
Mark M. Fulco
Chief Transformation Officer
Sisters of Providence Health System

3rd Annual GPO and Institutional Sales Strategy Summit

July 21, 2015
TODAY, FEE FOR SERVICE IS DEAD
4.10.2015

A CARE MANAGER, SOCIAL WORKER AND HEALTH COACH WORKING TOGETHER WITH A PCP TO KEEP PEOPLE HEALTHY AND AT HOME.

The direct reimbursement fee for Steward’s Coordinated Care Team is $0. So why do it? Because your health is our success.

FEE FOR SERVICE IS DEAD.
THE NEW HEALTH CARE IS HERE.
The opinions expressed are those of the presenter and do not represent the opinions of the Sisters of Providence Health System, the Accountable Care Organization of New England, Mercy Care Alliance, Mercy Medical Center or Trinity Health.
Health Reform – The Push to Value
The Threats Are Real

“Our contracts do not require us to show cause for termination.”

“We took this response to customer demands for smaller networks...that can lead to lower health care costs.”
Huge Variation in Cost
Massachusetts Inpatient Cost Per Case Adjusted Discharge

Expense difference between 25th and 75th percentiles

$2000 (23%)

Each column represents one Massachusetts acute hospital

Highest: $19,127
75th percentile: $10,032
Median: $9,053
25th percentile: $8,157
Lowest: $6,545
Variation in Quality Performance
Operating Expense/Readmission

Higher efficiency

Lower efficiency

Excess readmission ratio

20% better than median

20% worse than median

Median expenses

U.S. average performance

Median performance

Inpatient operating expenses per discharge

Each data point represents one Massachusetts acute hospital.
Population Health & Clinical Integration
Infrastructure and Functional Capabilities

• **Contracting**
  – Contract negotiation & management

• **Care Management**
  – Episode management
  – Identification of chronic disease and other vulnerable patients
  – Disease management
  – Appropriate utilization

• **Hospitalist & SNFist Service**

• **Quality Assurance**
  – Clinical protocols
  – NCQA reporting, compliance, audit
  – Reporting

• **Cost Management**
  – Cost reporting
  – Practice coaching
  – Incentive management and PMPM reconciliation

• **Risk Management**
  – Risk adjustment
  – Coding & retro-coding

• **Information Technology**
  – Patient Registry
  – Data Warehouse
  – Workflow and coding tools
  – Claims reconciliation
  – Informatics and analytics
 Appropriately Reduce Unnecessary Utilization

Acute Admissions/1000

Acute Readmission Rate

SNF Admissions/1000

SNF Readmissions to Acute Rate

*Claim data is complete. Shading indicates per reg data.
*Data excluded transfert, i.e. transfers are not counted as separate admissions.
Population Management
3 Actionable Opportunities

1. In-patient & Post-Discharge Management
   • Hospitalist rounders
     – LOS management
   • Dedicated Care Managers
   • Homecare Disease Management services
Population Management
3 Actionable Opportunities

2. Post-Acute Management

• SNFist team

• High value SNF provider selection and management
  – SNF survey and scoring
    • Readmission rates
    • Average LOS
    • Direct admits

• High value homecare provider selection and management
  – Readmission and ER visit rates
  – Performance
    • Begin care within 24 hours post discharge
    • Communication and adherence to protocols
Population Management
3 Actionable Opportunities

3. **Out-patient Clinical Management**
   - Panel and patient level “actionable information”
   - Physician workflow tools
   - Monitoring and tracking
The Special Sauce: Proactive Care Management

• Clinical best practices
  • Basic clinical standards and protocols
  • Reduce practice variation

• Stratify patients in need of care management
  • Focus on specific conditions

• Prioritize high risk patients
  • High likelihood of re-hospitalization
  • High likelihood of emergency room visit

• Clinical intervention and care coordination
  • Disease Management programs
  • Timely care & preventive care
  • Specialist referral
Assess how member is feeling:
- Excellent
- Good
- Fair
- Poor

Is this a recent change?
- Yes
- No

Assess member's medication:

Assess level of ADL Functioning:
- Independent
- Dependent
- Not able to assess

Assess ADL Function:

Details (Be specific with regard to activity and amount of assist)

Who assists you with these areas?

