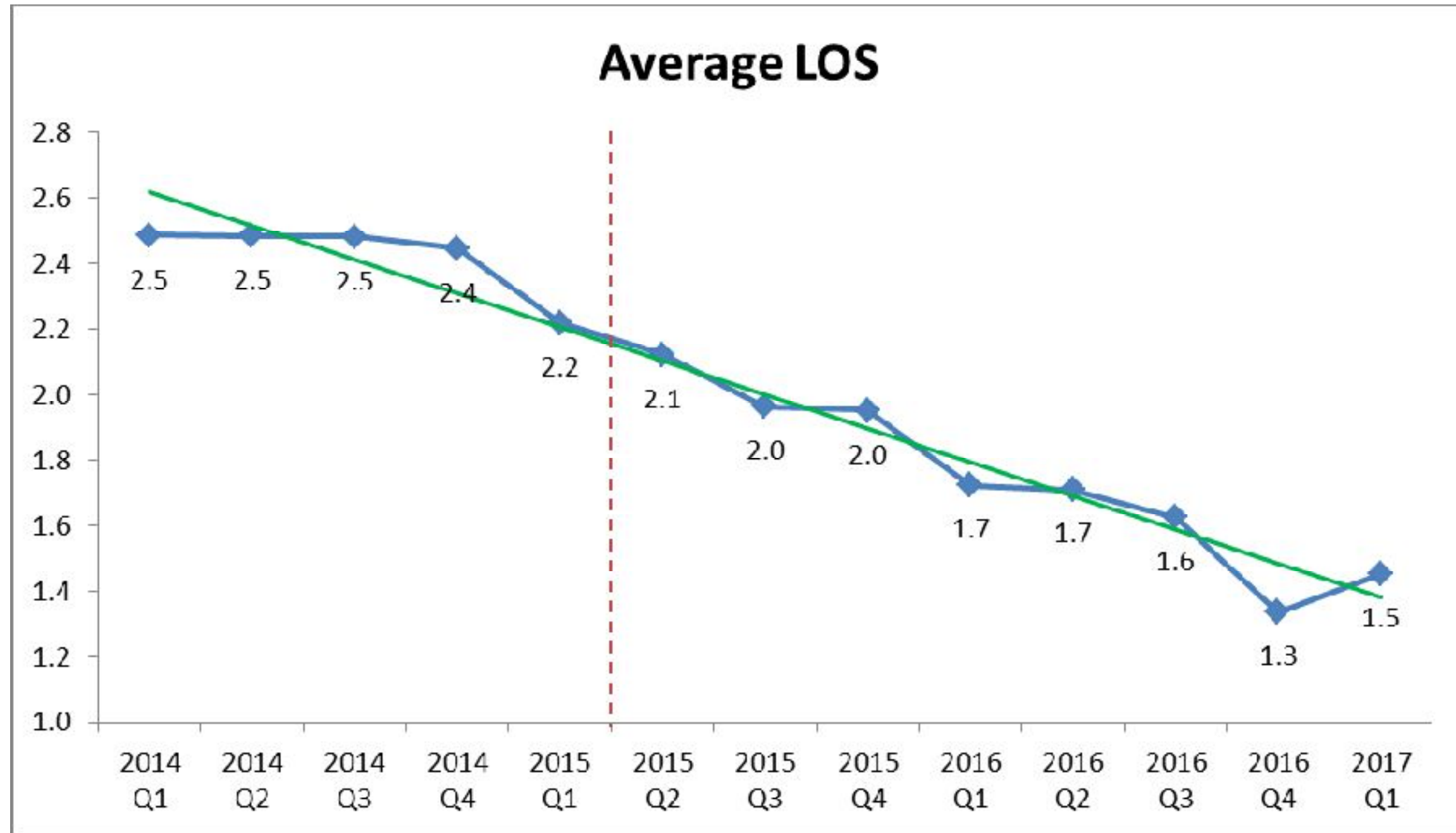
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016 (BPCI Patients Only)

Average NPRA per Patient



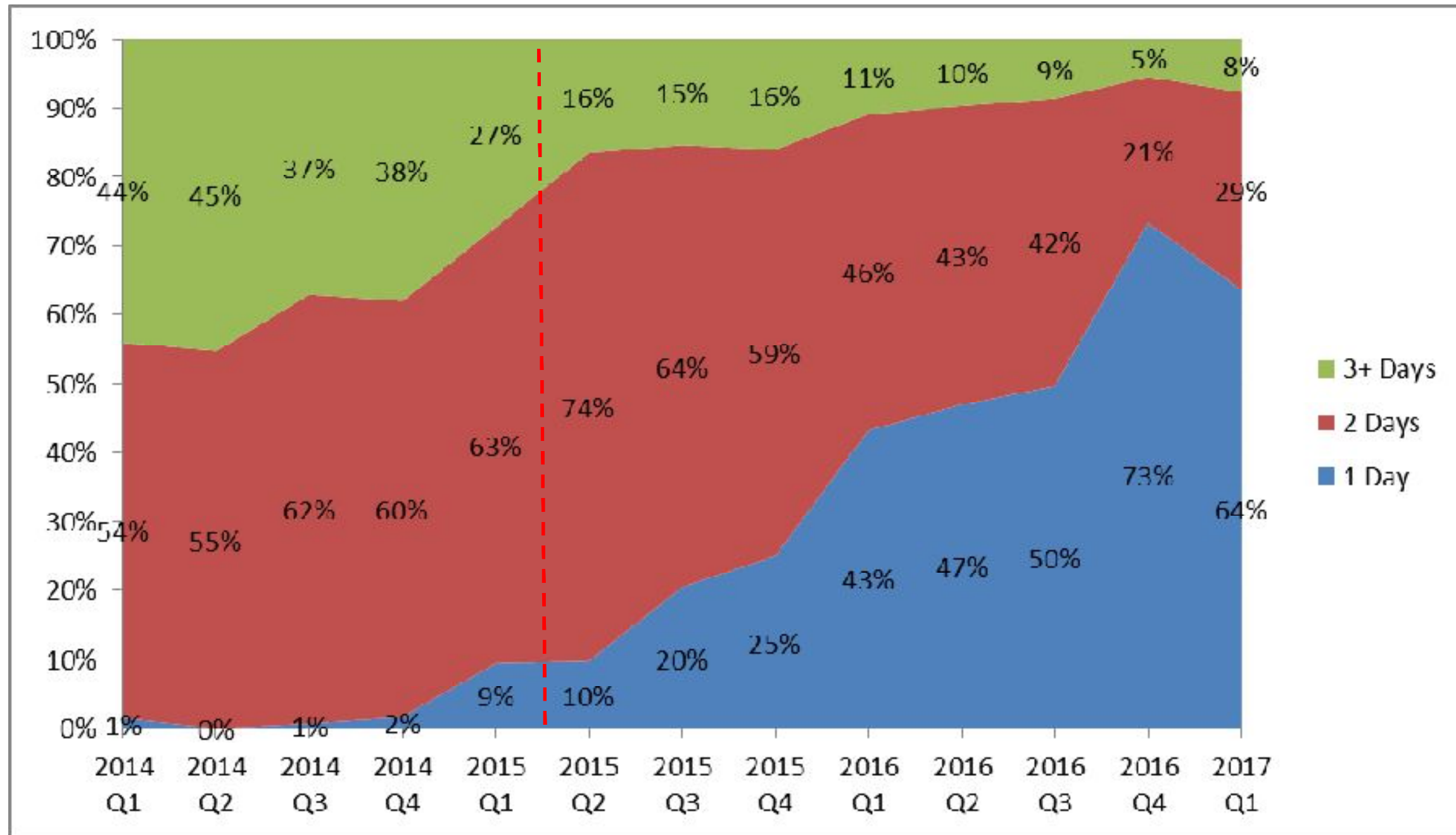
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016 (BPCI Patients Only)

