MOVING TOWARDS VALUE-BASED MEDICINE

September 21, 2016
• Introduction – the Landscape
• Departmental Impact
• Mitigating the Downside
• Care Coordination & Risk Management
• EMR Integration & EOC Care Continuum
• Future of Patient Reported Outcomes
Rich Capra, CEO, UCSF
President of AOC

Andrew Duncan, ED
Ortho & Rehab at UF Health

Theresa West, National VP, Healthcare Strategy, TAVHealth

Michael Sheerin, SVP
Rothman Institute

Carol Harding, Area VP
Johnson & Johnson/D-S

Ryan VanderWerff, Director, Ortho Center, University of Utah
Introduction – the Landscape

Rich Capra, CEO, UCSF, President of AOC
Michael Sheerin, SVP Rothman Institute
Healthcare Costs Out of Control

Fragmented Care

Information Systems

Patient Experience

Quality: Inconsistent

Disparities with Access

Payers Shifting Risk – Patients/Providers

Tier Providers

Narrow Networks

Transition to Episodic Care

from Volume to Value?
PARADIGM SHIFT
Volume to Value Transition
paradigm

noun | par-a·digm | \ˈper-ə-dēm, ˈpa-rē- əl·dēm\

Simple Definition of PARADIGM

: a model or pattern for something that may be copied

: a theory or a group of ideas about how something should be done, made, or thought about

paradigm shift

noun

Definition of PARADIGM SHIFT

formal

: an important change that happens when the usual way of thinking about or doing something is replaced by a new and different way <This discovery will bring about a paradigm shift in our understanding of evolution.>
THE LANDSCAPE

Fee-for-Service
Pay for Volume
Fragmented Care
Process Measures Rewarded
High Utilization
IT Fragmentation
Limited Analytics

Pay for Value
Big Data – Predictive
Navigation
Outcomes Rewarded
Provider Alignment
Systems Integration
Decreased Utilization
WHAT IS BUNDLED PAYMENT?

• A single prospective price for all services needed by the patient over an episode of care
• Incentivizes providers to focus on patient costs and outcomes beyond the inpatient stay and encourages close collaboration with post-acute providers

• Currently 1,522 CMS Bundled Payment Pilot Participants
• Mandatory in many market areas as of April 2016
• The bundled-payment pilot is the first to be mandatory and is projected to save Medicare $343 million.
WHAT IS BUNDLED PAYMENT?

What health care costs are included in the 90-day target price?
The 90-day Bundle Episode: Main Themes

**Preoperative Coordination**
- Patient selection and engaging surgeons will be essential

**Inpatient Coordination**
- Care Coordinator and automated reporting are necessary

**Postoperative Coordination**
- For the CMS' bundled payment system to work, hospitals will need to recruit high-quality post-acute partners, and that may be difficult in some markets.

**Program Analytics**
- All data surrounding your patient population

**WHAT IS BUNDLED PAYMENT?**

**Hospital Admission**
- Pre-Surgery

**Discharge**
- 90 Days Post-Discharge
WHAT IS BUNDLED PAYMENT?

- Identify Champions
- Physician Engagement
- Predictive Tools
- Patient Optimization
- Using an Health Care Navigator
- Care Coordination
- Pathways
- Multidisciplinary Teams
- Daily Tracking
- Improve MCC documentation
- Discharge Dispos Planning
- Post Acute Communication
- Post Acute education and outreach
- Controlled Readmissions
- Functional Outcomes
- EMR Integration
- Coding/Documentation/Claims Review
- Episode Payment Review
- Cost Reduction
- Monthly readmission review

Preoperative Coordination
Inpatient Coordination
Postoperative Coordination
Program Analytics
First things first:

- Don’t let CJR push you into panic mode
- Be calm
- Be rational
- Remain oriented to your values
- Develop a scoring system
- Develop a way to measure the performance of your patients as they advance through your care pathway of joint replacement
Bundles have created Opportunity & Opportunists
Opportunity Clarification

