Reports from the Front Lines of Health Care Transformation:
Paying for Value: Provider Responses to Readmissions Reduction, Value-Based Purchasing, and Hospital-Acquired Conditions Programs
February 1, 2013
About Health Policy at Advisory Board

Thirty Years of Experience Driving Innovation and Best Practice

A Trusted Advisor to America’s Hospitals and Health Systems

**National Expertise**
National expertise transforming policy into practice and understanding the impact of health policy changes on the U.S. health care system

**Deep Insights and Influence within the U.S. Health Care System**
On-the-ground experience with 150,000 healthcare leaders at 3,100 health care institutions in all 50 states, including 99 of 100 largest health systems in the U.S. and more than 1,000 small to medium-sized community hospitals

**Health Information Technology Industry Leader**
An industry leader in designing cutting-edge health information technology, which currently processes data covering 45% of U.S. inpatient admissions

**Convener of Health Care Leaders**
Convener of health care leaders throughout the nation, offering 180 national meetings annually in 46 content areas with 11,000 attendees and 900 online meetings with 80,000 on-line users
1. Intro to Medicare’s Value-Based Payment Programs

2. Keynote Address: Jonathan Blum, Deputy Administrator and Director, Center for Medicare, CMS

3. Reports from the Front Lines

4. Q&A
On the Journey to Total Cost Accountability

Continuum of Payment Models

Episodic Cost Accountability
- Traditional Fee-for-Service
- Pay-for-Performance
- Bundled Payments

Total Cost Accountability
- Shared Savings
- Partial Capitation
- Full Capitation

Provider Risk
- Minimal
- Substantial

Source: Advisory Board interviews and analysis.
### Medicare’s Value-Based Hospital Payment Programs

#### Side By Side: VBP vs. Readmissions vs. HAC

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Source: CMS, Advisory Board Analysis
Surprising New Data

Correlation of Quality Metrics Not Consistent Across Institutions

FY 2013 Final Readmission Penalty and VBP Incentive Payment

Net Revenue Change

1) Data points for each facility represent final FY13 readmissions penalty and final FY13 VBP incentive payment as provided at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2013-IPPS-Final-Rule-Home-Page.html

Source: CMS, Advisory Board Analysis
Road Map

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An Overview of the Administration’s Efforts Around Readmits, HACs, and Value-Based Purchasing
Road Map

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Reports from the Front Line

Our Panelists Today

Thomas Heleotis, MD, CPE
Vice President of Clinical Effectiveness

Ann Hendrich, RN, PhD, F.A.A.N
Senior VP of Quality, CNO, and Safety; Executive Director of Ascension’s Patient Safety Organization

Chris Lloyd
Chief Executive Officer
Dr. Thomas Heleotis
CMO, Monmouth Medical Center
Long Branch, NJ

The Impact of Readmissions Penalties on the Broader Readmissions Focus at Monmouth Medical Center
Monmouth Medical Center

Case in Brief: Monmouth Medical Center

- 527-bed teaching hospital, located in Long Branch, NJ
- One of six hospitals in St. Barnabas Health System
- Serves about 1 million year-round residents in beach community of Monmouth and surrounding area
- Medicare patients represent approximately one-third of all inpatient admissions
- 22,000 inpatient admissions, 53,000 ED visits per year

Recognitions

- Recognized as top performer by Joint Commission for key quality metrics related to acute myocardial infarction, heart failure, stroke, pneumonia, surgical care, children’s asthma
- *HealthLeaders* ranked our Emergency Department top 5% in the nation
Penalties Drive Concern Over Readmissions

Patient Experience Reinforces Focus on Readmission

Heart Failure 30-Day Readmission Rate

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<th>Monmouth CMS Average</th>
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<td>2010</td>
<td>25%</td>
<td>28.5%</td>
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Motivations to Reduce Readmissions

- **Margin Impact**
  - Already tight operating margins at further risk if readmissions not reduced

- **Grant Initiatives**
  - Robert Wood Johnson grant provided additional incentives to address readmissions

- **Mission to Improve Care**
  - Care coordination provides better care, improves patient experience
Readmission Reduction Key Focus for Monmouth

Redesigned Care Process Improves Outcomes, Patient Experience

Framework Built to Address Causes of Readmissions

*Initiatives Focus on Heart Failure and Geriatric Patients*

**Heart Failure Patients:**
- Identify all heart failure patients at high risk for readmission
- Evaluate patient needs, caregiver needs to facilitate transition through care continuum
- Develop care plan, including patient education and medication reconciliation
- Ensure patients are adhering to care plan through telemedicine, phone calls, home visits

