The Third National Medicare Readmissions Summit
Washington, DC *June 14, 2011*

Delivery System Performance Measurement
Using A "Cloud-based" Interactive Clinical Checklist

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Health Plan Environment

- Plans facing unprecedented public scrutiny, market pressure and regulatory challenges

- Plans need to demonstrate an ability to “add value” to care delivery processes, and not just pay claims and price insurance products

- Plan Opportunities:
  - Leverage their ability to collect and analyze data into meaningful interventions to drive cost-effective care
  - Use economic incentives with both providers, and members, to encourage behavior change
  - And for the privileged few… use their strong brand to get trusted engagement with sponsored tools and programs

BCBS Tennessee – Delivery System Improvement

- Promoting Primary Care Oriented Delivery System Improvement through Patient Centered Medical Home (PCMH) Development & Partnerships:
  - Partnership with key primary care physicians across the state
  - Improving outcomes for Chronic patients (Diabetes, Asthma, CAD, CHF, COPD, and Hypertension)
  - Evolving payment model to promote quality, outcomes and value to all stakeholders
  - Leverage medical homes to promote and support EHR adoption across Tennessee
  - Provide access to 50% of chronic patients by the end of 2012

BCBS Tennessee – Delivery System Improvement

- Promoting Specialty Care Oriented Delivery System Improvement through Quality Measurement & Payment Reform Strategies:
  - Partnership with key specialty physicians across the state
  - Pay for Performance (P4P) & Pay for Outcomes (P4O)
  - Need to capture evidence-based medicine adherence
  - Specific challenge in transitions of care – both information transfer/communication & tracking of evidence-based guideline and protocol adherence
  - Evolving payment model to promote quality, outcomes and value to all stakeholders

PCMH & Provider Partnership Challenges/Obstacles

- Moving quickly towards outcomes measurement
  - From Process Measures to Actual Outcomes
- Tracking Use of Evidence-based guidelines and Best Practices
  - Did we do everything we were supposed to do?
- Helping Primary Care Practices Implement *Systems-Focused* Performance Improvement
- Limited Information Technology (IT) Support at Practice Level
- Regional Resource Support and PCMH Alignment
- Acceptance of BCBST-only Administrative Data
- Performance Bonus Program

The Challenge

- There is a compelling need to improve clinical outcomes
- There is a compelling need to reduce defects in clinical care
- There is a compelling need to support better coordination of care

The NEW ENGLAND JOURNAL of MEDICINE

Study indicates we only supply the care that is needed 55% of the time. *"...there is a chasm between what we know and what we do for our patients"*

-McGlynn et al, New England Journal of Medicine

NCQA 20 YEARS

"It's not a question of knowing how to treat heart disease, diabetes or mental illness. We know how. We're just not doing it. We're literally dying, waiting for the practice of medicine to catch up with medical knowledge."

-Margaret E. O'Kane, president, NCQA

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A Specific Health Plan Opportunity for Enabling Community Physicians to Improve Transitions in Care

- Partner with specific hospitals and medical groups to support the deployment of high-impact clinical HIT solutions, using NEW web-based “cloud” technologies
  - Assist hospitals and medical groups with implementing “best practice” care guidelines, and processes
  - Assist Hospitalists in driving better transitions of care - “Bridging the Gap” between hospitals and ambulatory care
  - Collect targeted critical clinical data elements (labs, medications, etc.) to enhance administrative data sets and use them for collaborative care management, performance assessment and hospital network management
- Impact on Readmissions

Transitions of Care Today
Staggering Readmission Rates

- **20%** of Medicare patients are readmitted within 30 days… **50%** never had any follow-up visit with a primary care MD[1]
- In one recent study, the rate of timely PCP follow-up was only 49%, and **those those patients lacking timely PCP follow-up were 10 times more likely to be readmitted**, 21% in patients lacking timely PCP follow-up vs. 3% in patients with timely PCP follow-up[1].
- For patients who were readmitted within 30 days after a surgery was performed, **70%** were admitted for a medical condition such as pneumonia or a urinary tract infection[1].

1 S. F. Jencks, M. V. Williams, and E. A. Coleman, "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine, Apr. 2, 2009 360(14):1418–28.*

2 Misky GJ, Wald HL, Post-Hospitalization transitions: Examining the effects of timing of primary care follow-up. J Hosp Med. 2010 Jun 23. [Epub ahead of print]

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Transitions of Care Today
Staggering Readmission Rates

- The problem is not confined to Medicare, recent estimate shows **18%** of all patients readmitted with 30 days[1]
- Based on intervention studies, estimated that **20-50% of readmissions are preventable.**
- Patients in one survey reported that **18%** percent of physicians unnecessarily repeated tests, and test results and medical records were missing when needed at **23%** of follow-up appointments[2]
- An estimated **60%** of medication errors occur during times of transition[2], and those, medication errors harm 1.5 million people each year in the United States, costing the nation $3.5 billion annually[3].

