Episode-Based Bundled Payments: Implications for Physicians

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Brandeis University

Massachusetts Medical Society
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Massachusetts is an ACO/global Payment Marketplace

Why Should you Care About Episode Payments?
Applications for Medical Groups?

• Participate directly
• Risk-share with partner hospitals
• Evaluate/reward network performance
• Accept risk for hospitalized patients not attributed to ACO

Overview

• Brief history of bundled payments
• Medicare’s current approach (BPCI)
• Lessons learned preparing for Medicare bundled payment
• Future directions for policy
• Developing a post-acute care strategy
### A Brief History of Bundled Payment

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicare Inpatient DRGs</th>
<th>Medicare Heart Bypass Demo</th>
<th>Medicare Acute Care Episode Demo</th>
<th>Affordable Care Act</th>
<th>Bundled Pmt. for Care Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2007</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
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<td></td>
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<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Will Bundled Payment Become the Next DRG System?
Bundled Payment

Payer

$\text{Single payment to cover costs of episode of care (30, 60, 90 days)}$

Shared Accountability

Hospital or Integrated Network

$\text{Group is responsible for all care within the episode}$

Prospective

$\text{Target budget for each episode}$

- All providers paid FFS
- Periodic CMS settlements
  - Distribute surplus
  - Reclaim deficit

Retrospective

- Health system decides
  - Whom to contract with
  - How to distribute bonuses
Opportunities to Improve Margins
From a Hospital Perspective

Primary
• Reduce supply costs (e.g. implants)
• Reduce errors and complications
• Reduce post-acute care costs

Conditional (dependent on backfill)
• Reduce readmissions
• Reduce length of stay

Opportunities to Improve Margins
From a Physician Perspective

• Reduce supply costs (e.g. implants)  ✓
• Reduce errors and complications  ✓
• Reduce post-acute care costs  ✓
• Reduce readmissions  ✓
CMS Innovation Center: Bundled Payment Pilot

CMS BPCI Awardees by State: N=467

Note: Awardees include 32 Model 1; 193 Model 2; 166 Model 3; 76 Model 4.
CMMI Bundled Payment Pilot

Model 1

<table>
<thead>
<tr>
<th>Professional services</th>
<th>Inpatient Professional</th>
<th>Outpatient Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Stays</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index Hospitalization</td>
<td>SNF</td>
<td>Readmission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brandeis University

CMMI Bundled Payment Pilot

Model 2

<table>
<thead>
<tr>
<th>Professional services</th>
<th>Inpatient Professional</th>
<th>Outpatient Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Stays</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index Hospitalization</td>
<td>SNF</td>
<td>Readmission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brandeis University
CMMI Bundled Payment Pilot

Model 3

Professional services

Inpatient Professional

Index Hospitalization

SNF

Readmission

Outpatient Professional

Model 4: Prospective Payment

Professional services

Inpatient Professional

Index Hospitalization

SNF

Readmission

Outpatient Professional

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Bundle Building Activities

• Select from 48 bundles
  – DRG Families

• Exclusions
  – Applicants must take all patients in selected DRGs
  – Readmissions
  – Part B services

• Risk Adjustment

Episodes by DRG: CHF and COPD

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Episode: CHF HOSPITALIZATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>291</td>
<td>Heart failure &amp; shock w MCC</td>
</tr>
<tr>
<td>292</td>
<td>Heart failure &amp; shock w CC</td>
</tr>
<tr>
<td>293</td>
<td>Heart failure &amp; shock w/o CC/MCC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Episode: ASThma &amp; COPD Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>202</td>
<td>Bronchitis &amp; asthma w CC/MCC</td>
</tr>
<tr>
<td>203</td>
<td>Bronchitis &amp; asthma w/o CC/MCC</td>
</tr>
<tr>
<td>190</td>
<td>Chronic obstructive pulmonary disease w MCC</td>
</tr>
<tr>
<td>191</td>
<td>Chronic obstructive pulmonary disease w CC</td>
</tr>
<tr>
<td>192</td>
<td>Chronic obstructive pulmonary disease w/o CC/MCC</td>
</tr>
</tbody>
</table>

Source: Prometheus Payment.
Calculating Prices Under Medicare BP Pilot

2009 - 11

Historical Cost Per Episode
$12,200

Episode Definitions
Risk Adjustment

2013

Target Price
$13,320

Actual FFS Cost
$12,900

Update Factor*
CMS Discount
* For illustration update = 3%/yr
discount = 3%

Settlement
$420

Risk Adjustment

- DRG case mix
- Clinical events during stay
  - Principal diagnosis
  - Other diagnoses
  - Severity indicators (e.g., hemorrhage)
- Patient risk prior to admission
  - e.g. CMS HCC model
Gainsharing

