Managing Care Transitions in a Value-Based System

Robert Klugman, MD, FACP
Vice President, Medical Affairs and Eastern Region
Kindred Healthcare Medical Director, Kindred at Home
Boston Integrated Market

Value Added Care and the Triple Aim; the Post-acute Perspective

Bob Klugman MD FACP
Voluntary Associate Professor of Medicine and Quantitative Health Sciences
University of Massachusetts Medical School
Adjunct Associate Professor of Medicine
Tufts University Medical School
Vice President, Medical Affairs, Kindred Healthcare
Medical Director, Kindred at Home, Boston Integrated Market
Disclosures

I am an employee of Kindred Healthcare
I am a consultant for Luminat
I am a consultant for Ubicare

Rebuilding the Airplane in Mid-air

1. The ‘burning platform’
2. Defining ‘The Triple Aim’
3. The post-acute paradigm
4. Care management

Due to the sagging economy, rising fuel prices, the cost of maintenance and healthcare premiums, the light at the end of the tunnel has been turned off. We apologize of any inconvenience.
We’ve all Seen This

If the annual growth in Medicare spending were to equal only 1% more than annual U.S. economic growth, the projected long term federal deficit would fall by more than one-third.


And This...

Price-adjusted Medicare Expenditures per Beneficiary by Hospital Referral Region (2008)*

What’s Wrong with the U.S. Health System

“We’re throwing a lot of money at it and we don’t know what we’re getting out of it.

A lot goes in and very little seems to be coming out the other side in terms of welfare and satisfaction and extended life.”

Q&A with Dr. Jack Wennberg
Founder Dartmouth Institute for Health Policy
March 2008
Efficiency in Healthcare

“Of all of the aims of the IOM, that healthcare should be safe, timely, effective, efficient, equitable and patient centered, our biggest priority for the immediate future is efficient.”

- Dr. Donald Berwick, former CMS Administrator, December 2011, IHI National Forum

From: Eliminating Waste in US Health Care

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The ‘Triple Aim’

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care
An arching silver bridge crosses the river into the city. The bridge, built in the 1930s by the US Army, survived the severe Hurricane Mitch of 1998.
The Key: Co-Evolution

Delivery System Redesign and Alternative Payment Models must support each other and evolve in parallel

Non-Risk Payment Methodology

<table>
<thead>
<tr>
<th>Non-Risk</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>Single Payment</td>
</tr>
<tr>
<td>FFS</td>
<td>Shared Savings</td>
</tr>
</tbody>
</table>

Delivery System

<table>
<thead>
<tr>
<th>Delivery System</th>
<th>Quality &amp; Efficient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragmented Care</td>
<td>Coordinated Care</td>
</tr>
</tbody>
</table>

Clinical Integration: The High Value Network
‘Shared’ Savings program

- One of many value-based purchasing initiative (e.g. hospital inpatient VBP)
- Promotes accountability for care
- Coordinates items and services under Medicare Part A and Part B
- Encourages infrastructure investment and redesigned care processes for high quality and efficient delivery
- Intent is to promote accountability for a population of Medicare beneficiaries
- As an incentive, Medicare can share a percentage of the savings with the ACO
- This only occurs if the quality performance standards are met and sharable savings are generated

ACO: AKA

[Cartoon image of a man sitting on a couch, looking at a TV with a woman saying, "Take cover! The death panels is coming!"]
Quality Care Measures (33)

- CAHPS Measures (7)
- Care Coordination (6)
- Preventative Health (8)
- At-Risk Populations (12)

Each group counts equally
In the second performance year, ACOs expanded from ‘start-up’ priorities—analyzing data, understanding their patient populations, engaging physicians, hiring new staff, identifying priority areas for care improvement, and aligning to program requirements and processes—including the expansion of quality measures to the tasks of implementing and scaling specific care management strategies, with a particular focus on postacute care and high-cost patients and deeper engagement of clinicians, patients, and communities in improvement efforts. CMS and Pioneer ACOs also developed greater letters from year to year the broader question of which care strategies yield the greatest improvement in patient outcomes and returns on investment, and the lack of some tools available in managed care settings. Equally important, ACOs took different approaches to developing their networks of physicians, facilities, and learned that growing too quickly as an organization could come at the cost of strategic engagement of physicians who could effectively manage their patients.

Pioneer ACOs to access a waiver of the 3-day hospitalization rule before a beneficiary becomes eligible for skilled nursing facility services was created, and shared learning activities focused on improving postacute care delivery and staffing were enlarged. Receiving feedback...

