

# a community model case study

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# agenda

- background
- current challenges in delivery system
- structure
- strategies and Initiatives
- case study: integrated discharge planning
- questions

# challenges in delivery system

## delivery system works in silos

- current delivery system creates health plan, hospital and medical group silos that do not work together to control cost and offer optimal patient care



## provider reimbursement

- fee for service provider reimbursement rewards more utilization and provides limited or no recognition for quality or efficiency



## sustainable approach for reducing costs & improving care

- provider costs are increasing and reducing the unit cost is not a long term sustainable approach for reducing costs and improving care



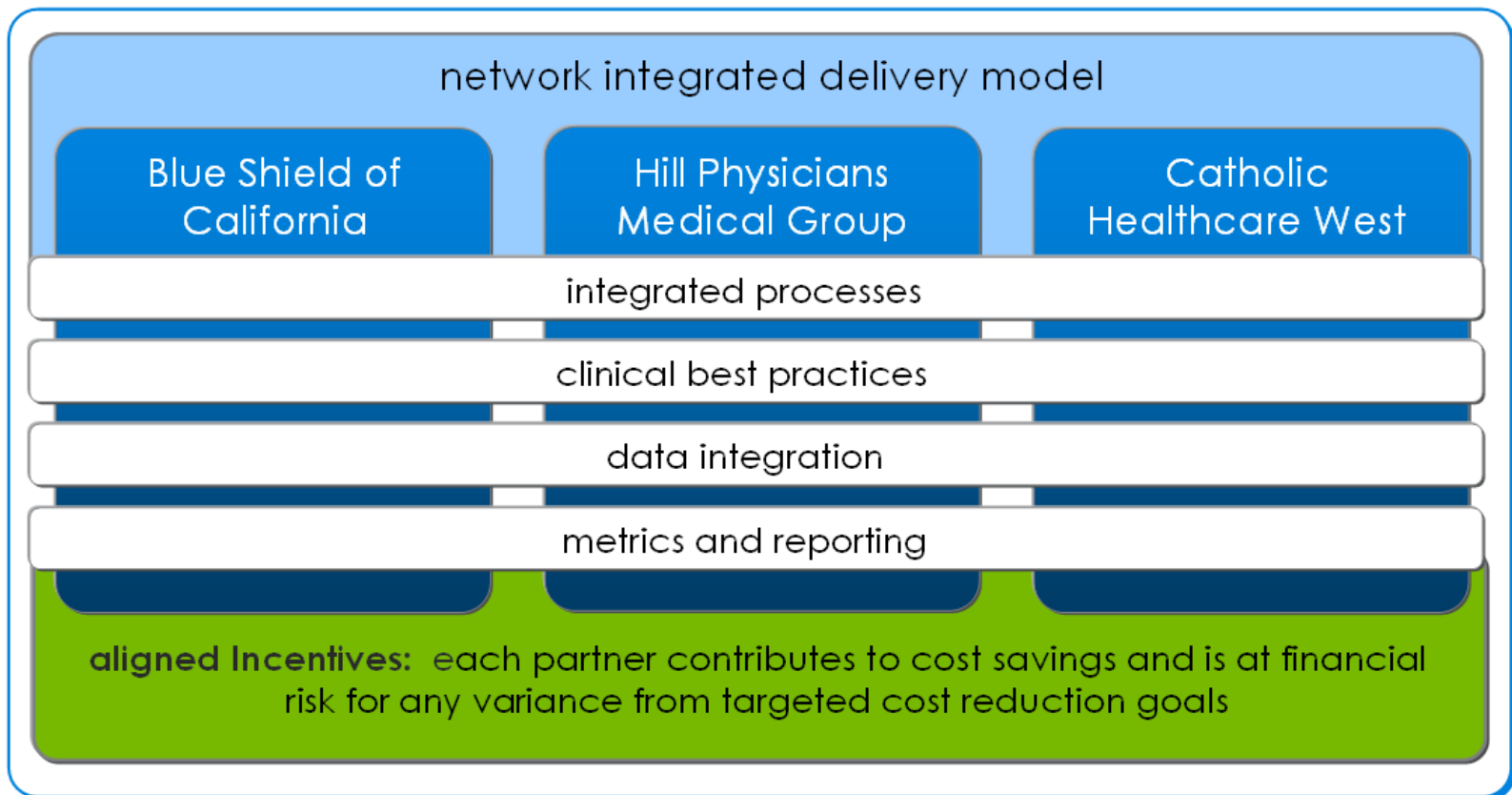
## incentives do not promote long-term, system wide approach