Over the past 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?

Over the past 2 weeks, how often have you felt down, depressed or hopeless?

Do you often have problems with your memory?
- Yes
- No

Assess support services in place:

Assess status of support services:

Record Timer: 00:00:00
Details:

Do you have a follow up appointment scheduled with your Primary Care Physician? (This should be within 7 days of hospital discharge)

○ Yes  ○ No  ○ Has already seen PCP

Details:

How will you get to your appointment?

Details:

Are you comfortable calling your doctor with changes in how you feel? (Remind member VNA services are available 24 hours, Urgent Care that is associated with PCP office, call PCP early and often for symptoms)

○ Yes  ○ No

Details:

How many NEW medications do you have since being discharged? (Remind member, Pharmacist is available for consult if needed)

Details:

Have you filled your NEW prescriptions?

○ Yes  ○ No

Why haven't you filled your medication?

How confident are you in your ability to take any of your medications as prescribed? One being the least confident and 10 being the most confident.
CareEvolution: Robust IT and Informatics for Population Health

**Payer Source Data**
- Attributed patients
- CMS Medical & RX claims
- Data:
  - Payment
  - Visits (office, ER…)
  - Admissions, LOS
  - Tests and screenings
- Care management data
- Patient generated data (HRAs) - Future

**Clinical Source Data**
- Hospital EHRs
- Physician offices EHRs/PMIS
- National Lab / Pharmacies
- Data:
  - Patient demographic
  - Lab and radiology values
  - Test results
  - BMI, Blood Pressure
  - Orders
  - Care Notes

**Apply Methods**
- Episodes of Care
- Predictive Risk Scores
- Clinical Rules & Measures

**HIEBus™**
Operational Data Store (ODS)

**Monthly**
Galileo™
ACO Online Analytics Processing (OLAP)
- Population Management
- Performance Management
- Medical Cost Reporting
- Patient Risk Analytics
- Referral Management

**Near Real Time**

**Beacon Alerts & Provider Portal**
- Integrated Patient Record
- Care Alerts/Patient Registry
- Secure Messaging
- Data Capture Automation

**Patient Portal**
- Integrated Patient Record
- Labs, Reports, Notes and Clinical Summary
- Certified MU Stage II
- Education Materials
Care Evolution—Population Health Console

Understanding Populations of Patients

Based on Role, select from one or more datasets

MCHP-United Healthcare—MCHP

Population Health

Cohort

Click the performance indicators below to drill into dashboards for each concept.

- Patient w/ Gaps in Care: 23,070
- Unmanaged High Risk Patients: 13,146
- $/Person (Yearly): $2,333
- Currently Attributed Patients: 23,628

Click to See Details on Patient That Represent High Risk
Click to See Details on Costs
Unique Patients Attributed to ACO
Utilization Dashboard
Disease Registries
Identify and Understand Patients with Specific Conditions

Anchor 5 chronic diseases responsible for high per patient cost and utilization – Click thru to review patients within registries
Care Evolution— Disease Registries
Identify and Understand Patients with Gaps in Care

DM HbA1c Control

ACO22 (NQF #0729)

Denominator: Patients 18 to 75 years of age with a diagnosis of diabetes mellitus in the last two years.

Exclusions: Diagnosis of polycystic ovaries, gestational diabetes or steroid induced diabetes.

Numerator: Patients with most recent HbA1c < 8.0 percent.

