The Brave New World
Population Health Management

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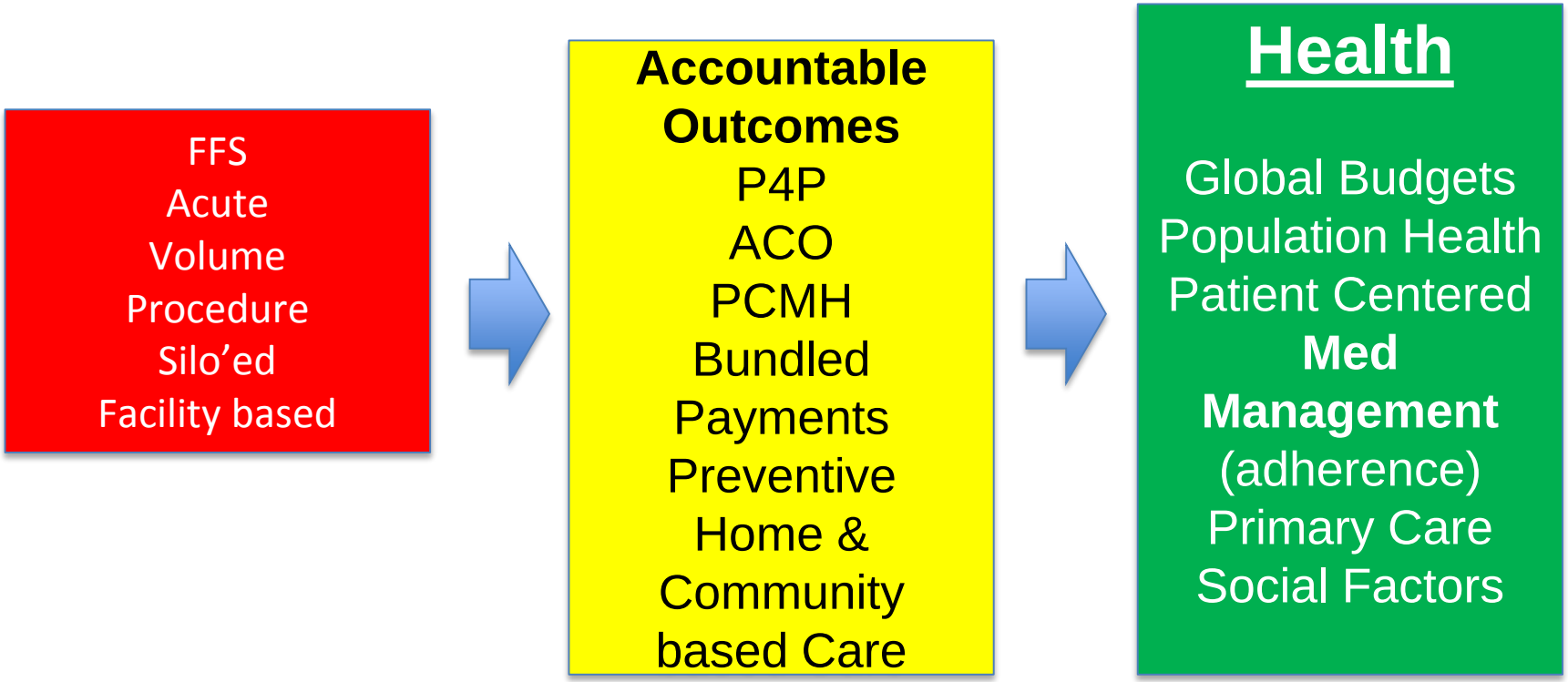
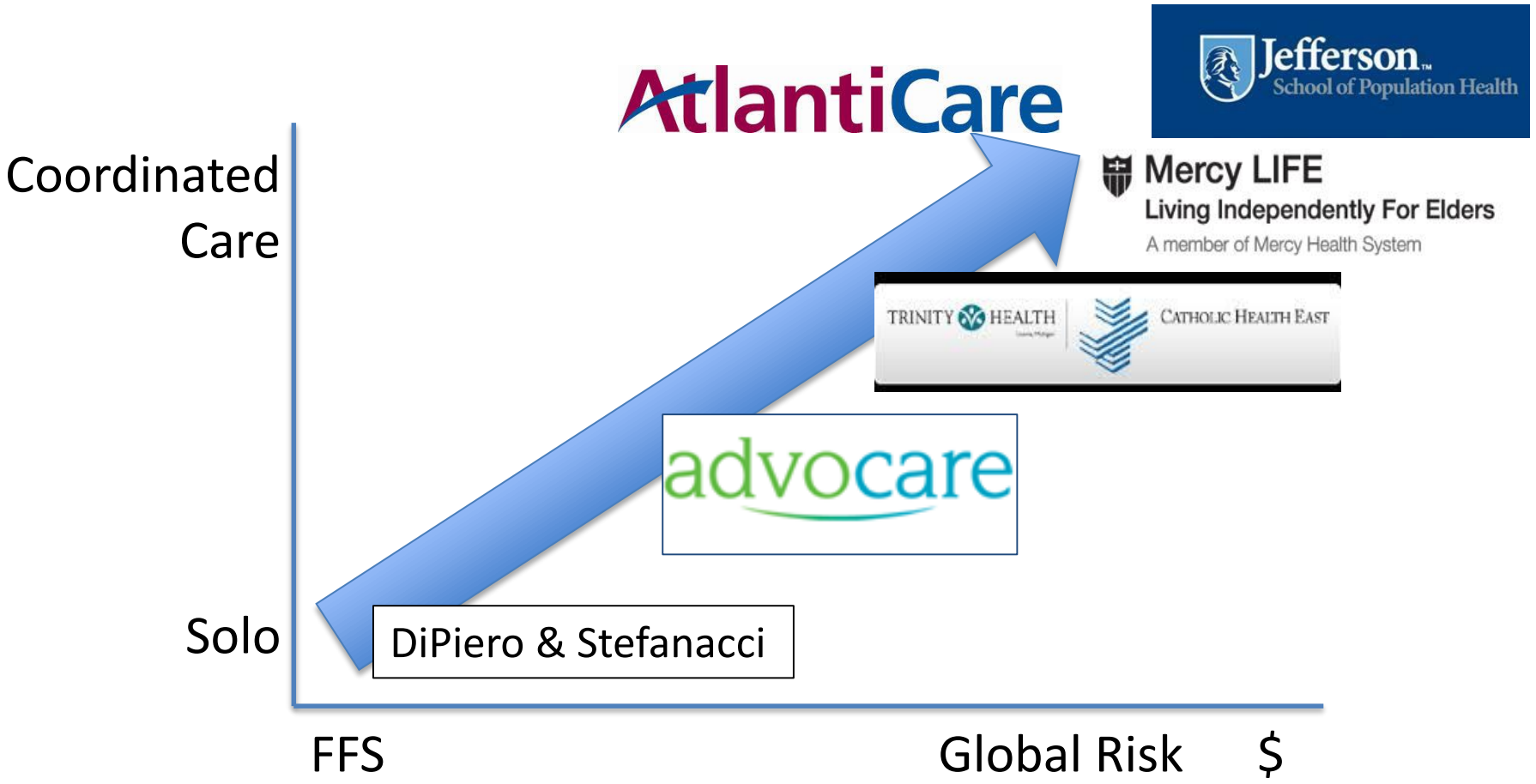
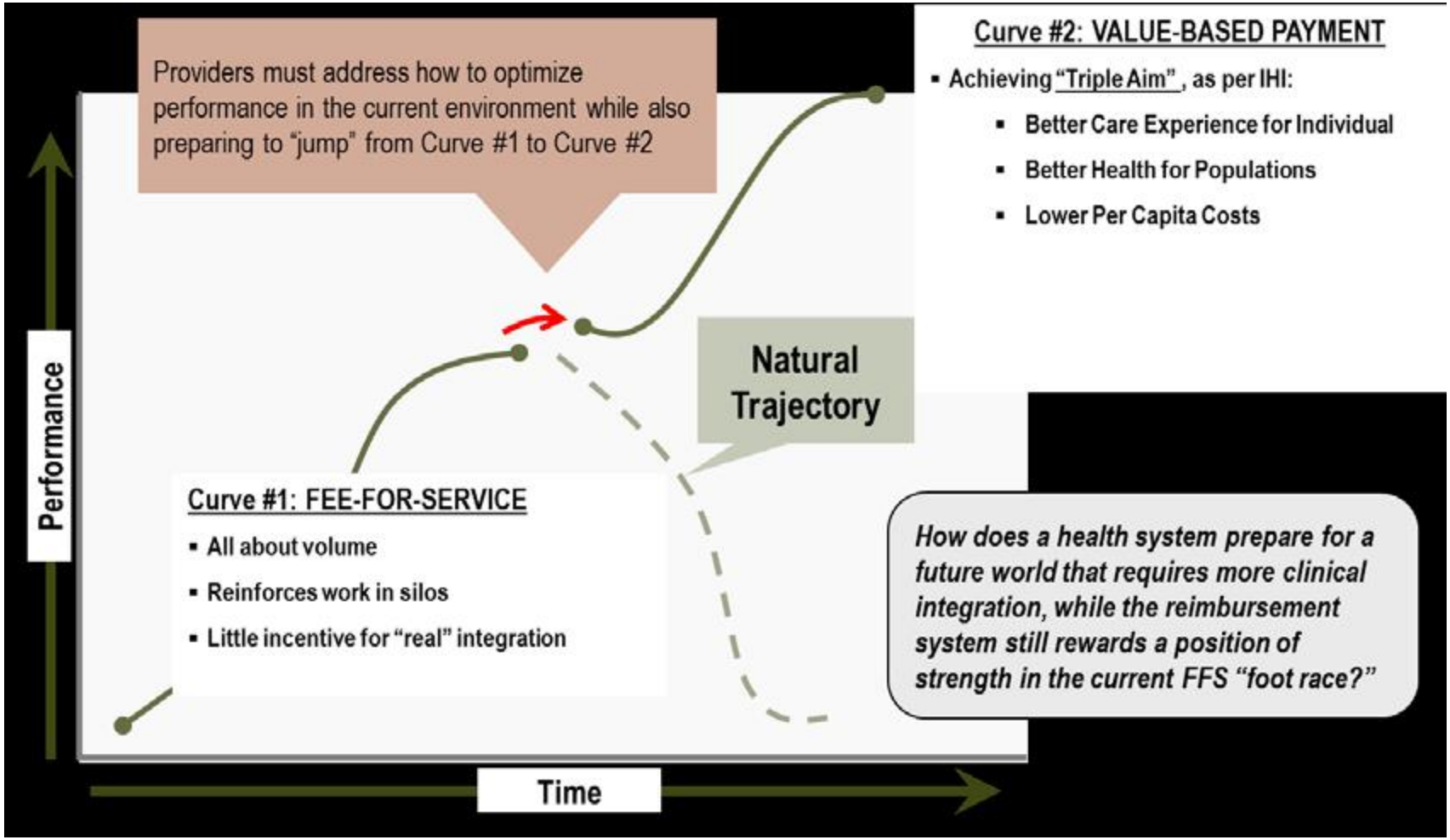
Successful models come into focus…

