The Post Acute Continuum

Kaiser Permanente Northwest

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Kaiser Permanente Northwest

Proudly serving NW Oregon and SW Washington

- Growing with the community—providing care from Longview to Salem
  - 1 hospital (a second will open in 2013).
  - 26 medical offices.
  - 16 dental offices.
- Serving small and large employers, individuals, and Medicare and Medicaid members
  - 480,000 medical members.
  - 192,000 dental members.
- The Kaiser Permanente Model
  - Commitment to prevention.
  - Evidence-based medicine.
  - Aligned incentives.
  - Community benefit.
  - Seamless integration between care delivery and the health plan.

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Continuing Care Services

Integral part of KPNW medical care delivery system

- Includes an array of post-acute care services and programs that assist in managing chronic to advance illness of our members.
- Vital link in promoting continuity of care, with timely and appropriate discharge planning from inpatient settings to home and transition of patients to and from the ambulatory care setting.

Internal Services	Contracted Services
▪ Home Health ▪ Hospice ▪ Home Infusion Therapy ▪ Palliative Care	▪ Skilled Nursing care ▪ Home Health and Hospice – Salem, Oregon & Longview, Washington service areas ▪ DME related to Hospice and SNF programs ▪ Long-Term Acute Care (LTACH)

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Skilled Nursing

ADC demand is estimated to increase 16% by 2015 and 37% by 2020

- Average daily census ~110
- $17M+ annual spend
- Members age 65+ accounted for 86% of total SNF discharge volume
- 90% of SNF volume are referrals from a hospital with almost half coming from KSMC

Eliminate barriers to hospital discharge	Avoid hospital admissions	Achieve lower ALOS and Cost per care
1. Patient transfers from ED (Care Coordinators in ED) 2. SNF placement coordinator to problem solve complex transfers 3. Transfer patients 7 days/week	1. Waive Medicare 3 day hospitalization requirement for SA members 2. 4-5 day/week clinician rounding in SNF 3. Screen patient for stability and appropriate level of care as part of SNF placement process	1. Rate increases tied to quality and efficiency (new 2011) 2. Contract for beds to allow facility staff to specialize in KP patients 3. Maximize use of contract facilities (50% lower LOS than non contract facilities)

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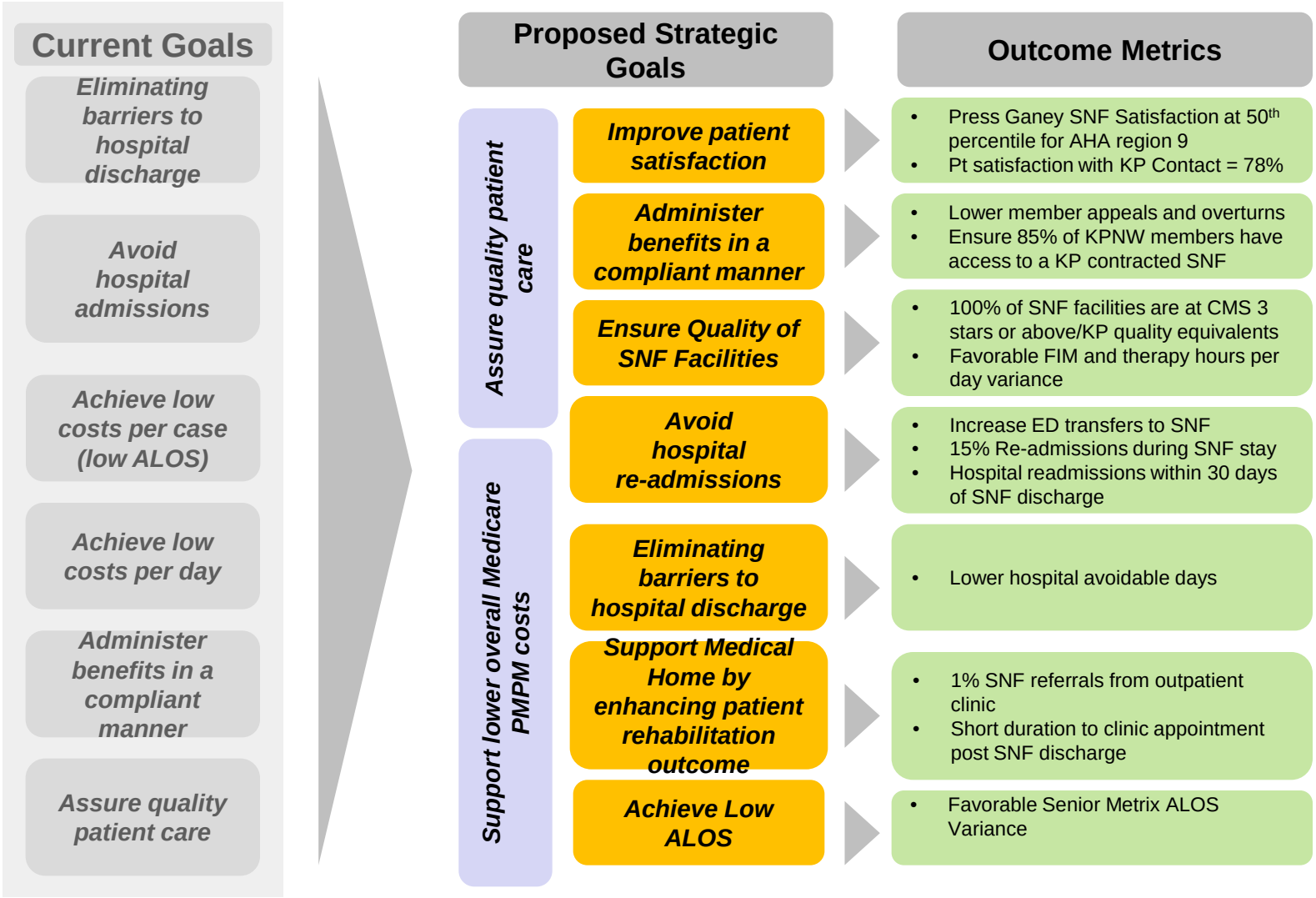
Skilled Nursing Strategic Focus

