remedy partners™

THE EPISODES OF CARE COMPANY

National Health Policy Forum

December 2014
COURSE OUTLINE

REMEDY PARTNERS OVERVIEW

BPCI APPLICANT TYPES

ELIGIBLE BPCI PARTNERS

REMEDY CAPABILITIES
WHO IS REMEDY PARTNERS?

- Remedy Partners is an Episode of Care company serving as an Awardee Convener (general contractor) for CMS.

- We help hospitals, physician groups, skilled nursing facilities and home health agencies develop and manage bundled payment programs for CMS, commercial health insurers, employers and Accountable Care Organizations.

- We Convene multidisciplinary healthcare leaders that seek to add positive value to the healthcare ecosystem. Leaders who – just as importantly – have an enlightened view on the art of collaboration.

- Remedy Partners currently operates the largest and most complete program within the BPCI demonstration.
  - Our provider partners or prospective provider partners are located in all 50 states.
**HIGH LEVEL SCHEMATIC OF ROLES**

Awardee Conveners participate in BPCI as a convening organization that brings together multiple health care providers, enter into agreements with CMS and bear financial risk for the model, including all Episode Initiators that they convene.

### Submission Type

- **Risk-Bearing**
  - Single Awardee (Episode Initiator)
  - Awardee Convener (Remedy Partners)
  - Designated Awardee (Episode Initiator)
    - The entity takes risk under the facilitator convener.

- **Non Risk-Bearing**
  - Facilitator Convener
  - Designated Awardee Convener
    - The entity takes risk under the facilitator convener.

### Source

*BPCI Model 2 & Model 3 Only

Source: CMS. BPCI Background on Model 2 & 3 for Prospective Participants. February 2014.
As an Awardee Convener, Remedy Partners works with partners to redesign care. Eligible partners fall into two categories:

- **Physicians / Practitioners**, including those who may be separately paid by Medicare for their professional services (e.g. physicians, nurse practitioners, physician assistants, physical therapists).

- **Participating Organizations**, including all other providers or suppliers with whom the applicant plans to partner (e.g. acute care hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health agencies).

  - **Episode-Initiating Bundled Payment Participating Organizations** are a subset of Bundled Payment participating organizations that initiate episodes.
REMEDY CAPABILITIES

Remedy’s Data Analytics team helps Partners monitor performance and leverage opportunities through data review.

<table>
<thead>
<tr>
<th>Data Management + Analytics</th>
<th>1. Managing Data Flows</th>
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<tbody>
<tr>
<td></td>
<td>• Monthly Claim Files +</td>
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<td></td>
<td>Quarterly Reconciliations</td>
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<tr>
<td>CM / Care Coordination Center: Centralized Team of Nurses</td>
<td>2. Benchmarking</td>
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<td></td>
<td>• Versus peers + national leaders</td>
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<tr>
<td>Care Management Software Solutions: Episode Connect</td>
<td>3. Bundle + Risk Track Selection</td>
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<tr>
<td>Program Financing, Risk Pooling + Reinsurance</td>
<td>4. Risk Modeling</td>
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<td></td>
<td>• Dynamic view of risk</td>
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<tr>
<td>Contracting</td>
<td>5. Performance Reporting</td>
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<tr>
<td>Program Administration</td>
<td>6. Quarterly Reconciliations</td>
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<td>7. Advance Analytics</td>
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Remedy’s Care Coordination Center works with patients and their care team members to implement a custom care plan.

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1. Training Programs
2. Patient On-boarding Assistance
3. Care Plan Review Implementation + Coordination
4. Patient + Family Activation
Remedy and our partners can manage patients’ care using Episode Connect, a software that links care team members with real time data.

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1. Real-Time Clinical Data Aggregation
2. Patient On-boarding + Assessment
   - Eligibility + patient ID + tracking
3. 90-Day Care Templates
4. Site of Care Selection
   - Patient suitability for home or SNF care
5. PAP Assignment
   - Designates a specific practitioner for each stage of patient’s episode
6. Secure Communication
   - HIPAA compliant messaging
7. Quality Data
   - Collection and reporting
8. Provider/Patient/Family Portals + Apps
9. Workflow Tools for Nurses + Call Center
Remedy offers program financing and risk management solutions to manage the BPCI program.

