



GEISINGER

REDEFINING BOUNDARIES

# **Private Sector Payment Reform Experience: Geisinger Health System Example**

**Ronald A. Paulus, MD**

*EVP, Clinical Operations and Chief Innovation Officer*

# Payment Reform Environment

- Substantial incentives to “bend the curve” or reduce cost
- Inpatient care a very likely target
- Focus likely to be on both unit cost and on altered payment models
- Background items likely to add to the pressure:
  - Economic environment (elective care, payor mix)
  - Global pressure to reduce inpatient utilization

# Our Legacy

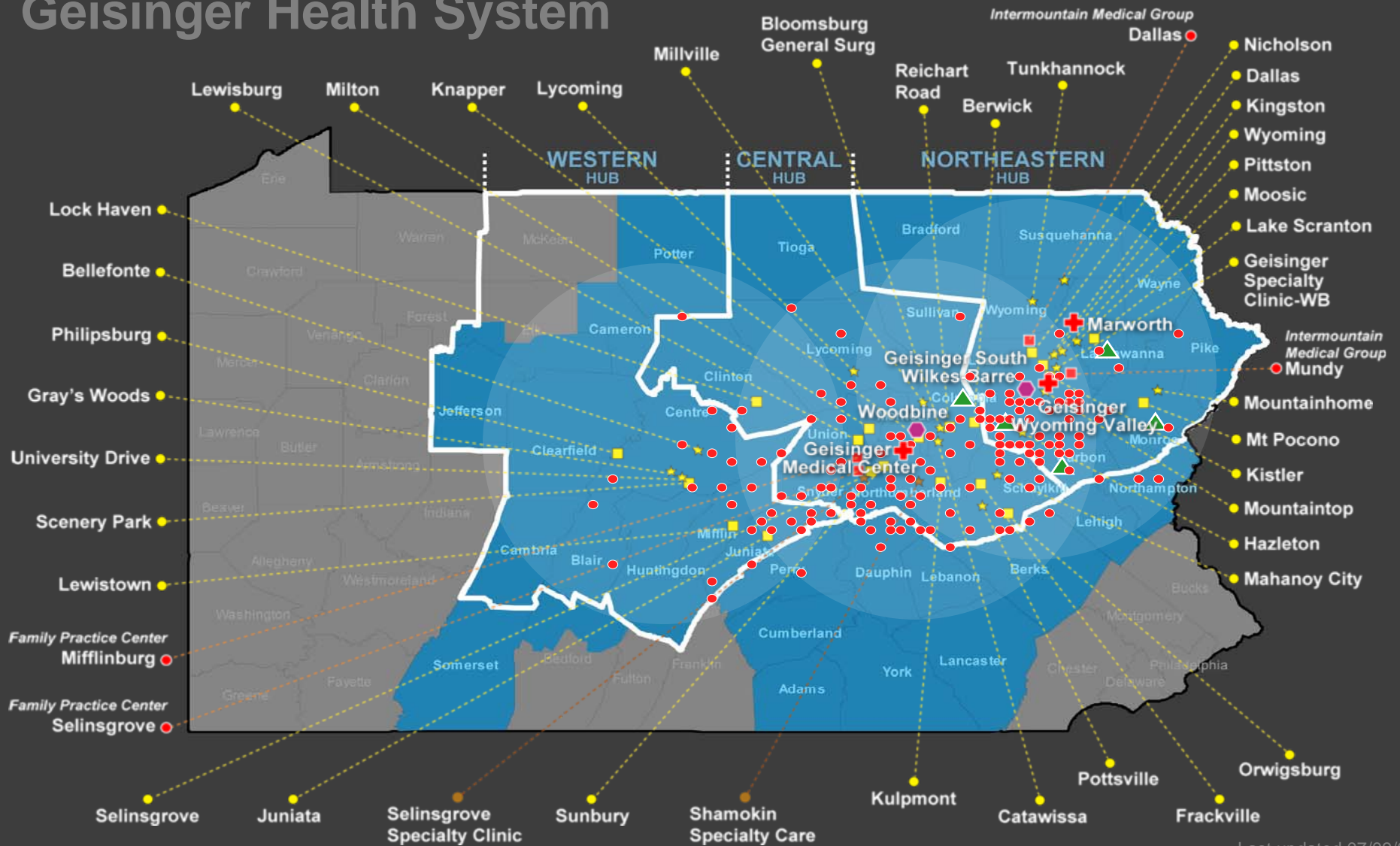


**“Make my hospital right,  
make it the best.”**





*Abigail Geisinger*  
*1827-1921*





**“Geisinger Quality – Striving for Perfection”**

# Geisinger Health System



Last updated 07/09/09

-  Geisinger ProvenHealth Navigator Sites
-  Contracted ProvenHealth Navigator Sites
-  Geisinger Medical Groups
-  Geisinger Specialty Clinics

-  Geisinger Inpatient Facilities
-  Ambulatory Care Facility
-  Geisinger Health System Hub and Spoke Market Area
-  Geisinger Health Plan Service Area

- ▲ Careworks Convenient Healthcare
- Non-Geisinger Physicians With EHR

# GHS “Sweet Spot” is Our Innovation Laboratory

- Background:
  - GHS provides ~45% of GHP medical care
  - GHP members account for ~30% of GHS revenue Our
- “Sweet Spot” is the overlap area where Geisinger has financial responsibility and provides the majority of care
- Shared in common within our “Sweet Spot”:
  - Clinicians
  - Population
  - EHR & Web Sites
  - Objectives and Values

# Creating Real Value: Geisinger's Core Care Transforms

**Fundamental payment reform for primary care**

– Chronic Disease Home Health Navigation

**Acute-episode bundling with a "warranty" ...**

– Acute<sup>®</sup> Optimization

**Bundled readmission payments (pending)**

**Patient engagement and activation initiatives**

– ProvenEngage

**Incentivize engagement and self-care**

– "non compliance"

# ProvenHealth Navigator®

Geisinger's Value-based Patient-Centered Medical Home

You may be involved...or you may be IMPACTED...



