THE WHAT AND WHY OF POPULATION HEALTH...AND A WHOLE BUNCH OF ALPHABET SOUP

RUTH KRYSTOPOLSKI, SR VICE PRESIDENT
Agenda

- Pathway to Population Health Management
  - CHRISTUS Health Accountable Care Organization (ACO) Development
  - Mission
  - Margin
  - Changing Environment

- Payment Reform and Reimbursement Trends

- Key Definitions and Concepts –
  - Medicare Shared Savings Program (MSSP)
  - ACO
  - BCPI

- Operational and Legal Considerations

- Transitional Care Workflows

- Future Opportunities and Challenges

- Questions
What is Population Health?

- School based clinics?
- Medical transportation for poor?
- Food security?
- Improving Housing Conditions?
- Better Education??
- Addressing Homelessness?
- VBP, MACRA, ACOs, MA, HIX?
- Parish Nursing?
- Reducing gun violence?
- Reducing Readmissions?
- SOLVING WORLD HUNGER?
Understanding the Goal

While improving “Population Health” is a comprehensive and important goal of society, CHRISTUS Health’s primary focus in our Congregations medical/health care ministries is providing high quality, well-coordinated medical services (and coordinating non-medical social support services as appropriate) that improve the quality/value/outcome of the care we provide in a coordinated manner so that they improve health of the community one patient at a time.
We will increasingly need to enhance our ability to manage and improve quality, outcomes and cost for various “bundles” of care which in some cases include our inpatient (DRGs); in some cases extend outside the walls of our hospitals (e.g. CCJR); can be our associates; and in some cases we will have responsibility of the total cost of care of a defined population of individuals (e.g., members in our Health Plan).
“Population Health” is Rooted in our Heritage: Sisters of the Incarnate Word

St. Mary’s Infirmary, Galveston
Photo of Operating Room, 1930

St. Mary’s Infirmary Operating Room, 1938

St. Mary’s Infirmary Nursery, Galveston 1930

“Pest House”, Galveston 1891
Temporary hospital ward for smallpox patients; first recorded quarantine set up by hospital Sisters to eliminate panic and spread of disease during city-wide epidemic; 6 Sisters volunteered to stay with and care for patients throughout the epidemic and set up make-shift kitchen, laundry and dormitory for duration. All Sisters survived the epidemic and reduced the spread of disease through isolation.
...And continues to be Who We are Today

JERRY’S STORY

- A1C 6.5 or higher indicates diabetes
- Jerry’s A1C was 14.
- Kidney Failure
- Four Foot Surgeries-Toe Amputated
JERRY’S STORY

How a New Door Can Open

- Blood Glucose: ~100
- No Longer Taking Insulin
JERRY TODAY

- 40 lbs lighter
- Outfitted with Diabetic Shoes
- No renal dialysis needed
THE WHY

MISSION

MARGIN
THE MISSION REASON:
We Are in Among the Poorest States in the Nation with the Highest Disease Burden

Louisiana
RANK: 50  Declined from 2014
2014 Rank: 48  Declined: 2

Obesity/Diabetes
34.9% of adults in Louisiana are obese
11.3% of adults in Louisiana have diabetes

States with the most people below poverty

3. Louisiana
- Number of people living below poverty during 2013: 888,019
- Percentage of people living below poverty during 2013: 19.8%
- Number of people living below poverty in 2012: 891,981
- Percentage difference between 2013 and 2012: -0.1%
- Food stamp use ranking: Louisiana has the 7th highest food stamp use-percentage in the U.S.

2. New Mexico
- Number of people living below poverty during 2013: 448,461
- Percentage of people living below poverty during 2013: 21.9%
- Number of people living below poverty in 2012: 426,245
- Percentage difference between 2013 and 2012: 1.1%
- Food stamp use ranking: New Mexico has the 3rd highest food stamp use-percentage in the U.S.
Uninsured Texas Population

- Highest number of uninsured in country - 5 million with almost 1 million children (16% vs. 9% nationally)
- Among lowest employment-based health insurance in nation
- Disproportionally affects minorities – 30% Hispanic and 16% African American vs. 10% Caucasian
- According to the Agency for Healthcare Research and Quality, Hispanics receive worse care than non-Hispanic whites for about 60 percent of core measures, and African Americans are two to four times more likely than whites to have diabetes-related amputations. The list goes on and on…
The primary driver of the shift to population health will be the steady erosion of provider margins due to demographic and disease trends.

