MANAGING OUTPATIENT SPECIALIST ACCESS TO IMPROVE QUALITY, LOWER COST, AND MINIMIZE SYSTEM LEAKAGE

MetroHealth System
Cleveland, Ohio

VALUE-BASED CARE IN CARDIOLOGY FORUM

AMERICAN COLLEGE of CARDIOLOGY

AT A GLANCE

System Background

- Main campus safety net hospital with 26 satellite clinics
- Academic, employed practice with 800+ physicians, including 22 cardiologists
- Affiliated with Case Western Reserve University
- $1.47B total revenue, $180M cardiology revenue

Patient Population

- 35-40% Medicaid; 35% Medicare; 15% Commercial
- ~24,300 hospital admissions, 123,000 ED visits, 1,280,000 outpatient visits in 2020
- >155,000 cardiology encounters per year

Risk-Sharing Status

- Over 5 consecutive years of Medicare shared savings, provided CMS with $37.7 million savings at an average of 8% savings per year.
- Direct Contracting Entity: 100% risk for ~10,000 Medicare beneficiaries
- Medicaid HMO: 100% risk for ~90,000 Medicaid beneficiaries

Forum Presenters

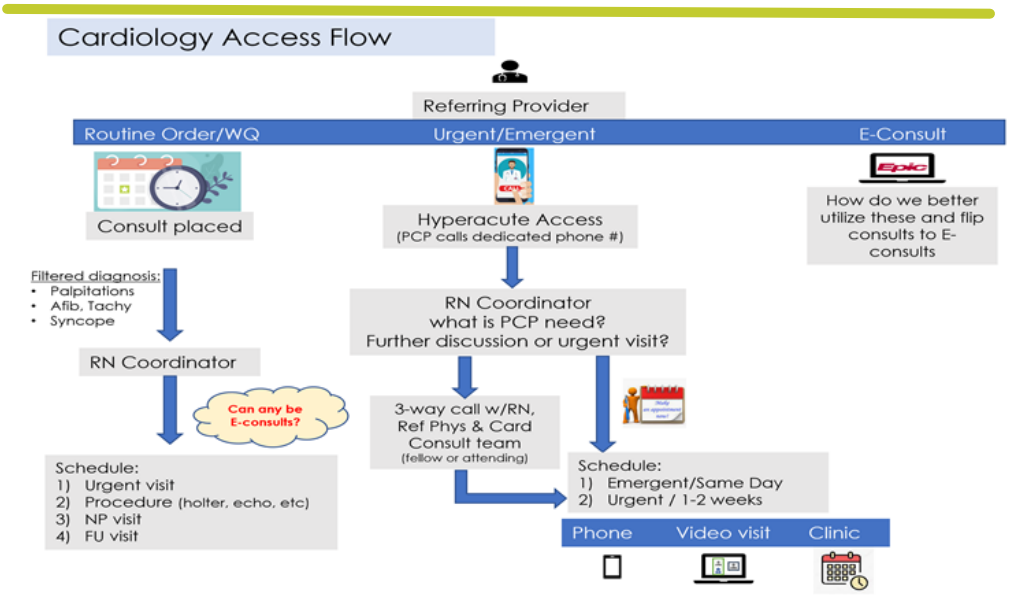
Sanjay Gandhi, MD, FACC
- President Elect, Medical Staff

Sherman Lee, MHA
- Manager, Population Health Operations

Medicare Beneficiaries	
White	70%
Black	25%
Hispanic	2%
Asian	2%
Native American/ Other	4%
Female	57%
Male	43%
Average Age	71 years

Top 10 Cardiology Diagnoses

- Essential primary HTN
- CAD without angina
- Abnormal EKG
- Paroxysmal atrial fibrillation
- Chronic systolic heart failure
- Long-term use of anticoagulants
- Hyperlipidemia, unspecified
- Presence of cardiac pacemaker
- Palpitations
- Mixed hyperlipidemia
- Chest pain, unspecified