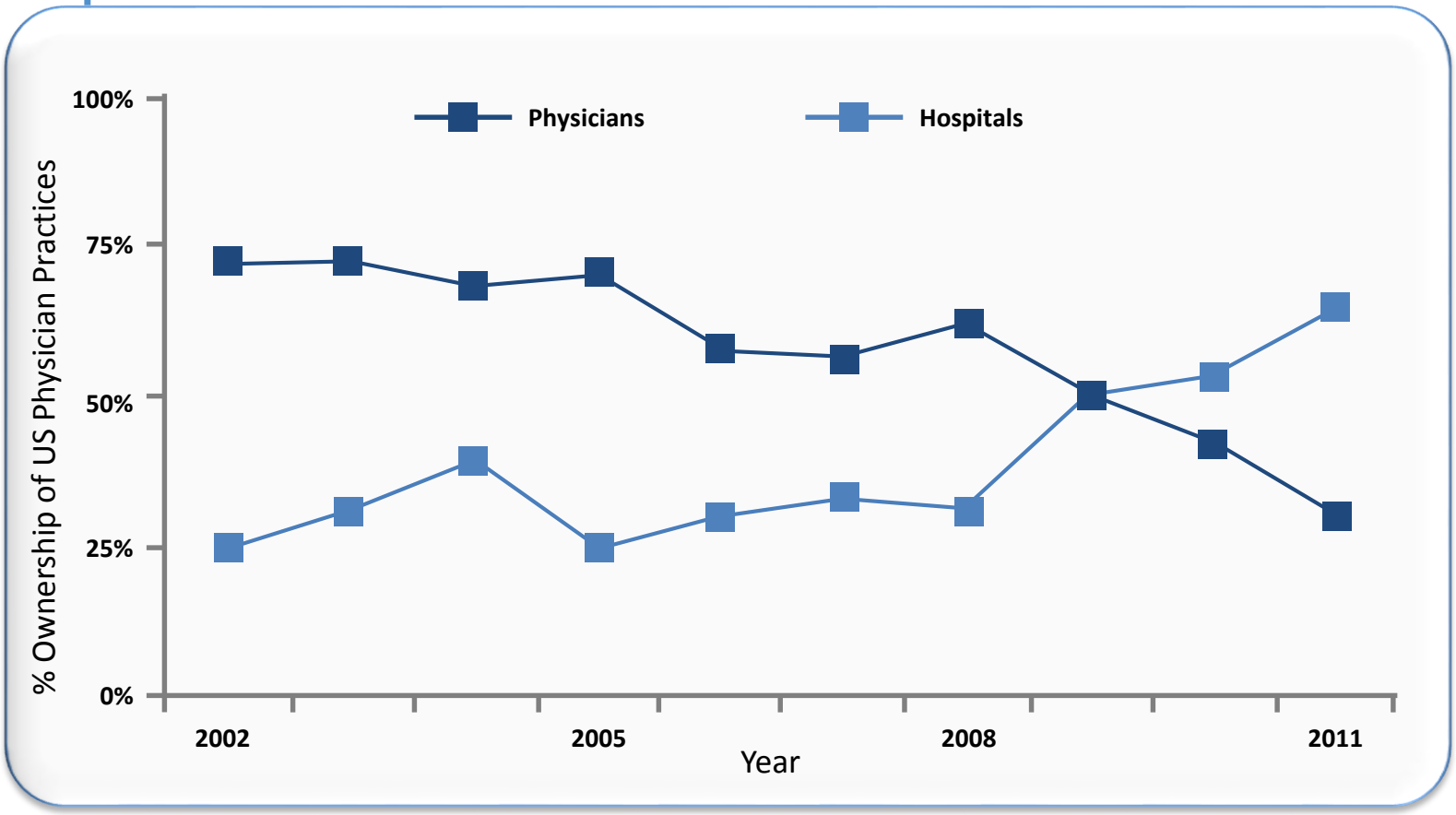


Integrated Health Care Systems



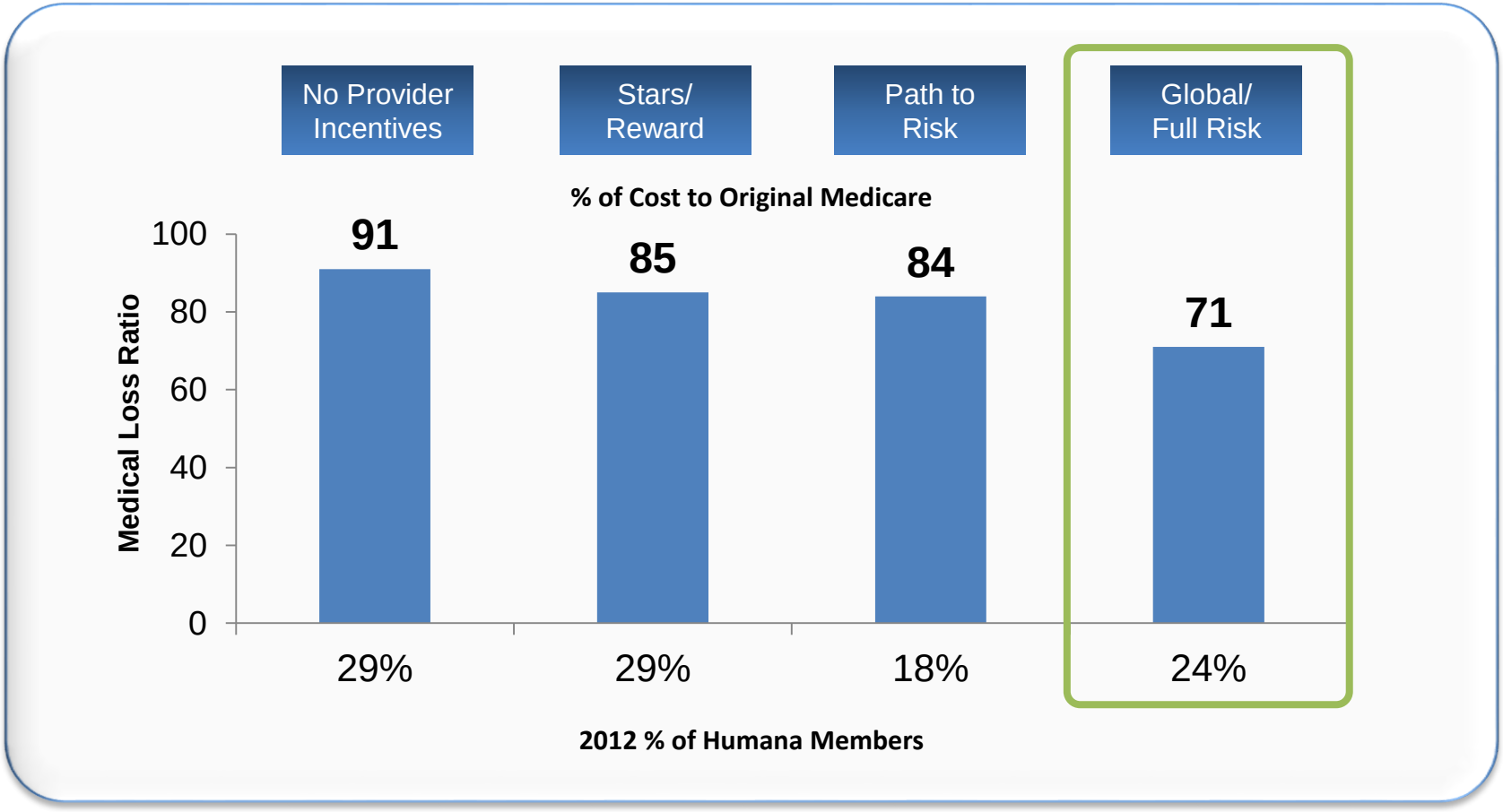

Providers must address how to optimize performance in the current environment while also preparing to "jump" from Curve #1 to Curve #2
Curve #2: VALUE-BASED PAYMENT
Achieving "Triple Aim", as per IHI:
Better Care Experience for Individual
Better Health for Populations
Lower Per Capita Costs
Natural Trajectory
Curve #1: FEE-FOR-SERVICE
All about volume
Reinforces work in silos
Little incentive for "real" integration
How does a health system prepare for a future world that requires more clinical integration, while the reimbursement system still rewards a position of strength in the current FFS "foot race?"
Performance
Time

Increased Shift From Private Practice to Hospital/IDN Models



Source: Quorum Health Resources. http://trustee.knowledgebase.co/assets/how_can_hospitals_afford_to_own_physician_practices_-_08-2012.pdf.

Greater Provide Risk…Lower Utilization



Source: Humana 2012 Investor Meeting.

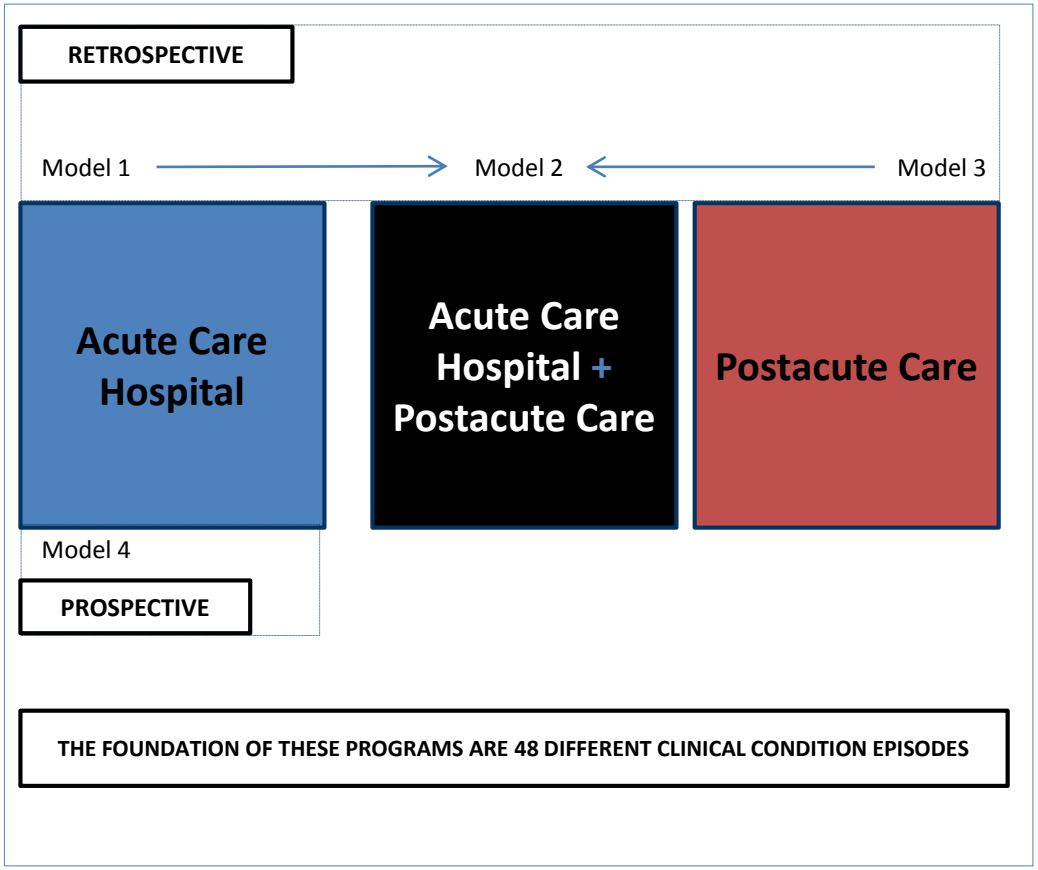
Three Reasons Today's Healthcare Providers are Different

PHYSICIAN ATTITUDES

FUNDING FLOW

ADMINISTRATIVE REQUIREMENTS

Bundled Payment for Care Improvement Initiative (BPCI)



Model 1	• CMS pays hospital discounted amount based on rates established in the Inpatient Prospective Payment System • CMS continues to pay physicians separately under the Physician Fee Schedule • Under certain circumstances, hospitals and physicians may share gains from providers' care redesign efforts
Model 2	• The episode will end either 30, 60, or 90 days after hospital discharge • Participants can select up to 48 different clinical condition episodes
Model 3	• Triggered by acute care stay and episode begins at initiation of postacute care services (ie, SNF, LTC, inpatient rehabilitation, home health agency) • Services must begin within 30 days of discharge and end a minimum of either 30, 60, or 90 days after the initiation of the episode • Participants can select up to 48 different clinical condition episodes
Model 4	• CMS makes a single, prospectively determined bundled payment to the hospital encompassing all services furnished during the episode • Physicians and other practitioners will submit "no-pay" claims to CMS and will be paid by the hospital out of the bundled payment • Related readmissions within 30 days will be included in the bundled payment • Participants can select up to 48 different clinical condition episodes