DM HbA1c Control

<table>
<thead>
<tr>
<th>Status</th>
<th>Patients</th>
<th>Measure</th>
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<tbody>
<tr>
<td>HbA1c Under 8.0%</td>
<td>1,676</td>
<td>34.6%</td>
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<tr>
<td>HbA1c Above 8.0%</td>
<td>422</td>
<td>8.7%</td>
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<tr>
<td>HbA1c Not Performed</td>
<td>2,063</td>
<td>55.0%</td>
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<tr>
<td>More Than 24 Months</td>
<td>78</td>
<td>1.6%</td>
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Target 55.0%

DM HbA1c Control Trend

Measure: 100%, 70%, 60%, 50%, 40%, 30%, 20%, 10%

Date: December, January, February, March, April, May, June, July, August, September, October, November, December
# Improved Outcomes By Reducing Gaps In Care

## Gaps In Care

Utilization Time Period: 1/1/2014 to 12/31/2014

<table>
<thead>
<tr>
<th>Physician</th>
<th>Smith, Jonathan</th>
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<tr>
<td>Patient Name</td>
<td>DOB</td>
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</table>

- **High Risk Pop.**: None
- **Conditions**: Congestive Heart Failure; Diabetes without Complication; Hemiplegia/Hemiparesis; Hip Fracture/Dislocation; Pancreatic Disease; Proliferative Diabetic Retinopathy and Vitreous Hemorrhage; Protein-Calorie Malnutrition; Renal Failure; Specified Heart Arrhythmias; Vascular Disease
- **Gaps In Care**: None

|            |     |     | 5      | 0    | 1.027      | $1,063.10 | 2/24/2015 | 6/23/2015 |

- **High Risk Pop.**: None
- **Conditions**: Specified Heart Arrhythmias; Vascular Disease
- **Gaps In Care**: BMI Screening (Due:07/01/2014); Clinical Depression Screening (Due:07/01/2014); Fall Risk Screening (Due:07/01/2014); HTN Control (Due:07/01/2014); Influenza Immunization (Due:07/01/2014)

|            |     |     | 0      | 2    | 2.887      | $53,782.30 | 8/20/2014 |           |

- **High Risk Pop.**: None
- **Conditions**: Cardio-Respiratory Failure and Shock; Congestive Heart Failure; Polyneuropathy; Specified Heart Arrhythmias; Unstable Angina and Other Acute Ischemic Heart Disease; Vascular Disease
- **Gaps In Care**: None

|            |     |     | 6      | 2    | 4.618      | $25,433.39 | 2/18/2015 |           |

- **High Risk Pop.**: 1 or more Readmissions (last 12mo); 2 or more Inpt (last 12mo); Heart Failure Registry; Risk Score above 3
- **Conditions**: Cardio-Respiratory Failure and Shock; Chronic Obstructive Pulmonary Disease; Congestive Heart Failure; Diabetes with Renal or Peripheral Circulatory Manifestation; Polyneuropathy; Renal Failure; Specified Heart Arrhythmias; Vascular Disease with Complications
- **Gaps In Care**: BMI Screening (Due:04/06/2015); Clinical Depression Screening (Due:07/01/2014); Fall Risk Screening (Due:07/01/2014); Influenza Immunization (Due:07/01/2014); Med Reconciliation (Due:04/08/2015); Tobacco Screening (Due:12/18/2014)
Risk Score Overview
Profiling the Population to Drive Clinical Interventions