Across the next ten years, the core economic model of acute care-driven health care will break down.
Why Do We Need to Focus on Population Health?

The burning platform of deteriorating provider economics mirrors the urgent priority of addressing the federal budget shortfall.

Making Medicare sustainable for the Baby Boomer generation will require a fundamental transformation of the delivery system.
The Margin Reason: ~$800 Million of our revenues are from Medicare – who are shifting to Value Based Care
The Problem: U.S. Health Care is High Cost and Poor Quality

- 250,000 deaths per year due to medical error
- Health care comprises 18% of GDP . . . and increasing
- Health care comprises 18% of GDP . . . and increasing
- US quality ranks low when compared to other developed countries
- $3.06 trillion spent in 2014*; growing at rate of 5.8 percent**
- “Waste” = $765 Billion (30% of total):
  - $210B – unnecessary services
  - $190B – excessive administrative costs
  - $130B inefficiently delivered services
  - $105B prices too high
  - $75B fraud
  - $55B – missed prevention opportunities
- Over 54 Million Enrolled in Medicare^; 78 Million by 2030 (last year of baby boomer eligibility)

Sources: *Office of the Actuary at the Centers for Medicare and Medicaid Services; **National Health Expenditure Projections, CMS; ^Kaiser Family Foundation; ^^Facts on Medicare Spending, Kaiser Family Foundation; ^^^2013 Actuarial Report, Department of Health and Human Services
Total Health Expenditures Have Increased Substantially Over the Past Several Decades

Total national health expenditures, US $ Trillions, 1970-2014

Source: Kaiser Family Foundation analysis of National Health Expenditure (NHE) data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group
CURRENT STATE AND QUALITIES OF FFS

Fee-For-Service (FFS) – the current payment model is characterized by fragmented experiences of care.

- Maximizes the cost and volume of services delivered.
- Fails to reward superior quality of care, better outcomes, improved efficiency, or care coordination.

<table>
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<tr>
<th>Current State</th>
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<tr>
<td><strong>Payers and Physicians</strong></td>
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<tr>
<td>Reimburse for all services regardless of their impact on patient health</td>
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<td>Practice “Defensive Medicine” tactics when prescribing care services to avoid lawsuits</td>
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<tr>
<td>Duplicative service lines with little to no coordination across lines of care</td>
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<td>Little to no discouragement for delivering unnecessary services</td>
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SPENDING ≠ QUALITY CARE

Delivering higher quality care with efficient implementation and effective outcomes can lead to cost savings.

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<tr>
<th>Waste</th>
<th>Solutions</th>
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<tr>
<td>Duplicative Services</td>
<td>Coordination Throughout the Episode of Care</td>
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<tr>
<td>Inefficient Delivery of Care</td>
<td>Reward Providers for Quality Instead of Volume</td>
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<tr>
<td>Potentially Avoidable Complications</td>
<td>Standardize Quality Metrics and Share Best Practices</td>
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<tr>
<td>Inflated Prices</td>
<td>Increase Cost Transparency</td>
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The Emerging Solution: Shift to Financial Risk

The emerging solution to these challenges is to shift financial risk for quality, cost, and utilization onto providers.