- current health plan and employer incentives generally impact one component of healthcare delivery and do not reinforce a long-term, system wide approach
  - benefit changes impact member cost and behavior, but do not address the lack of efficiency between providers and the health plan
  - health plan incentives do not generally benefit hospitals for being more efficient
  - disease management and wellness programs are not well integrated into the delivery system



# collaboration is required to...

- develop an integrated delivery model
- provide coordinated care
- improve quality outcomes
- drive out cost

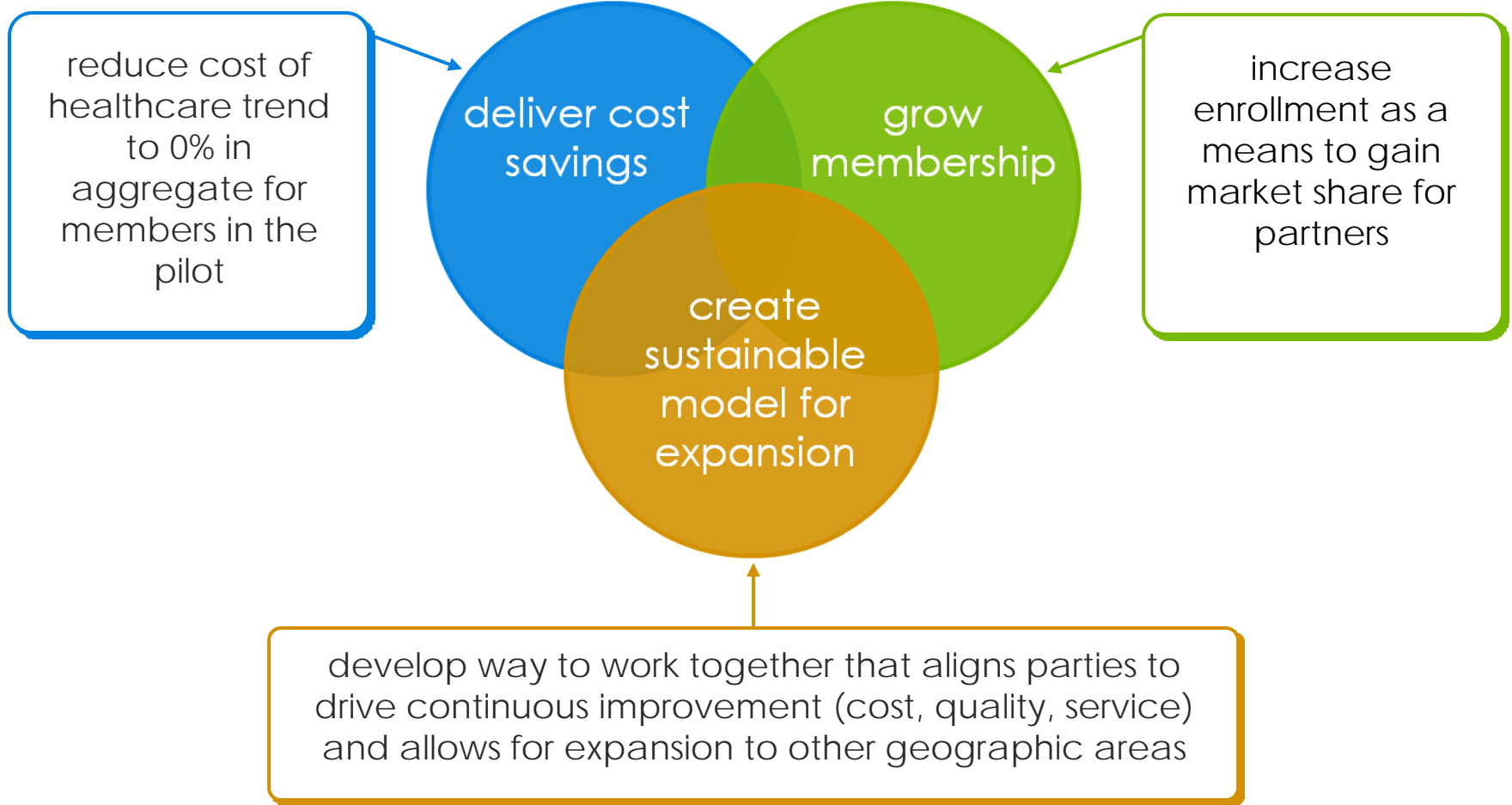


# our guiding principles

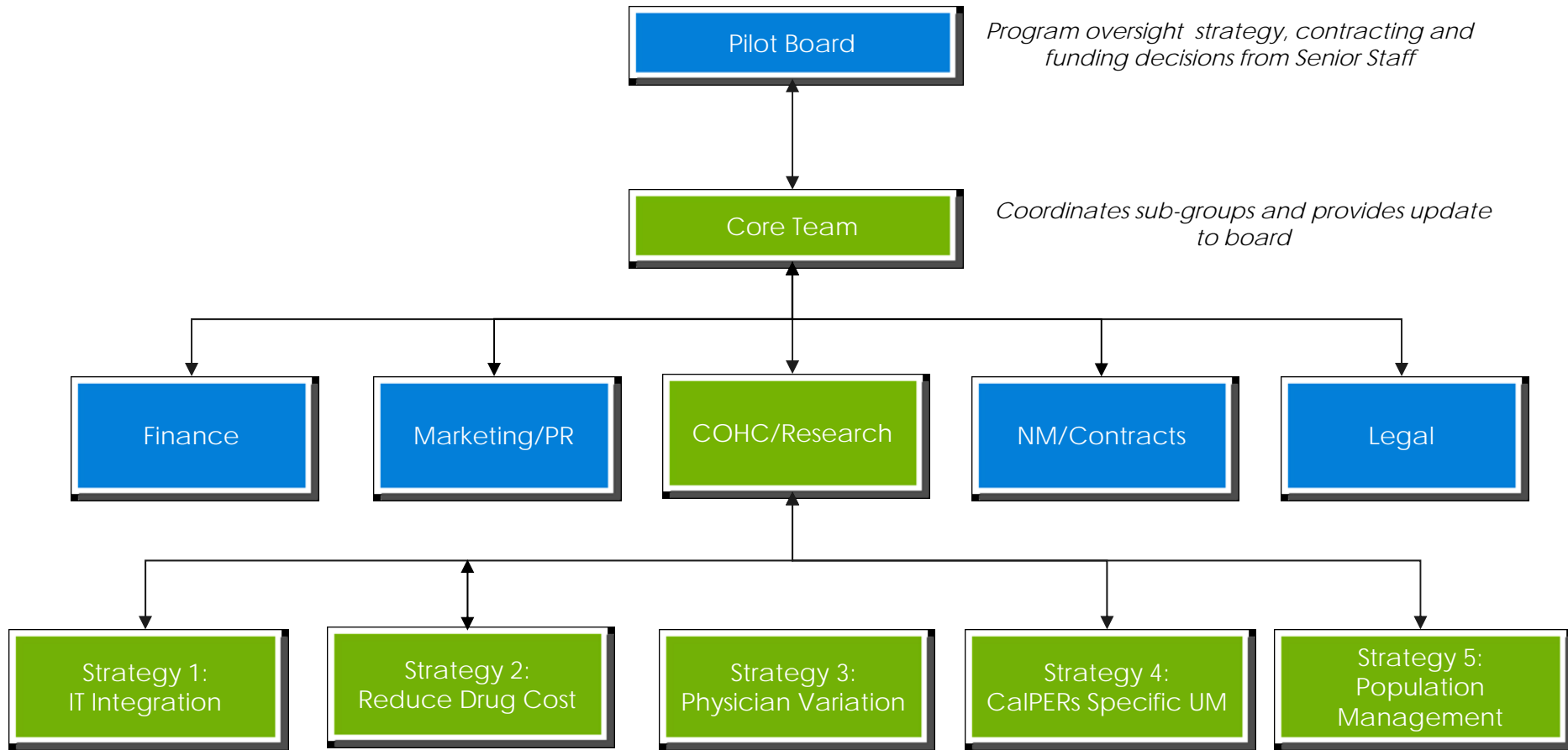
- 1 Reward the customer
- 2 Keep it simple
- 3 Be transparent
- 4 Focus on the target
- 5 **Be bold**



