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Transitions in Care & the Bundled Payment Population

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FACULTY

Toni G. Cesta, Ph.D., RN, FAAN is a founding partner of Case Management Concepts, LLC, a consulting company that assists institutions in designing, implementing and evaluating case management models, new documentation systems, and other strategies for improving care and reducing cost. Dr. Cesta is the author of eight books, a frequently sought-after speaker, lecturer and consultant and is considered one of the primary thought leaders in the field of case management. Dr. Cesta also writes a monthly column called "Case Management Insider" in AHC Media's Hospital Case Management newsletter in which she shares insights and information on current issues and trends in case management.

Dr. Cesta has been active in the research and development of case management for over 20 years. Her research in case management has included two funded studies measuring the effects of a case management model on congestive heart failure and fractured hip patient populations, with measures of patient satisfaction, quality of life, and short and long term clinical perceptions and outcomes.

Dr. Cesta has presented topics on case management at national and international conferences and workshops. She has published extensively including the fourth edition of her book, "Nursing Case Management: From Essentials to Advanced Practice Applications," the second edition of "The Case Manager's Survival Guide: Winning Strategies for Clinical Practice" which won the AJN Book of the Year award, "Survival Strategies for Nurses in Managed Care" and her newest book: "Core Skills for Hospital Case Managers".

Bev Cunningham, RN, MS is a founding partner of Case Management Concepts, LLC. She has a 25-year deep working knowledge of case management with specific expertise in denials management, patient flow and the role of the Case Manager and Social Worker in the Case Management process. She has served as a Commissioner on the Commission for Case Management Certification and is a fellow with the Advisory Board.

Bev is also former Vice President Resource Management at Medical City Dallas Hospital where she had responsibility for Case Management, Health Information Management, Patient Access, Physician Integration and Solid Organ Transplant. Prior to her position as Vice President, Bev served as Regional Director of Clinical Effectiveness for Mercy Health Partners, Toledo, Ohio. In this role she directed the Case Management, Quality Management, and Pre-Authorization Departments. She also served eight years as a consultant, assisting hospitals in implementing, evaluating and improving their case management programs. As a Clinical Assistant Professor for the Master of Nursing Program at the University of Oklahoma, she coached students in their clinical practicums. Bev continues to mentor students in a Master's of Healthcare Administration program.

Bev is a well-known speaker in the Case Management field. Her publications include a chapter CMSA's Core Curriculum for Case Management Certification and most recently, co-author of the book, Core Skills for Hospital Case Management. Bev has a BSN from Pittsburg State University, Pittsburg, Kansas and a Master of Science, Nursing Major, from the University of Oklahoma.

OBJECTIVES

- Identify outcome measures affected by case managers in internal and external transitions.
- Explain the bundled payment model initiatives.
- Explain new and revised case management standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate case management protocols and penalties.

BUNDLED PAYMENTS: HISTORY

- 1983 DRGs: 1st start of bundled payment
- 1991 bundled payment demonstration for CABG
- 2013 bundled payment care improvement initiative (BPCI)
- 2015 voluntary oncology care model
- 2010 Patient Protection and Affordable Care Act announced mandatory bundled payments by January 1, 2016

SHIFTING GREATER FINANCIAL RISK TO PROVIDERS IS CORE ELEMENT OF PAYMENT AND DELIVERY INNOVATIONS, SUCH AS BUNDLED PAYMENT INITIATIVE

- Risk shifting from payer to providers in an effort to improve quality of care and decrease healthcare spending
- Attempt to move away from FFS to paying for "value over volume"—value-based reimbursement
- Transitioning from low-risk to higher-risk patient population

