Payment Models Work Group Meeting Agenda 4-07-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Agenda
Monday April 7, 2014 1:00 PM – 3:30 PM.
DVHA Large Conference Room, 312 Hurricane Lane, Williston
Call in option: 1-877-273-4202
Conference Room: 2252454

Item #	Time Frame	Topic	Presenter	Relevant Attachments
1	1:00 – 1:05	Welcome and Introductions Approve meeting minutes	Don George and Steve Rauh	Attachment 1: Meeting Minutes
2	1:05 – 1:10	Update on ACO/SSP	Richard Slusky & Kara Suter	
3	1:10– 1:15	Update on Other Work Groups	Georgia Maheras	
4	1:15 – 3:15	EOC Presentation	Chris Tompkins, Brandies	Attachment 2: EOC Presentation
5	3:15 – 3:20	Public Comment	Don George and Steve Rauh	
6	3:20 – 3:30	Next Steps and Action Items	Don George and Steve Rauh	Advisory Group Meetings Scheduled Next Meeting: May 12th, 1 – 3:30 pm. Montpelier

Attachment 1 - Payment Models Work Group Minutes 3-03-14

VT Health Care Innovation Project
Payment Models Work Group Meeting Minutes

Date of meeting: March 3, 2014 2pm to 4:30pm: EXE - 4th Floor Conf Room, Pavilion Building, Montpelier.

Call in: 877-273-4202, Passcode: 2252454

Attendees: Steve Rauh, Don George, Co-Chairs; Sarah King, Rutland Area Visiting Nurse Assn; Paul Harrington VT Medical Society; David Martini, Dept. of Financial Regulation; Joyce Gallimore, Bi-State PCA; Heather Bushey, Planned Parenthood of Northern NE; Michael Curtis, Washington County Mental Health Services; Mike Del Trecco, VT Assn of Hospitals and Health Systems; Marlys Waller, VT Council; Kelly Lange, Blue Cross of VT; Sandy McGuire, Howard Center; Julia Shaw, and Lila Richardson, Vermont Legal Aid; Michael Bailit, Bailit Health Purchasing; Diane Cummings, Julie Wasserman, AHS-Central; Marybeth McCaffery, Jennifer Woodard, DAIL; Catherine Fulton, VT Prog. for Quality in Health Care; Julie Tessler, VT Council for Dev. and Mental Health; Alicia Cooper, Erin Flynn, Lori Collins, Kara Suter, AHS-DVHA; Richard Slusky, Pat Jones, and Spenser Weppler, GMCB; Georgia Maheras, AOA; Darren Chips, Stan Shapiro, Kim McDonnell, Rutland Regional Medical Center; Sharon Winn, Sandy Maguire, Ted Sirotta, Tom Pitts, Rachel Hickey, Bill Marder, Truven Analytics; Cindy Parks Thomas, Chris Thompkins, Brandeis University; George Sales, Nelson LaMothe, Jessica Mendizabal, Project Management Team.

Agenda Item	Discussion	Next Steps
1 Welcome & Introductions; Approval of Minutes	Don George called the meeting to order at 2:01 pm. Mike Del Trecco motioned for approval of the minutes, Kelly Lang seconded, all were in favor.	
2 Update on ACO/SSP	Richard Slusky discussed that commercial shared savings program agreements have been sent out to the ACOs and will then be sent to the payers for execution. They have received agreements back from BCBS and One Care. MVP needs to attain corporate approval, but they do not expect any major issues. Kelly Lange noted BCBS is working on another agreement as well. Next steps for the ACOs is to send participation agreements to their providers. Given the tight timelines, program deadlines have been and may continue to be extended to allow providers sufficient time to review the details of the program. The existing timeline is as follows: by March 31 participating providers will send formal notification of their intent to participate to the ACO; by April 15th ACOs will submit provider lists to payers, by May 15th payers will submit patient attribution lists to ACOs, and by May 31st payers will submit claims extract to ACOs with	**Richard will complete a written version of the timeline and share with the group.**

Agenda Item	Discussion	Next Steps
	12 month look back ; One of the causes of delay has been reported as delays in getting information from the Exchange to the payers. The Green Mountain Care Board (GMCB) released a RFP for a third party independent analytics contractor to assist in the collection, analysis, and reporting of relevant data, such as performance against expenditure targets, performance measures, and other calculations, on behalf of both payers and ACOs in both the Medicaid and Commercial shared savings programs.. The GMCB received several proposals, which are currently being reviewed and scored by a bid review team, which will meet to discuss the decision this week. Paul Harrington requested that a written version of the ACO implementation timeline be distributed to all work groups, to which Richard agreed. Kara Suter added that she expects that both Medicaid Shared Savings Program contracts will also be signed by the end of the week. Don George asked if the time frame for the shared savings programs begins April 15th, but it was explained that the time frame for the calculation of savings is retroactive back to January 1st, regardless of the date of execution of program agreements and contracts. Richard explained the final cut-off of the eligibility threshold will be June 30th. For the commercial shared savings program, membership eligibility thresholds have been set at either 5,000 attributed lives with one payer or 3,000 attributed lives with each of the two payers. That said, even if an ACO drops below the threshold, there is a process in place for f payers to meet with ACOs and discuss whether or not they will continue participation in the program. Don asked if GMCB has talked about information flowing from the Exchange and how the issues impact the project, which Richard explained they have. Richard explained that mid-level Nurse Practitioners and Physician's Assistants can attribute lives to an ACO per the Blueprint methodology, as well as Primary Care Physicians. Don acknowledged that the work delays were unanticipated and not unreasonable. He requested an update on this topic at each meeting.	
3 Update on Other Work Groups	Georgia Maheras gave an update on the status of other work groups: - Quality and Performance work group will be looking at adding measures for year two of the ACO programs. - The Disability and Long Term Services and Supports work group will also be looking at performance measures relevant to the DLTSS population, and plan to make recommendations to the quality and performance measures work group. - HIE/HIT work group recently approved the recommendation of the "ACTT" proposal to the Steering Committee, to be reviewed on Wednesday March 5th. The proposal has three components: 1) Expanding the Health Information Exchange capabilities of Designated Agencies and Special Services Agencies; 2) data analysis and research around LTSS; 3) development of a universal patient transfer form.	

Agenda Item	Discussion	Next Steps
	- The population health work group will meet next week. - The Work Force work group, which is moving to a monthly meeting format, will meet the week of March 17th. The Core team is reviewing grant proposals and will meet to make decisions on March 14th. Decisions will be announced March 25th. The new website is up and functioning. All meeting materials will be posted there (in addition to Project Reporter) as well as work group member lists. The lists need to be hand typed into web pages and will take a few weeks to complete.	
4 Introduction of Analytics Consultants and Review of Draft Agenda for April Meeting	Kara Suter introduced two consultants from Brandeis University (sub-contractors of Truven Analytics), Chris Thompkins and Cindy Parks Thomas, who will be contracting with the work group to help support work surrounding the Episodes of Care (EOC) model. She referenced attachment 4b, the draft agenda for April (which is subject to change) and asked the group to consider what they want to be working on. At the next meeting, she hopes to hand out agendas for the next several meetings and also to distribute timelines and other materials to track deliverables. Chris and Cyndi briefly introduced themselves and their biographies can be found in attachment 4a.	**Members can email agenda suggestions to Kara, Richard Slusky and the co-chairs Don George and Steve Rauh.**
5 Case Study: Example from EOC from Arkansas	Kara Suter presented a high level overview of an example of an Episode of Care program for Attention Deficit/Hyperactivity Disorder (ADHD, which is part of Arkansas' Payment Improvement Initiative (attachment 5). Kara mentioned that although she has observed presentations and participated in discussions with Arkansas regarding this program, she also plans to facilitate direct communication between the work group and leaders from Arkansas in order to better facilitate questions. Kara noted that this presentation along with the presentation from Rutland Regional's EOC program will help illustrate to the work group that there are different approaches to developing an EOC program, and that it doesn't have to look exactly like either of these examples. She also explained the phases of implementation of the program in Arkansas and that the approach for determining performance is retrospective. Mike DelTrecco asked who will determine the clinical perspectives in Vermont? Kara offered that the Payment Models work group would be charged to assign a clinical advisory sub-committee to create the episode definition and task the Quality and Performance work group to set up benchmarks. In the beginning, the data would come from the costs of medical care. This group can also look into the feasibility of adding other data sources from social service areas. Kara discussed the concept of the Principal Accountable Provider (PAP) described on slide 7. This person or entity is the "quarterback" provider who becomes accountable to the total cost of care. She noted there	

Agenda Item	Discussion	Next Steps
	are pros and cons to this approach and VT may not go down this path. VT will need to identify who is the principal driver. Michael Bailit noted that Arkansas is unique and went this way because their providers were not ready to go any other way. Paul Harrington questioned who the single provider would be in VT and do EOC related bundled payments throughout care settings in VT have a leader? Kara explained that in Arkansas, it can be an entity (hospital, physician), depending on what the episode is. Michael Bailit confirmed that provider participation in Arkansas is mandatory. Kara referenced slides 16-18 explaining a six-part process on how the program works. Specifically, Arkansas created a performance threshold system ranging between "commendable, acceptable, and unacceptable" to ensure that a minimum threshold is met and that penalties are associated with poor performance in order to protect against cutting services to save on costs. This is just one approach to consider. Kara reviewed the remaining slides discussing technical work to follow. If the group has specific questions please send them to Kara and she can work to get them answered and coordinate a webinar if there is interest. She opened the discussion up for questions. Richard Slusky asked how the role of a PAP is defined: if they are a hospital or physician, educator, convener, collaborative? The majority of cases determine the PAP who is then accountable to convene all the others involved. The built-in incentives go to the PAP, not to the other providers in the episode. This is a design choice, and the work group will need to look at how to share provider accountability and incentives. This process can be burdensome and Kara asked the group to think about how can we make this operationally feasible and reduce burden for those involved, noting that in Arkansas the PAP is assigned and is not voluntary.	
6 Case Study: Example from EOC from Rutland BPCI Program	Darren Childs, Director of Quality Improvement Services at Rutland Regional Medical Center began the presentation of their Community Wide Congestive Heart Failure Collaborative, also known as the Medicare Bundled Payment Project (attachment 6). He was joined by colleagues Dr. Stan Shapiro, MD Cardiology Medical Director and Kim McDonnell, Reimbursement Advisory Analyst. Darren walked the group through the first part of the presentation noting the support they received to begin the project. Dr. Shapiro discussed congestive heart failure and why it was a good candidate, citing the 27% hospital readmission rate (ref. slides 4-9). He referenced slide 9 and stressed that managing patient care well in the early stage (Stage A) may help avoid end stage management (Stage D), noting the cost of care will only increase over time. The team at Rutland Regional worked with the GMCB, learning about bundled payments. They familiarized themselves with data and put a proposal together for three year bundled payment. Rutland Regional	

