

Maryland on the Leading Edge: Transforming Healthcare

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Objectives

Opportunity
for Maryland
to be a
**NATIONAL
LEADER**
in health
care

CHANGE
the way we
pay for and
provide
health care

BUILD
on the great
system we have
and make it
even better:

- *More affordable*
- *Safer*
- *A healthier Maryland*

History

- MARYLAND – only state where hospitals don't decide how much to charge for care payment
- “All-Payer” system of hospital payment
- A 40-year agreement with Medicare
- Allows Maryland to “waive” Medicare payment rules, set rates hospitals charge
- Can keep as long as we meet waiver “test”
 - Growth in Medicare spending per hospital stay less than the nation

History

40-year-old waiver “test” was out of date

Old Test

Inpatient care



Medicare only



Cost of care per hospital stay



New Test

All hospital care

All payers

Cost of care per person overall

Starts with Hospital Care

- Work together to slow growth in spending for hospital care
- Continue Maryland's unique way of setting hospital prices
- Change how hospitals are paid to reward the right things

Affordable

Slow growth in spending for hospital care

- Track spending in inpatient and outpatient care in Maryland
- Grow no faster than the overall economy
- Cut growth in hospital spending in half

Safer



COMPLICATIONS: patients who get infections and complications while in the hospital

Maryland rates of infection **HIGHER** than nation

REDUCE infections and other “hospital-acquired conditions” by 30% in 5 years

Better, **SAFER** care

Safer



READMISSIONS: patients who return to the hospital within 30 days of hospital discharge

Maryland ranks poorly (almost last) – 49 of 51 states and D.C.

Bring Maryland readmission rates to **NATIONAL AVERAGE** in 5 years

Better, **SAFER** care

All About You

Change how hospitals are paid to reward the right things

- Hospitals previously paid more to do more
- Can lead to unnecessary procedures, visits and care
- Hospitals now rewarded for helping people stay healthy, well and out of the hospital
- Nearly all hospital payments will reward health and wellness in five years

Challenges

- Never been tried or tested before
- Hospitals in serious financial condition
- New hospital spending limits tight
- Aggressive quality targets
- Will require hospitals to redefine themselves
- Will require communities to work together to keep people healthy
- Will require patients and families to truly engage in their care

“Railroad Moment”

- Railroads went out of business because they thought they were in the railroad business instead of recognizing they were in the transportation business
- Hospitals realize they are in the health care business, not the hospital business

Source: 2012 Kaufman, Hall & Associates, Inc; Jason Sussman

Readmission Reduction: Recommendations for Hospitals

1. Adopt a portfolio of strategies

Adopt a Portfolio of Strategies



- No “silver bullet” intervention
- Opportunities are
 - numerous;
 - involve multiple departments;
 - utilize existing and new staff; and
 - require new partnerships

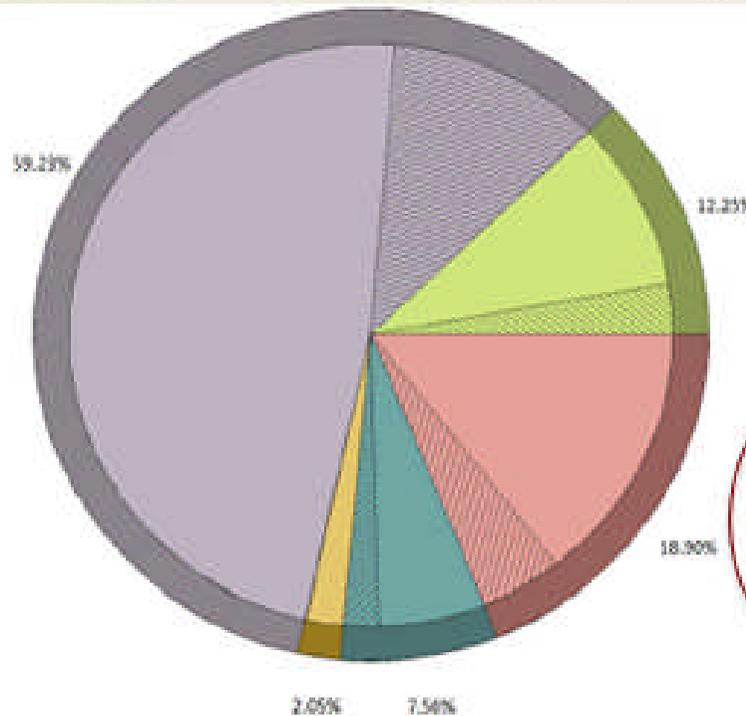
Readmission Reduction: Recommendations for Hospitals

1. Adopt a portfolio of strategies
2. Focus on Readmissions from Post Acute Settings

Post-acute Readmissions: Data

Maryland Post-Acute Care Readmissions by Setting – CY2012

59% of d/c to home
 55% of all RA from home
 19% RA rate
 25,654 RA in from home 2012



12% of d/c to HH;
 14% of all RA from HH
 21% RA rate
 6,262 HH RA in 2012

18% of d/c to SNF;
 21% of all RA from SNF
 22% RA rate
 9,879 SNF RA in 2012



Dr. Amy Boutwell. *Transitions: Handle with Care* Statewide Meeting. November 14, 2013.

