Maryland Hospital Association

Experiment, or Our Future? Key Insights

Monday, March 25, 2013
Maryland Hospital Association

Below are several key insights from MHA's program on Total Patient Revenue (TPR). To view the full presentation, click here.

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- In comparison to the current charge-per-case system, TPR encourages wellness and cost effective delivery of care; there are no adjustments for volume or changes in case-mix; 100% fixed revenue regardless of volume; and there is only positive reasonableness of charges-related scaling; TPR hospitals revenue is adjusted for performance on HSCRC quality programs.

- In order to be successful under the TPR program, hospitals must support the growth of primary care doctors and specialists in their communities and dedicate time and money to institute care coordination activities through trusted relationships with local health planning agencies.

- One of the main challenges TPR hospitals face is aligning physician incentives with the TPR incentives. Some hospitals have developed physician incentives related to patient satisfaction and quality metrics.

- Several hospitals pay specialist doctors for blocks of time to ensure that patients who need follow up specialist care, receive that care. Hospitals that employ physicians ensure that high risk patients receive follow up within three to five days.

- TPR hospitals benefit from cost reduction strategies such as addressing physician preference items and driving care to lower cost settings, such as physician offices and other outpatient settings.

- Data analysis informed TPR strategies for patients with high readmission rates and high Emergency Department utilization. For example, 56 percent of the high utilizers had a behavioral health condition either alone, or in combination with another chronic health condition; and discharging high utilizers to home care reduced their readmission rate by 30 percent.

- To address behavioral health issues, hospitals are sending nurse practioners to patients' homes for up to a month following discharge to manage care and assist with the transition from the hospital to home. Other hospitals with only inpatient behavioral health or outpatient substance abuse services have entered into arrangements with each other to ensure that patients with co-occurring needs get comprehensive care.

- All the TPR hospitals have expanded their post-discharge and Emergency Department Care Management with nurse case managers available eight hours per day, seven days a week; and by doing things like phoning patients to ask clinically-related questions and following up on outstanding lab results.

- During the first three-year agreement (2010 – 2013) TPR hospitals focused on reducing readmissions and unnecessary Emergency Department visits. In the program's first two years:
    - TPR hospitals' total admissions decreased twice as much as non-TPR hospitals (-13.2% vs. -6.0% respectively)
    - TPR hospitals' total inpatient days decreased more than four times as much as non-TPR hospitals (-8.3% vs. -2.0% respectively)

- Hospitals attributed these significant reductions to several new programs, including:
    - Development of relationships with surrounding home care facilities;
    - Adoption of the Coleman Model — a discharge model that provides an in-home visit within 72 hours of discharge for patients who don't qualify for home care services;
    - Addition of a full-time Emergency Department Care Manager focused on development and communication of a comprehensive discharge plan; and
    - Creation of a Discharge Advocacy Center with personnel who assist patients in following the discharge plan by making follow-up doctor appointments for them, among other things.

- Hospitals under the TPR Program take a financial risk. In order to implement change, hospitals must make a significant investment to provide the resources for change that will ultimately improve patient outcomes; institute comprehensive care management; and reduce readmissions and unnecessary admissions.