Agenda Item	Discussion	Next Steps
	agreed to be the sole financial risk bearer. They chose model two, a 30-day EOC noting there were more things they could help manage within 30 days. Kim McDonnell discussed the financial aspects stating that they have not yet built infrastructure for partners. They needed to establish a target price, relying on CMS information for the target price, and find a risk track to limit outlier exposer. Analysts must work within the data to make it understandable. The hospital does not expect a gain sharing. CMMI struggled with waivers and is still in the beginning stages. Darren noted infrastructure and overhead, keeping participants engaged, stating they've had good results. They host collaborative meetings once a month and sub groups meet to get the work done. Mike DelTrecco asked how the information is shared back and forth and if the patient knows they are part of a bundle. Darren offered that data sharing occurs at monthly meetings, and there is hospital based email notifications that can go to outside partners. Developments in the HIE may take away some of the physical burden, but that depends if there is communication between EMRs. Dr. Shapiro noted this information does not substitute direct communication across providers. Rutland Regional is not using any one specific tool for communication, although "Doc book" is a program where providers can text securely. The feed from EMRs can generate secure email to notify other providers. A lot of the issues can be solved by getting people together and discussing the care people receive. This can help address reasons why patients may fall through the cracks. The group discussed palliative care and ways to introduce it early on. Richard Slusky referenced Dr. Allan Ramsay of the GMCB and his work on palliative care issues, defining it more as symptom management instead of end of life care. Dr. Shapiro also noted that students need to be introduced to coping with the idea of palliative care. Don George asked what the role is of the Blue Print community health team? Dr. Shapiro stated that Blue Print was not as involved in the beginning but their role is to help underserved patients get access to the care they need. The team approach is essential and breaking down the silos between providers is key. Don stated there is a high percentage of readmissions related to mental health issues and asked if there is a process to help mitigate this? Dr. Shapiro noted that clinical anxiety, depression etc. can be complicated to assess which may play a role in the readmission. Regarding organizations and participation agreements, Darren stated that providers had to participate in 80% of collaboratives to share in the gain, and they have had 100% participation so far. He discussed Education and Improvements (ref slide 24), and stressed the importance of post-discharge calls, asking	

Agenda Item	Discussion	Next Steps
	how the hospital can improve. He stated dietary education has also been very helpful. Dr. Shapiro noted if there was more trust in the health care provider, it would free up their energy to focus more on direct patient care. Kara Suter asked what the pros and cons of engaging in this program have been and why Rutland Regional chose to pursue the bundled payment project? Darren stated they recognized the state is moving away from fee for service already and they wanted to begin to experiment. There was concern over less revenue for the hospital but they knew it was the right thing to do. The ultimate goal is that people are healthier and kept out of the hospital. Steve Rauh asked how the hospital plans to adjust costs to keep the balance once they expand the project to other service areas? Dr. Shapiro acknowledged that there is intrinsic value to moving away from fee for service but changes in staffing etc. don't happen as fast. They need to look at what the health care facility should be for their community, sustaining a hospital with declining utilization, and thinking about what kind of reimbursement system to design that can cover fixed costs and variable costs. Don George thanked the presenters and commended them. Kara concurred and asked for advice on a statewide approach. Darren offered: infrastructure building; asking for the providers and care delivery systems to work together; keeping the burden modest; centralize and consolidate when you can. Paul Harrington stated that the HIE/HIT work group recently approved $2.5 mil grant and there may be an EOC grant application that could come back to the committee for this type of work. Georgia then clarified the following: the HIE work group has $9.3 mil to make recommendations for proposals to the Core Team. The Grant Program is a separate competitive bid process in which the Core Team review applications next week and they could potentially send to other work groups for review. However, the Payment Models work group does not have funding for proposals. Dr. Shapiro discussed situations in ways people might end up returning to hospital, and that he worked with care staff to understand how to mitigate the issues so they don't escalate. Open communication is the key to success. Don George thanked the presenters, noting he was very impressed, and acknowledged the "future value" of this work. He urged the group to think about how to support it and not get stuck on the financial loss immediately.	
7 Discussion and Next Steps April Meeting	Draft agendas for April, May and June will be in the next round of materials. Send any feedback to Kara. Kara noted they need to memorialize process for convening sub-committees. She asked for comments/questions and none were offered.	

Agenda Item	Discussion	Next Steps
8 Public Comment	Don George asked for additional comments, and none were offered.	
9 Next Steps & Action Items	Before Don George closed the meeting he noted that the group is ready to move forward and will need to vet the down-stream questions, understanding Arkansas' process, but knowing VT's process will be different. Steve Rauh agreed noting the financial impact of this process, whereby reducing admissions is a result of great patient care, but it can affect revenue. This group will keep that idea in mind and make sure there are reimbursements in place. Next meeting: April 7, 2014, 1-3:30 pm, DVHA Large Conference Room, 312 Hurricane Lane, Williston.	

Attachment 2 - EOC Presentation

Episodes of Care: Analytics and Options

Christopher P. Tompkins, Ph.D.

April 7, 2014

Topics for Today

1. Background on episodes
   a) Efforts underway
   b) Concepts and terminology
2. Walk through analytics and options
   a) Selecting episodes of interest
   b) Using statistics to analyze costs
   c) Informing options

Government Led Initiatives

Initiative	Participants	Selected Episodes
Bundled Payment for Care Improvement Initiative	Medicare. More than 450 providers participating. Rolled out in 2013 and 2014.	Most popular episodes (from 48): major joint replacement of lower extremity, congestive heart failure, CABG, COPD, Percutaneous coronary intervention (PCI). Half of chosen bundles are surgical, half are medical. Can choose from four models.
Minnesota Baskets of Care	Legislation (2008) and supporting statute. Program started 2010. Voluntary for private payers.	8 baskets: Asthma for children, diabetes, low back pain, obstetric care, preventive care for adults, preventive care for children, total knee replacement, pre-diabetes.
Primary Care Payment Reform Initiative	MassHealth MCOs and Primary Care Case Management program plans and associated providers. Enrollment started 2013.	Primary care services - Comprehensive primary care payment with shared savings, risk, and quality incentives. Option to include behavioral health in the bundle.

Private Payer Led Initiatives

Initiative	Participants	Selected Episodes
Blue Cross Blue Shield of North Carolina	Private payer linking with individual providers. Using PROMETHEUS model.	2 episodes: total knee replacement, total hip replacement. Starting with inpatient procedural and chronic medical. Will then expand to acute medical.
Blue Cross Blue Shield of South Carolina	Private payer linking with individual providers. Using PROMETHEUS model.	4 episodes: total knee replacement, CABG, outpatient diabetes, outpatient back pain.
Horizon Blue Cross Blue Shield of NJ	Private payer linking with 10 practice partners (orthopedic surgeons). Hospital centric. Statewide. Bundles considered in conjunction with PCMH, ACO activities. Launched 2011. Using PROMETHEUS model.	2 episodes: hip and knee joint replacement.

Employer Led Initiatives

Initiative	Participants	Selected Episodes
Lowes	Agreement with Cleveland Clinic initiated in 2010. Part of Employers Centers of Excellence Network.	Examples: Cardiac surgery and joint replacement.
PepsiCo	Agreement with Johns Hopkins for employees.	Certain joint replacements or cardiac surgery.
Walmart	Partnered with Cleveland Clinic, Geisinger Health System, three hospital sites within Mayo Clinic, Mercy Hospital in Springfield, Mo., Scott & White Healthcare in Temple, Texas, and Virginia Mason Medical Center in Seattle. Part of Employers Centers of Excellence Network.	Examples: Cardiovascular, spine, joint replacement bundles. Focus on the employee (e.g., employers often pay for the airfare, lodging and other out-of-pocket expenses associated with patient and a companion travelling to a selected provider).

CMS/CMMI Roadmap

Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-Acute Care	Post-Acute Care Only	Chronic Care
"Retrospective" (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
"Prospective" (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

= Current = Future

Building the Episodes

1. Episode timeline	What are the basic constructs of the timeline? What are the different model considerations? What do we know about payments along the continuum of care?
2. Identifying topics	What are the implications of various conditions and settings? What are the tradeoffs narrow versus broad scope?
3. Clinical design & cost containment	What clinical design & cost containment strategies have proven to be effective? What cost savings can be realized?
4. Participating providers	What organizations participate in the care delivery? What is the intensity of payments and costs for the participating organizations?
5. Quality	What are expected quality improvements from clinical design strategies? What measures will be selected to assess performance?

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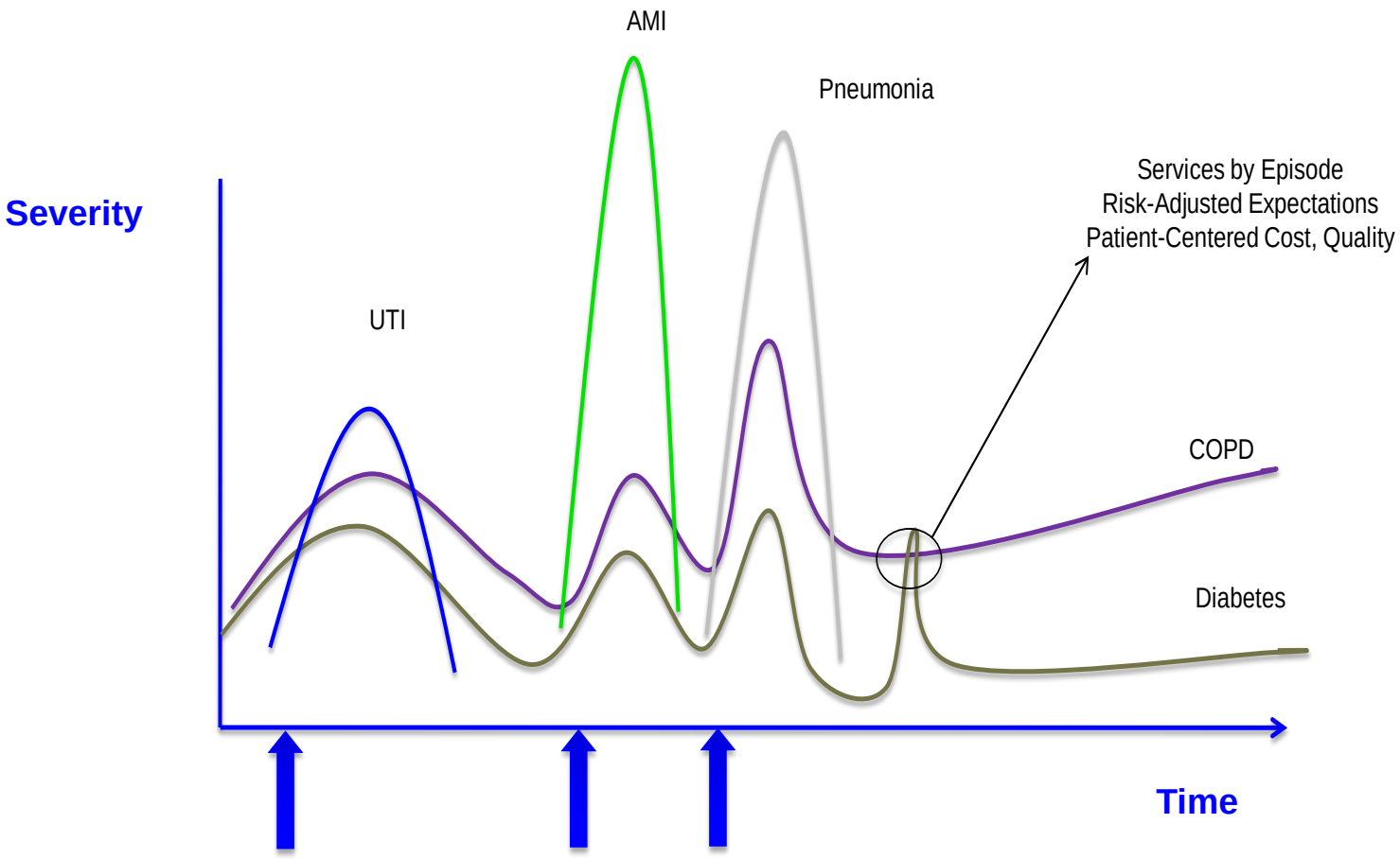
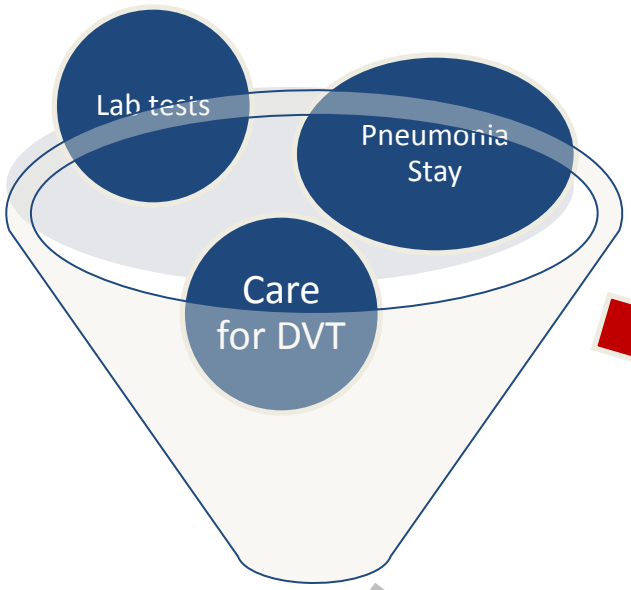
Complex Patients