Now in its third year, the Pioneer model is adding key features designed to give ACOs more tools and flexibility for care management. Two ACOs opted to have a portion of their fee-for-service revenue...
### Bundled Payment

#### Types of Services by Model

<table>
<thead>
<tr>
<th>Type of Services Included in Bundle</th>
<th>Model 1: Acute Hospital Stay Only</th>
<th>Model 2: Acute Hospital Stay + Post-Acute Care</th>
<th>Model 3: Post-Acute Care Only</th>
<th>Model 4: Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-acute care services</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Related readmissions</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Other services defined in bundle (Part A &amp; Part B)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

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### Bundled Payment Model Designs

<table>
<thead>
<tr>
<th>Model 1: Acute Hospital Stay Only</th>
<th>Model 2: Acute Hospital Stay + Post-Acute Care</th>
<th>Model 3: Post-Acute Care Only</th>
<th>Model 4: Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>Selected DRGs, post-acute period only</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>All Part A services paid as part of the DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective based on preset target price</td>
<td>Retroactive based on preset target price</td>
<td>Prospective</td>
</tr>
<tr>
<td><strong>Number of initiatives</strong></td>
<td>32</td>
<td>183</td>
<td>186</td>
</tr>
</tbody>
</table>
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PAC Providers are Engaged with ACOs in Different Ways

- **Preferred Provider Network**
  - PAC providers agree to clinical quality improvements and reduction in ALOS in exchange for guaranteed volume

- **Investment**
  - PAC providers invest in ACO infrastructure in exchange for portion of shared savings

- **Gainsharing**
  - PAC providers receive portion of shared savings attributed to PAC without up-front investment
Hospital and Physician Interests:
Converging under Value-Based Payment Models

Relationships with PAC providers will be key to performance for both hospitals and physicians on quality measures such as readmissions and efficiency.

**PHYSICIAN VBP MODIFIER**
- Efficiency and Cost Reduction (15)
- Effective Clinical Care (183)
- Person & Caregiver-Centered Experience and Outcomes (10)
- Patient Safety (30)
- Community/Population Health (12)
- Communication and Care Coordination (35)

**COMMON MEASURE**
- Medicare Spending per Beneficiary Measure (MSPB)

**HOSPITAL VBP PROGRAM**
- Clinical Process of Care (8)
- Patient Experience of Care (8)
- Outcomes and Patient Safety (8)

The MSPB measure is emblematic of this shift toward value-based care across the continuum.

Source: Avalere analysis of 2014 PQRS Measures that will be used in VBPM and 2016 Hospital VBP Program. Numbers in parentheses refer to total number of measures currently within that category.

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Towards Increased Adoption of Complex Care Management

Hong, et al. NEJM 371;6: 8-14

**Barriers:**
1. FFS
2. Lack of capital for start up
3. Lack of collaboration
4. Lack of expertise
5. Analytics and HIT
6. Little short term ROI
Unsustainable Traditional Model

- $27,776
- 2-10 Docs
- Drugs & Tx
- Home Care 1->6 Visits $870
- No Home Support
- ER Visit $1516
- Hospital Stay $14,200
- Rehab/LTC Stay $11,190
- (373/ day x 30 days)
- Unpredictable/Predictable Care Crises
An estimated 70% of Americans ages 65 and older are projected to experience some level of need for long-term services and supports. (1) Those who survive to age sixty-five have a 46% chance of spending time in a nursing home. (2)

‘29% of the sample who lived alone, were in the worst health and had the highest prevalence of activity limitations of any group in the sample’

2. New estimates of lifetime nursing home use: have patterns of use changed- Med Care. 2002;40(10)

Tremendous Opportunities Exist to Better Manage Patient Care for Patients Discharged from Acute Care Hospitals

Currently there are 47.6 million Medicare beneficiaries with an estimated 9,100 individuals added to the program each day. (1)

35% of Medicare Beneficiaries Discharged from Acute Hospitals Need Post-Acute Care (2)

Medicare Patients’ Use of Post-Acute Services Throughout an “Episode of Care”

Higher ↓ Intensity of Service ↓ Lower

(1) Kaiser Family Foundation, 2011 statehealthfacts.org and AARP 2011 projections
(2) Source: RTI, 2009: Examining Post Acute Care Relationships in an Integrated Hospital System
Trends in discharges to post–acute care (PAC) facilities and home are shown. Each year is compared with 1996 values to calculate a relative percentage change.
From: *Rise of Post–Acute Care Facilities as a Discharge Destination of US Hospitalizations*

JAMA Intern Med. Published online December 01, 2014. doi:10.1001/jamainternmed.2014.6383

Trends in Length of Stay in Patients Discharged to Post–Acute Care (PAC) Facilities and Home
Concurrent trends in mean length of stay are presented; lengths of stay greater than 31 days were excluded from the analysis. Trends are calculated as a relative percentage change compared with 1996 levels. Length of stay is reported as mean number of days.