**Geriatric Patients:**
- Frail, elderly patients with dementia and co-morbidities enrolled in “Transition in Care Program”
- Multidisciplinary care team works together to evaluate patient condition, assess needs, identify gaps in care
- “My Care Plan” developed for patient and caregiver, including goals and potential barriers to success
- Follow-up conducted in both home, post-acute care setting

**Goal:**
Well-informed patients proactively manage their care at home

1) Primary care physician.
Targeted Initiatives Reduce Readmissions

Patients Leave Hospital More Satisfied, More Prepared to Manage Health

**HF 30-Day Readmission Rate**

*All-Cause, Medicare*

- 2010: 28.4%
- 2012: 12.4%

**TIC\(^1\) 30-Day Readmission Rate**

*All-Cause, Medicare*

- 2011: 17.0%
- 2012: 13.4%

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**Results of HF Outpatient Management Program**

- **1,033** Patients receiving HF-specific follow up
- **290** Readmissions avoided, through the HF Outpatient Management Program in 2012

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**Results of “Transitions in Care” Program for Geriatric Patients**

- **92%** Patients reporting follow-up with PCP\(^2\) within two weeks
- **76%** Patients who understand their responsibilities to manage their health

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1) Transitions in Care.
2) Primary Care Physician.
“Real Time” Supports Broader Readmissions Efforts

Care Teams Built Around Ability to Identify High-Risk Patients

New Care Process for Inpatients at Monmouth

- Real Time prepares report to help identify at-risk patients
- Multidisciplinary care team ensures proper interventions are run for each risk category
- Pharmacist consulted for medication reconciliation
- Transition Care Nurse follows up with patient post discharge

“Real Time” User Interface

- Patient’s 30-day readmission risk
- Unique risk factors
- Suggested interventions based on risk level

Technology in Brief: Real Time

- Developed by Advisory Board’s Crimson Performance Technologies
- Analytics tool that categorizes patients’ chances of readmission based on medical profile, individual risk factors
Overcoming Challenges to Preventing Readmissions

### Challenges to Preventing Readmissions

- **Assessment Processes Highly Confusing, Time Consuming**
  - Care teams unaligned toward overall patient needs, goals
  - Information siloed across clinicians, clinical and financial systems

- **Risk Assessment Often Biased and Not Actionable**
  - Manual assessments misidentify majority of patients as high risk
  - Information not conveyed across care team, available in real time

- **Variable Care Standards and Inconsistent Accountability**
  - Few hardwired protocols for preventing readmissions
  - Poor adherence to protocols in existence

### Monmouth’s Solutions

- **Real Time simplifies identification process of high-risk patients, allows care teams to work at top of license**
- **Develop systems that support patient needs across entire continuum of care**

- **Utilize predictive modeling to better predict risk of readmission**
- **Implement actionable interventions that better accommodate patient needs**

- **Create standardized order sets to support intervention completion, accountability**
- **Include all team members responsible for interventions in care rounds to avoid gaps in care**

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“The most important thing we need is information that helps align all the care team members toward optimal care of the patient. This tool helps us achieve that goal.”

*Dr. Thomas Heleotis*

*Chief Medical Officer, Monmouth Medical Center*
Key Takeaways

1. Readmission reduction incentives would be most powerful if structured in a way that supports hospitals’ efforts to develop new infrastructure and overcomes disincentives to reducing volume (e.g., bundling or shared savings-type payment models).

2. Such programs should help hospitals generate and understand financial returns for investing in the outpatient resources necessary for reducing readmissions.

3. Successful reduction of readmissions requires a multi-disciplinary, team-based approach to care coordination, bridging gaps across the continuum.

4. To drive and manage the care improvements that reduce readmissions, hospitals need accurate data and processes for communicating that data back to the entire care team.

5. Ultimately, hospitals won’t be able to make progress on readmissions (or other value-based payment initiatives) without engaging and aligning with physicians.
Quality and Innovation in the Era of Health Reform

ANN HENDRICH, RN, PhD, F.A.A.N.
Senior Vice President, Clinical Quality & Safety,
CNO & Executive Director, Patient Safety Organization,
Ascension Health

February 1, 2013
Ascension Health, part of Ascension Health Alliance, is the largest Catholic health system, the largest private nonprofit system and the third largest system (based on revenues) in the United States, operating in 21 states and the District of Columbia.