Clinical Relevance



Typical
- Diabetes
- Hypertension

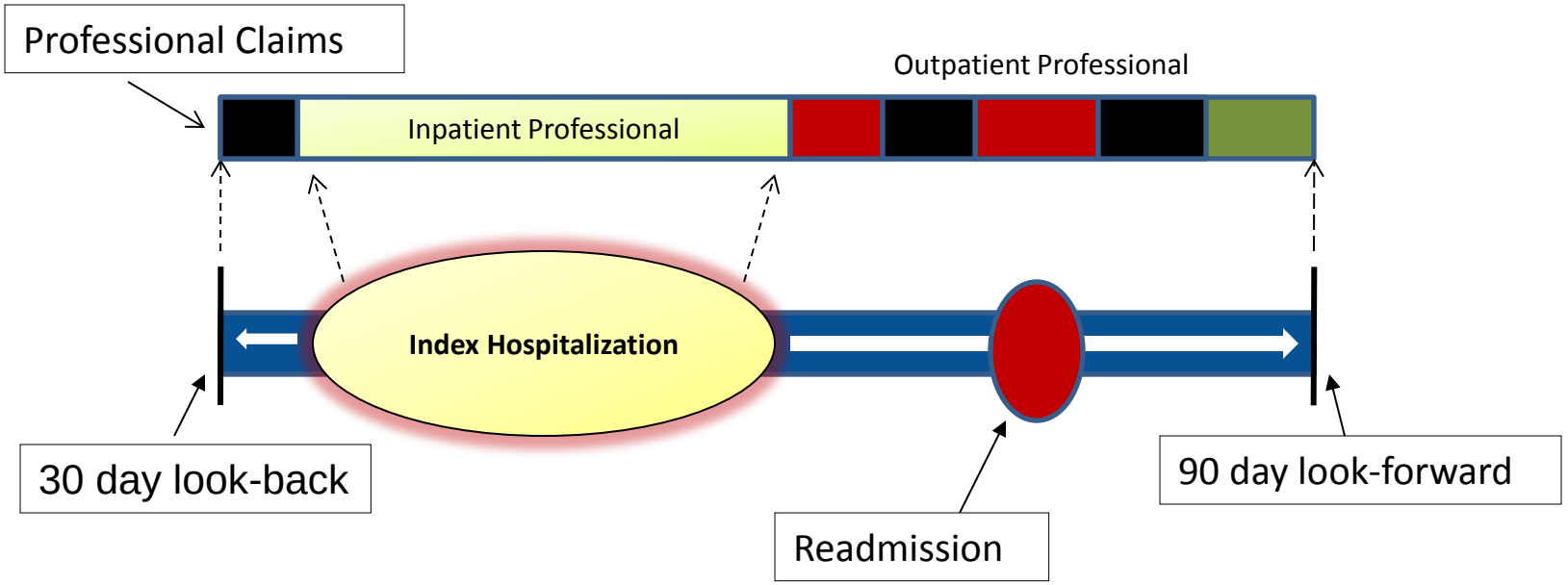
Complications
- Care for DVT
- Hypoglycemia

Irrelevant claims are excluded

Types of Episodes - Examples

- Acute Medical:
  - Child delivery, AMI, Stroke, Pneumonia
- Chronic Condition:
  - Asthma, Diabetes, CAD, COPD
- Procedural:
  - Total Knee Replacement, CABG, Colonoscopy

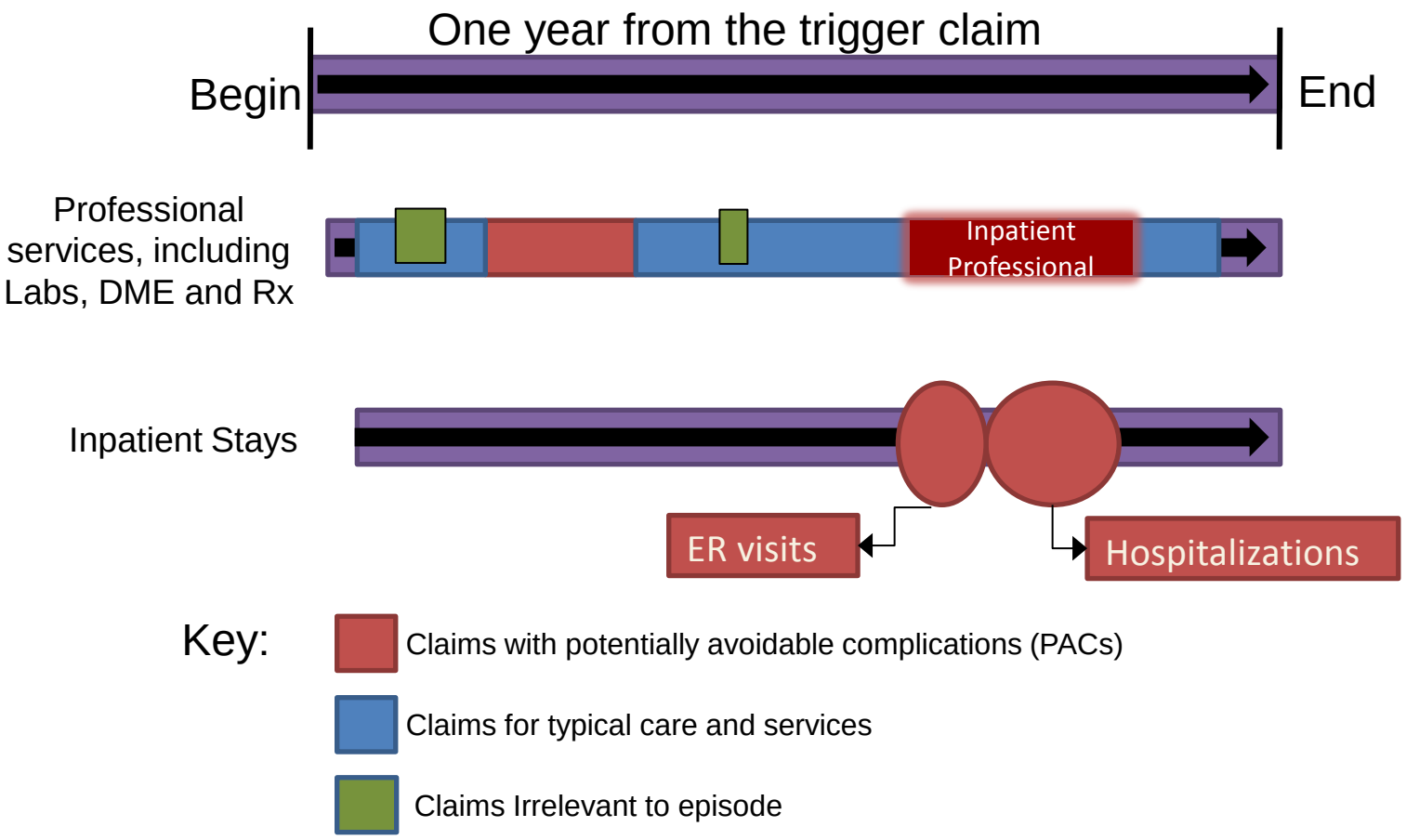
Acute Episodes



Key:

- Irrelevant
- Claims with potentially avoidable complications (PACs)
- Either typical or PACs
- Claims for typical care and services

Chronic Condition Episodes



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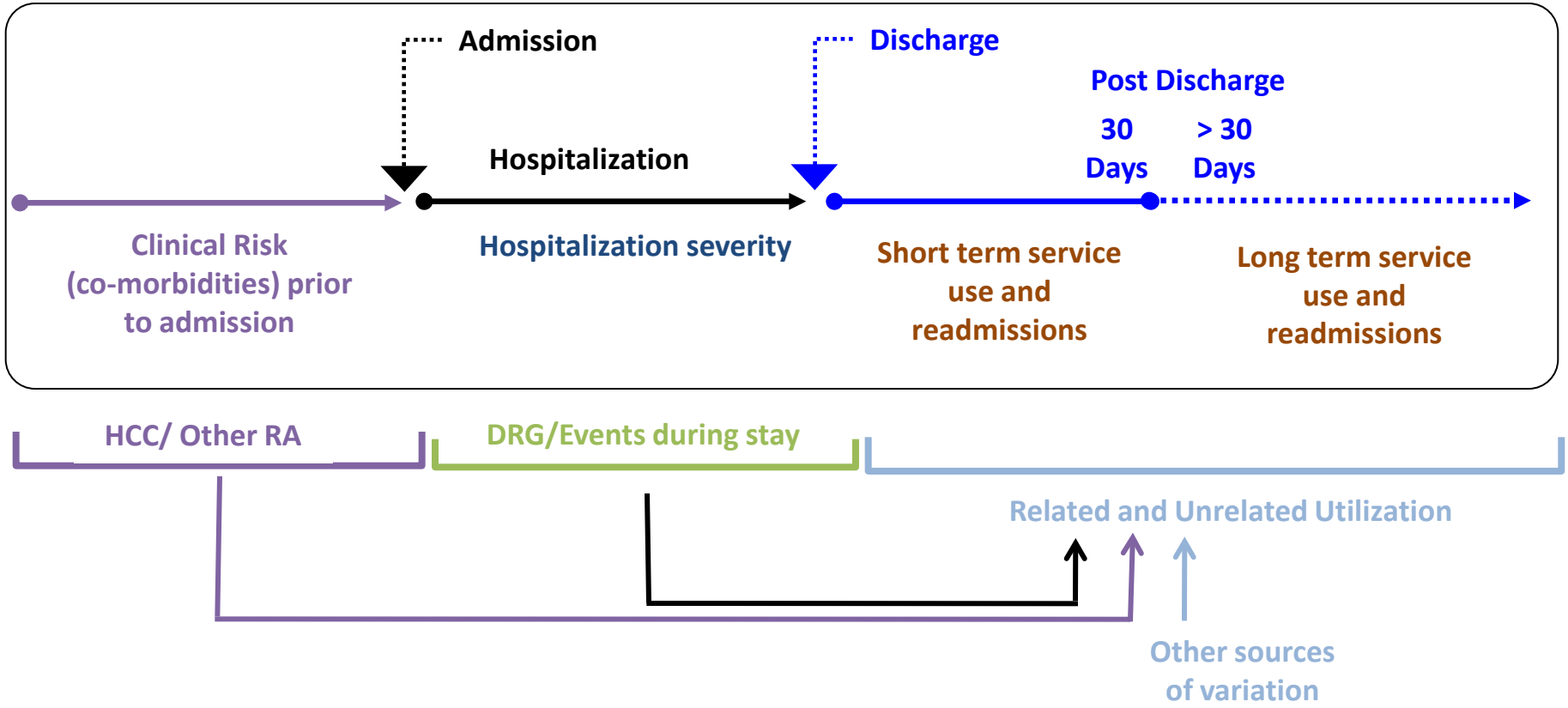
Risk


Admission
Discharge
Post Discharge
30 Days
> 30 Days
Hospitalization
Clinical Risk (co-morbidities) prior to admission
Hospitalization severity
Short term service use and readmissions
Long term service use and readmissions
HCC/ Other RA
DRG/Events during stay
Related and Unrelated Utilization
Other sources of variation

