Managing Episodes of Care

Core Competencies for Clinicians and Healthcare Organizations

Win Whitcomb, MD, MHM

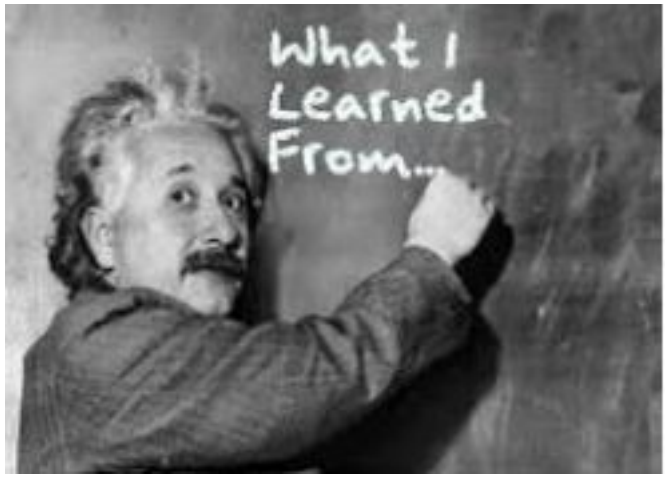
Chief Medical Officer

remedy partners

To Take Home

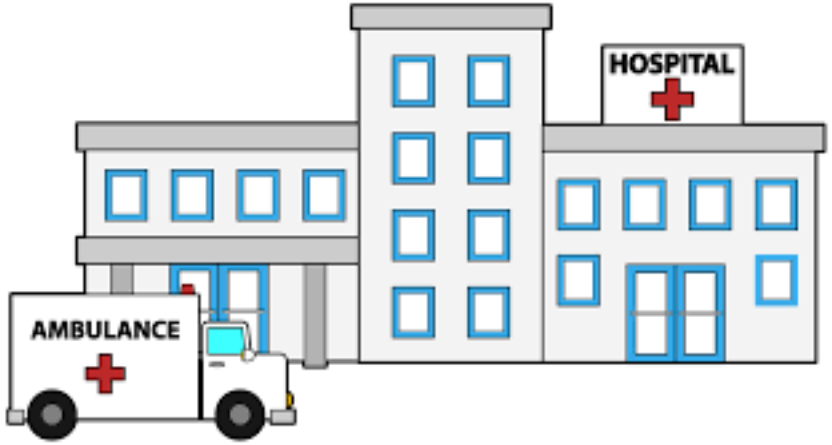
New competencies are required to manage bundled payments and episodes

- Clinical competencies
- Healthcare organizational competencies



Today's perspective

- Focus on episodes initiating with an inpatient stay
- Describe key competencies for
  - inpatient phase
  - the transition to postacute care
  - the postacute phase in facilities and in the community



Mission

- We create software and services that enable payers, employers and at-risk providers to organize and finance health care delivery around a patient's episode of care.

Remedy at a Glance

585
ACUTE CARE HOSPITALS

12%
OF U.S. ACUTE CARE HOSPITALS

426
SKILLED NURSING FACILITIES

67
HOME HEALTH AGENCIES

143
PHYSICIANS GROUPS

Provider Partner Footprint

Information based off Acute partners and performance networks as of October 13th 2016