VBP: Value-based payment
FFS: Fee-for-service

VALUE-BASED CARE SYSTEMS HAVE DIRECT IMPLICATIONS ON PROVIDERS

Fewer FFS Patients

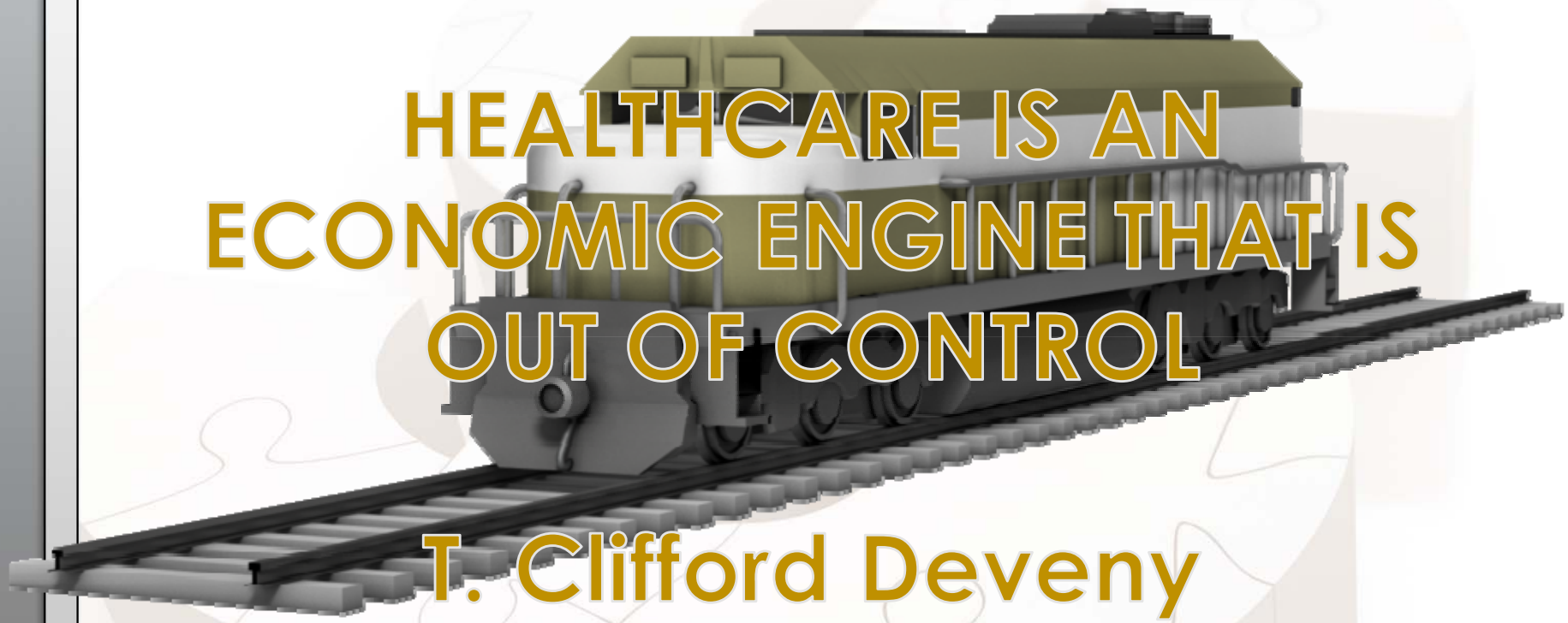
Shorter LOS for every level of care

Fewer Readmissions

Less Use of Costly Settings

HIGHER EXPECTATIONS FOR QUALITY, VALUE AND SERVICE DELIVERY FROM PAYERS, PROVIDERS AND PATIENTS

INCREASED NEED FOR CARE COORDINATION AND TRANSITIONAL PLANNING



HEALTHCARE IS AN ECONOMIC ENGINE THAT IS OUT OF CONTROL

T. Clifford Deveny

PURPOSE OF BUNDLED PAYMENT INITIATIVE

- Develop model of pay for quality, rather than pay for quantity
- Impact spend for high-cost patients
- Impact quality of high-need, high-cost patients
- Shift value-based care of high-cost patients from CMS to hospitals
- Transition financial accountability of Medicare patients' post-acute care to hospitals

HOW SHOULD WE PREPARE?

Know and track key financial and clinical performance data points

Continuous learning processes and accountability at all staff levels

Partnerships with other providers – clinical and non-clinical

Patient / caregiver engagement strategy

"We are so excited that thousands of providers in the Bundled Payments for Care Improvement Initiative have joined us in changing the healthcare system to pay for quality over quantity—spending our dollars more wisely and improving care for Medicare beneficiaries. By focusing on outcomes for an episode of care, rather than separate procedures in care delivery, we are incentivizing hospitals, physicians and other providers to work together to provided high quality, coordinated care for patients"

Patrick Conway, MD, acting principal deputy administrator and CMO at CMS

CMS HAS PLEDGED TO SHIFT 50% OF MEDICARE PAYMENTS TO ALTERNATIVE FORMS, LIKE ACOS AND BUNDLED PAYMENTS BY 2018

More than 1500 facilities nationwide are currently involved in bundled payment models

BUNDLED PAYMENTS FOR CARE IMPROVEMENT INITIATIVE (BPCI): A DEMONSTRATION

- Goal: higher quality, more coordinated care at a lower cost to Medicare
- Financial and performance accountability for episodes of care: link payments for multiple services during an episode of care into a bundled payments
- Voluntary
- Risk-bearing

- http://innovation.cms.gov/initiatives/bundled-payments/index.html

4 BPCI MODELS INCLUDE PARTS A AND B

- Model 1: Retrospective acute care hospital stay only (discontinued 3/2016)
- Model 2: Retrospective acute care hospital stay plus post-acute care
- Model 3: Retrospective post-acute care only
- Model 4: Acute care hospital stay plus cost of readmission (very few hospitals participating)

THE IMPACT OF BUNDLED PAYMENTS

No More Blank Checks!