Building the Episodes

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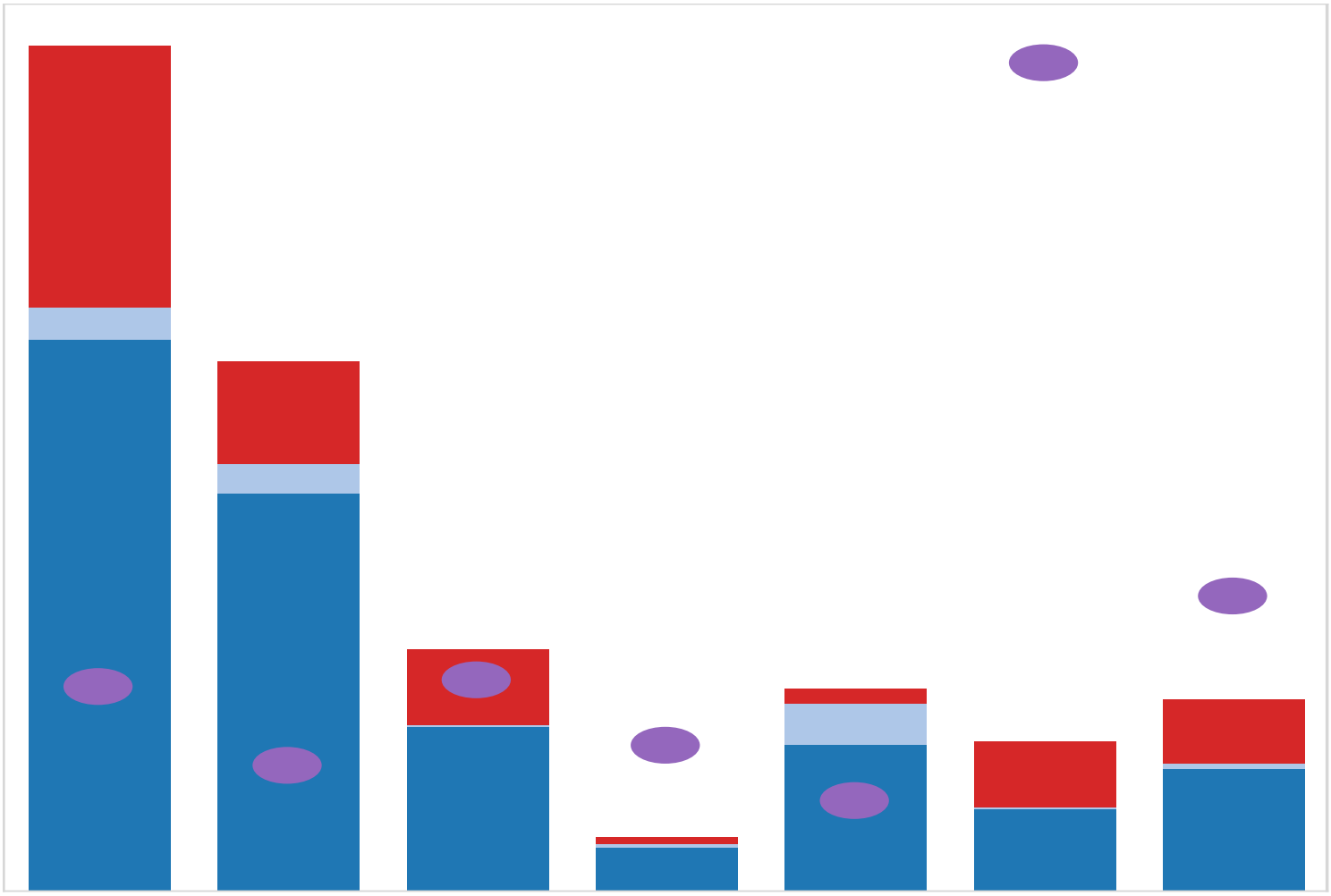
MS-DRG Descriptive Statistics

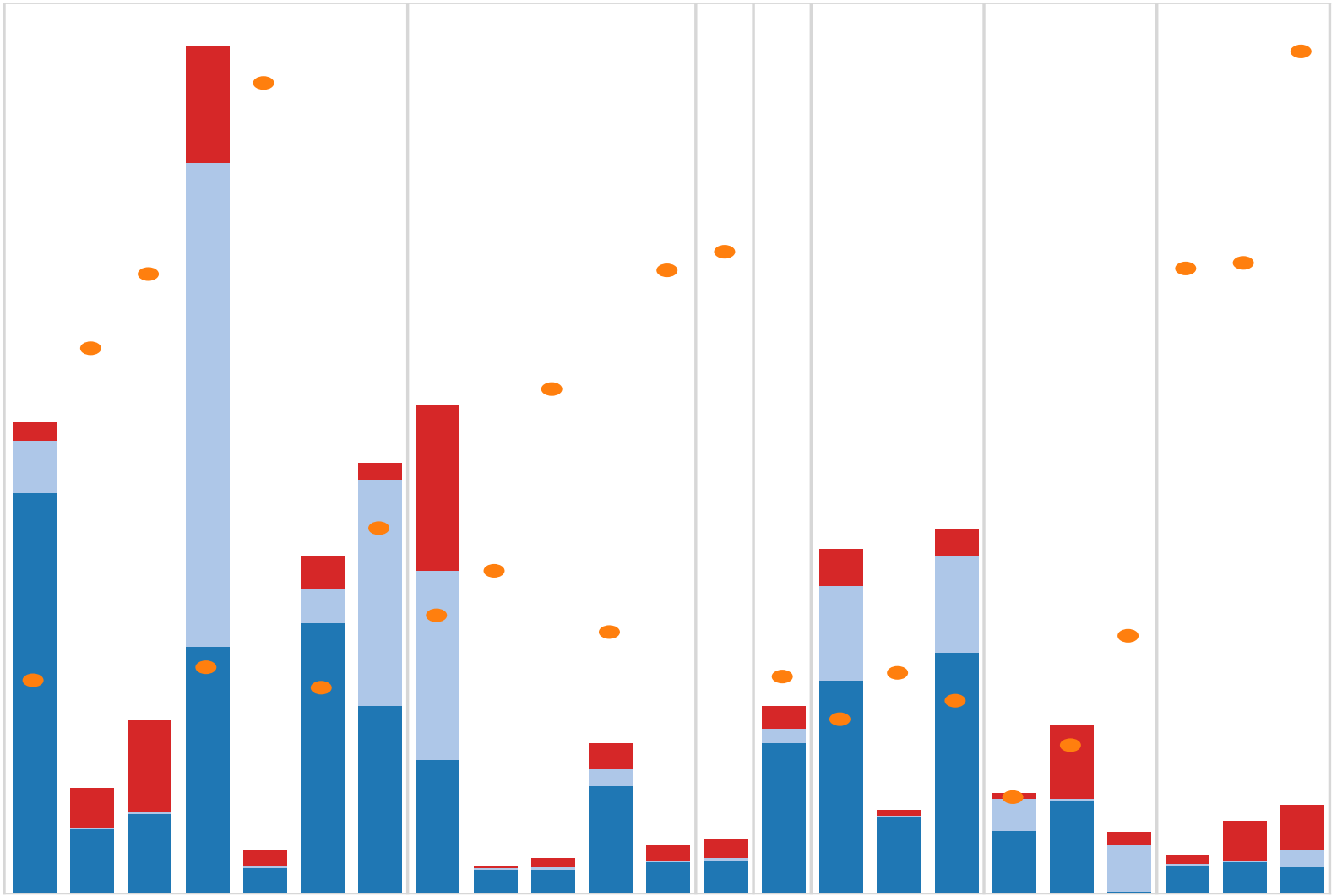
MS-DRG	TYPE	MS-DRG Title	Admission Count	Total Cost	Average Cost per Episode
470	SURG	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	29,946	808,591,280	27,002
871	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	16,193	567,651,547	35,055
392	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	15,333	240,873,168	15,709
312	MED	SYNCOPE & COLLAPSE	12,880	214,168,787	16,628
690	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	12,262	269,398,008	21,970
885	MED	PSYCHOSES	12,194	350,289,156	28,726
291	MED	HEART FAILURE & SHOCK W MCC	12,104	408,700,721	33,766
194	MED	SIMPLE PNEUMONIA & PLEURISY W CC	11,021	235,878,181	21,403
313	MED	CHEST PAIN	10,814	145,040,274	13,412
292	MED	HEART FAILURE & SHOCK W CC	9,693	255,354,775	26,344
310	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	9,437	116,971,480	12,395

