All Payer Hospital System Modernization

Physician Alignment and Engagement Workgroup (8:00 – 10:00)

June 4, 2014, 8:00 am to 10:00 am
Health Services Cost Review Commission
Conference Room 100, 4160 Patterson Ave, Baltimore, MD 21215

Meeting Agenda

8:00 Discussion of Report on Physician & Other Provider Alignment Strategies: Recommendations and Wrap-up

8:30 Post-Acute Opportunities Discussion

- Lou Grimmel, CEO, Lorien Health System
- Dr. Scott Rifkin, Founder, Chairman & CEO, Mid-Atlantic Health Care
- Nicole Stallings, AVP, Quality Policy & Advocacy, MHA

9:45 Future Work: Care Coordination, etc.

ALL MEETING MATERIALS ARE AVAILABLE AT THE MARYLAND ALL-PAYER HOSPITAL SYSTEM MODERNIZATION TAB AT HSCRC.MARYLAND.GOV

Maryland All-Payer Model

The Centers for Medicare & Medicaid Services (CMS) and the state of Maryland are partnering to modernize Maryland's unique all-payer rate-setting system for hospital services that will improve patients' health and reduce costs. This initiative will update Maryland's 36-year-old Medicare waiver to allow the state to adopt new policies that reduce per capita hospital expenditures and improve health outcomes as encouraged by the Affordable Care Act.

All Payors Model / Compound Fraction

$$\frac{3x^2}{5} \div \frac{2x}{y} = \frac{3x^2}{5} \cdot \frac{y}{2x} = \frac{3x^{\cancel{2}}}{5} \cdot \frac{y}{2\cancel{x}_{1}} = \frac{3xy}{10}$$

$$\frac{4x-8}{6} \div \frac{x-2}{3} = \frac{4x-8}{6} \cdot \frac{3}{x-2}$$

$$= \frac{4(x-2)}{6} \cdot \frac{3}{(x-2)}$$

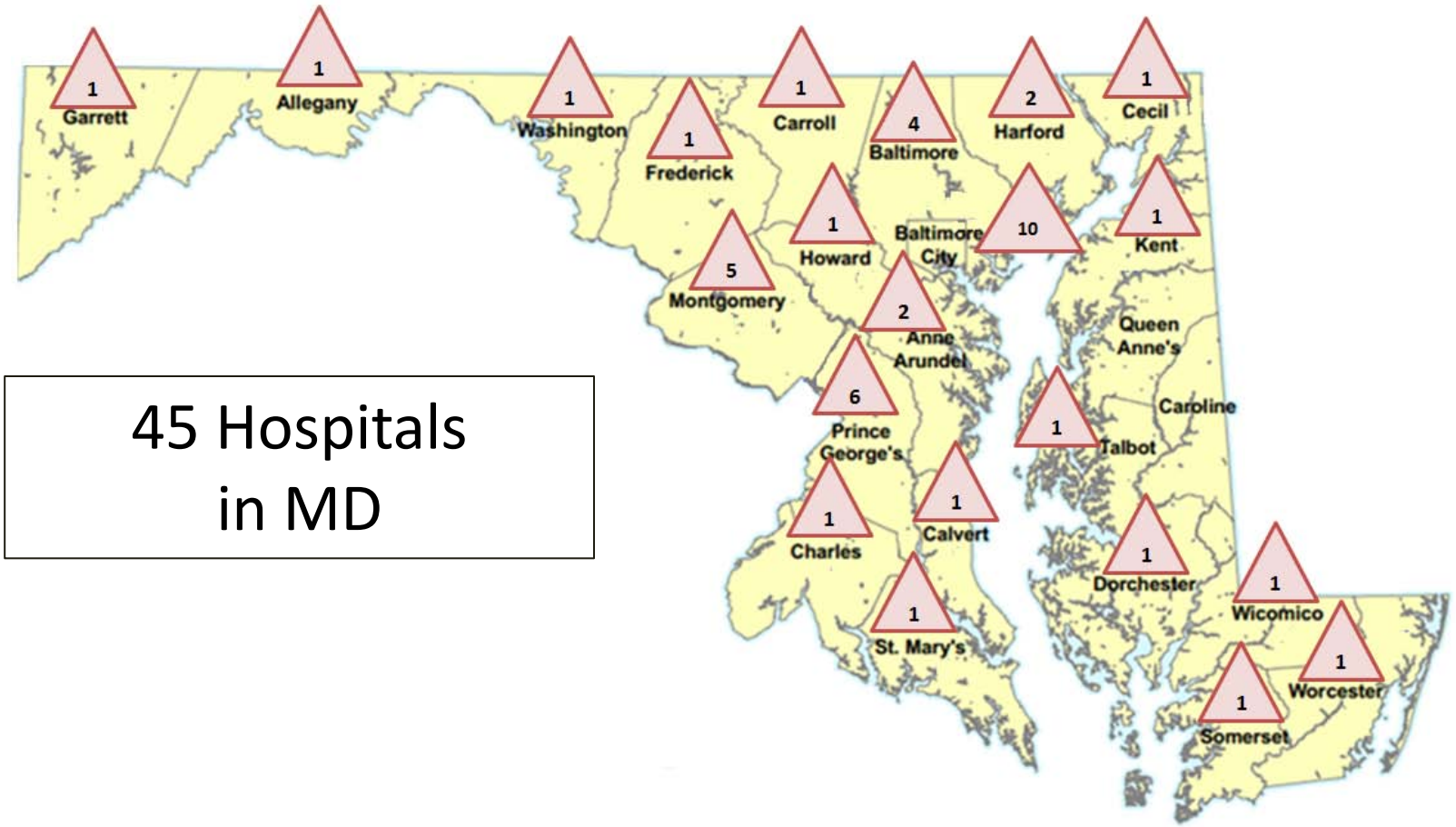
$$= \frac{4\overset{1}{\cancel{(x-2)}}}{\underset{2}{\cancel{6}}} \cdot \frac{\overset{1}{\cancel{3}}}{\underset{1}{\cancel{(x-2)}}}$$

