Post-Acute Care Transitions: An Essential Component of Accountable Care

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GroupHealth

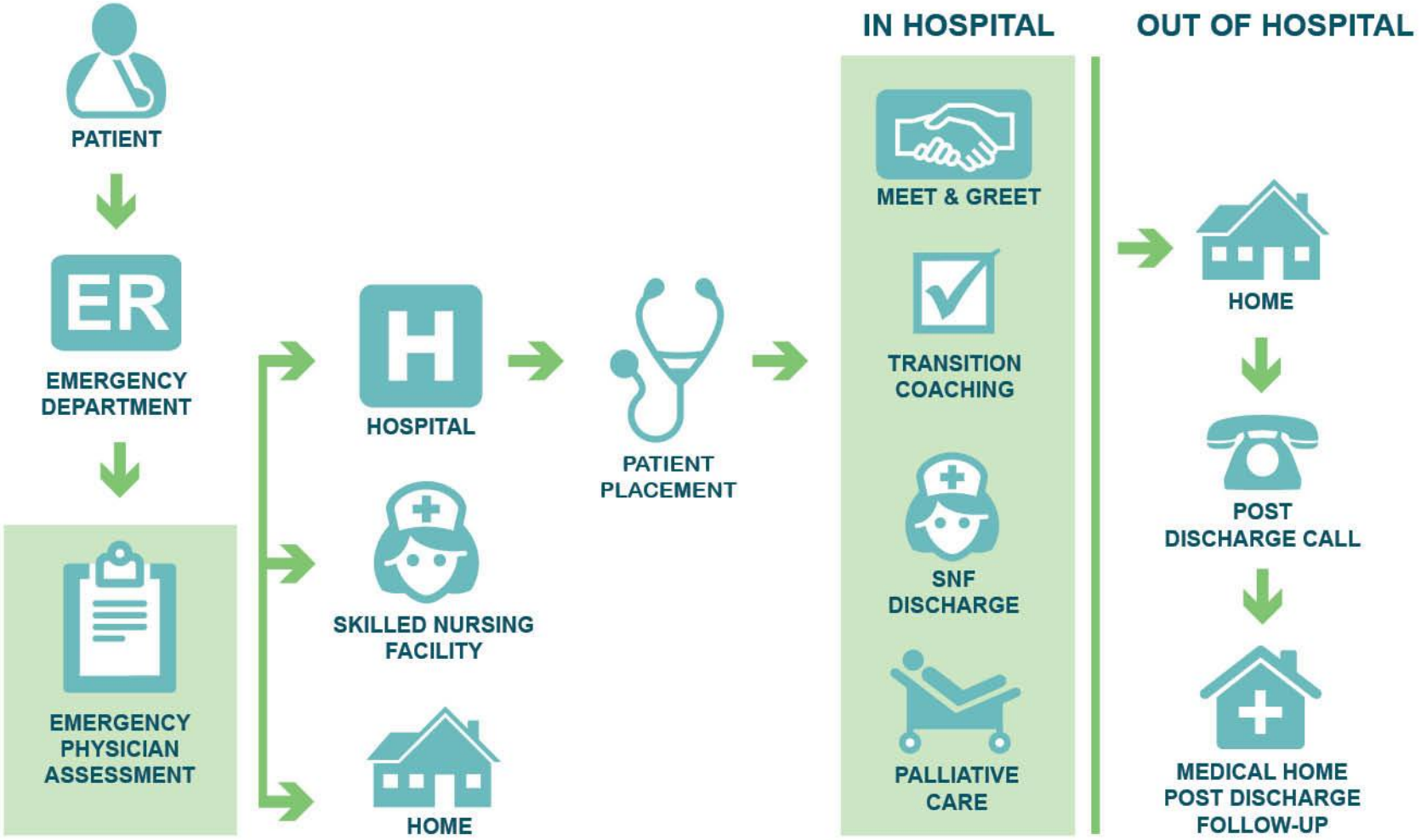
OBJECTIVES

- **Improve health care quality for patients by coordinating care transitions throughout the continuum of care**
- **Reduce avoidable costs during care transitions**
- **Reduce preventable hospital admissions, readmissions, and ER visits**

GOALS

- Improve the patient experience
- Ensure the best possible outcomes

PATIENT EXPERIENCE



STRATEGIES

EPRO

- **Pre-admission assessment to assure appropriate placement and services**

Transition Mgmt

- **Personalized transition management for hospitalized patients**

SNF Discharge

- **Coordinated transitions with skilled nursing facilities and home health agencies**

Palliative Care

- **Engaging patients with their end-of-life choices**

PRE-ADMISSION ASSESSMENT : Emergency Patient Resources and Options (EPRO)