Costs and PAC Rate by MDC

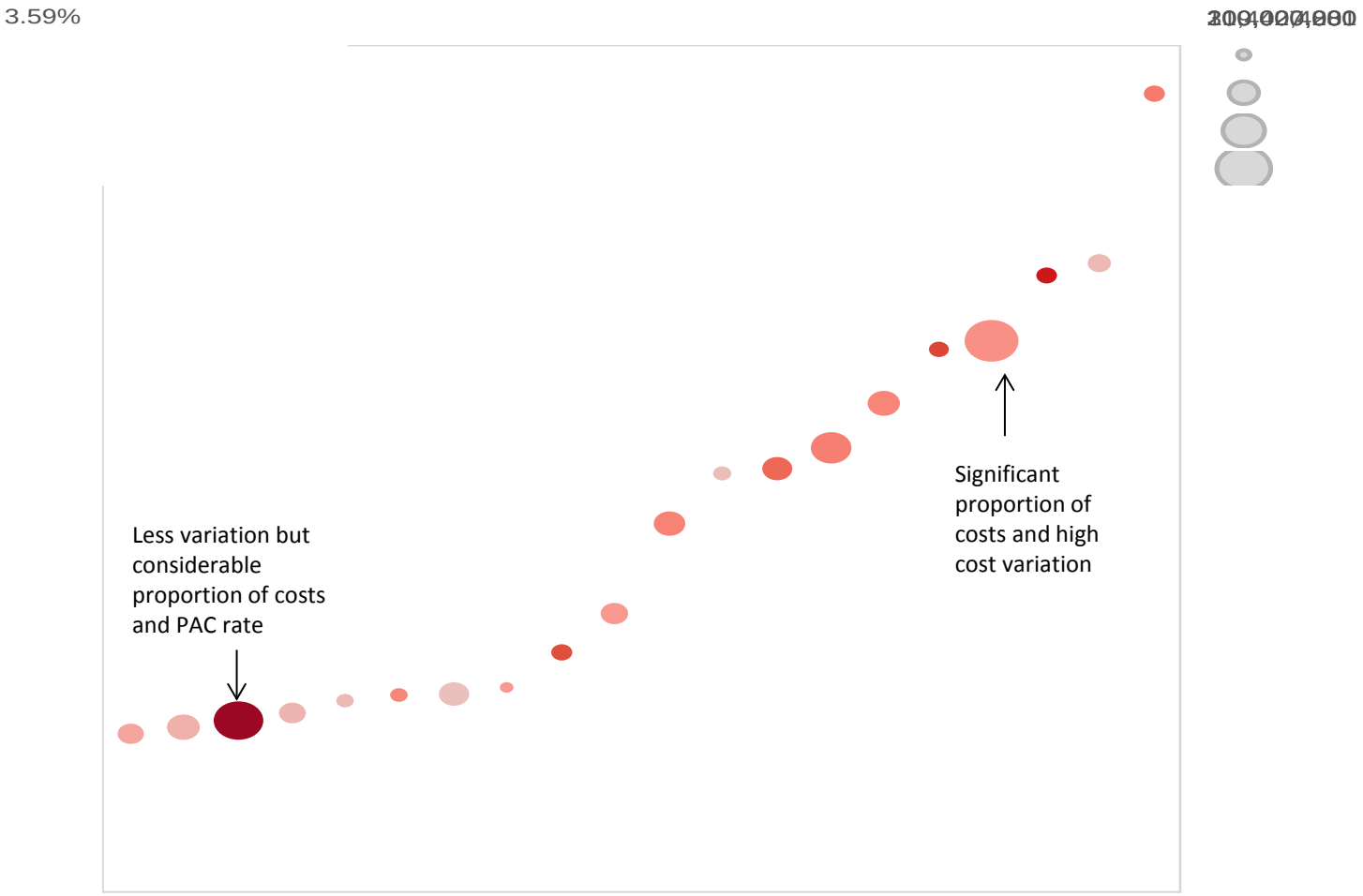


PAC%= % of Episode Costs for Potentially Avoidable Complications

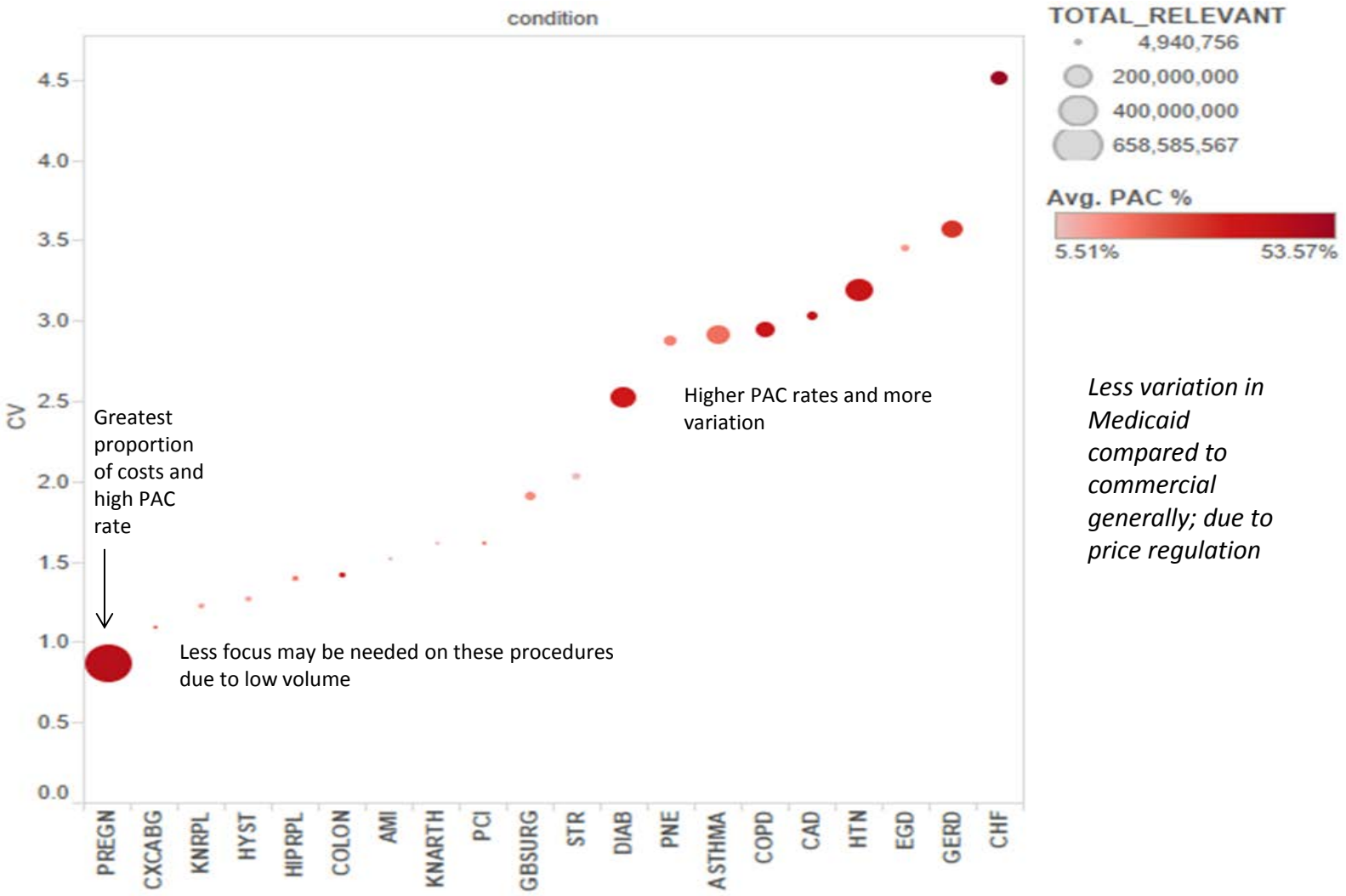
Costs by Selected Conditions



Focus on Episodes with High Costs, PACs and Variation - Commercial

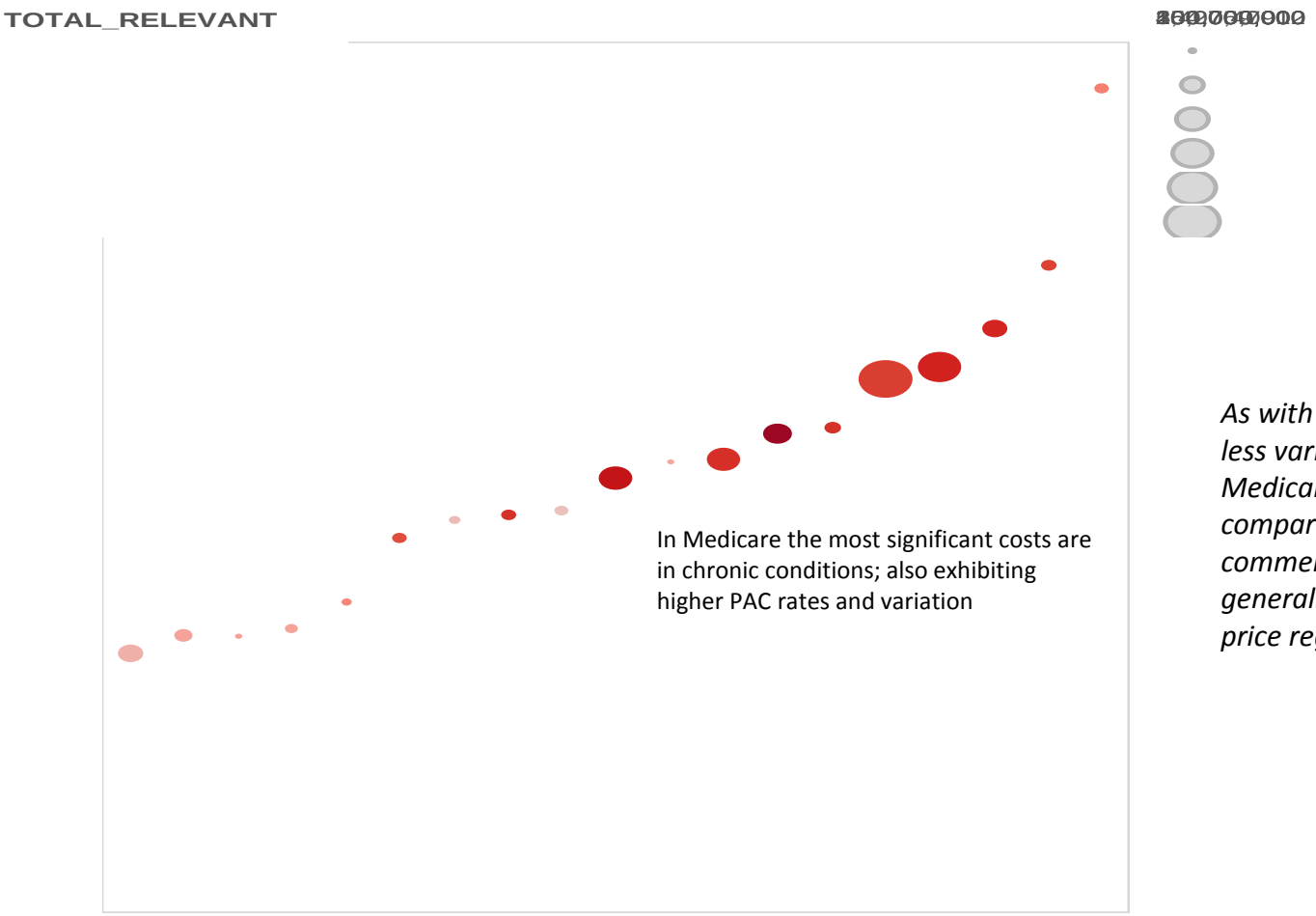


Focus on Episodes with High Costs, PACs and Variation - Medicaid



Less variation in Medicaid compared to commercial generally; due to price regulation

Focus on Episodes with High Costs, PACs and Variation - Medicare



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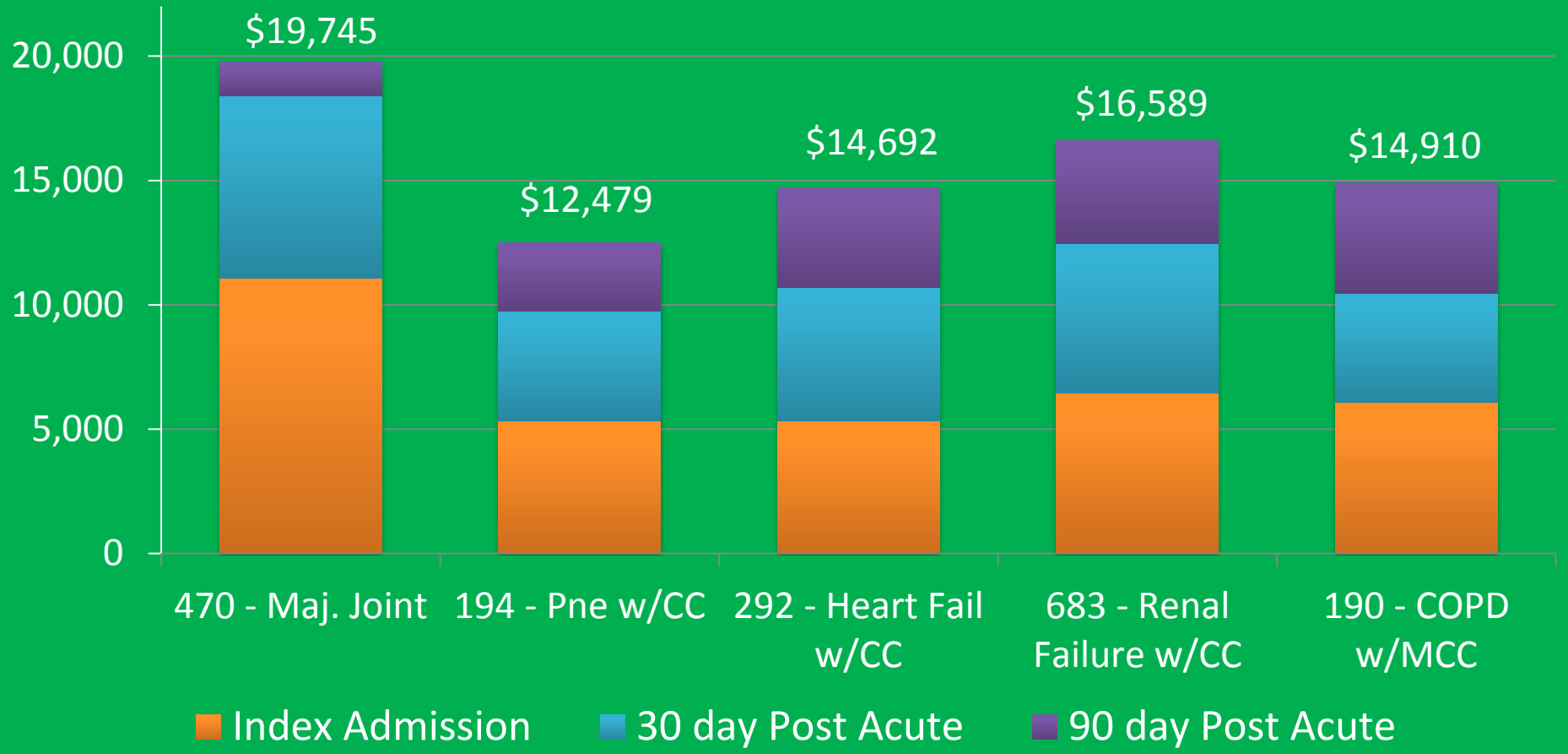
Post-Acute Statistics by DRG: Hospital and PAC