Changes in Medicare Financing

- **Pay-for-Performance** (“P4P”)
  - No payment for certain complications; disincentives for avoidable hospitalizations
- **Bundling of payments** for episodes of care
- **Accountable Care Organizations** that include hospitals, physicians, home health agencies, and SNFs that are responsible for the care of a defined group of patients

Hospital Avoidance

- Myocardial infarction
- Congestive heart failure
- Pneumonia

2015

Chronic obstructive pulmonary disease

Total hip arthroplasty (THA) and total knee arthroplasty (TKA) [elective]

Nursing Home Value-Based Purchasing (NHVBP) Demonstration[1]…

Quality Domains (% of total score)	Measures
Staffing (30%)	• RNs, director of nursing hours per resident-day • Total licensed nursing hours per resident-day • Certified nurse aide hours per resident-day • Nursing staff turnover rate
Appropriate Hospitalizations (30%)	• Separate measures for short and long stays • Based on hospitalization rates for potentially avoidable hospitalizations, risk adjusted using covariates of Medicare claims and MDS
MDS Outcomes (20%)	**Chronic care residents:** • Percentage of residents whose need for help with daily activities increases • Percentage of residents whose ability to move in and around their room worsens • Percentage of high-risk residents who have pressure ulcers • Percentage of residents who have had a catheter left in their bladder • Percentage of residents who were physically restrained **Postacute care residents:** • Percentage of residents with improving level of ADL functioning • Percentage of residents who improve status on mid-loss ADL functions • Percentage of residents experiencing failure to improve bladder incontinence
Survey Deficiencies (20%)	• Citation for substandard quality of care or actual harm: ineligible for performance payment • Score values assigned according to scope and severity of survey deficiencies

RN=registered nurses; MDS=Minimum Data Set; ADL=activity of daily living.

Reference: 1. Centers for Medicare & Medicaid Services. *Nursing Home Value-Based Purchasing Demonstration: Fact Sheet*. Baltimore, MD: Centers for Medicare & Medicaid Services; August, 2009. http://www.cms.gov/DemoProjectsEvalRpts/downloads/NHP4P_FactSheet.pdf. Accessed August 24, 2010.