Know the Local Providers

- What is their 30-day hospital readmission rate?
- What is their standard communication when sending a patient to the hospital, especially ED?
- Do they have an EMR? Subscribe to CRISP?
- Do they offer programs for chronic disease management? Hospice and/or palliative care services?
- What is their average length of stay?
Disposition statistics?

INTERACT



Interventions to Reduce Acute Care Transfers

Home ❖ About INTERACT ❖ INTERACT Tools ❖ Educational Resources ❖ Links to Other Resources ❖ Project Team ❖ Contact Us

- [INTERACT Version 3.0 Tools For Nursing Homes](#) (Authorized printed INTERACT materials are available for your convenience, for more information [click here](#).)
- [INTERACT Version 1.0 Tools For Assisted Living](#)
Currently undergoing pilot testing projected release in mid 2014 (if you have a Username and Password for pilot testing these Tools [click here](#))
- [INTERACT Version 1.0 Tools For Home Health Care](#)
Currently undergoing pilot testing projected release in mid 2014 (if you have a Username and Password for pilot testing these Tools [click here](#))
- [INTERACT Version 1.0 Tools For ACOs and Health Systems](#)
Under Development (if you have a Username and Password for pilot testing these Tools [click here](#))

MOLST

POLST is effective in reducing unwanted hospitalization & medical intervention

The image shows a pink POLST form with the following sections:

- Header:** "Physician Orders for Life-Sustaining Treatment (POLST)", "State of California", "Patient Name", "Date of Birth", "Last Four Digits of Social Security Number".
- A. CARDIOPULMONARY RESUSCITATION (CPR):** "Person has no pulse and is not breathing".
 - Advanced Resuscitation (AR) - Full Treatment required.
 - Do Not Attempt Resuscitation (DNAR) - (Give Patient's Name)
- B. MEDICAL INTERVENTIONS:** "Person has pulse and/or is breathing".
 - Comfort Measures Only - Use medication to ease pain, sedation, anxiety, and other measures to relieve pain and suffering. Use oxygen, suction, and manual respiration if always indicated as needed for comfort. Intubation only in extreme cases. Transfer if comfort needs cannot be met in current location.
 - Limited Additional Interventions - Include care described above. Use medical treatments, medications, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid invasive care.
 - Do Not Transfer to Hospital for Medical Interventions. Transfer if comfort needs cannot be met in current location.
 - Full Treatment - Intubation and mechanical ventilation as indicated. Hospital to hospital if indicated. Includes intubation and additional interventions as indicated. Transfer to hospital if indicated.
- C. ARTIFICIALLY ADMINISTERED NUTRITION:** "Offer food by mouth if feasible and desired".
 - No artificial nutrition by tube.
 - Long-term artificial nutrition by tube.
- D. SIGNATURES AND SUMMARY OF MEDICAL CONDITION:**
 - Physician Signature: _____ Date: _____
 - Physician License Number: _____
 - Signature of Patient, Surrogate/Proxy, or Representative: _____ Date: _____

Journal of the American Geriatrics Society,
Volume 58, Issue 7, 2010. Pages: 1241–1248.

POLST
CALIFORNIA

Recommendations

1. Adopt a portfolio of strategies
2. Focus on Post Acute Settings Facilities
3. Partner across the continuum

Partner Across Continuum

“Rehospitalization is a system issue and the problem does not lie with one organization or one provider, but with the community and the local health care system. Addressing this issue will require organizations and providers to work together.”

- Anne-Marie Audet, VP, The Commonwealth Fund

Recommendations for Hospitals: Recap

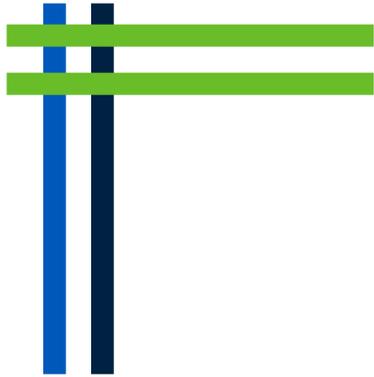
- Readmissions
 - Adopt a portfolio of strategies
 - Focus on post acute settings
 - Partner across the continuum

Recommendations for Post Acute Facilities

- Know your readmission rates and top reasons for acute hospital transfers
- Review every acute hospital transfer as a potentially avoidable event
- Download and use the INTERACT toolkit
- Meet monthly with hospitals to identify shared opportunities for improvement
- Tell hospitals what you need from them when accepting a patient to your care

How do we Get There?





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