



**Pursuit of Value Driven
Healthcare
Post-Acute Care Transitions**

**Wisconsin Focus
2015 Conference
November 18, 2015**

Ed Gamache
Fourth Aim Consulting, LLC

|

Central Medical Trading Area

MiHIA supports the Central Medical Trading Area. As defined by the State of Michigan, this area includes 14 counties:

- Arenac
- Bay
- Clare
- Gratiot
- Gladwin
- Huron
- Isabella
- Iosco
- Ogemaw
- Midland
- Saginaw
- Sanilac
- Roscommon
- Tuscola

*More than 780,000 people
live in the trading area*



|

Confronting the Status Quo!

"Our Iceberg is Melting"

John Kotter



John Kotter 8 Steps

- | | |
|---------------------------------|--|
| Establishing a Sense of Urgency | Creating the Guiding Coalition |
| Developing a Change Vision | Communicating the Vision for Buy-in |
| Empowering Broad-based Action | Generating Short-term Wins |
| Never Letting Up | Incorporating Changes into the Culture |

|

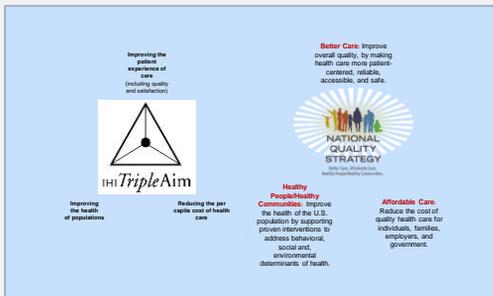
Affordable Care Act - 5 Years Old

- Expand Health Coverage to Everyone
- Provider Payment Reform
- Reform the Healthcare Delivery System



|

Reform the Healthcare system - IHI Triple Aim and NQS Three Aims



|

The National Quality Strategy: How it Works



12

|

Healthcare Cost Equation

Demographic Utilization Drivers
 Size, Age, Gender, Health Status, Chronic Care, Social Economic Status,
 Insurance Status

$$\text{Health Care Costs (\$)} = (\text{Population}) \times (\text{Technology Utilization per Pop}) \times (\text{Technology Unit \$})$$

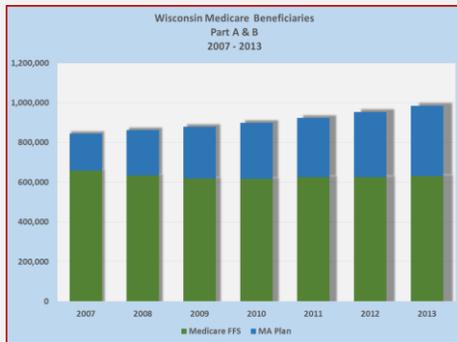
Inpatient Example

100,000 people X 100 discharges/1,000 people X \$9,500/discharge

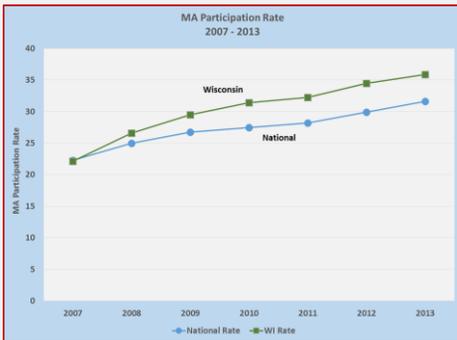
10,000 discharges X \$9,500/discharge

Inpatient Subtotal = \$95,000,000

Wisconsin Medicare Demographics



Medicare Advantage Plans



Reducing Cost of Healthcare

$$(\$) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\text{\$ per Utilization})$$

Healthcare Cost \$ Drivers



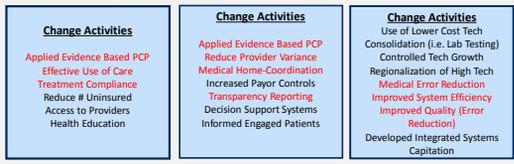
Determinants and Change Activities

$$(\$) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\text{\$ per Utilization})$$