**Figure Legend:**

Deconstructing and Reconstructing the Care Continuum

**View from the Hospital**

- Admission criteria
  - Observation
  - 3 midnight rule
- Readmissions
  - Revenue vs penalties
- New payment schemes
  - Total medical expense
  - Pay for performance
- Length of stay
  - DRG
- Patient flow
  - High census
  - Case mix
Post-Acute Options

- Remain in hospital; AKA-long stay
  - Guardianship
  - One-on-one
  - High level of need
- LTACH
  - Long stay
  - Vent patients
- Inpatient rehabilitation hospital
  - Generally younger patients
  - Ability to tolerate 3 hrs of rehab daily
- SNF
  - Voltage drop in MD attention, access to testing, specialists, level of nursing care variable
- Home
  - Home health

Proportion of Medicare Patients Placed in an Avoidably High-Cost Setting: Study Findings by Post-Acute Setting

Adapted from: Advisory Board; Post-acute collaborative
Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark Y. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

<table>
<thead>
<tr>
<th>Condition at Index Discharge</th>
<th>30-Day Rehospitalization Rate</th>
<th>Proportion of All Rehospitalizations</th>
<th>Most Frequent</th>
<th>2nd Most Frequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>21.6</td>
<td>77.6</td>
<td>Heart failure (8.8)</td>
<td>Pneumonia (7.1)</td>
</tr>
<tr>
<td>Heart failure</td>
<td>26.9</td>
<td>7.6</td>
<td>Heart failure (17.9)</td>
<td>Pneumonia (5.1)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>26.1</td>
<td>6.3</td>
<td>Pneumonia (28.3)</td>
<td>Heart failure (7.4)</td>
</tr>
<tr>
<td>COPD</td>
<td>22.6</td>
<td>6.9</td>
<td>COPD (16.2)</td>
<td>Pneumonia (13.4)</td>
</tr>
<tr>
<td>Psychosis</td>
<td>24.6</td>
<td>3.5</td>
<td>Psychosis (67.3)</td>
<td>Drug toxicity (1.9)</td>
</tr>
<tr>
<td>GI problems</td>
<td>19.2</td>
<td>5.1</td>
<td>GI problems (21.1)</td>
<td>Nutrition-related or readmitted</td>
</tr>
</tbody>
</table>

Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk

Harlan M. Krumholz, M.D., N Engl J Med 368:2

- Recovering from acute illness
  - “perturbed physiologic systems”
- Stress
  - Sleep deprivation
  - Disruption of normal circadian rhythms
  - Poorly nourished
  - Have pain and discomfort
  - “...confront a baffling array of mentally challenging situations”
  - Receive medications that can alter cognition and physical function
  - Can become deconditioned by bed rest or inactivity
- Lead to impairments in the early recovery period
  - Inability to fend off disease
  - Susceptibility to mental error
CMS to the Rescue
Misaligned Incentives

- **Medicare Part A**
  - FFS
    - Churning
  - Hospital DRG
    - Push out patients
  - SNF
    - Can’t bill for both usual care and hospice care
    - Overuse of rehab services at EOL
  - Hospice
    - Benefit designed for home bound patients
      - Does not take into account acuity and resource needs
      - Not a fit for SNF due to costs of room and board
      - 6 mo designation deters patients

- **Medicare Part B**
  - Promotes over-testing and treatment
Gaps in the ACA

- Does not address the needs of EOL care
  - No metrics
  - No $s
- Does not address financing the LTC system to better match the ageing population
- Managed Medicare may have to carry expenses of Hospice per MedPAC
- Home-based Palliative Care is not covered
- No reimbursement for EOL conferences/planning*
  * Medicare considering new code

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

In October 2014, the bipartisan Improving Medicare Post-Acute Care Transformation (IMPACT) Act became law. The legislation is an important step forward in improving the quality of health care for millions of Americans, providing consumers and government critical information regarding outcomes and costs. IMPACT will standardize assessments for critical care issues across the spectrum of post-acute care (PAC) providers and build a bridge to ensure that patient care is delivered based on what the patient needs, eliminating the site-focused approach to quality measurement and resource utilization.