$500mm OF ANNUAL SAVINGS IN 2017

45
STATES OPERATIONAL

295,375
ANNUAL BPCI EPISODES

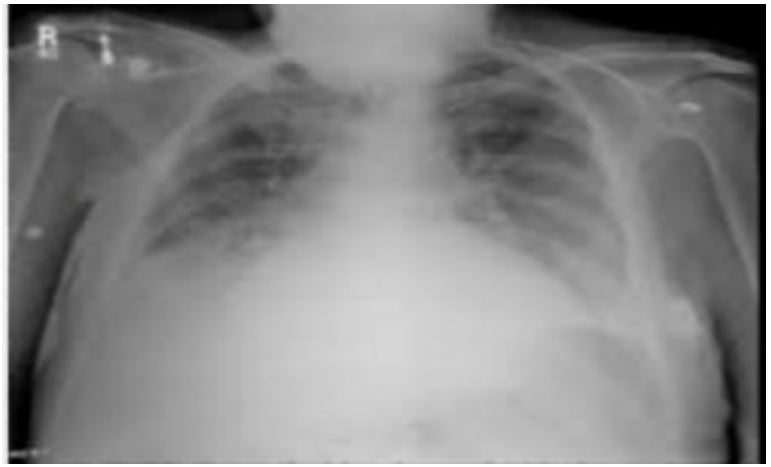
$5.7B
MEDICARE FFS SPENDING

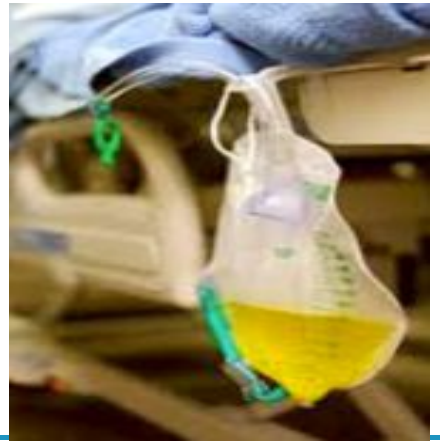
$120M
ANNUAL SAVINGS FOR CMS

315
EMPLOYEES

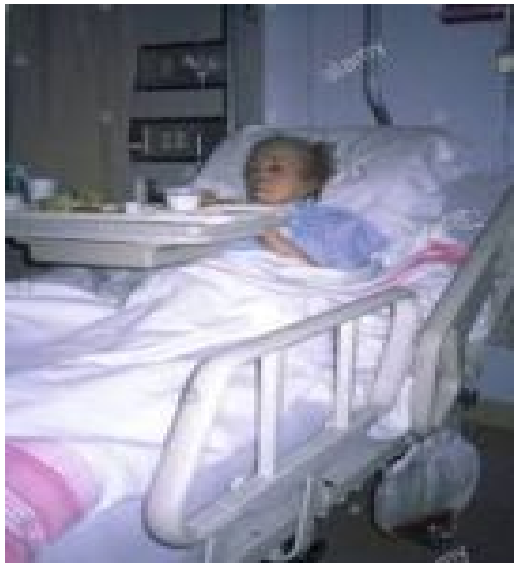
Mrs. Jones

Day 1





Days 2-5



"I didn't get out of bed for 5 days"

Day 6

"Not safe for home.
Needs SNF"

Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk

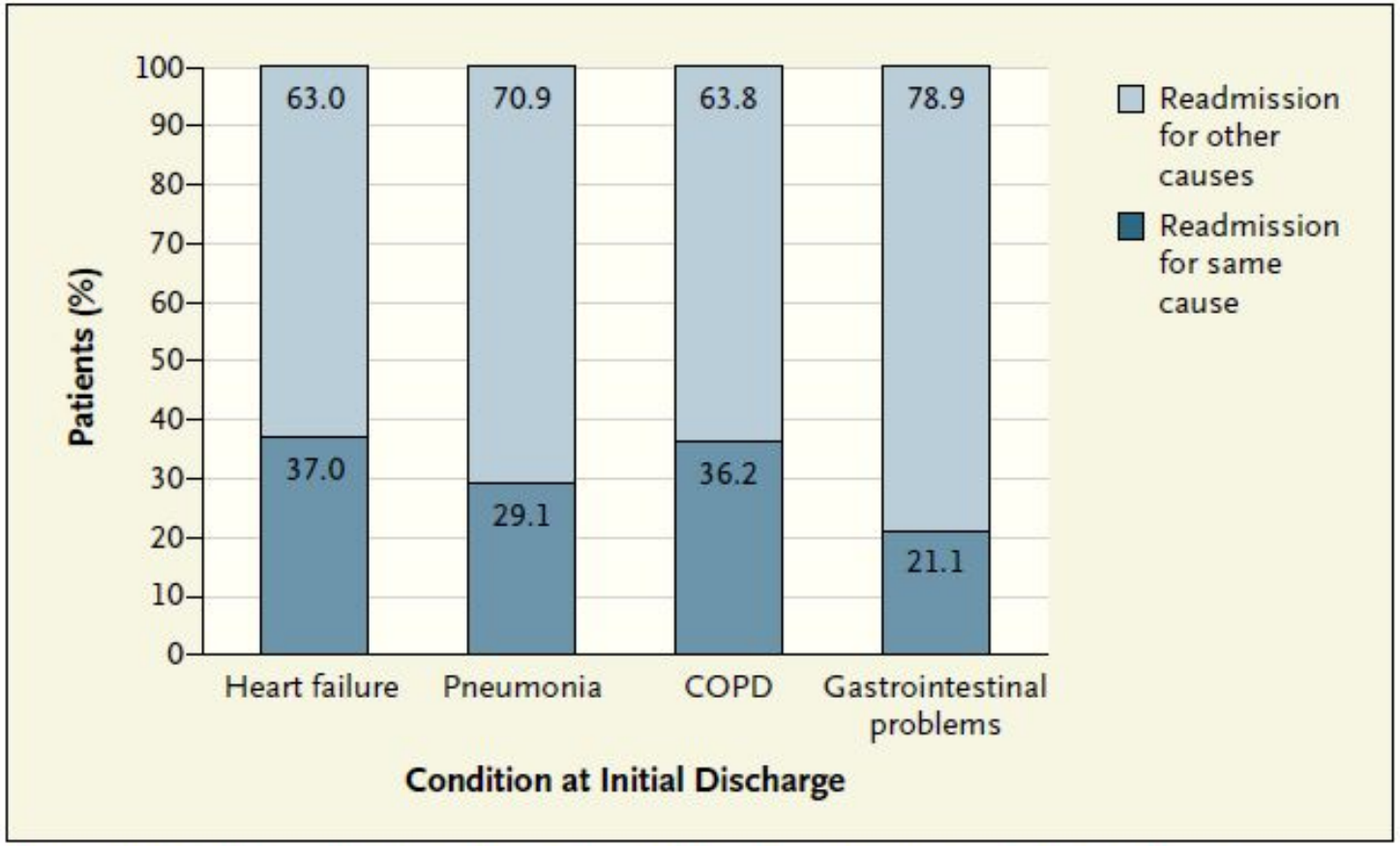
Harlan M. Krumholz, M.D.