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<th>REMEDY CAPABILITIES</th>
<th>REMEDY'S ROLE: HOW WE FIT IN</th>
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<td>2. Accessing Scale Economics</td>
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<tr>
<td>Care Management Software Solutions: Episode Connect</td>
<td>3. Financing for Program Development</td>
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<tr>
<td>Program Financing, Risk Pooling + Reinsurance</td>
<td>4. No Upfront Premiums or Consulting Fees</td>
</tr>
<tr>
<td>Contracting</td>
<td>5. Sliding Scale of Risk / Reward Options</td>
</tr>
<tr>
<td>Program Administration</td>
<td>• Providers can “dial-up” or “dial-down” their level of risk / reward</td>
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</table>
Remedy leverages data and expertise to create custom agreements between parties.

REMEDY CAPABILITIES

1. Analytics + Templates to Guide Contract Negotiations
   - Library of contracts
   - Dedicated team of experts

2. Identifying key physicians, structuring and executing physician gainsharing arrangements

Data Management + Analytics

CM / Care Coordination Center: Centralized Team of Nurses

Care Management Software Solutions: Episode Connect

Program Financing, Risk Pooling + Reinsurance

Contracting

Program Administration
REMEDIY CAPABILITIES

Remedy manages administrative tasks and CMS compliance so that Partners can focus on driving care redesign.

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1. Recruitment + Training
2. Call Center
3. CMS Compliance
4. Quarterly Reconciliation + Compliance
Remedy’s Care Model is composed of the following components:

**Interventions**

- **Next Site of Care Optimization**
  - Assist provider when deciding appropriate next site of care, identify discharge needs and facilitate preferred provider network development.

- **Patient Engagement and Education**
  - Communication throughout episode to patient and family members to check recovery progress, promote self-care, address issues and concerns.

**Care Coordination**

- **Assessments**
  - Assessments to determine patient’s current condition, needs and readmission risk.

- **Care Coordination Plans**
  - Diagnosis-specific care coordination plans, customizable by patient’s unique needs and comorbid conditions.

- **Contact Frequency Guidelines**
  - Dictates the minimum amount of contacts for each patient by the care coordination team.
CARE MODEL COMPONENT TIMELINE

Acute and Post-Acute interventions from providers optimize BPCI program performance, patient outcomes and cost savings.

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<th>INTERVENTIONS</th>
<th>CARE COORDINATION</th>
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<td>Next Site of Care Optimization</td>
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<td>Patient Engagement and Education</td>
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<td>Contact Frequency Guidelines</td>
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NEXT SITE OF CARE TOOL

A tool in Remedy’s Post-Acute Toolkit that uses evidence based guidelines to help hospital teams select the optimal next care setting for each patient.

- Provides specific post-acute needs and services to support optimal progress through the episode.
- Captures all relevant domains that impact safe and clinically appropriate best next care setting.
- Maximizes the role of the patient and their caregivers.
- Tracks all content regarding independence level, caregiver availability, professional services and skilled needs frequency.
- Embedded into Episode Connect with full reporting functionality.
- Comes with training manual for case management departments and their support staff to optimize tool use.
POST ACUTE TOOLKIT

A communicative and collaborative post-acute infrastructure focused on mitigating risk, improving outcomes, and lowering cost.

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>DESCRIPTION</th>
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<tr>
<td>SAFE TRANSITIONS</td>
<td>• Early involvement of Home Health Agencies in discharge planning</td>
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</table>
| EPISODE CONNECT          | • List of active patients for SNF operators and Home Health providers  
                           | • SNF users enter transitions and clinical LOS updates                                                                                      |
| CAPABILITIES SURVEY      | • Business intelligence questionnaire to learn about and assess SNF capabilities                                                               |
| LENGTH OF STAY GUIDELINES | • Evidence-based protocols for determining medically appropriate LOS                                                                     |
| READMISSION REVIEW       | • Root cause analysis to identify trends or gaps in SNF and Home Health Services processes                                                   |
POST ACUTE TOOLKIT IMPACT

Deployment of the toolkit’s components leads to meaningful improvement across key success drivers.