ALIGNMENT WITH CMMI STRATEGIC PRIORITIES

Accountable

- Timely access to high-value consult
- Reduce wait time for cardiology contact from 48 days to 48 hours

Equitable

- Right care, right time, right cardiologist, right setting
- Improve content and timing of primary care referral to cardiology

Innovative

- Urgent access to cardiologist with option for virtual or STAT encounter
- Reduce ED use and move patients efficiently within system

Affordable

- Reduce low-value care
- Reduce total spend outside system for CV service line

Transformative

- Create testing ground to scale up for more population-based care

UTILIZING PAYER-PROVIDED DATA TO IMPROVE CARE DELIVERY

Jamaica Hospital Medical Center
MediSys Health Network
New York, NY

VALUE-BASED CARE IN CARDIOLOGY FORUM

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AT A GLANCE

System Background

- MediSys Health Network: New York not-for-profit corporation
- Entire network includes 2 hospitals and 28 outpatient clinic sites with 578 employed physicians

Patient Population
(Jamaica Hospital Medical Center)

- 60% Medicaid; 20% Medicare; 15% Commercial; 5% Uninsured
- 28,000 inpatient admissions; 762,000 outpatient visits; 118,000 ED visits per year
- 120,000 cardiology encounters per year

Risk-Sharing Status

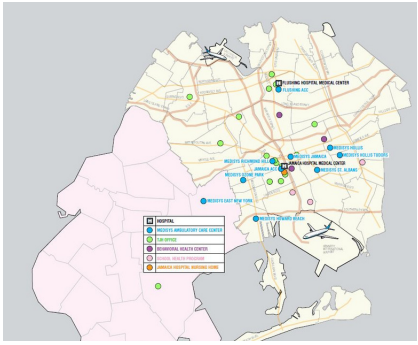
- Positive excess medical revenue in past 5 years
- Medicaid HMO: ~100% risk for ~170,000 Medicaid and Medicare beneficiaries
- Positive findings year over year when comparing capitation performance with estimates of putative equivalent fee-for-service performance

Forum Presenter

Robert I. Mendelson, MD, MS, MBA, FACC
- Chair, Department of Medicine
  Jamaica Hospital Medical Center
- Medical Officer
  TJH Medical Services, PC

Jamaica Hospital Medical Center

- Located in Jamaica, Queens
- 404-bed medical center with 25 outpatient sites staffed by employed physicians
- Safety net hospital



Insights

Payment
- Medicaid HMO insurance company provides capitated payment; however, patients are unaware of cardiology sub-capitation and go out-of-network
- Despite capitation, insurance company still requires authorization for tests and specialist referrals, creating delays in care

Quality
- Quality metrics (HEDIS/QARR) are responsibility of primary care; cardiology could have an impact, but normally has not been given access to population health databases

Collaboration
- PCPs rely on direct conversations with cardiologists to understand ACC/AHA and ESC guidelines
- Common electronic medical record and familiarity between clinicians key to coordination between PCPs and cardiologists

ALIGNMENT WITH CMMI STRATEGIC PRIORITIES

Accountable

Goal: Maintain patients in network
High percentage of patients seen by PCP at least yearly; reduction in out-of-network spending

Equitable

Goal: Easy availability of PCP and specialist appointments at ambulatory clinics and cardiac testing facilities
Reduction in appointment wait time

Innovative

Goal: Reduce utilization and improve health of high-risk, high-cost patients through care management system
Reduce hospital admissions and ED visits for patients identified as high-utilizers

Affordable

Goal: Increase PCP-specialist coordination and communication to increase care efficiency and reduce duplication
Reduction in out-of-network spending; continue positive excess medical revenue

Transformative

Goal: Payer-provided claims data in usable format informs understanding of patient and physician utilization to optimize care outcomes and revenue
Reduction in out-of-network spending; increase in excess medical revenue; increase in quality ranking