N Engl J Med 2013;368:100-102

Transient, vulnerable period associated with the critical time (30 day period) after discharge

Factors contributing

- **Sleep deprivation**
- **Poor nourishment**
- **Altered cognition (environmental, medications)**
- **Physical deconditioning (bedrest)**
- **Stress, pain and other discomforts**



Proportions of Rehospitalizations for Causes Other Than the Condition at Initial Discharge.

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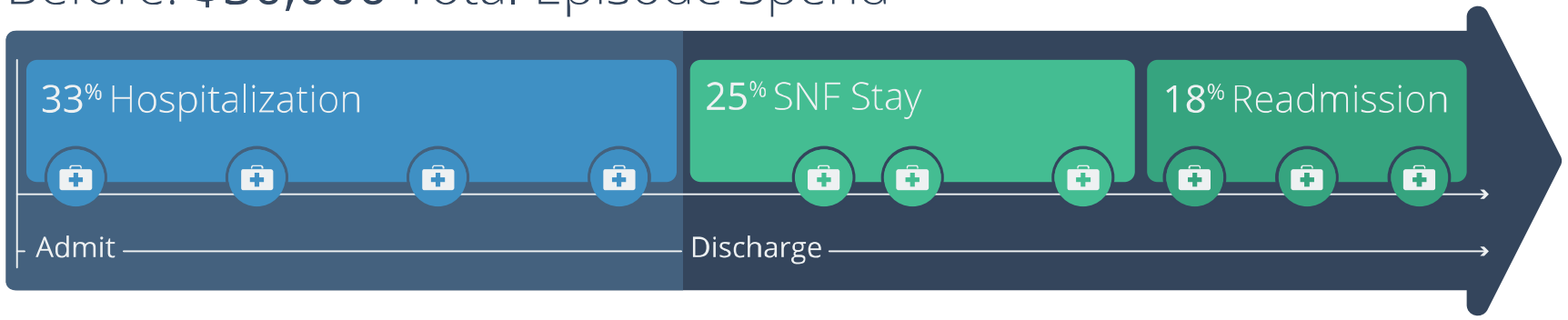
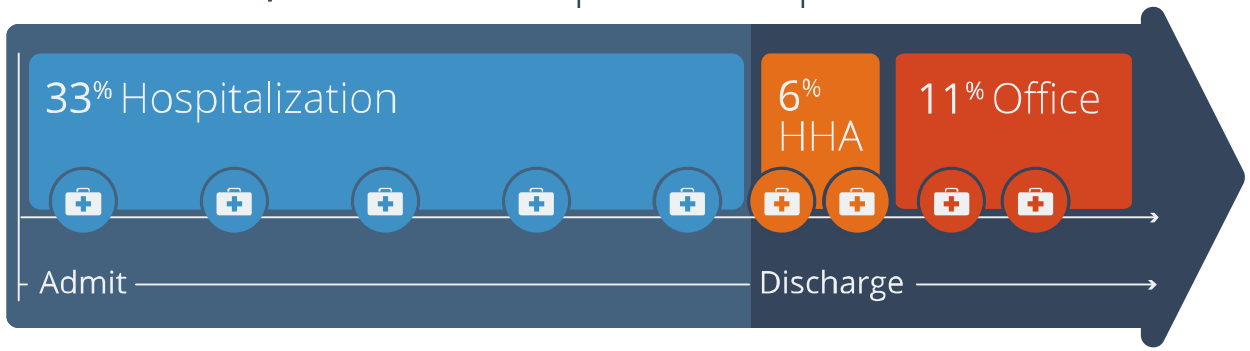
Deconstructing an Episode: Before and After Care Redesign