- This is not a sustainable strategy for physicians to make more money
- This is not a sustainable strategy for hospitals to make more money
- There is a short term opportunity to improve contribution margin, but there is a ceiling
It Brings Us Back to the Basics of Value

• Stay oriented to your value equation:
  o Value = Quality/Cost
  o Value = Outcome/Cost
  o Value = (Patient Satisfaction + Quality)/Cost

• The principle driving bundled payments is value

• Be careful not to make decisions that compromise value which on the surface, appear to improve your BP bottom line
DEPARTMENTAL IMPLICATIONS

Panic! Or... Do the Math!

Do I...?
• Do nothing?
• Hire Care Navigators?
• Hire a Service line Consultant?
• Engage Vendors?
• Enter into Quality or Medical Director agreements?
• Employ clinic based Social Workers?
• Film and run a joint education class?
• Etc.

Do I...?
• Calculate and understand what the hospital penalty will be?
• Make rational decisions that:
  • Reduce costs
  • Improve outcomes
  • Improve service
  • Add value
Post acute care and readmissions are where the opportunity is
Post Acute Care Patient Management

- **3rd Party Option- Utah TAV Health**
  - Purchase license to a software into which our staff and TAV staff enter data collected from patient calls following surgery. These are scripted and scheduled according to algorithms. TAV produces real time reporting back to physicians, nurses, and admin.

- **EMR Option- Epic Healthy Planet**
  - Leverage capabilities of your current EMR to collect and track data and produce reporting.

- **Internal logistics- Florida**
  - Produce and manage your own database. Cost effective. Remember, bundled payments are not a sustainable strategy for adding to the bottom line.
Mitigating the Downside

Carol Harding, Area VP, Johnson & Johnson/D-S
Michael Sheerin, SVP, Rothman Institute
Organizing for Population Health But Alignments Persist Still Focused on Acute Episode

GOAL: POPULATION HEALTH*

* Required for Success For Migration from Volume to Value Based Payment & Assumption of Risk

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MITIGATING THE DOWNSIDE

Continuum of Care Focus and Alignment of Key Stakeholders

Population Health

Intervention

Wellness

Recovery

Hospitals/ASCs

Primary Care/Medical Home

Post-Acute Services

Intermediaries: Payors, GPOs, Distributors, Consultants, Suppliers
## Example: City, Ohio

<table>
<thead>
<tr>
<th></th>
<th>Hosp A</th>
<th>Hosp B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Joint Replacements</td>
<td>423</td>
<td>287</td>
</tr>
<tr>
<td>(procedural volume)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to home</td>
<td>83%</td>
<td>33%</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>days per patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episode Cost*</td>
<td>$16,783</td>
<td>$20,913</td>
</tr>
<tr>
<td>Excess Re-Admits</td>
<td>0%</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Footnotes:
- Source: CMS, DePuy Synthes Evidence Based Medicine and J&J Informatics
- * Note that analysis does not include spending on home health care
Hospitals That Have Successfully Participated In Previous CMS Bundles
Cite Key Ingredients For Success

**Downside Risks**

- Clinical and operational process inconsistencies leading to less than optimal outcomes and higher costs
- Analytics framework not powered to provide population/other insights
- Lack of substantial provider alignment across the continuum
- Inadequate focus on structural cost basis reduction

**Sustainable Cost Structure**

**Process**
- Consistency across entire episode of care

**Analytical and IT tools**
- To track patients' vital, clinical, and functional outcomes

**Provider alignment**
- (including PAC)

**Bundled payment success**
Focus On Managing Risk

4 Key Risks

1. Process Variation
2. Inadequate Analytics Framework
3. Lack of Provider Alignment
4. Unsustainable Cost Structure

Mitigating Strategies

• Focus on determining best practices deployment and reducing variation across the board
• Leverage key sources of data for decision support, to analyze population needs, track outcomes
• Identify needed investments in data/analytics to power the analytic framework
• Assure optimal alignment mechanisms in place across the continuum and all key providers
• Analyze/tackle costs (direct, indirect) at every level /establish as an organizational priority
• Encourage key suppliers/vendors to demonstrate ability to offer value and potentially needed capabilities
Focus on Structural Cost Basis Reduction