Effect of Downward Funding Pressure *on Post-Acute / LTC*

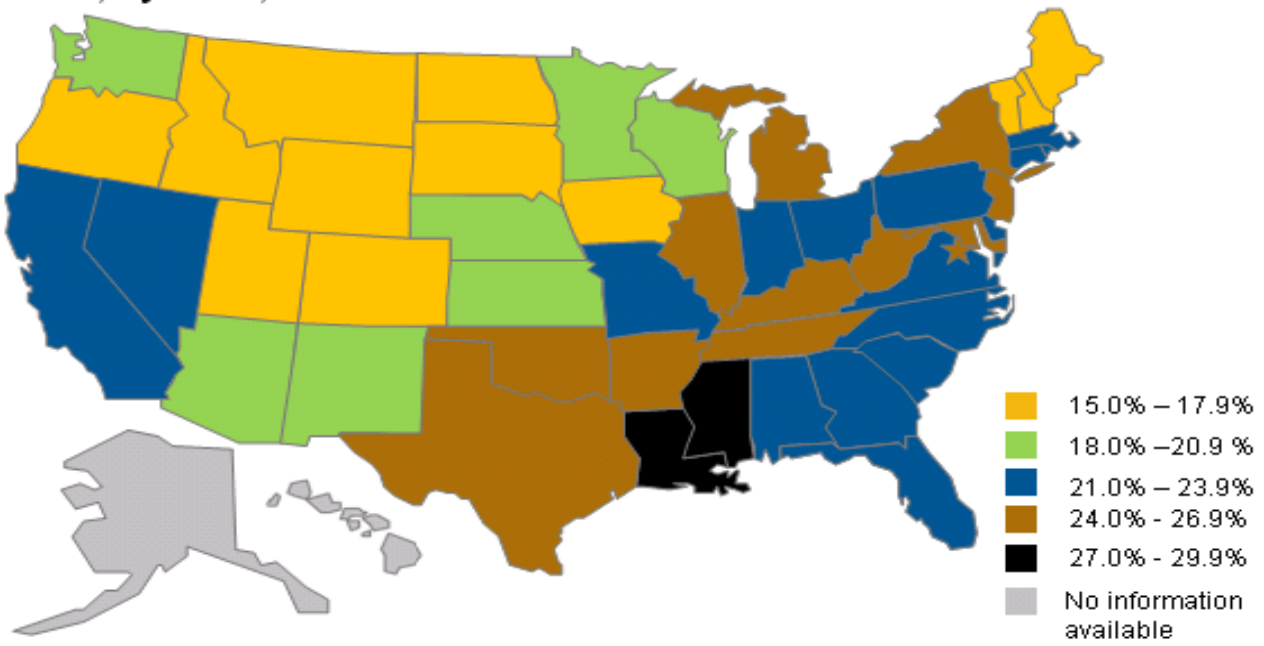
Hospital SNF ALF Home

Medicare

Medicaid

1 in 4 patients admitted to a SNF are re-admitted to the hospital within 30 days at a cost of $4.3 billion

Figure 3: Frequency of Rehospitalization of Short-Stay Nursing Home Residents, by State, 2006



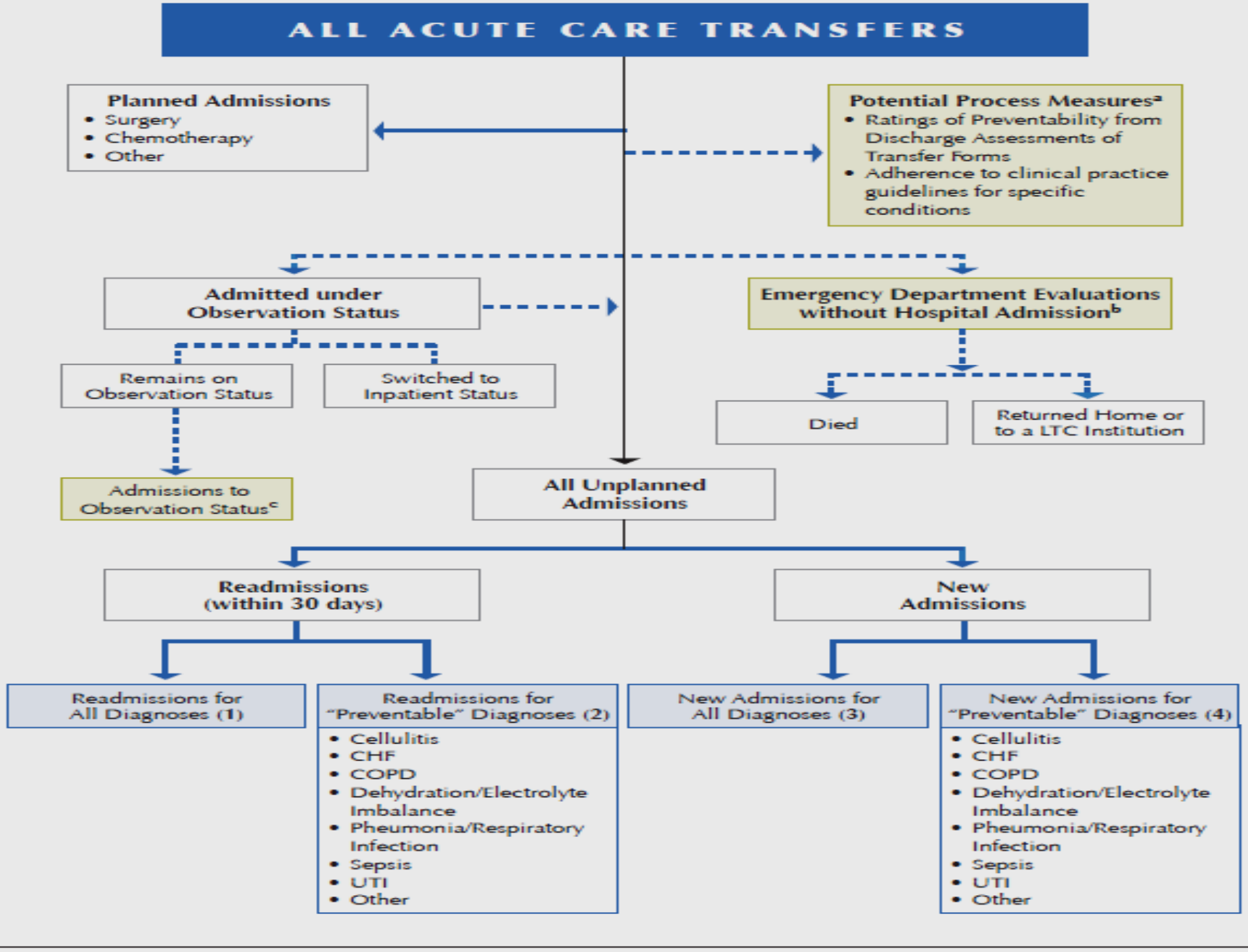
Source: Vincent Mor, et al. (2010) Medicare SNF Rehospitalizations: Implications for Medicare Payment Reform. Health Affairs.

Mor et al. Health Affairs 29: 57-64, 2010

Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool

Getting Started: Keys to a QI Program:

- Tracking, trending, and benchmarking well-defined measures
- Root cause analysis to learn and guide care improvement and educational activities


ALL ACUTE CARE TRANSFERS
Planned Admissions
• Surgery
• Chemotherapy
• Other
Potential Process Measures[a]
• Ratings of Preventability from Discharge Assessments of Transfer Forms
• Adherence to clinical practice guidelines for specific conditions
Admitted under Observation Status
Emergency Department Evaluations without Hospital Admission[b]
Remains on Observation Status
Switched to Inpatient Status
Died
Returned Home or to a LTC Institution
Admissions to Observation Status[c]
All Unplanned Admissions
Readmissions (within 30 days)
New Admissions
Readmissions for All Diagnoses (1)
Readmissions for "Preventable" Diagnoses (2)
• Cellulitis
• CHF
• COPD
• Dehydration/Electrolyte Imbalance
• Pheumonia/Respiratory Infection
• Sepsis
• UTI
• Other
New Admissions for All Diagnoses (3)
New Admissions for "Preventable" Diagnoses (4)
• Cellulitis
• CHF
• COPD
• Dehydration/Electrolyte Imbalance
• Pheumonia/Respiratory Infection
• Sepsis
• UTI
• Other

