PREMIER

Leveraging Analytics in the Bundled Journey

Achieving Noteworthy Success within Existing and Upcoming Bundled Payment Programs

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Bundles – What do we already know?

Basic concepts you will hear many times:

- Variance drives high costs
- Need to have physician alignment
- Care coordination is key
- You need to understand your data
- Post-acute management will help control costs

But how is this translated to actual operations?

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Transforming Data into Action

There are three stops in the Bundled Payment Journey in which data can have a major impact:

Pre-bundle

- Mandatory Bundles – Are we identifying key areas for opportunity?
- Voluntary – Are we choosing the correct bundles?

Starting (and maintaining) the Bundle

- Are we using data to enhance our operational performance?

Moving to the Next Phase

- Are we using data to prepare for the next phase of bundles?

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Mandatory vs. Voluntary Bundles

Mandatory

- Advantage
  - Offers regional mix
  - National peers to learn form
  - Initial risk-free periods
- Disadvantages
  - May not be ready for bundles
  - May not have physician alignment
  - May take away from other planned investments

Voluntary

- Advantage
  - Better prepared for bundles
  - Physician alignment may occur before program start
  - Planned investment
- Disadvantages
  - Constantly compete against self
  - Clinical episode may not national education
  - Immediately take on risk

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Are you ready for Bundles?

Do you know what kind of infrastructure you need?

- Analytics platforms and analytics owners are key
- Care coordination nurses drive operations
- Dedicated resources may appear as major expenses until reconciliation is performed

Will you have physician buy-in?

- Who owns the bundle?
- Can there be agreement on community protocols?

Do you understand the post-acute space?

- Are you aware of how many PAC providers are in your area?
- Do you know the relative quality of each PAC?

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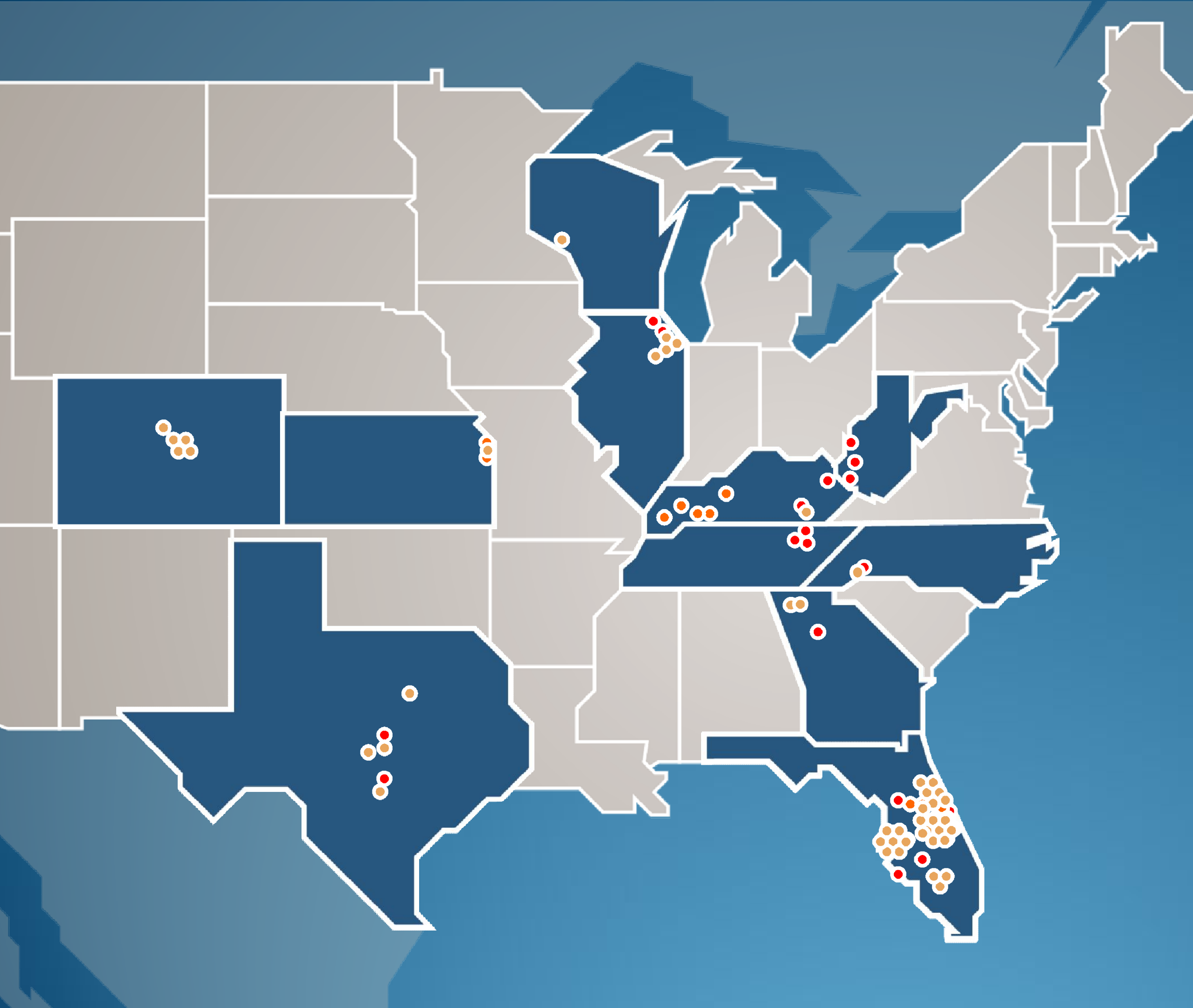