How it Works
The IMPACT Act has five parts:

1. Incorporate standardized assessment, including components of the Care Tool, into existing assessment tools across PAC providers: skilled nursing facilities (SNF), long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), and home health agencies (HHA). This tool will measure quality based on a variety of metrics: pressure ulcers, functional status, cognitive status, and special services.
   - Data will be collected at admission and discharge.
   - Implementation begins October 2014 (fiscal year 2015).

2. Development and public reporting of quality measures across settings, including hospitalizations, rehospitalizations, rehospitalizations after discharge from PAC provider, discharge to community, pressure ulcers, medication reconciliation, incidence of major falls, patient preferences, and average total Medicare cost per beneficiary.
   - Any measures must be approved by National Quality Forum or through rulemaking and comment making.

3. Hospitals and PAC providers are required to provide quality measures to consumers when transitioning to a PAC provider. Conditions of participation are modified to incorporate Quality Measures (QM) into the discharge-planning process.
   - There is a market basket payment penalty of 2% for failure to effectively collect and report data.

4. Requires HHS and MedPAC to conduct studies and reports to link payment to quality. HHS and MedPAC must develop a plan to link Medicare PAC payment to quality of care. Review current risk adjustment methodologies, and study the effect of beneficiaries’ socioeconomic status on quality, resource use, and other measures.
   - Requires implementation by fiscal year 2016.

5. Requires a study to examine how payment can be linked to quality in the Medicare PAC setting.
   - Requires submission by fiscal year 2016.
CARE Tool

- Administrative Items
- Pre-Morbidity Patient Information
- Current Medical Information
- Interview Items: Cognitive Status, Mood and Pain
- Impairments
- Functional Status
- Discharge Information

LTACH, IRF and SNF, (and Home Health)

- The development of Case Mix Systems
- PAC payment systems can be improved by:
  - The inclusion of patient acuity measures
  - Separately examining and modeling the routine, therapy, and non-therapy ancillary aspects of patient-specific resource use.
- Multiple approaches to the unit of payment are possible. The choice of payment unit will be largely driven by policy considerations rather than empirical results.
- Evidence supports the potential for development of a common payment system for the three inpatient PAC settings: LTCHs, IRFs, and SNFs.
- Due in part to the nature of home health service provision of care, a payment model combining home health with the other types of PAC providers is not supported by the analysis.
Pilot Findings

- After controlling for the patient acuity measures, provider type is a statistically significant predictor in the models of change in self care functional ability from admission to discharge.
  - IRF better, but maybe not
  - HH better, for some
- Change in mobility
  - No differences
- LTCH patients appear to have significantly lower probabilities of being readmitted to an ACH within 30 days of discharge relative to a SNF setting.

Impact
### CMS New Coordination of Care Codes

- Non-face-to-face services provided by clinical staff, under the
direction of the physician or other qualified health care
professional, may include:
  - Communication (with patient, family members, guardian or caretaker,
surrogate decision makers, and/or other professionals) regarding aspects
  of care
  - Communication with home health agencies and other community services
    utilized by the patient
  - Patient and/or family/caretaker education to support self-management,
    independent living, and activities of daily living,
  - Assessment and support for treatment regimen adherence and medication
    management,
  - Identification of available community and health resources,
  - Facilitating access to care and services needed by the patient and/or
    family

### AND...

- Non-face-to-face services provided by the physician or other
qualified health care provider may include:
  - Obtaining and reviewing the discharge information (e.g., discharge
    summary, as available, or continuity of care documents);
  - Reviewing need for or follow-up on pending diagnostic tests and
    treatments;
  - Interaction with other qualified health care professionals who will assume
    or reassume care of the patient’s system-specific problems;
  - Education of patient, family, guardian, and/or caregiver;
  - Establishment or reestablishment of referrals and arranging for needed
    community resources
  - Assistance in scheduling any required follow-up with community providers
    and services.
AND

- TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. The first face-to-face visit is part of the TCM service and not reported separately.
- Additional E/M services after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.
- These services address any needed coordination of care performed by multiple disciplines and community service agencies.
- The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access.