Dedicated resources to help address the total cost of care

Episode of Care Cost Over a 90-Day Bundle

Dedicated resources
- End-to-End Supply Chain
- Perioperative Efficiency
- Bundled Payment
- Infection Risk
- Clinical Standardization
- Patient Outreach
- Healthcare Consumer Engagement*

1. Some capabilities require coordination across the Johnson & Johnson Family of Companies
2. Average Medical Device Cost Percentage of Total Healthcare spending
3. Based on Total Healthcare spending that includes the Total Continuum of Care: Hospital Costs, Medical Device Costs, Clinical/Physician Costs, Home Health Costs, Prescription Drugs, Durable Medical, and Non durable Medical products.

- Programs are in development

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EPISODE OF CARE - MSK
Best Opportunity For Savings

Cost Drivers(1):

1. High-Risk Patients (co-morbidities)
2. Readmission (HF; COPD; Infections)
3. Post Acute Care (HHA; SNF; IRF)
4. Episode Family Selection (Related DRG’s)

(1) Source: Data Gen – “Evaluating Opportunities in Medicare Bundled Payment Program” Gloria Kupferman; January 2014
NAVIGATION
The Risk Assessment

Patient answers Yes/No Questions

43 Medical & 15 Social Questions

Example

Do you have:
Diabetes?
Seizures?
Sleep Apnea?
Do you live alone?
Do you require assist with daily activities?

Auto-Scores Risk Result, Pertinent Positives Displayed

RISK:
MITIGATING THE DOWNSIDE

EPISODE OF CARE - MSK

Focus Areas

Demand Matching:
Site of Service
surgical & post-op

Risk Assessment/
Stratification

Navigation System & Process

Care Coordination Network (post-op)

Data, Data, Data
MITIGATING THE DOWNSIDE

COMMERCIAL MARKET DATA: JOINT & SPINE*
25th, 50th, 75th, 90th Percentiles: Surgical Facilities*

JOINT REPLACEMENT

<table>
<thead>
<tr>
<th>Percentile</th>
<th>25th</th>
<th>50th</th>
<th>75th</th>
<th>90th</th>
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<tr>
<td>Payment</td>
<td>$14,642</td>
<td>$20,836</td>
<td>$32,836</td>
<td>$36,366</td>
</tr>
</tbody>
</table>

*Demand Matching – Selecting the appropriate implant (facility) based on five demand categories: age, weight, expected activity, general health, bone stock. (Lahey Clinic – 1995)
CARE COORDINATION NETWORK
Quality Care Alliance Partners (QCAP)
“Care Coordination” Purpose

Care Coordination Agreement

“Value” Providers

Virtual Narrow Network – Each Market

MITIGATING THE DOWNSIDE
MITIGATING THE DOWNSIDE

CARE COORDINATION NETWORK
Quality Care Alliance Partners (QCAP)
“Care Coordination” Providers

Physical Therapy
Home Health Agencies (Nursing, Rehab)
Skilled Nursing Facilities
Inpatient Rehab Facilities
Urgent Care Centers
EPISODE OF CARE DASHBOARD ANALYTICS
Bundle Snapshots – Facility Demand-Match (Individual)

IBC JOINT EPISODES - LOW MEDICAL RISK, BY PROVIDER, BY HOSPITAL

PCSH - RMH

Jan Feb Mar Apr May Jun July Aug Sept Oct
Bundle Snapshots – Facility Demand-Match (Cohort)
### IBC Joint Episodes – Index Hospital Shared Savings Opportunities

