Accelero SM
HEALTH PARTNERS

Accelero Helps Hospital to Improve Quality and Lower Episode of Care Costs

Success in bundled payment through patient optimization, patient education and coordination of post-discharge services

AT A GLANCE

- 128 bed acute care hospital in the Northeast
- Part of a 14 hospital healthcare system
- Participant in the CJR mandatory bundled payment program
- Averaging over 360 joint replacement cases per year

ISSUES

- Higher clinical complication rate compared to CMS Hospital Compare average
- Large number of patients being discharged to Skilled Nursing Facility (SNF) vs. home or home health
- Lack of infrastructure to ensure entire episode of care is managed appropriately and efficiently

IMPLEMENTATION FOCUS

- Engaged surgeons, physicians and clinical staff to develop an evidence-based, best practice order set, pain management protocol and rehabilitation guidelines
- Met with SNF and home health providers regularly to establish progressive rehabilitation program, monitor outcomes and report metrics to the hospital

INTRODUCTION

This 128 bed acute care hospital is located in the Northeast and is part of a 14 hospital healthcare system. The hospital performs over 300 joint replacement cases per year and is in a geographic region for the mandatory Comprehensive Care for Joint Replacement (CJR) program.

The CJR program focuses on a hospital's episode of care costs for Medicare total hip and knee replacements. In brief, hospitals can be rewarded or penalized based on their total episode of care costs compared to a blended average of their past costs and the regional average. To be successful in the CJR model, a hospital needs to not only manage the cost of the index admission (length of stay, operating room costs, in-hospital complications, supply costs) but also their costs for 90 days after discharge (post-acute skilled nursing/homecare/outpatient physical therapy utilization and certain defined readmissions). The post-discharge costs depending on utilization can be on average as high as 40% of the 90 day episode of care cost and is an area where a hospital in the past did not have any incentive to manage.

While the hospital had spent some time on creating a joint replacement program with emphasis on consistent order sets and pathways and length of stay management, there was no infrastructure in place to manage the entire episode of care both efficiently and effectively. Their key baseline joint replacement metrics are presented in FIGURE 1.

Metric	Baseline	Post-implementation
Length of stay 2 days and less	9%	60%
Coded complication rate	6.5%	5.0%
First case on time start	69%	90%
Surgeon turnover time	32 minutes	19 minutes
Discharge to home/home health	38%	60%

FIGURE 1 I Key hospital metrics at baseline and post-implementation

SOLUTION

Accelero Health Partners worked with the hospital on implementing change through the formation of three teams; a Clinical Transformation Team, a Perioperative Team and a Post-acute Care Team.

The main focus of the clinical transformation team was to develop an evidence-based/best practice order set along with updating their pain management protocol and in-hospital rehabilitation process. A dedicated quality resource performed a root-cause analysis for hospital acquired complications and the team used that information to enhance the patient optimization process and implement a risk reduction protocol in high risk patients. Goal-based discharge criteria were established to optimize the length of stay and discharge location. Based on the work the team performed, there was an improvement in the length of stay and a decrease in in-hospital coded complication rate (FIGURE 1).

The perioperative team focused on creating standard work processes around case cart accuracy and patient scheduling processes to ensure that the first case on start time improved. The team implemented parallel processes to improve turnover time. The results of this team's work are reflected in the improvement in first case on time start metrics and surgeon turnover time (FIGURE 1).

A Post-Acute Care Team was established which integrated SNF, home health and outpatient providers with the hospital. Rehabilitation guidelines were established at each level in order to optimize care and decrease post-discharge variability and costs. Communication processes were established in order to decrease the readmission rate. FIGURE 1 outlines the improvement in discharges to home/home health.

SUMMARY

The improvement in episode of care metrics in this case study revolves around three key areas in which Accelero Health Partners was able to help the hospital: understanding episode of care costs/key levers to improve these costs, creating an infrastructure that promoted action and a mindset of continuous improvement in all processes. These three areas drove the changes that are displayed in FIGURE 1. In combination, these changes led to costs savings on the anchor hospital admission of $863/case and a decrease in the episode of care cost of $1,858/case (FIGURE 2).

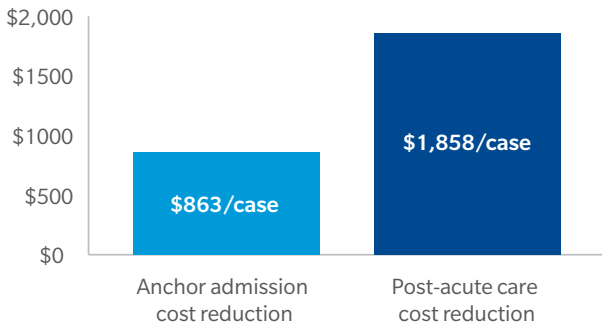

FIGURE 2 I Overall cost savings

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