Acute Length of Stay



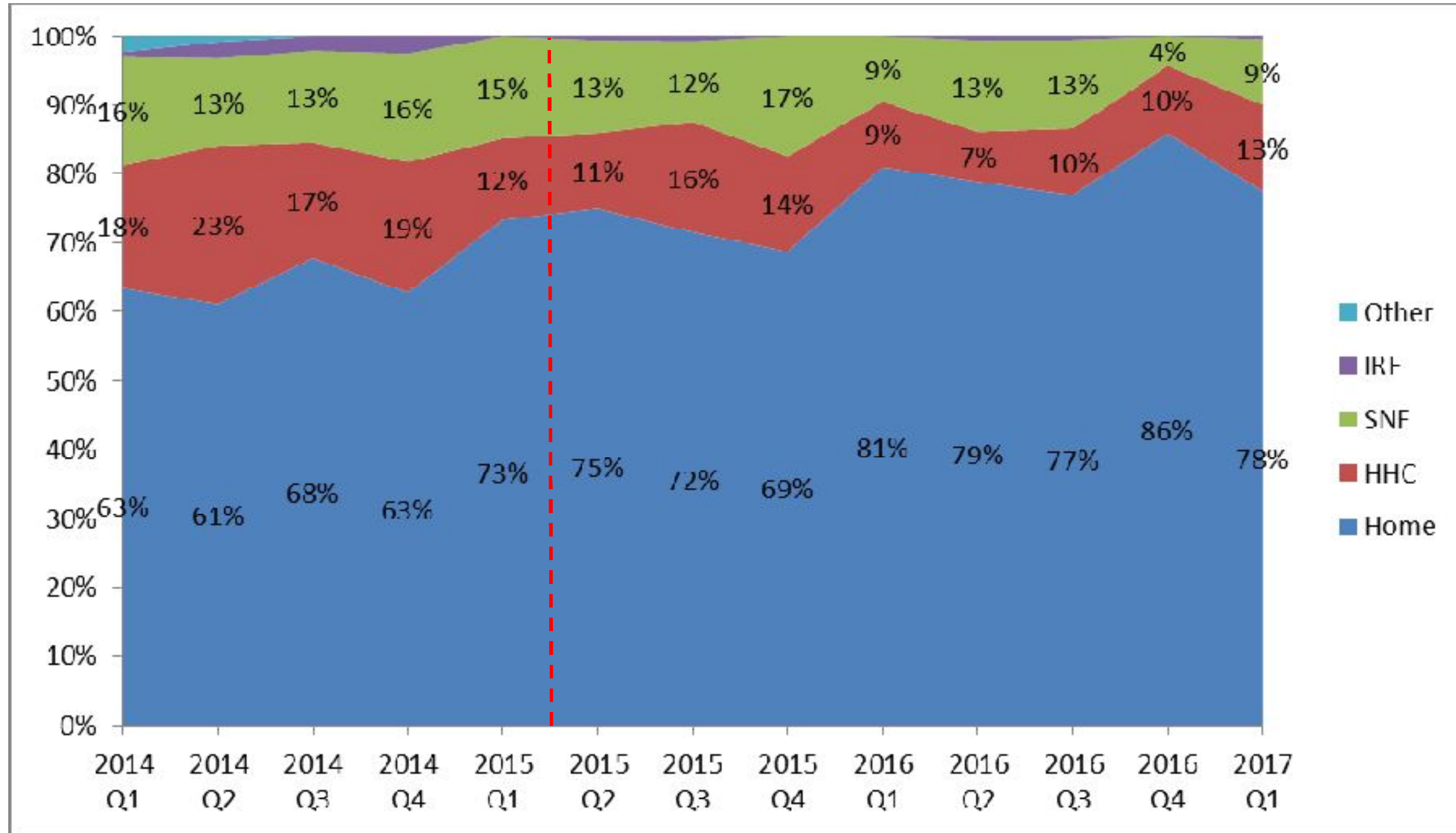
Source: Porter CMS Reconciliation Data; 1/1/2013 – 3/31/2016; and Internally Collected Data; 4/1/2016 – 12/31/2016 (BPCI Patients Only)