HCC Risk Score vs. Utilization

HCC Chronic Diseases

<table>
<thead>
<tr>
<th>Chronic Dx.</th>
<th>Patients</th>
<th>Total $</th>
<th>$ /Patient</th>
<th>Risk Score</th>
<th>% Pts w. Inpt</th>
<th>% Pts w. ED</th>
<th>Age</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vascular Disease</td>
<td>4,848</td>
<td>$79,391,478</td>
<td>$16,376</td>
<td>2.17</td>
<td>30.4%</td>
<td>45.2%</td>
<td>76.1</td>
<td>58.9%</td>
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<tr>
<td>Diabetes without Complication</td>
<td>4,783</td>
<td>$48,759,881</td>
<td>$10,194</td>
<td>1.52</td>
<td>19.6%</td>
<td>34.0%</td>
<td>72.5</td>
<td>59.3%</td>
</tr>
<tr>
<td>None</td>
<td>3,477</td>
<td>$5,931,524</td>
<td>$1,700</td>
<td>0.38</td>
<td>2.2%</td>
<td>12.4%</td>
<td>70.8</td>
<td>65.8%</td>
</tr>
<tr>
<td>Specified Heart Arrhythmias</td>
<td>3,297</td>
<td>$77,017,336</td>
<td>$23,630</td>
<td>2.72</td>
<td>42.1%</td>
<td>55.3%</td>
<td>77.8</td>
<td>54.0%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>3,144</td>
<td>$63,942,863</td>
<td>$20,338</td>
<td>2.64</td>
<td>37.5%</td>
<td>53.7%</td>
<td>73.0</td>
<td>57.5%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>2,912</td>
<td>$83,221,982</td>
<td>$28,579</td>
<td>3.28</td>
<td>50.0%</td>
<td>61.9%</td>
<td>76.3</td>
<td>55.6%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>2,783</td>
<td>$62,473,127</td>
<td>$22,448</td>
<td>2.85</td>
<td>44.6%</td>
<td>57.0%</td>
<td>76.5</td>
<td>53.1%</td>
</tr>
<tr>
<td>Breast, Prostate, Colorectal and …</td>
<td>2,185</td>
<td>$28,836,036</td>
<td>$13,197</td>
<td>1.69</td>
<td>24.3%</td>
<td>36.3%</td>
<td>75.6</td>
<td>48.4%</td>
</tr>
<tr>
<td>Diabetes with Renal or Peripheral …</td>
<td>1,537</td>
<td>$36,059,300</td>
<td>$23,461</td>
<td>2.77</td>
<td>33.4%</td>
<td>47.6%</td>
<td>74.4</td>
<td>52.8%</td>
</tr>
<tr>
<td>Polynephropathy</td>
<td>1,389</td>
<td>$35,397,437</td>
<td>$25,484</td>
<td>2.83</td>
<td>39.7%</td>
<td>57.5%</td>
<td>71.6</td>
<td>57.2%</td>
</tr>
<tr>
<td>Rheumatoid Arthritis and Inflamm…</td>
<td>1,180</td>
<td>$20,843,872</td>
<td>$17,664</td>
<td>2.22</td>
<td>31.0%</td>
<td>50.8%</td>
<td>72.1</td>
<td>75.8%</td>
</tr>
<tr>
<td>Major Depressive, Bipolar, and …</td>
<td>1,113</td>
<td>$21,151,354</td>
<td>$19,004</td>
<td>2.21</td>
<td>30.5%</td>
<td>55.4%</td>
<td>53.3</td>
<td>65.5%</td>
</tr>
</tbody>
</table>
## Risk Stratification