**Facilities and Staff**
- Locations: 1,400
- Acute Care Hospitals: 71
- Long-term Acute Care Hospitals: 3
- Rehabilitation Hospitals: 3
- Psychiatric Hospitals: 6
- Available Beds: 18,450
- Associates: 122,000
- Physicians: 30,000
- Nurses: 23,000

**Financial Information** (FY 12) (in millions) *
- Total Assets: $23,776
- Operating Revenue: $16,611
- Operating Income: $934
- Excess of revenue & gains over expenses and losses, controlling interest: $968

*Financial information reflects Ascension Health Alliance
The next step in our unending journey to the highest quality, safety and satisfaction for patients and clinicians is called **Healing without Harm by 2014**, which builds on the success of the Priorities for Action.

The Agency for Healthcare Research and Quality defines high-reliability organizations as “**organizations with systems in place that are exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors.**”
Two Over-Arching Hospital Engagement Networks Goals

- Reduce hospital-acquired conditions by 40%
- Reduce readmissions by 20%

Hospital Engagement Networks Core Focus Areas

1. Adverse Drug Events (ADE)
2. Catheter-Associated Urinary Tract Infections (CAUTI)
3. Central Line-Associated Bloodstream Infections (CLABSI)
4. Surgical Site Infections (SSI)
5. Ventilator-Associated Pneumonia (VAP)
6. Injuries from Falls & Immobility
7. Obstetrical Adverse Events
8. Pressure Ulcers
9. Venous Thromboembolism (VTE)
10. Readmissions
Early Results from the Hospital Engagement Network Efforts

This composite graphic represents System and hospital-level targets and results assessing a broad set of patient harm.

It allows the comparison of hospital performance to System performance, and across baseline, current, and target rates.
Examples of How Efforts Have Improved Patient Care

Number of injurious falls per 1,000 patient days

Early Elective Delivery [%]
Policy Implications on our Quality Journey

- In general, changes in Medicare reimbursement on readmissions and HACs have incentivized hospitals to improve patient safety and led to innovation.
- Readmissions - “zero” may not be possible given the complexity of individual and societal factors, but the policy is helping drive care coordination across the continuum.
- Need alignment among private and public payers on quality metrics *Example – Early Elective Deliveries*
- Maximize utilization and results from Patient Safety Organizations, including making open communication with patients when an unexpected event occurs a standard of care.
HEALTHCARE THAT WORKS.
HEALTHCARE THAT IS SAFE.
HEALTHCARE THAT LEAVES NO ONE BEHIND.

For Life.
Christopher Lloyd
CEO, Memorial Hermann Physician Network

Houston, Texas

HAC and VBP Initiatives Within the Larger Care Transformation Movement at Memorial Hermann

February 1, 2013
Largest non-profit healthcare system in Texas with 129 sites across Houston

- 5,000 practicing physicians
- Partnership with the University of Texas Health Science Center of Houston
- 9 Acute Hospitals, 3 Heart & Vascular Institutes
- Dedicated Children’s & Rehabilitation Hospitals
- 98 Outpatient Sites: Ambulatory Surgery, Imaging, Sports Medicine, Lab
- Sports Medicine, Neuroscience COE’s
- One of the nation’s busiest Trauma programs
- Awards: Reuter’s Top 5 Hospital System
Clinically Integrated Physician Organization

Physicians: Fully Integrated Physician Network

9 Independent Medical Staffs

3 Distinct Practice Models

Private

Employment

Faculty
A Changing Industry

**Current Model**
- Fee-for-Service
- Disparate Payments
- Illness & Cure
- Volume Incentive
- Fragmentation

**New Model**
- Fixed Payment
- Bundled Payment
- Population Health
- Value Incentive
- Integration

Integration

Population Health
Influencing Drivers

- Value-based purchasing and hospital acquired condition programs
- Payment reforms
- Employer health insurance cost concerns
- Drive for quality and patient outcomes
- Access to data
Memorial Hermann and MHMD have established shared objectives and goals for inpatient quality and safety as part of a new Inpatient Quality & Safety (IPQS) Initiative.