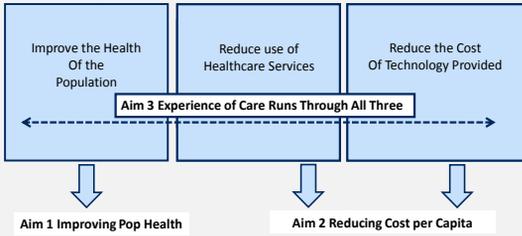
Determinants and Change Activities

$$(\$) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\text{\$ per Utilization})$$

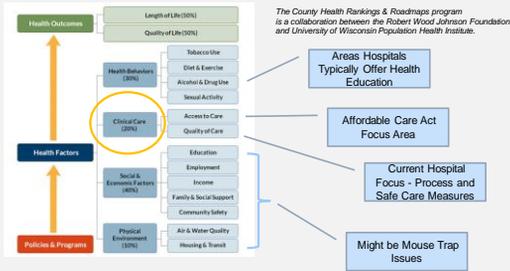


Triple Aim Relationship

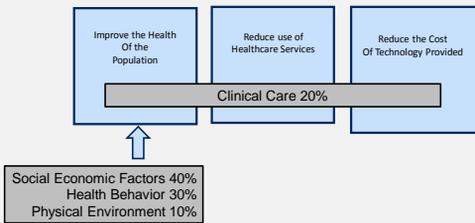
$$(\$) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\$ \text{ per Utilization})$$



County Health Ranking Weights



Health Ranking Weights Alignment



Healthcare Provider Role

Population Change Access to Providers Applied Evidence Based PCP Treatment Compliance Effective Use of Care Informed Engaged Patients	Improved Utilization Applied Evidence Based PCP Reduce Provider Variance Medical Home-Coordination Transparency Reporting Decision Support Systems Applied Decision Support Informed Engaged Patients	Technology Cost \$ Use of Lower Cost Tech Consolidation (i.e. Lab Testing) Regionalization of High Tech Medical Error Reduction Improved System Efficiency Improved Quality (Error Reduction) Developed Integrated Systems
---	---	--

1

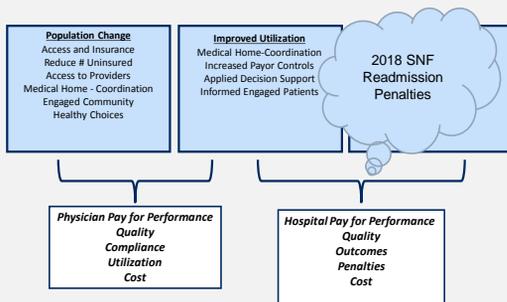
New Story - Value Equation

Value = Cost/Quality

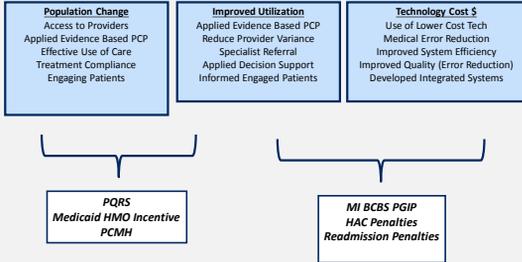


1

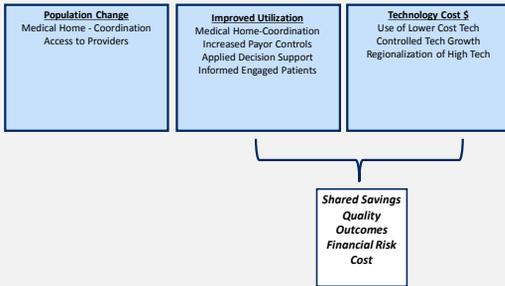
Third Party Insurer Role



Hospital & Clinic Provider Roles



Accountable Care Organization Short Term Role



Provider Accountable Care Organization Long Term Role



Other Payment Programs



Post Acute Nursing Home

$$(\$) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\$ \text{ per Utilization})$$