### Profiling High Risk Patients Using Multiple Markers

<table>
<thead>
<tr>
<th>High Risk Population</th>
<th>Patients</th>
<th>Total ($)</th>
<th>% of All ($)</th>
<th>$ / Patient</th>
<th>Risk Score</th>
<th>% Pts w. Inpt</th>
<th>% Pts w. ED</th>
<th>Age</th>
<th>% Female</th>
<th>Unmanaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1% Patients By Cost</td>
<td>115</td>
<td>$17,542,389</td>
<td>11.8%</td>
<td>$152,543</td>
<td>6.79</td>
<td>96.5%</td>
<td>96.5%</td>
<td>68.2</td>
<td>59.1%</td>
<td>96</td>
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<tr>
<td>Top 5% Patients By Cost</td>
<td>675</td>
<td>$56,731,994</td>
<td>38.1%</td>
<td>$84,047</td>
<td>4.72</td>
<td>89.0%</td>
<td>85.9%</td>
<td>72.1</td>
<td>59.0%</td>
<td>573</td>
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<tr>
<td>1 or more Readmissions (last 12mo)</td>
<td>476</td>
<td>$32,607,217</td>
<td>21.9%</td>
<td>$68,503</td>
<td>4.31</td>
<td>100.0%</td>
<td>97.1%</td>
<td>72.6</td>
<td>60.3%</td>
<td>414</td>
</tr>
<tr>
<td>2 or more Inpt (last 12mo)</td>
<td>1,079</td>
<td>$61,035,152</td>
<td>41.0%</td>
<td>$56,566</td>
<td>3.79</td>
<td>100.0%</td>
<td>94.4%</td>
<td>73.0</td>
<td>59.6%</td>
<td>928</td>
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<tr>
<td>4 or more ED (last 12mo)</td>
<td>849</td>
<td>$36,226,769</td>
<td>24.3%</td>
<td>$42,670</td>
<td>3.29</td>
<td>72.3%</td>
<td>100.0%</td>
<td>67.2</td>
<td>62.1%</td>
<td>735</td>
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<tr>
<td>Risk Score above 3</td>
<td>1,627</td>
<td>$69,277,399</td>
<td>46.5%</td>
<td>$42,580</td>
<td>4.48</td>
<td>67.7%</td>
<td>77.0%</td>
<td>74.6</td>
<td>54.5%</td>
<td>1,399</td>
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<td>2 or more avoidable ED visits...</td>
<td>405</td>
<td>$16,663,254</td>
<td>11.2%</td>
<td>$41,144</td>
<td>3.14</td>
<td>68.2%</td>
<td>100.0%</td>
<td>65.0</td>
<td>64.7%</td>
<td>349</td>
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<tr>
<td>Heart Failure Registry</td>
<td>2,450</td>
<td>$62,258,180</td>
<td>41.8%</td>
<td>$25,412</td>
<td>2.99</td>
<td>46.9%</td>
<td>59.1%</td>
<td>76.0</td>
<td>56.0%</td>
<td>2,131</td>
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<tr>
<td>Diabetes Registry</td>
<td>4,839</td>
<td>$54,321,044</td>
<td>36.5%</td>
<td>$11,226</td>
<td>1.55</td>
<td>20.5%</td>
<td>36.4%</td>
<td>65.9</td>
<td>54.7%</td>
<td>4,193</td>
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<td>5 or more Gaps</td>
<td>14,859</td>
<td>$139,850,097</td>
<td>93.9%</td>
<td>$9,412</td>
<td>1.39</td>
<td>18.6%</td>
<td>32.9%</td>
<td>72.1</td>
<td>60.1%</td>
<td>13,659</td>
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<td></td>
<td>15,341</td>
<td>$148,924,555</td>
<td>100.0%</td>
<td>$9,708</td>
<td>1.42</td>
<td>19.1%</td>
<td>33.6%</td>
<td>72.0</td>
<td>60.0%</td>
<td>14,010</td>
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</table>

- **Cost**
- **Care Gaps**
- **Utilization**
# Risk Stratification: Identifying the “Complex” Member

## High Risk Member Report

<table>
<thead>
<tr>
<th>Med Group: 210</th>
<th>PCP</th>
<th>Last Name</th>
<th>First Name</th>
<th>MID</th>
<th>DOB</th>
<th>Instit.</th>
<th>ESRD</th>
<th>M/S Admits</th>
<th>CMS High Risk</th>
<th>Rx 7+</th>
<th>Top 20%</th>
<th>Cost</th>
<th>85+</th>
<th>Falls Reg</th>
<th>Ambulance</th>
<th>Recent Freq Flyer</th>
<th>Readmt</th>
<th>Pall. Care Reg</th>
<th>HF COPD</th>
<th>Admit Prob</th>
<th>Complex Member</th>
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<td>12/23/1933</td>
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The Case for Bundle Payment
Savings Due to Variation in Cost

Major Joint Replacement of the Lower Extremity: Average Bundle Cost

Hospital “A”
- Anchor: $13,432 (32.7%)
- SNF: $13,014 (31.7%)
- Readmit: $5,173 (12.6%)
- Part B: $5,636 (13.7%)
- DME: $162 (0.4%)

Hospital “B”
- Anchor: $13,204 (45.1%)
- SNF: $2,165 (7.4%)
- Readmit: $5,332 (18.2%)
- Part B: $4,833 (16.5%)
- DME: $122 (0.4%)

Source: Remedy Partners
The Case for Bundle Payment
Variation in Cost Distribution