<table>
<thead>
<tr>
<th>Length of Stay Management</th>
<th>Preferred SNF’s use proven benchmarks for guidance on length of stay and coordination of efficient transfer to the next site of care.</th>
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<tbody>
<tr>
<td>Efficient Transitions</td>
<td>Remedy BPCI patients receive earlier home health evaluations which allow for more efficient transitions back home.</td>
</tr>
<tr>
<td>Streamlined Care Coordination</td>
<td>Regular communication and a standard update process with Care Coordination Team keeps patient’s progress on track with goals stated in patient’s care coordination plan.</td>
</tr>
<tr>
<td>Re-admission Analysis</td>
<td>Concise tool used to investigate and trend the root cause for readmissions.</td>
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</tbody>
</table>
PREFERRED PROVIDER NETWORK DEVELOPMENT

Remedy works with Episode Initiators to develop a network of physicians and post-acute providers to enhance and coordinate care.

- **Gainsharing:**
  - Create financial alignment with providers who invest time, effort and resources towards Care Redesign
  - The goal is to develop an engaged ecosystem in which current “gaps” in care are filled
  - Quality Measures

- **Preferred Provider Network:**
  - Leverage historical performance analytics to assess provider performance and narrow the network
  - Remedy’s Contracting Team offers a comprehensive solution that supports local pay-for-performance agreement negotiations and execution efforts
  - Benefits of narrow network:
    - Aligned providers working closely to seamlessly transition patients between sites of care, improved data sharing to enable root-cause analysis and engaged stakeholders across continuum
    - Enhanced communication with patients about their care coordination plan, medical condition, goals and site of care choices
ELEMENTS OF CARE COORDINATION

Standard care coordination plans and patient specific data gathered at the point of care are integrated to create customized care coordination plans that are updated on a regular basis.
CARE COORDINATION PLANS FOR BUNDLE DIAGNOSIS

The Care Coordination Plans are diagnosis-specific care guidelines.

- Educational plans are customizable by patient’s unique needs; by providing reminders and self-management techniques, they help the patient to recognize symptoms early and prevent readmissions.

- The Care Coordination Plans consist of:
  - **48 bundle specific** interventions for the Care Coordination Team to employ
  - Patient education on managing conditions, self-management techniques, preventing complications, and recognizing and reporting symptoms early

- Care Coordination Plans are activated:
  1. After a **patient’s discharge** from an Episode Initiator’s facility
  2. Upon **first contact** with patient or post-acute facility / service
Remedy utilizes several assessments deployed throughout the episode to gauge the patient’s condition and needs.

<table>
<thead>
<tr>
<th>ASSESSMENT TYPE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td><strong>Clinical Risk Assessment</strong></td>
<td>• Completed while patient in hospital or sub-acute facility  &lt;br&gt;• Stratifies patients by <strong>risk level</strong> (Low or High) for readmission and determines the follow-up frequency  &lt;br&gt;• Re-administered at any time, but mandatory approximately half-way through episode</td>
</tr>
<tr>
<td><strong>Needs Assessment</strong></td>
<td>• Completed with <strong>each</strong> patient and/or family contact  &lt;br&gt;• Reviews patient’s needs and all attempts made to meet them  &lt;br&gt;• Complements <strong>readmission root cause analysis</strong>  &lt;br&gt;• Questions: general wellness, medications, follow-up appointments, ADL’s, pain, necessary services, goals, emergency plan</td>
</tr>
</tbody>
</table>
CONTACT FREQUENCY GUIDELINES*

Contact frequency guidelines shown below indicate how often the care coordination team contacts facilities, home health services, and patients based on the Risk Assessment.

- Between weeks 6 and 7 the Care Coordination Team re-administers a risk assessment to re-evaluate appropriate level of contact.