$$= \frac{4}{2} = \text{?}$$

Simplest Form

2

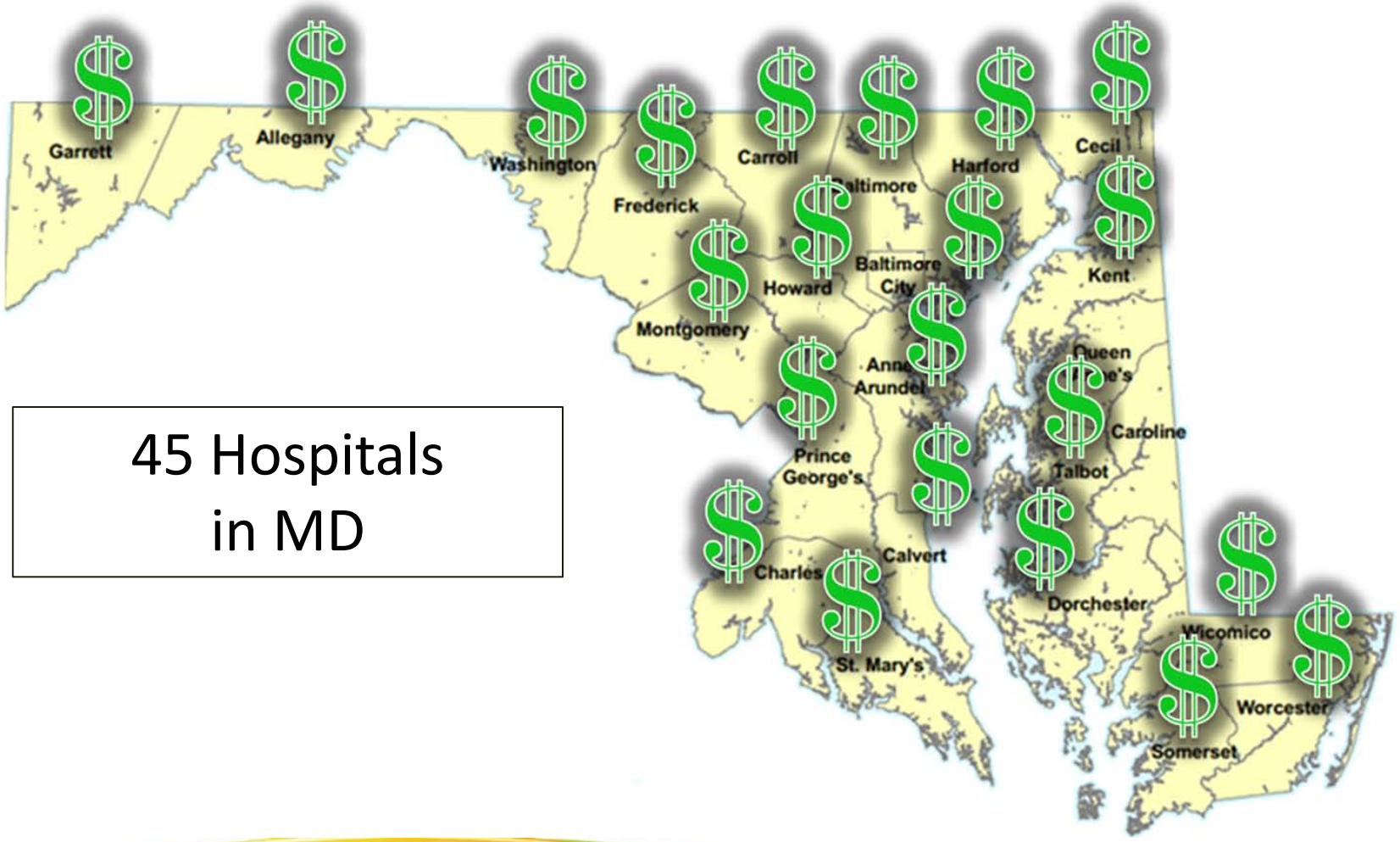
Hospitals in Maryland



45 Hospitals in MD

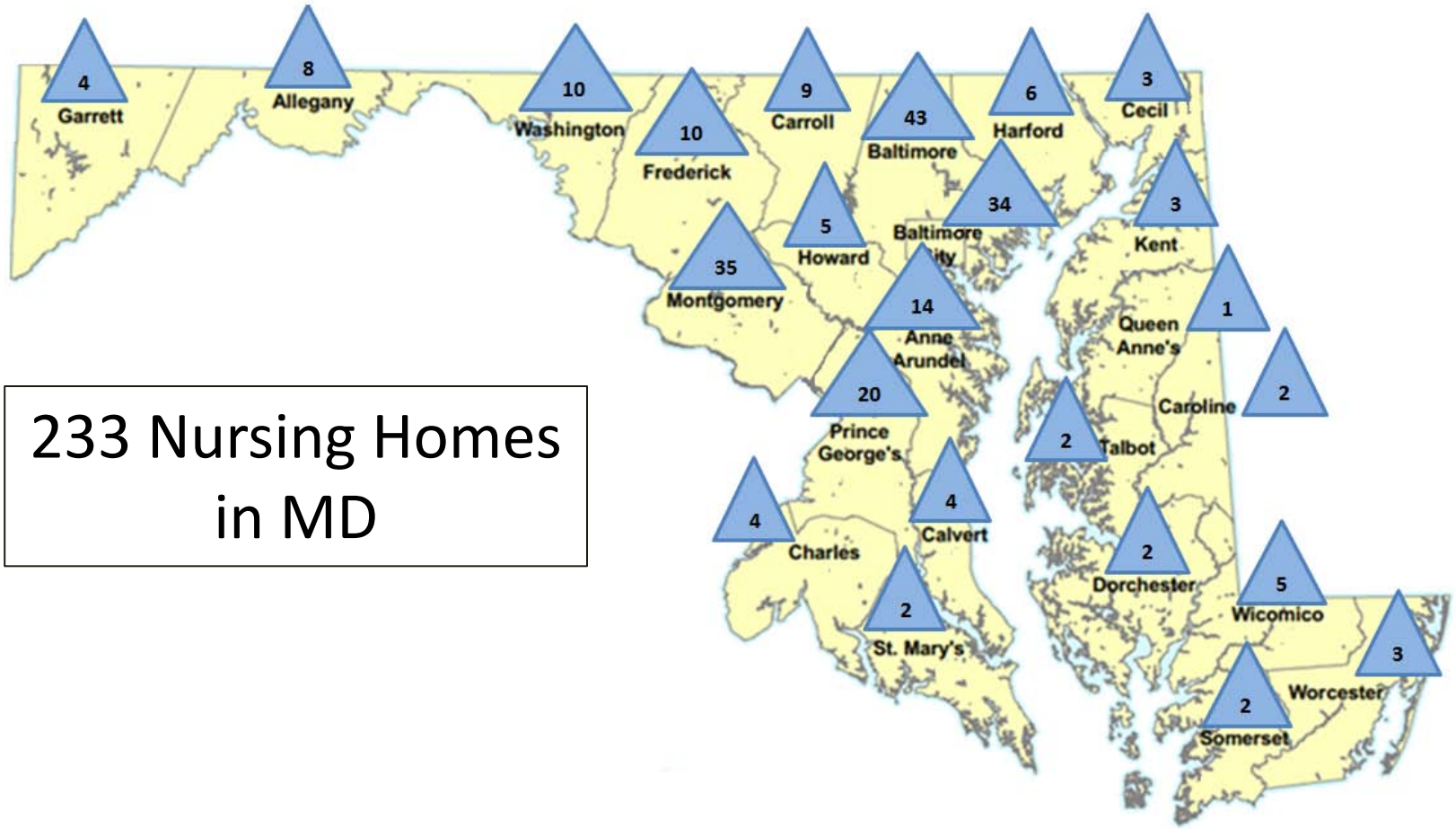
Source: mdh2e.org

Hospitals in Maryland



45 Hospitals
in MD

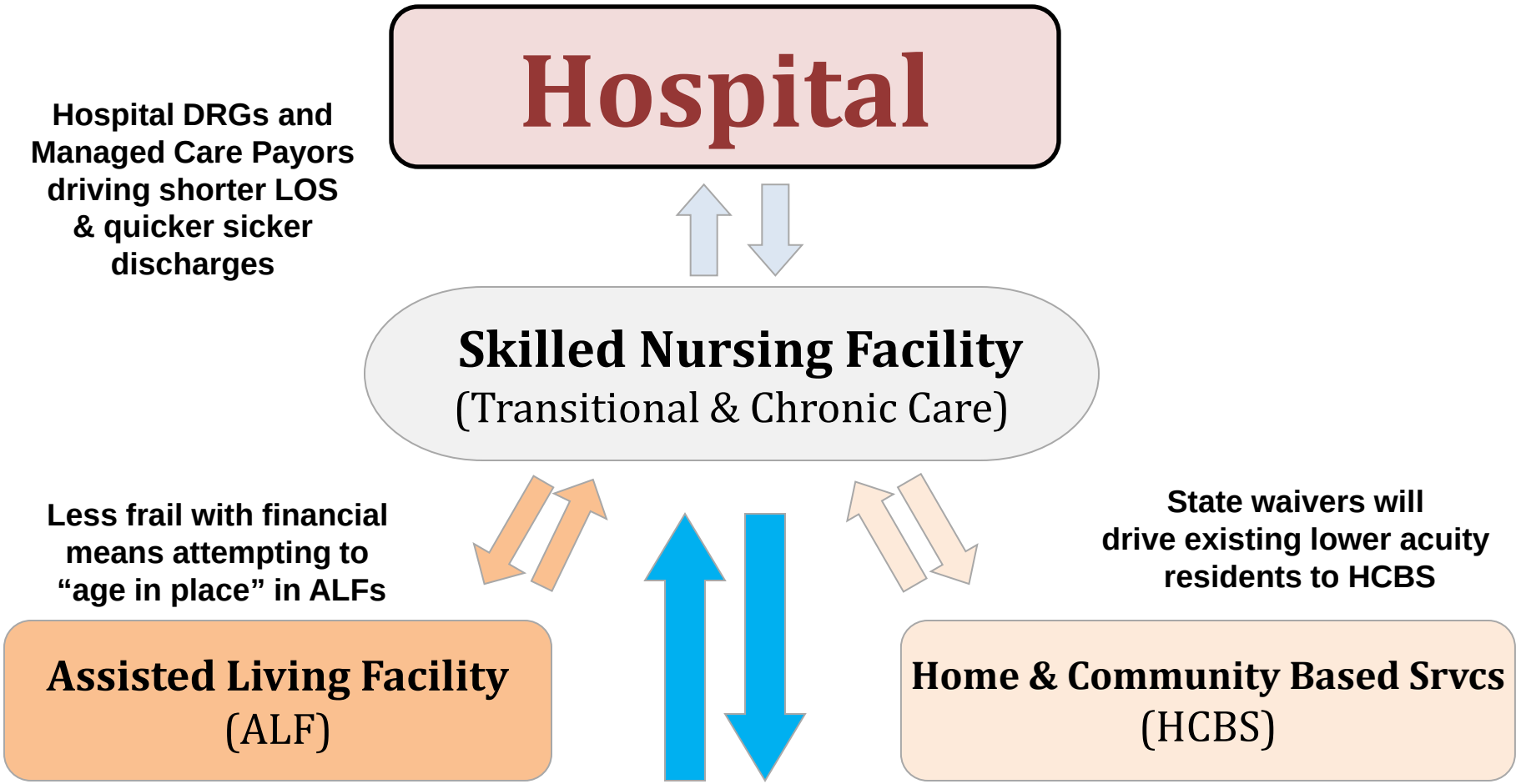
Nursing Homes in Maryland



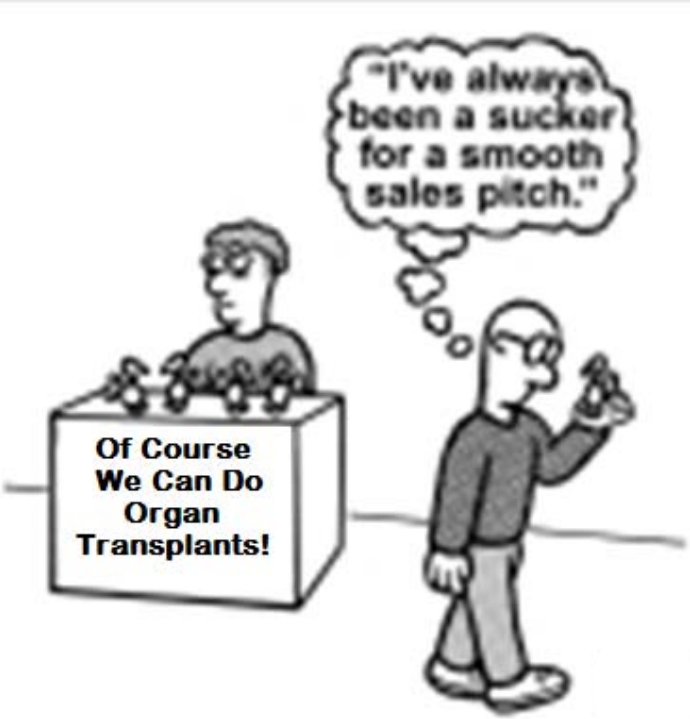
233 Nursing Homes in MD

Skilled Nursing the "BRIDGE" to recovery

Higher acuity requires increasing ***physician involvement***



Current SNF Sales Model



Maryland's All-Payer Hospital System Modernization

Physician Alignment and Engagement Workgroup

In general, this workgroup will make recommendations on how the new hospital payment models should align and engage with physicians and other health care providers in partnership with patients to achieve the goals of the new model. The Workgroup will address topics that include:

1. Alignment with Emerging Physician Models
2. Shared Savings
3. Care Improvement
    a. Care Coordination Opportunities
    b. Post-Acute and Long-Term Care
    c. Evidence-Based Care

HSCRC Workgroups Descriptions

Physician Alignment & Engagement Workgroup Membership

The Health Services Cost Review Commission (HSCRC) has appointed the a diverse group of individuals to serve on the Payment Models Workgroup. The list of workgroup members is available at the following link:

Physician Alignment & Engagement Workgroup Appointments - updated 3-25-2014

Meeting Schedule, Goals, and Documents

The Physician Alignment & Engagement Workgroup schedule is provided in the table below. Additional meetings will be added to the schedule. Please check back for the location and schedule of future meetings. Questions related to the schedule and location of meetings should be directed to: hscrc.alignment@maryland.gov.