BUILDING A VIRTUAL RURAL NETWORK THROUGH TELEMEDICINE

Augusta University Health
Augusta, Georgia

VALUE-BASED CARE IN CARDIOLOGY FORUM

AMERICAN COLLEGE of CARDIOLOGY

AT A GLANCE

System Background

- 478-bed medical center; 80 outpatient clinic sites
- Safety-net hospital serving over 24 counties in GA and SC
- Physicians and staff employed by the State of Georgia
- 650-member physician practice group including MDs and advanced practice providers

Patient Population

- 18% Medicaid; 22% Medicare; 38% Commercial
- 19,000 inpatient visits annually
- 400,000 outpatient visits annually
- Annual telemedicine visits: 7,000 (post-pandemic); 1,000 (pre-pandemic)

Risk-Sharing Status

- Participated in BPCI Advanced heart failure episode as AU Health's first experience with a two-sided risk model
- Achieved $561,000 in incentives for reducing cost of care, primarily through readmissions reduction
- Opted out of the program in Dec. 2020 due to methodology change at height of the pandemic

Forum Presenters

Matthew Lyon, MD, RDMS
- Vice Chair, Emergency Medicine and Service Chief, Virtual Care

Pascha E. Schafer, MD, FACC
- Chief Quality Officer, Associate Chief Medical Officer

Lauren Williams Hopkins, MPH
- Director of Population Health and Virtual Care

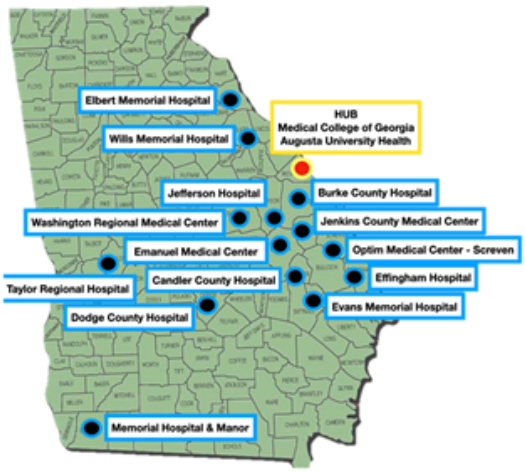
Phase 1
- ER to ER Telemedicine Consults
- **Avoidance of unnecessary transfers**

Phase 2
- Inpatient/Critical Care Telemedicine Consult
- Increase Rural Hospital Average Daily Census (ADC)
- **Decrease unnecessary transfers**

Phase 3
- Return of transferred patients
- Post-Acute Care Relationship
- **Increase Rural Hospital Average Daily Census (ADC)**

Phase 4
- Stop the Leakage, Turn the Valve
- Reduction of Unnecessary Transfers
- Meet Rural Hospital ADC Goals
- **Continued Post-Acute Care Partnership by Mutual Benefit Optimization**

Telemedicine Snapshot	#	%
Total Patients to Date	1068	
Total Telemed Days	5186	
Average Telemed Days/pt	4.78	
Total D/C or S/O	715	65.0%
Total EOL Care	114	10.7%
Transfers to AU	220	20.6%
Transfers to Other	39	3.7%
Deaths @ AU after Transfer	66	30.0%
COVID Consults	738	69.1%



ALIGNMENT WITH CMMI STRATEGIC PRIORITIES

Accountable
- Ecosystem with shared accountability and timely access to high-value virtual consult
- Keeping rural patients in their communities improves financial viability of rural hospitals

Equitable
- Improved quality of end-of-life care close to patient's social supports

Innovative
- Virtual rural network elevates capabilities and manages capacity
- Emergency waivers allowed for timely transfers, shared care, appropriate utilization of acute resources

Affordable
- Reduced transfer rate from 80% to 23% in one year
- Kept technology costs down; no use of proprietary software or hardware

Transformative
- Goal of returning to grow non-COVID business

HEART FAILURE BRIDGE CLINIC: CONSISTENTLY DELIVER EVIDENCE-BASED CARE THROUGH AN INTEGRATED DISEASE MANAGEMENT PROGRAM

Johns Hopkins Medicine
Baltimore, Maryland

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AT A GLANCE

System Background

- 6 academic and community hospitals with >40 outpatient care locations in MD and DC
- >2,600 patient beds across all hospital locations

