A Patient-Centered, Value-Based Approach to Discharge

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The answers to the test

- Consider post-acute quality and outcomes
- Informed patient choice
- Discharge planning across multiple transitions of care

How, when, and where we engage with patients is changing
Patients literally select providers like this.
Quality measures across post-acute providers are variable

### Quality Measure Variability Across Skilled Nursing Facility (SNF) Providers Medicare Fee-for-Service, 2013

<table>
<thead>
<tr>
<th>Quality Measure (Risk-Adjusted)</th>
<th>75th Percentile</th>
<th>25th Percentile</th>
<th>Performance Decrease from 75th to 25th Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients discharged to the community</td>
<td>46.6%</td>
<td>29.2%</td>
<td>37.3%</td>
</tr>
<tr>
<td>Potentially avoidable rehospitalizations during SNF stay</td>
<td>13.9%</td>
<td>8.0%</td>
<td>42.4%</td>
</tr>
<tr>
<td>Potentially avoidable rehospitalizations within 30 days from SNF</td>
<td>7.2%</td>
<td>3.4%</td>
<td>52.8%</td>
</tr>
<tr>
<td>Average mobility improvement across three mobility ADLs</td>
<td>52.5%</td>
<td>35.6%</td>
<td>32.2%</td>
</tr>
</tbody>
</table>

Source: Advisory Board
**Preferred provider networks are on the rise**

### What are the top two benefits of having a preferred post-acute network?

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriately decreased admissions to emergency department or hospital</td>
<td>55%</td>
</tr>
<tr>
<td>Able to improve quality metrics outcomes</td>
<td>38%</td>
</tr>
<tr>
<td>Appropriately decreased patient length of stay (LOS)</td>
<td>29%</td>
</tr>
<tr>
<td>Improved patient experience</td>
<td>26%</td>
</tr>
<tr>
<td>Improved triage of patients to home versus facility</td>
<td>17%</td>
</tr>
<tr>
<td>Appropriately decreased post-acute LOS</td>
<td>15%</td>
</tr>
<tr>
<td>Not applicable</td>
<td>6%</td>
</tr>
</tbody>
</table>

Sample size = 375; Multi-response

NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society
Advocate Health Care  
AHA Case Study

Largest health system in Illinois, 12 acute care hospitals, MSSP

Preferred provider group has superior outcomes

• 30-day readmission rate from SNFs dropped from 25 to 15% between 2010 – 2015
• ALOS at SNFs dropped from 30+ days to 17 days

Challenges

• Only 30% of ACO discharges to SNFs go to network SNFs
• Reducing patient care services outside network
• Variance in 30-day hospital readmission from SNFs

Source: AHA Trendwatch from December 2015 (http://www.aha.org/research/reports/tw/15dec-tw-postacute.pdf)
Why is this hard?

- Lack of clarity around patient choice
- Lack of information on post-acute quality
- Lack of awareness about IMPACT Act and other tools to help
Changing the discharge discourse to promote informed decision-making

- Assess post-acute quality and capabilities
- Educate case managers and provide scripting
- Engage patients and their families
Case Management Education
The Nitty Gritty

(6) The hospital must include in the discharge plan a list of HHAs or SNFs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.

7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare. Financial interests that are disclosable under Medicare are determined in accordance with the provisions of part 420, subpart C, of this chapter.
Medicare Patient Choice - 42 CFR 482.43

Summary

• Medicare certified SNFs and HHA
• Geographic area
• Documented in medical record that list was presented to patient
• Communication to patient of freedom to choose
• Identify SNF or HHAs where the hospital has a financial interest – i.e. an ”owned” SNF or HHA
Discharge Planning Proposed Rule Moves from Patient Choice to Informed Patient Choice

• “This requirement will allow patients and their families access to information that will help them to make informed decisions about their post-acute care, while addressing their goals of care and treatment preferences.”

