

Northwestern Medicine: Strengthening Post-Acute Care Ties to Improve Patient Care

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This Q&A is with Hannah Alphas-Jackson, program director of Value-Based Delivery at Northwestern Medicine and assistant professor in surgery at Northwestern University's Feinberg School of Medicine in Chicago. In this informative exchange from December 2015, Alphas-Jackson discusses how Northwestern Medicine established a post-acute care network to provide care to patients with major joint replacement of the lower extremity, congestive heart failure, stroke, and chronic obstructive pulmonary disorder as part of the CMMI BPCI initiative.

Northwestern Medicine is a large academic health system serving the Chicago metropolitan area with four hospitals, more than 60 outpatient clinics, and a large commercial patient base. Why did you decide to get engaged in Medicare bundled payments?

Our primary objective is to provide better care for our patients, and we believe that that aim is also at the heart of what CMS [Centers for Medicare and Medicaid Services] is trying to incentivize with these new payment models. BPCI encourages collaboration across service sites and providers, which in turn can lead to more coordinated patient care.

Our involvement in BPCI is also an acknowledgement of the evolving payment landscape. It's clear that as time goes on, more and more Medicare—and likely commercial—revenue will be shifted from fee-for-service reimbursement to value-based models. We believe that BPCI offers a strategic opportunity to build our competencies around alternative payment models. By selecting a few clinical episodes to accept risk for, we're able to “dip our toe in the water,” so to speak, rather than diving right in with an ACO [accountable care organization] across our entire population or with full capitation.

Finally, BPCI presents a mechanism for increased hospital-physician alignment. While Northwestern does employ a large, multispecialty faculty practice, we believe there's still more opportunity for hospital and physician collaboration.

Under BPCI, providers have the opportunity to assume financial risk for up to 48 clinical conditions. Northwestern spent the fall of 2014 examining historical Medicare claims data to better understand

Bundled Payment for Care Improvement: Examples in Practice

The Center for Medicare and Medicaid Innovation (CMMI) created the Bundled Payment for Care Improvement (BPCI) initiative as part of an effort to encourage hospitals, physicians, post-acute facilities, and other providers to work together to improve health outcomes while lowering costs. As of January 2016, the AAMC was supporting the efforts of more than 30 hospitals to implement BPCI through the AAMC Facilitator-Convener Group.

The Examples in Practice Series highlights the challenges faced and strategies used by leaders at five health systems while participating in BPCI. These examples offer potential lessons for other academic medical centers pursuing delivery reform under alternative payment models and for the insurance administrators and policy makers designing alternative payment models.

For more information on bundled payments, go to aamc.org/bundling.

pertinent clinical and financial trends associated with different conditions and ultimately decided to assume risk for four episodes: major joint replacement of the lower extremity, congestive heart failure [CHF], stroke, and chronic obstructive pulmonary disorder [COPD]. At this point, Northwestern had approximately six months before the program go-live date of July 1, 2015. What were your priorities for key actions prior to implementation?

We conducted a gap analysis to identify key competencies we needed to fill. While we had pinpointed readmissions and post-acute care [PAC] as areas for enhanced coordination, Northwestern had limited prior engagement with PAC facilities. In fact, we had no formal PAC network or performance standards. Coupled with the fact that we used a rather conservative approach to discharge planning, we recognized that our siloed care efforts would not be tenable under BPCI. However, we had to build this competency quickly, and that was the biggest challenge. “Speed of execution” can sometimes be a challenge at a large AMC such as ours.

What progress has Northwestern made to date in terms of developing a PAC preferred-provider network?

While I think Northwestern Medicine is still in the process of developing a truly cohesive PAC strategy across our enterprise, we have implemented a systemic approach to engaging with SNFs [skilled nursing facilities] and HHAs [home health agencies]. That is, Northwestern providers use shared contracting strategies; we agree on selection criteria, performance metrics, and patient communication standards. However, Northwestern Medicine providers

stretch across multiple unique geographies, each with different coverage capabilities. As a result, we use region-specific SNF and HHA providers as well as region-specific quality committees that meet on a quarterly basis to conduct root-cause analyses for readmissions, review internal and BPCI data, and discuss potential wide-scale interventions. To date, all of our regions have selected partners and have a network in place, but the most important part of building a PAC network is actually using it. Operationalizing the network to be able to enact change is the really hard work.

So, when you realized that you needed to operationalize a PAC network and had less than half a year to do so, what did you do next?