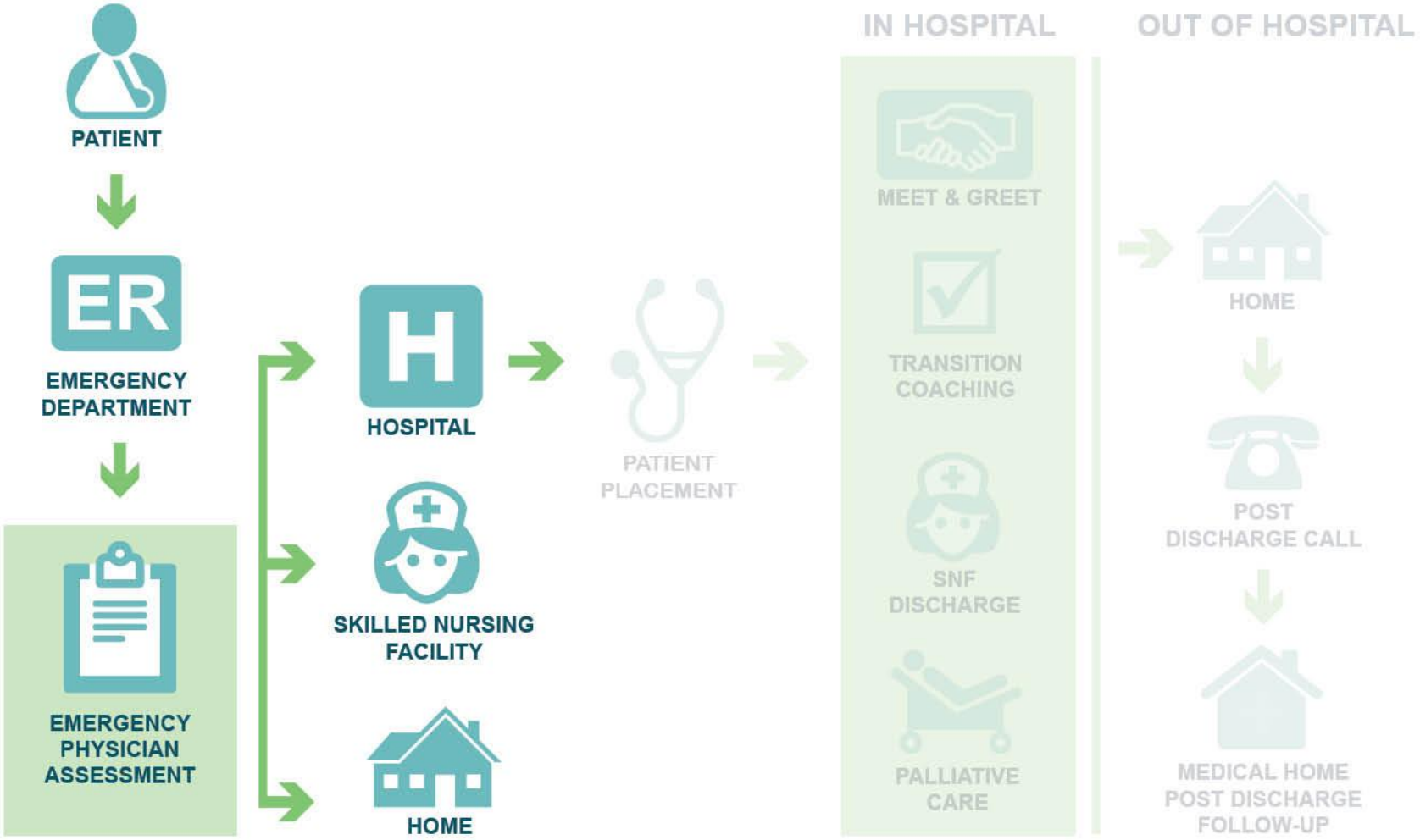
PROVIDING ALTERNATIVES TO ED AND HOSPITAL ADMISSION | 24/7 Telephonic Physician + Care Mgt RN Team

EPRO

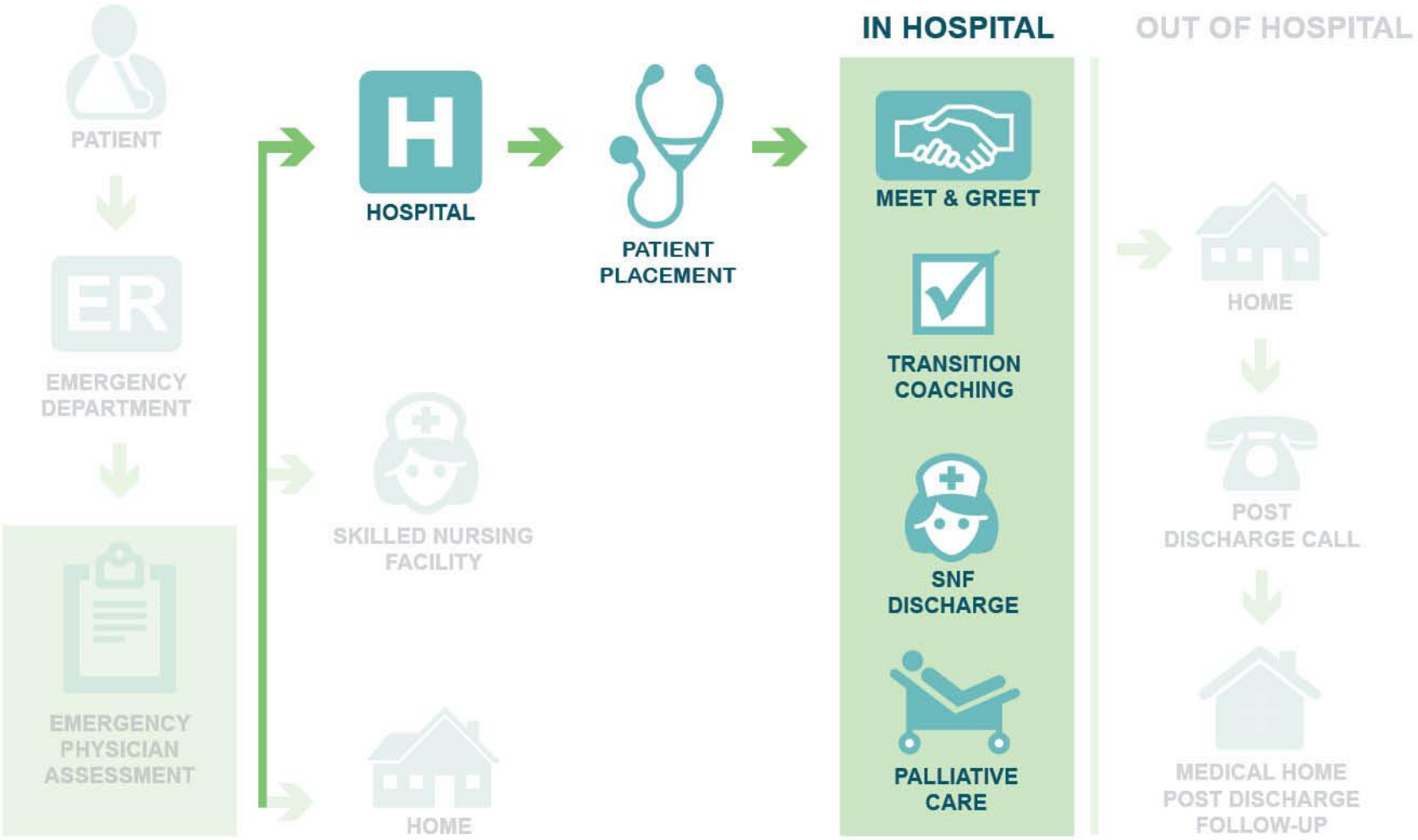
- Urgent Care access expanded
- Same day or urgent primary care and specialty appointing
- Next morning guaranteed home health RN visit
- Direct Skilled Nursing Facility placement – Able to waive 3-day stay requirement for Medicare Advantage and managed care patients
- Options to avoid “social admits”
- Telemetry Observation in UC or Extended Observation Service care
- 24/7 Benefit assessment and explanation