CMS Chronic Care Management Payment Program

- Planned for CY 2015
- $40/pmpm
- $480/yr
- 200 qualified patients = $96,000/yr
- 20% co-insurance for patient =$100/yr if no supplemental insurance
- Minimum of 20 min devoted to care planning/month

Adapted from: Edwards and Landon NEJM 371;22 Nov 2014
To Do’s

- 24/7 Access to CCM services and a linked provider
- Primary provider with easy access
- Care Plan*
  - Physical, mental, social, functional and environmental assessments and actions
  - Inventory of supports and resources
  - Patient document aimed at choice and values
- Chronic disease management
  - Systems-based plan
  - Prevention
  - Medication management
    - Reconciliation
    - Compliance
  - Regular updates of plan with respect to physical, mental and social
- Care transitions management
- Coordination of home, HH and community-based providers with plan
- e-Highway for patients and caregivers to communicate with team

*Care Plan Components

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Planned interventions
- Symptom management
- Medication management plan
- List of community and social services ordered
- Plan for directing and coordinating outside services
- List of responsible people for each intervention
- Requirements and schedule for plan reviews and updates
More To Do’s

- Authorizations
  - Regarding program and written agreement
  - To share PCHIS
- Documentation
  - That program fully explained
  - Accept or decline
  - Written care plan given to patient
  - Right to terminate
  - Explanation of benefit, in terms of sole provider overseeing and receiving payment

A Few Questions:

- Affordability for poor patients
- How will nonmembers perceive their care
- Will patients feel forced to accept in order to keep their doctor
- Who will pay for IT and staffing requirements as well as backbone and supports for implementation
- What if a specialist is the primary chronic disease manager, means the PCP can’t bill.
- Will this be sufficient to change practices or just be an add on to busy practices
- Will this really reduce overall cost

Adapted from: Edwards and Landon NEJM 371;22 Nov 2014
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Care Management

A comprehensive strategy for high quality, patient centered, cost effective care, aimed at restoration of function and independence
Why Do We Need Care Management?
Cost of Care Increases Dramatically with # of Chronic Conditions

<table>
<thead>
<tr>
<th>Number of Chronic Conditions</th>
<th>Average Expenditure ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>2,025</td>
</tr>
<tr>
<td>2-3</td>
<td>5,698</td>
</tr>
<tr>
<td>4-5</td>
<td>12,174</td>
</tr>
<tr>
<td>6 or more</td>
<td>32,658</td>
</tr>
</tbody>
</table>

NOTE: The 15 chronic conditions included in this analysis are high blood pressure, high cholesterol, ischemic heart disease, arthritis, diabetes, heart failure, chronic kidney disease, depression, chronic obstructive pulmonary disease, Alzheimer’s disease, atrial fibrillation, cancer, osteoporosis, asthma, and stroke.

Transitional Care Interventions Prevent Hospital Readmissions For Adults With Chronic Illnesses
Kim J. Verhaegh, et al, Health Affairs September 2014 33:9

“...high intensity transitional care interventions were associated with reduced readmissions in the short, intermediate, and long terms.”
The Exploding Home-Limited Elderly Population

Cost & Case Management Tiering Of Medicare Chronic Disease Patients

Home-Based Primary Care Model

- Comprehensive, longitudinal primary care
- Patients are visited monthly, more often as medically necessary
- **Team-Based approach**: Physicians collaborate with NPs/PAs; nurse clinical coordinators support team
- Model has been associated with strong quality and financial outcomes (cost savings)

**HBPC: Quality and Cost Outcomes**

**Keeping Readmissions Low...**

30-Day Readmission Rates:

- Kindred HBPC
- Mean Medicare 30-Day Rehosp. Rate

**Empowering Seniors with End of Life Decisions...**

Percent of Deaths at Home:

- Kindred HBPC: 86%
- Approx General Medicare Population: 25%

While Reducing Costs

- VA: 89%
- JAGS 2014: 83%
- Prelim IAH: 75%
- Prelim KNID: 33%
INSPIRIS Kindred HBPC

INSPIRIS achieved a 64% reduction in acute care admissions, and saved approximately $2,010 per member per month in eight markets where outcomes before and after care cycle management were compared.