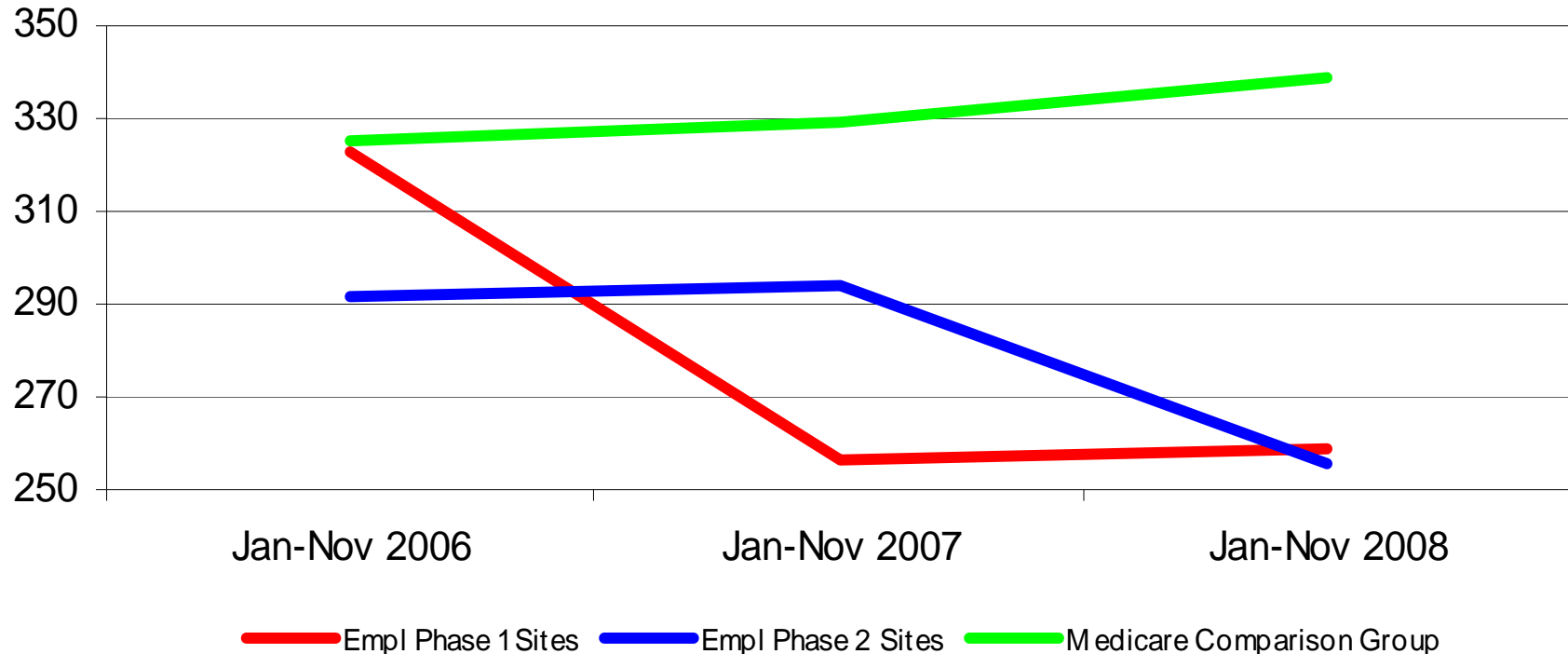
# Functional Components

1. Team-based, patient-centered primary care (including embedded care management nurse)
2. Joint payor-provider population management
3. High quality, efficient specialist identification and referral
4. Quality Outcomes Program
5. Value-based Reimbursement Program
  1. Baseline FFS
  2. Practice transformation stipends
  3. Quality-gated gain sharing