Unlike the managed care approach of the 1990s, this strategy relies on hospitals and doctors bearing risk – likely a more effective solution.
The Risk Continuum: From Pieces to Premiums

- PIECES (FFS)
  - Pay 4 Performance
  - Pay 4 Reporting
  - Per Diem
  - DRGs

- PACKAGES
  - Value Based Payment
  - Never Events
  - Pay 4 Performance
  - Per Diem
  - DRGs
  - Care Bundles - Services - Episodes - Conditions

- POPULATIONS
  - ACOs
    - Shared Risk
    - Shared Savings
  - Partial Risk
  - Medicare Advantage
  - Exchanges
  - Commercial Groups

- PREMIUMS
  - Global Risk
The Future:
Better Care, Smarter Spending, Healthier People

- While the current vehicle for conferring provider risk is the ACO, shared savings will be only a transitory model.

- Risk-bearing provider organizations will need capitated risk or something close to it — nothing short of full risk can defeat fee-for-service incentives.

- Government payment reforms will provide a roadmap and impetus to begin transformation, but will not be the primary avenue for change.

- Private sector innovation — employers, payers, and providers developing new payment and delivery strategies — will be the dominant engine for transformation.
“Improving the quality and affordability of care for all Americans has always been a pillar of the Affordable Care Act, alongside expanding access to healthcare,” Burwell said earlier this week. “The law gives us the tools to put patients at the center of their care, improve quality and help make care more affordable over the long term.”
CMS Payment Model Framework

**Category 1**
Fee for Service – No Link to Quality
- 100% volume

**Category 2**
Fee for Service Link to Quality
- Linkage to quality and/or efficiency

**Category 3**
Alternative Payment Models using FFS Architecture
- Track 1 MSSP ACO

**Category 4**
Population-based Payment
- At risk Pioneer ACO and others

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<th>2016</th>
<th>2018</th>
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<tr>
<td>CMS</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Medicare FFS</td>
<td>30%</td>
<td>50%</td>
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CMS=Centers for Medicare & Medicaid Services; DRA=Deficit Reduction Act; IOM=Institute of Medicine; MMS=Medicare Prescription Drug, Improvement and Modernization Act; QI=Quality Improvement;
Key Terms and Concepts

“Clinically Integrated Network”
- Provider network
- The “team” for clinical integration

“Clinical Integration”
- What the CIN does
- Participants collaborate on care
- Game plan and rules
- Operational and legal concepts

“Shared Savings Program”
- Payment method from funding source

“ACO”
- Market and payor engagement
- Clinical integration to achieve goals
- Population health management
- Shared savings and/or risk
UNALIGNED CURRENT STATE

Patients Served in Silos Across Assets
Medicare accountable care organizations have saved more than $1.29 billion since 2012, the Centers for Medicare and Medicaid Services announced Thursday.

“The coordinated, physician-led care provided by Accountable Care Organizations resulted in better care for over 7.7 million Medicare beneficiaries while also reducing costs,” CMS Acting Administrator Andy Slavitt said in a statement. “I congratulate these leaders and look forward to significant growth in the program in the coming year.”
Progression to Accountable Care

- Legal Entity Formation
- Participation Agreements
- Business Plan

- Business Plan Implementation
  - Time
  - Money
  - Change
  - Results

- Active Change
  - Following Plan
  - Refinement
  - Additional Change
  - Results

Time
ACO Development and Qualification

- In 2016:
  - Total of 434 MSSP ACOs
  - 22 MSSP ACOs in Track 2 or 3
  - 21 ACOs in Next Generation
  - 8.9 Medicare beneficiaries in ACOs
  - 287 additional commercial ACO (estimated) (not shown)

- Commercial CIN PHO/IPA
  - Unaccredited

- NCQA CIN/ACO
  - Accredited
  - Specific standards

- Pioneer ACO CMMI Approved
  - 32 Orgs
  - Application

- MSSP ACO CMS Approved
  - 27 (Dec. 2011)
  - 89 (Apr. 2012)
  - 106 (Jan 2013)

- Next Gen ACO CMMI Approved
  - Applications under review
Where the Medicare ACOs are
## ACO Value Proposition – Physicians, Payers and Health Systems