2016--MANDATORY BUNDLED PAYMENT INITIATIVE FOR TOTAL JOINTS (FROM PPACA IN 2010)

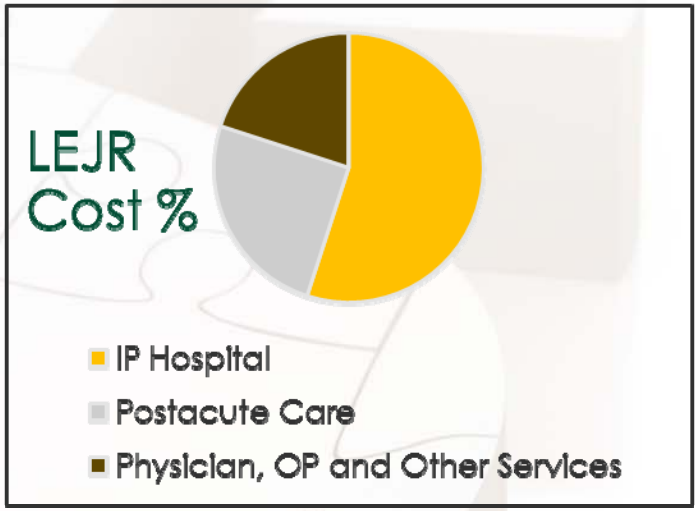
- 67 metropolitan service areas (MSAs)
- Includes most hospitals in those areas (approximately 800 hospitals)
- Hospitals excluded
  - Non-IPPS Hospitals (Critical Access and Maryland hospitals)
  - Actively participating BPCI hospitals
- Excluded MSA's
  - Low volumes
  - Large BPCI areas

MANDATORY BUNDLED PAYMENT ELEMENTS

- Traditional Medicare patients only
- Enrolled in both Part A and Part B Medicare
- Medicare as primary payer
- Episode begins with admission to hospital for surgery and ends 90 days later
- Excluded
  - Medicare on basis of ESRD
  - Medicare Advantage plan
  - Medicare secondary

WHY TOTAL JOINTS (CCJR)?

- Most of cost occurs in hospital episode
- Procedure easy to define
- Relatively routine and predictable
- Clear beginning, middle and end points
- Services much better documented with National Coverage Determination



NATIONAL COVERAGE DETERMINATION FOR TOTAL HIP AND KNEE PROCEDURE MEDICAL NECESSITY CONTINUES

- Medical record must specifically document complete description of patients' historical and clinical findings
  - From physician office records
    - History
    - Physical exam
    - X-ray results
    - Reason for deviating from outpatient care
- Hospital medical record
  - Records from office must be in hospital medical record
  - Operative report
  - Postoperative progress
  - Discharge plan and orders

SERVICES INCLUDED IN CCJR EPISODE

- Inpatient
- Outpatient
- Readmission
- Physician
- Inpatient Skilled Nursing Facility
- Home Health

SERVICES EXCLUDED FROM CCJR EPISODE

- Unrelated services
- Unrelated hospital admissions, as identified by MS-DRG
- Drugs paid outside MS-DRG (such as hemophilia clotting factors)
- IPPS new-technology payments

BUNDLED PAYMENT: PAYMENT PLAN TIMEFRAME

- 5 year testing: January 1, 2016 through December 31, 2020
- MS-DRGs 469 and 470
- Episode: Admission and any related care for 90 days

PAYMENTS ARE RETROSPECTIVE EACH YEAR

- Based on claims submitted by March 1, following the end of a performance year
- Retrospective calculation of hospital's actual performance compared to target price=raw Net Payment Reconciliation Amount (NPRA)
- Stop-loss and stop-gain limits, as applicable
- NPRA or penalty in Q2 following each performance year

CALCULATION OF TARGET PRICE

- 3 years historical Medicare payment data grouped in to episodes of care
- Historical date updated every other performance year

HISTORIC DATA TIME FRAME	PERFORMANCE YEARS
1/1/12-12/31/14	Years 1 and 2 (2016 and 2017)
1/1/14-12/31/16	Years 3 and 4 (2018 and 2019)
1/1/16-12/31/18	Year 5 (2020)

"ANCHORING HOSPITALIZATION"

- Hospitalization that triggers procedure
- Known as index hospitalization for readmission programs
- Charges for 3 days prior to hospitalization still included in DRG and in charges
  - Charges attributed to hospital only for service by the hospital or an entity wholly owned and operated by the hospital where anchoring hospitalization occurs

5 STAR SKILLED NURSING FACILIITY RATING SYSTEM

- Nursing home compare website
  - Health inspections: 3 most recent comprehensive (annual) inspections, and inspections due to complaints in the last 3 years
  - Staffing: 1) Registered Nurse (RN) hours per resident per day; and 2) total staffing hours per resident per day
  - Quality measures: Values on eleven quality measures (QMs--a subset of the 18 QMs listed on Nursing Home Compare) to create the QM rating

https://www.medicare.gov/nursinghomecompare/search.html

FINANCIAL IMPLICATIONS FOR HOSPITALS IN BUNDLED PAYMENT INITIATIVES

- Excess cost for poor management in episodes
- Hospital acquired infection
- Readmission
- Penalty

FINANCIAL IMPLICATIONS FOR HOSPITALS IN BUNDLED PAYMENT INITIATIVES

- Paying others out of the bundle
  - Physician
  - Medical device
  - Hospital
- Many billing systems not set up to administer bundled payment contracts
- Quality metrics accompanying payment not met
- Understanding financial benchmarks

WHO SHOULD BE THE CASE MANAGEMENT TEAM LEAD FOR CCJR EPISODES?