1 Arnold Milstein, data presented at Reducing Readmissions Conference, 11/15/2009

2 The Commonwealth Fund Commission on a High Performance Health System, *Why Not the Best? Results from a National Scorecard on United States Health System Performance* (Sept. 2006)

3 JD Rozich & RK Resar, Medication Safety: One Organization's Approach to the Challenge, J. Clin. Outcomes Manag. 8:27-34 (2001).

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Where do we need to go?
Three Elements of High Quality Transitions

1

Patient-Centered

The transition plan is tailored to the specific diseases and recovery challenges of this unique patient.

2

Continuous

Spans across the traditional chasms between settings, linking together hospital, patient & caregivers and primary physicians in a single community of care

3

Intelligent

Offers decision support and analytics that help all stakeholders ensure the highest quality possible care

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How does current care measure up?
A Typical Community Hospital in 2011

Standard Discharge Plan

Adherence / Outcomes

?

Patient Info & Hand-Off

?

Acute Care Hospital

Patient and Caregivers in Community

MD in Community

Discharge Summary
(often days later)

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How does current care measure up?
A Typical Community Hospital in 2011

1

Patient Centered

Often using a single generic set of discharge checklists with minimal or no tailoring to the specific needs of the particular patient.

2

Continuous

Transition plan often ends at the hospital door, follow-up burden solely on patient; receiving clinicians starved for information; no common portal to share information and ensure successful handoffs.

3

Intelligent

Typically a “dumb” paper process lacking decision support to encourage adherence to best practices.

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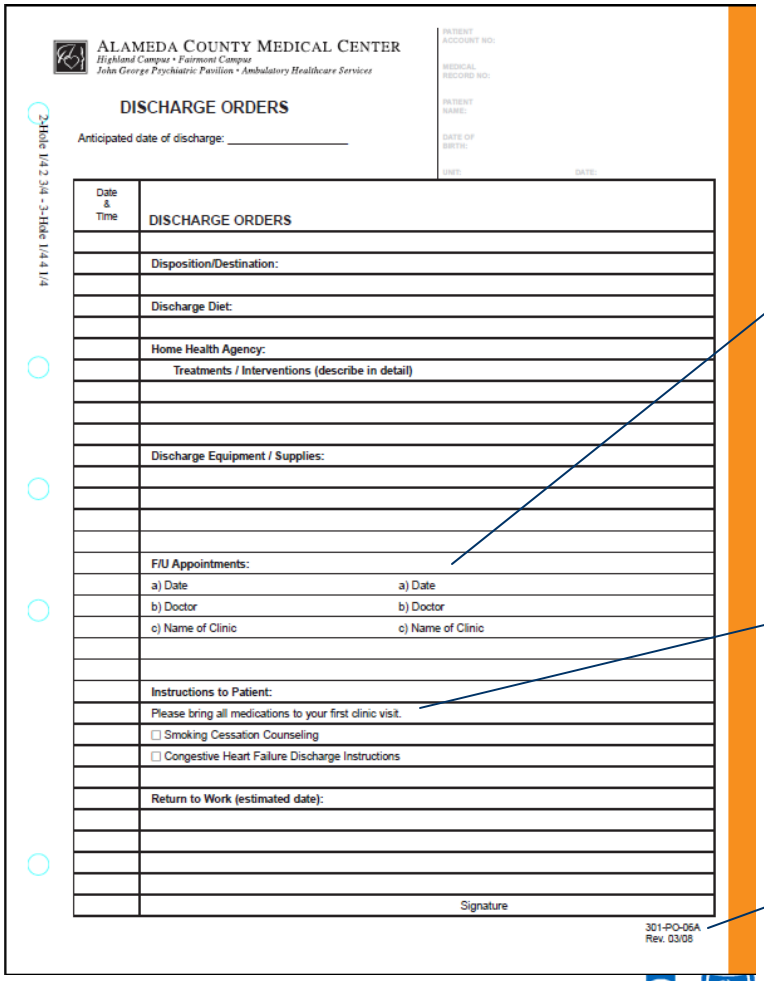
Example of extremely limited Discharge Orders at the community hospital level