% of Patients by LOS



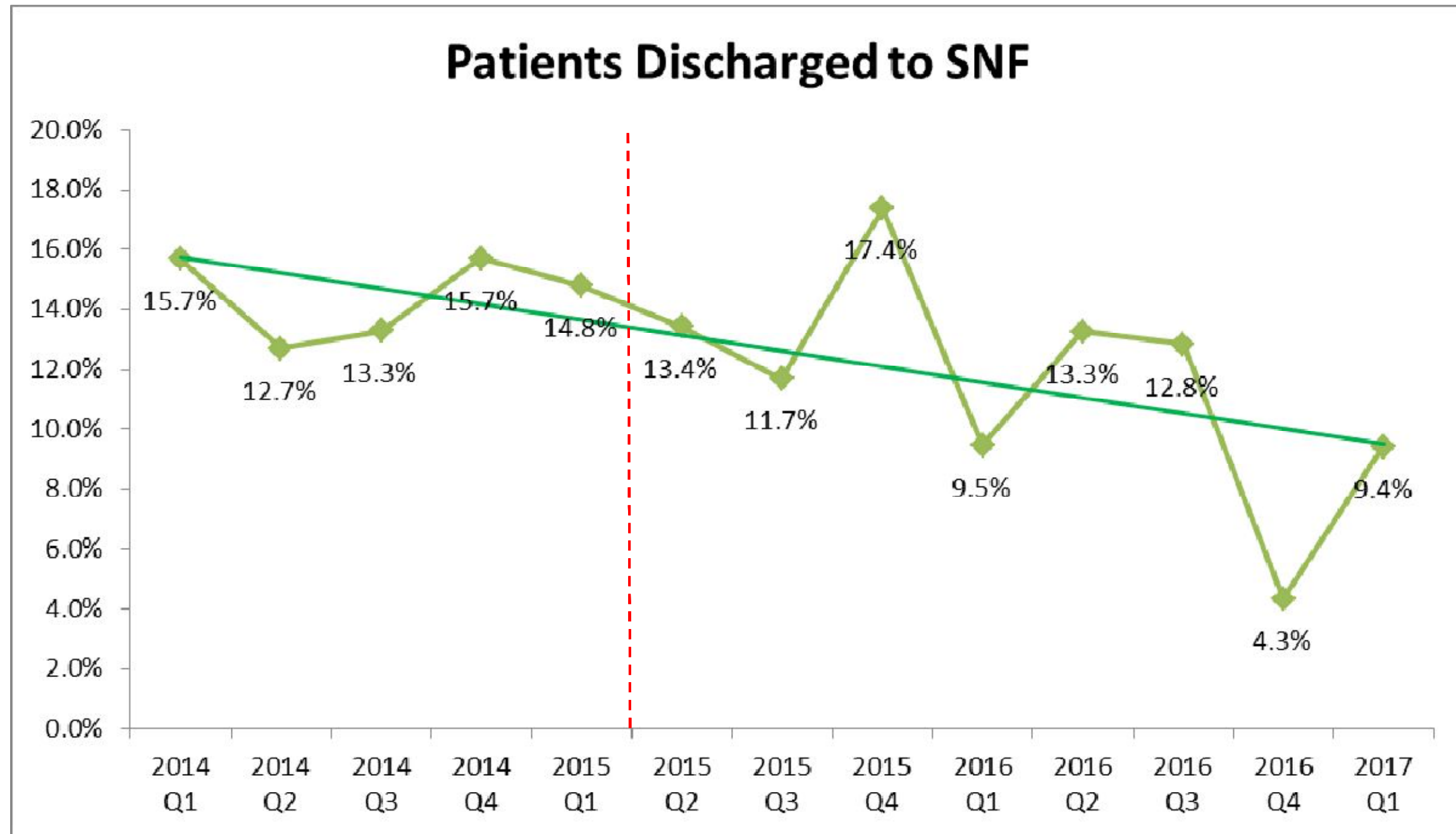
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016; and Internally Collected Data; 7/1/2016 – 3/31/2017 (BPCI Patients Only)

Discharge Dispositions



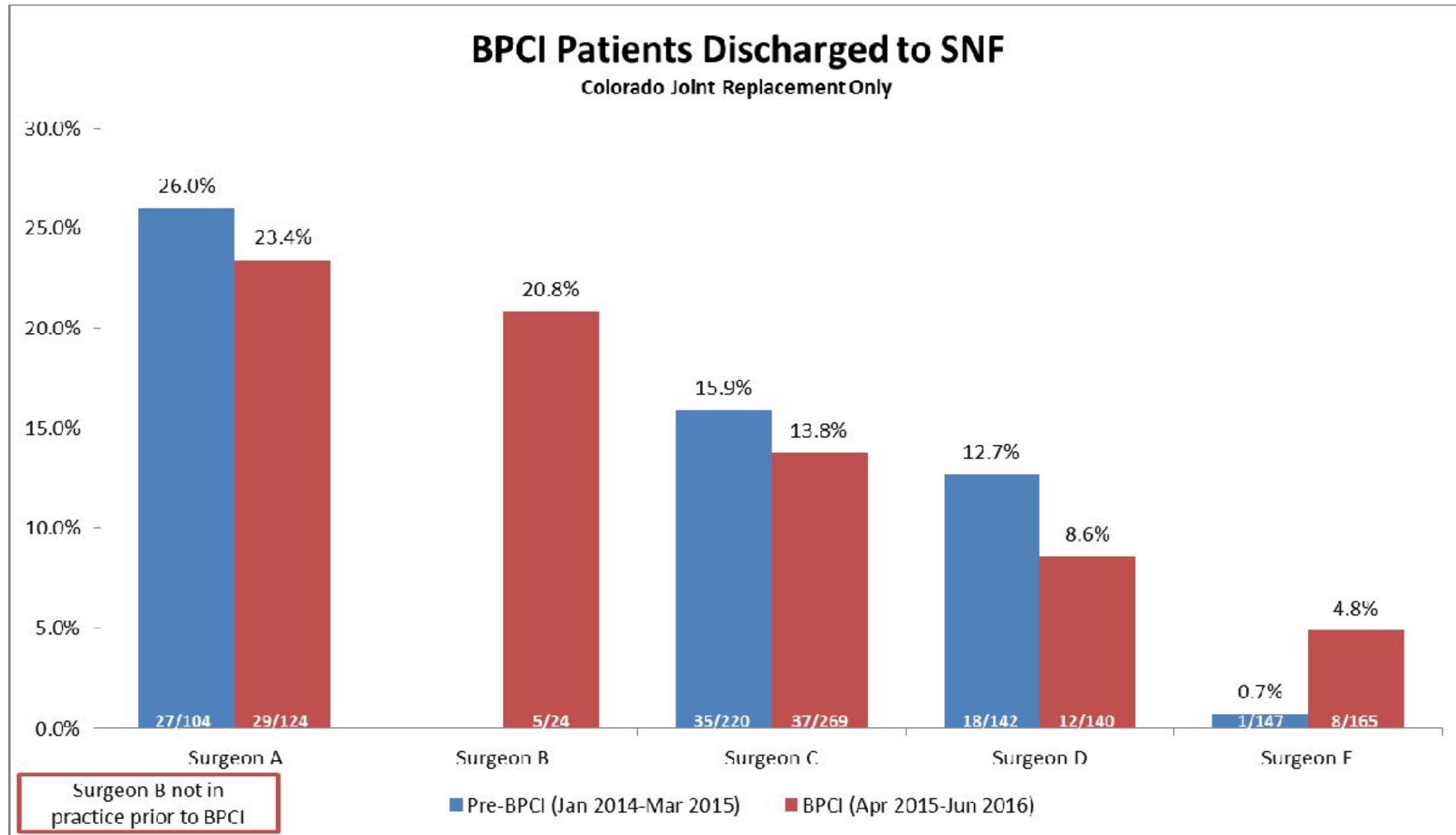
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016; and Internally Collected Data; 7/1/2016 – 3/31/2017 (BPCI Patients Only)