1/1/2011: Primary Care began using EPRO team for all hospitalizations

PLACEMENT


PATIENT
ER
EMERGENCY DEPARTMENT
EMERGENCY PHYSICIAN ASSESSMENT
HOSPITAL
SKILLED NURSING FACILITY
HOME
PATIENT PLACEMENT
IN HOSPITAL
MEET & GREET
TRANSITION COACHING
SNF DISCHARGE
PALLIATIVE CARE
OUT OF HOSPITAL
HOME
POST DISCHARGE CALL
MEDICAL HOME POST DISCHARGE FOLLOW-UP

ADMISSION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MEDICAL HOME POST DISCHARGE FOLLOW-UP

POST-HOSPITAL TRANSITION | Start at the Beginning

Transition Mgmt

URGENT CARE / EMERGENCY

- Urgent Care at large regional clinics (24/7 at some, but not all) with full EPIC access
- Hospitals each have ERs with hospital-employed ER staff with EPIC read-only access
- Our Hospitalists now evaluate potential admissions in the ER to evaluate placement options

HOSPITAL SYSTEM

- Contracted network of 7 Hospitals
- Our own Hospitalists (always)
- Our own Specialists (mostly)
- Our own Discharge Planners
- Read / Write in EPIC and Hospital EMRs

TRANSITION MANAGEMENT |

Transition Mgmt

WITHIN THE HOSPITAL – New Standard Work

- Daily Huddle, consistent care teams
- Stratify patients into transition pathways (via colored dots)
- Hospitalists agreed to standard templates for H&P and Discharge summaries. New aspects include routine:
  - -Discussions of goals of care, condition/prognosis, advance directives
  - -Medication reconciliation
- Transition Coaching (“4 Pillars”)
- 2-Day Post-Discharge Phone Call
- Readmit and Long Length of Stay Reviews by team
- Avoidable Days / Avoidable Admissions report
- Discharge summaries available <u>at the time of discharge</u>

THE METHOD | Eric Coleman's Four Pillars

Teach Medication Self-management

Teach a patient about their condition and use of a personal health record

Provide knowledge of warning symptoms and how to respond

Have a patient set up follow-up care with their doctor

DAILY HUDDLE AND PATIENT IDENTIFICATION

Using new standard scripting and processes, staff manage patient care tightly and collaboratively via a daily huddle:

- UPON ADMISSION, sort patients into 4 pathways
- EACH SUBSEQUENT DAY, review patient progress and daily plan, discharge planning, and expected next steps.
- FOCUS ON AVOIDABLE DAYS, review whether admission / day was avoidable, LOS against expected target, and if a re-admit, what they could have improved to avoid the re-admit.

Patient Sorting Criteria

Red Pathway – Needs Palliative Care

CMLN/MSW

- Would benefit from a Palliative Care Plan
- Score 4 or more on Palliative Care Screening tool
- "Would you be surprised if this person died in the next year – Answer, "no"
- Patient/Family expressing openness to talk about palliative care/end of life issues.

Yellow Pathway – Discharged Home

CMLN unplanned admissions, CMLN/DCP planned admissions if needed for leveling.

- Is a Readmit
- Plans are complex or have a need for continuity of care
- Has a primary diagnosis of a Chronic Disease
- Significant medications changes made during LOS
- Significant concerns with self-medication management

Green Pathway – Transferring to another facility

DCP/CMLN

Discharge Planning
Meets SNF/Rehab criteria
Transfer to LTAC for continued weaning, wound care, etc.

Blue Pathway – Meet & Greet

Care Partner

No significant discharge needs
Discharge planning prior to hospitalization
Less than or equal to 2 day LOS
Not in isolation
Not short stay/ambulatory surgeries

Evolution of Inpatient Risk Stratification and Interventions

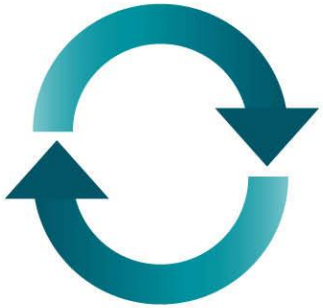
Original Standard Work		Revised Standard Work (Project Went Live: 1/17/12)	
		High Risk of Readmit	– Transition Coaching – FTF visit scheduled *prior to discharge* within 7 days – CIM appt strongly recommended *(GHP patients)*
Complex Chronic	– Transition Coaching for patients with chronic or complex conditions	Mod Risk of Readmit	– Transition Coaching – FTF visit scheduled during Post-Discharge Call within 14 days (PCP appt recommended)
Meet & Greet	– No discharge needs (minimal GHC clinical intervention)	Low Risk of Readmit	– No discharge needs (minimal GHC clinical intervention)
SNF Discharge	– Coordinated transitions with skilled nursing facilities and home health agencies	Facility Discharge	– No substantial change
Palliative Care	– Engaging patients with their end-of-life choices	Palliative Care	– Changed wording to “Advanced Illness Management” resulting in better MD and patient acceptance

*Patients seen in GH clinics receive assistance scheduling FTF visits. Patients seen by contracted providers receive FTF appointment coordination through GH Care Managers and facility staff and/or providers

HOSPITALIST / CARE MANAGEMENT PARTNERSHIP | Collaborative Standard Work

HOSPITALISTS

- Participate in daily huddle
- Standardized H&P and Discharge Summary Template to include: Transition management
  - **Health literacy**
  - **Medication reconciliation**
  - **"Red Flags"**
  - **Follow up plans**
- Advanced Illness Management discussion and documentation:
  - **Prognosis,**
  - **Goals of Care**
  - **Advance Directive/POLST**



CARE MANAGERS

- Participate in daily huddle
- Transition coaching using 4 pillars
- Schedule 7-day and 14-day follow-up visits with primary provider
- Readmit and long length of stay reviews
- Avoidable days/admissions capture and review

Upon patient discharge

- 48-hour post-discharge phone call

TRANSITION MANAGEMENT | How do we do it?