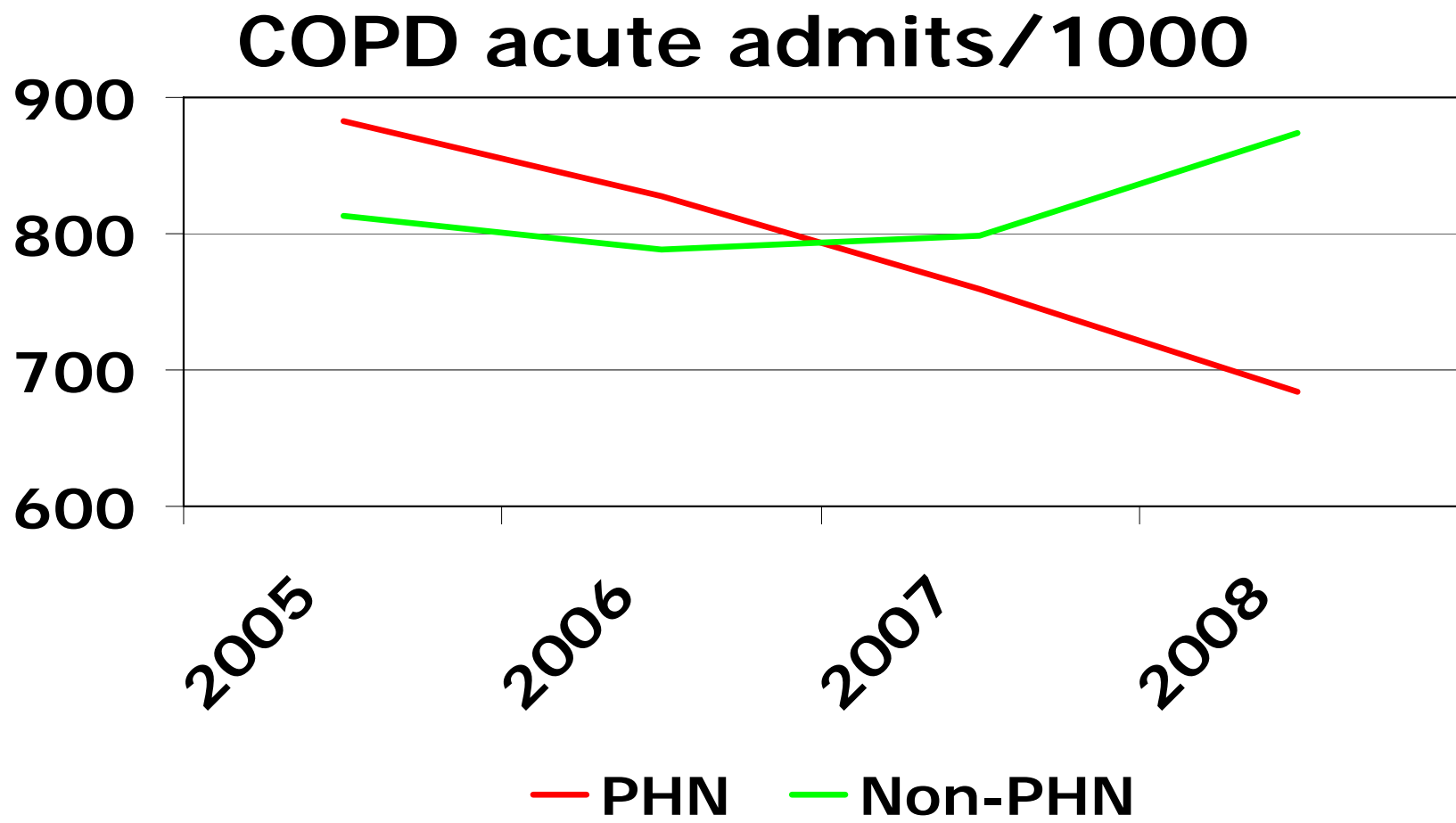


# Result: Substantial Inpatient Admission Reduction

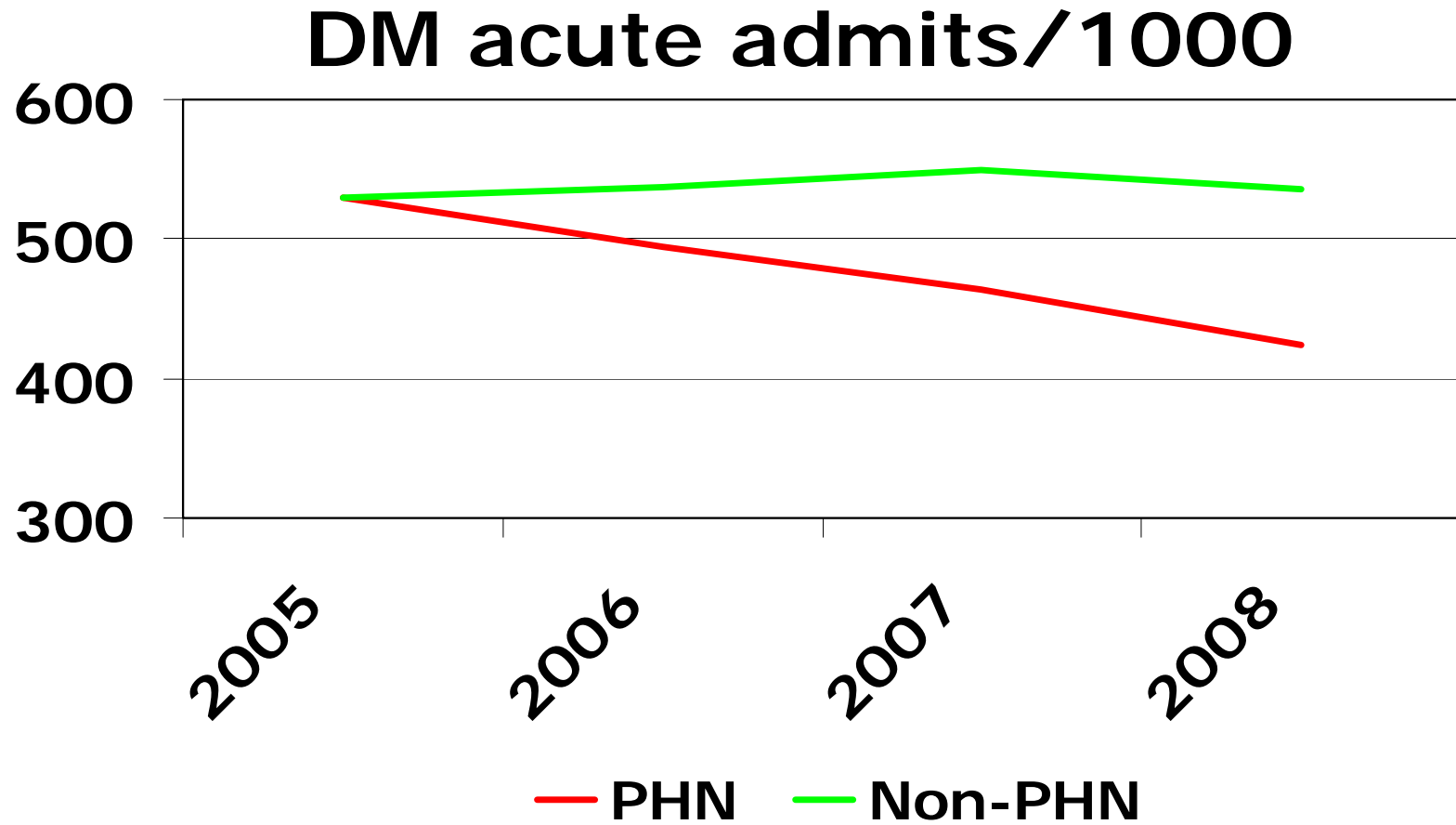
## Risk Adjusted Acute Admits/1000



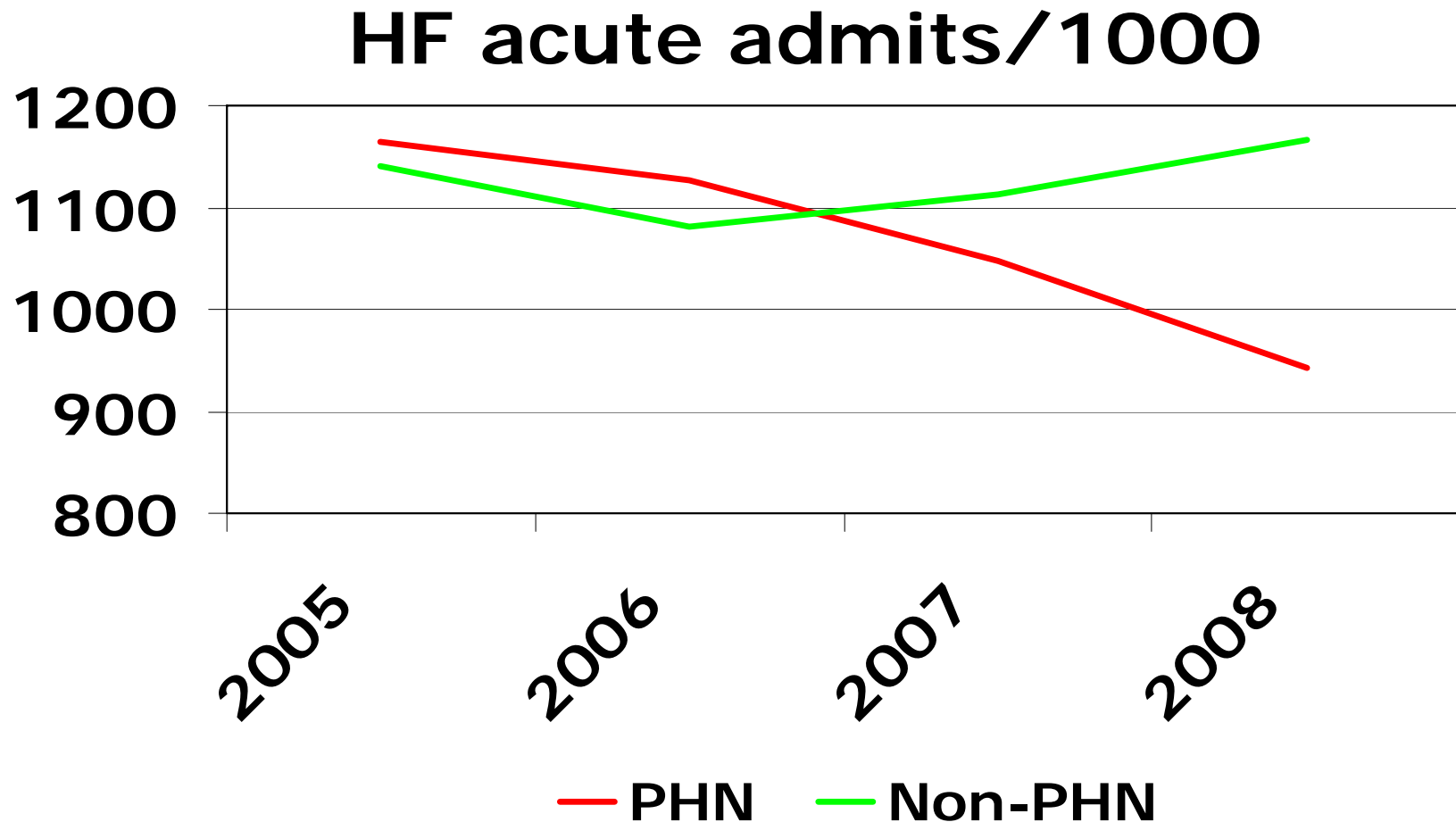
# Result: COPD Admission Reduction



# Result: Diabetes Admission Reduction



# Result: CHF Admission Reduction

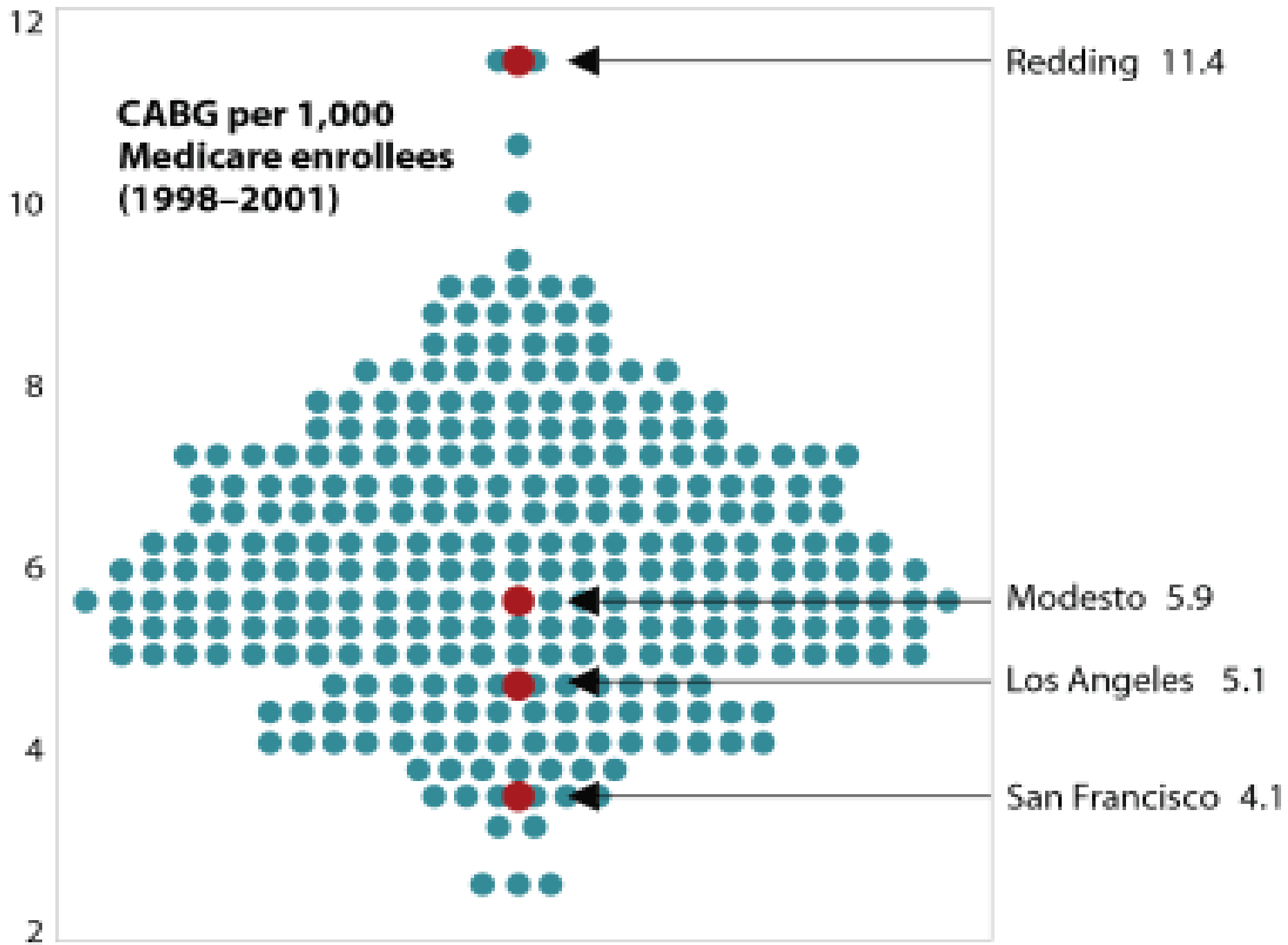


# **ProvenCare Acute<sup>®</sup>**

## Geisinger's Bundled Episodic Care

# Common Acute Care Scenario

- Clinical
  - Uncertain appropriateness
  - Variable compliance with known-to-be beneficial evidence-based care
  - Limited patient engagement
  - Variable outcomes
- Business
  - Lack of accountability for outcomes and quality
  - A la carte payment for services
  - No relationship between cost and quality
  - Perverse incentives: more payment for complications





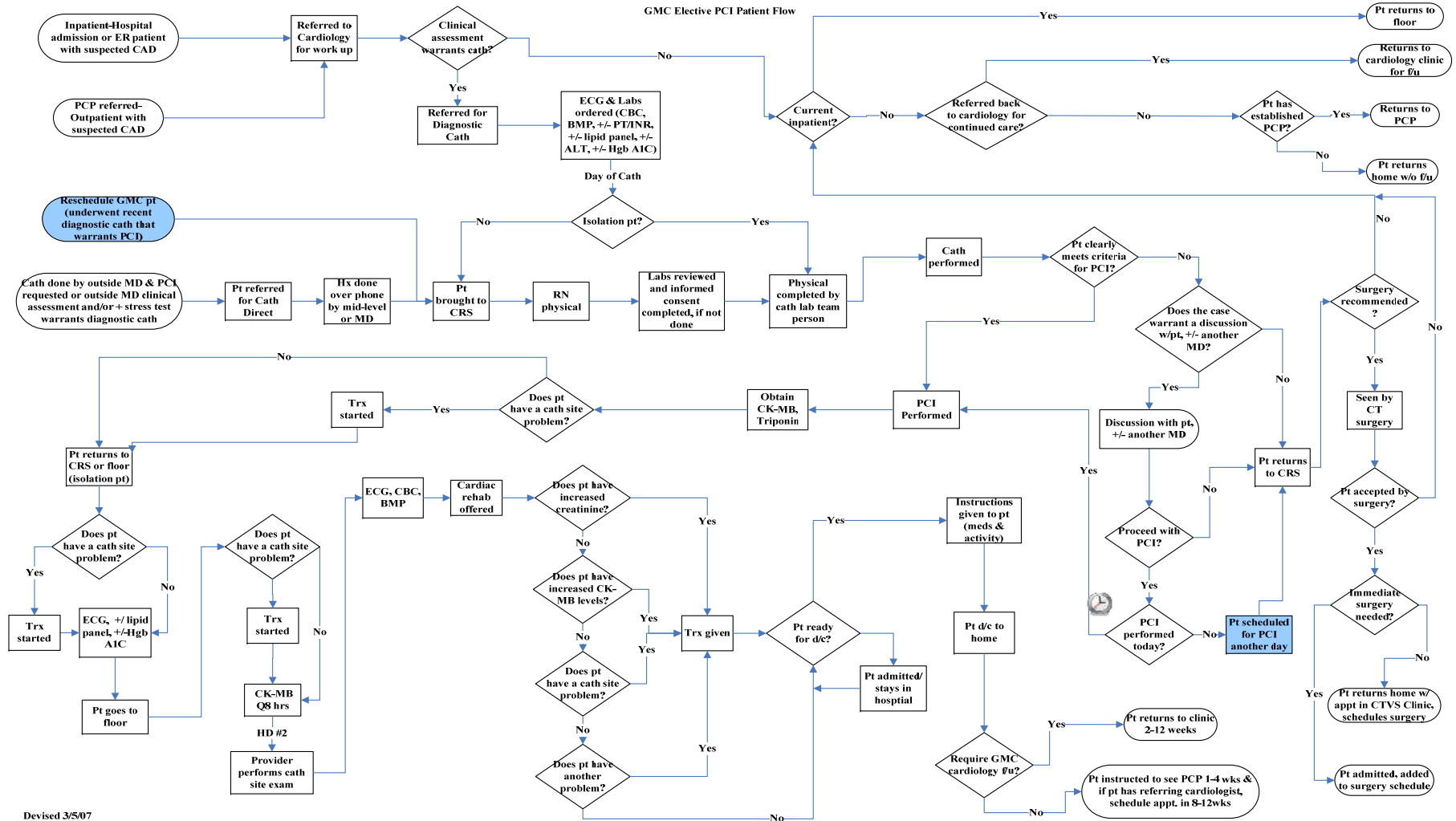
# GHS Receives “All In” Global Fee

- One fee for the ENTIRE 90-day period including all surgery-related care:
  - ALL surgery-related pre-admission care
  - ALL inpatient physician and hospital services, including cardiologists, cardiac surgeons, anesthesia, consultants, etc
  - ALL surgery-related post-operative care
  - ALL care for any related complications or readmissions
- Aligns incentives across provider, patient and payor

# ProvenCare Data Analytics

- Historical data trends:
  - allowable claims, payments, complications, readmissions, other...
- Establish patient inclusion/exclusion criteria
- Establish pivotal event comorbid diagnoses
- Establish related diagnoses: complications, readmissions
  - Historical claims review, EHR, clinical review
- Set bundled price to facilitate new model and reward ongoing quality/efficiency improvements

# Process Redesign: Work Flow



# Process Redesign: Hardwiring

**Visit Navigator (3/18/2008 visit with DOLL)**

SmartSets Open Orders SmartForms Images Questionnaires Graphs Scans Admin Benefits Print AVS Adv Dir

**Allergies** Latex, Sulfa Drugs, Chocobase, Strawberries, Bee, Tora, Orajel, Shellfish, Benadryl Allergy, Promethazine Hcl, Nuts, Lasi<sup>®</sup> Reviewed on 3/7/2008

