Integrating Acute and Post-Acute Care to Improve Outcomes

Session #146
February 13, 2019

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Conflict of Interest

Eva Bering

Has no real or apparent conflicts of interest to report.
Conflict of Interest

Donna Ford

Has no real or apparent conflicts of interest to report.
Agenda

• Creating an Integrated Care Network
• Narrowing Down Network of Post-Acute Providers
• Benefits of a Preferred Partner Network
• Understanding the Role of Post-Acute Providers
• Post-Acute Journey to Integrated Care
• Defining the Role of Care Transitions & Care Coordination
Learning Objectives

• Identify the technology components necessary to successfully achieve outcomes-based reimbursement across care settings and the degree of integration that must be achieved to create a true value-based care solution

• Recognize and document the benefits of standardized care/clinical plans for conditions such as congestive heart failure, pneumonia and hip fractures that commonly require post-acute care

• Identify and measure the negative effects of transactional information exchange during critical stages of care -- e.g., patient intake and care transition

• Define specific stages in automating care coordination, with the goal of shifting from a transactional perspective to a longitudinal view of patient information

• Create a framework for a collaborative effort between acute and post-acute providers that drives improved cost and quality performance, and alignment on clinical initiatives
Lancaster General Health Community Care Collaborative (LGHCCC)

Clinically Integrated Network

- Accountable Care Organization (ACO)
- Participating in Medicare Shared Savings Program as well as other value based reimbursement programs
- Working towards maximizing continuum management
- Taking varying stages of risk for total costs of care
Structure of an Accountable Care Organization (ACO)

Lancaster General Health
  Lancaster General Health Community Care Collaborative
    Clinically Integrated Network
      Physician Provider Network
        29 Independent Physician Practices
        SELHS (FQHC)
        Physician Owned Ancillary Services
        Other aligned providers
      Preferred Provider Network (Post Acute)
        SNF’s
        Home Health
        Acute Rehab
        Home Infusion
        Other aligned services
It Takes a Village to Care for a Patient/Resident
Identification of PAC Preferred Partner Network (PPN) Members

• Criteria
  – Volume of discharges
  – Participating payer plans
  – Use of LGHP Medical Director
  – Utilization of LGH Services including EPIC
  – Geography – county coverage
  – Willingness to be creative and engage in care transformation
  – Overall 5 Star rating and quality rating
  – Bed capacity and availability

• Scoring system where criteria was weighted and then top performers were identified
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<th>CMS 5-Star Rating</th>
<th>LGHP A</th>
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Post-Acute Preferred Provider Network (PPN)

- Reduce Re-admissions
- Improve Care Transitions
- Reduce PAC LOS
- Improve Advance Care Planning

PAC PPN Focus Areas
PPN Accomplishments and Outcomes

- Reduced re-admission rates
  - FY 16: 13%
  - FY 17: 8.83%
  - FY 18: 9%
  - FY 19 (YTD): 8.7%
  - Standardization of Care / Clinical Plans
    - Fx Hip: LOS from 34 days to 17 days
    - CHF: LOS from 28 days to 13 days
    - Pneumonia: LOS 16 days
- Gunderson training for PPN partners – Advance Care Planning
- Standardized SNF application process
- Updated TOC document
- Concentrated Educational Programming
  - 43% reduction in SNF cost and utilization in last ACO performance year
Post-Acute Preferred Provider Network (PPN)

- Benefits of Network Participation for SNFs and LG
- Improved performance
- Discharge Planning/Plan of Care
- Quality meeting engagement
- Data sharing tool
- Educational opportunities
- Bed availability for LG patients
- Marketing as applicable and appropriate
- Improved referral processes
Landis Homes

- 114 Acre CCRC Campus
- 875 Residents
  - 103 SNF, 124 Personal Care, remaining in cottages and apartments
- 550+ employees
- 5 Star Facility
- Part of Landis Communities
- One of 17 CCRC in the Lancaster County, Pa
Post-Acute Value-Based Care and New Pressures

- Reimbursement models are changing
- Length of stays are shorter
- Health systems narrowing networks
- Need to coordinate care upstream and downstream
Goals

- Improve quality of life
- Improve care coordination & data sharing capabilities
- Improved quality of care & outcomes
- Improve care transitions
- Reduce cost of care
Competing For Referrals

Post-Acute Providers

Lancaster General Health
The Journey to Integrated Care

Interoperability

Documentation Exchange
Standardizing data transfer with CCDs, labs, public health registries and health information exchanges

Secure, Direct Exchange
Direct Message internally as well as externally to the larger provider community, enabling coordinated care across the care continuum

Using a Certified EHR
Digitized but unconnected to the larger provider community

Transitions of Care
Point-to-point referrals within a single workflow

Query-based Exchange
Find/request information from other providers, such as discharge summaries

Integrated, Whole-person Care
Single patient record across the entire continuum

Query for Key patient information
6 Minutes vs. 29 hours
If the Market is Shifting... What is Required?

Tools designed to enable views of the population in new ways, with new capabilities on creating cohorts, and attributing lives to **ALL** models of care.

Providers must ask new questions about clinical and financial data and be able to share and **ACT** on that information in real-time.

Automated platforms that integrate data to drive new insights to the care **TEAM** assigned to manage and coordinate care for a population.
Skilled Nursing Transitions of Care

- Patient is Referred to Skilled Nursing
  - C-CDA/Assessments/Notes
  - Integrated Care Supported by Provider Collaboration and Bi-directional Clinical Data Exchange
  - Updated Post Acute data is shared with the Hospital

- Integrates the Hospital’s Patient Data and Begins the Admission
  - C-CDA/Notes
  - Clinical Services performed at the Skilled Nursing Facility

Lancaster General Health

Landis Homes

LTC
Seamless Care Transitions

PATIENT RECORD
- Demographics
- Doctor
- Allergies
- Related parties
- Diagnosis
- Unified resident/patient record
- Care plan
- Scheduling
- Medications

No duplicative data entry
No need for paper charts

ALL CARE SETTINGS
- Residential Living
- Assisted Living
- Skilled Nursing
- Home Health and Hospice
- Adult Day Care
- Memory Care

Single Record
Single, Unified Bill
No duplicative data entry
No need for paper charts
Care Coordination
Data exchange supports improved care coordination and minimizes risk

Medication Reconciliation Between Organizations

Safety

- 50 percent of hospital-related medication errors and 20 percent of adverse drug events result from poor communication at transition
- 60 percent of post-discharge adverse drug events could be prevented or improved by better intervention

Efficiencies

- Cost of reconciling medications without history
  - 10 hours/$290
- Cost with increased coordination between hospital and SNF
  - 1 hour/$35

Patient Medications

- 30% 8+ medications
- 40% don’t understand side effects
Shared Care Planning & Coordination System

**Type**

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<td>Report outcomes data</td>
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<td>Integration of clinical pathways (care protocols) and other critical patient data</td>
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<td>Participating in National Health Data Sharing Frameworks</td>
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<td>Supporting Industry Interoperability Standards</td>
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<td>Open Network supporting Fast Healthcare Interoperability Resources (FHIR) Application Program Interfaces (APIs)</td>
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Questions

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THANK YOU! Please complete the online session evaluation