ALAMEDA COUNTY MEDICAL CENTER
Highland Campus • Fairmont Campus
John George Psychiatric Pavilion • Ambulatory Healthcare Services

PATIENT ACCOUNT NO:
MEDICAL RECORD NO:
PATIENT NAME:
DATE OF BIRTH:
UNIT: DATE:

DISCHARGE ORDERS

Anticipated date of discharge: _____

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Date & Time	DISCHARGE ORDERS	
	Disposition/Destination:	
	Discharge Diet:	
	Home Health Agency:	
	Treatments / Interventions (describe in detail)	
	Discharge Equipment / Supplies:	
	F/U Appointments:	
	a) Date	a) Date
	b) Doctor	b) Doctor
	c) Name of Clinic	c) Name of Clinic
	Instructions to Patient:	
	Please bring all medications to your first clinic visit.	
	☐ Smoking Cessation Counseling	
	☐ Congestive Heart Failure Discharge Instructions	
	Return to Work (estimated date):	
	Signature	

301-PO-06A
Rev. 03/08

	F/U Appointments:
a) Date	a) Date
b) Doctor	b) Doctor
c) Name of Clinic	c) Name of Clinic

Instructions to Patient:
Please bring all medications to your first clinic visit.
☐ Smoking Cessation Counseling
☐ Congestive Heart Failure Discharge Instructions

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Better workflows. Better outcomes. Powerfully simple.
Introducing SmartTransitions

1 smart TRANSITIONS

✓ Patient-Centered

Supports hundreds of disease-specific provider checklists, with the ability to blend into unique, highly-customized plans for patient-specific needs. Electronically update with industry-wide best practices.

2 smart TRANSITIONS

✓ Continuous

Provides a Web-enabled portal that becomes the common source for hospital, primary physician, patient's family and associated caregivers. No HIE or EMR necessary! PMD is alerted via email to access the portal.

3 smart TRANSITIONS

✓ Intelligent

Offers point-of-care decision support to ensure best practices, while a rich suite of analytical tools drives the continuous improvement of processes.

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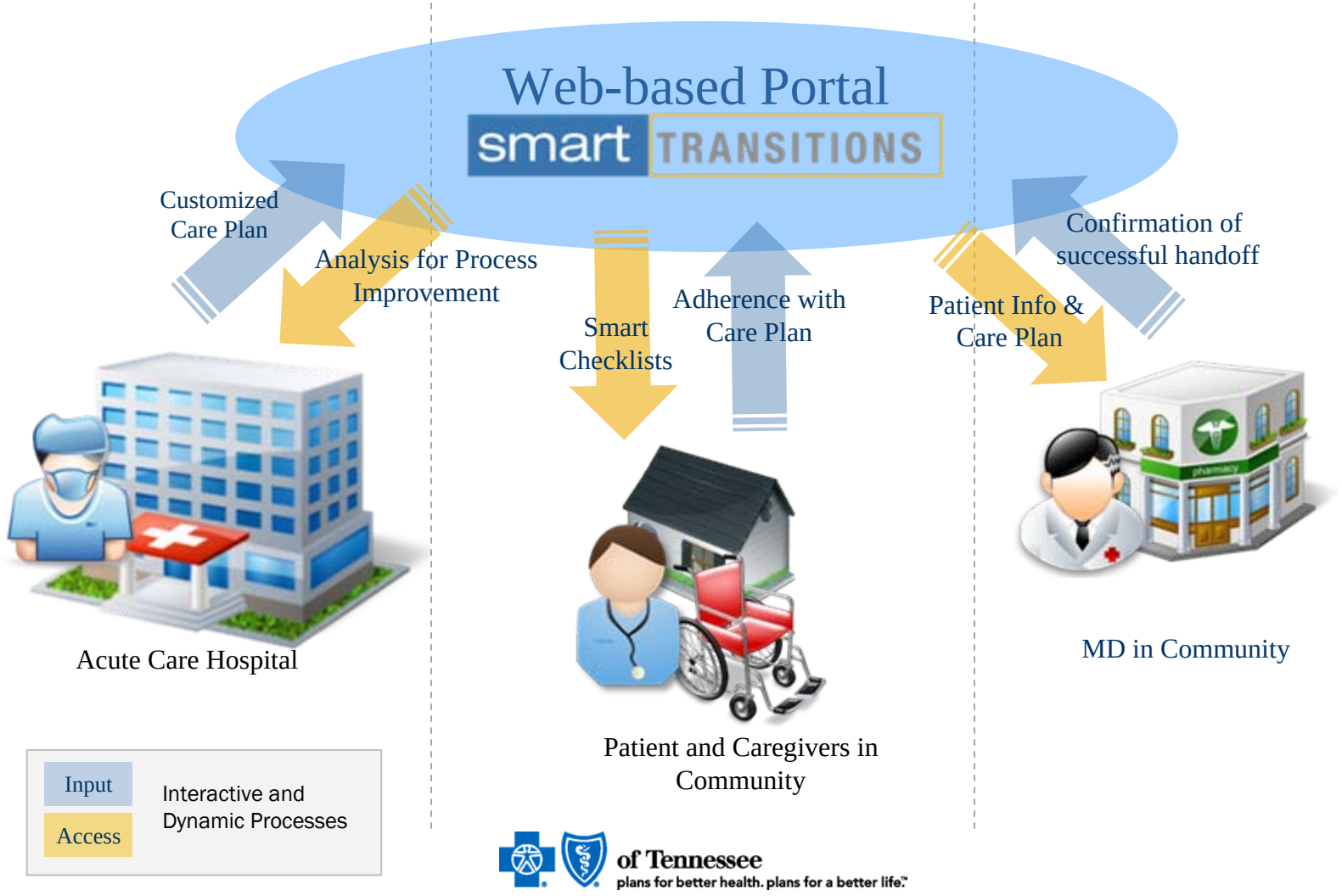
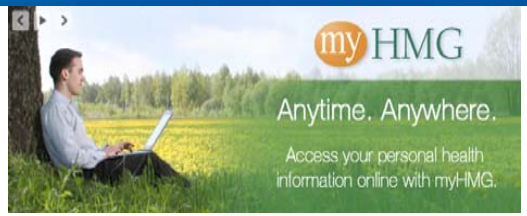
How SmartTransitions Introduces "Customized, Continuous and Intelligent" to Transitions of Care