SNF Stays and Readmissions – Large Contributors to Total Spending

Before: **$30,000** Total Episode Spend



After: **$20,000** Total Episode Spend



= Physician Visits

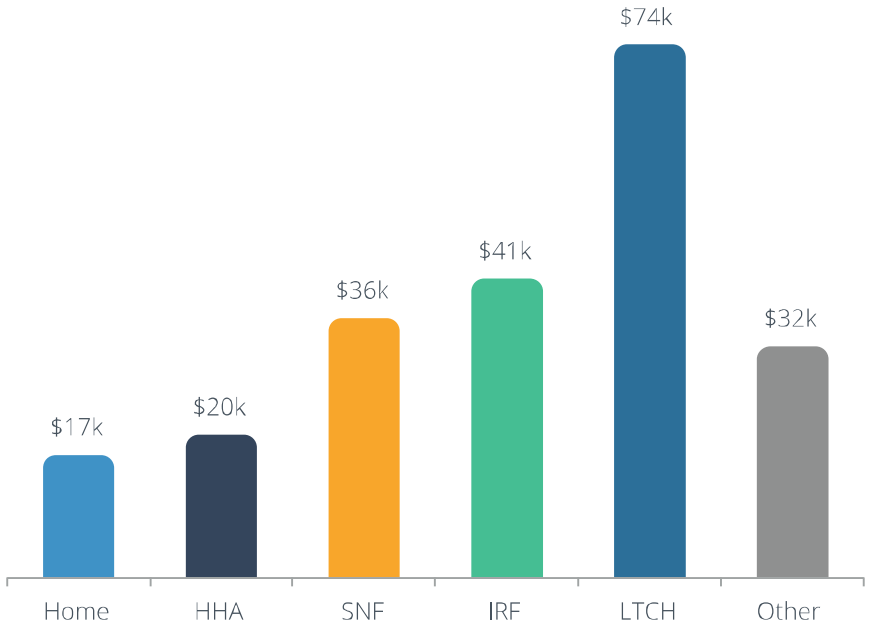
* % values refer to contribution to total average spending over a 90 day episode

SNF = Skilled Nursing Facility
HHA = Home Health Agency

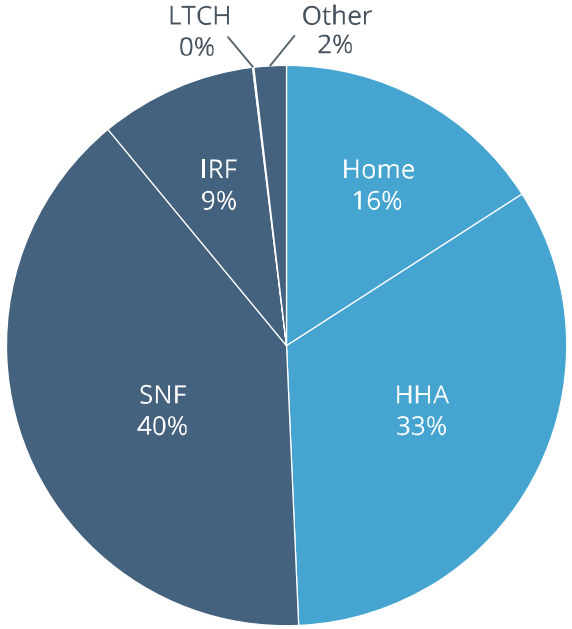
Relationship Between Cost and Volume

The first site of discharge causes dramatic variation in episode cost

- 70% Hip & Femur Procedures Except Major Joint bundle patients are discharged to a SNF.
- Episodes with SNF as the first site of discharge cost more than 2x as much as episodes where the patient is discharged home alone or home with home health services.