Emergency Physician: Job Description and Educational Requirements

The nature of emergency medicine is very unpredictable. Emergency physicians generally have very short-lived relationships with patients and treat conditions that span all areas of medicine.

Emergency Physician Job Description

Emergency physicians often treat patients who have life-threatening conditions. Their primary job functions are to resuscitate or stabilize patients and refer them to the appropriate medical departments. For this reason, emergency physicians often work as part of a team, with physicians of other specialties and other members of the emergency room staff. Emergency physicians must evaluate a wide variety of ailments, sometimes with little to no information. They must be able to think and act quickly to make a tentative diagnosis and determine the appropriate course of treatment.

Emergency Physician Educational Requirements

The first step that all aspiring physicians must complete in order to get into medical school is to take premedical courses during their undergraduate education. Premedical courses include biology, physics, inorganic chemistry and organic chemistry. These courses prepare students for the Medical College Admissions Test (MCAT), which is generally required by all medical schools in the United States. Premedical students should also participate in extracurricular activities, such as volunteering at a hospital or clinic, shadowing a physician and gaining leadership experience. Balancing a challenging schedule can show medical school admissions officers that a student is ready to handle the demands of a career in medicine.

The next step is to graduate from medical school. Medical school generally consists of two years of classroom education in the sciences,

BALTIMORE BUSINESS JOURNAL

WHY HOSPITALS NEED TO RETHINK THE ER

ONE HOSPITAL IS TRYING TO SAVE COSTS BY REVAMPING THE ER EXPERIENCE

BY SARAH GANTZ
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410-454-0514, @BaltBizSarah

It's 11 a.m. on a typical Tuesday and Sinai Hospital of Baltimore's emergency department is over capacity.

Patient beds line the hallways and are tucked in corners by the coffee maker and microwave – anywhere they will fit.

Emergency Medicine Chief Dr. William Jaquis is not sure exactly how many of the 72 people in his 50-bed unit have true emergencies, but he knows it's not all of them.

Jaquis recognizes ER patients, he gets to know them. He knows that if some of them made regular visits to a community doctor for help managing their diabetes, asthma and other chronic health problems, maybe they would not need him.

But after 22 years in the ER, Jaquis knows better than to question why some patients just don't get better.

"I gave up a long time ago trying to say, 'Why are you here?'" Jaquis said. "Because over time I've realized there is nowhere else."

Administrators at Sinai Hospital and parent LifeBridge Health think it's time to start asking

This story is part of an occasional series about how Maryland's new, unprecedented way of regulating hospital revenue will force Baltimore hospitals to confront the city's deep-seated health problems. The project is supported by a fellowship from the Association of Health Care Journalists and the Commonwealth Fund.

hospitals, is launching a new program with HealthCare Access Maryland that will aim to intercept patients who frequent the ER with ailments related to chronic health conditions. The Baltimore nonprofit will try to figure out what prevents these patients from getting the right care and help them overcome those barriers.

for triage, to quickly evaluate patients when they arrive and determine what care they need. It will also be a space to hold patients whose needs are less urgent – the exact patients HealthCare Access Maryland's community health workers will be trying to wean off the ER.

Emergency departments are common targets for hospital improvement projects because they are known for being overcrowded. These departments are getting even more attention as ER admissions continue to grow. Administrators fear that millions more Americans who now qualify for Medicaid under the federal Affordable Care Act could exacerbate the problem. Insurance gives people the ability to see a doctor without having to foot the entire bill, but it does not necessarily mean they can find a doctor or know how to take advantage of their new policy's benefits.

The stakes are especially high in Maryland. The state has long regulated hospital rates and beginning this year has a new five-year agreement with the federal government to radically change the way hospitals get paid.

Hospital budgets are capped and portions of their revenue are tied to their ability to reduce unnecessary hospital admissions and improve quality. Previously hospitals made more money by treating more

Definition of a Hospitalist

What is a hospitalist?

The Society of Hospital Medicine has adopted the following official definition of "hospitalist."

Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to Hospital Medicine.