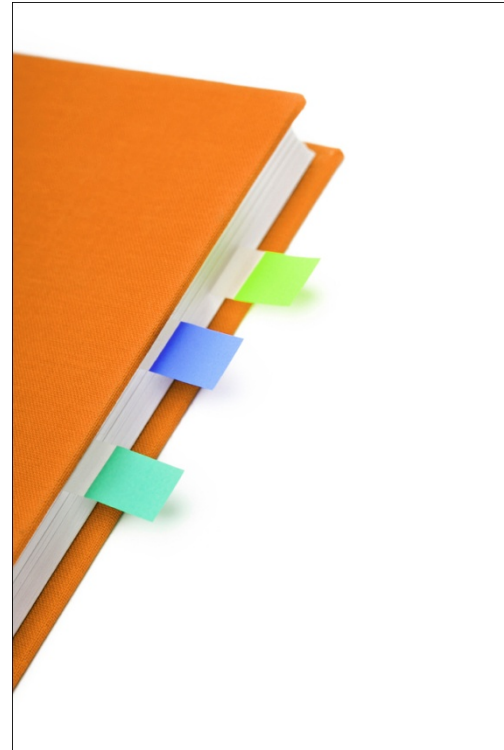
# result-oriented goals



# team approach



# strategies and initiatives



# strategies and outcomes: summary

strategy	outcomes
<b>integrate IT</b>	<ul style="list-style-type: none"> <li>• enable a strong technological framework to automate processes</li> </ul>
<b>reduce drug costs</b>	<ul style="list-style-type: none"> <li>• reduce drug costs</li> </ul>
<b>reduce physician variation</b>	<ul style="list-style-type: none"> <li>• narrow practice patterns</li> <li>• address inappropriate and over or under utilization of key services</li> <li>• reduce unnecessary length of stay, admissions and readmissions</li> </ul>
<b>implement CalPERS-specific utilization management</b>	<ul style="list-style-type: none"> <li>• reduce length of stay, admissions, readmissions, out-of-network spend</li> </ul>
<b>implement population management</b>	<ul style="list-style-type: none"> <li>• get more CalPERS members actively managed in a disease management / care management program</li> <li>• improve coordination and hand-off between programs</li> <li>• reduce the number of members “falling through the cracks”</li> </ul>

# strategy one: IT integration

## initiatives

<i>Physician Technology Acceptance</i>	<ul style="list-style-type: none"><li>• Increase the adoption and use of existing technologies (Relay Health, NextGen, Mobile MD, etc.) to facilitate the rapid and efficient communication of patient medical information to care providers</li><li>• Interconnect cross-organization technologies to streamline processes and support consistent communication</li></ul>
<i>CCD to Mobile MD</i>	Allow selected physicians to 'push' the ambulatory continuity of care (CCD) from the Hill Electronic Health Record (EHR) to CHW hospitalists upon scheduling of patient admissions
<i>Mercy Health Information Exchange (MHIE)</i>	Build a tool on the Mobile MD platform for the sharing of clinical information such as the clinical summary, patient summary and lab/radiology results

## expected outcomes and status

- strong technological framework to automate processes

# strategy two: reduce drug costs

## initiatives

<b><i>Oncology Co-Hort Case Rate</i></b>	Provide support to physician offices for the implementation of processes/workflows that support oncology case rate methodologies to reduce injectable medication costs
<b><i>Generic Drug Interventions</i></b>	<ul style="list-style-type: none"><li>• Increase use of generic medications through evaluation of PCP and specialist prescribing patterns</li><li>• Expanded BSC's Generic Smart program to drive generic utilization</li><li>• Identify brand users and perform pharmacist member outreach to promote conversion to generic</li></ul>
<b><i>Injectable Cost Management</i></b>	Affiliate Hill with CHW's drug purchasing program to reduce costs of injectable drug costs

## expected outcomes and status

- reduce drug cost

# strategy three: physician variation

## initiatives

<b><i>ER utilization strategy and management</i></b>	Reduce ER costs and utilization by shifting non-emergent ER visits to an urgent care clinic (UCC) setting or the primary care provider (PCP) office for improved patient management
<b><i>Outpatient surgery</i></b>	Optimize outpatient surgery utilization and reimbursement to lower cost alternatives; shift ASC from non-CHW facilities to CHW facilities
<b><i>Program development</i></b>	Developed end to end programs to include preauthorization, clinical pathways, care planning and adherence; educate and monitor physicians on outlier behavior based on accepted protocols with possibility for provider stratification <ul style="list-style-type: none"><li>• Knee and hips</li><li>• Bariatric</li><li>• Ob/gyn</li></ul>

## expected outcomes and status

- narrow practice patterns
- address inappropriate and over or under utilization of key services
- reduce unnecessary LOS, admissions and readmissions