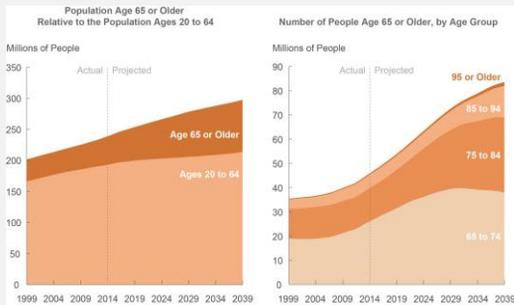


Restorative/Rehabilitation Care

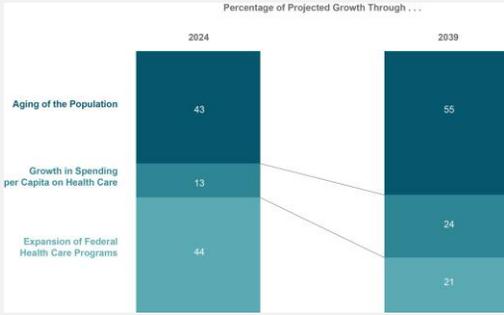
Cost of LTC/Rehab

Healthy Subpopulation
Extended Care – Primary Elder Care
End of Life Care

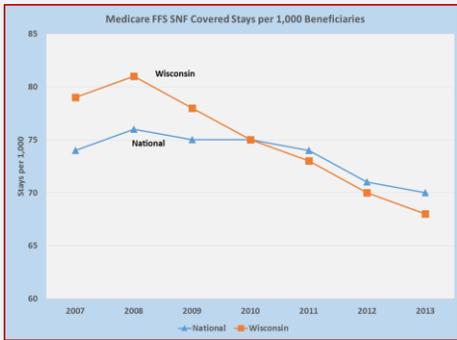
Changes in Population, by Age Group



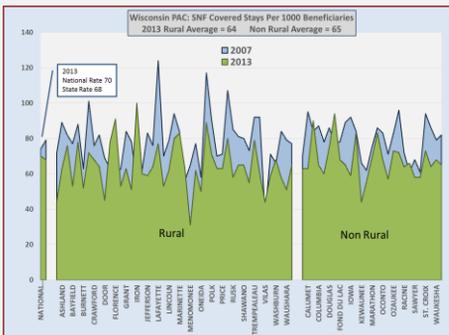
Causes of Projected Growth in Federal Spending for Social Security and Major Health Care Programs