Source: HospitalMedicine.UCSD.edu

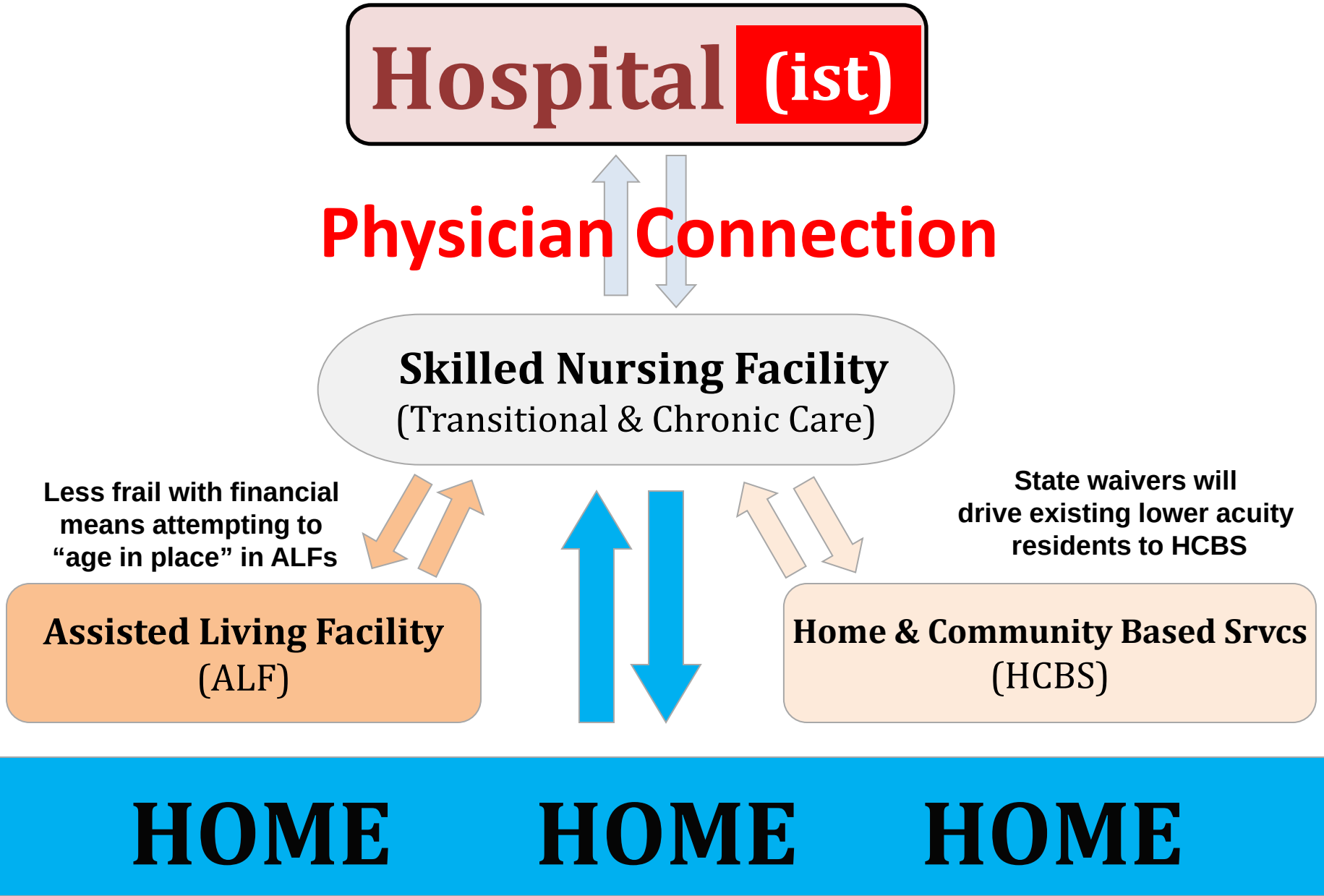
Hospitalist

The term ***hospitalist*** was first coined by Robert Wachter and Lee Goldman in a **1996** *New England Journal of Medicine* article.

The iPhone was first introduced in **2007**.

Skilled Nursing the "BRIDGE" to recovery

Higher acuity requires increasing ***physician involvement***



“Hospitalist” SNF Connect Model

- Coordinating Care for the growing number of patients historically cared for on hospital medical/surgical floors and are now be referred to SNF’s
- Verbal hand-off reporting from Acute Care to SNF to ensure smooth transition.
- Hospitalist daily rounds with case management team
- Twice a week rounds include Rehab., Nursing and Dietician representatives
- Bi- Weekly meetings with acute care Hospitalists group to give a greater understanding of what can be managed in SNF

Opportunities for Hospitalist Involvement in SNF's

1. Medical Director

2. Resident at Risk meeting (weekly) this is when falls, weight loss, decline in conditions, decline in skin integrity and hospitalizations are reviewed.

3. Utilization Review (PPS weekly) this reviews the appropriateness of stay and continuing care and setting discharge dates.

4. Monthly QA/QI (monthly) this is the committee where trends are identified and plans for improvement are developed.

Map of Harford County

- Upper Chesapeake Medical Center
- University of Maryland Harford Memorial Hospital
- Lorien Havre de Grace
- Citizens Care & Rehabilitation
- Forest Hill Health and Rehabilitation
- Lorien Bel Air
- Bel Air Health and Rehabilitation
- Lorien Riverside
- Denotes 5 Mile Radius

Broader Trend?

- **Catholic Health Initiatives-** entering the insurance business with plans developed by its newly acquired Arkansas insurance company.
- **Sutter Health-** expanding existing health plan and seeking a new license to contract directly with employers.
- **North Shore LIJ Health System-** projects their 2014 health plan will encompass 25,000 members.

Source: The Advisory Board Company

Ascension Health

- Largest non-profit health care provider in the country.
- Negotiating acquisition of an insurance company.
- A move of “significant escalation” in hospitals’ shift into the insurance business.