<table>
<thead>
<tr>
<th>Value to Physicians</th>
<th>Value to Payers</th>
<th>Value Health Systems</th>
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<tbody>
<tr>
<td>Affiliation with the ACO brand and strategy</td>
<td>Redefine provider relationship from combative to collaborative</td>
<td>Aligned independent practices and physicians</td>
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<tr>
<td>A more powerful voice in health plan relationships</td>
<td>Extensive, stable and top-tier network for products</td>
<td>Spread Health System reach (and risk) across broader population and geography</td>
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<tr>
<td>Demonstrate, improve and be rewarded for clinical quality</td>
<td>Collaboration in improving value for beneficiaries, members and customers</td>
<td>Communication venue with independent “affiliates”</td>
</tr>
<tr>
<td>ACO governance, leadership and input roles</td>
<td>Transition from FFS payment; address cost and quality</td>
<td>Demonstrate value to payers, businesses, and community</td>
</tr>
<tr>
<td>Participate in development of</td>
<td>Shift resources from Medical Management to other areas (benefit design, etc.)</td>
<td>Strategy to assess and assure quality practitioners support hospitals</td>
</tr>
<tr>
<td>• Value-based compensation models</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evidence-based care etc.</td>
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Key #1 – Patient Engagement and Relationships with Providers

- No population health strategy will succeed without intentional activation and engagement of individual patients.

- The best care management approaches will be built around the relationship between the patient and the caregiver.
What is a MSSP ACO?

- **MSSP Definition:**
  - “…a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a [TIN], and is formed by one or more ACO participant(s) that is (are) defined at § 425.102(a) and may also include any other ACO participants described at § 425.102(b).” 42 CFR § 425.20.

- **Overview of CHRISTUS ACOs:**
  - 4 MSSP ACOs –
    - CHRISTUS Louisiana ACO
    - CPG Quality Care Alliance
    - CHRISTUS Santa Rosa Quality Care Alliance
    - Trinity Mother Frances CareCompact, LLC d/b/a CareCovenant
  - Performance Year 1 Start Date – January 1, 2016
  - Track 1 (shared savings arrangement)
  - 2017 development includes consolidation to three entities and growth of participating providers
  - Attributed beneficiaries for 2017 estimated to be 80,000
## Key Characteristics of an MSSP ACO

<table>
<thead>
<tr>
<th>Key Characteristics</th>
<th>MSSP ACO</th>
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<tr>
<td>Who can form</td>
<td>• Physicians; Physicians and hospitals</td>
</tr>
<tr>
<td>Mandated legal requirements</td>
<td>• Yes; many</td>
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<td></td>
<td>• Legal/governance structure, contracts,</td>
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<tr>
<td></td>
<td>• 3 year terms etc.</td>
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<tr>
<td>Patients served</td>
<td>• Defined population</td>
</tr>
<tr>
<td></td>
<td>• Attributed MSSP FFS beneficiaries</td>
</tr>
<tr>
<td>Operating structure</td>
<td>• Defined in rules</td>
</tr>
<tr>
<td>Compensation model(s)</td>
<td>• Shared savings (95% Track 1)</td>
</tr>
<tr>
<td></td>
<td>• Risk</td>
</tr>
<tr>
<td></td>
<td>• Other</td>
</tr>
<tr>
<td>Application of existing laws</td>
<td>• Some federal waivers</td>
</tr>
<tr>
<td>Linkage to cost and quality</td>
<td>• Yes</td>
</tr>
<tr>
<td>End stage (mature) model</td>
<td>• Risk</td>
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MSSP ACO Background & Purposes

- MSSP is intended to:
  - Promote accountability for Medicare FFS beneficiary population
  - Improve the coordination of FFS items and services
  - Encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery
  - Promote higher value care

- Applicable to traditional Medicare FFS beneficiaries
  - ACO must have at least 5,000 beneficiaries – no beneficiary enrollment
  - CHRISTUS ACOs = Total of 36,171 beneficiaries
    - CHRISTUS Louisiana (CLA) ACO = 15,290
    - CPG Quality Care Alliance (QCA) = 12,887
    - CHRISTUS Santa Rosa (CSR) QCA = 8,074
    - CHRISTUS TMF ACO = 12,000
Requirements for MSSP ACO Participants & Provider/Suppliers