# strategy four: CalPERS specific um

## initiatives

<i>Pre-surgical checklist</i>	Developed pre-surgical checklists to use as part of patient calls performed for certain procedures including: knee/hip replacement, hysterectomy, and spinal surgery
<i>Variant days</i>	Built a process to identify, review and correct the root causes that lead to variant days (i.e., delay in service) to determine opportunities to modify the process or change behaviors for physicians, hospitals and/or support teams
<i>Readmissions Review</i>	Built a process to identify, review and correct the root causes for high-risk patients with 3+ readmissions
<i>Discharge planning</i>	Implemented coordinated pre- and post- discharge planning process to avoid discharge delays and readmissions
<i>Enhance prior authorization</i>	Defined and implemented enhanced evidence based guidelines for surgeries targeting high volume, high cost MS-DRG's. Identify by procedure the use of ineffective and marginal procedures (e.g. Spinal Fusion, Carotid Endarterectomy) and proactively monitor for avoidance
<i>Medical access planning</i>	Ensure CalPERS patients receive medical treatment and CHW hospitals, when possible, through the process of pre-patriation and/or repatriation

## expected outcomes and status

- reduction in LOS, admissions, readmissions OON spend

# strategy five: population management

## initiatives

<b><i>Chronic and Complex Care Mgmt</i></b>	Actively manage high risk patients and high costs through synchronized stratification, innovation, outreach and coordinated processes
<b><i>Palliative Care</i></b>	Developing a comprehensive palliative care program across hospital, physicians and care managers to proactively engage members and their families in end of life decisions
<b><i>Professional Home Visits</i></b>	Implementing home based medical care to high risk home-bound commercial and frail elderly patients which will enhance quality of life for the patients
<b><i>PT Centers of Excellence</i></b>	Identify PT Centers of Excellence partners to provide services to chronic pain patients so that patients will learn new behaviors and explore their underlying issues related to pain
<b><i>Patient Education</i></b>	Created back pain management website to support case managers and providers as well as for use by self-referral among patients receiving outreach materials
<b><i>Lose to Win</i></b>	Pilot a 12 week 'Lose to Win' program geared towards helping participants lose weight and promoting a safe transition to a healthier lifestyle

## expected outcomes and status

- more CalPERs members actively managed in a dm/cm program
- better coordination and hand-off between programs
- fewer members “falling through the cracks”

case study:  
integrated  
discharge  
planning



# CHW/Hill physicians/CalPERS ACO pilot: sample of key 2010 accomplishments

## **implemented industry best practice for:**

- discharge planning process including hospital teach back
- follow-up visit within 8-10 days, including measure adherence
- sharing of discharge plan with PCP and care managers within 24 hours

## **expanded Health Information Exchange (HIE) including:**

- hospital discharge summary and patient discharge summary to IPA Electronic Medical Record (EMR) and/or physician portal
- IPA continuity of care (CCD message) data into the hospital EMR
- re-admission discharge plan into hospital portal
- automation of ER 'time of day' report to expedite member outreach following ER encounters

# integrated discharge planning process

- a problem-oriented post-discharge needs assessment and summary of the key medical issues
- analysis of the clinical course and major events of the hospitalization
- integration of labs into confirming diagnoses
- identification of principal and relevant secondary discharge clinical diagnoses
- review of medication errors and interactions
- safety and studies
- ensuring follow-up appointments are scheduled within appropriate timelines
- redesign of the patient education process to improve patient and family/caregiver understanding of discharge plan and self-care
- provide patient a written discharge plan in lay terminology and forward to medical group



# primary cross-organizational stakeholders needed for integrated discharge

## hospital

- case manager communicates prospective discharge date and patient needs upon discharge
- clinical nurse performs medication reconciliation and patient/caregiver education
- discharge planner initiates discharge planning on day one or 48 hours after admission and coordinates services to meet patient needs upon discharge
- concurrent care review nurse communicates discharge summary to PCP
- director of case management educates case/clinical managers on new discharge planning tools/processes; educates physicians/hospitalists on new discharge planning processes/UM best practices; establishes toolkit for patient education
- analyst creates and run reports
- project resource manages implementation plan based on defined scope/timeline; serves as point of contact to Blue Shield program managers to provide project updates/issue escalation