<table>
<thead>
<tr>
<th>SITE OF CARE</th>
<th>HIGH RISK</th>
<th>LOW RISK</th>
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<tbody>
<tr>
<td></td>
<td>Weeks 1 - 6</td>
<td>Weeks 7 - 13</td>
</tr>
<tr>
<td>Home Without Services</td>
<td>7 – 8</td>
<td>7</td>
</tr>
<tr>
<td>Home With Services</td>
<td>6 – 7</td>
<td>7</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>6</td>
<td>7</td>
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</tbody>
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*90-day episode
INPATIENT CARE REDESIGN TASKS

Remedy supports Care Redesign across five inpatient components.

1. **FIND** – identify eligible BPCI patients by Working DRG or primary diagnosis.
   - Episode Connect assists in patient identification.

2. **ON BOARD** – first face-to-face patient interaction that educates patients on BPCI.
   - Remedy provides a script and collateral to educate the patient.

3. **FLAG** – notify internal and downstream providers they are caring for a BPCI patient.
   - Remedy process re-engineering, tools and Episode Connect help providers communicate across the continuum.

4. **INTERVENTION** – address gaps in care, improve care quality and facilitate cross-continuum network development.

5. **DISCHARGE** – suggest optimal next site of care; educate patients and downstream providers on the care plan.
   - Remedy’s Next Site of Care Tool helps determine most appropriate site of care.
Acute and Post-Acute interventions from providers optimize BPCI program performance, patient outcomes, and cost savings.

1. Flag BPCI patient soon after inpatient admission
2. Onboard the patient: educate about BPCI
3. Perform first risk assessment survey on patient
4. Use decision guideline to determine PAC Site of Care (SOC)
5. Discuss PAC plan and goals with patient + caregiver
6. Communicate with next PAC SOC facility about care transition
7. Complete patient discharge summary and med rec
8. Flag patient as BPCI at PAC SOC
9. Follow-up with SNF about patient’s care plan, LOS, + progress
10. Educate Patient on next site of PAC
11. Complete patient discharge summary
12. Perform second patient risk assessment (Day 40-50)
13. Follow-up with patient on their health and care plan adherence
14. Approve any changes to care plan
15. Connect patients to community resources
16. Contact patient based on risk level

* TIMELINE NOT TO SCALE, NOR AN EXHAUSTIVE LIST OF ALL INTERVENTIONS
REMEDIY TOOL CHEST

Remedy provides a portfolio of proprietary technology and tools to support our partners’ success in the BPCI program.

- **Clinical Risk Assessment Tool**: patient questionnaire that determines follow-up call frequency by stratifying patients into high or low risk levels based on clinical and social factors; administered at the beginning and half way points of the episode.

- **Needs Assessment Tool**: patient or caregiver phone interview administered by care coordinators to identify follow-up needs, appointment booking, social support systems, emergency plans, and patient symptom recognition; review other unmet needs that may lead to poor health outcomes and readmissions.

- **Next Site of Care Tool**: a case management decision tree that assists acute care partners in determining the optimal next site of care for patients.

- **Post-Acute Toolkit**: a communicative and collaborative post-acute infrastructure focused on mitigating risk, improving outcomes, and lowering cost.

- **Episode Connect**: BPCI care management platform that allows providers to access the episode’s data feed, manage care coordination plans, track patients and send HIPAA secure messages to care teams.

- **Patient Portal**: web service platform that provides patients access to their EHR, track their care coordination plan, engage in care coordination, and communicate with providers.

- **PAP Portal**: web service platform that provides real-time patient data to physicians, provides episode notifications, place to complete Cooperation Survey, and mobile enabled.
A payment system built around episodes of care is the beginning of a real effort to consider our options. It is an exploration, not an explanation. Not a blueprint, an exacting map, or a definitive guide. It is the first step in a longer journey to answer the fundamental question plaguing so many who face our healthcare industry with honesty:

*What do we do?*

History tells us that all great shifts have small beginnings. Realigning our healthcare system won’t come in a single dramatic leap. It will be the accumulation of millions of steps, day after day, away from oppression and toward liberty.