		Percent discharged to post-acute	Mean acute hospital payments	Mean Payments (30 days post)	Mean Payments (90 days post)
	All MS-DRGs	35.2	8,287	4,592	7,063
470	Major joint	87.7	10,434	7,134	8,429
194	simple pneumonia	34.2	5,028	3,682	5,989
65	intracranial hemorrhage	69.3	6,291	12,851	16,407
481	hip and femur procedures	87.1	9,739	15,032	18,500
690	kidney & urinary tract infections	38.8	3,896	4,445	6,927
66	Intracranial hemorrhage	56.6	6,044	8,045	10,590
641	nutritional & miss metabolic disorders	33	3,457	4,080	6,632
292	heart failure & shock	37	5,179	4,882	8,512
871	septicemia	51.8	9,217	6,741	10,077
482	hip & feamur	87.3	8,288	13,711	16,242
195	simple pneumonia	28.8	4,368	2,688	4,446
552	medical back problems	51.1	3,795	6,254	9,310
603	cellulitis	33.5	3,759	3,058	5,244
291	heart failure & shock	42.3	5,621	6,091	10,336
312	syncope & collapse	23.9	3,352	2,503	4,412
392	esophagitis, gastroent & misc	13.5	3,498	1,901	3,831
293	heart failure & shock	27.2	4,978	3,251	6,883
192	chronic obstructive pulmonary disease	20.4	4,134	2,370	4,764
683	Renal failure	38.4	6,649	4,883	8,236
536	fractures of hip & pelvis	84.8	3,422	11,184	14,093

2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 90-Day Episodes



Source: RTI Inc, Post-Acute Care Episodes: Expanded Analytic File, June 2011. 30-90 day amounts are estimated based on RTI, Analysis of Acute Care Episode Definitions Chart Book, November 2009.

High vs. Low HF Patient Cost

Admission Plus 30 days Post Discharge

Comparing Hospitals in the Low and High Resource Use Quartiles

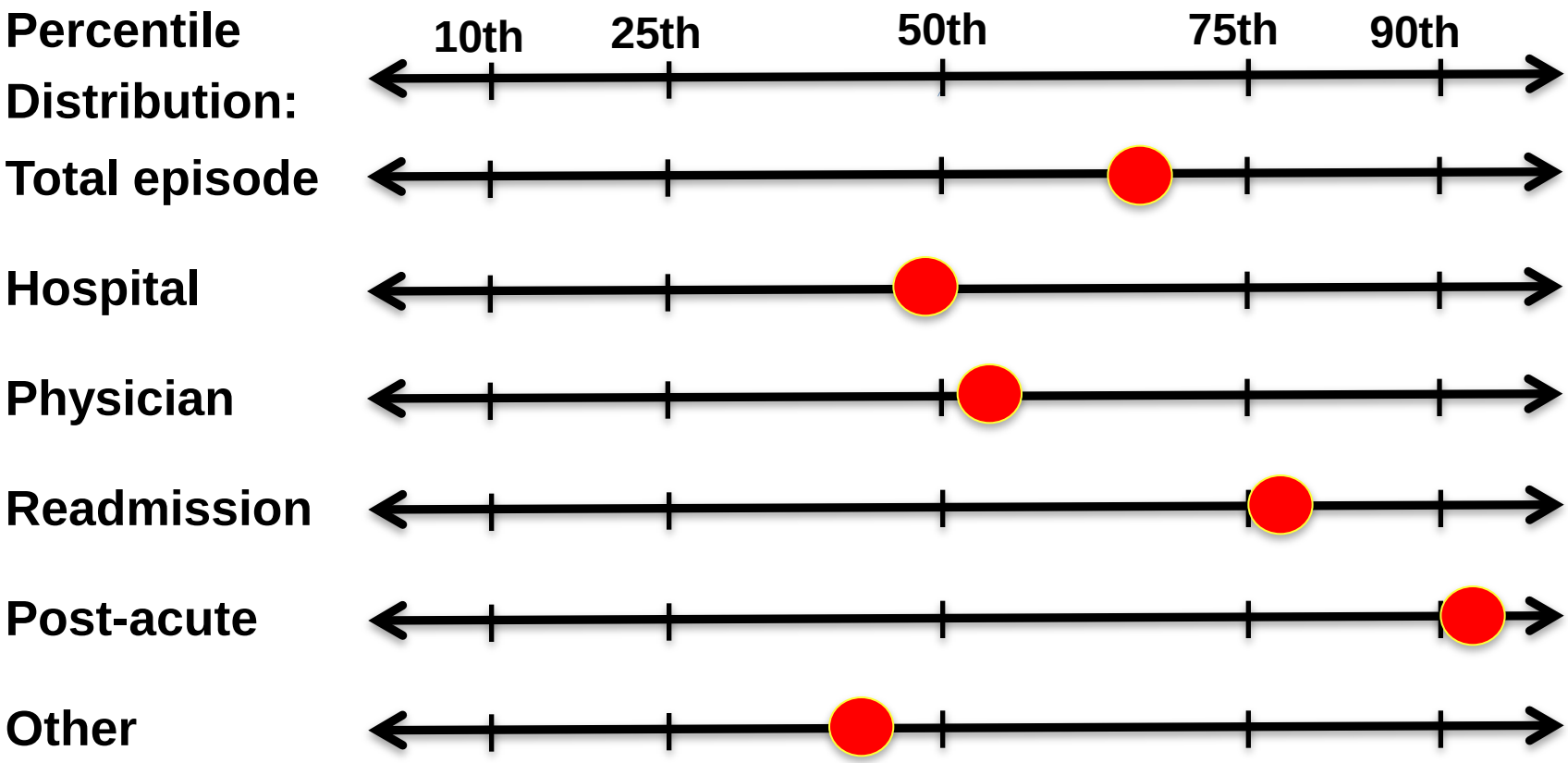
Service	Low	Average	High	Percent	Dollars
Total episode	$7,757	$9,278	$11,019	42.0%	$3,262
Hospital	4,837	4,826	4,824	0.0%	(13)
Physician	612	647	650	6.9%	38
Readmission	1,102	1,986	2,965	169.0%	1,863
Post-acute	842	1,378	2,041	142.0%	1,199
Other	363	441	539	48.5%	176

Building the Episodes

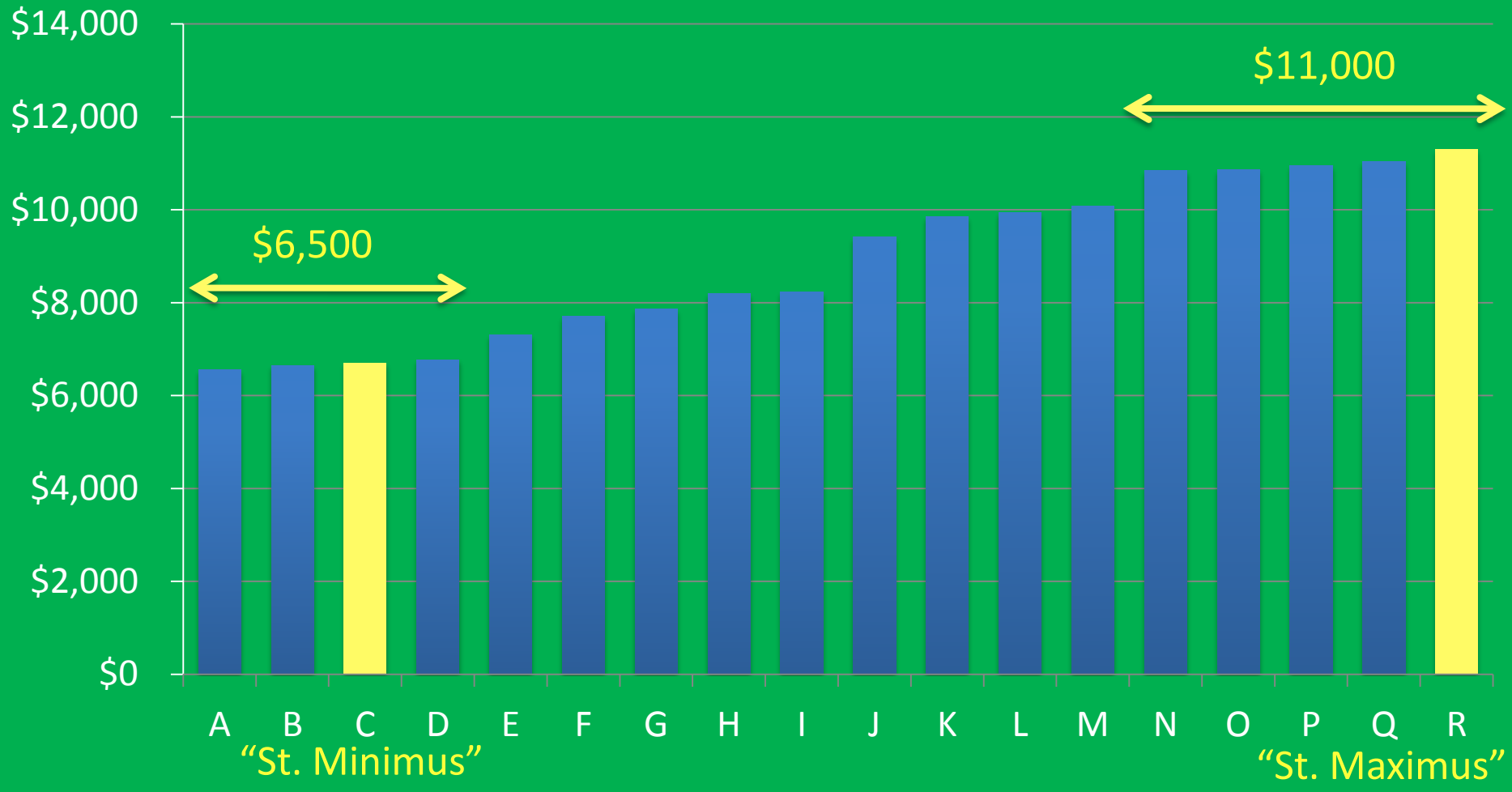
1. Episode timeline	What are the basic constructs of the timeline? What are the different model considerations? What do we know about payments along the continuum of care?
2. Identifying topics	What are the implications of various conditions and settings? What are the tradeoffs narrow versus broad scope?
3. Clinical design & cost containment	What clinical design & cost containment strategies have proven to be effective? What cost savings can be realized?
4. Participating providers	What organizations participate in the care delivery? What is the intensity of payments and costs for the participating organizations?
5. Quality	What are expected quality improvements from clinical design strategies? What measures will be selected to assess performance?

“St. Francis” HF Patient Cost vs. Regional Peers

Admission Plus 30 days Post Discharge



Average 2009 Post-Acute Care Spending per Episode for CHF Admission (90 day)



Source: Brandeis University analysis of Medicare Claims data. Figures adjusted for hospital wage index.