**Low Medical Risk, By Month, By Provider:**

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Low-Risk</th>
<th>@ Tier 2 Hosp</th>
<th>@ Tier 3 Hosp</th>
<th>Savings Opportunity</th>
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<tr>
<td>Jan</td>
<td>4</td>
<td>3</td>
<td></td>
<td>$36,000</td>
</tr>
<tr>
<td>Feb</td>
<td>7</td>
<td>5</td>
<td></td>
<td>$60,000</td>
</tr>
<tr>
<td>Mar</td>
<td>1</td>
<td>1</td>
<td></td>
<td>$12,000</td>
</tr>
<tr>
<td>Apr</td>
<td>7</td>
<td>3</td>
<td></td>
<td>$36,000</td>
</tr>
<tr>
<td>May</td>
<td>10</td>
<td>8</td>
<td></td>
<td>$96,000</td>
</tr>
<tr>
<td>Jun</td>
<td>4</td>
<td>3</td>
<td></td>
<td>$36,000</td>
</tr>
<tr>
<td>Jul</td>
<td>4</td>
<td>3</td>
<td></td>
<td>$36,000</td>
</tr>
<tr>
<td>Aug</td>
<td>5</td>
<td>2</td>
<td></td>
<td>$24,000</td>
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<tr>
<td>Sep</td>
<td>9</td>
<td>2</td>
<td></td>
<td>$24,000</td>
</tr>
<tr>
<td>Oct</td>
<td>8</td>
<td>3</td>
<td></td>
<td>$36,000</td>
</tr>
<tr>
<td>Nov</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>59</td>
<td>0</td>
<td>33</td>
<td>$396,000</td>
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</tbody>
</table>
EPISODE OF CARE DASHBOARD ANALYTICS
Discharge Disposition Management

IBC JOINT EPISODES - DISCHARGE DISPOSITION
LOW SOCIAL RISK, BY MONTH, BY DISPOSITION
-------------
, MD

MITIGATING THE DOWNSIDE
## Episode of Care Cost Analytics

### Average EOC Cost Data (by Surgeon, compared to Practice Average)

<table>
<thead>
<tr>
<th>Joint</th>
<th>Episodes</th>
<th>Avg. Epi Cost</th>
<th>Avg. IP Cost</th>
<th>Avg. PAC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>14</td>
<td>$26,679</td>
<td>$14,166</td>
<td>$12,513</td>
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<tr>
<td>KNEE</td>
<td>31</td>
<td>$24,612</td>
<td>$14,024</td>
<td>$10,588</td>
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</table>

**Utilization Details by Joint**

<table>
<thead>
<tr>
<th>Joint</th>
<th>Utilization %</th>
<th>IRF</th>
<th>SNF</th>
<th>HHA</th>
<th>PT</th>
<th>Average Cost</th>
<th>Utilization Count</th>
<th>Total Cost</th>
<th>Per Diem/Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>7%</td>
<td>50%</td>
<td>43%</td>
<td>64%</td>
<td></td>
<td>$18,677</td>
<td>1</td>
<td>$18,677</td>
<td>13</td>
</tr>
<tr>
<td>KNEE</td>
<td>0%</td>
<td>65%</td>
<td>45%</td>
<td>90%</td>
<td></td>
<td>$-</td>
<td>1</td>
<td>$-</td>
<td>17</td>
</tr>
</tbody>
</table>

**Program Average for Bundle Eligible Surgeons**

<table>
<thead>
<tr>
<th>Joint</th>
<th>Episodes</th>
<th>Avg. Epi Cost</th>
<th>Avg. IP Cost</th>
<th>Avg. PAC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>364</td>
<td>$20,398</td>
<td>$14,242</td>
<td>$6,156</td>
</tr>
<tr>
<td>KNEE</td>
<td>531</td>
<td>$20,443</td>
<td>$13,784</td>
<td>$6,659</td>
</tr>
</tbody>
</table>