These objectives and goals include:

- Improving Clinical Quality and Safety
- Reducing Serious Safety Events
- Improving Quality and Safety Scores against National Benchmarks
Latest IPQS Measures: Northwest Hospital

NW Hospital - IPQS - Reducing Adverse Events

**Iatrogenic Pneumothorax Events**
- Actual: 0
- Target: 1
- Achieved target

**Hospital Acquired Infections**
- Actual: 55
- Target: 82
- Achieved target

**YTD September 2012**

**Adult PPE DVT**
- Actual: 2
- Target: 5
- Achieved target

**Serious Safety Events**
- Actual: 8
- Target: 16
- Achieved target

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2012 MHMD Inpatient Quality and Safety Initiative, Number of Events and Annual Targets
The IPQS Incentive Plan Year is from 1/1/2012 through 12/31/2012

- **Iatrogenic Pneumothorax Events**: Reduce Events to 50th %tile Benchmark
- **Hospital Acquired Infections**: Reduce Events by 15% compared to FY 2010
- **PPE / DVT**: Reduce Events to 50th %tile Benchmark
- **Serious Safety Events**: Reduce Events to achieve Distinguished results
Critical Care, Hospital Medicine, Cardiology, Surgery and Anesthesiology recommend: US guidance for central line placement
Iatrogenic Pneumothorax: Southeast

Southeast Adult Iatrogenic Pneumothorax
Do No Harm
Rate/1000 Discharges for Secondary Diagnosis

Mean = 0.55
UCL = 3.45

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Iatrogenic Pneumothorax: Southeast

Southeast Adult Iatrogenic Pneumothorax
Do No Harm
Rate/1000 Discharges for Secondary Diagnosis

20 Months
Zero Iatrogenic Pneumothorax

Mean = 0.00
Zero Serious Safety Events: TIRR

TIRR SSE Monthly Rate
Serious Safety Events Monthly Rate per 10,000 Adjusted Patient Days

UCL = 2.49
Mean = 0.62

Zero Serious Safety Events x 12 Months
Central Line Associated Blood Stream Infections (CLABSI)

System Adult ICU CLABSI
Central Line Associated Blood Stream Infections

- UCL = 9.42
- Mean = 5.53
- LCL = 1.64
- UCL = 5.79
- Mean = 3.04
- LCL = 0.29
- UCL = 5.13
- Mean = 2.52
- LCL = 0.38
- UCL = 2.55
- Mean = 1.17
- LCL = 0.38

CLABSI Rate per 1K Line Days

2006 2007 2008 2009 2010 2011 2012
0 2 4 6 8 10 12

Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1 Qtr 2 Qtr 3 Qtr 4 Qtr 1

CLABSI Rate per 1K Line Days

LCL = 1.64
LCL = 0.29
LCL = 0.38
UCL = 9.42
UCL = 5.79
UCL = 5.13
UCL = 3.86
UCL = 2.55
UCL = 2.97

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produced by System Quality and Patient Safety
1. Zero events
2. 12 Consecutive months
3. Certified Zero Category

ICU Central Line Associated Bloodstream Infections (6)
Hospital-Wide Central Line Associated Bloodstream Infections (1)
Ventilator Associated Pneumonias (15)
Surgical Site Infections
Retained Foreign Bodies (17)
Iatrogenic Pneumothorax (10)
Accidental Punctures and Lacerations (2)
Pressure Ulcers Stages III & IV (15)
Hospital Associated Injuries (3)
Deep Vein Thrombosis and/or Pulmonary Embolism
Deaths Among Surgical Inpatients with Serious Treatable Complications
Birth Traumas (7)
Serious Safety Events (1)
Key Takeaways

• The impact of VBP and HAC programs will drive ancillary benefits in care management delivery
• Incentives, and disincentives, produce outcomes
• Programs must “marry” the interests of physicians and hospitals and influence the reorganization of care delivery
• Access to “Real Time” information is critical
• Healthcare organizations must manage across the care continuum –”Population Management”
• Solutions must be grounded in Evidenced Based Medicine and outcomes data
• Patient first – cost, quality, and outcomes!
Road Map

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Today’s Panel

Moderated by Frederick Isasi

- Thomas Heleotis, MD, CPE
- Ann Hendrich, RN, PhD, F.A.A.N
- Chris Lloyd
- Eric Fontana
## Side By Side: VBP vs. Readmissions vs. HAC

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Source: CMS, Advisory Board Analysis

[Diagram showing payment changes over years: FY 2013 -1.0%, FY 2014 -1.25%, FY 2015 -1.5%, FY 2016 -1.75%, FY 2017 -2.00%]
Any Additional Questions?

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