SNF Discharge

WITHIN THE SNF

- Timely SNF Placement
- SNF team MD visit within 2 Days
- ARNP visit within the following 2-3 Days
- Admission and discharge summaries in EPIC
- Discuss and document Goals of Care, Advance Directives
- POLST / DPOA Confirmation or Completion
- Medication reconciliation in EPIC
- 4 Pillars teaching
- Plan for next transition (home, AL, LTC, etc.)

POST-ACUTE TRANSITION | How do we do it?

Transition Mgmt

SNF PLACEMENT OFFICE

- Centralized office with on-line connections to SNFs (and close personal contacts)
- Works to expedite SNF placement out of hospitals
- Insure appropriate level of care/expertise and bed availability

SNF Care

CARE MANAGEMENT

- Care Management Liaison Nurses (6) and Outcome Managers (2)
- Confirm SNF eligibility initially and on-going
- Attend weekly facility Medicare Meetings
- Track quality and outcomes metrics
- Plan for next transition (home, AL, LTC, etc.)

POST-ACUTE TRANSITION | How do we do it?

SNF Care

CONTRACTED SNF NETWORK

- Currently 16 SNFs + 2 LTACs in a broad geography
- Paid on annually adjusted, fixed per-diem basis (we also calculate Medicare FFS equivalent to compare)
- 90% of our SNF patients are in contracted SNFs, 10% in non-contracted, community SNFs
- Active management of rehab care and proactive planning for next transition (home, AL, LTC)
- Active quality and performance metrics (also used at contract renewal)
- ARNP, CMLN and Outcomes Managers attend weekly Medicare Meetings

POST-ACUTE TRANSITION | How do we do it?

SNF Care

CONTRACTED SNF NETWORK

- MD/ARNP teams at each SNF, on-site 3-5 days per week depending on census
- 10 MDs staffing 6 FTEs and 20 NPs staffing 18 FTEs
- Document H&Ps and Discharge Summaries in EPIC with copies to PCP
- Templated H&Ps and Discharge Summaries modeled on Hospitalist documents (Standard Work)
- A facility “Vital Signs” performance report is reviewed with them quarterly (and used at annual contract renewal)

POST-ACUTE TRANSITION | How do we do it?

SNF Care

CONTRACTED SNF NETWORK

- We contract with Senior Metrix® to measure severity-adjusted predicted length of stay (LOS) (together with Kaiser Network)
- Measures functional status and rehab progress
- Allows us to case-mix adjust for appropriate LOS and track effectiveness of rehab therapies and on-going SNF eligibility
- Our average SNF LOS 14 days
  - Community average 20 days
  - National average 26 days
- 14% direct SNF-to-hospital readmission rate
- 10% 30-day post-discharge rehospitalization rate

POST-ACUTE TRANSITION | How do we do it?

SNF Care

CONTRACTED SNF NETWORK

Quarterly “Vital Signs” report summarizes quality and performance, including:

- # admissions overall
- Participation in functional measurement program
- Overall patient satisfaction (survey results)
- Patient understands meds at D/C (survey results)
- Variance from predicted LOS
- Functional level at D/C
- Appeal rate
- Appeals overturn rate (MA 5-star measure for us)

POST-ACUTE TRANSITION | How do we do it?

SNF Discharge

HOME HEALTH PROGRAM

- We have our own Home Health Program but also use community programs if needed
- 80% of SNF discharges are referred to Home Health
- Read only in EPIC, write in Horizon

HOSPICE PROGRAM

- We have our own Hospice Agency but also refer to community agencies if needed
- Read only in EPIC, write in Horizon

CONNECTING BACK WITH OUR MEDICAL HOME

Key leadership within our Primary Care and Specialty divisions helped guide how patients would be reconnected back to their primary provider.

Key Points include:

- All patients called within 7 days following discharge from the hospital by a clinical pharmacist to reconcile medication
- All patients receive a face-to-face visit with PCP within 14 days post-discharge (-higher risk patients within 7-days)
- Initiate Advanced Illness Management conversations as appropriate/when needed
- Specialists integrate transition management into hospital care of patients and incorporate palliative care planning into regular workload

PROVIDER TRAINING

Palliative Care

- Communication skills focused on “The Conversation”, setting Goals of Care, and End of Life planning
- Full-day interactive classes for all Hospitalists, SNF MDs / ARNPs, ER/Urgent Care providers
- Half-day classes for all Primary Care Providers
- Decision support tools for identifying patients in need of those conversations

PROVIDER TRAINING

However:

Even after extensive training, we were not seeing good participation in Palliative Care discussions

We discovered many providers and patients were still uncomfortable with discussions specifically about “Palliative Care”.

So we made some changes…

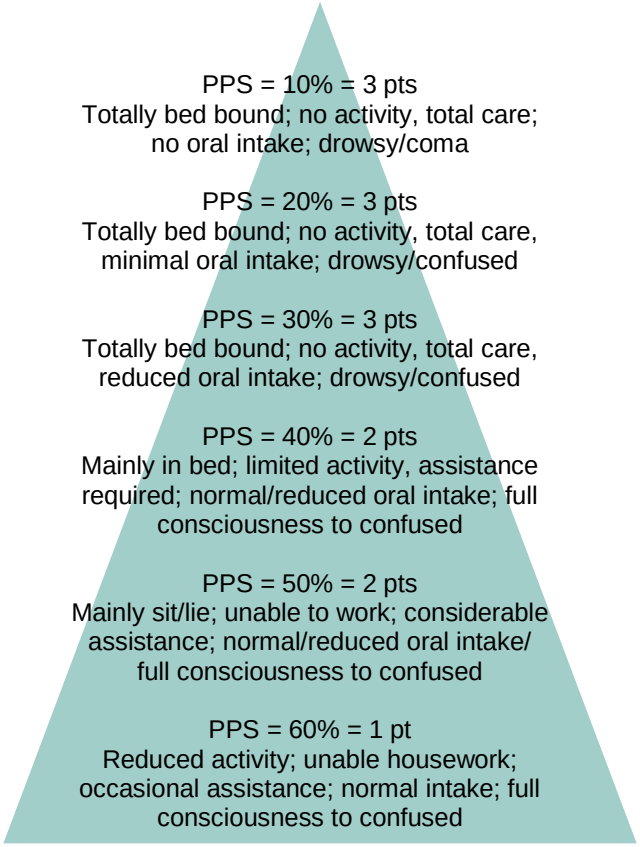
A LEAN Lesson: PALLIATIVE CARE

From This:

Palliative Care

"Palliative Care"

Functional Status + **Disease Process** = **Level of Intervention**



Basic Disease Process (2 pts each)
Cancer (metastic/recurrent), advanced COPD, stroke w/ decreased Function by at least 50%, end stage renal disease, adv. cardiac disease (CHF, severe CAD, etc), other life-limiting illness

Concomitant Disease Process (1 pt each)
Cancer (metastic/recurrent), advanced COPD, stroke w/ decreased Function by at least 50%, end stage renal disease, adv. cardiac disease (CHF, severe CAD, etc), other life-limiting illness

Other Criteria (1 pt each)
Not a candidate for curative therapy
Has life-limiting illness & declined life prolonging therapy
Unacceptable pain or symptoms > 24 hours
Has inadequate care system
Readmit < or = 7 days
Readmit < or = 30 days
Frequent visits to ED
Prolonged LOS w/o evidence of progress
Prolonged stay in ICU w/o evidence of progress
Is in an ICU setting with poor/futile prognosis

Score = 2 pts
No intervention
Score = 3 pts
Observation
Score = 4+ pts
Palliative Care Discussion

Source: Pyramid tool adapted from Victoria Hospice Palliative Performance Scale; Disease Process Assessment adapted from a variety of hospital-based palliative care service tools.

A LEAN Lesson: PALLIATIVE CARE
To This:

Palliative Care

"Advanced Illness Management"

- A single screening question:
  - -Would you be surprised if this patient died within the next 2 years?

If not, then discuss Advanced Illness Management and document in EPIC, including:

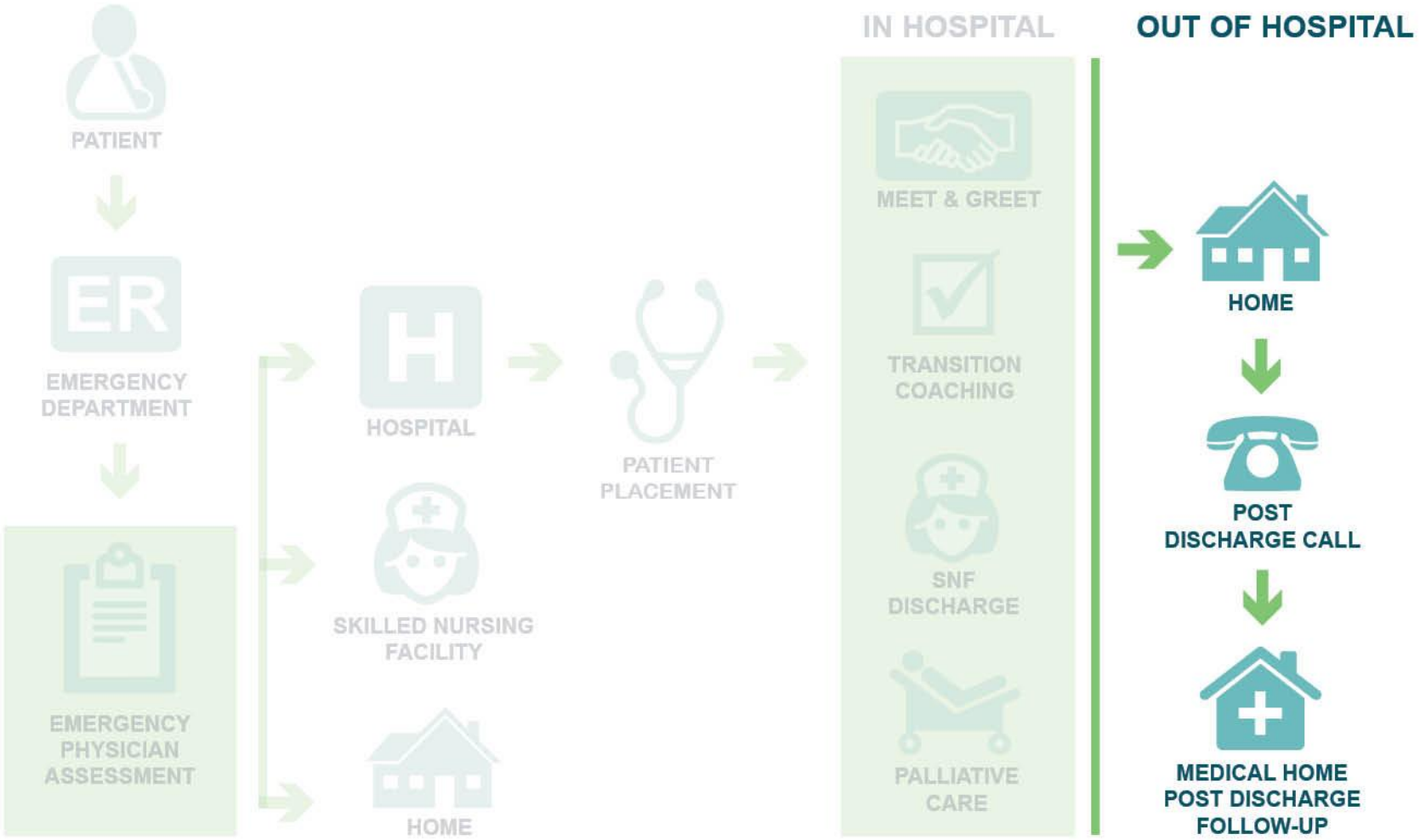
- Prognosis (in general terms)
- Patient's own Goals of Care
- Advance Directives/POLST

A LEAN Lesson: PALLIATIVE CARE → "Advanced Illness Management"

