Transforming Care

Making Our Nursing Facilities Safe To Provide Acute Medical Care On Site

Presented by
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Strategies for Transforming Care

Creating a Medical Foundation for Care
Agenda

1. What’s Driving Change
2. The New Health Care Paradigm
3. Why Change Now
4. Quality Care Strategy
5. Outcomes
   1. Clinical
   2. Financial
What’s Driving Change?

MONEY

Government Driven Change

• Health Care is bankrupting our country
  • % of GNP spent on healthcare climbed from 15% in 2000 to 17.9% in 2011.

• Medicare is running out of money

• Medicaid is running out of money

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The New Health Care Paradigm

• Hospital New Reality
  • Increasing Penalties
  • Empty Beds

• Accountable Care and Bundled Payments are coming

• Managed Medicaid is coming
What The New Paradigm Demands?

- Hospital - Empty Beds

- Nursing Facilities - Keep the Beds Filled
  (But not for too long)
Managed Medicaid launch is now set for July 2014
  - 5 to 8 companies set to aggressively enroll our Medicaid patients
  - Will want to manage residents and control high cost events
    - Prevent Hospitalizations
    - Obtain Advanced Care Directives (POLST)

Health Plans
  - Blues entering risk contracting
  - United will have 5 Products in market and is sharing risk (and reward) with nursing facilities
  - Amerigroup is thinking about more value based relationships
  - All payers in process of developing value based contracting structures

Hospitals are Partnering with their physicians and other providers (SNFs and Home Care agencies), creating ACO’s and transition of care models.
  - From large systems (Robert Wood Johnson), to smaller systems (Raritan Bay)
What the Market is looking for?

- Quality Nursing Facilities
- Reliable care partners
- Control hospital admissions
- Be able to provide advanced care on site
- Able to measure performance
- Able to manage their physicians
The Train Has Left the Station...
Which Way to Go?

It was the best of times.
It was the worst of times.
The Quality Strategy

Quality on site medical/nursing care
Post Acute Care

Quality is Front Page

- Reducing Unnecessary Hospitalizations of Nursing Home Residents

Joseph G. Ouslander, M.D., and Robert A. Berenson, M.D.

- 23% of post acute patients in SNFs are return to hospital in 30 days.
- At least 40% of these are believed to be avoidable.
- Cost $4,000,000,000 Billion per year
The Foundation Requires

- **Cultural Transformation**
  - Create a Caring Environment

- **Clinical Transformation**
  - Provide Low Tech Hospital Level Care

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Our Prescription

“The Better Care Model”
A medical/nursing model supporting Safe Care on Site
The Key Ingredients

- Devoted Organized Medical Staff
- Adherence to Best Care Practices
- Minimize Phone Based Medicine - *on site care for change of condition*
  - Onsite Care by an NP 5 days per week
  - LiveMD - Our After Hour Care Physician Care Program
- Admission Risk Assessments
- Heroes Program – *cultural transformation*
- Clinical Enhancement Initiative
- Post Discharge - *integration and follow up*
- Software to measure what we do and how well we do it - *outcomes*
It Starts with the Medical Staff

- Create Integrated Medical Staff
- Adopt Medical Staff bylaws
- Establish Medical Executive Committee in each facility
  - **The Committee is Responsible:**
    - Creates and enforces a professional code of conduct
    - Defines attending responsibilities
    - Creates standards of care
    - Creates and approves guidelines and protocols
- Corporate Medical Director provides support and guidance to the facilities
  Medical Directors

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Sample Programs...
Clinical Protocols (Samples):

• Coumadin Clinic
• Heart Strong™ a engagement system of care for people with Heart Conditions
• POLST – integrating advanced care planning and palliative care
• Proton Pump Inhibitors Guidelines
• Blood Transfusion Guidelines
• DVT Prophylaxis Guidelines
• Respiratory Care Systems
• DM Care Protocols
• Cardiac Medication Monitoring Protocols
The NP - Provides

- Acute Onsite Care
- Chronic Condition Management (not monthly routine visits)
- Resident Risk Assessments and Re Admission Avoidance Interventions
- Quality Indicators Management (“Survey Ready”)
- RN/ LPN/Aide Directed ongoing Educational Program
- Transition of Care - Provide discharge summary and calls to patients community physicians, assuring a safe transition and follow up physician care.
Heroes Program

- **Making All Of Our Associates Part Of Our Care Team:**
  - Applying the Interact – “Stop and Watch” early warning tool
  - Education, training and support for all of our associates, bringing them into our residents' lives and to help keep our residents well.

