



Coordinated Care Delivery

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AtlantiCare / Geisinger



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Notice of Disclosure:

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Living Independently For Elders



AtlantiCare LIFEconnection Benefits

Quality Care

- ✓ Substantially improve the **quality of life** for frail older adults in our community
- ✓ Develop best **triple aim practices** (cost effective, population based, individualized care) that can be applied throughout our AtlantiCare system

Caring



LIFE truly maintains *Independence*...



<https://vimeo.com/153548475>

Password: LIFEconnection

LIFE provides innovative, person-centered care for older adults that allows them to stay in their homes and communities and out of nursing homes.

If it wasn't for the LIFE team I'd be in a nursing home instead of living in my own apartment.

LIFE Participant

Integrated, Comprehensive Care...a More Efficient Use of Health Care Resources

- medical care
- personal care
- Prescription
- drugs
- social services
- audiology
- dentistry
- optometry
- podiatry
- home health care



- transportation
- physical therapy
- occupational therapy
- recreational therapy
- meals
- nutritional counseling
- speech therapy
- respite care

Hospital and nursing home care when necessary

LIFE is more than FFS & Bricks & Mortar...



Adult Day Center

All Medicare & Medicaid Benefits
(including long term SNF) plus all
services the LIFE IDT determines to
be of benefit to keep a Participant
safe at home



Primary Care Services



A Single Monthly
Capitated Payment

...LIFE is a fully at risk provider

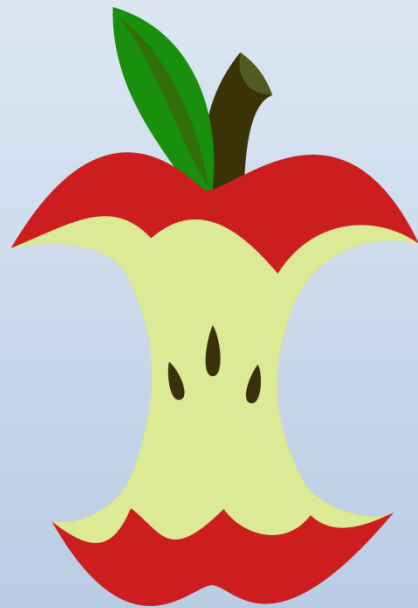


Home
Improvements





Ranking of Impact/Significance of Six Focus Areas in Avoiding ED/Hospital Use



Participant and Caregiver Healthcare System Literacy

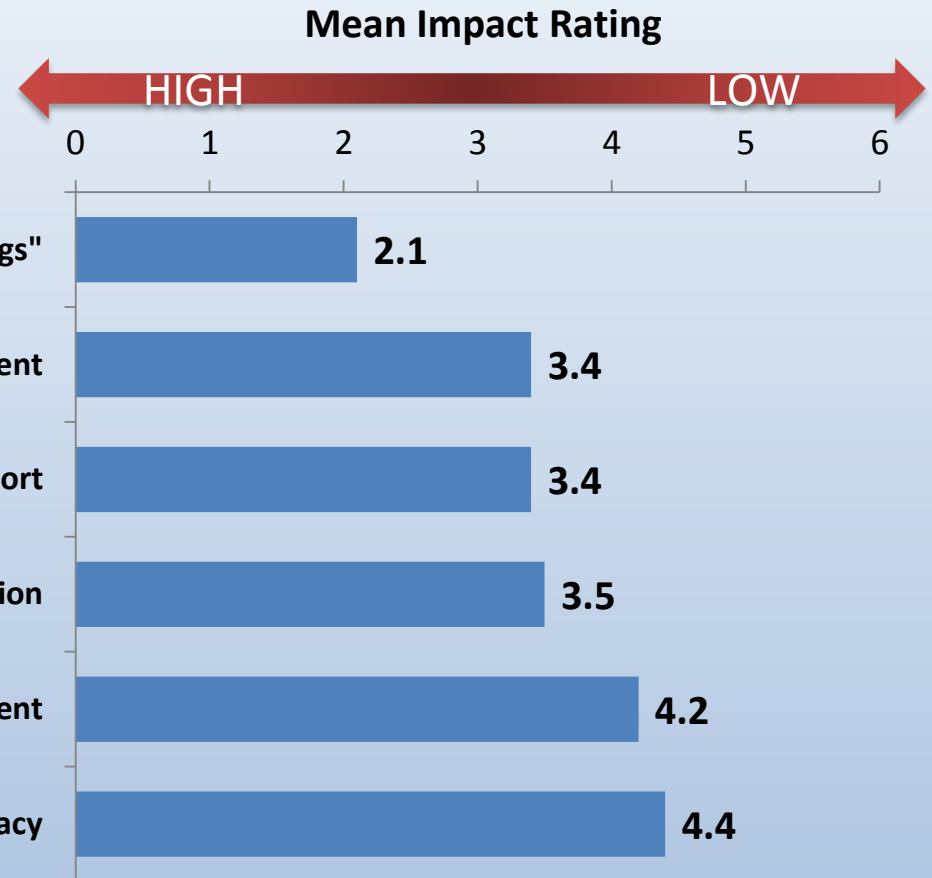
Management of "Red Flags"