• CMS gets first 2% of savings (90-day episodes)
• Additional savings can be shared between facility, physicians, post-acute providers
  – Physician gain share capped at 50% of Medicare
  – No cap on other providers
• Useful principals
  – Quality gates to ensure clinical performance
  – Distribute based on contribution and performance
CMMI Bundled Payment Initiative

• November 2011 hospitals submitted LOI
  – Received 100% of claims for all Medicare patients
  – Brandeis analysis focused on 90-day episodes
• June 2012 hospitals submitted applications
• October/November 2012 Awardees notified
  – Choose up to 48 bundles
• BP “no-risk” period began January 1, 2013
• Regular BP program begins October 1, 2013?

What Did We Learn?

Lesson #1

Medicare Spends a Tremendous Amount in the 30 – 90 Days After Patients Are Discharged from the Hospital
Avg. 2008 Medicare Inpatient Payments for Select DRGs

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>DRG Description</th>
<th>2008 Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>470</td>
<td>Major Joint</td>
<td>$11,079</td>
</tr>
<tr>
<td>194</td>
<td>Pneumonia with CC</td>
<td>$5,347</td>
</tr>
<tr>
<td>292</td>
<td>Heart Failure with CC</td>
<td>$5,322</td>
</tr>
<tr>
<td>683</td>
<td>Renal Failure with CC</td>
<td>$6,437</td>
</tr>
<tr>
<td>190</td>
<td>COPD with MCC</td>
<td>$6,075</td>
</tr>
</tbody>
</table>


2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 30-Day Episodes

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>DRG Description</th>
<th>30-Day Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>470</td>
<td>Major Joint</td>
<td>$18,414</td>
</tr>
<tr>
<td>194</td>
<td>Pneumonia with CC</td>
<td>$9,732</td>
</tr>
<tr>
<td>292</td>
<td>Heart Failure with CC</td>
<td>$10,636</td>
</tr>
<tr>
<td>683</td>
<td>Renal Failure with CC</td>
<td>$12,456</td>
</tr>
<tr>
<td>190</td>
<td>COPD with MCC</td>
<td>$10,470</td>
</tr>
</tbody>
</table>

Source: RTI Inc, Post-Acute Care Episodes: Expanded Analytic File, June 2011. Thirty day fixed episodes include the full amount of all claims incurred within 30 days of discharge even if they extend beyond the 30 days period.
2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 90-Day Episodes

Source: Calculated based on RTI Inc, Post-Acute Care Episodes: Expanded Analytic File, June 2011. 30-90 day amounts are estimated based on RTI, Analysis of Acute Care Episode Definitions Chart Book, November 2009.

2008 Post-Acute Care Spending For 30-Day Episode: DRG 292 – Heart Fail. With CC

Episode includes all claims incurred within 30 days of hospital discharge

<table>
<thead>
<tr>
<th></th>
<th>Percent With Claim</th>
<th>Mean Cost Per Service User</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index Admission</td>
<td>100.0%</td>
<td>$5,322</td>
</tr>
<tr>
<td>Rehab</td>
<td>2.0%</td>
<td>$14,999</td>
</tr>
<tr>
<td>SNF</td>
<td>43.0%</td>
<td>$10,674</td>
</tr>
<tr>
<td>LTAC</td>
<td>0.9%</td>
<td>$22,971</td>
</tr>
<tr>
<td>Home Health</td>
<td>60.3%</td>
<td>$2,545</td>
</tr>
<tr>
<td>Readmission</td>
<td>21.7%</td>
<td>$10,765</td>
</tr>
</tbody>
</table>

Lesson #2

There is Significant Variation in Post-Acute Care Spending Across Hospitals

Average 2009 Post-Acute Care Spending per Episode for CHF Admission (90 day)

Source: Brandeis University analysis of Medicare QIPs data. Figures adjusted for hospital wage index.
A Tale of Two Hospitals: CHF Episode