EPISODE	CASE MANAGER
Inpatient hospital	RN Case Manager supported by Social Worker
Outpatient	RN Case Manager or Physical Therapist
Physician office	RN Case Manager or Physician Assistant
Inpatient rehab	Physical Therapist supported by Social Worker
Skilled nursing facility	Physical Therapist supported by Social Worker
Home health	RN Case Manager and/or Physical Therapist supporting each other and supported by Social Worker

SHARING RECONCILIATION PAYMENTS

HOSPITALS CAN SHARE RECONCILITAITON PAYMENTS WITH COLLABORATING PROVIDERS AND SUPPLIERS

QUALITY METRICS TO BE ELIGIBLE FOR RECONCILIATION PAYMENT

- Complications: infections and PE within 90 days of hospitalization
- HCAHPS survey
  - Sampling of all patients, not just LEJR
- To be eligible for reconciliation must score on both measures:
  - At or above 30th percentile each year for years 1-3
  - At or above 40th percentile each year for years 4-5

QUALITY METRICS TO BE ELIGIBLE FOR RECONCILIATION PAYMENT

Meet or exceed payment thresholds for both measures

NOT JUST ONE MEASURE

WAIVERS

- Medicare patient who does not qualify for home health can receive post discharge visits in home (up to 9 post discharge home care visits)

- 3 day qualifying inpatient requirement for SNF—only if SNF is 3 stars or better
  - For anchor hospitalization only
  - Years 2-5 only

NO WAIVERS

- Civil monetary penalty: federal anti-kickback or physician self-referral laws (CMS to consider comments on this)
- Choice exists for Medicare patient to choose among Medicare providers
- No limit in the range of services available to patient
- Would allow participant hospitals to recommend preferred providers—but only under the constraint of the current law

CMS IS WATCHING YOU……..IN CASE YOU……..

- Withhold or delay medically necessary care until after episode ends
- CMS to examine post-episode payments to hospitals
  - Assess Part A and Part B for the 30 day period after episode and region, looking for 3 STD above regional average compared to all CCJR eligible hospitals in region
- Compare case mix before and after performance period

CMS ENFORCEMENT MUSTS

- Comply with model
- Comply with CMS monitoring of model
- Not take action that threatens health or safety of patient
- Not avoid at-risk Medicare beneficiaries
- Not avoid patients on the basis of payer status

PATIENT REQURIEMENTS

- Cannot opt out of CCJR model
- Must be given choice

THE NEXT STEPS IN BUNDLES

Five-year demonstration would start July 1, 2017, in 98 randomly selected areas

- AMI:
  - AMI discharged alive: MS-DRGs 280-282
  - Percutaneous CV procedure (PCI): MS-DRGs 246-251, with an AMI ICD-CM diagnosis code in principal or secondary code position
- CABG: MS-DRGs 231-236
- Surgical hip femur fracture treatment (SHFFT): MS-DRGs 480-482

THE NEXT STEPS IN BUNDLES

- Patient must be in an IPPS hospital located in one of selected metropolitan statistical areas
  - 90 for AMI/CABG
  - 67 SHFFT)
- Episodes include all Part A and Part B expenditures that occur within 90 days of discharge
- Limited number of services CMS considers unrelated are excluded
- BPCI beneficiaries proposed for exclusion
- July 1, 2017 through December 31, 2021

THE NEXT STEPS IN BUNDLES

PERFORMANCE YEARS	% REGIONAL	% HOSPITAL SPECIFIC
1-2	33	66
3	66	33
4-5	100	0

CMS to use 3 years historic blended hospital-specific and regional payment data grouped into episodes of care

Blended target price will increasingly be based on regional data

Low-episode volume hospitals will have target price based on regional data for all five years

THE NEXT STEPS IN BUNDLES: QUALITY

- Composite performance score plus improvement score
- Performance component more heavily weighted
- Low volume participants are assigned to 50th performance percentile

THE NEXT STEPS IN BUNDLES: AMI QUALITY

- 30 day all-cause risk-standardized mortality rate after AMI
- Excess days in acute care after hospitalization for AMI
- HCAHPS Survey
- Voluntary hybrid hospital 30 day all cause risk-standardized mortality rate following AMI

THE NEXT STEPS IN BUNDLES: CABG QUALITY

- 30 day all-cause risk-standardized mortality rate following CABG
- HCAHPS Survey

THE NEXT STEPS IN BUNDLES: SHFFT QUALITY

- Risk-standardized complication rate following elective primary THA and/or TKA (hip/knee complications)
- HCAHPS Survey

THE NEXT STEPS IN BUNDLES: WAIVERS

- SNF 3-day stay during performance years 2-5
  - Beneficiaries discharged from anchor admission of AMI episode to SNF with 3 star rating or higher—coverage of stay even without "qualifying" 3-day stay
  - No waiver for CABG (concerns about link between short hospital stays and increased mortality)
- Home Health
  - No waiver for homebound requirement
  - AMI: 13 visits
  - CABG: 9 visits
- Telehealth geographic site requirements are waived

WHAT DO THESE 3 PROPOSED BUNDLES MEAN TO HOSPITALS?

