Managing the Unique Needs of Different Patient Populations

Physician Leadership Forum Webinar
May 16, 2012
INTRODUCING ACCESS DuPage
WHAT IS ACCESS DUPage?

A collaborative effort, involving some 225 organizations, to provide access to medical services to the low-income, uninsured residents of DuPage County, IL.
How did Access DuPage get started?

- Late 1990s – issue of uninsured identified; several early attempts to address the issue fail
- 1999-2000 – 1-on-1 conversations with key players
- Oct. 2000 – meeting of CEOs endorses a common planning process
- 2001 – plan presented, refined, & approved
  - 7 DuPage hospitals requested to provide a total of $1 million per year for 3 years, supplemented by other public & private funds
- July 2001 – Access DuPage incorporated as 501(c)(3) with 14 corporate members
- Feb. 2002 – first Access DuPage member enrolled
- 2002-2012 – gradual growth in credibility, support, and documented results
WHO IS ELIGIBLE?

Eligibility criteria:
- Resident of DuPage County between 18 & 65
- Household income under 200% of the Federal Poverty Level
- Not eligible for public programs such as Medicaid, Medicare, or Social Security

Persons must apply for membership at one of 40+ enrollment sites

Eligible applicants are enrolled for one year, then must re-apply annually.
ASSIGNMENT TO MEDICAL HOME

- Types of Medical Homes:
  - Federally-qualified community health centers
  - Free clinic
  - Private physician offices

- Functions:
  - Ongoing primary care in the context of family and community
  - Management of access to more intensive services
Access Across Continuum of Care

- Medical specialists
- Diagnostic tests
- Prescription medications
- Hospital services
- Mental health services
- Oral health services
Mosaic Strategy

- Multiple models & programs
- Not central control but coordination across continuum of care
- Lean management infrastructure
- Emphasis on “Fair Share”
SELECTED RESULTS, 2011

- 14,990 members were provided with services
- Average weekly enrollment = 9,971
- 26,892 PCP visits; 93,267 Rx; 19,251 hospital services.
- Direct cost PMPY = $441.81
- Retail value of donated services = $79.8 million
- Age-adjusted hospitalization rates 35% less & ER use rates 17% less than general public rates
- Total cost PMPY at managed care rates = $4,332, 20% less than the average cost of employer-sponsored insurance
- Self-assessed physical health (via SF-12) being maintained; mental health improving
Why does it work?

- Sufficient local resources
- A culture of collaboration
- Leadership within partner organizations
- Effective management
COLLABORATION

Driving premise: You can get further working together rather than working alone

Hallmark: mutual capacity building
A Different Business Model

- **Mainstream**
  - Focus: the individual
  - Goal: derive the greatest good for the patient (often without regard for resource usage & often with incentives for extensive utilization)

- **Access Dupage**
  - Focus: the population
  - Goal: derive the greatest good for the greatest number within a defined set of resources
Building a continuum for the highest complexity patients

Rahul Koranne, MD, MBA, FACP
Medical Director, Post-Acute Services
About me

• Internal medicine & Geriatrics physician
• MBA from University of Minnesota
• Art of Convening Graduate
• Medical Director: HealthEast Bethesda Hospital, Home Care, Dual eligible Care Management, Care Navigation Strategy
• Active on MN DHS committees around Reform work
• Connection to U of MN: MILI, OCEH, Adjunct faculty
Today:

Complex Critical Patients

What is an LTACH

Transitions in

Transitions out

Transition Coach Program

Discussion/ Questions
HealthEast Care System  St. Paul,  Minnesota

Woodwinds  St. Joseph’s  St. John’s  Bethesda

HealthEast Care System
• 3 STAC, 1 LTAC Hospitals
• 14 Primary Care Clinics
• More than 35 specialty services
• Home Care & Hospice
• Medical Transportation

Some Statistics
Licensed Beds  925
Employees  7300
Volunteers  1200
Credentialed Physicians  1400
In 2005, the Congressional Budget Office noted that the US spent nearly $1.9 trillion on healthcare; a mere five years later, that number jumped to $2.6 trillion. Costs are growing over 2% more per year than growth in gross domestic product. The CBO predicts that if allowed to continue at this rate, by 2040, 1 of every 2 dollars spent in America will be on healthcare.