% Discharged to SNF



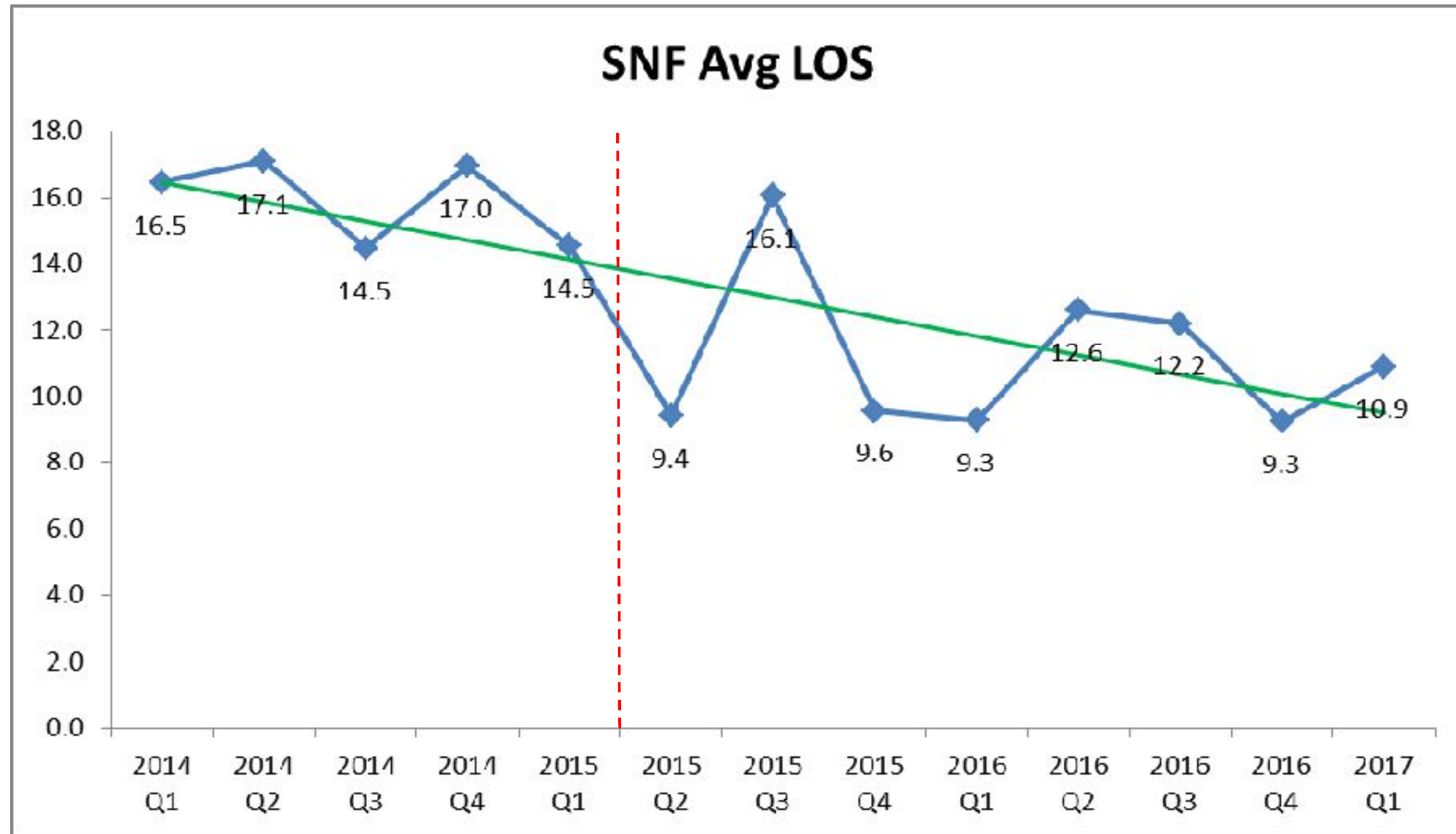
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016; and Internally Collected Data; 7/1/2016 – 3/31/2017 (BPCI Patients Only)