Source: The Advisory Board Company

National Post-Acute Healthcare

Mid-Atlantic Health Care's vision to create an independent strategic network of providers committed to reducing potentially avoidable acute care stays

NPH National Post-Acute Healthcare

- Created as an independent company from Maryland's largest locally owned SNF operator
  - Mid-Atlantic Health Care – 3400 beds, 18 facilities in Maryland, Pennsylvania, and Delaware.
- Scott Rifkin, MD, Board Chair – Managing Member of Mid-Atlantic Health Care
- Rick Grindrod, CEO

NPH National Post-Acute Healthcare

- Managing the participation of 209 SNFs & 12HHA's in 19 States in the CMS Bundled Payment for Care Improvement Initiative.
- Managing MAHCs BPCI program in Pennsylvania – Five facilities went live January 1, 2014.
- Building Post-Acute SNF Networks in PA and Maryland – In contracting but not live.

NPH National Post-Acute Healthcare

- Philadelphia properties have decreased readmissions from 45% to 18%.
- Maryland properties have decreased readmission rates from 24% to 12% or less.
- Live with BPCI in PA.
- Well funded and supported with the infrastructure and financial resources of MAHC.

NPH Proposal Concept

- NPH will work with SNF operators to create a Maryland equivalent of the Bundled Payment program.
  - SNF operators will not be limited to MAHC.
- Each specific arrangement will involve one or more SNFs and one or more hospitals
- Reduce readmissions and reduce potentially avoidable hospitalization
- Contribute to meeting new Medicare Waiver Test

NPH Proposal Specifics

- NPH will create strategic partnerships with SNFs and hospitals to take risk for an episode of care for specified DRGs.
- Initial focus on a subset of DRGs identified as preventable hospital utilization
- Each identified DRGs will be addressed with specific clinical protocols and programs to reduce preventable hospital utilization.
- These programs will include diversion from the hospital to SNFs when medically appropriate.

NPH Proposal Specifics

- Specific Clinical Conditions to be considered:
  - Congestive Heart Failure
  - COPD
  - UTI
  - Pneumonia
  - Others

NPH Proposal Specifics

- The Hospital-SNF partnership will request a waiver from the three-day prior hospital admission rule subject to conditions.
- Involved SNFs will agree to strict QA and Utilization Management.
- Appropriate patients will be diverted from the ER to the SNFs.

Three Day Rule Waiver

- Only for Hospital-SNF partnerships.
- Only with SNF agreeing to UM and QA.
- Only with the hospital agreeing to participate.
- Maintained only with a decrease in total costs, total hospital days, and SNF LOS.
- Maintained only with one-to-one SNF for hospital day substitution.

Risk

- NPH and its partners are willing to take full risk on bundles that are based in the actual experience of that hospital-SNF partnership.
  - Risk on admissions from the SNF
  - Risk on re-admissions from the SNF
  - Risk on hospital costs form the community when a three day waiver is part of the program.

Gainsharing

- Hospital and SNF gainsharing based on the total system cost savings.
- Hospitals will share some negotiated savings with participating SNFs.

Program Success Metrics

- Lower total cost to the system for these patients.
- Lower total hospital days for these patients
- Better than day for day substitution of SNF LOS for hospital LOS.
- SNFs to agree to general utilization management and a reduction in average LOS for their skilled population.
- Quality outcome measures that demonstrate equal or improved quality outcomes