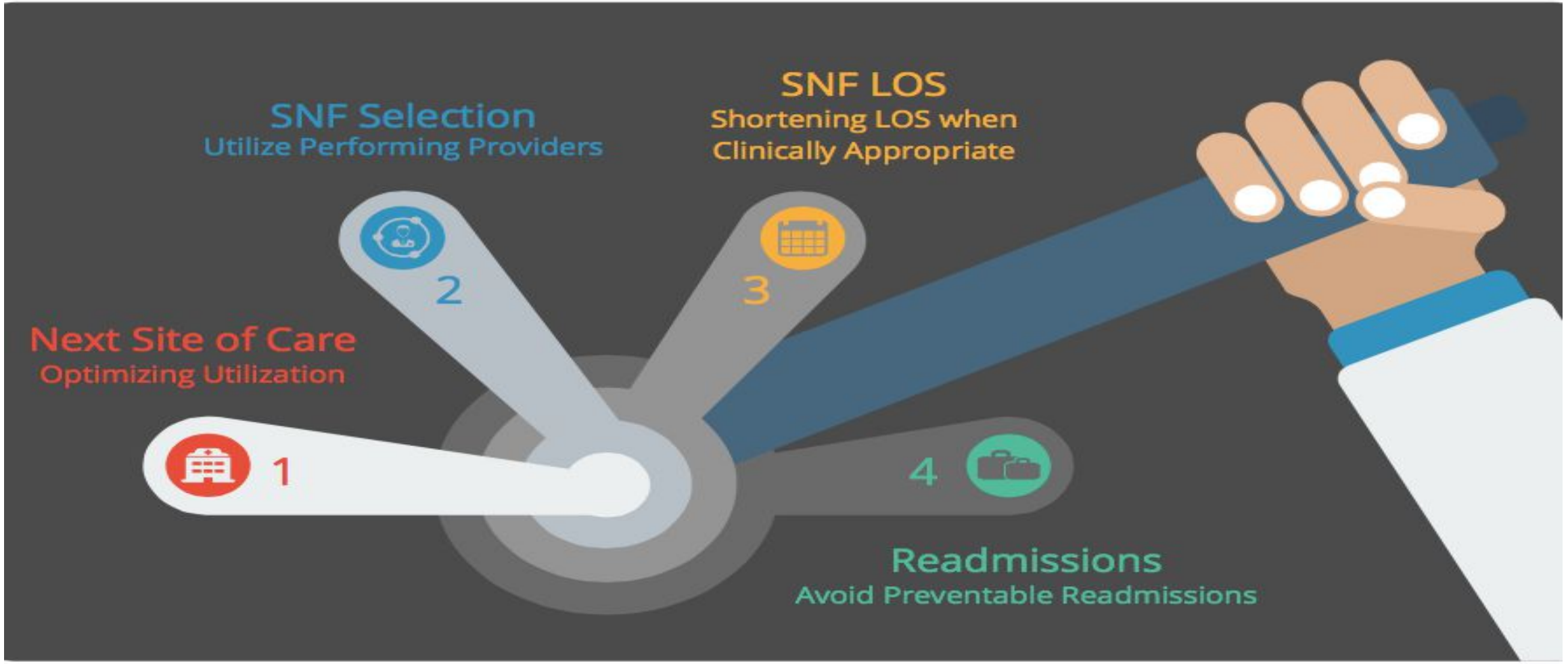


Average Episode Cost by First Site of Discharge



Percent of Episodes by First Site of Discharge

Four Levers for Bundled Payment Success

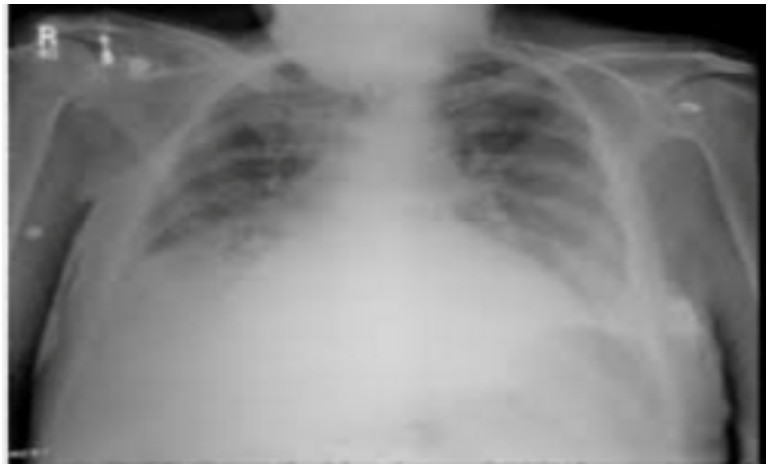


Clinical Competencies

How Does a Redesigned Episode Look?

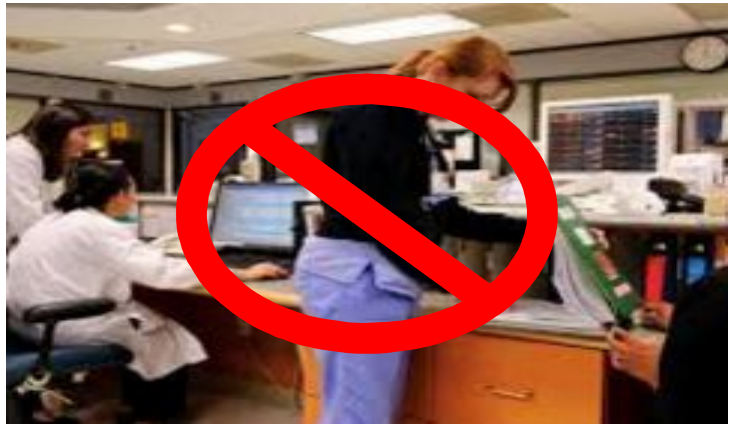
Inpatient Phase

Day 1



Days 2-5

"I didn't get out of bed for 5 days"



Days 2-5

"Needs gait training,
Transfer/bed mobility training,
edema mgt.,
Falls education."

"Why not home?"