- **All of our Associates**-
  - Nurse Assistants
  - Environmental Services
  - Maintenance
  - Dietary
  - Recreation
  - Social Services
  - Rehabilitation

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Clinical Enhancement Initiative
“The Ingredients”

- **Nursing Engagement and Training:**
  - Symptom Specific Tools
  - Driving Improved Assessments, Documentation and Communication
  - Implement DON Morning Rounds
  - Imbed a CQI Process and Measures into all we do
- **Symptom Specific Assessment Tools Include:**
  - Respiratory Symptoms - SOB
  - Abdominal Symptoms
  - Fever / Sepsis
  - Chest Pain
  - Change in Mental Status / CVA
  - Hypo and Hyperglycemia
  - Suspected UTI
  - Falls
Setting the Culture

- **Rewarding Caring**
  - Medals
  - Gift certificates
  - Internal Newsletter
  - Letting our physicians know
  - External Press Releases

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After Hours (First Call for Acute Care Issues)

LiveMD After Hours Telemedicine Program

Powered by eSNF

- Only for serious medical concerns (not sleep meds, or patient falls unless injury and contemplating sending to hospital).
- Each patient seen by MD via telemedicine:
  - Exams Heart Lungs and Abdomen
  - Exams Skin and Wounds
- Call Attending and Patient family
- Prescribe on site
- Send in note to support visit
- Install equipment and Train staff
- Teach staff when to call
- No Medicare or Medicaid Billing done
- 100% physician acceptance

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Outcome Tracking Powered by eSNF

- Will track all patient events leading to ED or hospital admission:
  - Shift
  - Nurse
  - Physician
  - Diagnosis
  - Reason for Transfer
  - LOS
  - Insurance

- Able to report to hospital on readmission and quality indicators
# Customizable Tracking Platform

## Population Tracking

### Patient Disposition:
- Admissions/Readmissions
- Deaths
- ED visits
- Discharge to home with and without home care
- Discharged to alternative facility
- Hospice
- Transfer to LTC

### Event Variables:
- Reason for discharge
- Ordering physician
- Responsible nurse
- Diagnosis
- Length of stay
- Time/shift
- Hospital
- Insurance
- Potentially Avoidable
- Type of admission

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Live MD  Powered by eSNF
Impact Of Telemedicine Program

Skilled Patient Hospitalization (80 SNF bed facility)
Facility has a full time MD and NP

Patients Hospitalized - eSNF Client

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Live MD Powered by eSNF
Impact Of Telemedicine Program

Skilled Patient Hospitalization (80 SNF bed facility)

Facility has a full time MD and NP

Decreased Hospitalization Rates from 20 to 12 % per Month

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Admissions by Attending

Able to track hospital admissions by physician as a percentage of their total patient census

Percent of Hospitalizations By Attending

- Doctor A: 9.94%
- Doctor B: 50.00%
- Doctor C: 9.94%
- Doctor D: 11.11%
- Doctor E: 1.75%
- Doctor F: 0.58%

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Financial Value Equation

• The Medicare Reimbursement per diem for the average subacute patient is $500/day.
• When a patient returns to the hospital, on average the Nursing Home loses about 8 days of revenue ($4,000)
• This often means that preventing one readmission/month makes eSNF pay for itself
Financial Impact Case Study

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<thead>
<tr>
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<th>2012 – Before eSNF</th>
<th>2013 – After eSNF</th>
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<tbody>
<tr>
<td></td>
<td>Avg. Subacute Census</td>
<td>Total Subacute Bed Days</td>
</tr>
<tr>
<td>March</td>
<td>34</td>
<td>1,069</td>
</tr>
<tr>
<td>April</td>
<td>40</td>
<td>1,194</td>
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<tr>
<td>May</td>
<td>36</td>
<td>1,116</td>
</tr>
<tr>
<td>Total</td>
<td>3,379</td>
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</tbody>
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YoY Change: +338*

- 338 add’l bed days X $500/day reimbursement = $169,000 add’l revenue
- 338 add’l bed days X $175/day therapy costs = $59,150 new costs
- eSNF cost for March – May = $9,300 in new costs
- Customer 3-month ROI = $100,550 eSNF ROI
- Annualized ROI = $402,000

*This does not include this facility’s YoY increase in long-term resident census, which in this period was 472 bed days

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Quality Care Transformation

Everyone Wins