- A much bigger "ask" for providers
- Continued mandatory hospital assignment with challenge for those hospitals who have no bundle experience—if they are chosen
- Patients with increased risk
- More skin in the game
- ED now becomes the centralized entrance point for these proposed bundles

MORE CHALLENGES

- Building expanded post-acute care relationships
- Managing post operative mortality, which is increased in the first 3 months postop:
  1/3 of deaths in US from heart attacks and strokes
- Smaller hospitals with high Medicare population will have a higher percentage of patients at risk

MORE CHALLENGES

- Identifying bundle patients through registration
  - 7-10% of incoming patients have inaccurate data from registration
  - 30-40% of all denials are due to errors in the registration process (TransUnion)
  - Reworking a denied claim costs at least $25 to rework (Becker's Aug 2016)
- Varying quality of skilled-nursing facilities
- Inadequate ED case management and social work

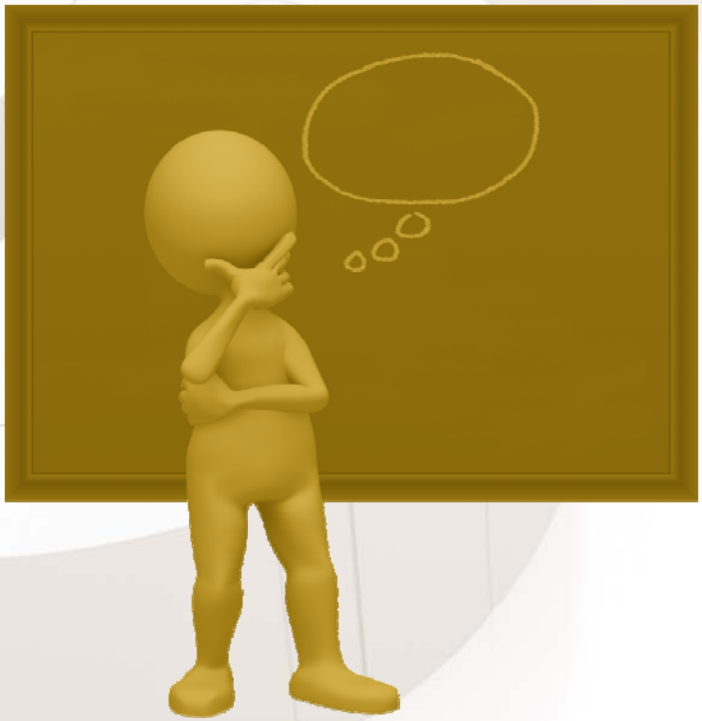
CHANGES IN PRACTICE MIGHT WE SEE WITH THIS SECOND SET OF MANDATORY BUNDLES

- Increased use of cardiac rehab for AMI
  - Reduces risk of 2nd heart attack and mortality
  - 15% of current AMI patients receive cardiac rehab
  - Hospitals would receive $25 per rehab service, for up to 11 services, for patients post AMI or CABG

OUTCOME MEASURES IMPACTED BY TRANSITION CASE MANAGERS AND CASE MANAGEMENT LEADERS

- Readmissions
- Mortality
- Costs
  - Hospital length of stay
  - Overall costs
  - Costs at each level of care during the 90 days
- Patient satisfaction
- Avoidable delays in transitions at each level of care
- Evidence-based metrics for bundled payment diagnoses
- Case manager/care coordinator satisfaction

SO……WHAT'S A HOSPITAL TO DO?



THE HOSPITAL'S PLAN TO PREPARE FOR BUNDLED PAYMENTS

- Develop an oversight committee
- Assure appropriate key stakeholders are present, committed and engaged
- Identify savings opportunities
- Plan improvements
- Develop dashboard
- Review results
- Implement strategies---quickly

THE ULTIMATE SOLUTION #1: COLLABORATION

- Collaboration among all parties exceeding anything in the past
- If you think you collaborate well now……..it probably isn't enough to succeed with bundled payments

THE ULTIMATE SOLUTION #2: COLLABORATION

- Effective transitions between each episode
  - In hospital
  - Out of hospital
- Continue to make care seem seamless for patients and families

BUNDLED PAYMENT SUCCESSES AND STRATEGIES

ALLEGHENY HEALTH

- Decreased readmissions by 5%
- Primarily due to home health business unit
- $4.5M cost avoidance with decrease in readmissions

UNITY HEALTH

- "Our bundled payment program would fail if we had high readmission rates"
- Readmission rates decreased by 60%
- Halo effect to other joint replacements
- Commercial payers have noticed a decrease in readmission rates

CATHOLIC HEALTH

- 1st 6 quarters of participation in BPCI initiative
  - 35 different bundles in BPCI and CJR
  - Decreased readmissions and complication rates by 46%
  - Increased patient experience score 10 points on a 100 point scale
- Shared bonus check from CMS with each hospital (for joint replacements)
- Results have been sustained

CATHOLIC HEALTH

- Increased transitions to home: decreased SNF use by 45%
- Improved patient post op functional assessment scores by 25%

CATHOLIC HEALTH INITIATIVES STRATEGIES

3 types of collaboration

- Multidisciplinary approach: everyone knows and understands role and what is expected each day of care
- Collaboration with patient through system-wide standards
  - Joint academy attendance required
  - Smoking cessation a "must" six weeks before surgery
  - Good control of hemoglobin A1C
- Post acute care providers: patients can choose, but they are encouraged to use hospital's network

Chris Stanley, MD, VP Population Health

COXHEALTH

- Joint quality improvement initiative with Cox HealthPlans initiated in 2014-- primarily with goal to decrease readmissions
- 1st focus: pneumonia and respiratory infections
- 2nd focus: HF and AMI
- Most recent: Hip and knee total joint replacement