ACUTE CARE TRANSFER LOG

INTERACT II
Interventions to Reduce Acute Care Transfers

Facility Name _____ Month/Year _____/_____

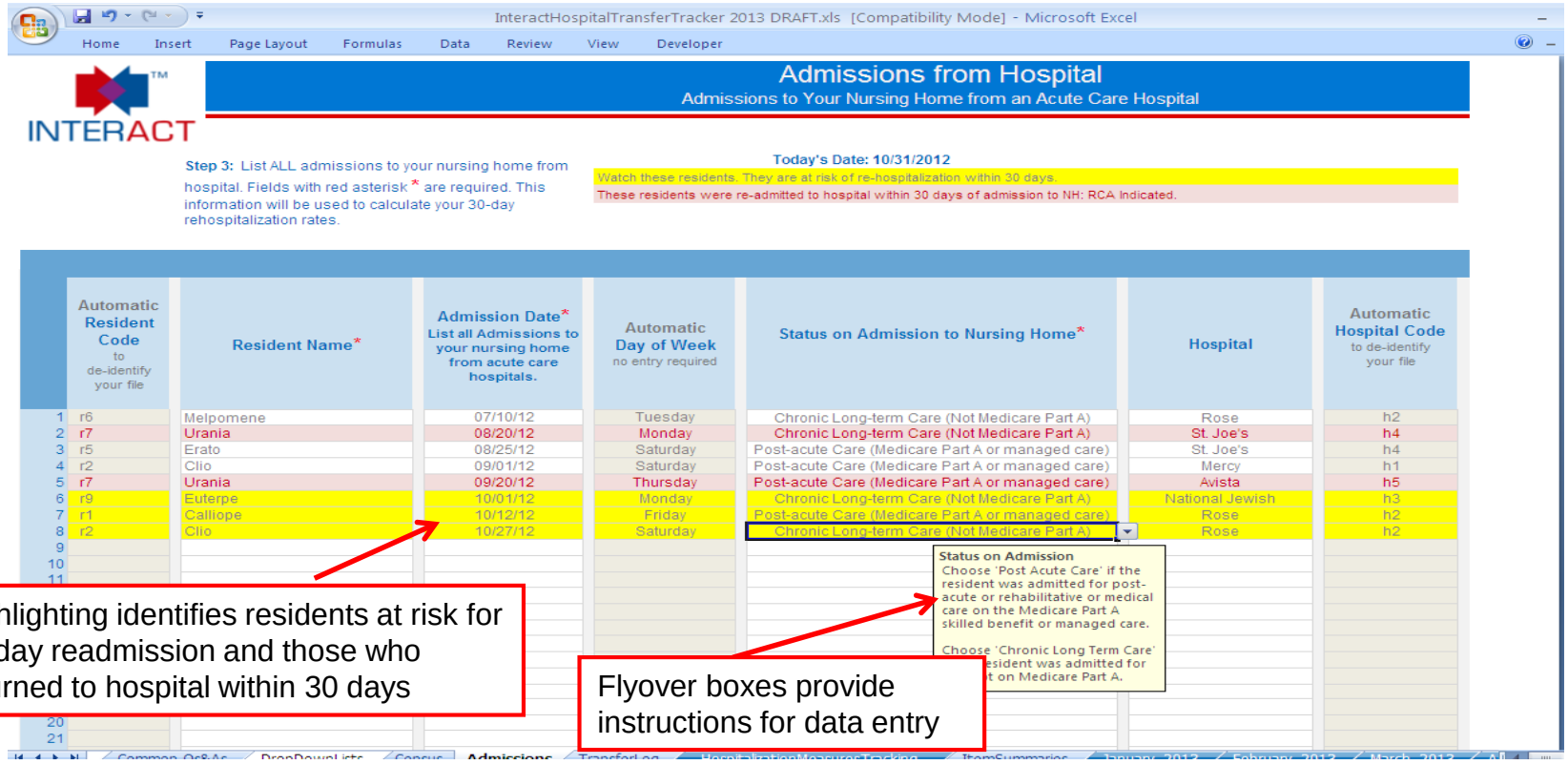
Resident Room Number	Date of most recent admission to the facility	Admitted to the facility from* (circle)	Status at time of Transfer* (circle)	Date of Transfer	Time of Transfer (circle a.m. or p.m.)	Outcome of Transfer (check which applies)		Hospital Diagnosis for ED visit or admission
						ED visit only (returned to facility)	Admitted to the hospital	
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			
	___/___/___	Hosp H O	S LT O	___/___/___	a.m. p.m.			

*Hosp = Hospital
H = Home
O = Other

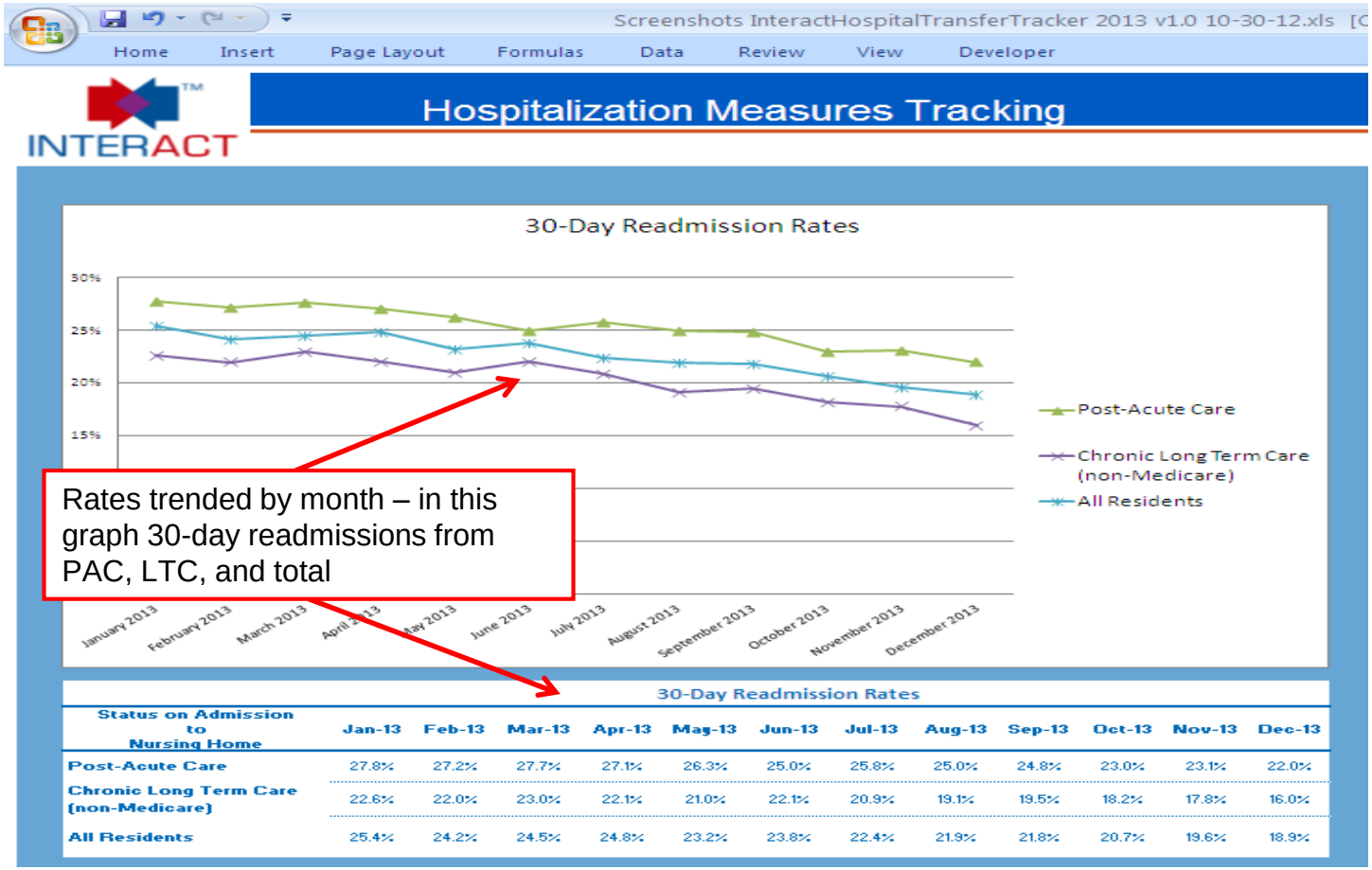
* S = Skilled (Medicare Part A)
LT = Long-term (Medicaid, private pay)
O = Other (e.g. managed care)

Updated January 2011

Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool



Getting Started: Tracking Hospital Transfers and The Quality Improvement Review Tool



30-Day Readmission Rates

Status on Admission to Nursing Home	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
Post-Acute Care	27.8%	27.2%	27.7%	27.1%	26.3%	25.0%	25.8%	25.0%	24.8%	23.0%	23.1%	22.0%
Chronic Long Term Care (non-Medicare)	22.6%	22.0%	23.0%	22.1%	21.0%	22.1%	20.9%	19.1%	19.5%	18.2%	17.8%	16.0%
All Residents	25.4%	24.2%	24.5%	24.8%	23.2%	23.8%	22.4%	21.9%	21.8%	20.7%	19.6%	18.9%