End of Life Management

Caregiver Support

Care Coordination

Medication Management



Stefanacci RG, Reich S, Casiano A. Application of PACE Principles for Population Health Management of Frail Older Adults. Pop Health Management. 2015 Oct. 18(5):367-72.

Coordinated Care Delivery

Managing an Integrated Practice Unit

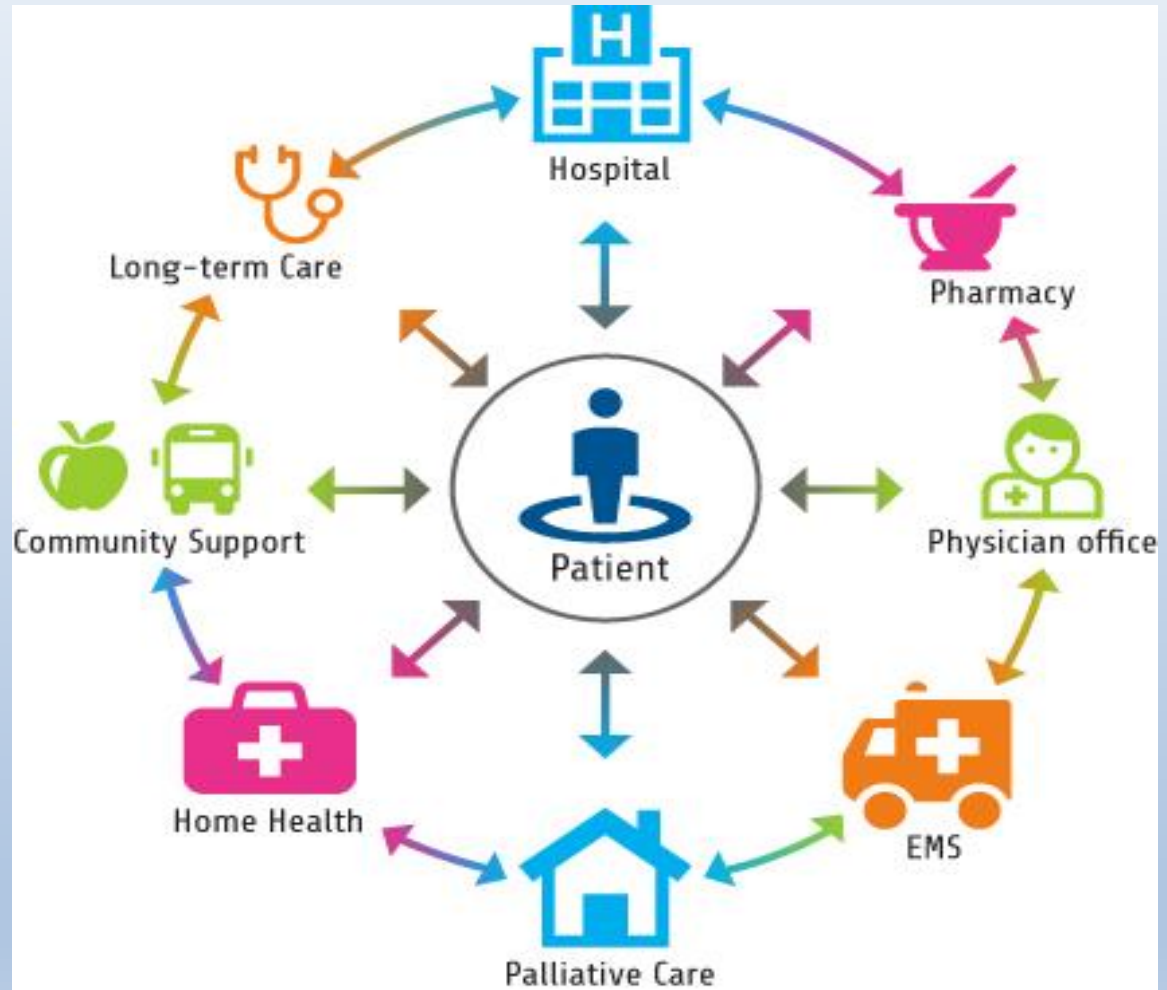
- Establish medical neighborhood roles
- Ensure quality referrals
- Coordinate care
- Manage care transitions