<table>
<thead>
<tr>
<th></th>
<th>St. Maximus</th>
<th>St. Minimus</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$16,524</td>
<td>$11,822</td>
<td>$4,702</td>
</tr>
<tr>
<td>Index Stay (facility)</td>
<td>$5,142</td>
<td>$4,554</td>
<td>$588</td>
</tr>
<tr>
<td>Index Stay (prof.)</td>
<td>$1,272</td>
<td>$1,284</td>
<td>($12)</td>
</tr>
<tr>
<td>Acute Readmission</td>
<td>$5,947</td>
<td>$2,333</td>
<td>$3,614</td>
</tr>
<tr>
<td>Rehab Hospital</td>
<td>$859</td>
<td></td>
<td>($859)</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$1,153</td>
<td>$1,886</td>
<td>($733)</td>
</tr>
<tr>
<td>Home Health</td>
<td>$1,234</td>
<td>$525</td>
<td>$709</td>
</tr>
<tr>
<td>Other Professional</td>
<td>$917</td>
<td>$1,240</td>
<td>($323)</td>
</tr>
</tbody>
</table>

Source: Brandeis University analysis of Medicare Claims data. Unadjusted data.

A Tale of Two Hospitals: CHF Episode

[Graph showing readmission rate, percentage seen by PCP in 30 days, percentage SNF, and percentage home health for St. Maximus and St. Minimus.]
Opportunities for St. Maximus

- Put a program in place to monitor patients following discharge
  - Medication reconciliation
  - Home assessment
  - Primary care visit within 7 days
  - Emergency plan for likely events
- Evaluate SNF and HHA performance
  - Develop programs/partnerships to improve service levels and effectiveness

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Average 2009 Post-Acute Care Spending per Episode for Total Joint Replacement (90 day)

Source: Brandeis University analysis of Medicare claims data. Figures adjusted for hospital wage index.
# A Tale of Two Hospitals: Joint Replacement Episode

<table>
<thead>
<tr>
<th></th>
<th>St. Maximus</th>
<th>St. Minimus</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$26,231</td>
<td>$18,509</td>
<td>$7,722</td>
</tr>
<tr>
<td>Index Stay (facility)</td>
<td>$10,459</td>
<td>$10,805</td>
<td>($346)</td>
</tr>
<tr>
<td>Index Stay (prof.)</td>
<td>$2,756</td>
<td>$2,038</td>
<td>$718</td>
</tr>
<tr>
<td>Acute Readmission</td>
<td>$1,729</td>
<td>$389</td>
<td>$1,340</td>
</tr>
<tr>
<td>Rehab Hospital</td>
<td>$283</td>
<td>$0</td>
<td>$283</td>
</tr>
<tr>
<td>Long-Term Hospital</td>
<td>$503</td>
<td>$0</td>
<td>$503</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$8,475</td>
<td>$2,816</td>
<td>$5,659</td>
</tr>
<tr>
<td>Home Health</td>
<td>$1,054</td>
<td>$1,978</td>
<td>($924)</td>
</tr>
<tr>
<td>Other Professional</td>
<td>$972</td>
<td>$483</td>
<td>$489</td>
</tr>
</tbody>
</table>

Source: Brandeis University analysis of Medicare Claims data. Unadjusted data.

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Source: Brandeis University analysis of Medicare Claims data.

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![Chart showing readmission rate, percent seen by PCP in 30 days, percent SNF, and percent home health for St. Maximus and St. Minimus hospitals.](attachment:image.png)
Opportunities for St. Maximus

• Expand home health and reduce use of SNF services where appropriate
• Review surgical quality
• Put a program in place to monitor patients following discharge
• Evaluate SNF costs and consider preferred relationships with efficient facilities.

Lesson #3

Hospitals face significant risk of random variation in year-to-year spending per episode (due to low volumes) – and require program features that mitigate risk.
Illustration of Risk within a Bundle (or DRG)

Cost by Episode - DRG 312

Post-Discharge Cost Distribution: CHF (90 Days)

25th 50th 75th

$60,000
$40,000
$20,000
Impact of Random Variation on Year-to-Year Change in Average Episode Cost by Volume: CHF Admission

CHF: 90 Day Episode

*Averages do not include risk adjustment or stop loss protection.

