

ADHD: promoting use of evidence-based guidelines and encouraging consistent interaction with parents and patients

How ADHD is treated today

- Non-medication interventions account for over 50% of total costs for ADHD patients¹ and are in many cases used when evidence-based clinical guidelines recommend alternative approaches including careful medication management
- The choice of interventions is closely related to setting of care and not necessarily to needs

Our vision for improved delivery of ADHD care

- Providers will use assessments in line with AAP/AACAP² guidelines to determine the appropriate combination of medication, parent/teacher behavior support, and psychosocial therapy for the child's condition
- The providers most involved in a child's care will educate the patient and the patient's family on appropriate support and coordinate care to ensure consistent monitoring

Why the episode model encourages improvements in ADHD care delivery

- Providers delivering ADHD care will share financial responsibility for the costs of non-medication interventions; cost thresholds will be set in line with certifications identifying the guideline-prescribed level of care for each patient's condition
- Providers who effectively educate families on how to support their children and who consistently coordinate care to monitor the children's conditions will be rewarded, as they share in the savings from reduced need for inpatient stays or residential treatment

ADHD will provide a model for the design of other clinical episodes

- **Episodes for other behavioral and mental health conditions**
- **Episodes in which coordinating care with families plays a key role in effective management**

¹ Based on ADHD patients age 6-17 with no major comorbidities

² American Academy of Pediatrics / American Academy of Child and Adolescent Psychiatry

Ambulatory Upper Respiratory Infections: encouraging appropriate use of antibiotics and choice of care setting

How Ambulatory URIs are treated today

- Nearly 50% of adults receiving care for simple upper respiratory infections in AR receive antibiotics, even though nearly all of these infections are viral and unaffected by antibiotic treatment
- Follow-up care often occurs in-person when a telephone call would suffice, as providers are only compensated for in-person follow-up
- Approximately 10% of patients who seek care for a cold or sore throat visit the Emergency Department

Our vision for improved Ambulatory URI care

- Clinicians invest time in patient education about the typical course of upper respiratory infections
- Antibiotics are prescribed only in cases in which the infection is likely bacterial and the patient could benefit from antibiotic therapy
- Patients are able to receive follow-up consultation over the phone or by email, instead of having to return to a physician clinic
- Emergency Departments (EDs) refer patients to PCPs when the clinic is a more appropriate setting

Why the episode model encourages improvements in Ambulatory URI care delivery

- Clinicians share financial responsibility for the costs of antibiotic prescriptions, encouraging more judicious use
- Providers are rewarded for offering follow-up care in lower-cost, more convenient care settings (e.g., by phone, email, or PCP if needed), as they share in the costs of additional in-person follow-up
- EDs are incentivized to refer URIs to more appropriate settings, as they share accountability for costs incurred

Ambulatory URI will provide a model for the design of other clinical episodes

- **Episodes with many patients who are not treated in the appropriate setting of care:** e.g., otitis media, ankle sprains
- **Episodes in which the primary care provider is principally accountable:** e.g., diabetes, hypertension

Congestive Heart Failure: extending the hospital's accountability beyond the point of discharge

How CHF acute/post-acute care is treated today

- Care is fragmented among many providers – hospitals, cardiologists, primary care providers, hospitalists, SNFs/rehab facilities, and others – and no single provider is accountable
- Quality patient education at discharge is not rewarded, and care after discharge is rarely coordinated with hospital care
- Across all payors, ~20% of CHF admissions have at least one all-cause readmission within 30 days

Our vision for improved delivery of CHF care

- Providers will work together as a team to deliver care for a CHF episode, and the hospital will be accountable for coordinating
- Hospitals will invest in patient education, improving the quality and accessibility of discharge instructions
- The hospital will be accountable for managing the transition to chronic care management, improving coordination of care

Why the episode model encourages improvements in CHF care delivery

- Innovations that reduce the rate of complications (e.g., due to medical errors, infections, etc.) will be rewarded, as providers will receive a share of the resulting cost savings
- The hospital will share financial responsibility for readmissions, encouraging investment in patient education, transition management, and other services that improve post-discharge outcomes