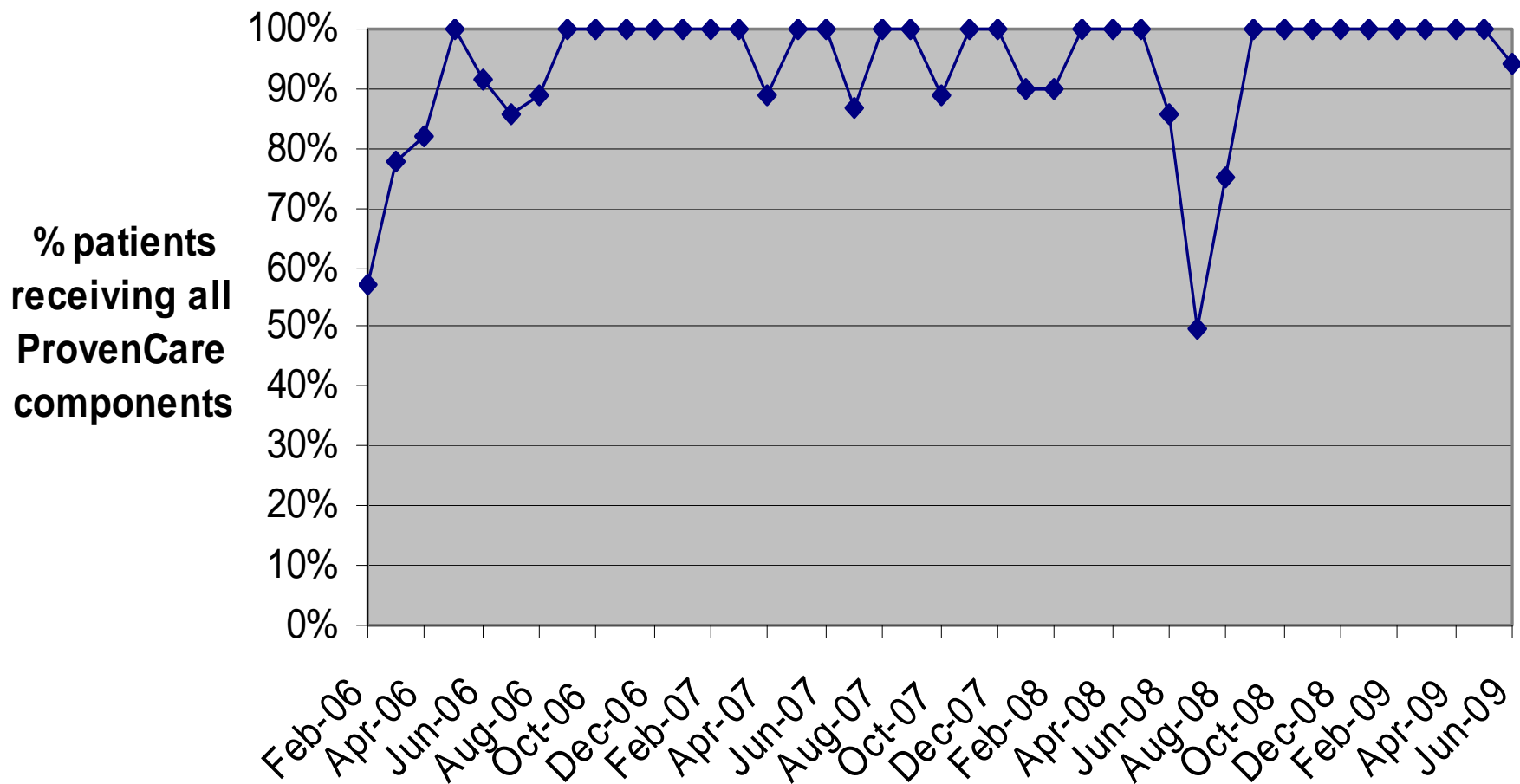
MRN: Z70000021 ZEPICCAR,INPATIENT PLEASANT Sex: F DOB: 1/1/1982 Age: 26 \*DOLL

Primary Payor: GHP COPAY PLA\* PCP: [Not avail.] Practice: [Not avail.]

Nurse	History and Physical
BestPractice	Is patient 75 years of age or older & SBP >180mm/hg? Yes - Needs Epia ... <b>No</b>
Chief Complaint	Pre-OP LV EF <25%? Yes - Needs IABP ... <b>No</b> Ballon Pump not ... No ...
Episodes	Is patient on a Beta-Blocker? Yes <b>No - Order Beta- ...</b> No - Beta Blocke ... No - Order Bet ...
Vitals	Is patient on a Statin? <b>Yes</b> No Other (See Comment)
Med. List	Does patient have dx of PVD; h/o TIA/CVA; Carotid Bruit on exam? <b>Yes</b> No
Nursing Notes	Has Carotid Doppler been done within the last 6 months? N/A Yes <b>No - Order Carot ...</b> Pending
<b>Specialty Info</b>	Are Carotid Doppler Results available in EPIC? N/A Yes - No action ... No - Scan report ... <b>Pending</b>
Filtered Results	Patient has Carotid Doppler requiring Vascular consult? N/A Yes No <b>Pending</b>
Filtered Enc	Vascular Consult completed and report in EPIC? <b>N/A</b> Yes No
<b>Provider</b>	Has the patient had an Anterior Wall MI within the past 7 days? N/A Yes <b>No</b>
Progress Notes	Has the patient had an Inferior Wall MI with RV involvement within the past 7 days? <b>N/A</b> Yes No
<b>Cardiac Pre</b>	If yes to the previous question, has a consult with another Cardiac Surgeon and a Cardiologist taken
Cardiac Post	
30-Day Post	
Diagnoses	
Orders	
Med. Reconciliation	
Pt. Instructions	
LOS & Follow-up	
AVS	
Communication	
Close Encounter	

[View Hotkeys](#)

# ProvenCare<sup>®</sup> CABG: Reliability



# CABG Clinical Outcomes

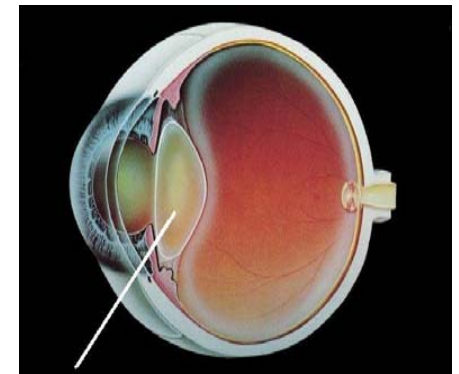
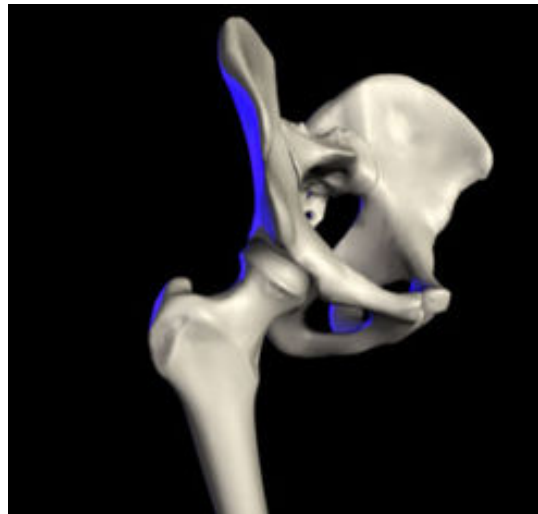
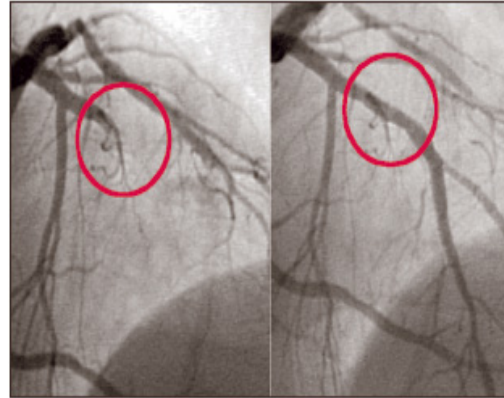
	<i>Before ProvenCare<sup>®</sup> (n=132)</i>	<i>ProvenCare<sup>®</sup> (n=321)</i>	<i>% Improvement</i>
In-hospital mortality	1.5 %	0.3 %	<b>80 %</b>
Patients with <u>any</u> complication (STS)	38 %	33 %	<b>13 %</b>
Patients with >1 complication	8.4 %	5.9 %	<b>30 %</b>
Atrial fibrillation	24 %	21 %	<b>13 %</b>
Neurologic complication	1.5 %	0.9 %	<b>40 %</b>
Any pulmonary complication	7 %	5 %	<b>29 %</b>
Re-intubation	2.3 %	0.9 %	<b>61 %</b>
Blood products used	24 %	22 %	<b>8 %</b>
Re-operation for bleeding	3.8 %	2.8 %	<b>26 %</b>
Deep sternal wound infection	0.8 %	0.3 %	<b>63 %</b>
Readmission within 30 days	6.9 %	5.6 %	<b>20 %</b>