% Discharged SNF by Surgeon



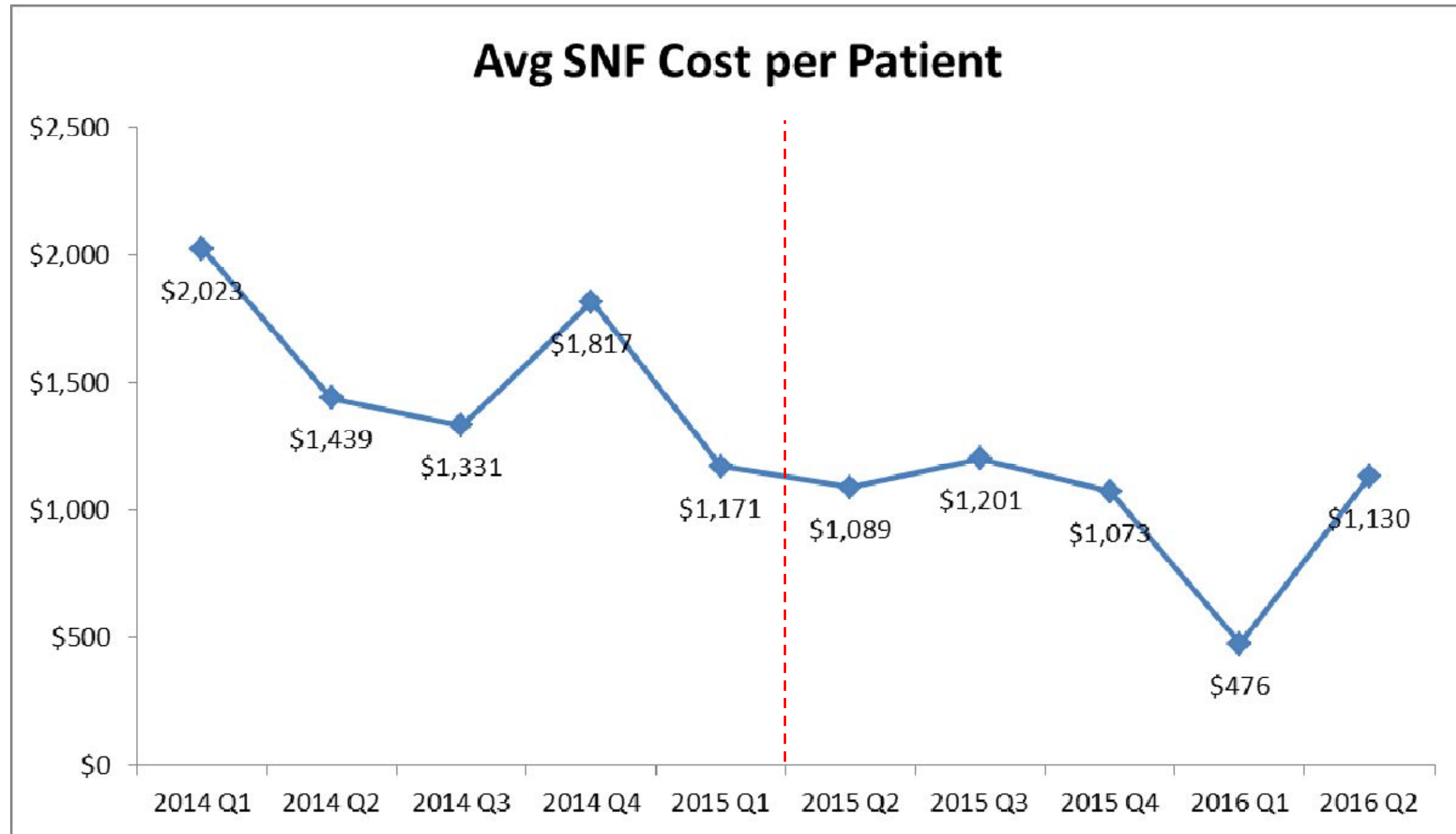
Source: Porter CMS Reconciliation Data; 1/1/2013 – 3/31/2016; (BPCI Patients Only)

SNF - Length of Stay



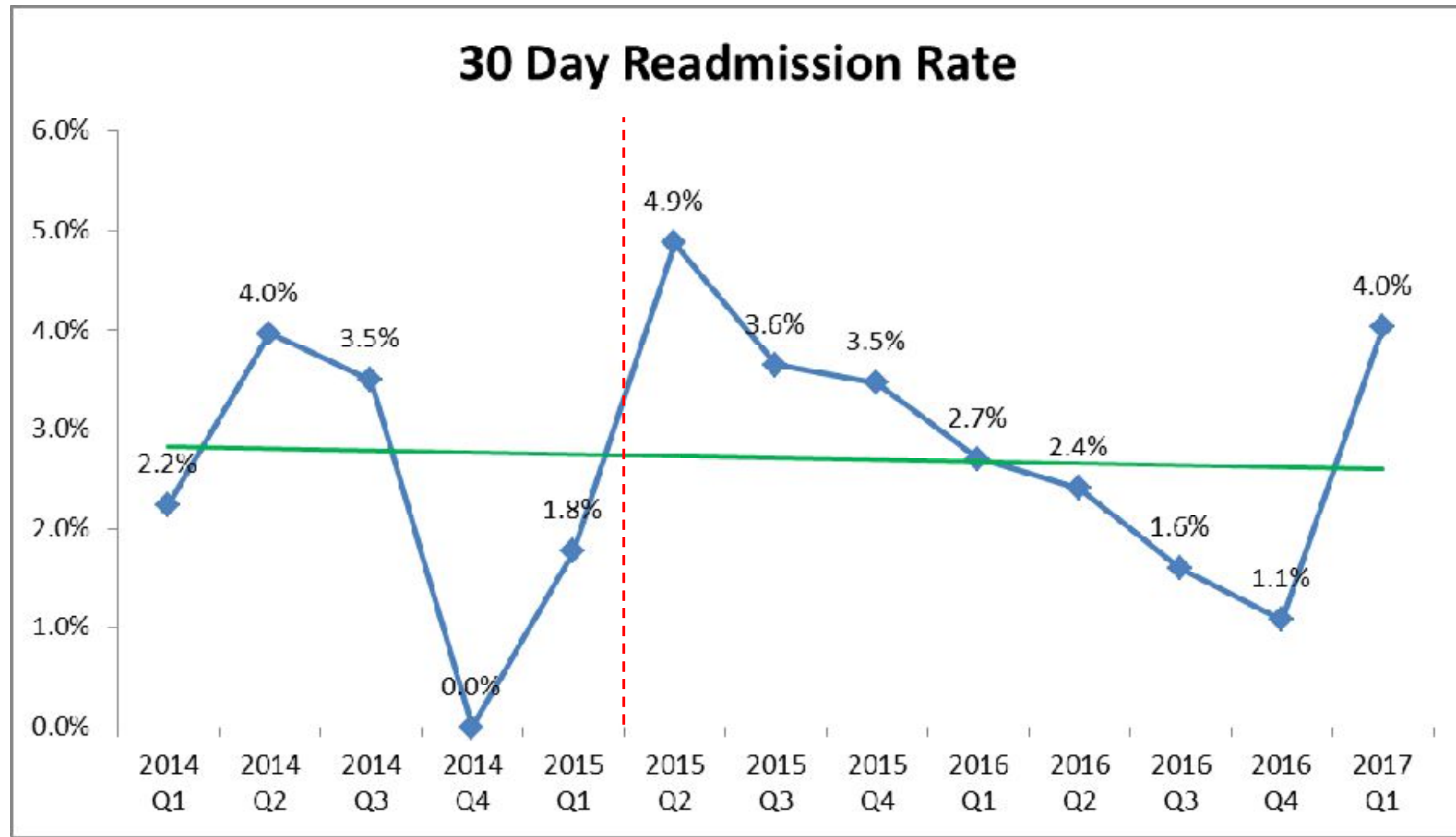
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SNF - Avg Cost Per Patient