Impact of Random Variation on Year-to-Year Change in Average Episode Cost by Volume: Multiple Episodes

Percent Gain/(Loss) by Case Volume*

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Mitigating Risk in Bundled Payment

- Episode selection and design
- Exclusions
- Risk adjustment
- Stop-loss protection
- Strong clinical process improvement and care coordination interventions

Impact of Risk Adjustment and 95th Percentile Stop Loss Protection on Gains/(Losses) from Random Variation

Percent Gain/(Loss) for Hospitals With 500 – 749 Cases*

* Analysis based on aggregated spending for 9 episodes.
Clinical Strategies Under BPCI

- Implement inpatient care pathways
- Rationalize supply chain (particularly devices)
- Put programs in place to monitor patients following discharge
  - Medication reconciliation and home assessment
  - Primary care visit within 7 days
  - Emergency plan for likely events
- Evaluate SNF and HHA performance
  - Programs/partnerships to improve service levels
  - Consider preferred relationships

Conclusion

Health Systems Have Significant Opportunities to Reduce Unneeded Medicare Spending (and Improve Quality) Through Care Coordination

Bundled Payment Creates Financial Opportunities But Also New Risks That Must Be Carefully Assessed
Developing a Strategy for Post-Acute Care for Medical Groups

Post-Acute: MedPAC/CMS Perspective

- $62 billion in 2012 – growing rapidly
- Wide geographic variation in spending
- Wide variation in quality
- Current rates overpay
- Fuzzy guidance re: site of care
- Inappropriate use/fraud
Post Acute Strategy Components

1. Right setting
2. Right post-acute care providers
3. Right relationships
   – Patient
   – Physician
   – Post-acute care provider

2008 Medicare Post-Acute Care Payments Per User by Site of Service: DRG 292 (CHF w/CC)

Within 30 Days of Hospital Discharge

Percent with Service:
- Admission: 100%
- Home Health: 60%
- SNF: 43%
- Rehab: 2%
- LTAC: 0.9%
- Readmission: 22%

$0 $5,000 $10,000 $15,000 $20,000 $25,000

## SNF Performance Tracking

<table>
<thead>
<tr>
<th>Provider</th>
<th>Admits</th>
<th>LOS</th>
<th>Cost per Admit</th>
<th>Readmit</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNF A</td>
<td>65</td>
<td>25.0</td>
<td>$13,122</td>
<td>18.6%</td>
</tr>
<tr>
<td>SNF B</td>
<td>44</td>
<td>28.8</td>
<td>$15,604</td>
<td>23.1%</td>
</tr>
<tr>
<td>SNF C</td>
<td>63</td>
<td>15.8</td>
<td>$9,101</td>
<td>11.1%</td>
</tr>
<tr>
<td>SNF D</td>
<td>34</td>
<td>24.8</td>
<td>$14,345</td>
<td>17.8%</td>
</tr>
<tr>
<td>SNF E</td>
<td>32</td>
<td>27.9</td>
<td>$14,986</td>
<td>19.3%</td>
</tr>
<tr>
<td>SNF F</td>
<td>39</td>
<td>20.7</td>
<td>$12,152</td>
<td>16.5%</td>
</tr>
</tbody>
</table>

Source: Atrius Health.

## Variation in 2009 Risk Adjusted Readmission Rates from Skilled Nursing Facilities

![Graph showing variation in 2009 risk adjusted readmission rates from skilled nursing facilities](image)

Expert Panel Ratings of Whether Hospital Admissions from Nursing Home Were Avoidable

<table>
<thead>
<tr>
<th>NH Resident Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare (n=94)</td>
<td>69%</td>
<td>31%</td>
</tr>
<tr>
<td>Medicaid/Other (n=106)</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>High Rate NHs (n=101)</td>
<td>75%</td>
<td>25%</td>
</tr>
<tr>
<td>Low Rate NHs (n=99)</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>All Residents (n=200)</td>
<td>67%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Source: Ouslander et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs. JAGS 58:627-635, 2010.

Causes of Potentially Avoidable Admissions

<table>
<thead>
<tr>
<th>Diagnoses for Potentially Avoidable Admissions n=100</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular (mostly CHF, chest pain)</td>
<td>22%</td>
</tr>
<tr>
<td>Respiratory (mainly pneumonia, bronchitis)</td>
<td>21%</td>
</tr>
<tr>
<td>Mental status change</td>
<td>13%</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>11%</td>
</tr>
<tr>
<td>Sepsis or fever</td>
<td>8%</td>
</tr>
<tr>
<td>Skin (cellulitis, wound, pressure ulcer)</td>
<td>8%</td>
</tr>
<tr>
<td>Dehydration</td>
<td>7%</td>
</tr>
<tr>
<td>Gastrointestinal (bleeding, diarrhea)</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Ouslander et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs. JAGS 58:627-635, 2010.
### Ratings of Factors Associated with Potentially Avoidable Admissions

<table>
<thead>
<tr>
<th>Factors that could have prevented hospitalization</th>
<th>Important</th>
<th>Somewhat Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH should have been able to do everything done by hospital</td>
<td>50%</td>
<td>34%</td>
</tr>
<tr>
<td>Better quality by NH physician or AP</td>
<td>55</td>
<td>28</td>
</tr>
<tr>
<td>One MD visit could have avoided the transfer</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>Better quality by NH staff</td>
<td>24</td>
<td>48</td>
</tr>
<tr>
<td>Better advance care planning</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>Residents condition limited ability to benefit from the transfer</td>
<td>19</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: Ouslander et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs. JAGS 58:627-635, 2010.