High Value Practices/Competencies[1]

PRACTICE	HOW IT ADDS VALUE
Elicit the patient's goals of care	May reduce needless testing, treatments, and readmissions
Use early mobility/ambulation program*	May improve recovery, reduce need for postacute facility, services
Identify need/deliver palliative care in appropriate patients	May reduce needless testing, treatments, and readmissions
Deploy optimal sleep program*	May improve recovery, reduce delirium and need for postacute facility, services

** Choosing Wisely ™*

1. Whitcomb W, The Hospitalist. December 2016.

Journal of HOSPITAL MEDICINE

ORIGINAL RESEARCH

Prognostic value of Braden Activity subscale for mobility status in hospitalized older adults

J. Hosp. Med. 2017 June;12(6):396-401

By: Vincenzo Valiani, MD, Zhiguo Chen, PHHP-BIO, Gigi Lipori, MT, MBA, Marco Pahor, MD, Carlo Sabbá, MD, Todd M. Manini, PhD, FACSM

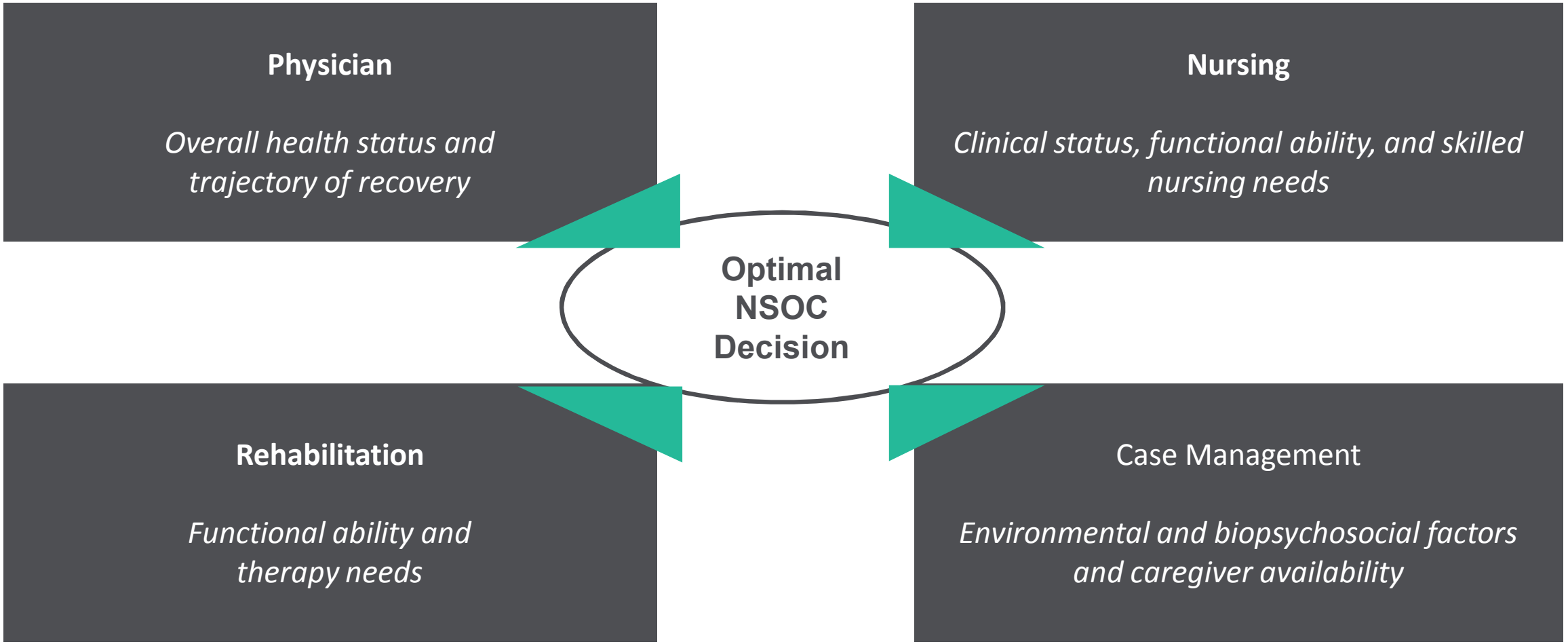
admission, 4734 (52.3%) recovered to a state of walking occasionally or frequently. Older adults who developed mobility impairment during hospitalization had an odds of death higher than that of those who remained mobile (odds ratio [OR], 1.23; 95% confidence interval [CI], 1.08-1.39). This effect predominately occurred within the first 6 follow-up months. Older adults who recovered from mobility impairment had an odds of death lower than that of those who did not recover mobility in the hospital (OR, 0.54; 95% CI, 0.49-0.59). This effect was slightly stronger

High Value Practices/Competencies[1]