Management of hospital utilization, costs and improving quality of care



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Home Health

Patient episode volume will increase 16% by 2015 and 37% by 2020

Goals

- *Reduce Hospital Admissions*
- *Improve quality of care*
- *Provide unique value to KP*
- *Support lower Medicare PMPM costs*
- *Support Medical Home for geriatric population*

Strategies

- Proactively provide HH for at risk patients
- Implement re-hospitalization risk assessments
- Explore telehealth
- Increasing nursing and therapy FTEs to assure 80% of admissions within 2 days and visit frequency is sufficient to prevent over use of SNF
- Increase QM resources to 1 FTE per 150 patient to achieve national average OASIS outcomes

	Home Health	Hospice	Total
No. Referrals per year	5,142	1,683	6,807

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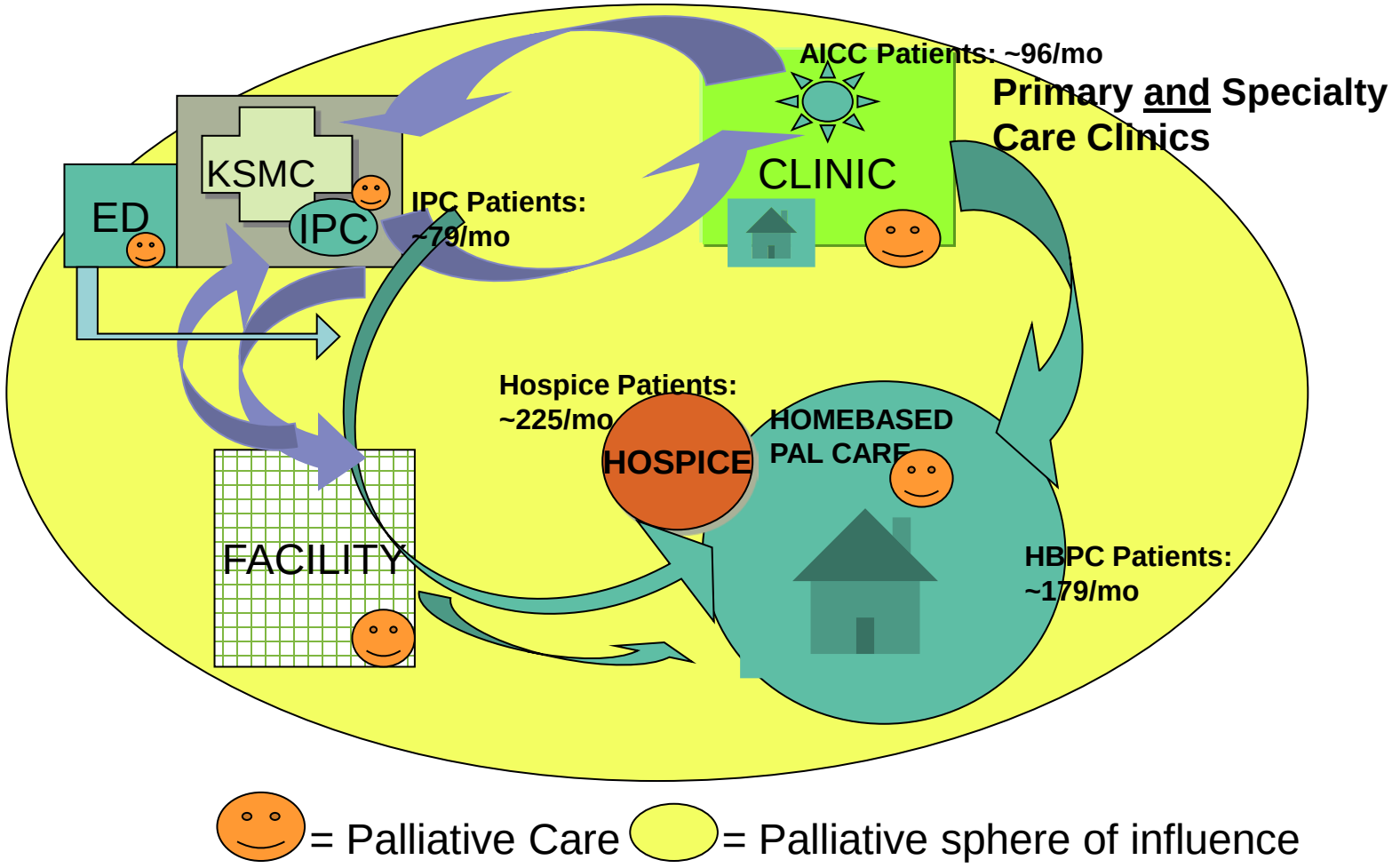
Palliative Care: Future State