COXHEALTH

- Physician buy-in (84 clinics)—distributes 50% of savings to participating physicians
- Used working Medicare Severity DRG (MS-DRG) with CDI to identify patient population at discharge
- Revamp requirements for discharge appointment
  - 93% adherence to appt when scheduled by hospital staff
  - 73% when patient or clinic makes appt
  - Call center for after hours appt scheduling

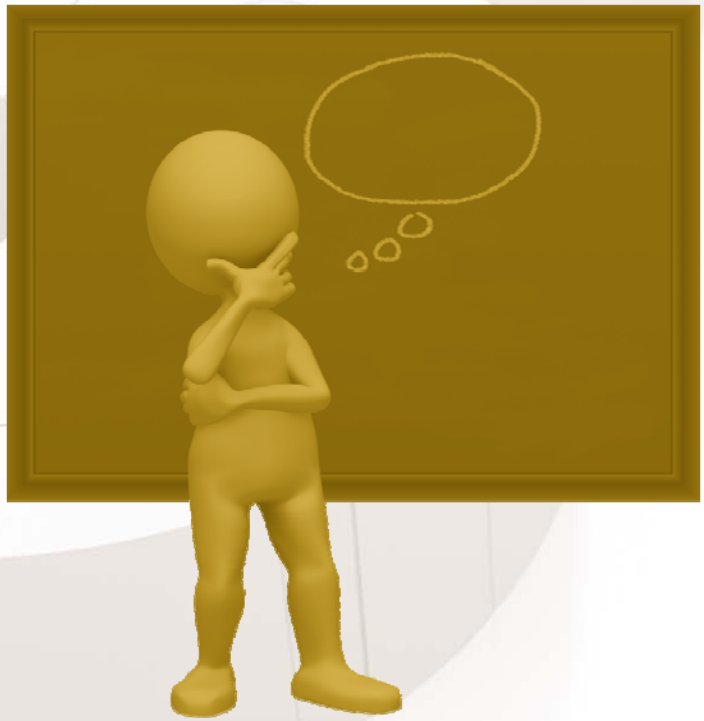
COXHEALTH

- Social worker in ED
- Hospital connects patient with primary care physician if patient has none
- Outcomes
  - Decreased readmissions
  - Decreased ED visits

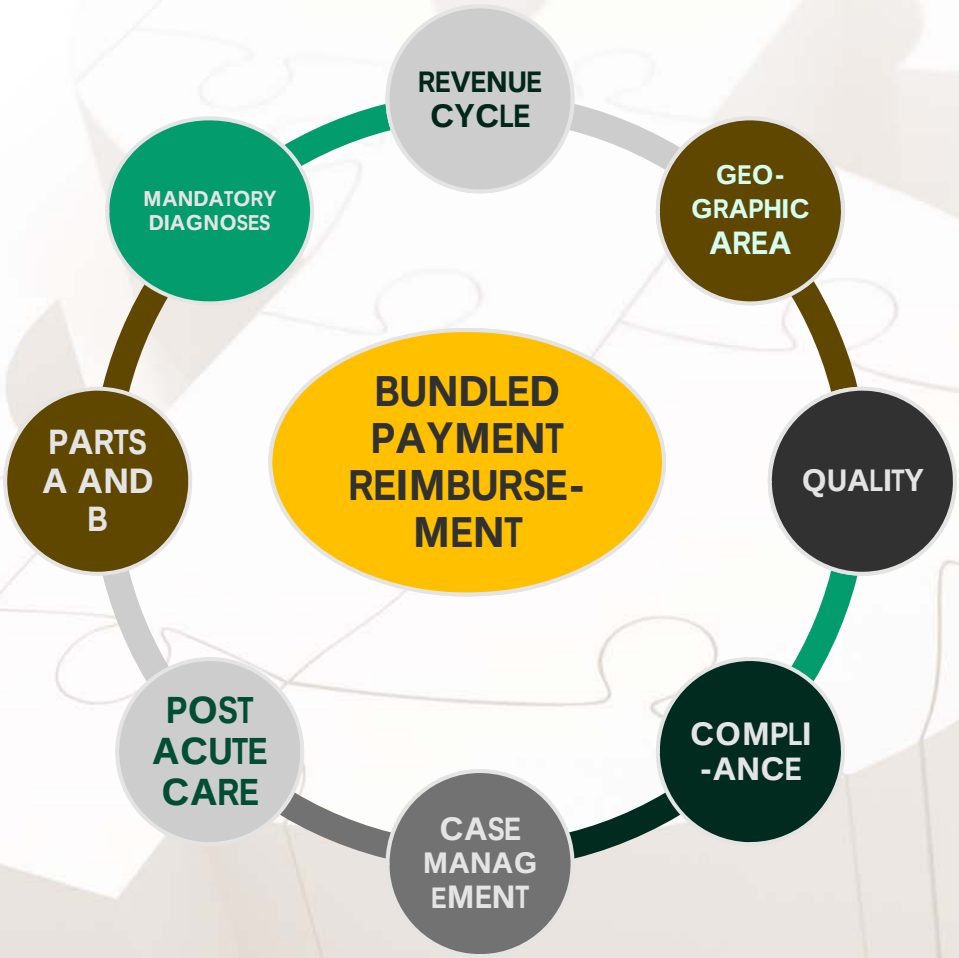
Bundled payments may have some widespread enthusiasm---but fan club may be limited to early adopters

60% of hospitals mandated to participate in CJR program may face penalties due to costs exceeding their regional peers

WHAT'S A CASE MANAGEMENT DEPARTMENT TO DO?