Our efforts were focused in two domains: performance management and care management. In terms of the performance-management piece, we launched our joint quality committees with very basic metrics, focusing for now on a very limited, mutually agreed-upon set of actionable information on which, we believe, collaborative process-improvement efforts can be effective. On the care-management side, we had virtually no existing processes or resources devoted to transitions of care within SNFs or HHAs, so we were essentially faced with the decision to buy or rent the capability. That is, do we hire and train employees to monitor patients discharged to the PAC setting and help maintain our PAC relationships and care pathways, or do we hire a partner in the short term to help us operationalize necessary interventions?

After weighing quality, time, and resource constraints and organizational considerations, we ultimately decided to hire a vendor to help implement a transitional care-management pilot program. The care managers participate in interdisciplinary rounds in the inpatient setting to understand patients' clinical profiles and track patients post discharge. They are in regular contact with skilled nursing facilities and home health agencies, and, in concert with these facilities, they ensure that relevant care protocols are adhered to and conduct reviews of readmissions.

What lessons have you learned from your decision to partner for a PAC transition program?

A vendor's program can't be taken out of the box and layered directly into your system—a lot of customization is needed. Their programs must fit within existing processes, avoiding duplication, redundancy, and non-value-added activities. For example, many PAC providers employ their own version of a transitional-care "liaison" to help smooth the transition from our hospitals to the next setting of care. This individual is used slightly differently by each of the PAC

providers, sometimes only focusing on communicating with the patient and supporting nonclinical needs, while other PAC providers help coordinate communication of key clinical information between the hospital and the facility. Navigating the needs of each provider partner and the supplemental processes, communication, resource allocation, etc., that are needed is key to not only maintaining an efficient program but also to keeping the PAC partners engaged.

Perhaps most importantly, the vendor needs internal buy-in. AMCs are extraordinarily complex organizations with unique people, processes, and workflows that can be challenging to learn. Ultimately, a program like this necessitates learning the unique features of complex organizations and actually integrating them into the frontline teams. What was and continues to be key to our success is ensuring that the care managers are embedded as part of frontline operations. We have used our unit-based structured interdisciplinary rounds [SIDR] process and other care-team "huddles" to engage our transitional-care managers as key players in conversations about the patient's plan of care.

Do you believe these efforts are having an impact on care yet?

It's probably too soon to tell from a numbers perspective as we haven't yet received our first quarterly reconciliation results, but I am extremely optimistic. Physician and multidisciplinary-team engagement has been extraordinary. In terms of some initial trends, we don't focus on one single number. Because our goal is better patient care, we try to frame things around more patient-centric outcomes. Readmissions, for instance, by most definitions, excludes stays in the hospital for observation. To the patient, however, being admitted as an inpatient or being observed under observation status doesn't necessarily "feel" different. Therefore, we track all "bounce-backs," whether inpatient, observation, or emergency room visits. All of those encounters can be equally important in revealing potential opportunity for improved coordination of care. Initial trends in the data seem positive. But we recognize that this is a journey, and six months of moving in the right direction doesn't mean that there isn't a lot more incredibly important work to be done!

Do you have any recommendations for other AMCs with interest in managing and improving episodes of care?

Truly managing and improving episodes-of-care experience and outcomes often requires significant care redesign. The way that providers have been compensated and incentivized historically has enabled evolution of siloed

systems of care. Within any single dimension, elements may be high-performing, but from a patient-centric perspective, it often feels disjointed. The redesign required for episodes-of-care management, at least in my experience, particularly at a high-performing AMC, is more about culture change and enabling process improvements across silos and less about implementing evidence-based practices within any one silo. Based on our early experiences, here are a few lessons learned for other providers considering managing episodes of care:

- Physician engagement and leadership is absolutely critical. Effective and lasting care redesign can't and won't happen without an energetic, passionate physician champion driving the change.
- Access to comprehensive data and robust, meaningful analytics is paramount to success in episodes of care, not just for performance management, but for defining your opportunities, engaging your care teams, and justifying your efforts.
- You have to be willing to go deep on operations, sometimes really deep. This could mean anything from understanding your inpatient registration process to emergency room throughput, to understanding how discharge follow-up appointments are made, to understanding clinic access and availability scheduling templates—the list goes on. Which areas to focus on and why are driven by comprehensive data and robust, meaningful analytics (see previous item!).
- Think beyond your walls. You don't have to own every piece of the continuum to make meaningful change across an episode of care.
- You have to be willing to invest in additional resources to support this work.