Medication Management

- Manage medication reconciliation

Managing an Integrated Practice Unit (IPU)

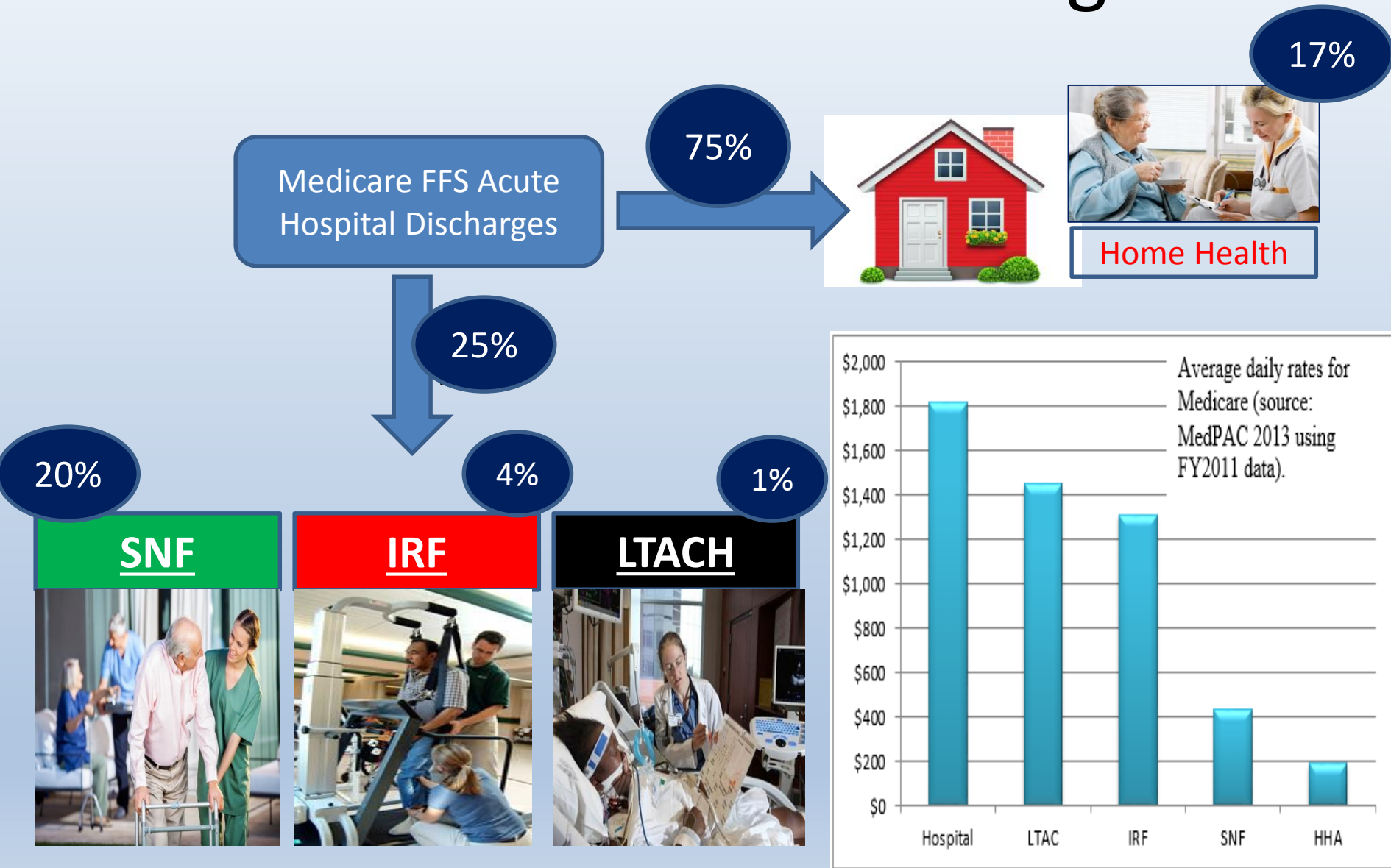
- Establish medical neighborhood roles
- Ensure quality referrals
- Coordinate care
- Manage care transitions