## medical group

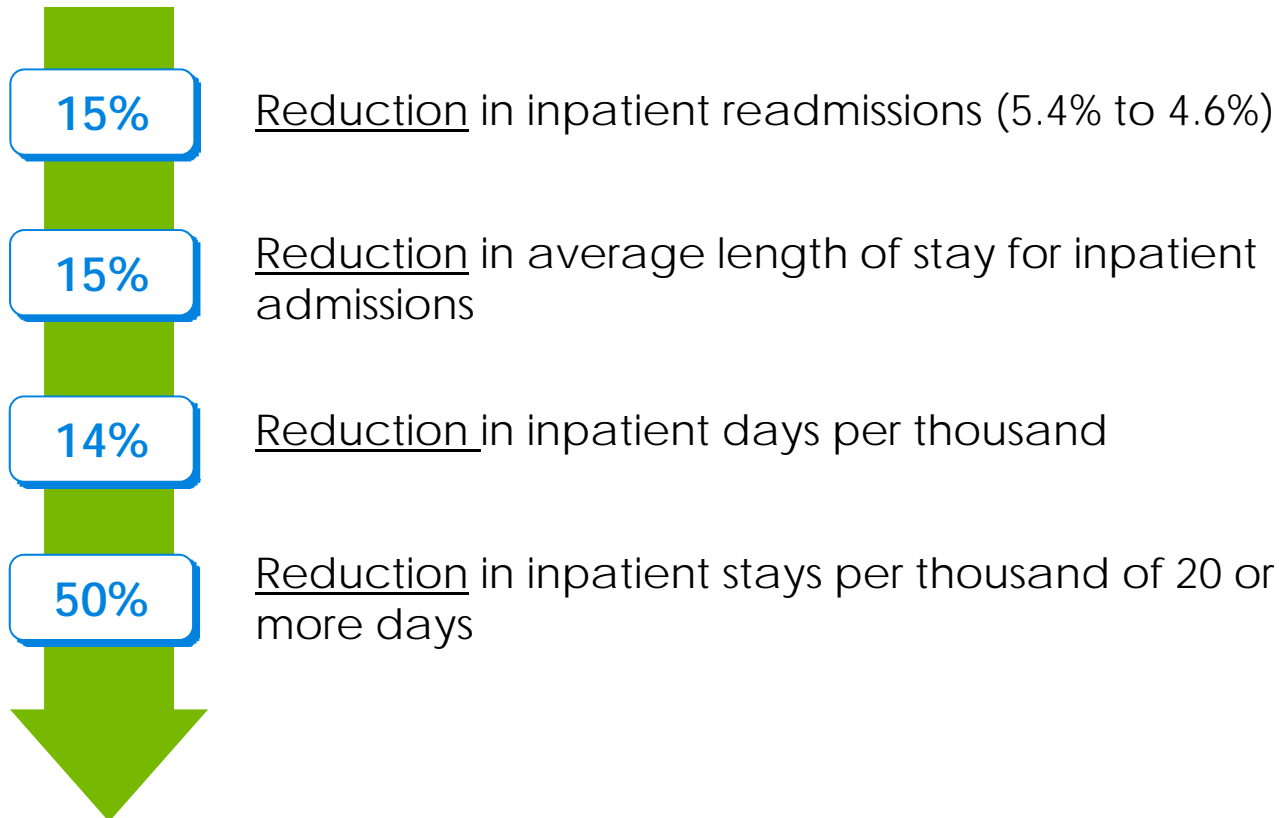
- attending physicians discharge in a timely manner
- staff schedule patient appointment with PCP
- director of case management serves as project driver

## Blue Shield

- program manager engages stakeholders to define scope and implementation plan; provides ongoing project monitoring

# 2010 results exceeded targets

Exceeded 2010 target of **\$15.5M** healthcare cost savings for the 42,000 member pilot population



# lessons learned

- automatically schedule the PCP follow-up appointment for two weeks from the admit day
- if multiple facilities are involved, identify a point person at each facility and a designated manager over all the facilities who can handle exceptions for individual facilities
- implement changes in small increments as soon as they are ready
- agree on best-in-class discharge practices early in the project



# ACO expansion

- Blue Shield is committed to expanding the ACO framework that we have developed in Sacramento across the state
- 4 active programs were added as of mid 2011

## San Francisco

- **collaboration between**
  - Blue Shield
  - CPMC/Brown & Toland
  - CHW/UCSF/Hill Physician
- **savings:** 0% premium increase for 26,000 San Francisco Health Service System members

## Stanislaus

- **collaboration between**
  - Blue Shield
  - AllCare
  - Doctors Med Center
- **savings:** no increase in healthcare costs for ACO members in 2012 and low single digit increases in 2013 & 2014

## Orange

- **collaboration between**
  - Blue Shield
  - St Joseph Hospital & IPA/MG
- **savings:** no increase in healthcare costs for 2012

questions?