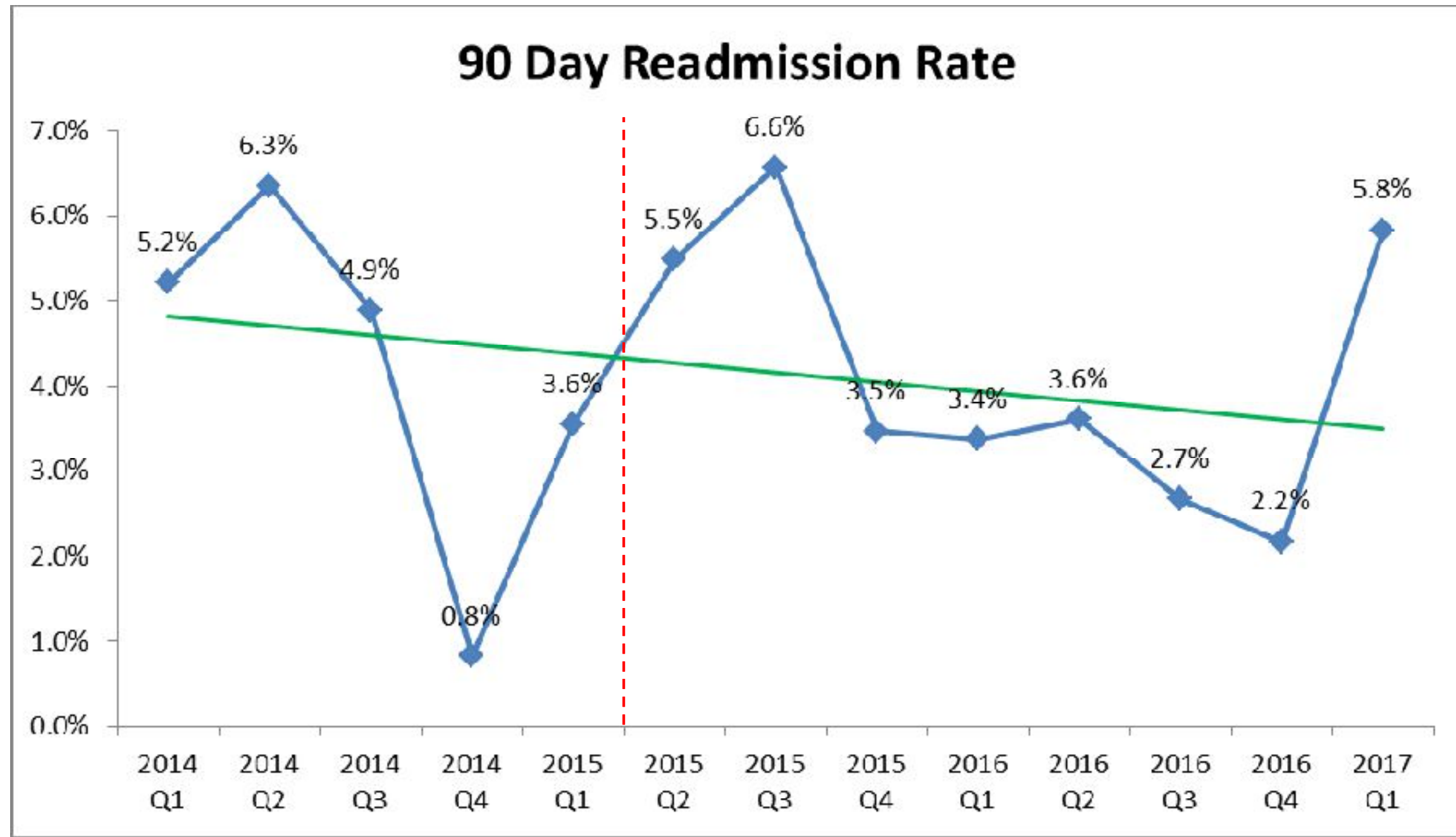
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016 (BPCI Patients Only)

30-Day Readmissions



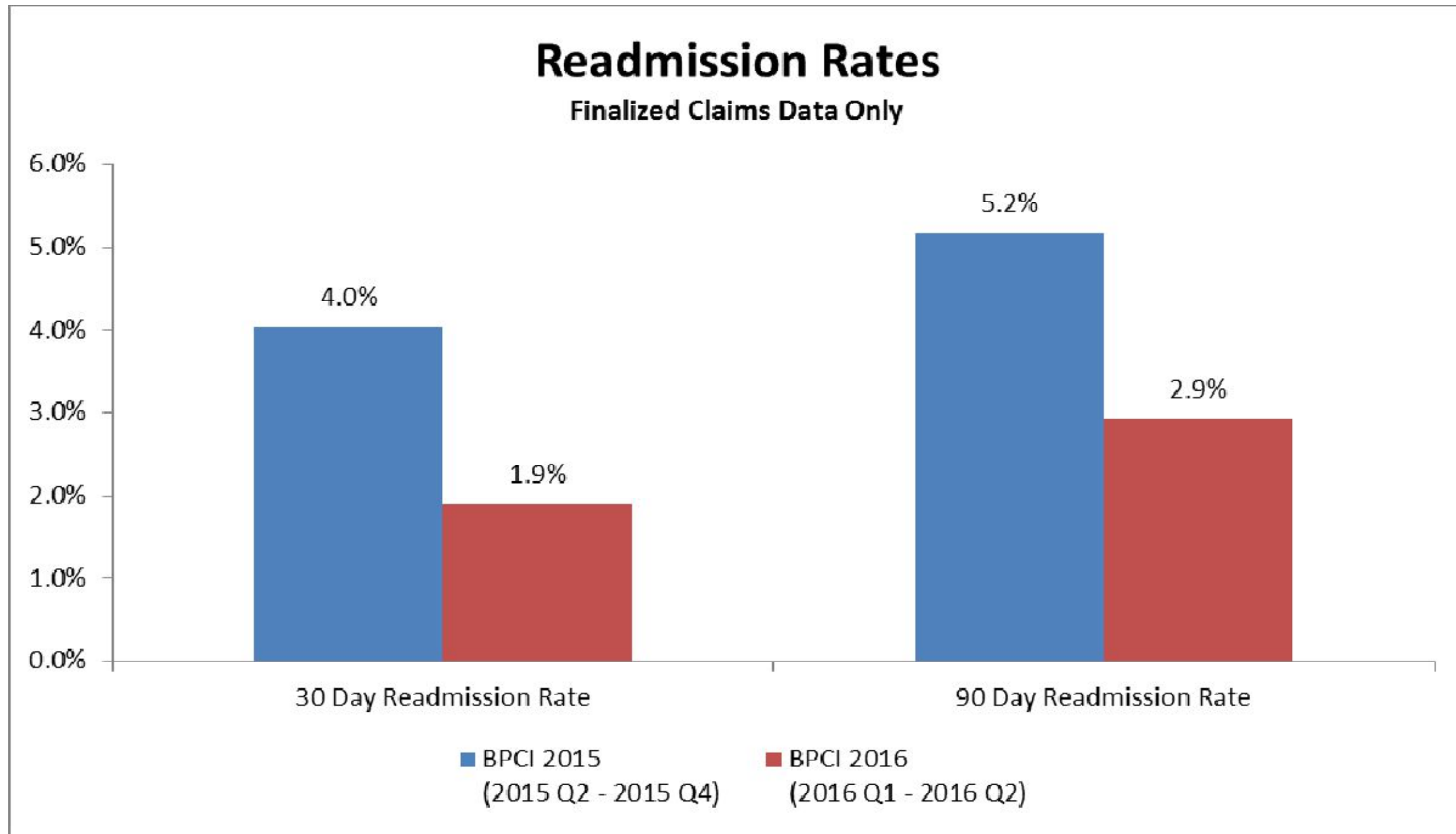
Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016; and Internally Collected Data; 7/1/2016 – 3/31/2017 (BPCI Patients Only)