**The “Right” Care for our
AtlantiCare Patients...**

Post-Acute Care Discharges



HOME FIRST

‘focus is getting and
keeping patients safely to
their Homes...

...rather than LOS or
PAC Facility transfers’

Reasons for SNF Preferred Network

Outcomes

- Reduce Hospitalizations & ED use
 - Hospital discharge 30Day
 - SNF
 - SNF discharge 30Day
- Decrease SNF Hospital Deaths
- Decrease Hospital to SNF LOS

(Increase ability to place high-acuity and other challenging patients and ease transfer for all patients)



Quantitative Cost, Utilization, and Quality Information

Overall Performance

	SNF Admissions	Cost Per Admission	Length of Stay	30 Day Acute Readmission Rate	Hospitalization During SNF Rate	Readmission from SNF (30 Days)
Your Facility	430	\$ 12,182	25	18%	20%	33%
Average	192	\$ 10,812	23	15%	17%	28%

Performance By Top DRGs

Major Joint Replacement

	SNF Admissions	Cost per Admission	Length of Stay	30 Day Acute Readmission Rate	Hospitalization During SNF Rate	Readmission from SNF (30 Days)
Your Facility	30	\$ 10,181	18	13%	10%	23%
Average	24	\$ 8,317	15	7%	5%	10%

** DRGs 470, 469

Septicemia or Severe Sepsis

	SNF Admissions	Cost per Admission	Length of Stay	30 Day Acute Readmission Rate	Hospitalization During SNF Rate	Readmission from SNF (30 Days)
Your Facility	20	\$ 10,498	21	10%	15%	25%
Average	11	\$ 10,359	22	22%	24%	34%

** DRGs 872, 871, 870

Hip & Femur Procedures

	SNF Admissions	Cost per Admission	Length of Stay	30 Day Acute Readmission Rate	Hospitalization During SNF Rate	Readmission from SNF (30 Days)
Your Facility	11	\$ 19,057	38	18%	18%	27%
Average	5	\$ 16,243	35	16%	17%	23%

** DRGs 482, 481, 480

40%

OUTCOMES

Hospitalization Rates

30D s/p H Hospitalization

During SNF Hospitalization

30D s/p SNF
Hospitalization

CMS STAR Rating

Overall

Health Inspection

Staffing

QMs

Trend

others

OUTCOMES SCORE

40%



25%

PROCESS

**Hospitalization
Assessment**

Scope of Services

PROCESS SCORE
25%



15%

STRUCTURE

Average Cost
(Medicaid, Medicare FFS
& MCO)

LOS

Day Rate

Patient Risk Level (1-5)
score

Extent of Contracting
Staffing

Facility (location, appeal)