A Tale of Two Hospitals: Joint Replacement Episode

	St. Maximus	St. Minumus	Difference
Total	$26,231	$18,509	$7,722
Index Stay (facility)	$10,459	$10,805	($346)
Index Stay (prof.)	$2,756	$2,038	$718
Acute Readmission	$1,729	$389	$1,340
Rehab Hospital	$283	$0	$283
Long-Term Hospital	$503	$0	$503
Skilled Nursing	$8,475	$2,816	$5,659
Home Health	$1,054	$1,978	($924)
Other Professional	$972	$483	$489

Opportunities for St. Maximus

- Put a program in place to monitor patients following discharge
  - Medication reconciliation
  - Home assessment
  - Primary care visit within 7 days
  - Emergency plan for likely events
- Develop programs/partnerships with SNF & HHA to improve coordination

Building the Episodes

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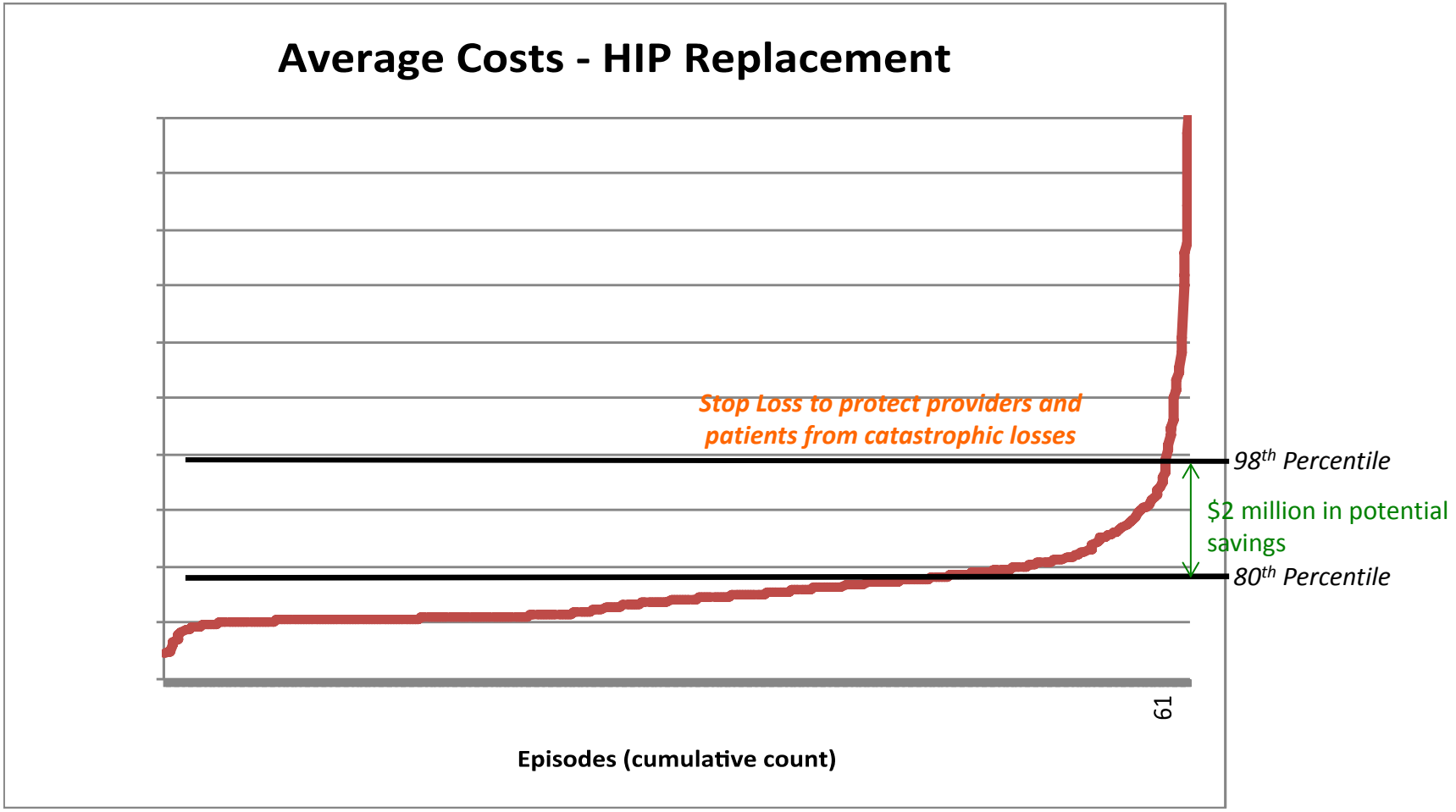
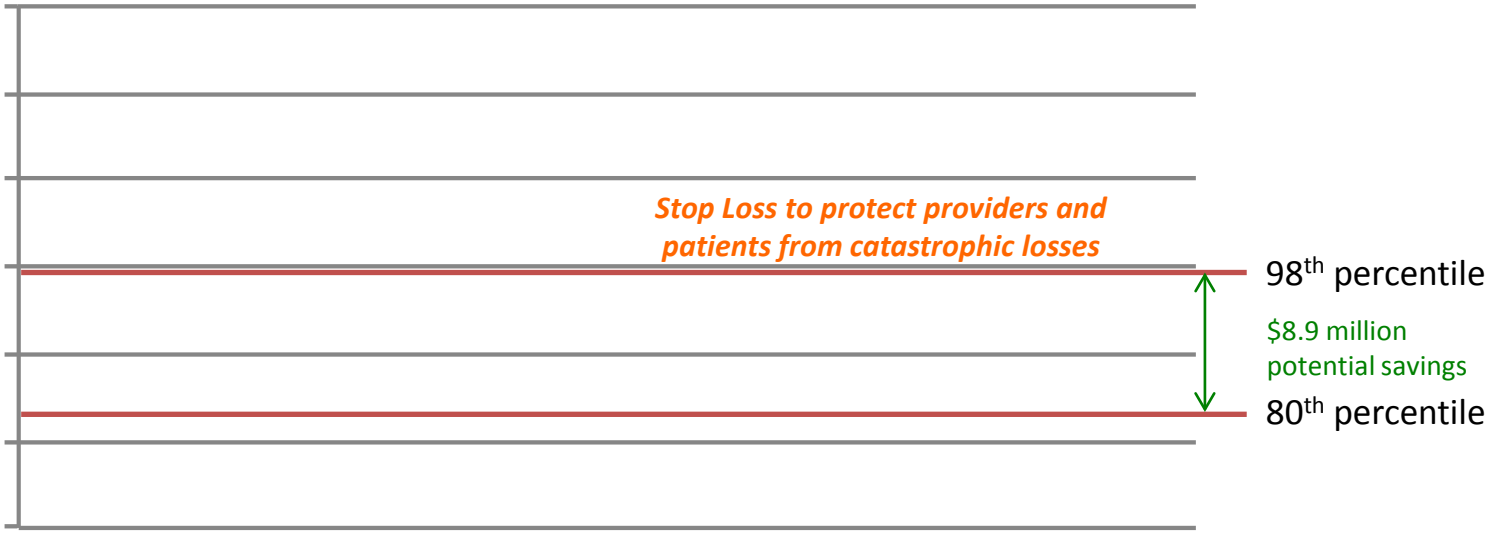
For Most Episodes The Tail Wags the Dog

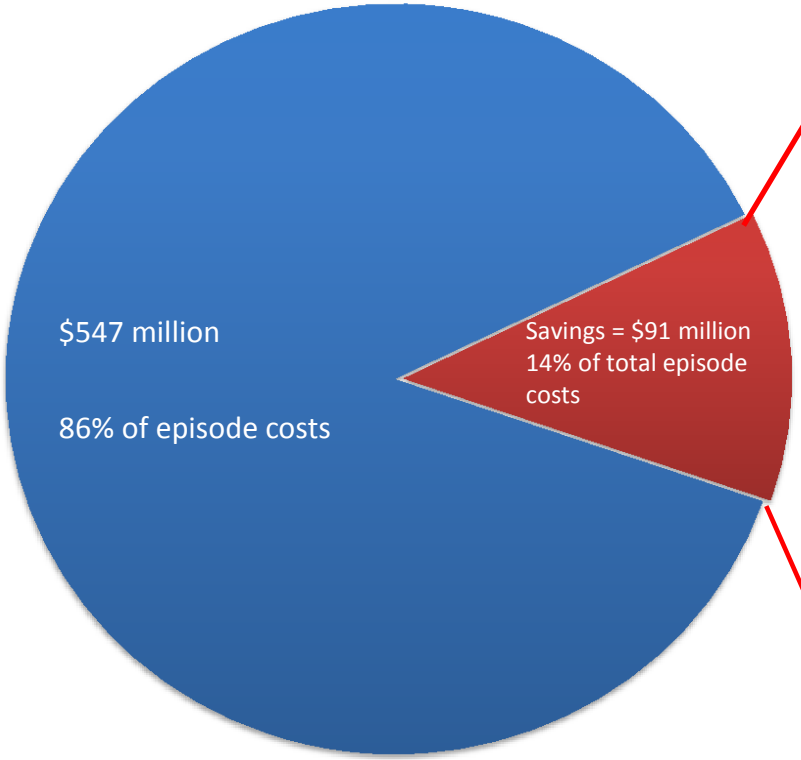


Potential Savings Can be Substantial with High Volume/High Cost Episodes



Potential Savings is Substantial Across All Episodes

107k patients; $639 million in episode costs



Simulated savings at 80th percentile with 98th percentile stop loss

Condition	Total Savings	% Episode Savings	% Total Savings
HTN	$9,484,851	20%	1.5%
PREGN	$8,895,520	9%	1.4%
CAD	$8,753,610	34%	1.4%
COLOS	$7,087,935	11%	1.1%
DIAB	$6,312,965	20%	1.0%
STR	$5,175,083	30%	0.8%
KNARTH	$5,007,218	14%	0.8%
HYST	$4,087,835	12%	0.6%
GERD	$4,022,260	20%	0.6%
GBSURG	$3,905,899	11%	0.6%
ASTHMA	$3,726,895	18%	0.6%
PNE	$3,582,603	27%	0.6%
KNRPL	$3,529,483	7%	0.6%
EGD	$3,145,564	13%	0.5%
CHF	$3,100,427	32%	0.5%
COLON	$2,758,976	15%	0.4%
AMI	$2,388,896	14%	0.4%
HIPRPL	$1,958,383	6%	0.3%
CXCABG	$1,853,715	12%	0.3%
COPD	$1,718,238	21%	0.3%
PCI	$796,928	9%	0.1%
Total	$91,293,284		14.3%

Building the Episodes

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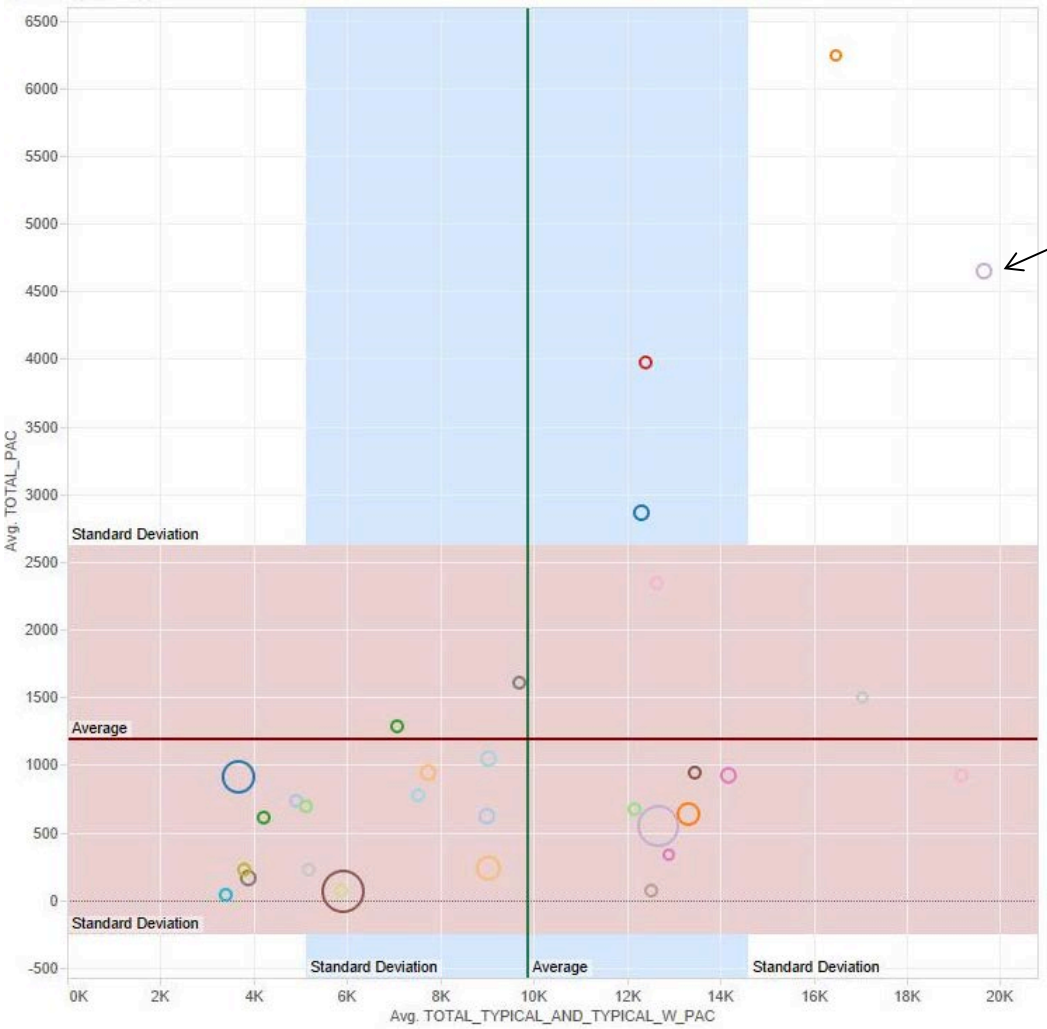
Tools to Aid Providers in Process Improvement