Adventist HEALTH SYSTEM

1973

Adventist Health System was established

45

Hospital campuses operated in nine states

80,000

Employees and physicians

5 million+

Patients served annually

15

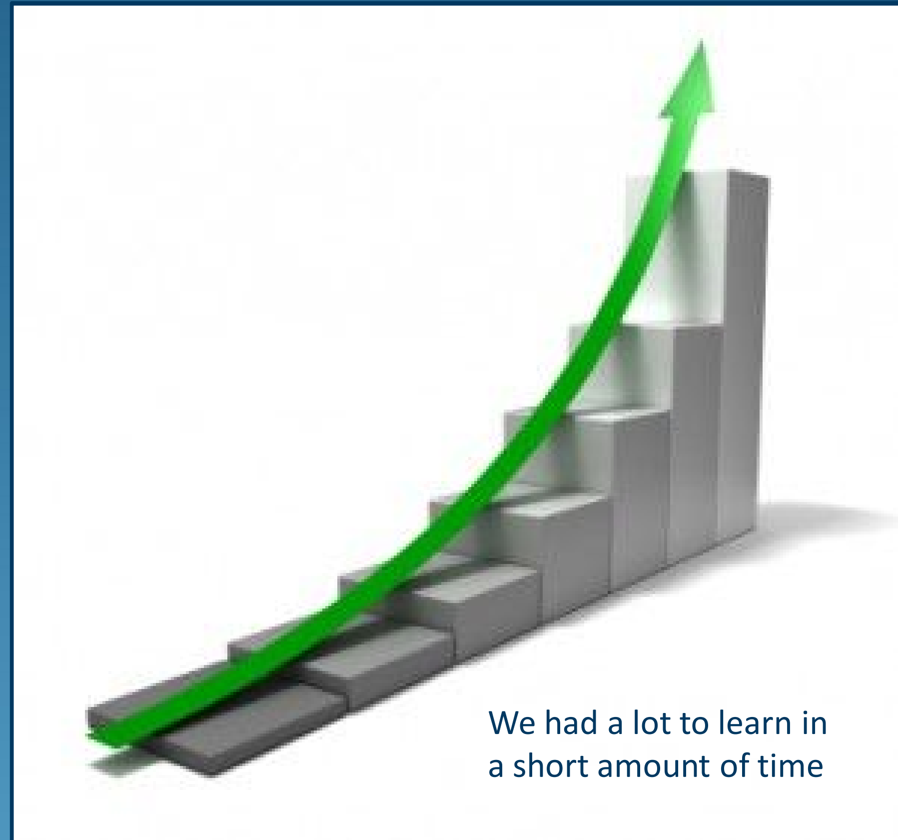
Skilled nursing facilities

22

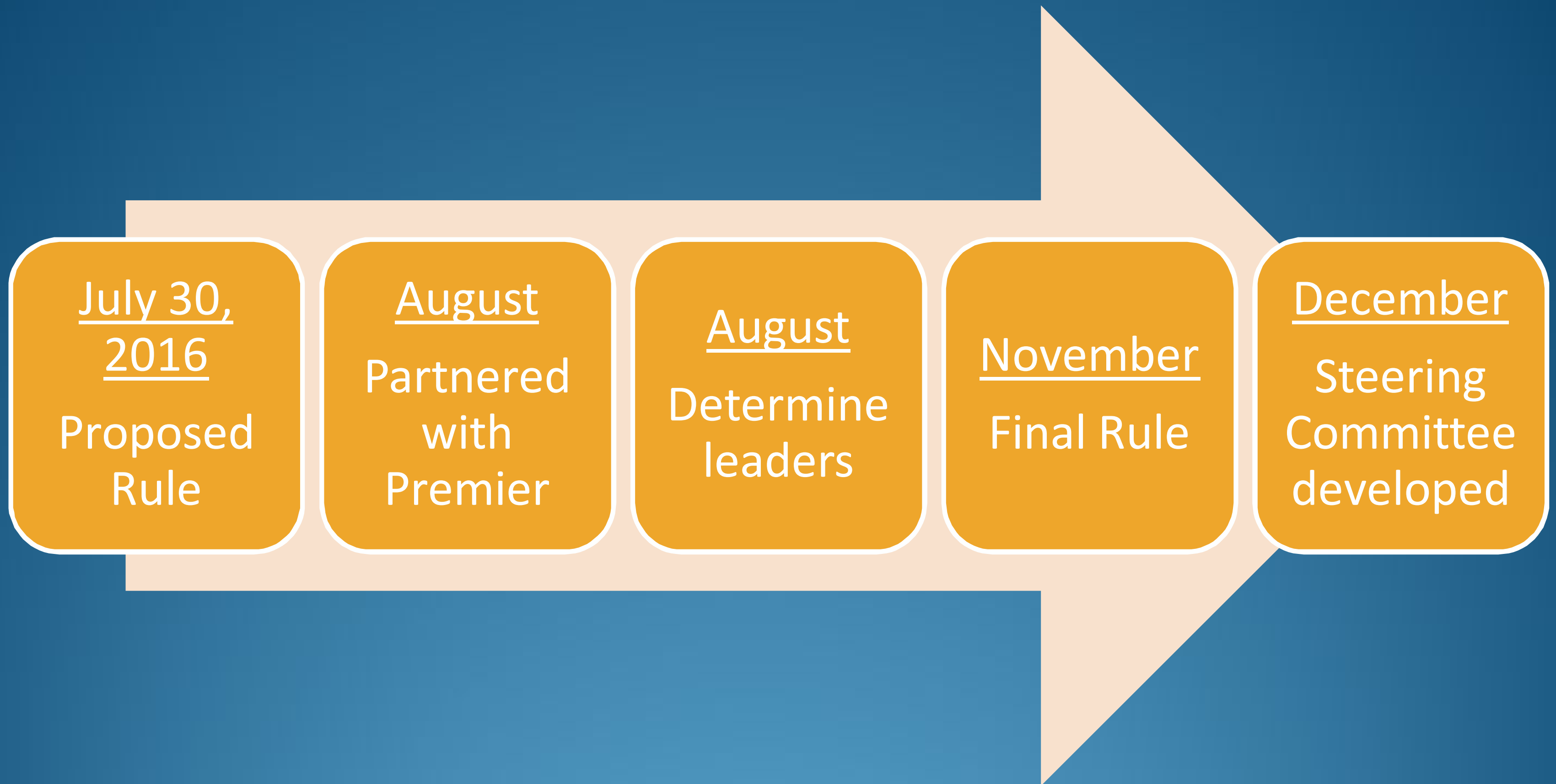
Home health and hospice agencies

Learning Curve

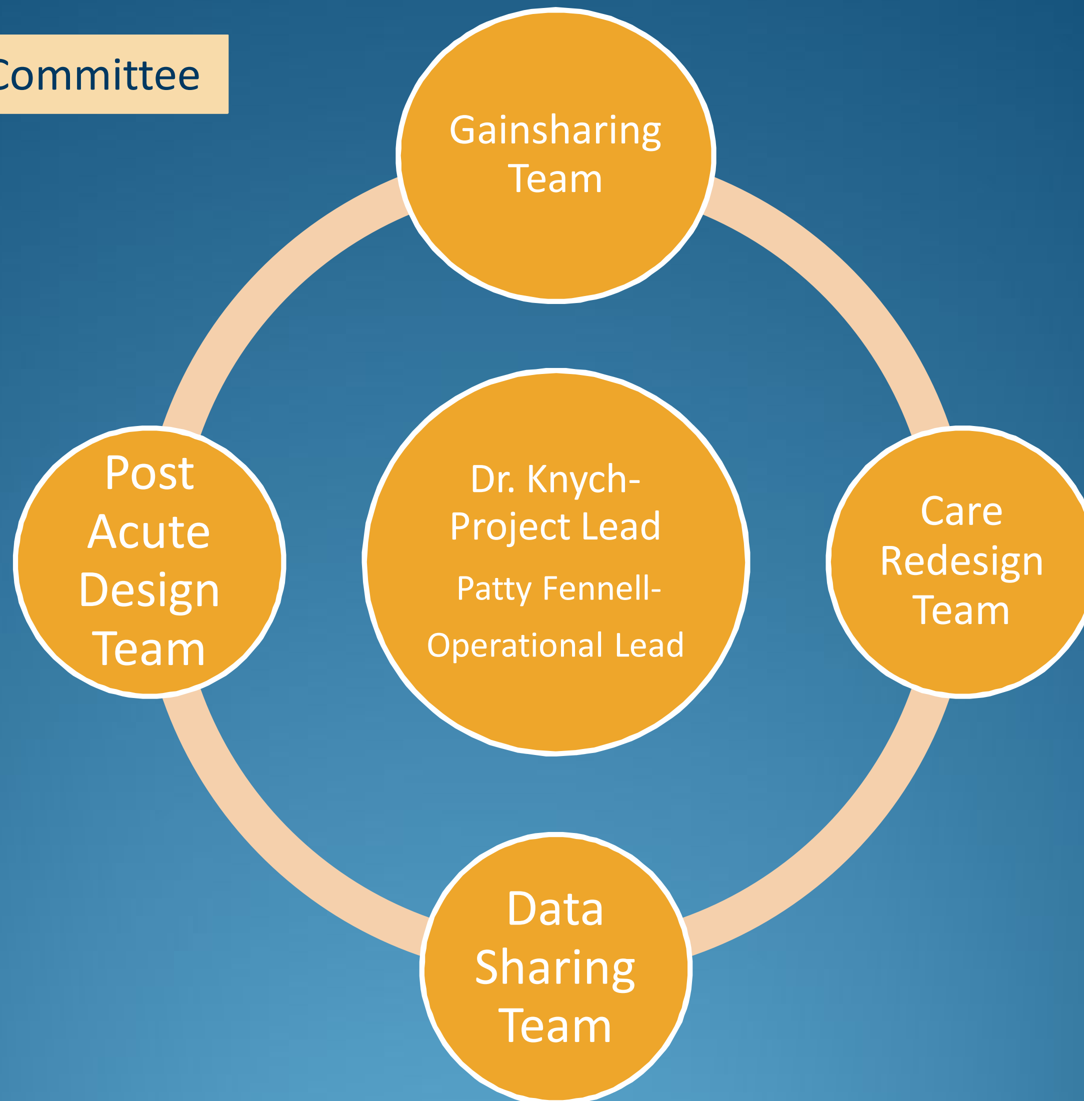
AHS had not participated in BPCI and we had a large learning curve. AHS partnered with Premier in the Bundled Payment Collaborative after the proposed rule was announced.



Timeline



AHS CJR Steering Committee



OMG! What do we do now???

Example of Gap Analysis performed with Premier

CJR Planning for all Sites	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facilit y 7	Facility 8	Facility 9	Facility 10	Facility 11
PROJECT GOVERNANCE, COMMUNICATION AND OVERSIGHT											
Establish Oversight Committee											
Identify roles and responsibilities and timeline											