STRUCTURE SCORE
15%



2016 SNF RFI

20%

Case & Care Manager Survey Monkey Survey



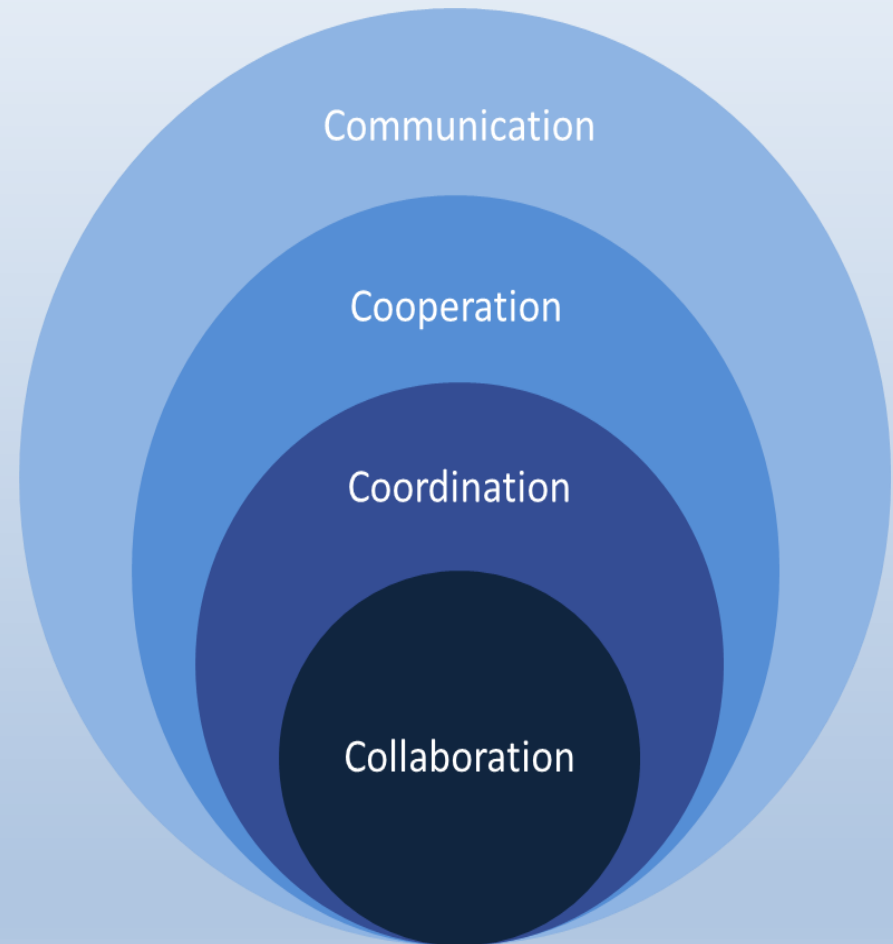
Positive Dealings

Clinical Abilities

**Desire to Admit Self
or Family Member**

SNF Expectations...

- Tactics for improving care between acute and post-acute partners include “warm handoffs”
- Ability for new staffing models such as SNFists and Nurse care navigators
- Focus resources on improving EOL care with hospice and use of POLST forms



SNFplus Staffing



- Dedicated RN
- Advanced Practice Nurse



- AtlantiCare Attending Physician

Typical Main Focus Opportunities...

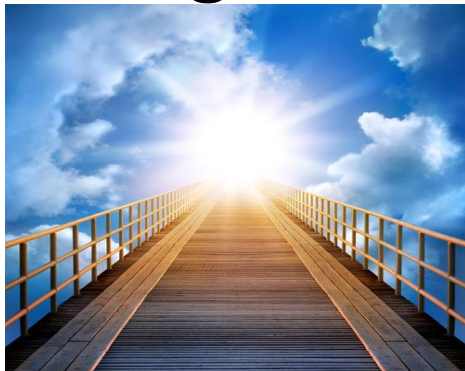
Scope of services



Hospitalization Assessment



End of Life Management



Hospitalizations after SNF stay



Hospital Transfer Analysis



Chart Review Audit Tool - Hospital

Reviewer: _____ Date: _____

MR#: _____ Discharging Physician: _____

First Admission Date: _____ Discharge Date: _____

Discharge/Disposition: _____

Readmitted in _____ days Readmission Date: _____ Planned Resident? ☐ Yes ☐ No

1st Admission, Primary Diagnosis: _____ Secondary: _____

2nd Admission, Primary Diagnosis: _____ Secondary: _____

1. Was the patient discharged to the level of care recommended, e.g. SNF, home health care, PCMH? ☐ Yes ☐ No
Comment: _____

2. Was the recommended follow-up with the physician noted on discharge? ☐ Yes ☐ No

3. Was the patient readmitted prior to the physician follow-up? ☐ Yes ☐ No

4. If the patient had home health/care arranged after the first admission, did the home health/ hospice agency see the patient before readmission?
☐ Yes ☐ No ☐ Unable to determine ☐ Referred, but refused once home

5. Did the patient have a community resource referral, such as Area Agency on Aging, arranged after the first admission?
☐ Yes ☐ No ☐ Unable to determine ☐ Referred, but refused once home



Respecting Chooses

- Provide training of innovative advance care planning program —Respecting Choices®.
- Improve EOL through completion of Advanced Directives / POLST Forms.