According to an AHRQ estimate, 5% of Medicare fee-for-service beneficiaries accounted for 43% of total spending; 25% of Medicare beneficiaries represented 85% of total spending. Additionally, more than 75% of these high-cost patients had one or more chronic conditions. AHRQ notes that patients with multiple chronic conditions cost up to seven times more to care for than patients with only one chronic condition.
Three Dimensions of Value

Population Health/Quality Outcomes

Experience of Care

Cost of Care

Triple Aim
Dimensions of Patient-Centered Care

Access to Care

Patients’ Preferences

Coordination of Care

Information and Education

Physical Comfort

Continuity and Transition

Family and Friends

Emotional Support

Overall Evaluation of Care

NRC PICKER
## Patient Level Segmentation

<table>
<thead>
<tr>
<th>Patient Type Definitions</th>
<th>Sample Diseases</th>
<th>Example Values</th>
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<tbody>
<tr>
<td><strong>Occasional</strong></td>
<td>Healthy and engaged</td>
<td>Knee/ankle sprain</td>
</tr>
<tr>
<td><strong>Elective</strong></td>
<td>Active, demanding and aging</td>
<td>Hip/knee replacement</td>
</tr>
<tr>
<td><strong>Perpetual</strong></td>
<td>Living with multiple conditions</td>
<td>CHF COPD Cancer</td>
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<tr>
<td><strong>Complex Critical</strong></td>
<td>High risk for multiorgan failure</td>
<td>Renal failure</td>
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</table>

CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease.

Obtained from SG2 2010
Different Patient Types Present Different Growth Trajectories

2009 IP/OP Total Volume

Inpatient
- Elective: 26%
- Occasional: 28%
- Perpetual: 41%
- Complex: 6%

Outpatient
- Elective: 39%
- Occasional: 49%
- Perpetual: 12%

Inpatient Growth, 2010–2019

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>IP Forecast 2009–2019</th>
<th>Office Visit Forecast</th>
<th>PT Visits Forecast</th>
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<tbody>
<tr>
<td>Elective</td>
<td>18%</td>
<td>(1%)</td>
<td>27%</td>
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<tr>
<td>Occasional</td>
<td>No change</td>
<td>(18%)</td>
<td>23%</td>
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<tr>
<td>Perpetual</td>
<td>(9%)</td>
<td>(11%)</td>
<td>16%</td>
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<tr>
<td>Complex Critical</td>
<td>10.5%</td>
<td>n/a</td>
<td>n/a</td>
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</table>

PT = physical therapy.

Obtained from SG2 2010
Meet Bouncing Bob!
LTACH: Specialty Hospital for Specialty Patients

- **Specialty Hospital** that focuses on patients with serious medical problems requiring specialized treatment for 20-30 days

- **Specialized patient population** that is generally transferred from ICU requiring ventilator or other complex medical care
Bethesda Signature Programs

- **Outpatient Services**
- **Respiratory Care**
  - 49 Beds
- **Complex Medical Care**
  - 34 Beds
- **Brain Injury Services**
  - 30 Beds
- **Medical Behavioral Care**
  - 13 Beds

_**Acute Specialty Care Focus**_
A Patient’s Viewpoint

• All I wanted . . .

All I wanted was to use my body again.

And I got there with Bethesda Hospital, member of HealthEast® Care System.

When a 1700-pound tree crushed Don Obernolte, he thought everything was over. But with the help of Bethesda, he’s reinvented his life. As one of the first and largest long-term acute care hospitals in the nation, Bethesda cares for chronically ill patients or victims of catastrophic accidents, with higher-than-national-average vent wean rates. So patients can recover, relearn and restart, creating a new normal for their lives.

For more information about Bethesda Hospital in St. Paul, Minnesota, visit betheshahospital.org or call 651-232-2000.
Building on Partnerships

Superior Outcomes

Driven Executives and Committed Staff

Guiding Principles

Engaged Medical Directors and Physicians

Most Complex and Critical Patients in MN

Bethesda’s History and Location
<table>
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<tr>
<th>DRG</th>
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<tbody>
<tr>
<td>207 Respiratory system diagnosis w ventilator support 96+ hours</td>
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<tr>
<td>189 Pulmonary edema &amp; respiratory failure</td>
</tr>
<tr>
<td>57 Degenerative nervous system disorders w/o MCC</td>
</tr>
<tr>
<td>208 Respiratory system diagnosis w ventilator support &lt;96 hours</td>
</tr>
<tr>
<td>56 Degenerative nervous system disorders w MCC</td>
</tr>
<tr>
<td>166 Other Resp system O.R. procedures w MCC</td>
</tr>
<tr>
<td>884 Organic disturbances &amp; mental retardation</td>
</tr>
<tr>
<td>919 Complications of treatment w MCC</td>
</tr>
<tr>
<td>86 Traumatic stupor &amp; coma, coma &lt;1 hr w CC</td>
</tr>
<tr>
<td>539 Osteomyelitis w MCC</td>
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</table>
Payer % by Inpatient Cases

Year | Medicare and Medicaid | Commercial
--- | --- | ---
2007 | 69.2% | 30.8%
2008 | 66.0% | 34.0%
2009 | 63.0% | 37.0%
2010 | 64.7% | 35.3%
2011 | 67.0% | 33.0%
2012 | 67.3% | 32.7%
**RESPIRATORY CARE SERVICE LINE**

- **Primary Patient Population includes:**
  - Ventilator dependent patients
  - Intubated patients (oral/tracheostomy)
  - Respiratory Brain Injury patients