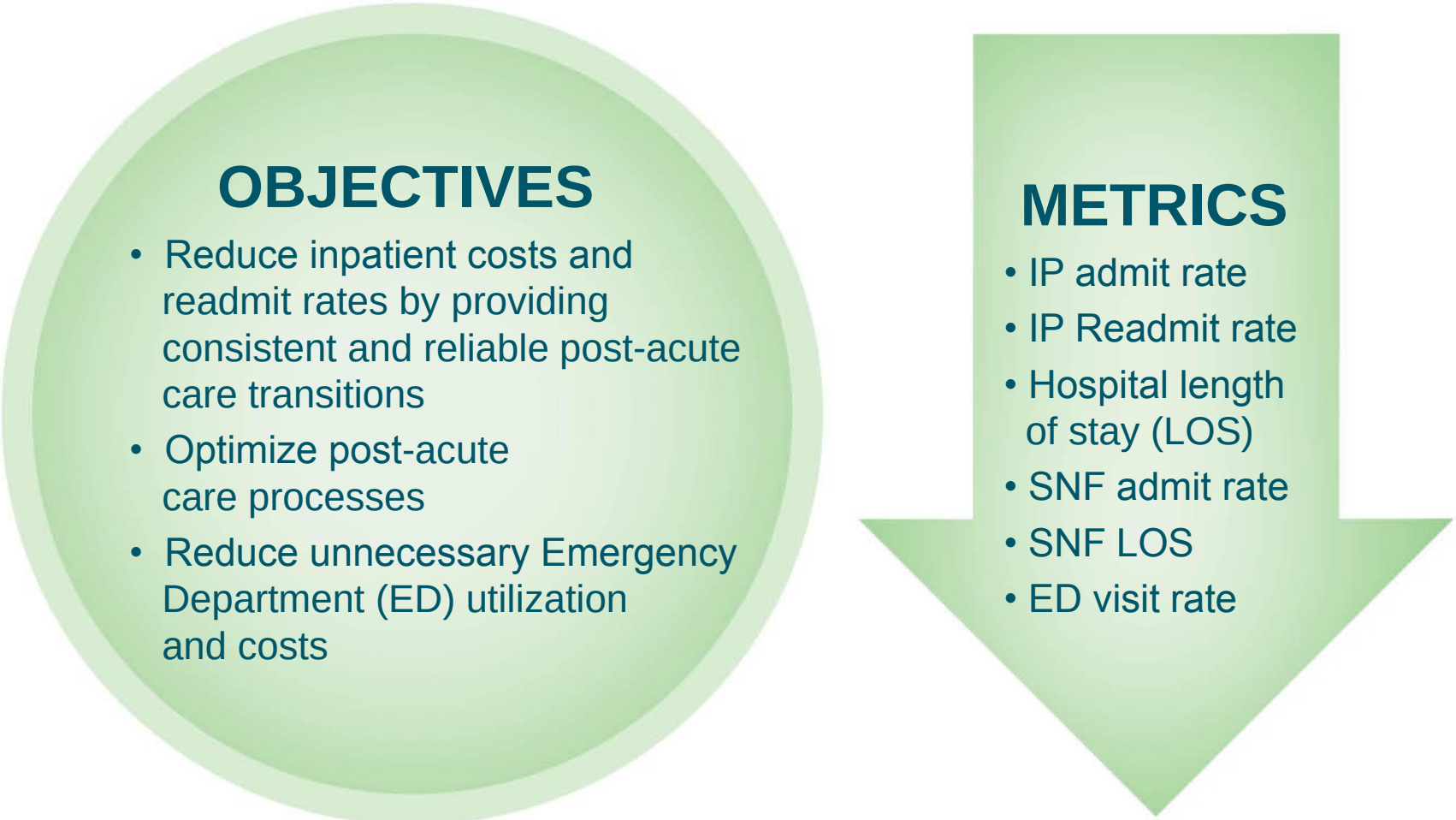
Palliative Care

- **Results:**
- **Both providers and patients were much more accepting of the term "Advanced Illness"**
- **Much better participation in meaningful discussions and documentation of prognosis and goals of care**
- **"Advanced Illness" is now our standard verbiage instead of Palliative Care**

POST-DISCHARGE



GOALS AND MEASUREMENT



MEDICARE 30-Day Readmission rate:

NATIONAL:

19.6%

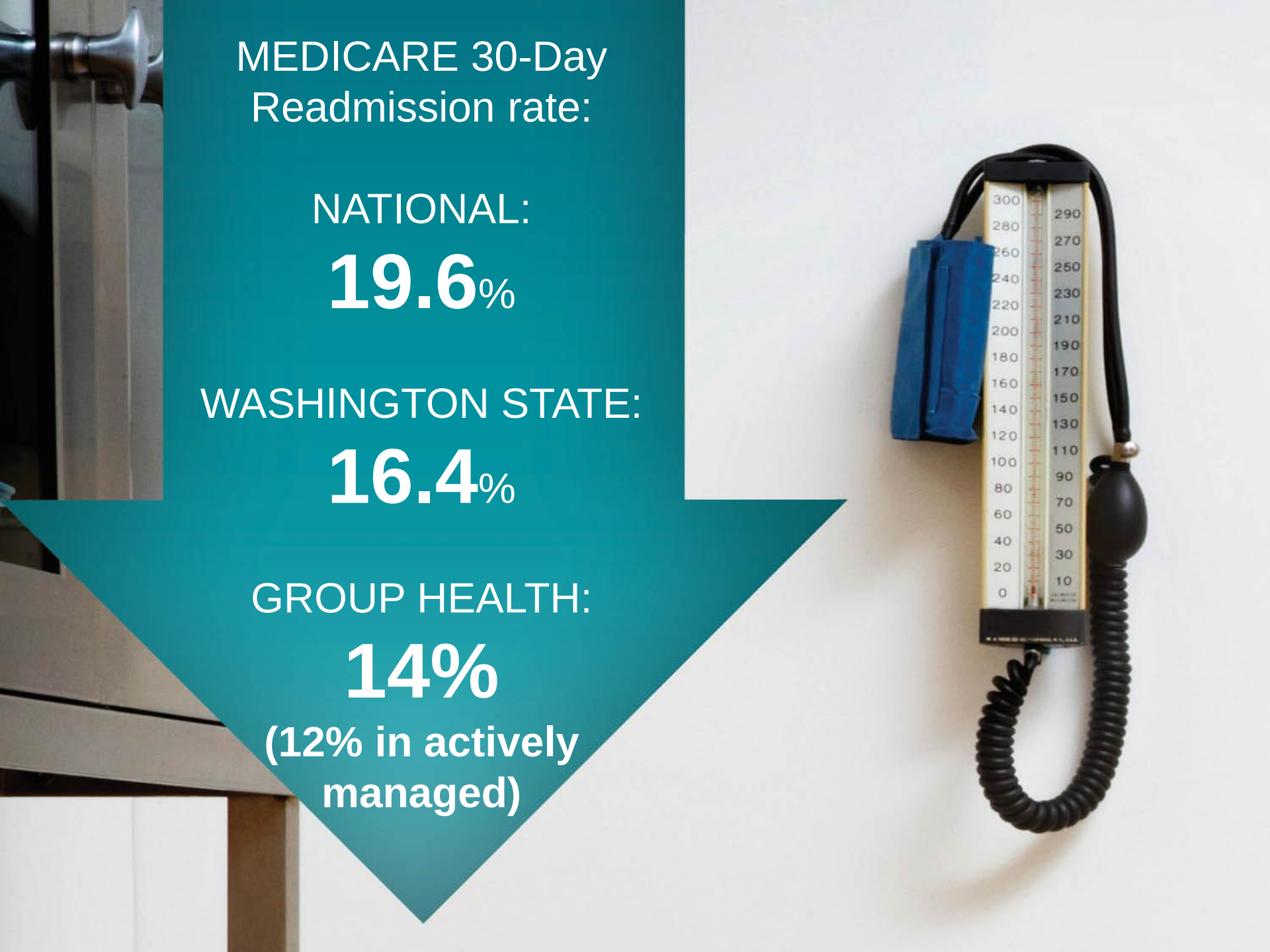
WASHINGTON STATE:

16.4%

GROUP HEALTH:

14%

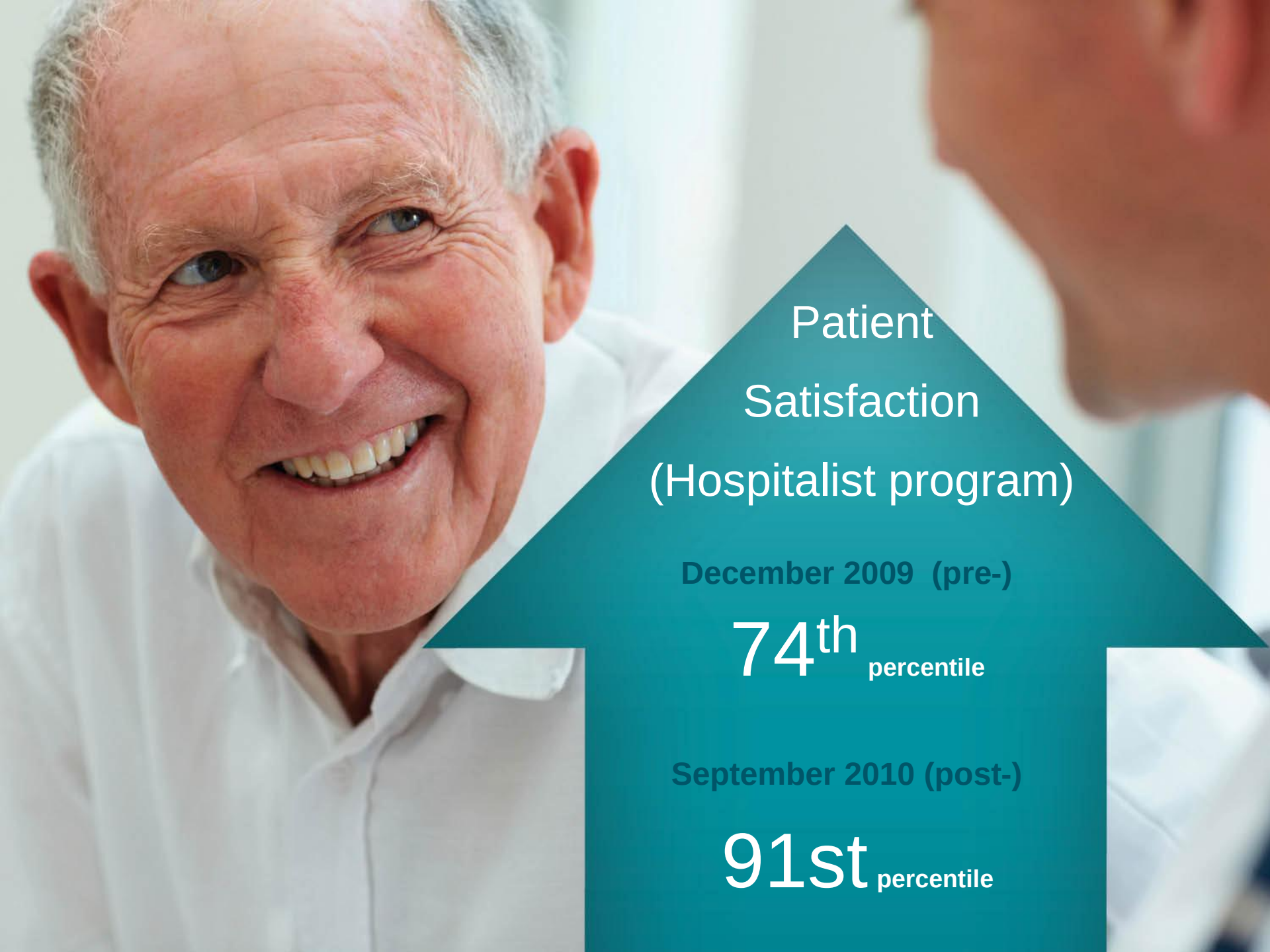
(12% in actively managed)



OUTCOMES

(all normalized per 1000 patients)

Measure	2009→10	2010→11	2011→12
Medicare Hosp Admissions	↓6.3%	↓1.1%	↓6.4%
Medicare Hosp Days	↓3.3%	↓1%	↓5.9%
Non-Medicare Hosp Admissions	↓7%	↓0.5%	↓1.8%
Non-Medicare Hosp Days	↓10%	↓5.6%	↓0.4%
Medicare SNF Admissions	no change		
Medicare SNF Days	↓5%	↓1%	↓9%
ER Visits	↓5%	no change	no change
Hospital costs	↓$51M		


Patient
Satisfaction
(Hospitalist program)
December 2009 (pre-)
74th percentile
September 2010 (post-)
91st percentile

How Did We Get Here?