# Hospital Financial Outcomes

Time Period	Net Revenue Change	Cost Change (Variable Direct/Total)	Net Margin Change
July 2006 – March 2009	+7.8%	-5.1% / -5.2%	+160%



# Other ProvenCare Acute Programs



# ProvenTransitions®

## Care Hand-off Optimization

# A Major Medicare Issue...

- “Potentially Preventable” admissions account for \$12+ billion in Medicare spending (>8% of \$146B total Part A spend in 2006)

30 Day Readmission Rate	60 Day Readmission Rate	90 Days Readmission Rate
18%	35%	67% (or dead)

**TABLE 5-2**

## Potentially preventable hospital readmission rates

### Patients readmitted to hospital within:

	7 days	15 days	30 days
Rate of potentially preventable readmissions	5.2%	8.8%	13.3%
Spending on potentially preventable readmissions (in billions)	\$5	\$8	\$12

Source: 3M analysis of 2005 Medicare discharge claims.

# Drivers to Reduce Readmissions

## GOAL

## DRIVERS

## KEY TACTICS

Readmissions

Screening

Care Mgmt:  
Inpatient/  
Outpatient

Team  
Communi-  
cations (IDTs)

Patient  
Education/ Med  
Rec

Post-  
Transition  
Care

Early identification of readmission risk

Target interventions based on risk level

Early DC needs assessment of high risk pts

DC Planning – choose best next care setting

Outreach to OP Care Mgmt based on risk level

Seamless transition between IP & OP Care Mgt

Consistent documentation (location, content)

Multi-disciplinary care coordination

Ready the patient for successful self-care

Multidisciplinary Teaching - patient and family

Teach Who-What-When-Where if help needed

IP Pharmacist consult on high risk pts/meds

Post-DC Follow-up appt for EVERY patient

Instant communication of hospital course and follow-up needs to post-DC providers/agencies

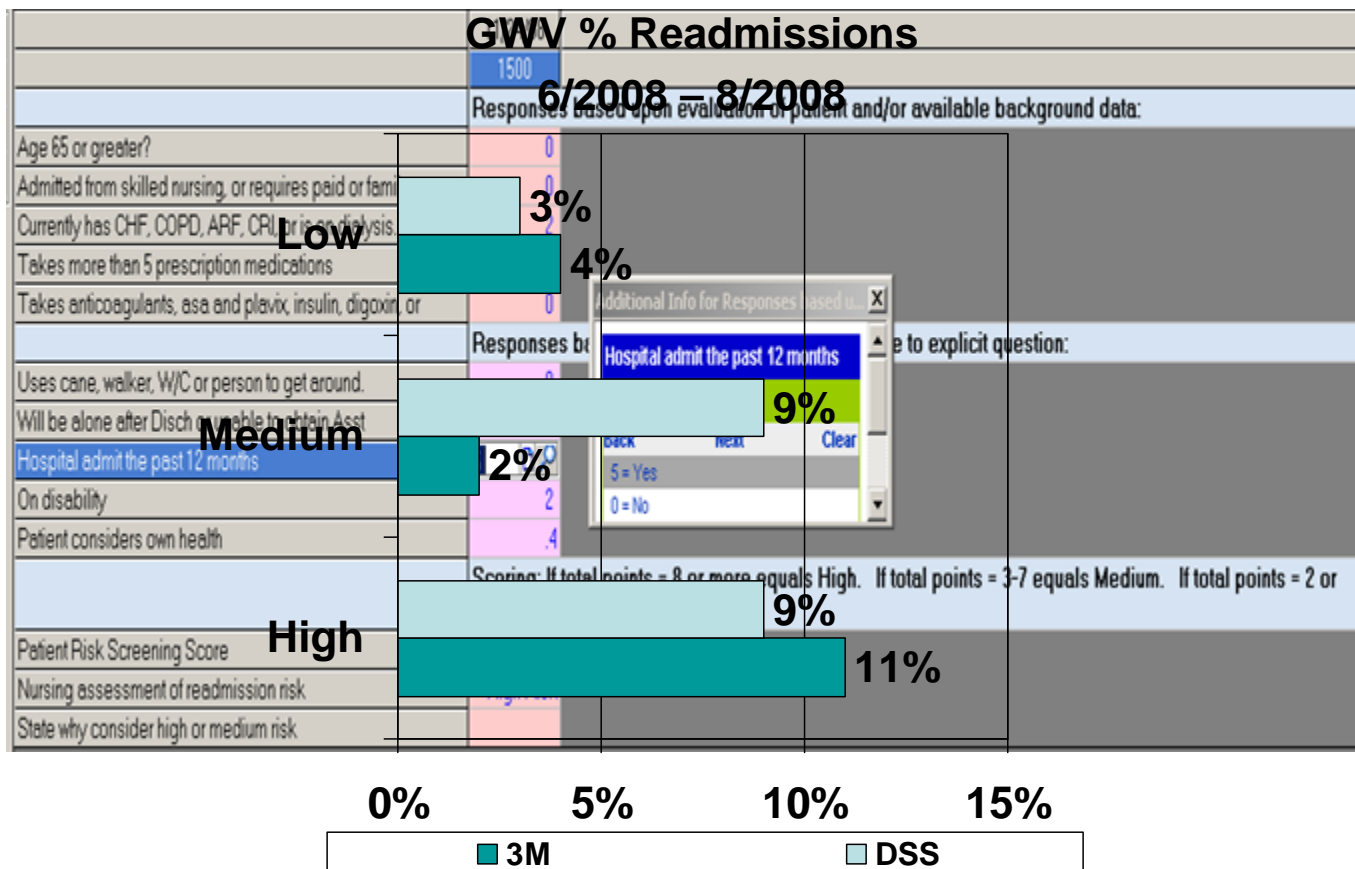
MH with tele-monitoring, follow up phone calls, SNF management

Social issues addressed (non-compliance, ability to buy meds, advanced directives)

