Post Acute Care Integration: Connecting the Continuum for a Value-Based World

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Renée Coughlin PT, DPT, MHS
Cindy Vunovich RN, BSN, MSM
Shane Woodley RN, MSN, MBA

Objectives

1. Identify three quality standards that Health Systems and Accountable Care Organizations (ACOs) will be held to under the Affordable Care Act (ACA)

2. Describe how these quality standards aim to align incentives, and the value partnering with home health providers brings to the equation

3. Discuss three key programming considerations for home health providers to consider in an effort to redefine themselves as providers of solutions, rather than vendors of visits
Cleveland Clinic Enterprise

Since 1921
A Unique Model of Care

- Four doctors share a vision
  - Non-profit, physician-led group practice
  - Collaboration across disciplines
  - All physicians are salaried
  - Patient-centered mission
Cleveland Clinic Today

- 44,000 caregivers
- 5 million total visits
- 145,000 hospital admissions
- 3,000 physicians & scientists
- 1,800 residents & fellows

Cleveland Clinic Locations

9 Hospitals in Northeast Ohio
27 Specialty Institutes
16 Family Health Centers
2012 Cleveland Clinic
U.S. News & World Report

• #1 in Cardiology & Heart Surgery; 18th consecutive year
• #1 in Nephrology
• #1 in Urology
• 10 specialties ranked in Top 3
• Ranked in 14 specialties
• Cleveland Clinic Children’s ranked in all 10 pediatric specialties

Fully Integrated Home Care Services in the Cleveland Clinic Health System

CCF Ventures

CCHCS

Meridia

Fairview

Lakewood

Marymount
# Center for Connected Care

## SCOPE OF OPERATIONS

<table>
<thead>
<tr>
<th>Home Care Services</th>
<th>Transitional Care</th>
</tr>
</thead>
</table>
| • Medical Care at Home: physician house call program / IAH  
  • Home Health Agency  
  • Home Infusion Pharmacy and Respiratory Therapy | • SNF/LTAC Connected Care Units  
  • Disease based transitional care programs – Heart Care at Home  
  • Relationships with PAC providers |

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Post Acute Knowledge and Solutions Center</th>
</tr>
</thead>
</table>
| • At-home Hospice  
  • Palliative care  
  • End of Life community care | • Technology: EMR integration  
  • Distance Health  
  • Payor Contracting  
  • Scholarship / Outcomes Research |

### TODAY’s Census:
- 2,152 Home Health
- 272 Hospice at Home
- 900 Home Infusion Pharmacy
- 214 Medical Care at Home (IAH)
- 135 IRF and SNF inpatients
- >10,000 RT patients

### 13,523 Patients
A Tale of Home Care

It is the

Best of Times   Worst of Times

The Future of US Healthcare

• Starts with understanding and owning our history...

Click here to play video
Key Points

- 50 million uninsured / 25 million under insured
- 40 million > 65y/o
- 80 million seniors in 2040
- 5% of population use 49% of healthcare resources
- Payment cuts (medi-medi, commercial)

Broken System supported by the largest per capita health care spending in the world

Affordable Care Act

- Enacted March 23, 2010
- Designed to:
  - Improve access for 32 million lacking insurance coverage
  - Improve quality of Medicare services
  - Support innovation
  - Establish new payment models
  - Align payment models with provider cost
  - Strengthen program integrity
  - Improve financial footing of Medicare model
ACA – Breaking it Down

Quality Standards: 4 Key Areas

1. Patient / Caregiver care experience (7 measures)
2. Care coordination / Patient safety (6 measures)
3. At-risk population / Frail elderly
4. Preventive health (8 measures)

Patient / Caregiver Experience

Quality Standard 1

“So, as you can see, customer satisfaction is up considerably since phasing out the complaint forms.”
Care Coordination and Safety

- All Cause Readmissions
- Medication Reconciliation Post Hospital Discharge
- Falls Risk Assessment Screening and Intervention

Quality Standard 2

At Risk Population/Frail Elderly

- Monitoring, screening, educating, and influencing
  - Diabetes
  - Hypertension
  - Ischemic Vascular Disease
  - Heart Failure
  - Coronary Artery Disease

Quality Standard 3
Accountable Care Organizations

- By the end of Jan 2013, a total of 428 ACOs were in existence
- More than 40% are in only 5 states
- 9 of 32 Pioneer ACOs (28%) may leave the program
- Don’t wait to see if your referring providers will be part of an ACO to make changes…because

All Health Systems, Hospitals and ACOs are Subject to:

- Value-Based Purchasing
- Readmission
- Patient Safety
- Patient Satisfaction
- Clinical Integration
- Technology
- Case Management
- Care Transitions
Aligning Incentives…

- Market-based Incentives
- Provider Incentives
- Patient Incentives

Rewarding Quality Through Market-Based Incentives

- Quality reporting
- Effective case management
- Care coordination
- Chronic disease management
- Medication and care compliance initiatives
- The medical home model
### Provider Incentives

- **Bundled payment strategies**
  - Shared risk/shared savings
- **Penalties/Rewards**
  - Pay for Performance bonuses
  - Readmission penalties
  - Bonus for Health IT implementation
- **Reference pricing (fixed-dollar coverage)**

### Patient Incentives

- **Choose high-performing physicians and hospitals**
- **Co-pay/co-insurance reductions for using decision-support system for elective procedures**
- **Participation in care management or coaching to reduce health risks**
- **Preventive screening compliance**
- **Condition-specific incentives to reduce financial barriers to medication adherence and encourage condition management**
The Future is Here

- Health System success will be defined by those who attain the Triple Aim

- Improve the Health of the Population
- Improve the Experience of the Individual
- Improve Affordability (Reducing Costs)

Care / Health / Cost

Choices

- Home Health providers are faced with two post-acute business strategies:
  - Vendor of Services
  - Specialized solutions provider
Post-Acute Care Value Continuum

Vendor to those accountable for patients’ costs

Provider partnering to solve the problems of the costliest patients

Goal: Shift to the Right

Valuation:
3X - 5X EBIDA

Valuation:
5X-13X EBIDA

Wyatt and Matas, Consultants, 2012

National Network

Owned & Partnered
Center: Specialized Solution Provider

- Branding
- Care Transitions / Coordination / Innovation
  - Heart Care @ Home
  - Connected Care
  - Go Right Home
  - Care Path Development
  - Care Delivery / Compensation Models
  - Bundled Payments

A new center focused on value-based home, transitional and post-acute care

Center for Connected Care

Reporting to the Chief of Medical Operations, the Center aims to be a resource and partner for Institutes and Hospitals as they carry out ‘connected’ care throughout the continuum
Center for Connected Care

- The mission of the Center for Connected Care is to provide world-class transitional care services, connecting patients to care at home and at community-based post-acute facilities.

Patient-Centered Vision

- Cleveland Clinic will remain at your side as you transition from the hospital back to the community (home or facility) – safer, faster, and with fewer complications.
Connected Care

Heart Care at Home
Transitional Care Model

- Identifies patient
- Introduces program
- Begins coaching
- Visits at home
- Coaches
- Installs tele-health equipment
- Nurse Practitioner oversight
- Physician input
- Outcomes tracking
- Monitoring
- Telephonic coaching
- Care coordination
- Tracks outcomes
Connected Care Units

- CCHS discharges ~22,000 patients annually to over 800 different SNFs
- Less than 10% go to CCHS SNFs (Euclid, Lakewood, Fairview)
- 40% of patients experience multiple care transitions

"Trap Door" Reality

Why focus on SNF?

- Variable Quality: 25-30%+ re-admit rates
- Fragmented: over 12,400 SNF beds in Cuyahoga County (over-bedded by 1,800)
- Costly: estimated $175M in SNF cost annually to payors for CCHS post-acute patients
- Value-based Post Acute model targets significant improvement in SNF quality / cost
**Connected Care Units**

- **CCU Model for Tomorrow**
  - Total electronic integration of documentation across venues
  - Practice and facility business based on value to patient / payers
  - Technology increases access to sub-specialists
  - Reduced variability, increased care path adherence, aligned incentives across venues

- **Usual SNF Care Today**
  - Fragmented and variable documentation
  - Physician business based on volume of visits and stipends / facility business based on volume of per diem payments
  - Often disconnected from sub-specialty care teams in hospital
  - Variation in clinical practice and incentives

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**What is Difference Between CCF CCU Model and Usual SNF Care?**
CCU Relationship

• Shared Responsibility
• Joint Quality Committee
  - Administrative & Clinical Representation
• Collaborative Review of Outcomes
• Education and Implementation of Evidence-based Practice

Connected Care Units

Specific Facilities Being Engaged Based on Quality, Interest, Current Collaboration with CCF, Practitioner Availability, Strategic Factors
Target Patients for CCU

- Post acute Main Campus SNF patients without a community PCP who provides SNF care

- Key institute service lines:
  - Heart Failure and Heart Surgery
  - Pneumonia and COPD
  - Stroke and Neurosurgery
  - Joint Replacement / Hip Fracture

- Payor-driven models with ‘shared savings’
  - Traditional Medicare Readmission Risk
  - Employee Health Plan
  - Medicare Advantage Risk Contracts

Readmissions

Source: ECIN/Readmission Report, Jan-June 2013 top 50 placed providers
Care Delivery Model

How did we get started?