- **ACO Participation Agreement:**
  - ACO must contract directly with ACO participant or provider/supplier
  - Exclusive to 1 ACO if ACO participant TIN bills for primary care services
  - Individual agreement/acknowledgement required

- **ACO Participant:**
  - Participates in ACO - identified by a Medicare-enrolled Tax Identification Number (TIN)
  - Note re: ACO participant acquisitions – ACO may include an acquired provider entity on its ACO participant list if the acquired provider was subsumed in its entirety by an ACO participant and no longer participates in Medicare under the old TIN

- **ACO Provider/Supplier:**
  - Individual or entity that is a Medicare provider or supplier enrolled in Medicare and bills for services under an ACO participant TIN
Need to Adapt to New Environment
Key #2 – Change in Culture and Behavior

- The most difficult challenges to overcome in population health will be *cultural barriers to change*

- We cannot delay the complex work of addressing physician, patient, payer and administrator behavior
MSSP ACO Physician Engagement & Alignment

- Governance, participation, data and other systems to promote:
  - Physician-led ACOs
  - Physician involvement, engagement and leadership
  - Not traditional “medical director” models
  - Data systems to provide useful information related to quality and cost
  - Cultural development and transformation
  - Eventual decision-making ability based on quality and/or cost efficiency

- Potential MSSP benefits:
  - Patients, information and data creating “raw materials” and opportunity to engage in population health management
  - ACO fraud and abuse waivers (and opportunities)
  - “Deemed” clinical integration for antitrust purposes
MSSP ACO Governance, Leadership & Management

- **Governance:**
  - Limit on ACO parent reserved powers
  - Restrictions on non-ACO activities
  - At least 75% of Board must be ACO Participants and 1 Medicare FFS beneficiary

- **Leadership & Management:**
  - Executive appointed/removed by governing body
  - Clinical management by senior level medical director
  - Physician-directed committees responsible to oversee quality assurance/process improvement
  - ACO Compliance Officer – compliance plan, compliance hotline and beneficiary help line
Key #3 – Infrastructure Development

- At the heart of any successful population health strategy will be **robust data** on clinical and financial performance.

- The best systems will harness data through **advanced analytics** to manage clinical and financial risk.

- At the heart of any successful population health strategy will be a **comprehensive care management infrastructure** that delivers coordinated, integrated care.

- Effective care management will require significant investment in **physician and non-physician** clinical workforce and workflow.
MSSP ACO Operational Infrastructure & Systems

- IT and data sharing
  - Sufficient information systems to (i) support beneficiary assignment and attribution and (ii) receive and distribute determined payments for shared savings, if any

- Must promote:
  - Evidence-based medicine
  - Patient engagement — Patient-centeredness criteria includes: (i) beneficiary satisfaction survey; (ii) patient involvement in governance; (iii) assessment of population needs with consideration of diversity; and (iv) written standards for access and communication
  - Quality/cost reporting feedback
  - Care coordination

- People and processes required for redesigned care
- Marketing Requirements
Wellcentive: Managing Risk Across “Episodic” and “Longitudinal” Views

LONGITUDINAL PERFORMANCE MANAGEMENT
(Population Health Management)

LEGEND
- Health Information Exchange (HIE)
- Payer
- Lab Information System (LIS)
- Practice Management (PM)
- Patient Portal
- Data Warehouse
- Home Monitoring Devices
- E-Prescribing (eRx)
- Hospital Information System (HIS)
- Electronic Health/Medical Records (EHR/EMR)

Physician Orgs
Integrated Networks
ACOs
Payers
Employers

Healthcare Delivery Ecosystem
Analyze – Physician Scorecard

Wellcentive allows users to monitor real-time performance for all 22 reportable ACO measures using our Quality Program Scorecard feature. These measures are included out-of-the-box with no additional configuration needed by users.