# Transition Patient Flow Design

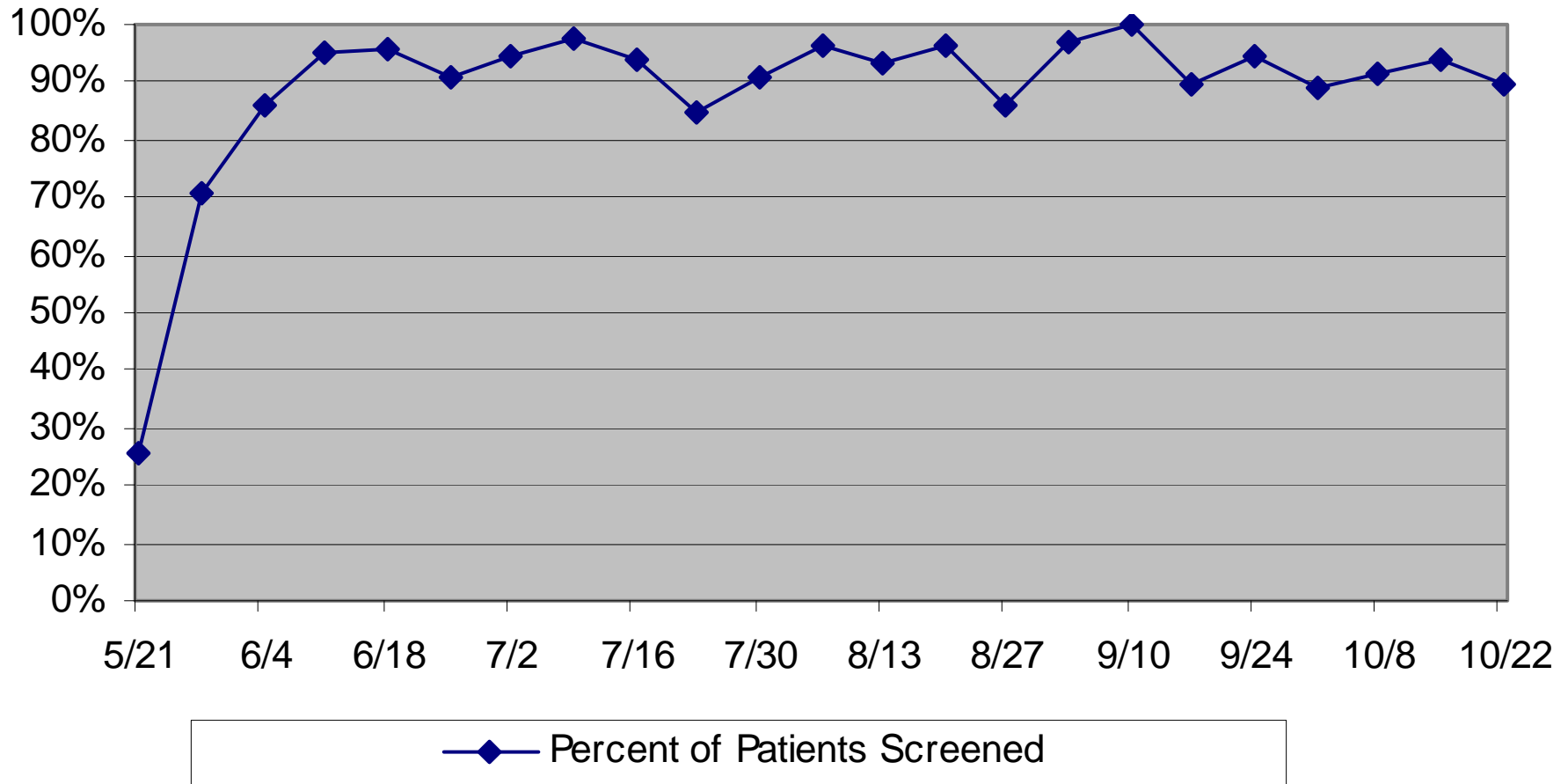
Pre-admit/ED	Admit	Inpatient Stay	Discharge	Post Acute
Screening for High Risk	Detailed Assessment	Interdisciplinary Rounds	PCP Appointment	Proactive Outreach
Pre-Admit Care Mgmt for Elective Pts	Early Nurse Care Activation	Patient Education/ Teach Back	Discharge Synopsis	Enhanced Nsg. Home Clinical Capabilities
	Discharge Plan	Palliative Care		

# ED Screening Instrument



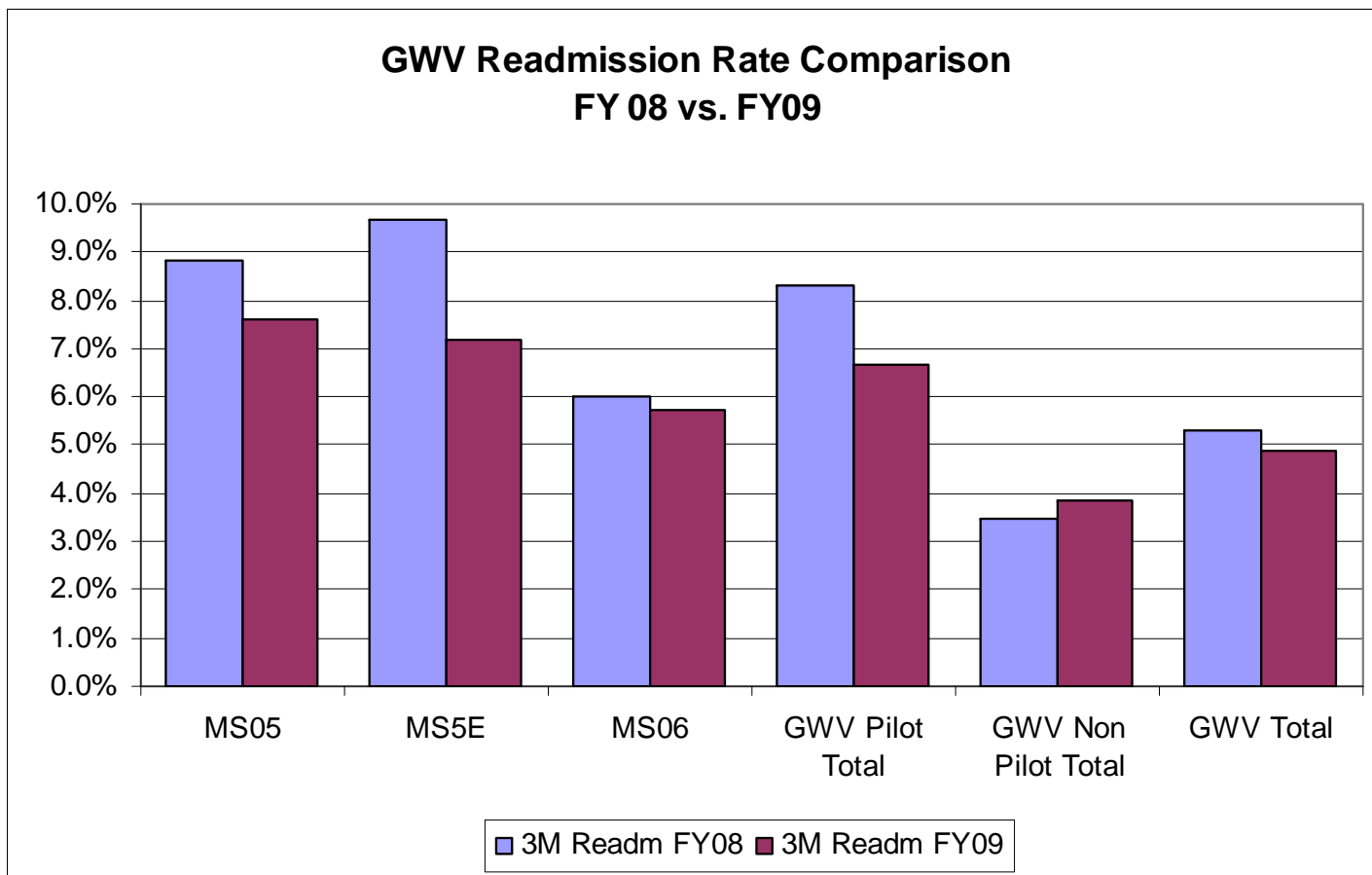
Based upon combination of literature review, expert interviews, Geisinger data and clinician experience