Expansion of services in 2012 to serve an additional 1171 patients, ultimately reaching 1902 patients



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Transitions of Care

Decreasing hospital readmissions & improving satisfaction with hospital discharge and follow-up care

- Readmit rate
  - KSMC overall rate down from 10.9% → 10.0%
  - KSMC rate for Medicare patients has fallen from 14.1% → 13.0%
- Discharge med list errors
  - Significant decrease in error rate
  - In many cases, these errors are now fixed before discharge by a transition pharmacist
- Satisfaction
  - HCAHPS discharge information composite score is trending upward and KSMC has the highest rate in the program

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Transition Care Bundle

Needs from the member's perspective:	All hospitalized members receive:	Members at high-risk for readmission ALSO receive
I will have what I need when I return home	Standardized process for identifying who might be at risk for readmission and documenting patient goals and needs at home	High risk defined as: ▪ The physician or RN believes the patient may be at risk for readmission ▪ Heart Failure diagnosis ▪ Prior hospitalization in last 30 days
I have one person in the hospital who will help plan for my return home	Define a single point of contact responsible for supporting the patient's transition out of the hospital including identification of patient needs and plan to meet them	
I understand my medications, how to take them, and why I need them	Accurate medication list (in lay person language) will be reviewed and given to the patient which includes: ▪ How to take and purpose of medications ▪ Potential medication side-effects ▪ Changes to medications ▪ Assessment of patient understanding	
My family/caregiver who will participate in my care at home will get the information they need to help me	Identify and include the appropriate caregiver/family member in transition planning. Provide training as needed.	
I will see my doctor soon after my hospitalization	Primary or Specialty Care follow-up appointment is scheduled during hospital stay and occurs within 10 days of leaving hospital	Appointment is scheduled within 5 days of leaving hospital
The people caring for me in and out of the hospital work together to plan my care	Creation of integrated multidisciplinary care plan in KPHealthConnect	
I know when to call and what phone number to call if I need help	Before leaving the hospital, the patient will have written information that includes: ▪ Single phone number to call for worsening condition ▪ A clear designation of the responsible / covering clinician and a means to reach them for medical questions ▪ Signs and symptoms of when to call and when to go to the ED	
I know someone will check on me when I am home	Follow up phone call by Transition RN within 72 hours and staging of clinician visit. Clinician "ownership" of patient care: Hospitalists ownership of Medicine Patients for 48 hours after patient leaves the hospital.	Intensive follow-up care to include: ▪ Pharmacist intervention within 2 days for medication reconciliation, supporting adherence and understanding ▪ Follow-up call by Transition RN within 24 hours with staging of clinician visit and case management for 30 days with minimum weekly contact. ▪ Home visit regardless of homebound status

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METRICS FOR EVALUATING CARE TRANSITION QUALITY

DISCHARGE PLANNING

Admissions in which **patients and family caregiver are included in assessing post-discharge needs**[1]

Patients able to teach back >70 percent of information taught[2]

Patients with a cardiovascular event referred to an outpatient cardiac rehab program prior to hospital discharge, or who have a documented reason why such a referral was not made*[3]

PATIENT AND FAMILY INFORMATION AT DISCHARGE

Patients **discharged from an inpatient facility to home** or any other site of care, or to their caregiver(s), who received a **transition record (and with whom a review of information was documented) at the time of discharge**[4,5,6,7]

Patients **discharged from ED to ambulatory care** or home health care who received a **transition record at the time of ED discharge***[4,5,6,7]

Patients discharged from an inpatient facility to home or any other site of care, or to their caregiver(s), who received a reconciled **medication list at the time of discharge***[4,5,6,7]

3-Item Care Transition Measure (CTM-3)*[3]

INFORMATION TRANSFER TO OTHER SITES OF CARE

Notification to PCP that patient was admitted to an acute inpatient facility within 24 hours of admission[2]

Patients discharged from an inpatient facility to home or any other site of care for whom a **transition record was transmitted to the facility or to PCP** or other health care professional designated for follow-up care within 24 hours of discharge*[4,5,6,7]

FOLLOW-UP CARE

Follow-up phone calls conducted for high-risk patients within 48 hours of discharge[2]

Patients **discharged with a follow-up appointment scheduled** within 5 days of discharge[2]

Patient compliance rate with **showing up at first follow-up** appointment[2]

The Advisory Board Company

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