PRACTICE	HOW IT ADDS VALUE
Structured dialogue re: optimal next site of care; Ask “why not home?”	May avoid excess PAC facility use; fosters home recovery
If SNF-bound, discuss expectations for LOS and recovery in the facility	Aligns expectations for PAC facility length of stay w/ patients, families
Use a SNF Performance Network	May avoid prolonged SNF LOS, readmit
Safe x-ition out of hospital/facility, including info x-fer, med rec, f/u appointment w/ MD	May reduce readmissions

1. Whitcomb W, The Hospitalist. December 2016.

Next Site of Care: A Team Approach



Elective Lower Ext Joint Replacement Workflow

PRE OPERATIVE

PHYSICIAN OFFICE: *SURGEON/EXTENDER*

- Next Site of Care (NSOC) Conversation with Patient
- Pre-Op PT & Joint Class Referral
- Medical optimization if applicable
- Identify patient as Bundle

HOSPITAL JOINT CLASS: *JOINT PROGRAM LEAD*

- Assess Post-Acute Discharge Disposition
- Clinical Risk Assessment
- Pre-Surgical Checklist & On-Boarding Folder
- Exercise and home d/c education if not in pre-op PT
- Complete Discharge Prescription

PRE-OP VISIT: *HHA or OP PT*

- Assess Baseline Function, Fall Risk, DME needs
- Assess Post-Acute Discharge Disposition
- Exercise Instruction, Mobility Training and Education for Return Home

ACUTE

THOUGHTFUL DISCHARGE

- Reinforce Next Site of Care
- Complete Med Reconciliation & Discharge Summary

CASE MANAGEMENT

- Identify Patient in Bundle
- Confirm Discharge Disposition
- Confirm follow-up appointments
- Provide written DC instructions to patient w action plan for change in condition

POST ACUTE

HOME WITHOUT SERVICES

FOLLOW UP CALL

- Confirm Follow-up MD, outpatient PT appointments
- Inquiry: Medications, Infection, DVT

HOME WITH HOME HEALTH AGENCY

COMMUNICATION WITH VNA

- Use Network
- Bundle Patient Identification
- Discuss Goals and Discharge Plan
- Reinforce HH LEJR Care Guidelines
- Confirm Discharge

SKILLED NURSING FACILITY

FACILITIES TEAM

- Use Network
- Bundle Patient Identification
- Set expectation (Estimated Length of Stay)
- Reinforce SNF LEJR Care Guidelines
- Receive Status Update Following Utilization Review meetings
- Confirm Discharge

Organizational Competencies

Creating a Postacute Network

SNF and Home Health Performance Networks

Goal: Identify and utilize the highest value post-acute facility/agency for the right patient at the right time in order to optimize outcomes and satisfaction.

- **Work with partner and hospital site** stakeholders to evaluate relevant skilled nursing facilities and home health agencies using quantitative and qualitative data
  - Star ratings
  - Specialty programs (ortho, cardiac, pulmonary, etc)
  - Cost/spending performance
  - On-site MD/provider availability
  - Readmission rate
  - Survey results

SNF and Home Health Performance Networks

Goal: Identify and utilize the highest value post-acute facility/agency for the right patient at the right time in order to optimize outcomes and satisfaction.

- **Build a narrow network** of facilities that are capable and willing to provide high-quality, high-value care to bundle patients
  - Share data
  - Manage changes in condition on-site if appropriate
  - Manage optimal length of stay
  - Safe care transitions
- **Educate patients** and/or care teams about Network members via a published list
- **Engage post-acute providers** to continually drive toward performance improvement through information sharing and collaboration

Clinical documentation and coding to capture illness severity

The Importance of Clinical Documentation and Pricing

- 6 of 122 DRG 469 (LMJ with major comorbid complications), 116 of 122 DRG 470 (LMJ without MCC)
- An accurate clinical documentation process is critical for illness severity, coding and pricing
- MDs should answer the queries of the clinical documentation professional