90-Day Readmissions



Source: Porter CMS Reconciliation Data; 1/1/2014 – 6/30/2016; and Internally Collected Data; 7/1/2016 – 3/31/2017 (BPCI Patients Only)

Readmission Trends



Source: Porter CMS Reconciliation Data; 4/1/2015 – 6/30/2016 (BPCI Patients Only)

Our BPCI Program Roadmap...



Key Elements Driving Results

- Established Care Coordination Program
- Alignment with Acute Care Stakeholders
- Developed Post-Acute Care Partnerships
- Improved Joint Education Coaching & Compliance
- Perioperative Clinic - Risk Assessment & Medical Optimization
- Standardized Pain Management & PT Protocols
- Employed Physicians Under Co-Management

Care Coordination Program

- **Prepare** Patients for Efficient Discharge
- **Front-Load** Discharge Planning
- **Partner** with Acute Case Management Team
- **Promote** use of **Preferred Partners**
- **Extend** Patient Management Post-Discharge

Role of Transition Care Manager

Pre-Surgery

- Meet with patients to discuss expectations regarding hospital stay, discharge plan and rehabilitation needs. Establishes individualized care plan to address challenges and barriers that may impact quality of care and outcomes.

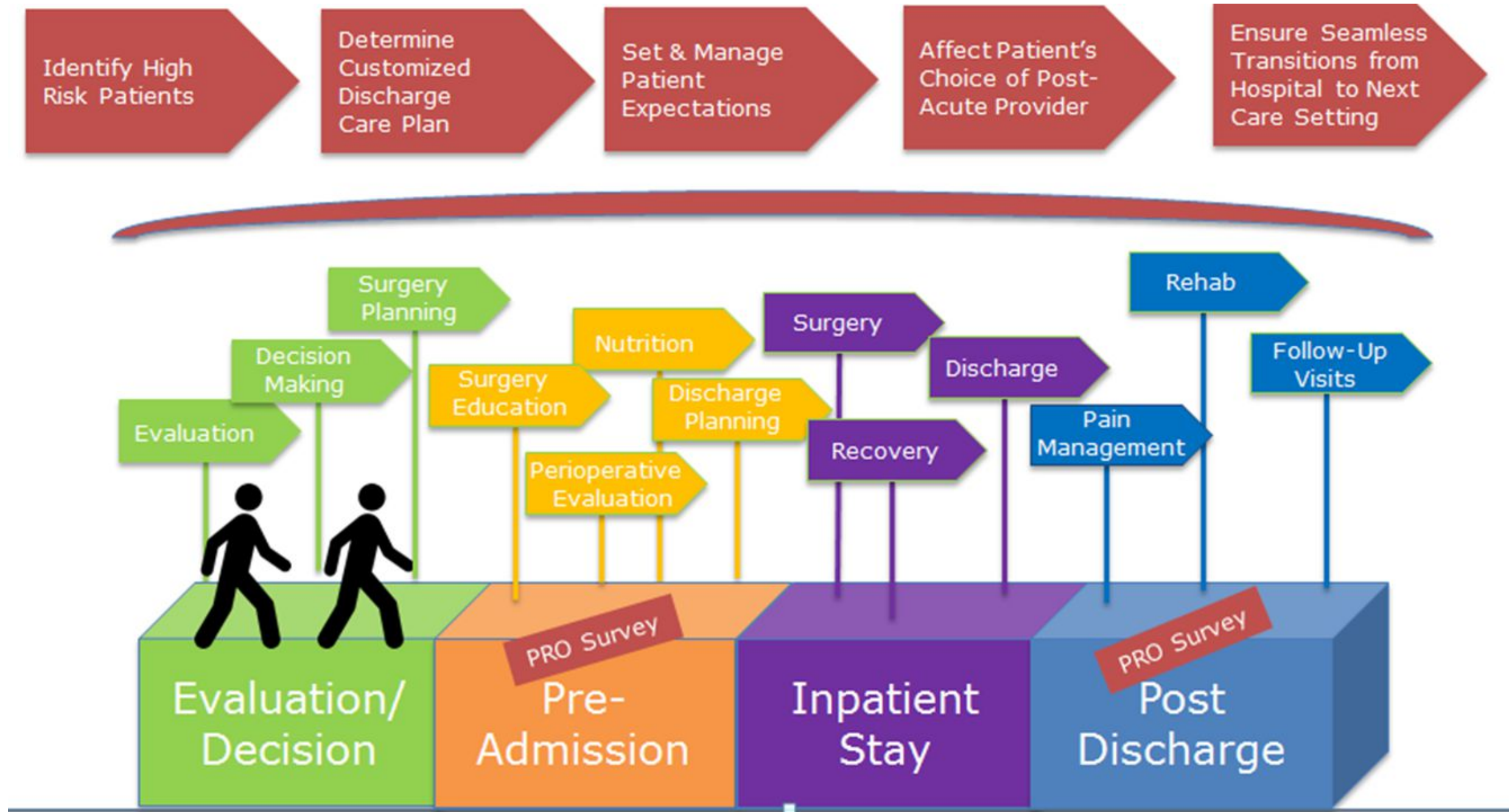
Acute Stay

- Work closely with surgeon and care team to track patient's progress, monitor discharge transition plan and ensure a successful recovery.