2014 target: <500/1,000

Patient Facing Tactics
- Health Risk Assessments and patient stratification
- Care plan development and tracking; Care Team
- Advanced care planning, including placement
- Care transition management, Medication reconciliation
- Technology usage / tools in care giving, monitoring
- Expanded “HH of the Future”:
  - Chronic care, disease mgmt
  - Ongoing monitoring
  - Intervention algorithms/processes, resources
  - Other services, including Hospice, Palliative
- Patient education, engagement, data mechanisms
- Patient satisfaction surveys and feedback

Provider Facing Tactics
- Provider support and education: disease pathways, care plans, care team, placement, protocols
- Resources of HBPC Network
- Network development, including specialists, DME, lab services, radiology, etc.
- Support / coordination in patient management
- Provider feedback mechanisms
- Provider training on tools, IT system, data/analytics
- Reporting on cost/utilization and quality/outcomes:
  - Dashboards
  - Real-time notifications of hospitalizations, care transitions, alerts / interventions needed, etc.
  - Capabilities to spot / manage “frequent flyers”

Health Information Technology Tactics
- Integrated and complete EHRs for Health Info Exchange across network
  - Analytics to identify and manage “frequent flyers”:
    - risk pools, placement, care plans, tracking

HBPC-driven care management provides most immediate, impactful care model for Tier 3 Patients
Key Elements of Kindred’s Care Transitions Program

<table>
<thead>
<tr>
<th>Identify Patients At High Risk for Readmission</th>
<th>Deploy Care Transitions Managers to ensure smooth transition</th>
<th>Coordinate Patient Access to PCP/Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment Tool</td>
<td>Patient Choice</td>
<td>Schedules follow up appointment within 7 days of transition home</td>
</tr>
<tr>
<td>External Referrals</td>
<td>Assesses patient for transition readiness (Teach Back)</td>
<td>Attends appointment(s) when indicated</td>
</tr>
<tr>
<td>Internal Referrals</td>
<td>Present on the day of transition - ensures thorough handoff</td>
<td>Review Medications/Treatment Plan pre and post PCP visit</td>
</tr>
<tr>
<td>Interdisciplinary Collaboration</td>
<td>Transitional Care Pharmacist Referral</td>
<td>Ensures additional follow up appointments are made and kept</td>
</tr>
<tr>
<td>Internal Data Trigger Reports</td>
<td>Transitional Care Rehab Specialist Referral</td>
<td>Obtains new provider for patients without a PCP</td>
</tr>
</tbody>
</table>

Care Transitions Program Data 2014 YTD

- Readmission rate 30 days post discharge from a Kindred site of care = 6.1%
- Patient satisfaction with transition score = 3.6 (1-4 scale)
- PCPs were notified of admission and transition 97% of the time
- 93% of patients kept their scheduled PCP appointment within 7 days of discharge to home
- 98% of medications were administered as scheduled on the day of transition
- 98% of patients did not miss a meal on the day of transition

Cost & Case Management Tiering Of Medicare Chronic Disease Patients

Detailed Examples of Care Management Flow

**Tier 3**

- Patient admitted and followed, new information emerges. Could require tier change.
- CHF, COPD, AMI, Pneumonia, Sepsis AND any 1 of the risk factors below. They qualify for Tier 3.
- CHF, COPD, AMI, Pneumonia, Sepsis OR 3 or more of the risk factors below. They qualify for Tier 2.
- If patient does not meet the above criteria, they do not qualify for either tier.

**Tier 2**

- Patient admitted and followed, new information emerges. Could require tier change.
- CHF, COPD, AMI, Pneumonia, Sepsis AND any 1 of the risk factors below. They qualify for Tier 3.
- CHF, COPD, AMI, Pneumonia, Sepsis OR 3 or more of the risk factors below. They qualify for Tier 2.
- If patient does not meet the above criteria, they do not qualify for either tier.

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**Patient Risk Factors:**
- Age > 85/Poorly controlled depression/Poorly managed chronic pain/Uncontrolled diabetes

**Environmental Risk Factors:**
- Socio-economic factors places patient at risk (no or unreliable caregiver, suspected poor health literacy, poor adherence to treatment plan, can't afford meds/visits)
- Barriers to medical follow-up (i.e. transportation, physical immobility)

**Event Risk Factors:**
- >Prior hospitalizations of 2 or more in the past year
- History of falls within the past 30 days

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**Medication-Related Factors:**
- Patient prescribed >1 High Risk Medications (list attached)
Rebuilding the Airplane in Mid-air

1. The ‘burning platform’
2. Defining ‘The Triple Aim’
3. The post-acute paradigm
4. Care management

Questions
THANK YOU!!!

Thank you

Robert Klugman
(508) 726-6058
Robert.Klugman@kindred.com