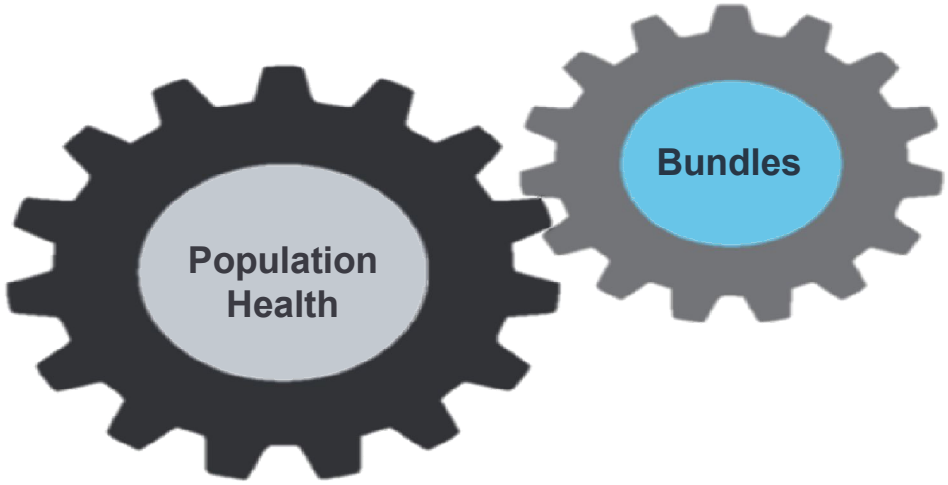
2016Q1 to 2016Q4 Financial Overview

Quarter	DRG	Volume	Avg. Episode Cost	Target Price
2016Q1	469	2	$55,172	$66,278
2016Q1	470	18	$32,498	$33,805
2016Q2	469	0	$0	$0
2016Q2	470	34	$37,811	$33,727
2016Q3	469	3	$44,754	$65,197
2016Q3	470	29	$29,827	$33,577
2016Q4*	469	1	$59,612	$64,903
2016Q4*	470	35	$37,408	$33,426
	Total	122	$35,648	$35,180

1) Claims and Adjusted Historic based on 170428 claims file for 2017Q3 bundle selection
** Performance data for most recent quarter is incomplete due to claims lag*

Integrating Episode and Population Health Management

A Powerful Combination: Bundled Payments and Population Health



Bundles Integrate into Population Health

- Pop Health focuses on prevention and chronic disease
- Bundles address acute medical surgical care and recovery
- They can work together on
  - Postacute networks
  - Care transitions
  - Data sharing

Primary Care Physicians are best positioned to control chronic care quality and costs
Specialists are best positioned to influence episode of care quality and costs

MACRA Overview

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) institutes new ways that physicians will be paid to care for Medicare patients

Before MACRA:
Pay for Volume

MDs reimbursed according to Part B claims adjusted per the Sustainable Growth Rate (SGR) formula

After MACRA:
Pay for Value

Option #1:

Merit-Based Incentive Payment System

Reimbursement based on:

1. Quality
2. Resource use
3. Clinical practice improvement
4. EHR meaningful use

Option #2:

Advanced Alternative Payment Models

Includes ACOs, Patient-Centered Medical Homes, others; Advanced BPCI (2018)

Viewpoint | Vital Directions from the National Academy of Medicine

October 25, 2016

Competencies and Tools to Shift Payments From Volume to Value

Mark B. McClellan, MD, PhD[1]; Mike O. Leavitt[2,3]

Viewpoint | Vital Directions from the National Academy of Medicine

JAMA

October 25, 2016

Competencies and Tools to Shift Payments From Volume to Value

Mark B. McClellan, MD, PhD[1]; Mike O. Leavitt[2,3]

- Governance and Culture
- Financial Readiness
- Health Info Technology
- Patient Risk Assessment
- Care Coordination
- Quality
- Patient Centeredness

Viewpoint | Vital Directions from the National Academy of Medicine

JAMA

October 25, 2016

Competencies and Tools to Shift Payments From Volume to Value

Mark B. McClellan, MD, PhD[1]; Mike O. Leavitt[2,3]

- Board representation for clinicians, community, and patients; decision-making processes aligned with value-based objectives
- Ability to assess longitudinal patient resource use; mechanisms to distribute shared savings payments
- Analytics to predict intervention impact
- Assess patient risk using validated tool
- Sharing of encounters, tests results, and other key information across care team and continuum
- Capacity to make care safer, timely, efficient, effective, etc.
- Incorporation of patient perspective into care system
- Capturing patients' values, preferences, and needs in care plans

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Importance of Physician and Clinician Executive Leadership

- We are in a stage of fairly dramatic health system transformation
- Skills of past may not be what is needed for future
- Population health management, quality improvement, system redesign, collaborative teamwork, measurement and data feedback, and change management leadership are critical skills
- Physicians and other clinicians MUST help lead the change to achieve better care, smarter spending, and healthier people
- THANK YOU

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What can you do to help our system achieve the goals of Better Care, Smarter Spending, and Healthier People?

- **Eliminate** patient harm
- **Focus** on better care, smarter spending, and healthier people within the population you serve
- **Engage** in accountable care and other alternative payment contracts that move away from fee-for-service to model based on achieving better outcomes at lower cost
- **Invest** in the quality infrastructure necessary to improve
- **Focus** on data and performance transparency
- **Help us** develop specialty physician payment and service delivery models
- **Test** new innovations and scale successes rapidly
- **Relentlessly pursue** improved health outcomes

Care Redesign

"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."

Thank you!

wwhitcomb@remedypartners.com