**Utilization Details by Joint**

<table>
<thead>
<tr>
<th>Joint</th>
<th>Utilization %</th>
<th>IRF</th>
<th>SNF</th>
<th>HHA</th>
<th>PT</th>
<th>Average Cost</th>
<th>Utilization Count</th>
<th>Total Cost</th>
<th>Per Diem/Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>3%</td>
<td>24%</td>
<td>41%</td>
<td>54%</td>
<td></td>
<td>$15,410</td>
<td>12</td>
<td>$184,922</td>
<td>19</td>
</tr>
<tr>
<td>KNEE</td>
<td>2%</td>
<td>23%</td>
<td>35%</td>
<td>65%</td>
<td></td>
<td>$12,814</td>
<td>10</td>
<td>$128,138</td>
<td>17</td>
</tr>
</tbody>
</table>

**Mitigating the downside**

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MITIGATING THE DOWNSIDE
## Episode of Care Cost Analytics

### Average EOC Cost Data

(by Best Financial Performance, compared to Practice Average)

<table>
<thead>
<tr>
<th>Joint</th>
<th>Episodes</th>
<th>Avg. Epi Cost</th>
<th>Avg. IP Cost</th>
<th>Avg. PAC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>19</td>
<td>$14,954</td>
<td>$13,484</td>
<td>$1,470</td>
</tr>
<tr>
<td>KNEE</td>
<td>61</td>
<td>$17,171</td>
<td>$13,765</td>
<td>$3,406</td>
</tr>
</tbody>
</table>

### Financial Best Practice – Lowest Average Episode Cost

<table>
<thead>
<tr>
<th>Joint</th>
<th>Episodes</th>
<th>Avg. Epi Cost</th>
<th>Avg. IP Cost</th>
<th>Avg. PAC Cost</th>
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</thead>
<tbody>
<tr>
<td>HIP</td>
<td>364</td>
<td>$20,398</td>
<td>$14,242</td>
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</tr>
<tr>
<td>KNEE</td>
<td>531</td>
<td>$20,443</td>
<td>$13,784</td>
<td>$6,659</td>
</tr>
</tbody>
</table>

### Program Average for Bundle Eligible Surgeons

<table>
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<tr>
<th>Joint</th>
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<th>Avg. PAC Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>364</td>
<td>$20,398</td>
<td>$14,242</td>
<td>$6,156</td>
</tr>
<tr>
<td>KNEE</td>
<td>531</td>
<td>$20,443</td>
<td>$13,784</td>
<td>$6,659</td>
</tr>
</tbody>
</table>

### Utilization Details by Joint*

<table>
<thead>
<tr>
<th>Joint</th>
<th>IRF</th>
<th>SNF</th>
<th>HHA</th>
<th>PT</th>
</tr>
</thead>
</table>
| HIP   | 0%  | 0%  | 0%  | 5%
| utilization | 32% |
| Average Cost | $5,479 | $749 |
| Utilization Count | 6 |
| Total Cost | $4,496 |
| Per Diem/Visit | 10 |

<table>
<thead>
<tr>
<th>Joint</th>
<th>IRF</th>
<th>SNF</th>
<th>HHA</th>
<th>PT</th>
</tr>
</thead>
</table>
| KNEE  | 2%  | 23% | 35% | %
| utilization | 65% |
| Average Cost | $12,814 | $1,415 |
| Utilization Count | 346 |
| Total Cost | $489,543 |
| Per Diem/Visit | 19 |

### Mitigating the Downside

- Compare to practice average for financial best practice.
- Analyze episode cost data by joint type.
- Utilize utilization details to optimize costs.
- Consider per diem/visit costs for better financial performance.
## EPISODE OF CARE COST ANALYTICS