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS	
Physician Orders for Life-Sustaining Treatment (POLST)	
First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.	
Last Name	
First Name/ Middle Initial	
Date of Birth	
A Check One	CARDIOPULMONARY RESUSCITATION(CPR): Person has no pulse and is not breathing. <input type="checkbox"/> Resuscitate/CPR <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B, C and D.
B Check One	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing. <input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care, and manual treatment to relieve pain and suffering. Use oxygen, suction and manual treatment to relieve airway obstruction as needed for comfort. <i>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</i> <input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medication and cardiac monitor as indicated. Do not use intubation, advanced airway intervention, mechanical ventilation. <i>Transfer to hospital if indicated. Avoid intensive care.</i> <input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway intervention, mechanical ventilation, and cardioversion as indicated. <i>Transfer to hospital if indicated. Include all interventions.</i> Additional Orders: _____
C Check One	ANTIBIOTICS <input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs.

Telemedicine

The opportunity to utilize our telemedicine system, a virtual technology platform, to increase patient engagement.



The introduction of this system in your SNF for identified high risk patients with continuation as these patients transition home. This program is aimed to reduce hospitalizations both during their stay in your facility as well as upon their discharge home.

Care ‘Right’ Where You Are...



Deciding About Going to the Hospital



Older nursing home residents commonly develop new or worsening symptoms. When this occurs, a decision may be needed about whether to continue care in the nursing home or go to a hospital.

Because there are risks as well as benefits of care in a hospital, it is important to make the right decision. The decision depends on a number of factors, and how the nursing home resident and her or his relatives view the benefits and risks of care in the hospital as opposed to the nursing home.



Research has shown that some hospitalizations may be unnecessary. Whether hospitalization can be prevented depends on the resident's condition, the ability of the staff to provide the care necessary in the nursing home, and the preferences of the resident and her or his family.

Benefits of Hospital Care

There are many symptoms and conditions that usually require treatment in the hospital – for example, if vital signs are very abnormal (temperature, heart rate, or breathing rate), or if symptoms are severe and can't be controlled (such as pain or vomiting). Hospital care offers benefits in these situations, including:

- Ready availability of sophisticated lab tests, X-rays, and scans
- Access to doctors and specialists who are in the hospital every day
- Availability of surgery and other procedures if needed
- Intensive care units for people who are critically ill

Risks of Hospital Care

Nursing home residents are prone to many complications of care in a hospital. These complications may occur even in the best hospitals, because older age, chronic medical problems, and the condition that caused the transfer all combine with the hospital environment to put nursing home residents at high risk for complications. These complications include:

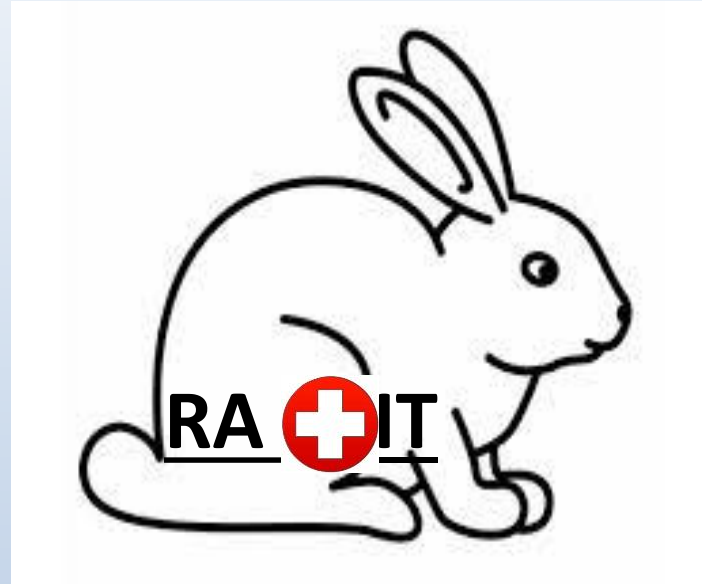
- New or worsening confusion
- More time spent in bed, which can increase the risk of blood clots, pressure ulcers, muscle weakness, loss of function, and other complications
- Less sleep and rest due to tests, monitoring, and noise
- Increased risk for:
 - Falls with injuries, such as cuts, bruises, and broken bones
 - New infections
 - Depression due to limited opportunities to socialize with friends and family as well as being in an unfamiliar environment