Identify CJR Lead administrator (CJR-Adm)- responsible for leading CJR/knowledge of program											
Set up regularly scheduled meetings											
Identify Physician Champions, Physician Stakeholders and Other Stakeholders (e.g. Physician Assistants)											
Identify CJR Focused Stakeholder Communication and Education needs											
Education and ongoing communication process on CJR program for staff											
Education and ongoing communication process on CJR program for physicians											
Communication and education with post acute care (PAC) facilities											
Have you engaged your legal officer for the following:											
Review any CJR Agreements (e.g. Gainsharing from AHS Corporate)											
Review CJR waivers											
Have you engaged your compliance officer for the following:											
Identify compliance process, as needed											
Corporate Policy for CJR											
CMS CJR Audit Process Owner and Data Collection											
Have you engaged your Finanace officer to consider the following:											
Inclusion of CJR risk into budget											
Monitoring gainsharing calculations (optional)											
Identify Primary Contact for overall program & data (may be the same individual)											
Do you have an analytics support structure at your hospital?											
Project Updates & Communication process with Sr. Executives, System, and Community											
CURRENT STATE AND BUNDLE PAYMENT READINESS											
Are you aware of the following for your hospital:											
Current PAC utilization											
Current PAC readmissions											

Gainsharing/Collaborator Design

*Template for facilities
*Education for facilities
*How to identify partners and establish terms
*Gainsharing-reconciliation vs. internal cost
*Identify collaborators on agreement and on website
*How will reconciliation be handled?
*Education for Board
*Compliance