### Average EOC Cost Data

*(Clinical Risk Assessment of Patient Population by Surgeon)*

<table>
<thead>
<tr>
<th>Surgeon</th>
<th>Clinical Risk Score (average)</th>
<th>Episode Cost (average)</th>
<th>Clinical Risk Score-Practice (one unit of risk)</th>
<th>Expected Episode Cost</th>
<th>Risk Adjusted Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon1</td>
<td>2.27</td>
<td>$26,679</td>
<td>$8,813</td>
<td>$20,029</td>
<td>$(6,650)</td>
</tr>
<tr>
<td>Surgeon2</td>
<td>1.53</td>
<td>$14,954</td>
<td>$8,813</td>
<td>$13,451</td>
<td>$(1,503)</td>
</tr>
<tr>
<td>Surgeon3</td>
<td>2.00</td>
<td>$17,824</td>
<td>$8,813</td>
<td>$17,625</td>
<td>$(199)</td>
</tr>
<tr>
<td>Surgeon4</td>
<td>2.60</td>
<td>$18,466</td>
<td>$8,813</td>
<td>$22,913</td>
<td>$4,447</td>
</tr>
<tr>
<td>Surgeon5</td>
<td>1.62</td>
<td>$16,278</td>
<td>$8,813</td>
<td>$14,236</td>
<td>$(2,043)</td>
</tr>
<tr>
<td>Surgeon6</td>
<td>2.25</td>
<td>$24,593</td>
<td>$8,813</td>
<td>$19,828</td>
<td>$(4,765)</td>
</tr>
<tr>
<td>Surgeon7</td>
<td>1.86</td>
<td>$14,808</td>
<td>$8,813</td>
<td>$17,185</td>
<td>$1,889</td>
</tr>
<tr>
<td>Surgeon8</td>
<td>1.57</td>
<td>$18,628</td>
<td>$8,813</td>
<td>$13,794</td>
<td>$(4,834)</td>
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<tr>
<td>Surgeon9</td>
<td>3.00</td>
<td>$27,581</td>
<td>$8,813</td>
<td>$25,338</td>
<td>$5,665</td>
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<td>Surgeon10</td>
<td>-</td>
<td>$20,058</td>
<td>$8,813</td>
<td>$18,754</td>
<td>$(825)</td>
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<tr>
<td>Surgeon11</td>
<td>1.95</td>
<td>$20,574</td>
<td>$8,813</td>
<td>$23,016</td>
<td>$2,443</td>
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<tr>
<td>Surgeon12</td>
<td>2.25</td>
<td>$22,456</td>
<td>$8,813</td>
<td>$22,856</td>
<td>$401</td>
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<tr>
<td>Surgeon13</td>
<td>2.00</td>
<td>$23,311</td>
<td>$8,813</td>
<td>$17,625</td>
<td>$(5,686)</td>
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<tr>
<td>Surgeon14</td>
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<td>$24,593</td>
<td>$8,813</td>
<td>$19,828</td>
<td>$(4,765)</td>
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<tr>
<td>Surgeon15</td>
<td>1.86</td>
<td>$24,593</td>
<td>$8,813</td>
<td>$24,247</td>
<td>$(5,493)</td>
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<td>Surgeon16</td>
<td>3.40</td>
<td>$24,907</td>
<td>$8,813</td>
<td>$20,443</td>
<td>$(2,043)</td>
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<tr>
<td>Program Average</td>
<td>2.31</td>
<td>$20,398</td>
<td>$8,813</td>
<td>$20,398</td>
<td>$</td>
</tr>
</tbody>
</table>
### Outlier Cost Analysis

