Senate Special Committee on Aging

Field Hearing | July 31, 2015 | Five Star Senior Center, St. Louis, Missouri

Testimony Delivered by Sandra Van Trease – Group President, BJC HealthCare

Introduction

Members of the Committee, I thank you for the opportunity to speak before you today. My name is Sandra Van Trease, and I am a Group President for BJC HealthCare (BJC). BJC is one of the largest nonprofit health care organizations in the United States with 12 hospitals, multiple community health locations and some 26,000 employees. BJC delivers the full spectrum of health care services including inpatient and outpatient care, primary and critical care, community health and wellness, home health, behavioral health, rehabilitation, long-term care and hospice to residents primarily in the greater St. Louis, southern Illinois and mid-Missouri regions.

In my role, I am responsible for the BJC Medical Group, the BJC Accountable Care Organization, the BJC Collaborative – a consortium of six leading not-for-profit health systems in Missouri and Illinois – and several of our community hospitals. My comments before the committee will be focused on BJC's journey toward accountable care, what makes the BJC ACO unique and how we have impacted the senior populations we serve. I will also discuss some of the challenges we have faced along our journey toward providing the best possible care to our seniors.

BJC's Journey toward Accountable Care

In July 2012 BJC became the first health care provider in the St. Louis area, and one of only 89 in the country, to take on the challenge of forming an accountable care organization to take better care of seniors by participating in the Medicare Shared Savings Program (MSSP). Our current three-and-a-half year contract with CMS includes no downside risk and allows for equal savings between CMS and the BJC if we reach the necessary targets. When our current contract expires on December 31st of this year, we will be applying for Track III which will hold us to a higher level of accountability for our patients.

BJC's efforts over the past several years have focused on establishing the framework needed to better manage the care of our patients and the costs associated with their health care to help move us toward accepting additional risk for our patients and the cost of their care. In BJC's view, improving the quality of patient care and lowering health care costs can only be achieved through better collaboration between patients, physicians, health care providers and hospitals. The ACO has given us a platform to develop and accelerate these objectives by focusing on complex care management, transitional care management post-discharge and social work support.

The BJC ACO includes 10 BJC hospitals, BJC home health, three BJC long-term care facilities and the BJC Medical Group along with 200 independent community physicians, both primary

care and specialty. Our ACO is unique in that it is one of the few ACOs nationally that not only utilizes home care as a service provider but also places it within the ACO's governing body. The close integration of home care within our ACO is essential to our efforts to keep patients out of the hospital and lower health care costs as a result. Together, over 500 physicians across 23 specialties serve the roughly 39,000 Medicare beneficiaries currently attributed to the BJC ACO. Just over half of our beneficiaries live in urban and suburban areas including St. Louis City and County (34 percent) and St. Charles County (17 percent). The remainder of our Missouri beneficiaries resides in more rural areas in and around St. Francois County near Farmington (6 percent), Franklin and Crawford Counties near Sullivan (4 percent) and Boone County in Columbia (6 percent). Our Illinois beneficiaries are located in Madison County and its surrounding areas (19 percent).

Over the past several years as the ACO developed, BJC has initiated many projects to better coordinate care, improve population health and lower costs. Of particular note, we achieved National Committee for Quality Assurance (NCQA) Level III Patient-Centered Medical Home (PCMH) accreditation for all 43 BJC Medical Group primary care practices. Our journey toward PCMH accreditation allowed our practices to develop enhanced capabilities around patient access, patient education and record sharing, referral tracking, follow-up and care coordination.

Throughout BJC's accountable care journey, we have learned several key lessons that I would like to share with the Committee. Overall, we have tried to move away from unnecessary variation and instead focus on gaining efficiencies by better standardizing work flows and operations. In regards to physician operations, we found that it was essential to establish a centralized call center for our patients. We also extended the availability of physician office hours and increased our focus on year-long care planning with our patients. In regards to clinical data integration and data mining, we have learned the importance of sharing physician notes between providers as well as ensuring that the patients' data follows them in a single chart. In addition, we analyze data trends to risk-stratify patients and better align our resources to the patients that are most in need of assistance.

Thinking about lessons learned in care management, a cornerstone of our ACO model, we have embedded care managers that provide focused support for high-risk patients and monitor gaps in care. These care managers assist our patients in scheduling visits with their primary care physicians, medication adherence and reconciliation, and post-discharge follow up. While we continue to work to enhance our management capabilities, our early data suggests that this approach is effective. For example, within our Transitional Care Program, between March and June of 2014, our care management team contacted 96 percent of our patients (787 out of 817) within 48 hours of discharge from the ED or hospital. Of those patients that were contacted, 64 percent (502 out of 787) had appointments scheduled within seven days. This type of consistent, timely contact with patients, particularly those considered high-risk, is essential in maintaining the health of our seniors.