Care Redesign

*Beneficiary identification
*Pre hospital care
* Acute care stay
*Acute care pathway-throughput
*Acute care costs
*Pre hospital and Acute care education
*Quality Indicators
*Care Transitions
*CJR Internal Committee

CJR

Data Sharing

*CMS Portal
*Premier Portal
*Identify areas for improvement from data
*Sharing of data within AHS
*PROM development
*Working with Post Acute data
*Review historical data- assist with gainsharing

Post Acute Care

*Understand data-current and historical
*Narrowing network
*Guidance on verbiage for network
*Selection process-Outcomes and Star rating
*Following patient for 90 days
*Quality Indicators
*Care Transitions
*Education for patients
*PROM

Ah Ha Moment

- Steering committee gave us directions and resources
- Workgroup meetings gave us focus
- How did we share this with our sites?
- Feedback from our sites?
- Started CJR all calls including the facilities that are mandated in CJR

Are we identifying key areas for opportunity?

Mandatory Bundle Considerations

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First Step: How to react

- Need a subject matter expert(s) who can:
  - Understand the bundle rules and its impact
  - Provide clinical guidance, both for the anchor and post-acute
  - Identify and consolidate both claims and internal data
  - **Lead the overall bundle program**
- Avoid analysis in isolation
  - Team approach to understand care pathways are essential
- Communicate, communicate, communicate
  - These bundles may not be your strongest areas
  - Ensure key stakeholders are aware of the bundle

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Second Step: Analytics before go-live

Claims Analytics:

- This may be a new area – may not have infrastructure to support
- Will demonstrate where opportunity is
- Key metrics – Discharge disposition, PAC utilization, readmission rates and causes

Internal Analytics:

- Can provide early indicators of barriers to care (e.g. early ambulation for CJR)
- Starts conversations between internal stakeholders
- Key metrics – Discharge disposition, early clinical indicators, clinical protocol adherence

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Which Bundles to Enter?

Voluntary Bundle Considerations

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Which Bundles to Enter?

What is Achievable?

DRG 470: Post Acute Care

Payment Categories	Total Post Acute Care (9-months) - 90 Days after Anchor Discharge (3)							Annual Potential Savings		
	Average Payments per Episode (1,2)	% of Episodes with Some Utilization in Category			Average Days per Service for those with a Claim for Service			-$244,114		
	2014 Experience	2014 Experience	Nationwide Average	10th Percentile Best Performing	2014 Experience	Nationwide Average	10th Percentile Best Performing	Utl. % Input	Avg. LOS Input	$ Potential Savings per Episode
Part A										
Inpatient Readmissions - Facility	$1,713	8.0%	8.5%	6.5%	9.9	5.9	5.2			0.00
Acute Inpatient Rehab - Facility	$1,691	15.9%	8.3%	1.8%	10.9	11.0	10.9	8.3%		-808.89
Long Term Acute Care (LTAC) - Facility	$0	0.0%			0.0					
Skilled Nursing Facility - Facility	$4,477	23.9%	38.8%	29.6%	33.4	23.9	20.1		23.9	-1,271.63
Home care	$2,533	78.4%	62.4%	55.4%						
Part B										
Outpatient	$750									

*based on annualized 9-month volume

Key Considerations:

1) Are my benchmarks realistic?
2) Will the bundle have an adverse impact on other parts of the system (e.g. PAC ownership)?
3) What is not captured in claims data alone?
4) Does low volume only create the impression of opportunity?
5) Medical vs. surgical considerations

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Starting (and maintaining) the Bundle