# Patients Screened





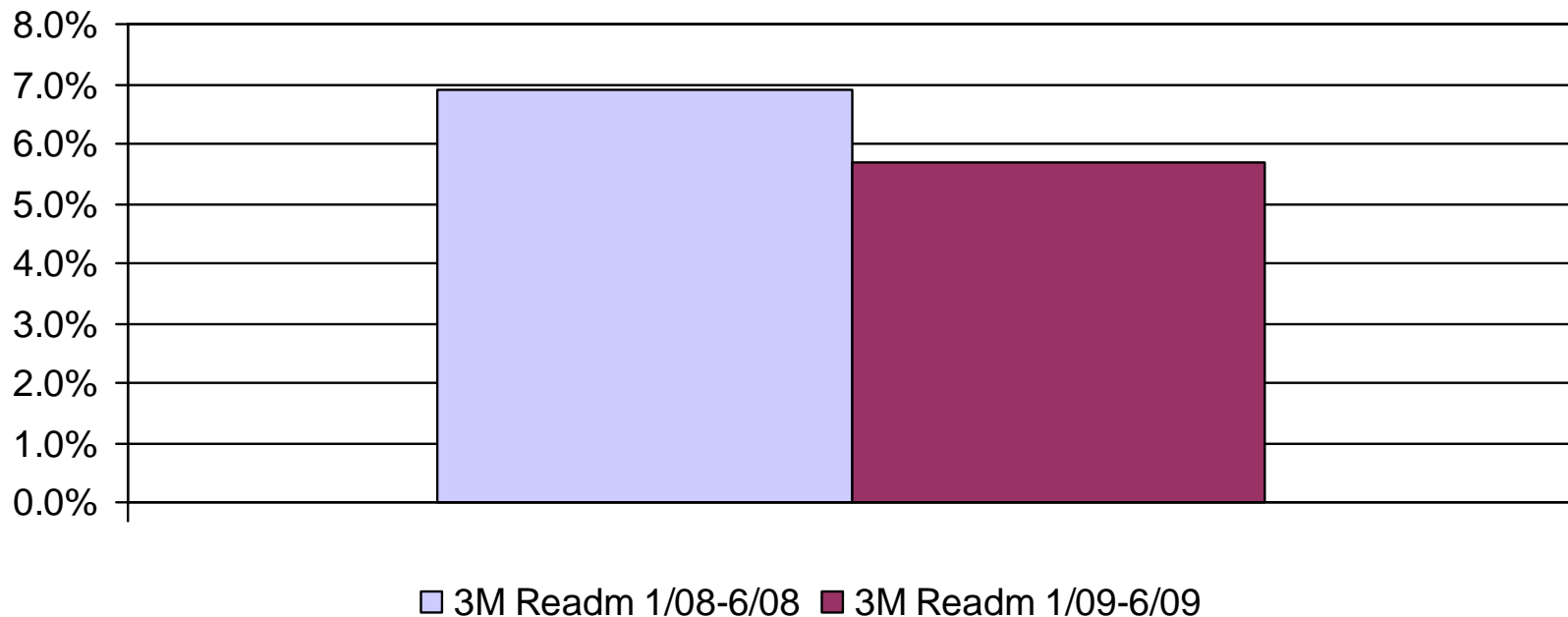
# FY 09 Final Results: GWV



30 Day Readmission Rate

# FY 09 Final Results: GMC Surgical Pilot

## GMC Surgical Pilot Readmission Rate Comparison FY 08 vs. FY 09



30 Day Readmission Rate

# Next Up: Bundled Readmission Payment

- Bundle proportion of historical readmission rate/payment into up-front DRG rate
- Step down the % of historical over a 3-5 year period (say, 95% to 60%)
- Key Advantages:
  - Provides a direct incentive to reduce rates
  - Enables hospitals to earn “windfall profits” during early years
  - Avoid abrupt change with negative impact
  - Sets a high bar, that can be reconsidered
  - Even 60% is higher than best performing Medical Home sites, so not unrealistic
  - Administratively simple

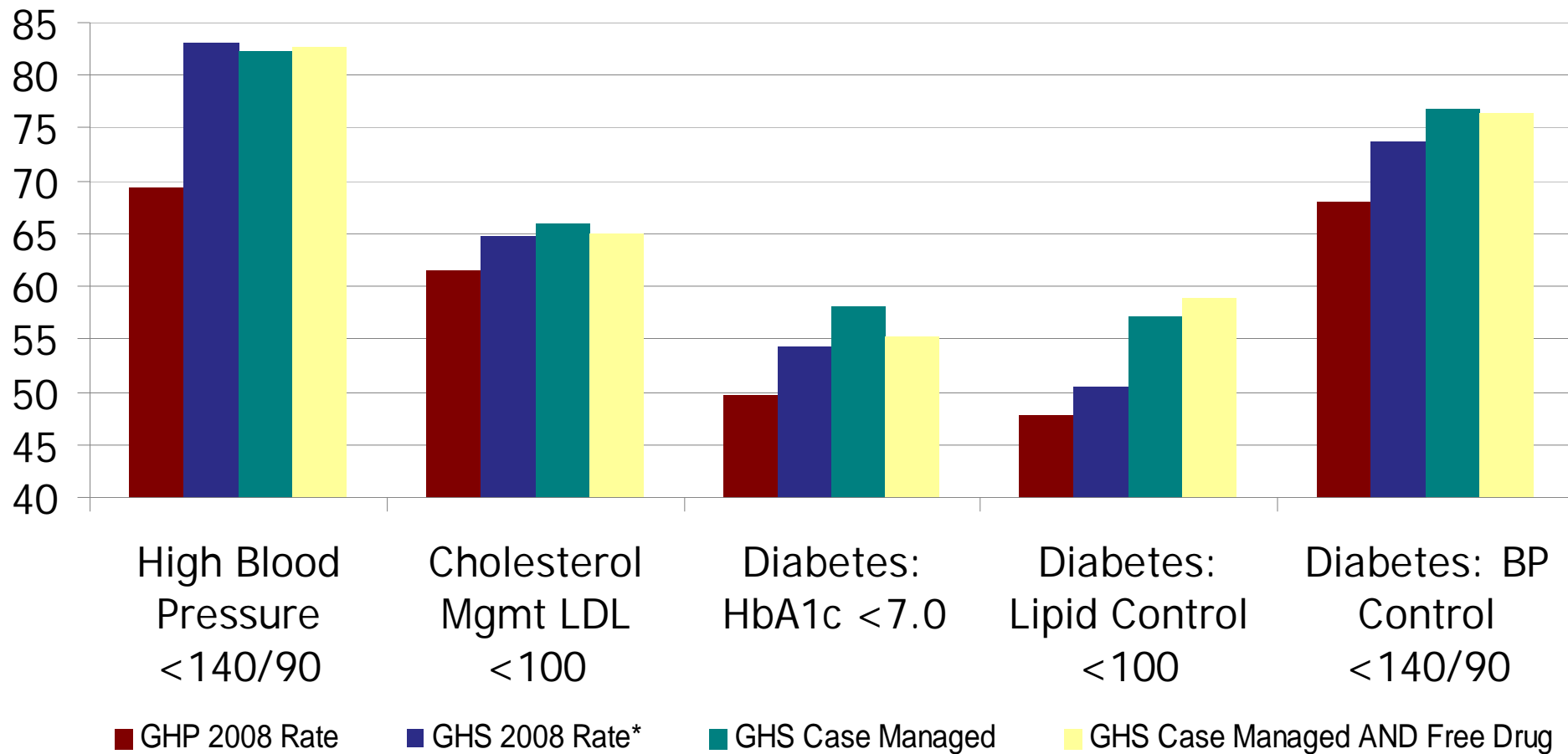
# ProvenEngagement

## Geisinger Employee Example

# Geisinger Employees: Chronic Disease Program

- Encouragement to take an HRA through:
  - Frequent reminders
  - Lottery to win \$200 or \$500 (ten drawings with ten winners in each)
- Incentives to participate in Care Management programs
  - \$200 payment to join
  - \$200 payment if one continues in the program for at least six months
- After satisfaction of a \$75 deductible, future co-payments are waived for prescriptions filled for Coronary Artery Disease, Hypertension, and Diabetes.
  - Both brand name and generic drugs covered

# Early Results



# Improved Care: Asthma

Asthma	Baseline	Follow up	Change
Pulmonary function test (breathing test)	40%	64%	24%
Validated use of inhaled steroid or leukotriene modifiers (Singulair, Accolate) medication	92%	97%	5%



# Improved Care: Chronic Kidney Disease

Chronic kidney disease	Baseline	Follow up	Change
Stage 3 and 4 - Blood pressure < 130/80	29%	63%	34%
Stage 5 – followed by nephrologist	100%	100%	--

# Summary

- Follow the current macro problems to find likely reimbursement changes downstream
  - Flat/Lower inflation-adjusted reimbursement likely
  - Bundled payments and reorganized primary care most impactful
  - Many, many interventions being put in place to reduce hospital utilization...
- These changes have both a positive clinical and economic impact (though not to every constituent)
- It will take time to “get ready”, so it’s never too early to start planning, testing
- Geisinger has an advantage due to our integrated delivery system “Sweet Spot”

# Thank You.