- Industry Challenges
  - Reimbursement changes & recovery audits
  - Regulatory changes
  - Call for transitional and disease management care
  - Fragmentation
  - Accountability for value, outcomes, cost reduction
  - Increasing consumers / decreasing providers

- Center Challenges
  - Limited direct care accountability for outcomes
  - Capacity management
  - Ability to monitor and maintain performance while building quality and reducing cost
  - Employee engagement
Current Challenges

There are challenges in Home Care that can negatively impact patient care, financial & clinical outcomes, job satisfaction, effectiveness of staff.

Change was essential

Fundamentally transform the system to make it more accountable, sustainable, and patient care focused

Measuring Success

- **Demonstrate improved quality of work life and effectiveness of care managers**
  - Allow more time for care planning and coordination activities. Focus on performance rather than visits
  - Provide staff with increased authority and accountability for achieving optimal patient, quality, and financial outcomes
  - Improve communication & collaboration
  - Decrease unpredictability in the day
  - Improve employee engagement
Measuring Success

- Demonstrate optimal financial and quality outcomes
  - Ensure effective care planning
  - Ensure accurate and timely completion of documentation (OASIS)
  - Ensure productivity standards
  - Ensure patient satisfaction – high service standards
  - Eliminate unnecessary and duplicative work

Where Did We Need to Go?

- Develop a care delivery/compensation model that would successfully address the needs of patients, management, and direct care staff
- Develop an model that would demonstrate improved workflow processes and optimal outcomes
- Develop an model that would lay the foundation to support our future
Care Delivery Model

- Operational Changes
  - Divided into smaller interdisciplinary teams - redistricting
  - Redefined the role of the Senior Clinician / Supervisor (SN, Therapy)
  - Revised scheduling guidelines to give more ownership of schedule to the care managers
Care Delivery Model

- Compensation Changes
  - Transition CM from per visit compensation to salary
    - Incorporate on-call and weekends
    - Add-on compensation for work above expected workload
  - LPNs and select therapy staff remained hourly
  - Weekend Staff remained per visit

- Care Delivery Changes
  - Increased focus on non-visit based care management / coordination
  - Move away from visits and move toward more non-visit based management and care plan oversight
  - Emphasize case conferences / case load review
  - Leverage specialty services and interdisciplinary collaboration
  - Develop enhanced performance management, build transparency.
Collaboration, Oversight, and Review

- Weekly Scheduling Conference
- Ongoing Scheduling Oversight
- Case Conferences & Case Load Review
  - Clinical Risk Stratification Tool
  - Financial & Utilization Tool
  - Tracer Visits & Chart Audits
- Continue to develop key competencies of effective care management

Performance Management

- Employee Engagement
- Patient Satisfaction
- Home Health Compare Scores
- Financial Outcomes
- Productivity

- Business Development
- Operational Efficiency
Performance Scorecard

- Patient Satisfaction
- Clinical Performance
- Financial Performance

Productivity Scorecard

- Direct Care
- Indirect Care
- Travel
- Administrative
- Unavailable

- Case Load Activity
Identifying the At-Risk HH Patient

- Challenge presented by size and complexity of our active patient population
- 350-400 Admissions weekly
- ADC > 2100
- Goal: develop a resource to focus increased attention to the POC for our more complex patients

Risk Stratification Tool

- Report created to extract data routinely collected at SOC, ROC and Recertification from Allscripts
- Available early in the episode – 48 hours following the visit
Financial / Utilization Tool

- Active Patients
- Length of Stay
- Revenue & Cost
- CMW
- Diagnosis
- Utilization

Demonstrated Results

- Clinical Outcomes Improved
- Clinical Outcomes Declined
- Acute Care Re-hospitalization
- Financial Outcome
- CMW
- LUPA
- Capacity Management
- Employee Satisfaction
- Patient Satisfaction
Bundled Payments

Rapid Recovery Post-TJA

- CMS Bundled Payment Initiative
  - DRG 469/470 Total Hip and Knee Arthroplasty
- Applicants offer a discount (2 or 3%) to CMS for Medicare FFS patients only
- Incentive: If a savings is achieved about the proposed discount rate, CMS retrospectively pays the difference back
Type of Bundle