Value Based Reimbursement and the Readmit Challenge: Four Steps

- Step One: Predictive Modeling allows for analysis of clinical and financial opportunity
- Step Two: Provider contracts include incentives for improved performance
  - P4P/P4O for evidence-based guideline adherence
  - Shared Savings methodologies in reducing re-admits
- Step Three: Improved care delivery processes and information coordination reduces readmits
- Step Four: Outcomes assessment, financial reconciliation, and re-targeting of efforts for coming contract period

Finding a Pilot Partner….
Holston Medical Group (HMG)



1977 - HMG is **founded in 1977**
1985 - HMG becomes **region's first provider of After-Hours Care**
1989 - HMG becomes the **region's first multi-specialty physician group**

1995 - HMG becomes the **region's first fully-integrated user of EMR**
1996 - HMG develops the **region's first Clinical Research Department** within a physician group.
HMG introduces **pediatrics** into the Group
1997 - HMG becomes the **region's first provider to incorporate care of a hospital team**

1999 - HMG opens the **region's first free-standing diagnostic facility**
HMG introduces the "Disease Management" concept, today known as **HMG Integrated Health Management**

2006 - HMG launches **OnePartner** and introduces **"Healthy U" wellness initiatives** along with **myHMG**

2007 - HMG combats childhood obesity, pilots **"Lose it 4Good for Kids & Teens"** at Kingsport City Schools
HMG unveils **Seasons, first regional women's health group**

2008 - HMG wins **"TechStar" and "TechMed" Award for EMR and myHMG.**
HMG introduces the **OnePartner ATAC**, the first commercial tier III certified facility in America.

2010 - HMG receives the region's first **NCQA accreditation for PCMH**
HMG enters into three risk\reward programs with three **Managed Care Partners**, all predicated on **PCMH**

2011 - HMG generates support for a multi-stakeholder approach initiation of **Accountable Care Organization** that parallels core values