PAYMENT ISN'T WHAT IT USED TO BE



BUNDLED PAYMENTS ARE ALL ABOUT:

Transition

Transition

Transition

Transition

Transition

Transition

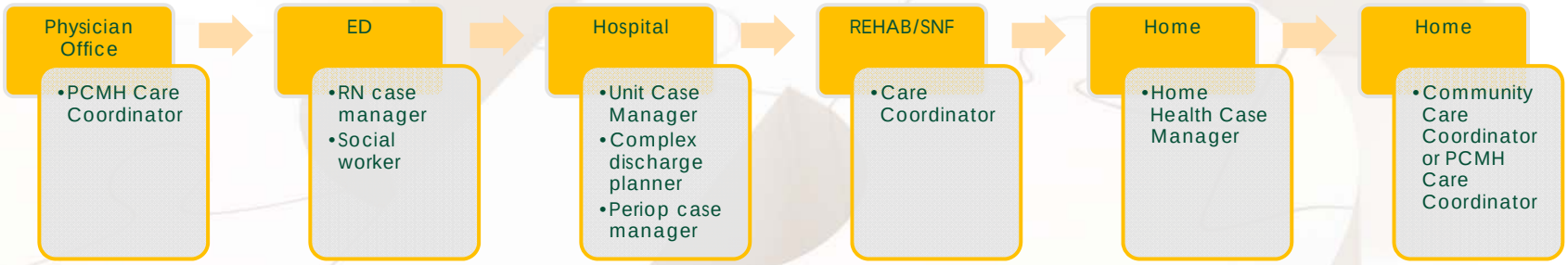
Transition

Transition

IT'S REALLY ALL ABOUT COLLAOBORATIVE TRANSITIONS, WITH HANDOFFS AND ACCOUNTABILITY AT EACH LEVEL OF CARE

OUR OLD TRANSITIONS PROCESS

BUNDLES REQUIRE A NEW TRANSITION PROCESS---WITH NEW TRANSITION MANAGERS

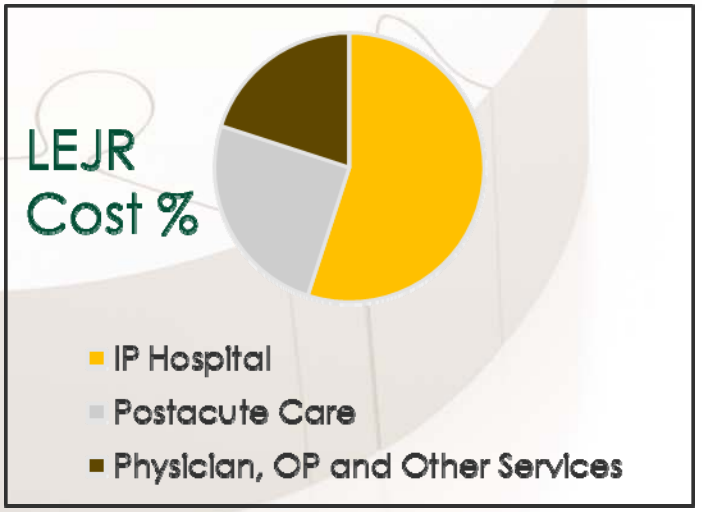


CASE MANAGEMENT LEADER ROLE

- Realize that you are now a part of the value-revenue cycle
- Know if you are in one of proposed geographic areas for any bundle
- Evaluate your model, your staff's roles and their functions
- Watch for any proposed and final rules

CASE MANAGEMENT LEADER ROLE

- Understand your cost per case
- Determine opportunities
  - Cost per case
  - LOS
  - Resource management (things ordered that have nothing to do with the procedure)
  - Physician impact



CASE MANAGEMENT LEADER ROLE

- Provide optimal care coordination
  - Understand your post-acute care environment:
    - Outcomes of SNFs, including readmissions and reasons for readmissions
    - Know the star ratings of all SNFs in your service area
    - Know the outcomes of home health agencies, including readmissions and reasons for readmissions
  - Be prepared that next level of care providers will be confused about this initiative
  - Optimal transitions with your staff
    - To next level of care
    - From post-acute care (example: readmission to ED
- Patient choice
  - Assure choice for home care and SNF is a part of the discharge planning process
  - Evaluate choice list to determine how to emphasize SNFs, based on star rating
  - Consider limiting your choice list—based on Condition of Participation requirements
  - Develop scripting for discharge discussions with patients

CASE MANAGEMENT LEADER ROLE

- Partner with the person responsible for total joint accreditation in your hospital
  - Understand total joint certification by accrediting bodies
  - Understand the total joint dashboard
- Educate your staff
  - Back to the basics of case management process
  - Bundled payment process
  - Plan to mentor your novice case management staff
  - Be aware that staff who work in other hospitals who may not be under this rule will need more focused oversight
- Assure adequate staffing