- Post-acute period of 30 days
- Discount rate of 3%
- Applicable to Medicare FFS patients as of January 1, 2013

Considerations to Reduce Cost

- Reduce discharges to SNF
- Reduce home care costs for those being discharged first to a SNF
- Reduce readmissions
- Shift appropriate home care volume to Outpatient Rehab
- Shift more SNF volume to the hospital-based SNF
- Decrease SNF LOS
Rapid Recovery Program Goals

- Early mobilization of post-operative patients (Day 0)
- Early return to activities of daily living
- Empower patients to actively participate in their POC
- Improve patient experience throughout the continuum
- Improved functional outcomes post-operatively
- Patient/caregiver education in the surgical and peri-surgical process

High Level Process

<table>
<thead>
<tr>
<th>I. Pre-OP</th>
<th>II. Acute</th>
<th>III. Post-acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-op Surgeon visit</td>
<td>Early initiation of PT and OT</td>
<td>Home Care: start of care date set up preoperatively</td>
</tr>
<tr>
<td>Pre-op patient education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-op home exercises</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Predicting Patient Discharge Disposition

Risk Calculator for Predicting Patient Discharge Disposition Following Total Joint Arthroplasty

<table>
<thead>
<tr>
<th>Type of Procedure</th>
<th>History of Total Knee Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>00</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>Body Mass Index</td>
<td>20</td>
</tr>
<tr>
<td>History of Heart Disease</td>
<td>Yes, severe narrowing</td>
</tr>
<tr>
<td>History of Diabetes</td>
<td>Yes</td>
</tr>
<tr>
<td>History of Hypertension</td>
<td>Yes</td>
</tr>
<tr>
<td>History of Chronic Obstructive Pulmonary Disease</td>
<td>No</td>
</tr>
<tr>
<td>Joint Revision due to Infection</td>
<td>No</td>
</tr>
<tr>
<td>Projected Weight Bearing</td>
<td>Full or Weight Bearing as Tolerated</td>
</tr>
<tr>
<td>History of Anemia</td>
<td>No</td>
</tr>
<tr>
<td>Pro-operative Ambulatory Status</td>
<td>Impaired Community Diaries</td>
</tr>
<tr>
<td>Number of Entry Steps</td>
<td>10</td>
</tr>
<tr>
<td>Bedroom Location</td>
<td>2nd Floor</td>
</tr>
<tr>
<td>Bathroom Location</td>
<td>1st Floor</td>
</tr>
<tr>
<td>Caregiver Assistance</td>
<td>Occasionally available (24/7)</td>
</tr>
<tr>
<td>Home Location</td>
<td>Less than 150 miles</td>
</tr>
</tbody>
</table>

Calculate

NOT going home at discharge, 81.55%

Euclid to CC Home Care
Population Overview Jan – May 2012

- 140 total joint/Birmingham hip referrals
  - 108 from acute care
  - 32 from IRF or SNF
- One readmission for Ludwig Angina
  - Sent to Outpatient after Hospital DC
CC Home Care to Outpatient
Jan – May, 2013

- 92 referred directly to OP with CCRST: 66%
- 22 with no OP ordered by surgeon: 15.7%
- 12 chose OP outside of CCHS: 8.6%
- 10 geographic outliers with “unknown” OP facility: 7.1%
- 3 refused OP therapy: 2.1%
- Potential OP referrals placed with CCRST: 87.6%

Type of Procedure
Home Care Referrals
Euclid Hospital Total, Jan-May

- Cleveland Clinic Home Care: 2012 - 566, 2013 - 717 (28% increase)
- Other agencies: 2012 - 185, 2013 - 248

Source: ECIN/Allscripts Care Management Opportunity reports

CC Home Care Referrals
Euclid Hospital Total, Monthly Trend

Cleveland Clinic Home Care referrals

- 2012: January - 20, February - 40, March - 60, April - 80, May - 80
- 2013: January - 20, February - 40, March - 60, April - 80, May - 80

Source: ECIN/Allscripts Care Management Opportunity reports
Home Care Referrals
Euclid Orthopedic Service, Q1

Average Home Care Placements per Month

<table>
<thead>
<tr>
<th>Year</th>
<th>Cleveland Clinic Home Care</th>
<th>Other agencies</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>2013</td>
<td>29</td>
<td>7</td>
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Source: ECIN/Allscripts Care Management Opportunity reports

Questions

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Shane Woodley RN, MSN, MBA – woodles@ccf.org
Cleveland Clinic
Every life deserves world class care.