Post-Acute Opportunities

Nicole Stallings
Assistant Vice President
Maryland Hospital Association

Readmission Reduction Playbook

HANDLE TRANSITIONS WITH CARE
Partners Preventing Avoidable Readmissions

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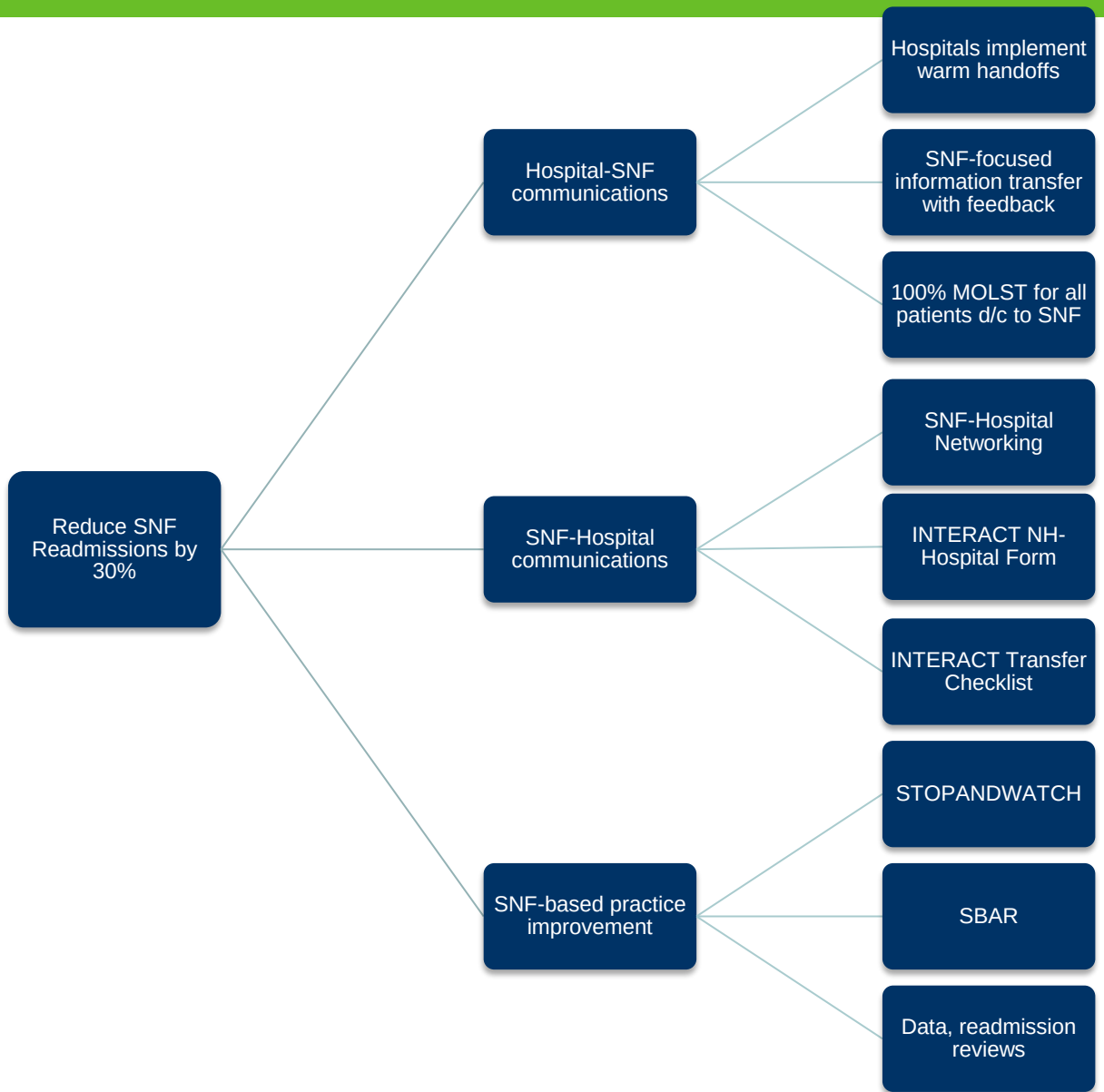
Care Transitions Steering Committee

SNF Driver Diagram



Physician Alignment and Engagement Future Work Plan

June 4, 2014

HSCRC
Health Services Cost Review Commission

HSCRC Model Development and Implementation Timeline

- Hospital global model
- Population-based
- Preparation for Phase 2 focus on total care model and costs

HSCRC Public Engagement
Short Term Process Phases

- Phase 1:
  - Fall 2013: Advisory Council - recommendations on broad principles
  - January 2014- July 2014: Workgroups
    - Four workgroups convened
    - Focused set of tasks needed for initial policy making of Commission
    - Majority of recommendations needed by July 2014
- Phase 2: July 2014 – July 2015
  - Always anticipated longer-term implementation activities
  - July Workgroup reports to address proposed future work plan
  - Advisory Council reconvening

Public Engagement Process Accomplishments

- Engaged broad set of stakeholders in HSCRC policy making and implementation of new model
  - 4 workgroups and 6 subgroups
  - 85 workgroup appointees
  - Consumers, Employers, Providers, Payers, Hospitals
- Established processes for transparency and openness
  - Diverse membership
  - Educational phase of process
  - Call for Technical White Paper Shared Publically
  - Access to information
  - Opportunity for comment

Role of Workgroups

- Purpose of Workgroups is to encourage broad input from informed stakeholders
- Commission decision making is better informed with robust input from stakeholders
- Workgroups identify areas where there is consensus as well as areas where there are differences of opinion
- Non-voting groups

Current Process, Looking Forward

- Aggressive work plans needed to meet deliverable schedule
  - Time and resource intensive for HSCRC and stakeholders
  - Staff driven work plans and leadership needed for tight timelines
  - Coordination among groups sometimes challenging
  - Subgroups effective strategy to address more technical topics and coordination among groups
- Looking ahead to next phase:
  - Less frequent meetings would allow more time for analysis and review between meetings
  - Ad hoc subgroups effective in engaging stakeholders in development of implementation plans
  - Work plan may require different configuration of workgroups
  - Opportunity to engage stakeholders to lead different initiatives
  - More focus on outreach and education about new model

Physician Alignment and Engagement Remaining Tasks

Early Fall Tasks

- Further Develop Maryland specific ACO-like option
- Coordinate with Stakeholder led alignment efforts
- Monitor progress on physician re-contracting from volume to value
- Outreach and Education Plan

Fall/Winter Tasks

- Care Coordination
- Post Acute/LTC Coordination
- Evidence Based Care
- Tort Reform/Cost of Defensive Medicine

Next Steps

- Finalize Reports for July
- Staff planning and analysis
- Fall – Take up remaining tasks