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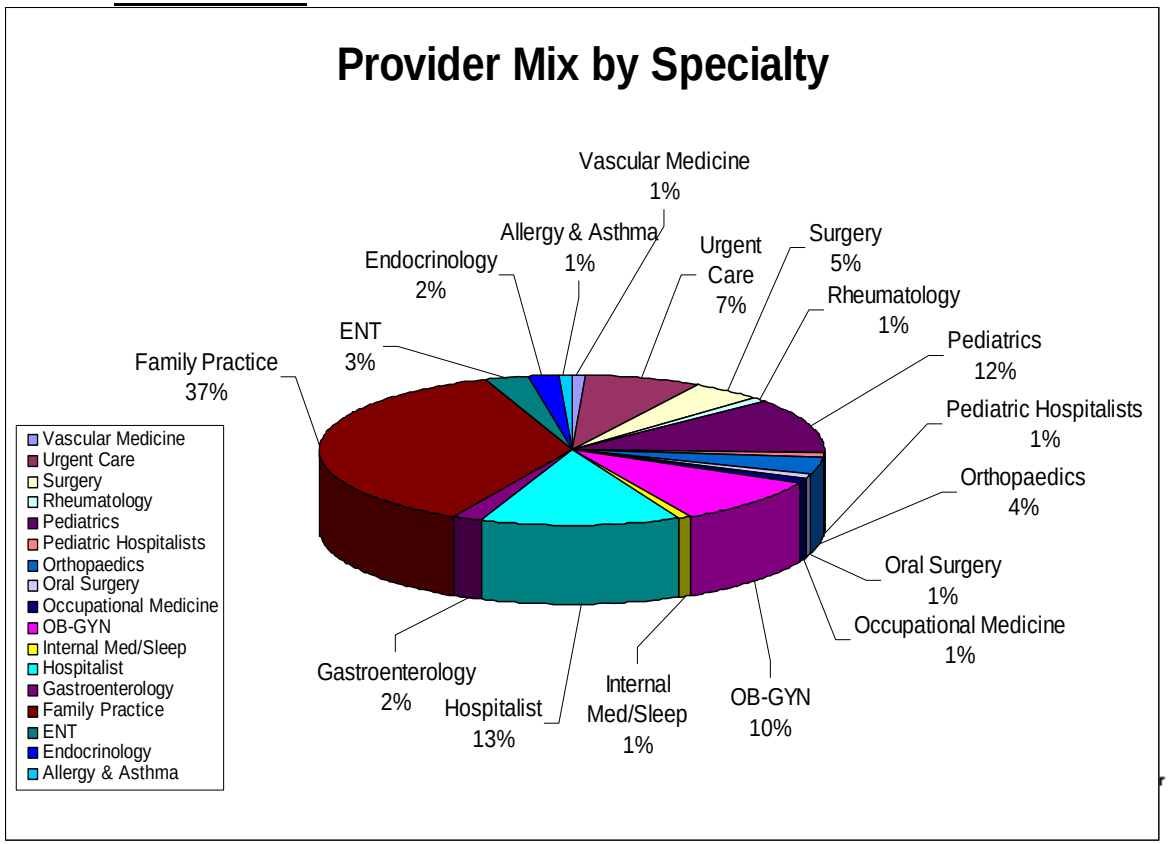
HMG Quick Facts (As of January 2011)

Total Physician and Mid-Level Providers:	155
Employees:	705
Total number of unique active patients:	174,573

Offices:	14
Sq. Ft. Occupied:	301,155
Counties of Presence:	5



HMG – Lessons Learned & Learning…

- There can be only one Medical Home, hence only one set of processes
- The ACO and the Medical Home that supports it must be built on a foundation of consistent process, not desired anecdotal outcome
- ACO and the shared gains have many contributing stakeholders and a flexible program approach must be supported by consistent process and data
  - Pediatrics, Surgeons, Facilities
- Progressively less dependent on claims data for clinical use
- Payors are partners (including employers)
- We are becoming progressively more dependent on our partners for shared effort and revision
  - Data sets are in silos from payors across providers
  - Gaps that exist are often cross provider documentation or the limitations of claim specific data (limited diagnosis)
- It is easy to be consumed by the administration and lose emphasis of the WORK of obtaining and retaining health

Key Stakeholders We (HMG) have Undervalued

- Hospitalists and a supportive and collaborative Hospital System culture
- Surgeons\Specialists are key components
  - Implants and discharge; extra time and effort
  - Capture of additional measure specific information
- Potentially, home health and transportation
- Health Plan Medical Directors with authority to act
- Health Plan creativity that recognizes a combination of compensation and transition capital
- Case management software is an imperative
- Urgent Care and expanded applications in Urgent Care

BCBST Next Steps… Expanding from Pilots to Programs

- Use of Web-based checklist management systems and advanced order entry systems to track increasing number of clinical conditions
- Pilot using Smart Transitions to manage interactions between :
  - Care Coordinators with Patients in PCMHs
  - Care Coordinators with Case Managers, Disease Management team and Health/Wellness Coaches
- Use of Smart Transitions to track adherence to evidence-based guidelines for evaluation, treatment and follow-up
- Accountable Care Systems development with increased use of systems to help track transitions
- Direct Patient use for monitoring own compliance/adherence to recommended care plans

And… We will continue to listen to the front lines of care delivery…

QUESTIONS ???

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