- Measures can be filtered by organization, provider group, provider, specialty, and/or program affiliation
- Filter measures for your specified time frames and recalculate on demand
- View Eligible Populations, Met/Not-Met Instances, Exclusions, and Exceptions. Click on any numeric result to display the list of patients making up the total
- View performance goals and rates quickly and easily with our performance indicators

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Key #4 – Significant Financial Investment

Population health strategies will require health systems to move beyond the core inpatient core business to invest in the full continuum of care.

The best systems will shift investments away from (solely) acute care assets to primary and community-based care.
Financial & Compensation Considerations

- Follow the money
  - Formation and operating costs
  - Financial management systems and budgets
  - Participant distribution/compensation systems
  - Information feedback/reporting systems (to influence behavior)

- ACO development and operating costs must be funded through capital contributions, loans or both

- Patient Care and Shared Savings
  - ACO participants receive FFS reimbursement from CMS
  - ACO has opportunity for shared savings payment

- ACO shared savings net of expenses:
  - Portion (budgeted) paid to ACO participants as incentive bonus
  - Portion paid to owners as return on investment

- Participants’ expenses/costs (incurred directly) as price of participation
What is BPCI
(Bundled Payment for Care Improvement)

- **Definition**
  This is a Medicare program comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries received during an episode of care. Typically the episode of care begins with the hospital stay and ends 90 days later. These models are intended to lead to higher quality and more coordinated care at a lower cost to Medicare.

- **Sound Relationship**
  - 30+ DRG’s?

- **Why bundled payment?**
BPCI in our Markets

- Sound Relationship: Sound has partnered with a convener (Remedy)
- Focus is on 30+ Bundles of service (DRG’s and post-acute services)
- Goal is to: Improve quality and outcomes and reduce Cost
- CHRISTUS is participating in shared savings
- CCJR/Beaumont, Tyler and Corpus Christi
Where are the costs?

For a typical 90 day bundle, Medicare spends more on a patient’s post-acute care than their initial hospitalization.

a. Post acute spending has doubled in the past decade and it is growing twice as fast as physician and hospital services.

b. Average inflation-adjusted inpatient spending has grown at 2% annually in the past decade.
Post Acute Costs

Integrated health care model with Population Health

• CMS is pursuing its Triple Aim through multiple alternative payment models such as BPCI/ACO with a stated goal of having > 50% of payments through an FFS alternative by 2018.

• BPCI/ACO model continues CMS’ trend of paying for value.

• Currently for the 90 days episode, 35% spending occurs in inpatient setting and 65% in post acute setting.

• CMS deems much of this post-acute spending to be avoidable.
Care Workflow Model

Inpatient Care
- Admission
- Hospital Stay
- Discharge

Post Hospital Care
- Care Coordination
- Post Acute/Home Services
- Primary Physician
Paths of Post Hospital Care

1. Acute Care Setting → Home Health
2. Home Health → Post Acute SNF
3. Post Acute SNF → Follow up Care with Primary Care Physician
4. Follow up Care with Primary Care Physician → Home
5. Hospital → Home
Program Operations → The Care Improvement Team

- Hospitalist
- HRN
- Transitional Care Nurse
- Home Visit NP
- Post-Acute MD/NP
- Care Coordinator
- Patient/Family
- UR Nurse
- Case Manager
- SNFs
- Home Health
- PCP Groups

Legend:
- Pop Health/TCS
- Hospitalist
- Hospital
Workflows
Transitional Care Inpatient Workflow

1. **Hospitalist Admits patient**
   - ADT feed: Create a new stay in Sound Connect
   - TCS List reviewed by TCRN
   - Are there any teams in the hospital that our team will meet with to collaborate? (IDR’s/Touch and Go’s, Huddle meeting so that all disciplines are aligned)

2. **Sound Physician Initiates Next Site of Care Conversation with patient and family**
   - Sound Hospitalist Flags for Anticipated DC in Sound Connect indicating DC in next 48 hours
   - TCRN discusses in IDR’s - Collaborates with C3’s Case Management
   - HRN Completes Discharge Facilitation Tasks
   - HRN Enters Next Site of Care in Sound Connect with PCP notification