Patient Population

- Johns Hopkins Hospital
  9% Medicaid; 45% Medicare
- Bayview Medical Center
  20% Medicaid; 47% Medicare
- ~100,000 hospital admissions; 325,000 ED visits; 902,000 outpatient visits; 160,000 home care patients annually
- >62,000 outpatient cardiology visits in FY 2021

Risk-Sharing Status

- Maryland Total Cost of Care Model
- Population-based payments for all hospital services during the year
- Incentive payments to collaborative nonhospital health care providers
- Per beneficiary per month payment for primary care management services
- Outcomes-Based Credits awarded based on performance

Forum Presenters

Scott Berkowitz, MD, MBA, FACC

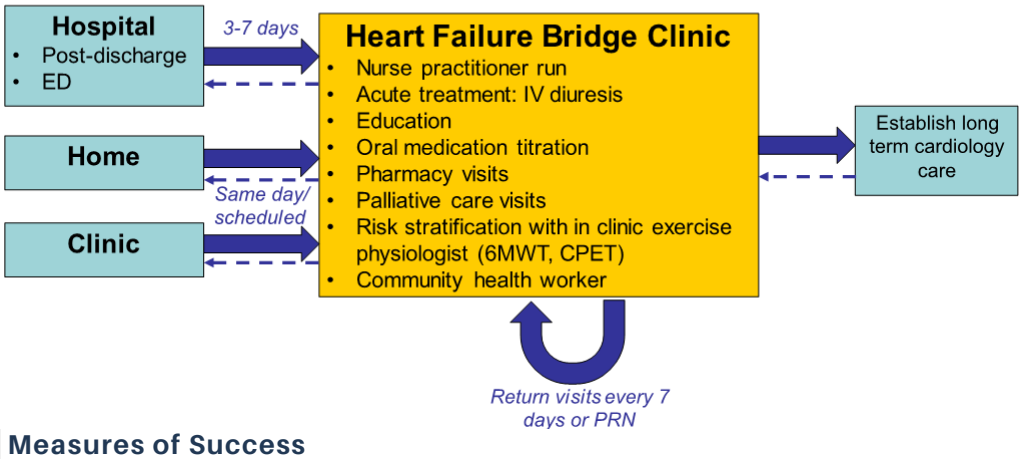
- Chief Population Health Officer and Vice President, Population Health
- Associate Professor of Medicine, Division of Cardiology
- Executive Director, Johns Hopkins Medicine Alliance for Patients

Nisha A. Gilotra, MD, FACC

- Assistant Professor of Medicine
- Director, Heart Failure Disease Management
- Advanced Heart Failure/Transplant Cardiology

Clinic Referral Workflow

JOHNS HOPKINS MEDICINE



Measures of Success

- Evidence-based care delivery metrics
- Impact on acute care utilization
- Patient reported outcomes

ALIGNMENT WITH CMMI STRATEGIC PRIORITIES

Accountable

- Guideline directed therapy; multi-disciplinary team; delivery of evidence-based medicine
- Continuous initiatives to improve % of eligible hospital discharges that complete Heart Failure Bridge Clinic

Equitable

- All-inclusive referral process to provide equitable access post-discharge
- Patient demographics: 47% Female; 57% Black; 36% White; 24% Medicare

Innovative

- Improved access to ambulatory care for acute worsening of chronic disease
- Focus on helping patients manage HF during care transitions

Affordable

- Consistently deliver access to evidence-based, integrated care
- During 3-month pre-and post-visit period, reduction in acute care charges was $15,311 per patient
- During 1 month pre-and post-index visit, percentage of patients seeking acute care reduced from 83 to 25%
- 30-day all cause readmission for patients seen in HFBC: 10-12% (vs. JHH HF readmission rate of 22-25%)

Transformative

- Scaling program to other JHM hospital communities to increase access across region
- All payors
- Learning collaboratives to share best practices