CASE MANAGEMENT LEADER ROLE

- Report bundled payment initiative proposed/final rules to UM Committee
- Review avoidable days for bundled payment diagnoses/procedures
- Assure your staff's optimal use of electronic case management program
- Have the right roles for your hospital, including
  - Clerical support
  - Appropriate ED coverage
    - RN case manager
    - Social worker
    - Hours of coverage
  - Appropriate manager support: possibly one manager or supervisor to oversee bundled payment initiative, as the expert

CASE MANAGEMENT LEADER ROLE

- Readmissions
  - Understand root cause of previous readmissions
  - Collaborate with a hospital-wide plan to address readmissions, especially those in bundled payment populations
  - Identify patients likely to readmit
  - Have effective strategy in place to decrease readmissions
  - Monitor rates and share results
  - Make readmissions part of your case management dashboard

CASE MANAGEMENT LEADER ROLE-- EVEN IF YOU ARE NOT IN A MANDATORY SERVICE AREA

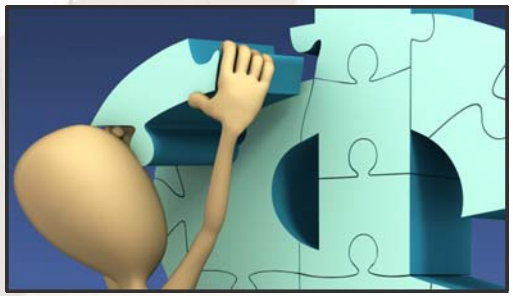
Use total joints as a pilot to prepare for future bundles

NOW

RN CASE MANAGER ROLE

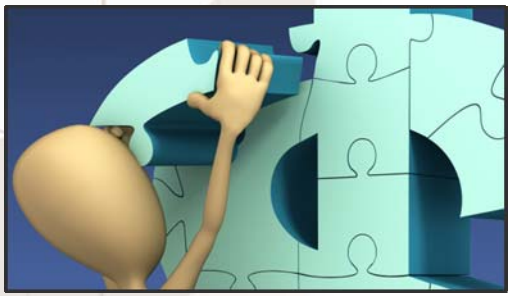
Optimize your case management roles

- Utilization management: You are now your own UM case manager
- Identify bundled payment patients
- Discharge planning:
  - Involve the social worker early, if needed
  - Provide preoperative discharge planning
  - Collaborate with perioperative case manager
- Care coordination: Decrease all avoidable/delay days
- Resource management: No procedures/treatments unrelated to reason for admission



ED RN CASE MANAGER OR SOCIAL WORKER ROLE

- Identify your bundled payment patients
- Manage readmissions
- Communicate effectively with post-acute care providers
  - Admission to hospital
  - ED treat and release



PERIOPERATIVE RN CASE MANAGER'S ROLE

- Early identification of bundled payment patients
- Early involvement in potential delays
- Initiate assessment
- Initiate discharge plan and refer to social worker, if appropriate

SOCIAL WORKER ROLE

Optimize your case management roles

- Identify bundled payment patients
- Discharge planning:
  - Timely response to all referrals
  - Timely self referrals, when appropriate
  - Participate in preoperative discharge planning, as needed
  - Collaborate with perioperative case manager
- Care coordination: Decrease all avoidable/delay days

CARE NAVIGATOR ROLE

- Provides “hand holding” throughout continuum
- Back to making care “seem seamless” to patients
- Irvine, CA-based Global Transitional Care has had no avoidable hospital readmissions by using this role

CASE MANAGERS IN THE WORLD OF THE NEW BUNDLES

- ED case manager
- Perioperative case manager
- Transitional care case manager
- Diagnosis-specific case manager
- Readmission case manager
- Complex discharge planning social worker
- Bundled payment outcomes case manager
  - Cost per episode
  - Patient analysis
  - Physician analysis

ONCE AGAIN--WHAT IS YOUR ROLE, LEADER?

- Develop appropriate specialty case management positions
- Assure readmissions are well managed
- Consider new role of medical necessity
- Appropriate staffing
- Appropriate leadership
- Effective orientation
- Annual competencies
- Education
  - Staff
  - Physicians
  - Nursing
  - Ancillary services

WHAT'S BEING SAID ABOUT THESE NEW BUNDLES?

"They are increasing the risk profile for the hospital and for the treating physicians who are falling within the bundled-payment program"

- Chief strategy officer for the Hoag Orthopedic Institute, Irvine, CA, Dr. James Caillouette

- This pace of CMS leaves "the healthcare system very little time to adapt or plan in advance"
  - Former regional chief medical officer CMS

WHAT'S BEING SAID ABOUT THESE NEW BUNDLES?

- "There will be more tipping points ahead"
  - Acting CMS Administrator, Andy Slavitt

"They've had plenty of time to prepare"

- University of Southern California professor and founder of the National Readmission Prevention Collaborative and the National Bundled Payment Collaborative, Josh Luke

- "We think it's important to keep pushing forward on delivery system reform"
  - CMS chief medical office, Dr. Patrick Conway

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Questions?

Thank you for Attending!

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