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### Resources Rated as Potentially Helpful in Preventing Avoidable Admissions

<table>
<thead>
<tr>
<th></th>
<th>Prevent Transfer</th>
<th>Very or Somewhat Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD or APC in NH 3 days/week</td>
<td>16%</td>
<td>80%</td>
</tr>
<tr>
<td>Regular NP availability</td>
<td>7</td>
<td>88</td>
</tr>
<tr>
<td>Exam by MD or APC within 24 hrs</td>
<td>40</td>
<td>52</td>
</tr>
<tr>
<td>RN providing care vs. LPN or Aide</td>
<td>6</td>
<td>85</td>
</tr>
<tr>
<td>Lab tests within 3 hours</td>
<td>15</td>
<td>74</td>
</tr>
<tr>
<td>IV Therapy</td>
<td>22</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: Ouslander et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs. JAGS 58:627-635, 2010.
Variation in Medicare Average Length of Stay in Skilled Nursing Facilities


Developing a Preferred SNF Network

Source: Adapted from Atrius Health.
Performance Expectations

• Ability to manage complex patients
• Appropriate staffing - low staff turnover
• Use “preferred” MD/APC provider
  – 24/7 coverage by provider with experience managing nursing home patients
  – MD/APC sees patient within 48 hours of admission
• Ability to treat acute exacerbations in place

Performance Expectations

• Commitment to collaborative QI work
• Process to receive “warm hand-offs” 24/7
• Point person for clinical updates
• Discharge planning that begins on admission
• Regular performance reporting
• Use preferred vendors (HHA, DME etc.)
Future Innovations

Preventing Readmissions for Skilled Nursing Facilities

- Bring ER-level care on site with telemedicine
- Prevent avoidable hospital readmissions
- Reinforce your clinical team
- Document your outcomes

New Ventures

naviHealth
Navigating Post-Acute Care

Brandeis University
Future Innovations

Our model makes it possible to deliver safe, hospital-level care in the comfort of the patient's own home. By combining our physician group model and proprietary care protocols with higher levels of service and sophisticated technology platforms, much of the care provided in hospitals can be safely delivered in the home, with greater patient satisfaction.

Learn More

“In this changes everything.”
- National Payer CEO

In a World of Expanded Accountability for Cost and Quality

An Effective Post-Acute Care Strategy is Essential
Questions

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Appendix
What’s Next?
Model 5: Chronic Care Episode

- Actionable and vetted with medical professionals
- Normative service categories
- Patient-centered
- Rapidly updated prospective risk adjustment
- Meet policy requirements
  - Measure episode performance
  - Support bundled payment systems
  - Quantify performance on total patient management
PACES/Prometheus Approach: Parse claims into Core, Typical, or Complications

Typical for Diabetes:
- Office visits
- Lab tests

Core services:
- HBA1C
- Eye exam

Complications:
- Care for DVT
- Hypoglycemia

NQF-Endorsed®

Irrelevant claims are excluded

Brandeis University

2008 Medicare Post-Acute Care Payments Per User by Site of Service: DRG 470 (Total Joint)

Within 30 Days of Hospital Discharge

# Ratings of Factors Associated with Potentially Avoidable Admissions

<table>
<thead>
<tr>
<th>Factors that could have prevented hospitalization</th>
<th>Important</th>
<th>Somewhat Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH should have been able to do everything done by hospital</td>
<td>50%</td>
<td>34%</td>
</tr>
<tr>
<td>Better quality by NH physician or AP</td>
<td>55</td>
<td>28</td>
</tr>
<tr>
<td>One MD visit could have avoided the transfer</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>Better quality by NH staff</td>
<td>24</td>
<td>48</td>
</tr>
<tr>
<td>Better advance care planning</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>Residents condition limited ability to benefit from the transfer</td>
<td>19</td>
<td>28</td>
</tr>
</tbody>
</table>

Source: Ouslander et al. Potentially avoidable hospitalizations of nursing home residents: frequency, causes and costs. JAGS 58:627-635, 2010.