Advancing Excellence tool will be located at: http://www.nhqualitycampaign.org

SNF Hospitalization Rate

subacute & long term residents

<u>MONTH CENSUS</u>

Census on First Day of the Month A

\+ Admissions During Month B

Month Census

<u>**HOSPITALIZATION PERCENTAGE**</u>

Number of Transfers to Hospital Over the Month C

Month Census = 

SNF Hospitalization Rate

subacute patients

MONTH CENSUS

Census on First Day of the Month 25

\+ Admissions During Month 15

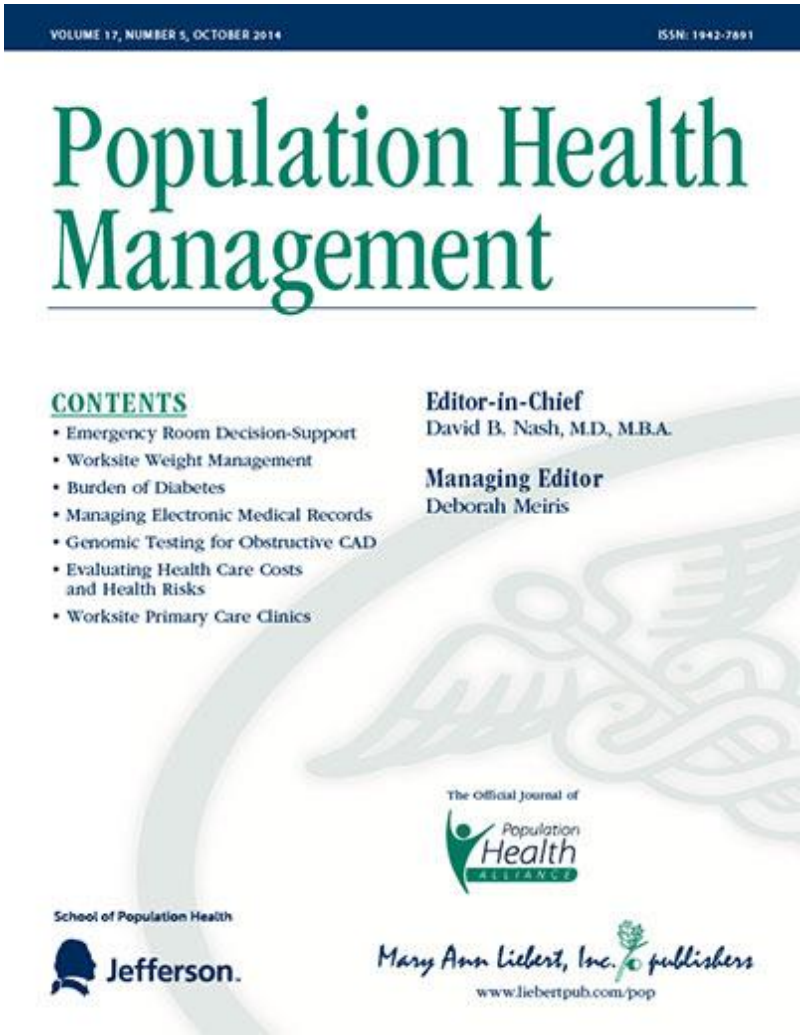
Month Census 40

HOSPITALIZATION PERCENTAGE

Number of Transfers to Hospital Over the Month 4

Month Census 40

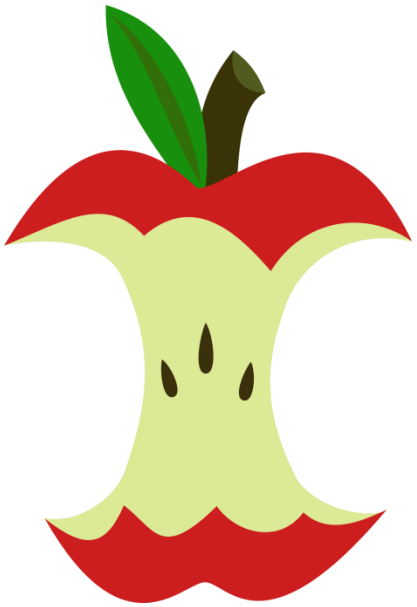
= **10%**



Stefanacci RG, Reich S, Casiano, A.

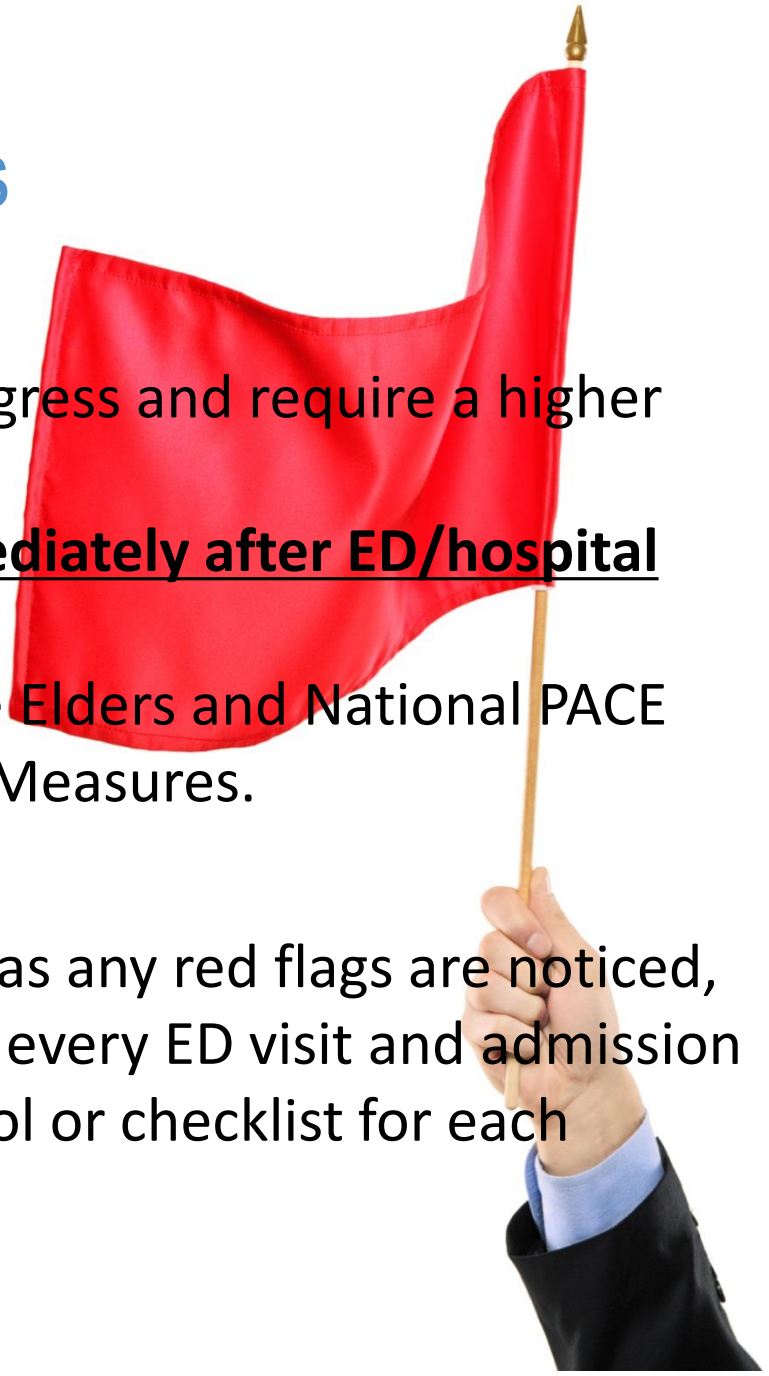
Application of PACE Principles for Population Health Management of Frail Older Adults

Ranking of Impact/Significance of Six Focus Areas in Avoiding ED/Hospital Use



Management of Red Flags

- Defined as:
  - clinical issues that could progress and require a higher level of intervention,
  - **PCP visits prior to and immediately after ED/hospital visits**,
  - Assessing Care of Vulnerable Elders and National PACE Association Disease Quality Measures.
- Best practices:
  - seeing a participant as soon as any red flags are noticed,
  - evaluation of what led up to every ED visit and admission in order to develop a protocol or checklist for each participant.



End of Life Management

- Defined as including:
  - advance directive completion,
  - assessment and intervention,
  - **health care wishes status**,
  - location of death.

- Best practices:
  - use of national standards and resources such as:
    - American Academy of Hospice and Palliative Care
    - Education in Palliative and End-of-life Care
    - PACE Pathways to Care

EOL Resources

www.ePrognosis.org

The information on ePrognosis is intended as a rough guide to inform clinicians about possible mortality outcomes.

www.Dignityincare.ca

Dignity in Care provides practical ideas and tools to support a culture of compassion and respect throughout the health care system.

www.POLST.org

The National POLST Paradigm is an approach to end-of-life planning based on conversations between patients, loved ones, and health care professionals designed to ensure that seriously ill or frail patients can choose the treatments they want or do not want and that their wishes are documented and honored.