3. **Hospitalist Dictates DC Summary (copy to PCP)**
   - Hospitalist or TCRN Inform PCP or Post Acute provider of discharge
   - Document Follow Up plans with TCS care team in Episode Connect
   - Discuss patient stats in Transitional care meetings
   - HRN and/or TCRN Confirm Final DRG and follow pt accordingly

CHRISTUS Health®
Transitional Care Discharge to SNF

1. IDR Team discusses pre-discharge plan
2. TCS Market Coordinator / TRCN Confirms that SNF Adm Coord received Key Clinical Information.
3. Sound SNF Physician (SNFist) Admits patient within 24-48 hours
4. Sound Patients care plan reviewed with SNF DON upon admission
5. SNFist Physician/NP participate in weekly UR care Conferences at SNF
6. Sound SNF patients are prepared for D/C-
7. TCRN Coordinates with SNF for comprehensive D/C planning into community
8. Sound SNFist Physician/NP completes D/C Summary and Communicates with PCP
9. TCRN initiates Discharge Plan home to include Home NP visit.
10. Inform PCP of Home Plan. Documentation forwarded by TCRN
11. Telephonic Follow up continues until Discharge at end of 90 day Episode
12. Final report and hand off to PCP
Transitional Care Discharge to Home

Sound Hospitalist Discharges Patient Home → TCRN calls all patients within 1-2 days after discharge from Hospital → TCRN/TCS Coord verify PCP received hospital D/C Summary and pertinent updates on inpatient stay → TCS NP visits patient at home and reports findings to PCP

Patient visit to PCP → TCRN and TCS NP follow patient after PCP visit and telephonically → TCM bill submitted → Follow up home visit by TCS NP as needed for intervention (G code – 9187) → Discharge patient at end of 90 day episode

Call patient post discharge tasks:
- Assess Health Status
- Assess Medication Compliance
- Confirm PCP appt
- Confirm TCSN appt
- Complete TCRN Note

Visit patient Home tasks:
- Assess Health status
- Complete Medications reconciliation
- Review TCP & Discharge instructions
- Assess compliance
- Provide Education
- Complete TCS note

CHRISTUS Health®
**Alternative Payment Models**

**Accountable Care Organizations (ACOs)** (Track 1)

The Medicare Shared Savings Program ACOs are partnerships among health care providers to coordinate and deliver high quality, cost efficient health care services to defined populations. ACOs will be rewarded if they lower their health care costs while meeting performance standards on quality of care and putting patients first. Each ACO must have at least 5,000 beneficiaries enrolled. The ACOs launched in January 2016.

**Accountable Health Communities Model (AHC)**

The AHC model tests whether addressing health-related social needs, such as food insecurity or unstable housing, improve health outcomes and impacts total healthcare costs. The model promotes the collaboration of community and clinical services to ensure that beneficiaries’ health-related social needs and medical care is managed and coordinated.

**Bundled Payments for Care Improvement (BPCI) Initiative Model 2**

The BPCI initiative links payments for multiple services beneficiaries receive during an episode of care. Specifically, Model 2 involves a retrospective bundled payment arrangement in which actual expenditures are reconciled against a set price for an episode of care.

**Comprehensive Care for Joint Replacement (CJR) Model**

The mandatory program requires acute care hospitals in 75 select geographic areas to be held financially accountable for the quality and cost of a CJR episode of care. The episode of care begins with an admission to a participant hospital of a beneficiary who is ultimately discharged under MS-DRG 469 or 470 (Major joint replacement or reattachment of lower extremity with and without major complications or comorbidities) and ends 90 days post-discharge in order to cover the complete period of recovery for beneficiaries. The five-year program started April 1, 2016.

**Health Care Innovation Awards**

Based on a competitive application process, 107 organizations are receiving funding through the Center for Medicare and Medicaid Innovation to test new payment and service delivery models that deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), focusing on those with the highest health care needs.