CHF will provide a model for the design of other clinical episodes

- **Episodes with a high rate of preventable hospital readmissions:** e.g., acute myocardial infarction (heart attacks), pneumonia
- **Episodes with follow-up chronic care management:** e.g., autoimmune disorders, chronic kidney disease
- **Episodes in which the hospital is the principal accountable provider:** e.g., trauma

Developmental Disabilities: minimizing resources not focused on delivering care and improving coordination of DD and medical care

How DD services are provided today

- Level of services provided varies significantly but is not tied to a consistently deployed assessment of the client's level of need
- Providers must maintain detailed activity logs for compensation, spending considerable resources on non-care activities
- DD clients incur greater medical costs than the population at large, often due to a lack of coordination between DD services and medical care

Our vision for improved delivery of DD services

- A consistent assessment will be used to determine each client's level of need, and providers will be compensated based on the level of services required to effectively match the client's need
- Information that providers are required to record and submit will be limited to that which is needed to ensure quality of care
- DD clients will be served by a health home which considers the client's full set of needs across the entire continuum of care, including DD, medical and behavior health, and coordinates among participating providers.

Why the new payment model encourages improvements in DD service delivery

- Instead of receiving fee-for-service payments tied to detailed activity logs, providers will receive a bundled episode payment set in line with the level of services suggested by an assessment administered annually
- Health homes will be rewarded for coordinating care for DD clients

The Developmental Disabilities episode will provide a model for the design of other episodes

- **Episodes in which significant resources are devoted to non-care services**
- **Episodes in which level of care is not effectively aligned today with level of patient/client need**

Hip/Knee replacement: reducing readmissions and rewarding efficient hospitals

How hip/knee replacements are performed today

- The operating surgeon is responsible for a patient while he or she is in the OR, but has limited accountability for care before and after the procedure
- There is wide variation in readmission rate by surgeon, ranging from under 5% to above 30%
- Surgeons and hospitals are not rewarded for innovations that allow for more efficient delivery of hip/knee replacements

Our vision for improved hip/knee replacements

- The surgeon who performs the procedure will coordinate care leading up to and following the procedure
- Surgeons and hospitals will partner to reduce the rate of post-op infections and to drive clinical innovations for more efficient care delivery
- Hip/knee replacements will be provided by the highest-quality, most efficient hospitals in a region

Why the episode model encourages improvements in hip/knee replacement care

- The orthopedic surgeon will be held accountable for a portion of the cost of readmissions, rewarding surgeons who succeed in coordinating pre- and post-operation care, patient education, and post-discharge management
- Hospitals will share financial responsibility for the overall episode costs, encouraging them to invest in finding operational efficiencies and reducing readmissions
- Surgeons also receive a share of episode savings, encouraging them to partner with hospitals to improve care quality and directing additional case volume to the most efficient hospitals

The hip/knee replacement episode will provide a model for the design of other clinical episodes

- **Episodes in which surgeons have a choice of hospitals for acute procedures**
- **Episodes in which there are multiple principal accountable providers**

Pregnancy: rewarding evidence-based prenatal care and promoting more appropriate use of C-sections

How pregnancies are cared for today

- Different segments of care – the prenatal phase, delivery, postnatal care for the mother, and neonatal care for the child – may be delivered by multiple, uncoordinated providers
- There is material variation among providers in the rate of elective C-sections, which drive higher costs and may expose patients to greater risk during delivery: 34% of all Medicaid pregnancies involve C-sections, and about one-third of providers have rates in excess of 45% in the Medicaid population

Our vision for improved delivery of perinatal care

- One physician will be accountable for the whole episode from prenatal care through delivery and will coordinate care among all providers involved
- Evidence-based prenatal care will be provided to maximize the likelihood of a successful delivery and health baby
- Patients will undergo delivery by C-section only when risk factors suggest that it is medically beneficial

Why the episode model encourages improvements in perinatal care delivery

- The physician overseeing prenatal care and delivery is accountable for the full episode of care; those who excel at delivering high-quality prenatal care share in the financial savings from improved outcomes in delivery and postnatal care
- The episode holds providers accountable for a portion of the additional costs and risks incurred for elective C-sections, while recognizing that such procedures are appropriate for patients with certain risk factors

The Pregnancy/NICU episode will provide a model for the design of other clinical episodes

- **Episodes with a significant period of monitoring and preventive care prior to an acute procedure**