Using Data for Low-Hanging Fruit

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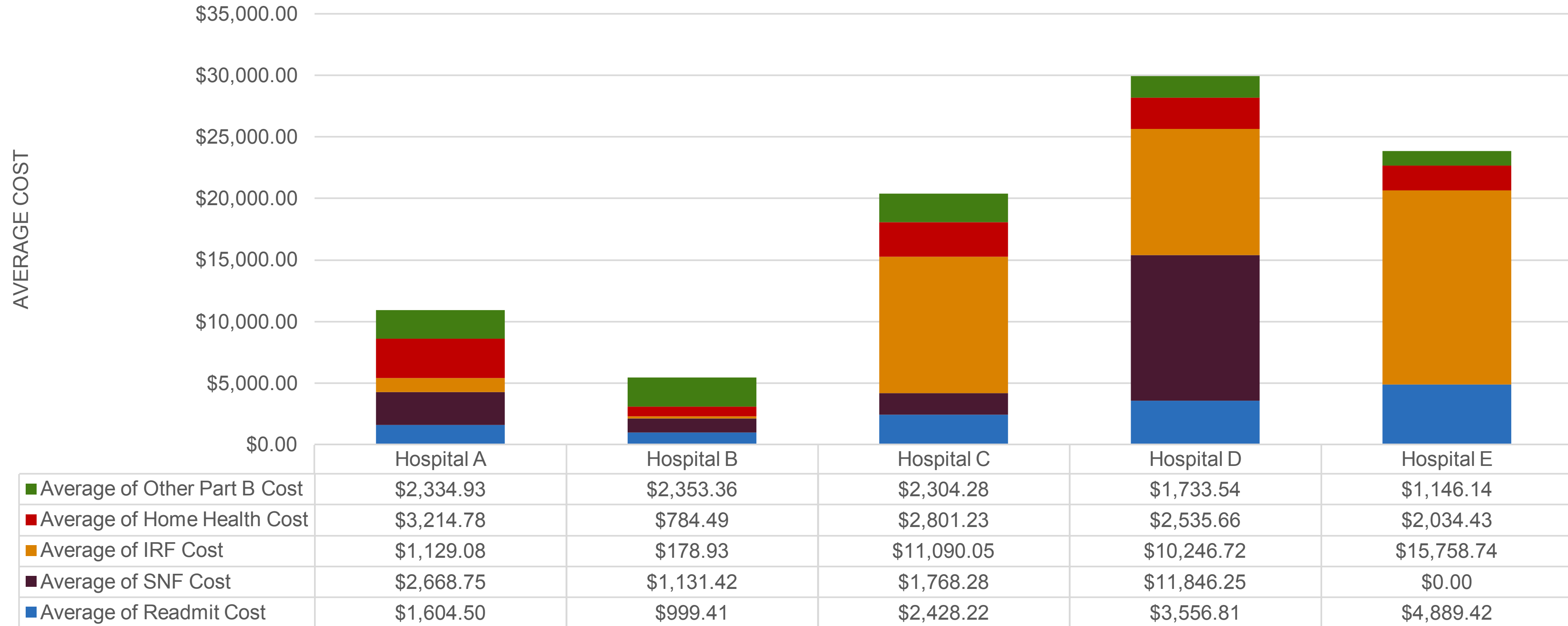
Starting (and maintaining) the Bundle
PAC Variability as a Starting Point



	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E
Average of Other Part B Cost	$2,334.93	$2,353.36	$2,304.28	$1,733.54	$1,146.14
Average of Home Health Cost	$3,214.78	$784.49	$2,801.23	$2,535.66	$2,034.43
Average of IRF Cost	$1,129.08	$178.93	$11,090.05	$10,246.72	$15,758.74
Average of SNF Cost	$2,668.75	$1,131.42	$1,768.28	$11,846.25	$0.00
Average of Readmit Cost	$1,604.50	$999.41	$2,428.22	$3,556.81	$4,889.42

First focus is on PAC utilization

1) Is the PAC setting appropriate?
2) What can be done prior to discharge to ensure optimal PAC selection?

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Starting (and maintaining) the Bundle
Variability in PAC Provider Costs

Average Cost per SNF Encounter for Facilities with 5+ Encounters

PAC Variability brings two major concerns:

1) Prevents use of standardized community protocols
2) Makes determining best performing PACs difficult due to low volume

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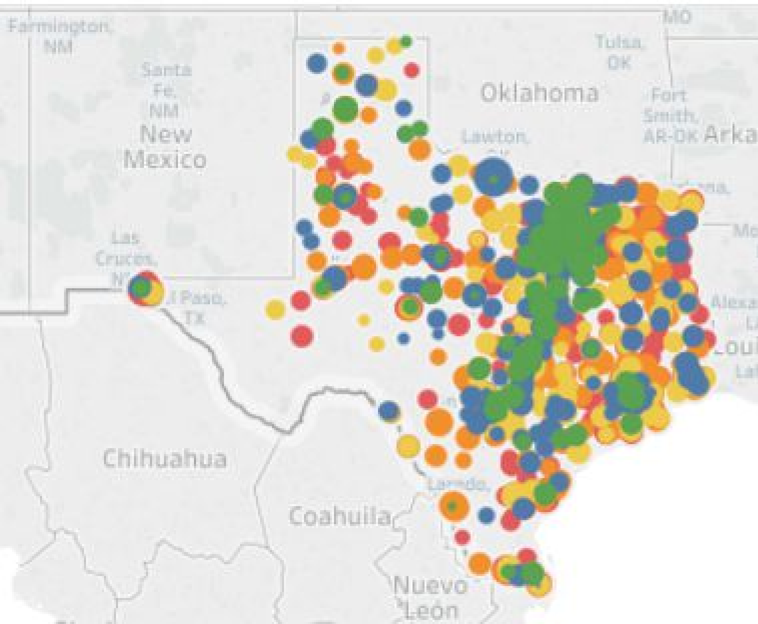
Starting (and maintaining) the Bundle