(continued)

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Rapid Assessment & Initial Treatment

RA⁺ IT



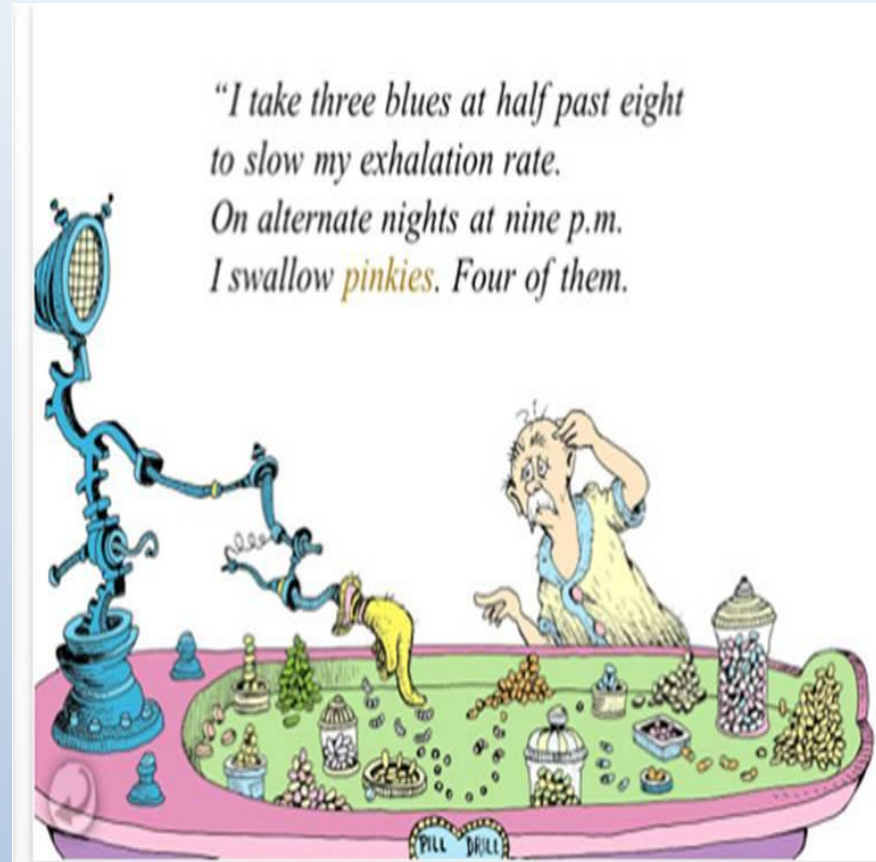
Rapid Assessment⁺ Initial Treatment ➡ Back to the SNF

End of Life Management



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY		
Physician Orders for Life-Sustaining Treatment (POLST)		Last Name
First follow these orders, then contact physician or NP. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.		First Name/ Middle Initial
		Date of Birth
A Check One	CARDIOPULMONARY RESUSCITATION(CPR): Person has no pulse and is not breathing. <input type="checkbox"/> Resuscitate/CPR <input type="checkbox"/> Do Not Attempt Resuscitation (DNR/no CPR) When not in cardiopulmonary arrest, follow orders in B , C and D .	
B Check One	MEDICAL INTERVENTIONS: Person has pulse and/or is breathing. <input type="checkbox"/> Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Do not transfer to hospital for life-sustaining treatment. Transfer if comfort needs cannot be met in current location.</i> <input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <i>Transfer to hospital if indicated. Avoid intensive care.</i> <input type="checkbox"/> Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i> Additional Orders: _____	
C Check One	ANTIBIOTICS <input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms. <input type="checkbox"/> Determine use or limitation of antibiotics when infection occurs. <input type="checkbox"/> Use antibiotics if life can be prolonged. Additional Orders: _____	
D Check One	ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food by mouth if feasible. <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Long-term artificial nutrition by tube. Additional Orders: _____	
E	SUMMARY OF MEDICAL CONDITION AND SIGNATURES	
Discussed with: <input type="checkbox"/> Patient <input type="checkbox"/> Parent of Minor <input type="checkbox"/> Health Care Representative <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Other: _____		Summary of Medical Condition
Print Physician/ Nurse Practitioner Name		MD/DO/NP Phone Number
Physician/ NP Signature (mandatory)		Date
		Office Use Only
SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED		