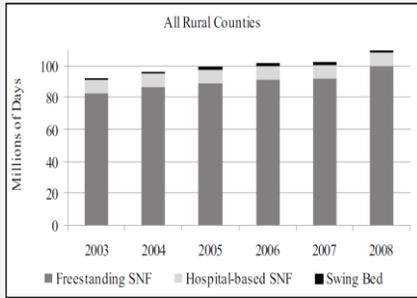
Wisconsin SNF Covered Stays



Wisconsin SNF Stays per 1000 Beneficiaries by County

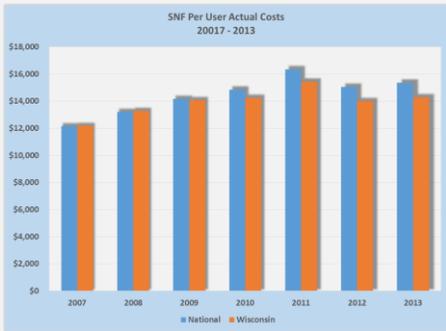


Rural Community Post-acute Days are Dominated by care in Free Standing SNFs



Source: NCRHRC analysis of CMS Hospital Cost Report Information System, 6-30-10

1



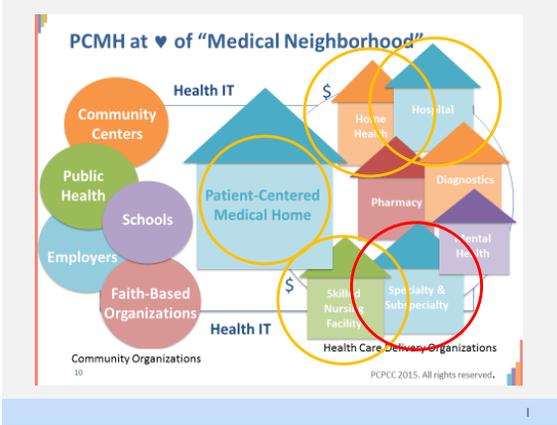
1

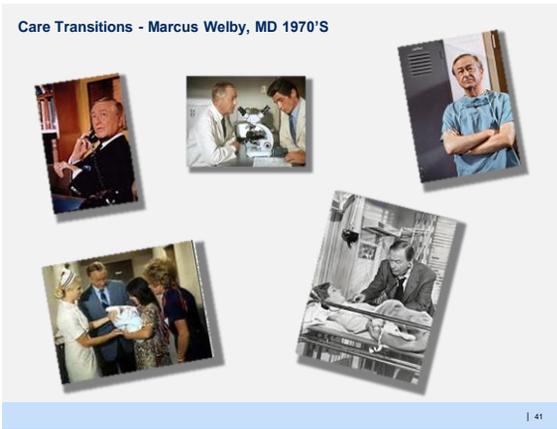
State Surveyor Role

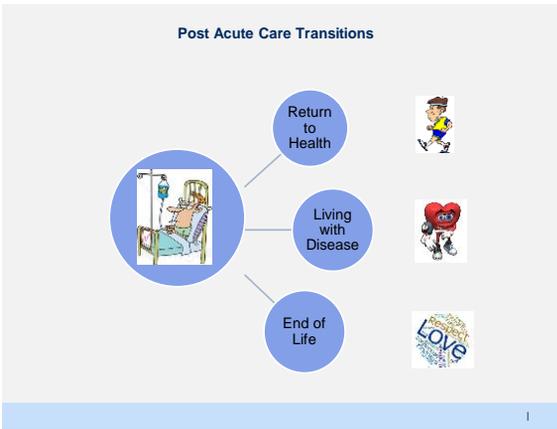
$$(\$) = (\text{Population}) \times (\text{Utilization per Pop}) \times (\$ \text{ per Utilization})$$



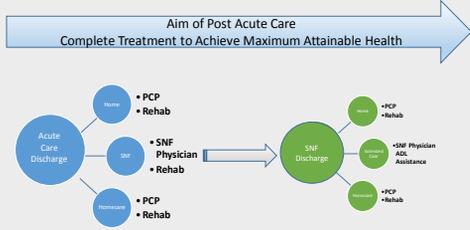
1



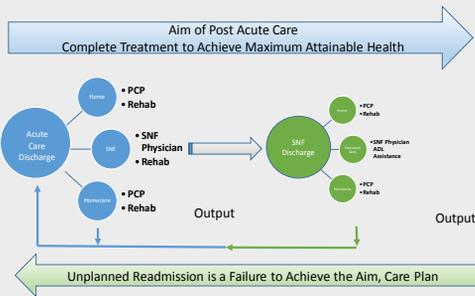




Post Acute Continuation of Care



Post Acute Continuation of Care



AMDA – The Society for Post-Acute and Long-Term Care Medicine Care Transitions Guide

Hospital Readmissions, Medication Errors, Adverse Events Transfers from nursing facilities constitute **8.5% of all Medicare admissions** to acute-care hospitals.

About **40% of these hospitalizations occur within 90 days** of nursing facility admission, 84% percent of these patients are discharged from the hospital back to their original care setting.

Jencks et al3 recently **2004 estimate that close to one fifth of all Medicare beneficiaries discharged from the hospital were readmitted within 30 days, 90% of these readmissions were unplanned**, and that the cost to Medicare of unplanned rehospitalizations amounted to \$17.4 billion.

Patients with **heart failure accounted for 26.9%** of all readmissions within 30 days; patients with **pneumonia, 20.9%**.

Office of Inspector General – HHS Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring November 2013

"In FY 2011, nursing homes transferred one quarter of their Medicare residents to hospitals for inpatient admissions, and Medicare spent \$14.3 billion on these hospitalizations.

Nursing home residents went to hospitals for a wide range of conditions, with **septicemia the most common**. Annual rates of Medicare resident hospitalizations varied widely across nursing homes.