**(Surgeon versus Program Comparison, Jan 2015-Dec 2015)**

<table>
<thead>
<tr>
<th>Surgeon #1</th>
<th>Case Counts</th>
<th>Outlier Cost Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EOC (count)</strong></td>
<td><strong>Cost Outlier (count)</strong></td>
<td><strong>Percentage of Cases Above Outlier Threshold</strong></td>
</tr>
<tr>
<td>141</td>
<td>7</td>
<td>5%</td>
</tr>
<tr>
<td>2409</td>
<td>60</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surgeon #2</th>
<th>Case Counts</th>
<th>Outlier Cost Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EOC (count)</strong></td>
<td><strong>Cost Outlier (count)</strong></td>
<td><strong>Percentage of Cases Above Outlier Threshold</strong></td>
</tr>
<tr>
<td>171</td>
<td>6</td>
<td>4%</td>
</tr>
<tr>
<td>2409</td>
<td>60</td>
<td>2%</td>
</tr>
</tbody>
</table>
MITIGATING THE DOWNSIDE

DISTRIBUTION OF CARE COSTS
Within Surgeon Patient Population (CMS)
Care Coordination

Theresa West, National VP Healthcare Strategy, TavHealth
Ryan VanderWerff, Dir., Ortho Center – Univ. of Utah
CARE COORDINATION

Value Based Patient/Person Engagement

- Social Determinants of Health
- Collaboration
- Care Plan / Care Setting
- Proven Process
- Success Elements
- Monitoring Metrics / Reporting
CARE COORDINATION

Social Determinants Impact Health

Medicare-Medicaid payments tied to alternative payment models

- 20% in 2015
- 30% in 2016
- 50% in 2018

Social and Financial Barriers at Discharge

CHI Franciscan

HHS
CARE COORDINATION

Care Plan vs. Plan Setting

80% IMPACT

80% EFFORT

COMMUNITY

CLINIC

HOSPITAL

TRANSITIONS

HOME
EMR INFO:
Charlene
Weight: 156
A1C: 10.9
BP: 145/90
Chronic Diseases: 4
Hospital Admits in past year: 1
ED Visits in past year: 1
Medications: 3+
LOS: 3.2
Discharged to: Home with Therapy

SOCIAL INFO:
Goes by Michelle
Lives Alone
Limited transportation requires friend or local church to provide
Lives on social security and minimal pension from husband who passed away 5 years ago, cannot afford medications
Has a daughter that lives in Chicago with 3 kids, rarely makes it back to Omaha, but can help make decisions if you can reach her
Struggles to get nutritious food because she can’t drive and make it to the market for fresh food
Attends church weekly and bingo at the hall Wednesdays
Relationship Impact Results
Readmission Rate vs Patient Story
CARE COORDINATION

Proven Process

1. Developing Personal Relationships
2. Identifying & Removing Barriers
3. Creating Meaningful Connections
4. Making Real-time Decisions

Collaboration Platform
CARE COORDINATION

Success Elements

REPORTING & Data Analytics
Real Information in Real-time

COMMUNITY RESOURCES MANAGEMENT
Creating Powerful Care Connections

SCALE INTELLIGENT ENGAGEMENT
Support From Real People

CONNECT
Community Based Collaboration Platform

Empathic STANCE
Find the Person Inside of Every Patient

WORKFLOW & Process Design
Best Practices for Better Outcomes

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**CARE COORDINATION**

**Reports**

**ARE PATIENTS EDUCATED?**

- **72%** had a successful patient education activity prior to surgery.
  - 69% Patient & Coach Attended
  - 18% Patient Attended
  - 6% No Attendance

**Did you know**
According to TAV Researchers, patients who attend class prior to surgery, are 15% less likely to readmit within 90 days.

**MY PATIENTS**

- **87%** patients have at least one family or friend relationship recorded in TAVConnect.
- **55%** patients have barriers solved.