- Committed to LEAN Management System in 2007
  - Respect the customer and the front line
  - Go See (Gemba Walks)
  - Continuous Improvement (Kaizen)
  - Standard Work
  - Daily Management System

How Did We Get Here?

1. **Primary Care: Patient Centered Medical Home pilot in 2007, then roll out to 24 primary care clinics in 2008-9**

2. **Specialty Value Stream initiative 2008-9**

3. **EDHI: 7 Rapid Process Workshops in 2009-10:**

- Transition Management
- SNF Transitions
- Proactive Palliative Care
- Alternatives to Admission
- Data Management
- Home Health
- Hospice

PROVIDER TRAINING

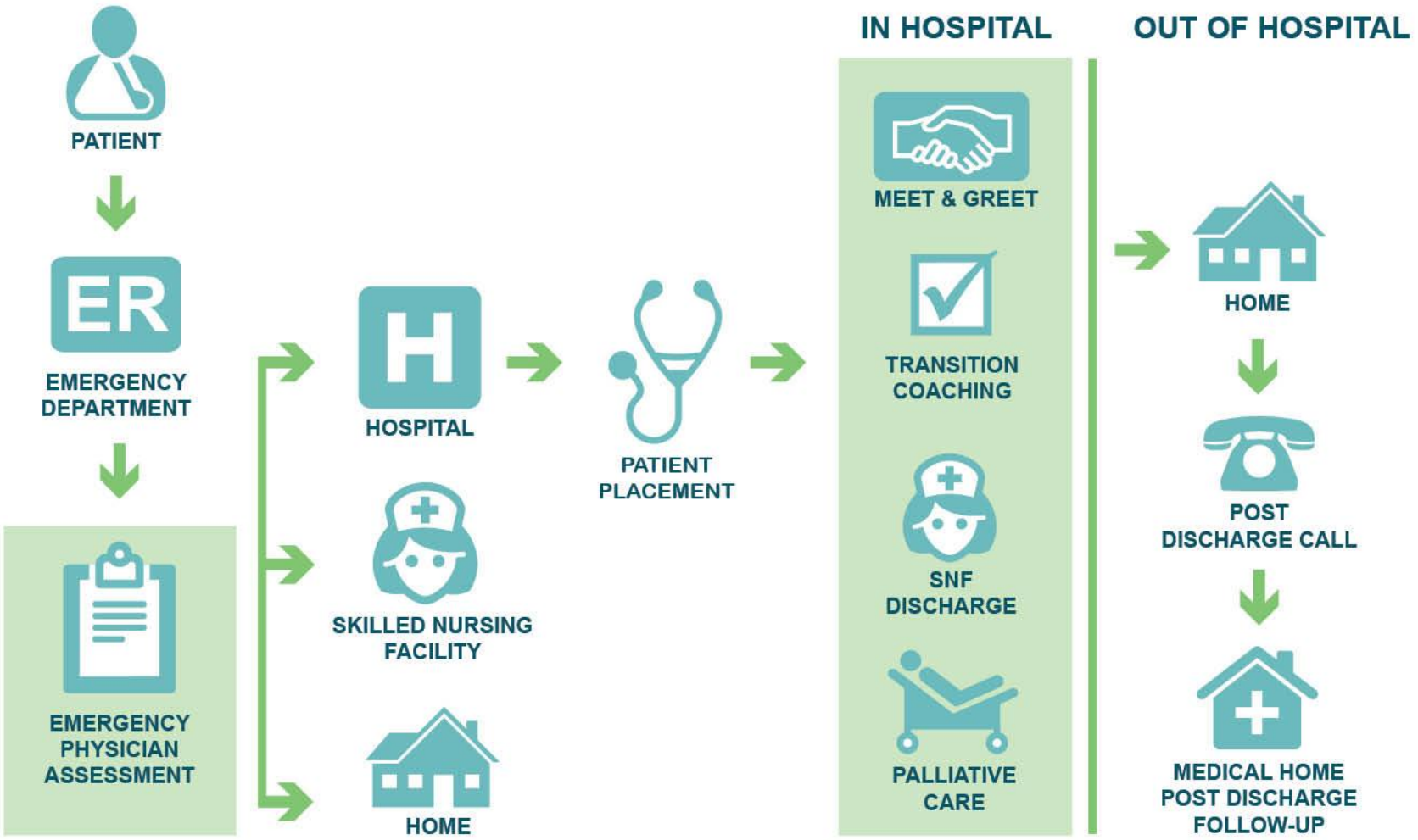
Palliative Care

- Communication skills focused on “The Conversation”, setting Goals for Care, and End of Life planning
- Decision support tools for identifying patients in need of those conversations
- Lean principles including Standard Work
- Daily Management system

SUMMARY

- A coordinated, system-wide, multi-pronged effort resulted in improved patient satisfaction reduced costs
- Organizational commitment to LEAN management system provided useful tools
- Standard Work including templates leads to fewer errors and a consistent expectations
- Daily management system promotes PDCA and continuous improvement techniques

TRANSITIONS



SUMMARY

- Focus on appropriate placement up front
- Begin transition planning at the time of hospital or nursing facility admission
- Develop relationships (and contracts) with selected hospitals and nursing homes
  - Allows improved communications and performance management
  - Allows true care coordination
  - Promotes accountability

SUMMARY

- Don’t leave Skilled Nursing, Hospice, or Home Health care to chance
- Advanced Illness Management including Goals of Care and Prognosis discussions and documentation are challenging and important
- Training and Change Management challenges may be significant

SUMMARY

- Good communications are essential—
  - When possible, use an EHR that is accessible in all sites of care
  - Keep PCP informed (and involved) even if they are not personally caring for the patient in each setting
  - Good business system interactivity is as important as good clinical information flow

Thank you.

Questions?

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