Nursing homes with the following characteristics had the **highest annual rates** of resident hospitalizations: homes located in **Arkansas, Louisiana, Mississippi, or Oklahoma** and homes with **one, two, or three stars** in the CMS Five-Star Quality Rating System.

| 46

Office of Inspector General – Recommendations 2013

"Develop a quality measure that describes nursing home resident hospitalization rates and



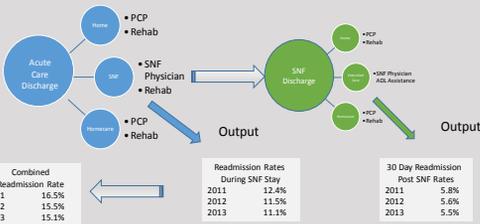
Instruct State survey agencies to review the proposed quality measure as part of the survey and certification process."



| 47

Post Acute Potentially Avoidable Readmissions

Aim of Post Acute Care
Complete Treatment to Achieve Maximum Attainable Health



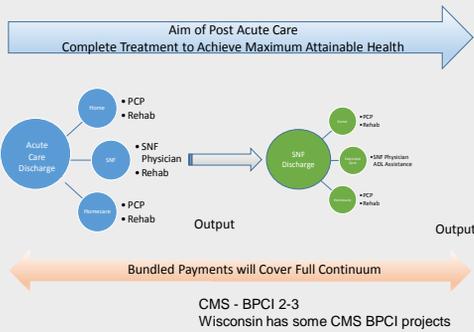
MedPac Report April 2015 Refinement of Community Discharge, Potentially Avoidable Readmission, and Functional Outcome SNF Quality Measures, for Fiscal Years 2011, 2012, and 2013

SNF Stay Potentially Avoidable Conditions

- | | |
|-----------------------------------|---------------------------------------|
| Electrolyte imbalance | Congestive heart failure |
| Respiratory illnesses, | Sepsis |
| Urinary tract / kidney infections | Hypoglycemia / diabetic complications |
| Anticoagulant complications | Fractures / musculoskeletal injuries |
| Adverse drug reactions | Acute delirium |
| Cellulitis / wound infection | Pressure ulcers |
| Blood pressure management | |

MedPac Report April 2015 Refinement of Community Discharge, Potentially Avoidable Readmission, and Functional Outcome SNF Quality Measures, for Fiscal Years 2011, 2012, and 2013

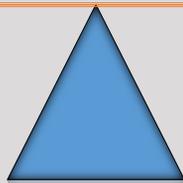
Post Acute Continuation of Care



SNF - Value Equation

• Value = function of (Price, Quality, Satisfaction, Safety, Pop Health)

Price/Cost (\$) Pop Health, Safety
Quality, Satisfaction



What Should You Include on Your Dashboard?



SNF Value Products

Quality

- Five Star
- Readmission Rates
- Patient Safety
- LOS
- Employee influenza immunization rate



Rehabilitation/Care Transition Success

Local Access to Family Support System

Support of High Risk Patients

Maintaining/Improving Health of Residents

SNF Value Products - Continued

Discharge Planning Process

Change in Condition Alert Process and Method for Intervention

Satisfaction Patient/Family/Employees/Medical Staff

Wanderer protection system

Cost/Price

LTC-PCMH Capabilities



SNF Post Acute Care Processes

Evaluation and Acceptance

- Physician Acceptance and plan input
- Readmission Risk Assessment
- High Risk Capability
- 24/7 Capability



Medication Reconciliation

Quality Metrics (Star rating, LOS, infection rate, readmission, functional assessment, employee influenza immunization rate, etc.)

Participation in Acute Care Protocol Support

SNF Post Acute Care Processes

Electronic Record Capability

Telehealth Capability

Integration of hospital providers/case workers

Discharge Planning Process

Networking Desire/Capability



Ed's Questions

What causes readmissions?

What causes transfers to emergency room?

What do you see as the PAC SNF responsibility?

What is the Acute Care Provider Responsibility?



Contact Information

Ed Gamache
Fourth Aim Consulting
edward@fourthaim.org
810 710-0386