Alternative Data Sources



SNF Compare
https://www.medicare.gov/nursinghomecompare/search.html

Home Health Compare
https://www.medicare.gov/homehealthcompare/search.html

IRF Compare
https://www.medicare.gov/inpatientrehabilitationfacilitycompare/

Premier SNF Compare Dashboard created to streamline analysis

State	Overall Rating	Survey Rating	Quality Rating	Staffing Rating	# of Cert Beds	# of Residents in Cert B..	# of Substantiated Complaints	Total Health Deficiencies	Compliant Health Deficiencies	Standard Health Deficiencies
TX	4	5	1		25	2	0	0	0	0
TX	1	1	3	3	54	55	16	15	11	8
TX	5	4	5	2	110	70	5	5	5	0
TX	3	3	2		202	101	3	8	4	6

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Adventist Health System Experience

- Significant shift in mindset for the hospitals
  - Previously did not have to worry about 90 day post-acute costs
- First area of concentration – PAC Utilization
  - Quickly saw that not only was PAC utilization an opportunity, bus ALOS and PAC stay costs were as well
- Knew had to set targets for selves – Based on National comparisons
- Review of SNFs necessary to understand their impact to bundles
- Collaboration helped provide insights into how to approach opportunities

Moving to the Next Phase

Getting to the Medium Hanging Fruit

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Collaboration is key!

Numerous resources can help you learn best practices:

- CMS annual evaluation of BPCI

- CJR Connect acts as a forum for sharing

- Collaborative opportunities with others in your bundle can help share best practices and difficulties
  - Current approach:
    - Biweekly key topic calls
    - “Wireside” chats
    - Focused sprints

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Moving to the Next Phase

Post-Acute Council

Stakeholder group focused on post-acute care redesign

Initial Focus

- Identify high performing PACs
- Define appropriate standard of care
- Create set protocols for post-acute management

Subsequent Focus

- Invite PACs to council to help address specific concerns
- Monitor and modify care redesign
- Patient review as needed

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Starting (and maintaining) the Bundle

Collaborative approach to improvement

Readmit DRG	Readmit Primary Diagnosis	Source of Admission	Source of Admission Type
857: Postoperative or post-traumatic infections ...	T814XXA: infection following a pr...		
862: Postoperative & post-traumatic infections ...	99859: other postop infection	Aalxwzw Dh Rmxa Dkohhmpwhk Plxrw & A...	SNF
862: Postoperative & post-traumatic infections ...	T814XXA: infection following a pr...	Gorr Vhwuwnal Xjlxgho Fibuef Mmo (2323...	Readmit_O
863: Postoperative & post-traumatic infections ...	99859: other postop infection	Xltaoaca Fdrq Sramc (075667)	SNF
863: Postoperative & post-traumatic infections ...	T814XXA: infection following a pr...	Xuw Au Cqnlywd Tf Rmmf (111339)	HH
863: Postoperative & post-traumatic infections ...	T814XXA: infection following a pr...	Kouukpcp Dmlcl Yyuktxv Jgedmf (747639)	SNF
864: Fever	R5082: postprocedural fever	Uabqv Mhhk Pspgut Yvbl Cehmhqou (6377...	SNF
871: Septicemia or severe sepsis w/o MV 96+ ho...	0380: streptococcal septicemia	Kwvwb Ueysrbek Kywph (416293)	HH
871: Septicemia or severe sepsis w/o MV 96+ ho...	0389: septicemia nos	Ndbmcfie Kezdgcwe Ixmna Vacvbfjonlm & ...	HH
871: Septicemia or severe sepsis w/o MV 96+ ho...	0389: septicemia nos	Xltaoaca Fdrq Sramc (075667)	SNF
871: Septicemia or severe sepsis w/o MV 96+ ho...	0389: septicemia nos	Uabqv Mhhk Pspgut Yvbl Cehmhqou (6377...	SNF

Major patterns to look for:

- Common readmission DRGs, irrespective of PAC setting
  - May indicate breakdown in acute care management
- PAC type source of readmission
  - May indicate breakdown or lack in community protocols
- Facility sources of readmission
  - May indicate individual quality of care concern