Caregiver Support

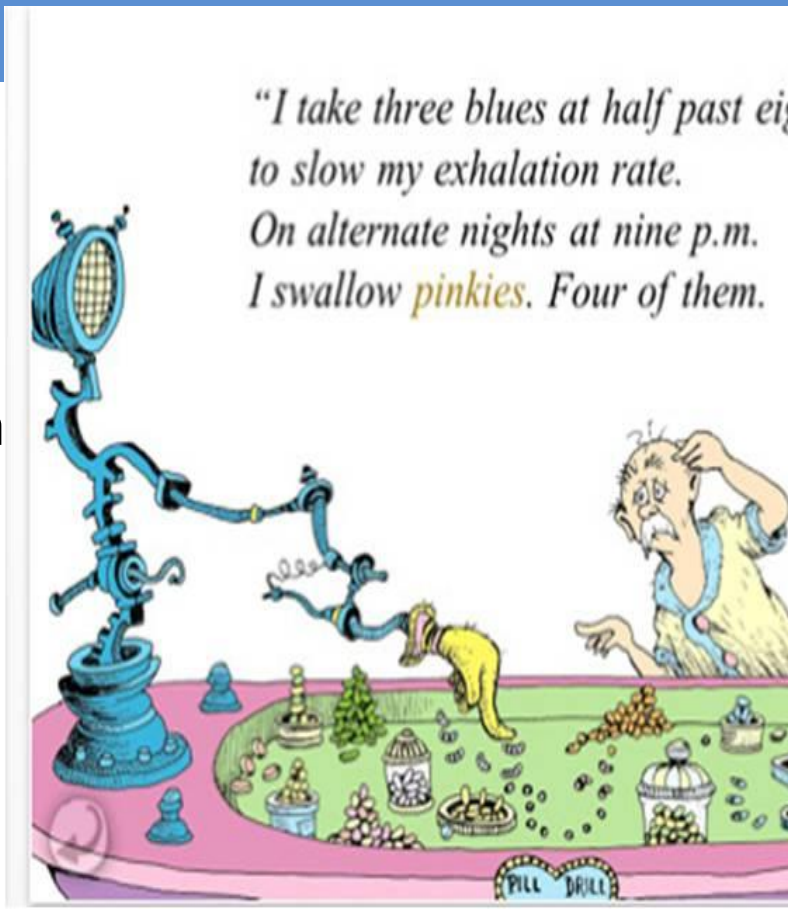
- Defined as:
  - Interventions that prevent burnout and
  - **<u>Use of respite days</u>**
  - Caregiver touches/notes
  - Caregiver survey
- Best practices:
  - scheduled respite care

Care Coordination

- **Defined as:**
  - transition of participants from ED, hospital, or nursing home, as well as specialist consultants,
  - **timing of PCP visit pre- and post-ED/hospital/SNF,**
  - timing of assessment of specialist recommendations from appointment.

- Best Practices:
  - follow-up and care plan update after a hospitalization
  - having a full-time case manager to efficiently and correctly manage transitions of care.
  - having PACE PCPs serve as attending physicians in the hospital.

Medication Management



- **Defined as:**
  - elimination of inappropriate medication
  - management of adherence issues,
  - **<u>hospital/SNF Rx reconciliation,</u>**
  - total Rx used,
  - psychotropic Rx use,
  - Beers Criteria use,
  - sedation score.

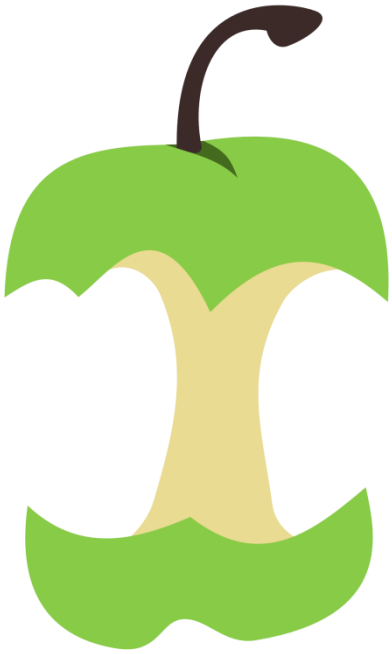
- Best practices:
  - pharmacist involvement monthly medication reviews
  - involvement of staff in medication management
  - adding medication administration to red flag checklist,
  - discontinuation and dose reductions while monitoring responses.

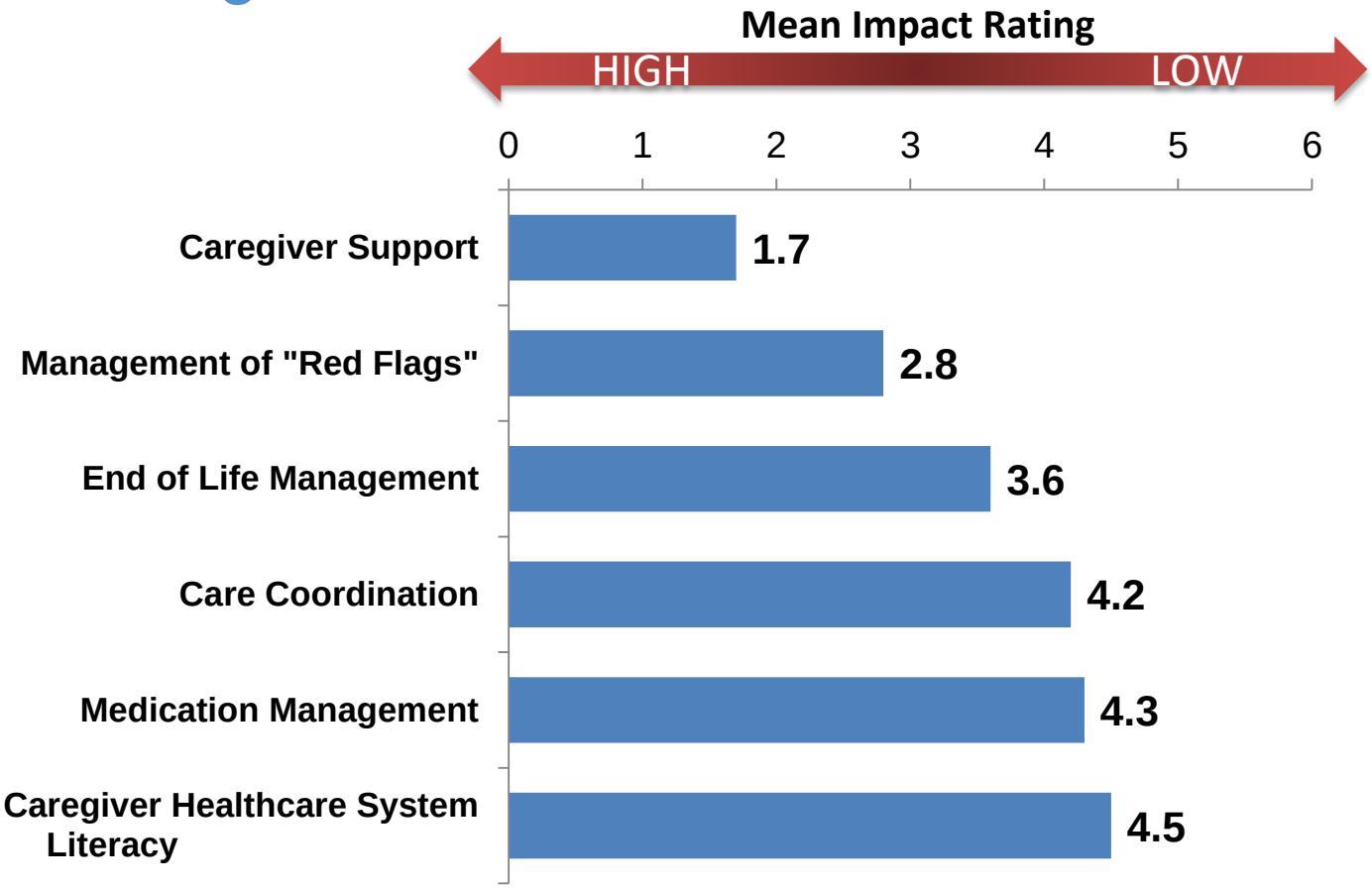
Participant and Caregiver Health Care System Literacy

- Defined as:
  - appropriate use of health care system resources
  - **survey participant and caregiver health care literacy at admission and every 6-12 months**