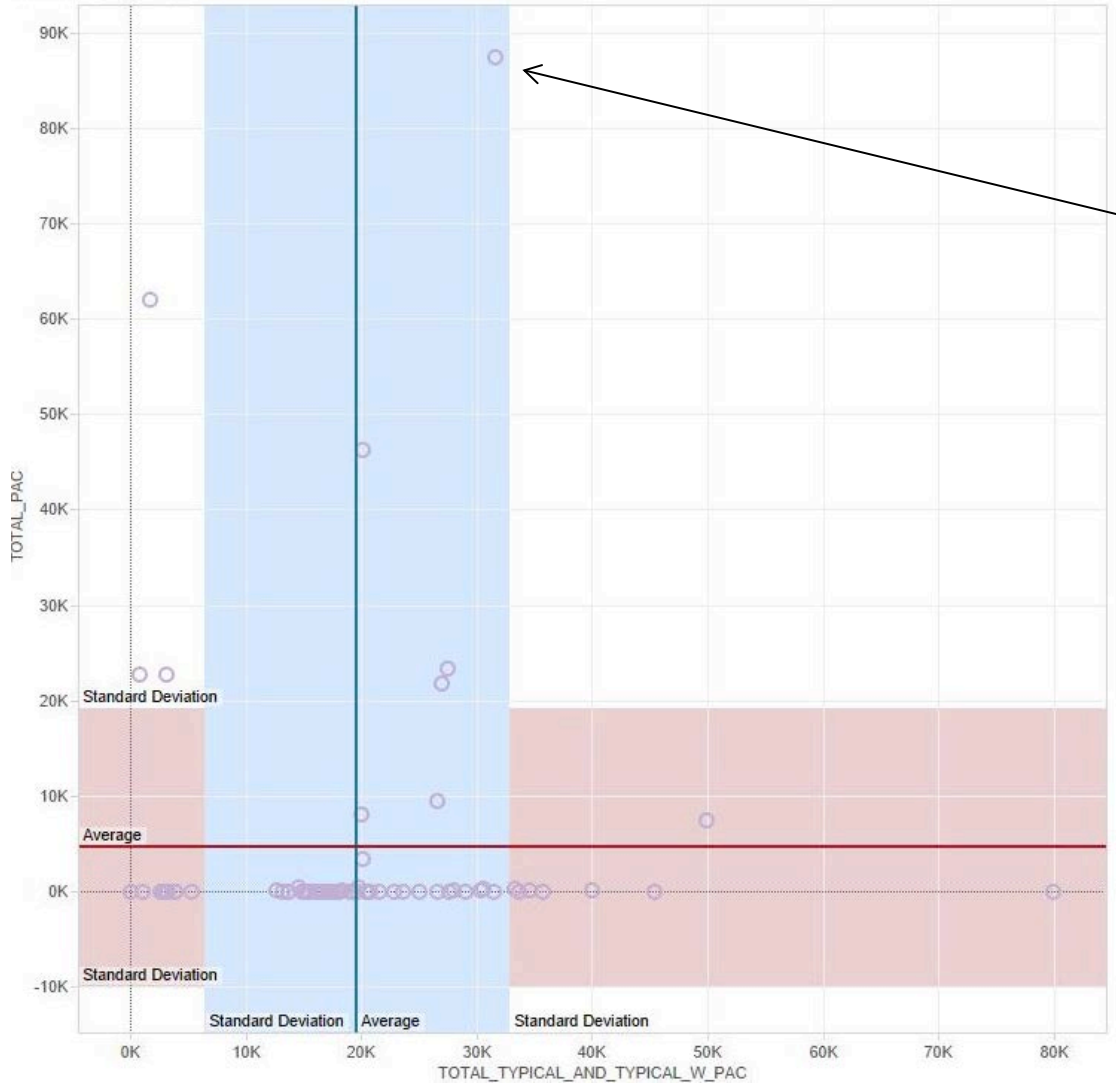
- Data visualization tools that allow providers to benchmark against peers and drill down into their patient details can aid in process improvement
- Average typical costs for gallbladder surgery range from $4k to 18k across facilities
- A facility with high average costs may be driven by a few outlier patients or relatively high costs across all patients
- Individual claim detail on PAC and typical encounters across time within the episode provides instant access to information on the full patient experience

Comparison of Facilities Performing Gall Bladder Surgeries



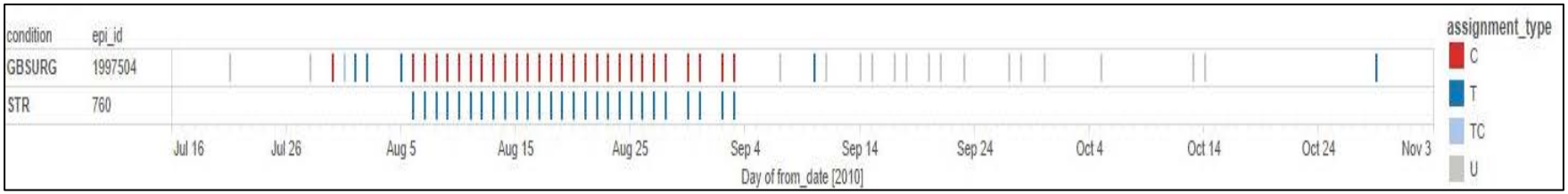
Select a facility to view its gallbladder surgery patients

Distribution of Gallbladder Surgery Episodes Within Single Facility



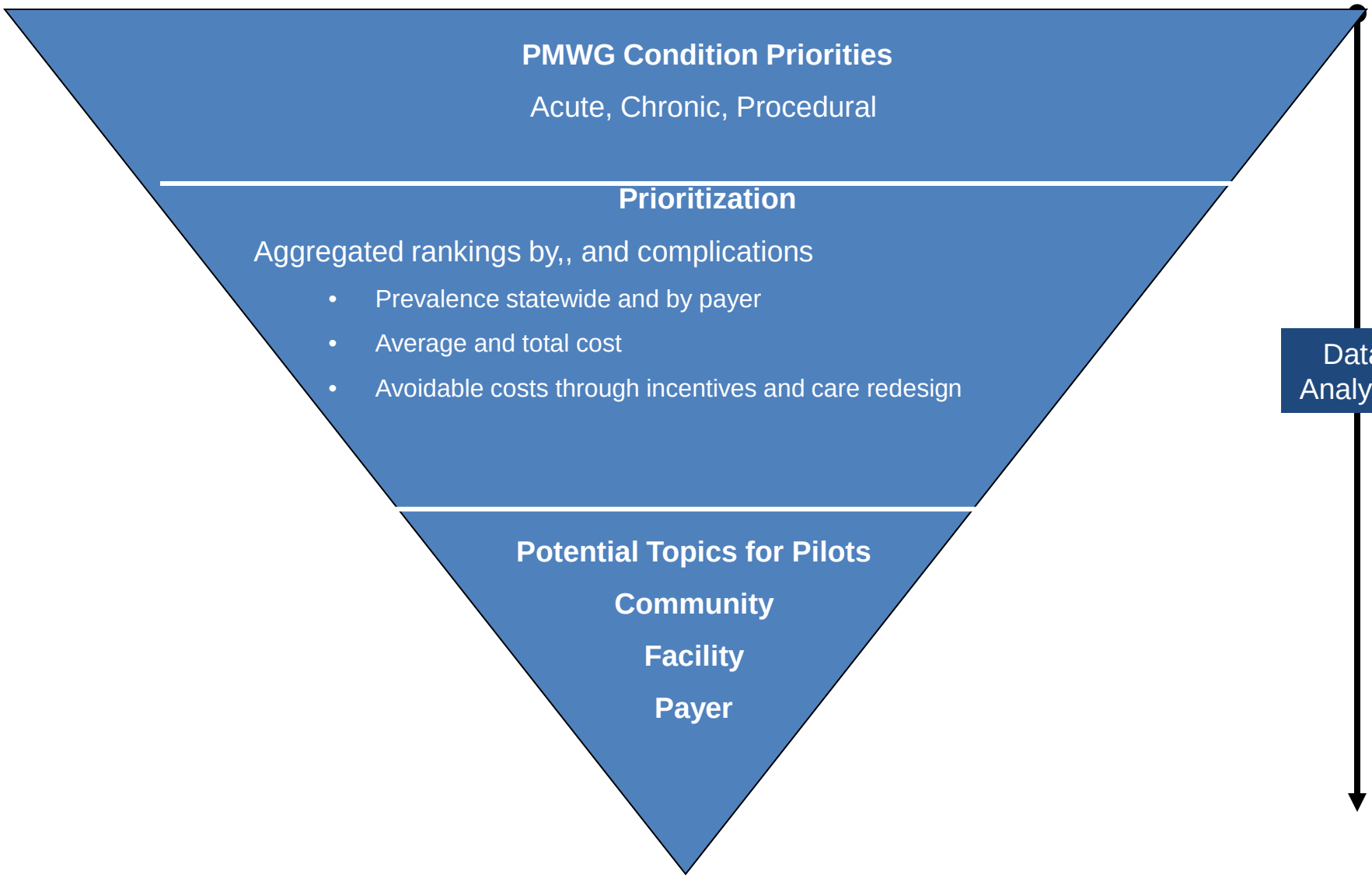
Select a patient to view detail on his/her episodes

Examine Services Within Each Episode for This Patient



- This patient had two episodes: Gall Bladder Surgery & Stroke
- The Stroke episode is associated to the Gall Bladder episode as a complication

Analysis Informing Decisions



Strategies for Success
Selecting the "right" episodes

1

Patient Condition Characteristics

- High case volume & high expenditures
- High variability in tx patterns & cost profiles across care continuum & length of episode
- Availability of evidence-based guidelines
- Defined start and endpoints for care

2

Provider Capacity/Capabilities

- Physician leadership
- Capacity for care redesign (systemic vs targeted); readiness/preparedness
- Availability of provider relationships along care continuum
- Quality improvement system and reporting
- HIT and information management support

3

Market Conditions

- Strategic business strategy
  - Local resources
  - Financial viability of providers

Selection of Episodes

4

Policy Criteria

- Reach many residents
- Affect broad categories of conditions
- Offer significant savings
- Offer opportunities to improve and redesign care
- Are designed to be scalable and replicable by similar health systems
- Already or could rapidly involve participation by other payers
- Can be implemented on aggressive timeline