• “Patients and their families that are well informed of their choices of high-quality PAC providers, including providers of community services and supports, may reduce their chances of being re-hospitalized.”
Scripting
Baystate Medical Center
CarePort Case Study

Teaching & 3 community hospitals; Next Generation ACO, BPCI

Developed standardized communication with SPAC committee, case management leadership and legal:

“The Baystate preferred skilled nursing facility network is a select group of nursing facilities around the Pioneer Valley that meet quality and safety standards set for by Medicare and endorsed by Baystate Health.”
Educating Patients and Families

But what constitutes meaningful patient education?
Is it more lists?
Is it brochures?

Cleveland Clinic Connected Care Program
An Innovative Approach To Care For Patients Discharged to a Skilled Nursing Facility

With the Cleveland Clinic Connected Care Program, Cleveland Clinic medical professionals continue the expert medical care patients received at Cleveland Clinic once they are discharged to a skilled nursing facility in the community.

Cleveland Clinic physicians, nurse practitioners or physician assistants will see patients participating in the Cleveland Clinic Connected Care Program every day, five days a week.

Keeping Patients on the Road to Better Health
Cleveland Clinic’s goal in providing medical care at skilled nursing facilities is to improve patient outcomes. The Connected Care Program allows us to continue to monitor our patients’ daily progress once they leave the hospital. By facilitating effective communication between patients and their physicians, we can help our patients enjoy an improved
Is it Medicare.gov?
Meanwhile at home…
Lots of information, difficult to navigate
Patients like being educated!

“[My] choices were narrowed down which made the selection process much easier.”

John T., Patient

“The content was clear and easy to use.”

Julieta K., Patient

“The site is useful, very easy to follow and provides accurate information.”

Alberto C., Patient

“One-stop-shopping. I know that anything listed is in network.”

Catherine J., Patient

“I liked being able to take virtual tours, getting places within a certain distance, the star ratings and ease of use.”

Carmela D., Patient

“The website was extremely helpful and very well constructed. Having a selection of rehabs and their overview was so easy.”

Patricia B., Patient

“I liked the detailed descriptions of the rehab establishments in my area.”

Rosalie J., Patient

“This puts all the options in one spot.”

Leroy A., Patient
Education is key for patients to make informed decisions about their post-acute providers

- Spending time to educate the patients
- Asking patients why they prefer one facility over another
- Highlighting preferred providers
- Showing and explaining to patients what star ratings and quality measures are
- Don’t be daunted just because you have a challenging patient population

“I don’t know which doctor to choose. One has more friends on Facebook, but the other one just retweeted my message.”
Navigation Across Multiple Transitions of Care
90% of health systems are investing in care coordination across the continuum

How coordinated is the care experience for your organization’s patients between the inpatient setting, post-acute setting, and home environment?

- Fully Coordinated: 7%
- Mostly Coordinated: 30%
- Somewhat Coordinated: 53%
- Not Coordinated: 10%

Sample size = 375
Evolving from case management to care coordination

- Blurring of inpatient case management and ambulatory care coordination
- New titles: System VP of Care Coordination
- Focus on care transitions - the “transition care coordinator”
Supporting care transitions is an evidenced-based practice to reduce readmissions

Re-hospitalization rates for patients who received care transition coaching and patients who did not

Source: Coleman, E., et al. (2006). The Care Transitions Intervention: Results of a Randomized Trial. Archives of Internal Medicine, 166, 1822 – 1828. Note: Results are cumulative.
Care coordinators track patients post-discharge like this
What care coordinators say…

• “I need information about my patients in real time – it can’t be a day or two days after the fact, then it’s too late to act.”

• “It’s not realistic to expect other care providers to log into a ‘one-off’ system to enter information just so I can have it. I can’t rely on manual workflows.”

• “I don’t want to log into another system.”
New discharge planning paradigms

- Focus on post-acute quality and outcomes
- Informed patient choice
- Discharge planning across multiple transitions of care
Questions?
Thank you

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