Medication Management

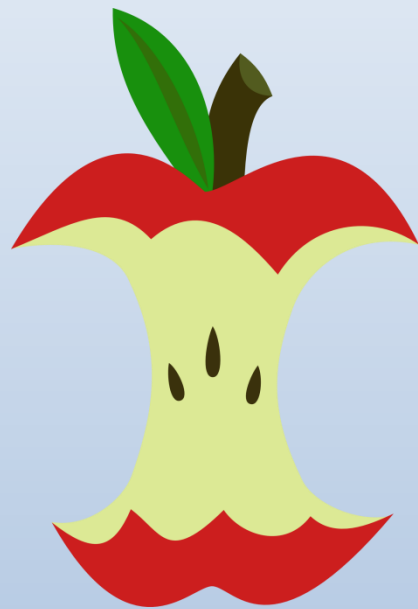


~~Medication Reconciliation~~

Medication Reminders & Managers



Ranking of Impact/Significance of Six Focus Areas in Avoiding ED/Hospital Use



Participant and Caregiver Healthcare System Literacy

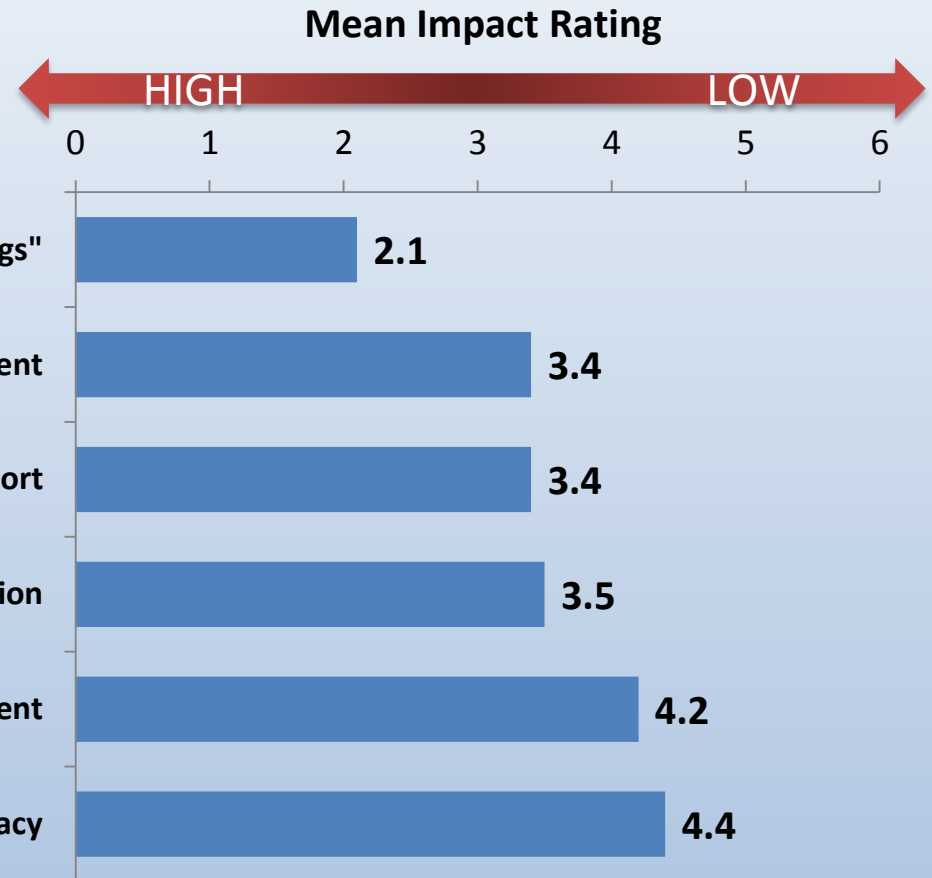
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Questions?

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