Hip and Femur Procedures except Major Joint: Avg. Bundle Cost = $43,457

Congestive Heart Failure: Avg. Bundle Cost = $23,000

Source: Remedy Partners
Potential Savings Based on Site of Discharge

**Hip & Femur Procedures**
Average Bundle Cost $42,457

**Average Episode Cost by First Site of Discharge**

- Home: $22k
- HHA: $21k
- SNF: $46k
- IRF: $48k
- LTCH: $78k
- Other: $31k

**Percent of Episodes by First Site of Discharge**

- IRF: 17%
- Home: 5%
- HHA: 5%
- LTCH: 1%
- Other: 2%
- SNF: 70%

Source: Remedy Partners
Major Spend Categories 90 Day Bundle

Core BPCI Elements
- Starts with a anchor admission (hospitalization)
- Defined at MS-DRG level
- CMS expects 2% savings for all 90-Day Model 2 bundles
- Includes all costs post 90 days after discharge
- No change in fee for service billing

Source: Remedy Partners
Bundle Management - Core Components

1. Bundle Selection
   - Detailed clinical, actuarial and statistical analyses can reduce risk and identify savings opportunities (Model 2+3)
   - Select bundles strategically aligned with current and future care improvement initiatives in your organization (Model 2+3)

2. Acute Care Management
   - Eliminating unnecessary services during hospitalization: consults and testing (Model 2)
   - Post-Acute site of care selection (Model 2+3)
   - Involvement in transition from hospital to PAC site & exchange related patient info (Model 2+3)
   - Device purchasing (Model 2)

3. Post-Acute Provider Alignment
   - Reduced unnecessary SNF admits and length of stay (Model 2)
   - Increased utilization of home health (Model 2+3)
   - Multi-site adherence to evidence-based 90 day care plan (Model 2+3)
   - Increased Home Health, telemedicine & field nurse (Model 2+3)

4. Readmission Reductions
   - Over 50% of unplanned readmissions are avoidable (Model 2+3)
   - Evidence – better care management reduces readmits (Model 2+3)
   - Engagement with physicians and Post-Acute care providers (SNFs, IRFs, LTACs, HHA) (Model 2+3)
Bundled Payment Management Timeline

1. IDENTIFY patient
2. EDUCATE Onboard the Patient
3. ASSESS risk
4. DETERMINE PAC Site of Care
5. DEVELOP PAC care plan
6. TRANSITION to PAC
7. COMPLETE discharge
8. REPORT BPCI PT to PAC
9. UPDATE care plan, LOS, + progress
10. EDUCATE Patient PAC
11. COMPLETE discharge
12. PERFORM 2nd risk assessment (Day 45)
13. REINFORCE to assure compliance
14. UPDATE care plan
15. CONNECT to community resources
16. NOTIFY patient of schedule

Acute Care Stay

Post-Acute Care (SNF)
Home w/ Home Health
Home w/o Services
Care Coordination – The Patient Navigator (C3)

• Identify and engage BPI patients
• Facilitate daily rounds and coordinate care conferences
• Complete assessments and care plans
• Educate patient and family on plan of care
• Actively engage in discharge process
• Transition of care to outpatient navigator
Care Coordination –
The Patient Navigator (Outpatient)

- Transition of care pre-discharge and with C3
- Coordinate care with post acute care partners
- Assess patient needs and continuously address care needs
- Use interventions to coordinate care across continuum
Physician Engagement in the BPI

• At admission
  – BPI patient identification
  – Establish patient expectations

• Tight management of inpatient stay
  – Manage consults and LOS

• Strong transition to post-acute setting
  – Site of care selection
  – Post acute LOS

• Active involvement and accessibility post-acute
  – Timely follow-up appointments
  – Coordination of care – readmission prevention
Post-Acute Care Provider Engagement

• SNFist team
• High value SNF provider selection and management
  – SNF survey and scoring
    • Patient outcomes
    • Readmission rates
    • Average LOS
    • Direct admits
• High value homecare provider selection and management
  – Readmission and ER visit rates
  – Performance
    • Begin care within 24 hours post discharge
    • Communication and adherence to protocols
TODAY, FEE FOR SERVICE IS DEAD
Thank You

Mark M. Fulco
mark.fulco@sphs.com
413-748-9704