**Oncology Care Model (OCM) (1-Sided Risk)**

Physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding the administration of chemotherapy to cancer patients. Seventeen commercial payers have aligned with Medicare in order to provide flexible and comprehensive incentives that aim to transform cancer care at the physician practice level. The five-year model began July 1, 2016, and runs through June 30, 2021.

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**CHRISTUS Participation**

- **Total of 57,234 beneficiaries enrolled in ACOs**
  - Louisiana ACO = 15,299
  - CPC Quality Care Alliance (QCA) = 12,887
  - Santa Rosa QCA = 8,074
  - Trinity Mother Frances CareComart, LLC d/b/a CareCovenant = 20,983

**CHRISTUS Participation**

- **Santa Rosa** (application submitted May 17, 2016; awards to be announced fall 2016)

**CHRISTUS Participation**

- All CHRISTUS Regions
- Spohn
- Southeast Texas
- Trinity Mother Frances

**CHRISTUS Participation**

- St. Michael

**CHRISTUS Participation**

- St. Vincent
## SUMMARY OF CHRISTUS MEDICARE PROGRAMS

<table>
<thead>
<tr>
<th>Market</th>
<th>MSSP</th>
<th>BCPI*</th>
<th>CJR*</th>
<th>OCM</th>
<th>Hospital Quality*</th>
<th>Physician Quality*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tyler</td>
<td>27,000 Members</td>
<td></td>
<td>475 Cases</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>$5.5M at risk</td>
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<tr>
<td>Texarkana</td>
<td>7,000 Members</td>
<td>1441 Episodes $34M in Revenue</td>
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<tr>
<td>Corpus Christi</td>
<td>CPG</td>
<td>295+ Episodes $7M in Revenue</td>
<td>170 Cases $200,000 at Risk</td>
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<tr>
<td>Beaumont</td>
<td>6,000 Members</td>
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<td>216 Cases</td>
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<tr>
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<td>$287,000 at Risk</td>
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<tr>
<td>Louisiana</td>
<td>19,000 Members</td>
<td>1100+ Episodes $38M in Revenue</td>
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<tr>
<td>San Antonio</td>
<td>8,500 Members</td>
<td>615 Episodes $15M+ in Revenue</td>
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<tr>
<td>Santa Fe</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>300+ Patients</td>
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</tr>
<tr>
<td>CPG</td>
<td>12,500 Members</td>
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</tr>
<tr>
<td>TOTAL</td>
<td>80,000 members</td>
<td>3451+ Episodes $94M in Revenue</td>
<td>861 Cases $6M at risk</td>
<td>300+ Patients</td>
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</tbody>
</table>

*Mandatory Program

- Hospital Value Based Purchasing
- Quality Reporting/ Meaningful Use
- Hospital Acquired Conditions
- 8% of Payment at Risk
- 9% of Payment at Risk
- Value Modifier
- Meaningful Use
- PQRS

**Alignment of Processes & Programs**

- Alignment of Processes & Programs
POPULATION HEALTH
CHRISTUS HEALTH’S DEFINED POPULATIONS & PROGRAMS

**POPULATIONS**
- Commercial BCBS
  - Interventions: Up
  - Outcomes: Up
  - Cost: Up
- Medicare MSSP
  - Quality: Up
  - Cost: Down
- Medicare Advantage
  - Quality: Up
  - HHC Capture: Up
  - Cost: Down
- Mandatory Bundles (CJR)
  - Cost: Down
  - Readmissions: Down
- Associate Health Plan
  - Wellness: Up
  - Cost: Down
- Health Plan
  - Quality: Up
  - Outcomes: Up
  - Cost: Up
  - HHC Capture: Up
- Uninsured & Vulnerable
  - Quality: Up
  - Outcomes: Up
  - Cost: Down

**PROGRAMS**
- Home Health
- Disease Management
- Emergency Department Intervention
- Transitions of Care
- Chronic Care Management
- Care Gap Closure
- Chronic Care Clinics
- Patient Centered Medical Homes
- Urgent Care

Deployment Over Time
Any Questions?