While the BJC ACO has made significant strides in improving the health of our patients, we have not yet reached the target necessary to achieve shared savings. We have, however, excelled in our quality performance scores. These scores are based on 33 quality of care metrics ranging from nationally recognized standards for heart disease and diabetes treatment all the way to the availability of physicians to see their patients and the overall patient care experience. For example, according to the preliminary[1] patient satisfaction results from 2014, 83% of BJC ACO beneficiaries are satisfied or very satisfied with how their physician is communicating with them. In addition, 63% of BJC ACO beneficiaries are satisfied or very satisfied with their ability to access specialists.

The Impact of the BJC ACO on the Senior Population

The ACO's expanded focus on care coordination benefits our patients because it enables the patient and his or her physician to share information and to sit down and have a very robust conversation about the care needs of that patient. Together, the patient and physician develop an individualized care plan that addresses the unique needs of the patient related to his or her health status. As part of this, we educate our patients about ways to better manage their health as well as how to identify the warning signs associated with their unique health conditions and to "call us first" when they experience these issues rather than going to the Emergency Department. This type of approach is particularly important and effective for patients with chronic conditions.

To better illustrate the impact of the BJC ACO, I would like to tell you about Ms. X, one of our seniors participating in the ACO. In April of this year, Ms. X was admitted to the hospital for an ischemic bowl perforation and peritonitis later followed by a multitude of other health issues including renal failure. For the next three months, she spent a total of 38 days in the hospital and 10 days in rehabilitation. Our team identified several challenges that were exacerbating Ms. X's situation and increased her risk of readmission, including a lack of transportation, lack of family support and that she lived a far distance from her primary care physician's office. With the assistance of a staff social worker who helped her identify her particular warning signs and what do to when she experiences them, Ms. X is now doing well at home and has not visited the Emergency Department or been readmitted to the hospital since June.

Another ACO patient, Mr. X, had been hospitalized for a series of abdominal issues which ultimately required surgery. Upon discharge, he was given instructions on how to care for his wound and perform daily self-injections at home. When a member of our ACO staff called Mr. X on his first night back at home, he was frantically trying to arrange all of his medications and had concerns about self-administering the injection. Although a home health visit was arranged for the next day, he was very anxious on this first night home. Our staff talked through the care plan with Mr. X and pointed out that his discharge instructions advised that he "stop taking these medications" for his usual prescriptions which he had not noticed. Mr. X was very reassured by

[1] Final data is expected in mid-September 2015

this call and felt that he could manage his care for the evening. Not only was Mr. X satisfied, but his care was provided and he avoided a potential readmission to the hospital as well.

Challenges We Face

Although we have made significant progress on behalf of our patients through the ACO, there are several challenges we continue to face in our efforts to provide the best possible care. While we have personally visited with CMS leadership to discuss some of our concerns, we wanted to relay a few challenges to you today which align around issues including reimbursement and current rules and regulations.

Our first area of concern with regards to reimbursement is related to home care services. Currently Medicare requires patients to qualify for "homebound" status in order for health care providers to receive reimbursement for services rendered by a home health nurse. In order to be considered "homebound," the patient must have a face to face visit with a physician so that they can provide documentation that 1) the patient is unable to leave home without "considerable and taxing effort" and 2) the patient has a "skilled need" that requires the skills of a licensed nurse, speech therapist or physical therapist to perform. Not only is this process arduous for health care providers who are seeking to provide the most appropriate care to the patient, at the right time and in the right setting – particularly for patients who were recently discharged from the hospital – but it is also a burden on the patients. Although BJC does not refuse home care services to our patients who have not yet received the "homebound" designation, it is important to note that we are not reimbursed for our services until that status is achieved. Our experience has taught us that it is vital to provide a home health visit as soon as possible after discharge in order to avoid a potentially unnecessary – and costly – visit to the Emergency Department. We respectfully request a review of this regulation.

In addition to the challenges we have faced with the designation of "homebound status," we have also encountered challenges with regards to the reimbursement of care management services provided by community-based service organizations. These organizations provide direct benefits to our seniors including transportation services and health management classes. Currently, these services are not reimbursed by Medicare which creates a significant burden for seniors with limited discretionary income. In order to help improve and maintain the health status of our seniors, we would respectfully request that Medicare consider reimbursement for the care management services provided by these community-based organizations.

Third, despite recent technological advances, reimbursement for telehealth has become a challenge as well. While telehealth offers many benefits to our seniors including increasing access to specialists by alleviating some of the burdens associated with transportation, we are not yet utilizing this tool to its full potential due to challenges associated with reimbursement. We would respectfully ask that Medicare consider developing waivers that specify when and under what circumstances telehealth services may be reimbursed.

Finally, the three-day inpatient rule for skilled nursing facilities (SNFs) has made it difficult for us to partner directly with local SNFs to the benefit of our patients. While we applaud Medicare's decision to approve a waiver to remedy this in 2017, these challenges will remain for the next year and a half until the waiver goes into effect.

Objectives – What we hope to achieve on behalf of the patients and families we serve

Overall, the goal of the BJC ACO is to provide our seniors with high-quality service and care at the right time and in the right setting. When the BJC ACO is successful, our patients will experience better health, our community will have better health care and we will be providing better value.

Conclusion

In closing, I want to thank the Committee for the opportunity to speak before you today. I would be happy to answer any questions you may have. Thank you.