**Did you know**
According to TAV Researchers, when a patient has friends or family at home their recovery speeds up by 4x.
CARE COORDINATION

Reports

Patient Barriers, Care Team Collaboration & Outcomes

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ACADEMIC ORTHOPAEDIC CONSORTIUM
CARE COORDINATION

Collaboration & The Continuum

Fee-for-Service

Value-Based

Community Collaboration Platform

BEFORE ADMIT/EPOISODE
START ADMIT/EPOISODE
END ADMIT/EPOISODE
END BUNDLE
HEALTH

OP Physicians
Transportation
Food Pantry
Financial Support
Area on Aging
Condition-Specific
Resources
Prescription Support
Mental Health
Home Care
Spiritual Support

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Patient Reported Outcomes

Andrew Duncan, ED, Ortho & Rehab at UF Health
Ryan VanderWerff, Director, Ortho Center, University of Utah
Options

• **EPIC**
  – Select surveys by division or provider
    • Patient receives message to complete prior to appointment
    • Patient can complete on an iPad
    • Patient can complete in clinic room

• **Other Programs**
  – We can continue to address through other programs
    • OBERD
    • Orotech
    • Division specific
    • Others
Patient Questionnaires in EPIC

• Gather patient responses electronically
  • Pre- and post-operative questionnaires
  • Pilot will use HOOS and KOOS surveys

• Patient responses can be collected
  • Within MyUFHealth
  • Within EPIC visit
    • Staff assistance
PATIENT REPORTED OUTCOMES

Patient Responses Captured in MyUFHealth

You Might Want To...

- Read your messages. You have 8 new messages.
- View instructions for your appointment on Thursday, September 10, 2015 with Hari Kiran P.
  Please complete any visit questionnaires before you arrive for your appointment.
- View your new MR Liver Mass Evist Icon wo/w results from 8/28/2015.

Appointment Details

General Information
- What: Office Visit with Hari Kiran Pantanowitz, MD
- When: Thursday September 10, 2015 10:00 AM
- Where: UF Health Department of Orthopedics and Rehabilitation (OP Orthopedics)
  9450 Hull Road
  Gainesville, FL 32607
- Phone: 352-273-7001

Confirmation
- Usually, clinic staff will telephone you a few days before your appointment to confirm. If you
choose to confirm online, we will not call.
- Confirm This Appointment

Questionnaires
- Save time at the doctor's office by filling out the following questionnaires:
  - Hip Dysfunction and Osteoarthritis Score
    - Incomplete

Cancellation
- Please be courteous to our staff and to other patients; if you must cancel an appointment, please do so as far in advance as possible.
PATIENT REPORTED OUTCOMES

- Uploaded real time to Epic via data warehouse
- Accessed by the Visit Navigator during patient’s clinic visit

PROs are collected via My Chart or email prior to the patient’s visit. Or upon checking in to their visit (clinic or surgery) via iPad.
PATIENT REPORTED OUTCOMES

Real time results can be uploaded to provider’s progress note.
The Mean Age Adjusted Assessment Percentile can be tracked in any time interval from any range of days pre-surgery to post surgery.

Distribution is shown over time including standard deviations to show the shift over time.

The Mean Age Adjusted Assessment Percentile can be tracked in any time interval from any range of days pre-surgery to post surgery.
- Patients are emailed a PRO annually for 3-5 years following procedure (varies by procedure)
- Clinical coordinators can be emailed a link to the BOE Report that shows patients who have scored above or below a certain thresholds, allowing for better patient care and timely interventions.
The Physical Function mEVAL assessment percentile over the course of care is shown in red on the 2nd y-axis.

The cost of each visit is shown on the y-axis, as well as date of visit and provider who saw the patient.

PATIENT REPORTED OUTCOMES

Ability to Track Individual Patient’s Care
### Ability to Track Individual Patient’s Care

Each visit number is a hyperlink to a report that shows all the detail line item costs allocated for that visit.

Clinical information such as diagnosis or surgical procedure, as well as patient class and some outcomes measures are shown for each visit for the selected patient.
What About the Data?

• Responses from the surveys can be downloaded into Excel
  – Can also be reported to a Registry

• Data summaries
  – General reporting
  – Research analyses
DISCUSSION