Recovery

- Facilitate effective care coordination across care teams with specific focus on providing post acute transition planning; supervising and coordinating the delivery of services in these settings to ensure seamless transitions from hospital to next level of care.

Bending the Cost Curve



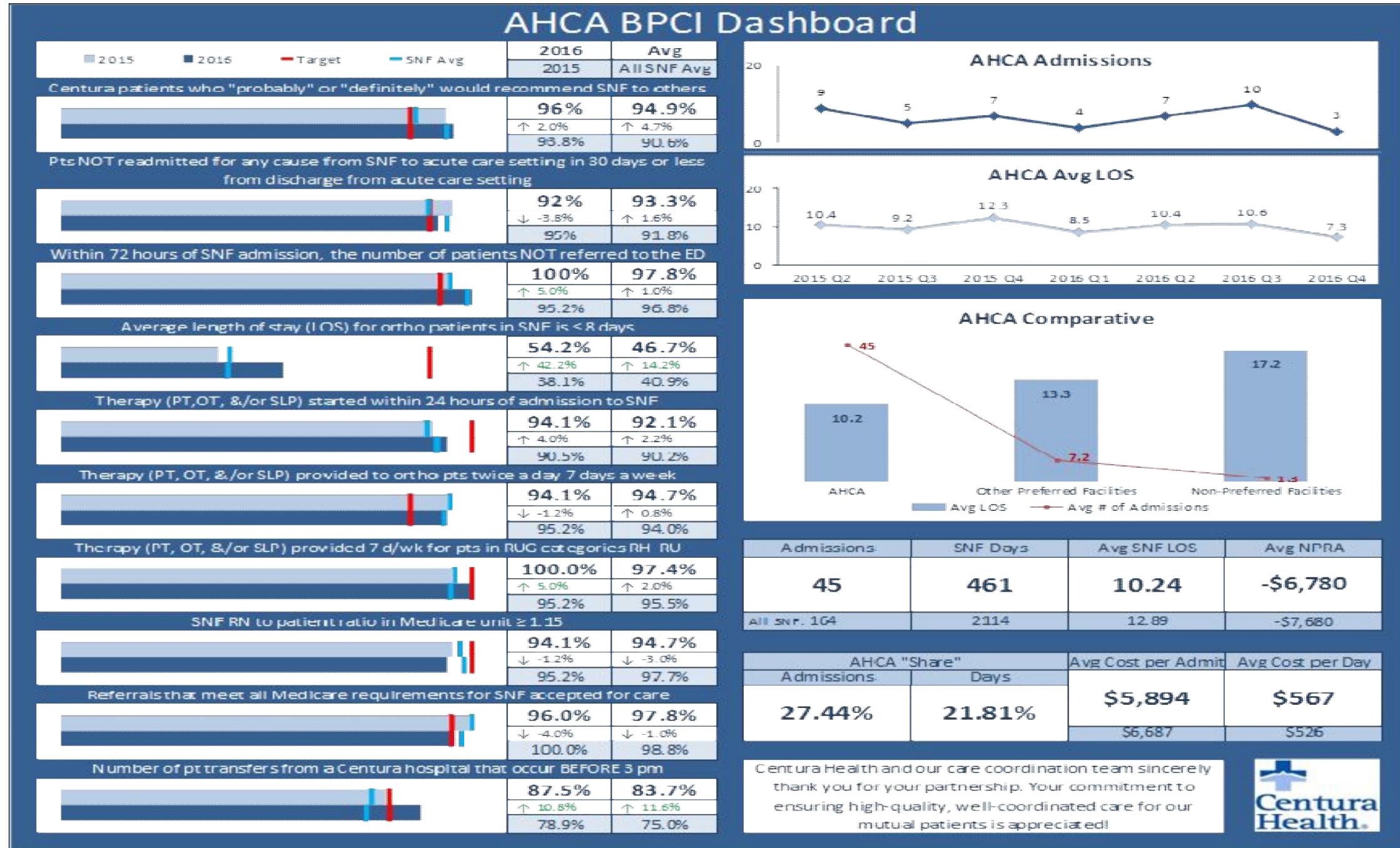
Cultivate Critical Partnerships

- **Transition** Acute Care Teams to think **Population Health**
- **Engage** with Post Acute Care Facilities (PAC)
- Develop **Metrics** to Track Partner Performance
- **Align and Share** Clinical Knowledge with PAC Providers
- Consistent **Presence of Care Coordinators** at Post Acute Care Facilities

SNF Metrics

Measure	Target
1) Average Length of Stay	≤ 8 days / 90%
2) Patient Transfers before 3PM	$\leq 20\%$
3) Nurse to Nurse Handoff	$\geq 80\%$
4) RN to Patient Ratio	$\leq 1:15$ / 24/7
5) Therapy started within 24 hours	100%
6) Therapy provided twice a day, 7 days per week	$\geq 85\%$
7) Therapy provided 6 days per week for patients in RUG categories from RH through RU	100%
8) Readmission from SNF within 30 days	$\leq 10\%$
9) Return to ED within 72 hours of SNF admission	$\leq 8\%$
10) Patient Willingness to Recommend	$\geq 85\%$

SNF Dashboard



Our BPCI Program Roadmap...



LESSONS LEARNED

**Be Payer
Agnostic**

**Resources
for Data
Analysis**

**Surgeon &
Admin
Champions
are Critical**

**Engage
Stakeholders
Early**

**Align Care
Coordinators
with Surgeons**

**Have A
Tolerance
for Failure**

**Be
Innovative**

**Program
Incentives vs.
Compensation**

QUESTIONS



Thank You!

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