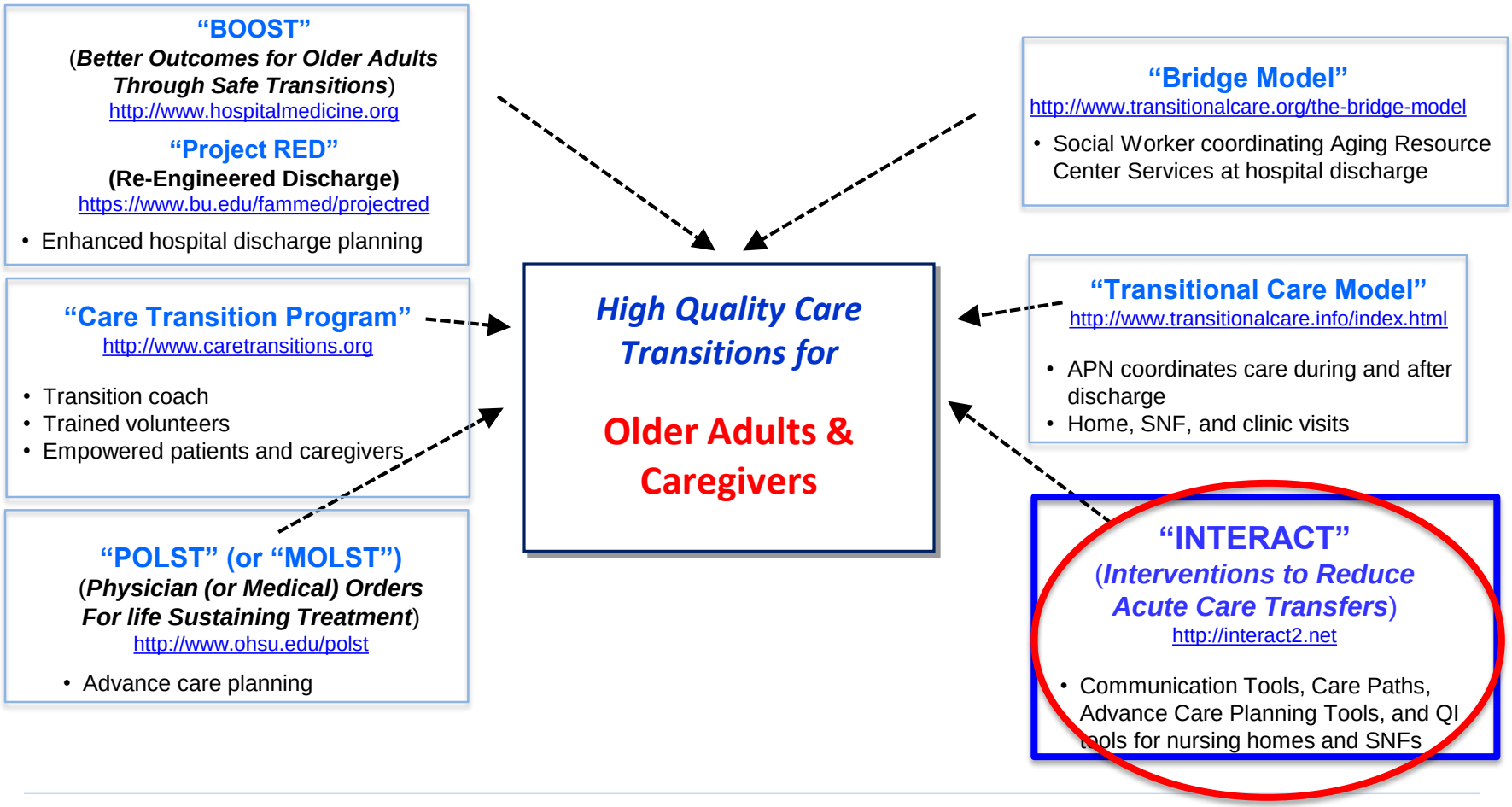
- Best practices:
  - educating participant/caregiver to use health care system appropriately
  - financial information for caregivers.

Ranking of Impact/Significance of Six Focus Areas in Avoiding NH Placement





INTERACT is One of Several Evidence-Based Care Transitions Interventions



INTERACT™

1. Advanced Care Planning
2. Medication Reconciliation
3. Change in Resident Status
   - Stop and Watch / Early Warning Tools
   - Signs & Symptoms
   - Care Paths
4. Communication
   - SBAR
   - Transfer Forms
5. Implementation & Quality Improvement

More Tools…

Improving PCP Urgent Care

Diagnosis

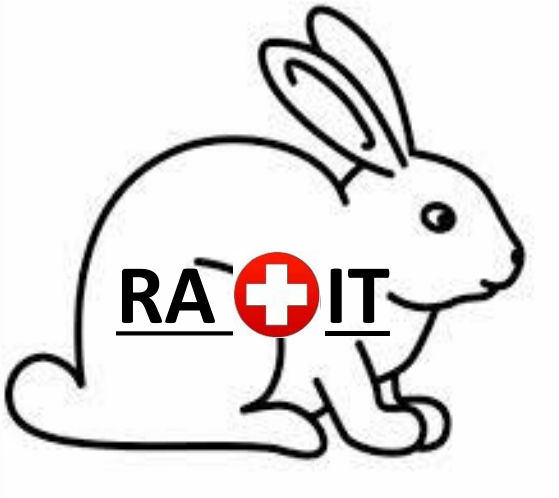
- RN Skill Set
- PCP Access
- Diagnosis Tool Access

Treatment

- Treatment Access
- Comfort with Treatment in NH over Hospital

Rapid Assessment & Initial Treatment

RA IT



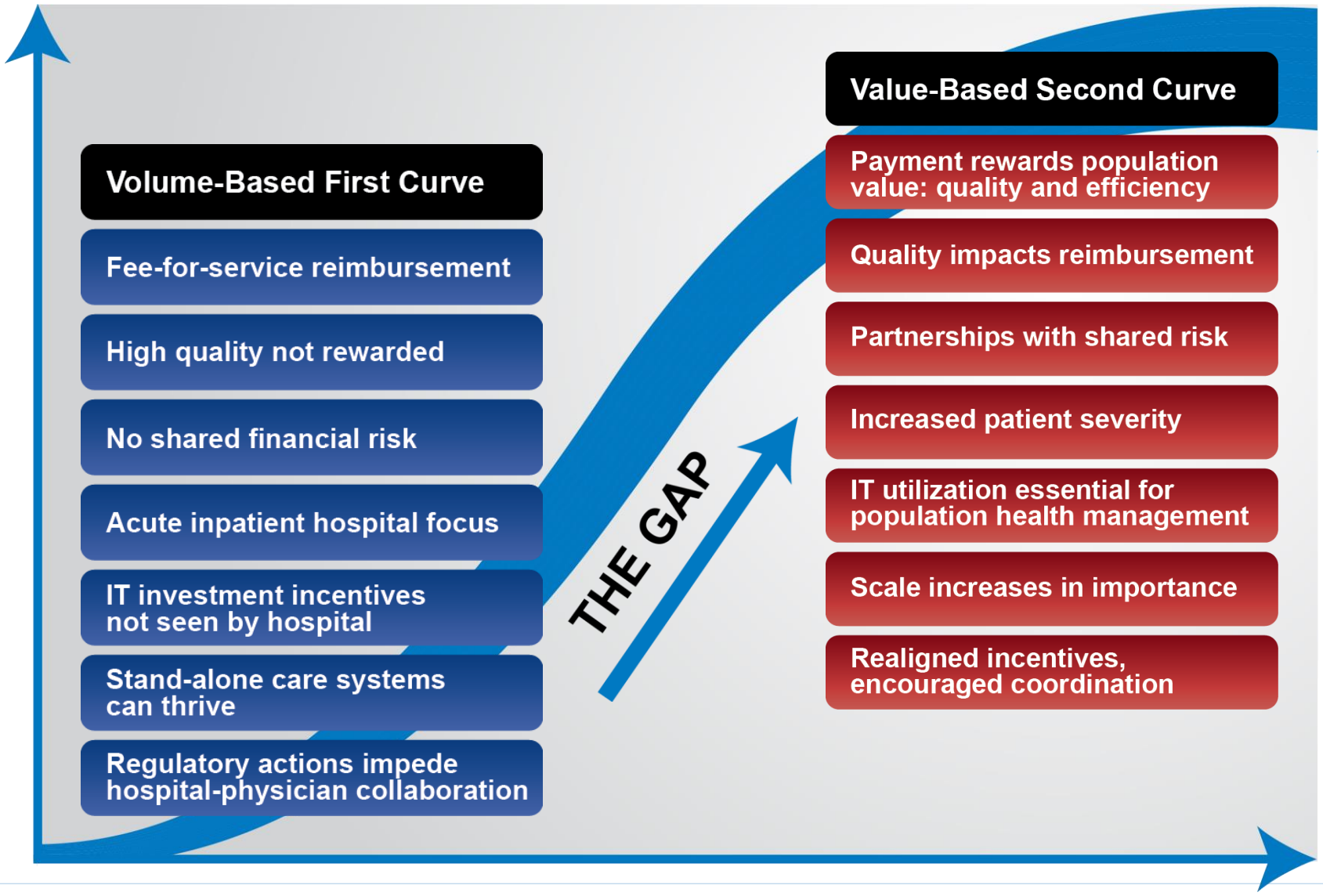
- Partnership with Hospital ER to provide:
  - Rapid Assessment
  - Initial Treatment
  - Transfer back to SNF with care plan

- Requires:
  - Proactive establishing process
  - Each time thoughtful communication of RA IT rather than admission
  - CQI process between ER and SNF team to access performance
  - Assess impact on hospitalization rate

Virtual On Call Physician

Bedside Examination

Pulling it All Together


Volume-Based First Curve
Fee-for-service reimbursement
High quality not rewarded
No shared financial risk
Acute inpatient hospital focus
IT investment incentives not seen by hospital
Stand-alone care systems can thrive
Regulatory actions impede hospital-physician collaboration
THE GAP
Value-Based Second Curve
Payment rewards population value: quality and efficiency
Quality impacts reimbursement
Partnerships with shared risk
Increased patient severity
IT utilization essential for population health management
Scale increases in importance
Realigned incentives, encouraged coordination

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