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Starting (and maintaining) the Bundle
Patient Case Review - Example

Patient Name	Medicare HIC Number	CMMI Member ID	Anchor Medical Record Number	Age	Member Status	Sex	Ethnicity	Date of Birth	Date of Death
Bidlaoku, Lyywkk	9999999999	987654321	123456789	58	Xam-Szww	Hnkjyi	Vwief	03/12/1946	-

Overall **Detail**

Claim ID	Provider/Claim Type	Primary Diagnosis	Primary Procedure	MSDRG
Claim1	Anchor Hospital Stay	M1712: unilateral primary osteoart...	0SRD0J9: replace of l knee jt with synth sub, ...	470: Major joint replacement or reattachment of lo...
Claim9	Skilled Nursing Facility			
Claim13	Readmit	I214: non-st elevation (nstemi) my...		233: Coronary bypass w cardiac cath w MCC
Claim110	Inpatient Rehab Facility	Z48812: encntr for surgical aftcr fol...		949: Aftercare w CC/MCC
Claim139	Home Health			

Drill down analysis to drive key questions

1) Was the readmission preventable?
2) Could more have been done during pre-admission work-up to identify cardiac risk?
3) Is this indicative of a larger pattern or a singular event?

Claims data alone will not answer these questions, but they will help you find the questions to ask.

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Key Takeaways

- Mandatory and voluntary bundles have unique opportunities in how data needs to be used
- Don’t go it alone; collaborative approach can provide valuable insights
- Post-acute provider utilization and readmissions are key areas to start
- Set realistic targets for organization

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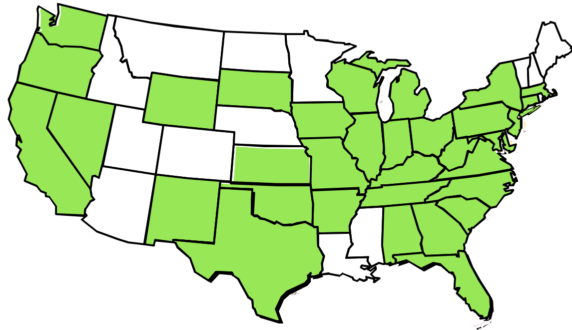
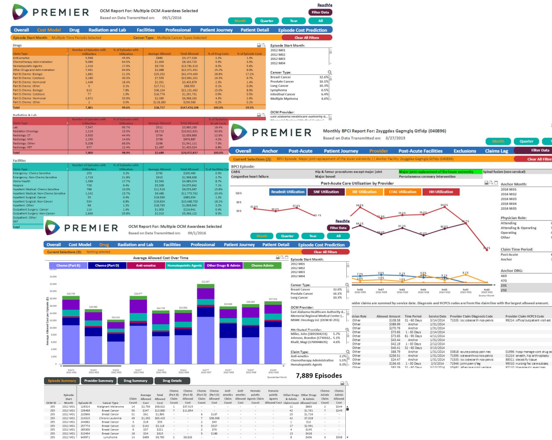
Premier Experience with Bundled Payments

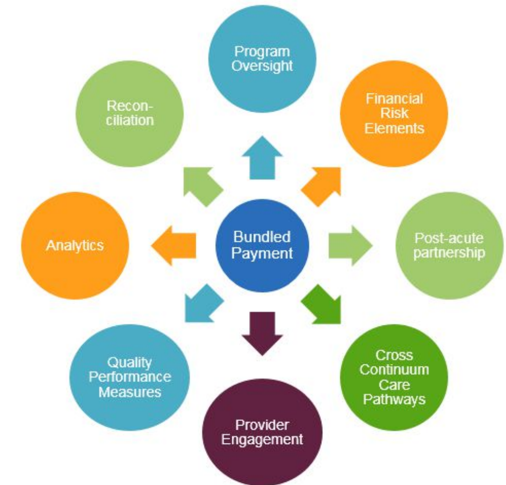
Connecting People: National Bundled Payment Collaborative

Connecting Data: Population Health Analytics

Connecting Knowledge: Operational Deployment







Bundled Payment Collaborative – Multiple Programs

120+ facilities collaborating on best practices and performance improvement across BPCI, CJR, and EPM

Bundled Payment Data Management

Meaningful claims analysis and benchmarking supporting performance improvement initiatives

Resources to build capabilities

Cohorts, best practices portal, webinars, tools, subject matter experts

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Interested in Learning More?

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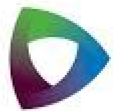

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