- **Program Differentiators**
  - Followed by Pulmonologists
  - Inter Disciplinary Team approach
  - Family involvement encouraged
  - High CMI with most patients coming from ICUs
  - Innovative Ventilator Weaning Pathway
Ventilator Weaning Rate

% of Patients Weaned

- Vent Weaning Rate
- Benchmark

Higher is Better

Internal Benchmark: 70
National Benchmark: 59.9
Ventilator Associated Pneumonia

Ventilator Associated Pneumonia

Benchmark

Lower is Better

Calendar Year
Complex Medical Service Line

- Multi-organ system failure patients
- Complex wounds- Plastic/General Surgery
- Transplant patients
- In room dialysis
- Telemetry Capabilities
- Multispecialty Support- Infectious Disease/ Heme/Onc/ Nephrology/Cardiology/Endocrinology/ Rheumatology
- All private rooms
Catheter Associated UTI

Infections Per 1000 Foley Catheter Days

CY 2009
CY 2010
CY 2011
CY 2012 YTD
Jan 11
Feb 11
Mar 11
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12

Catheter Associated UTI
Benchmark

Lower is Better

About Us
Central Line Blood Stream Infections

Infections Per 1000 Central Line Days

Calendar Year

Lower is Better
Blood Glucose Within Range

<table>
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<tr>
<th>Date</th>
<th>Checks Within Range</th>
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<td>79.00</td>
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<td>FY 2011</td>
<td>76.00</td>
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<td>FY 2012 YTD</td>
<td>86.38</td>
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<tr>
<td>Sep 11</td>
<td>90.50</td>
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<td>Oct 11</td>
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<td>Nov 11</td>
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<td>Feb 12</td>
<td>75</td>
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<td>Mar 12</td>
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</table>

Internal Benchmark: 75%

Higher is Better

FY 2010
FY 2011
FY 2012 YTD
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12

Blood Glucose Checks Within Range
Benchmark
Neurovascular Brain Injury Service Line

• Primary Patient Population includes:
  • Trauma
  • Aneurysm or Intracranial bleed
  • Stroke
  • Seizures, Delirium, Confusion

• Program Differentiators include:
  • Multi-disciplinary medical team with Hospitalist, Neurologist, PM&R and Psychiatrist
  • Strong technical support system (CT, MRI, EEG and EMG studies etc.)
  • Specialization in Traumatic Brain Injury and Respiratory Brain Injury patients
  • Newly renovated units with private rooms
  • Strong patient and family involvement on ongoing basis
  • Potential for Research/Publications and connection with Academic centers
Patient Falls

Fiscal Year

Falls Per 1000 Patient Days

FY 2008
FY 2009
FY 2010
FY 2011
FY 2012 YTD
Sept 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12

Patient Falls
Benchmark

Lower is Better
Neuroscience Research

- Bethesda Neuroscience Registry
  - Prospective patient research registry
  - Designed to evaluate the long-term health outcomes of the critically ill and to develop cost-effective, evidence based practice guidelines to optimize their recovery
  - Captures demographic, physiological, treatment, cost and long-term follow-up data on neurological patients admitted to Bethesda who have been in the ICU for two weeks or longer, and who are not able to ambulate independently at the time of admission
  - As of April 18, 2012, 133 patients have consented to participate in the registry

Current Research Focus:
- Use of anti-seizure medications in the management of traumatic brain injury patients
- Evaluation of outcomes among brain injury patients receiving antipsychotic medications for delirium
LTACH Fits HealthCare Reform

Managing Cost, Outcomes and Quality

- Bethesda key to LOS management post-ICU
- Improving care across the continuum while providing excellent outcomes at reduced cost
- As a specialty hospital Bethesda strategically positioned to partner and become part of all regional ACO’s
Total Cost of Care

PCP
SCP
Hospital
Outpatient
Ancillary Services
Home Care

Total Cost of Care
New Provider Relationship Model
Ex: Shared Incentive Contract with Care System

Pay for Performance

Guaranteed Fee for Service Increase

Year 1  Year 2

<table>
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<tr>
<th>Historical</th>
<th>Shared Incentives</th>
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<tr>
<td>Pay for Performance</td>
<td>Incentive Cost of Care</td>
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<tr>
<td>Guaranteed Fee for Service Increase</td>
<td>Incentive Cost of Care Earned if TCC &lt; prior year</td>
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<tr>
<td>Quality</td>
<td>Incentive Quality</td>
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</table>

- Guaranteed Fee for Service Increase
- Incentive Quality
- Incentive Cost of Care

Year 1 Year 2 Year 3

* Based on measurable improvements in cost, quality, outcomes
Best Value in Quality and Cost for Post-Acute Care of Complex and Critical Patients.

**Acute Care Providers**
- HealthEast
- Allina
- HCMC
- Fairview
- HealthPartners
- Park Nicollet
- Mayo
- St. Cloud
- VAH, WI, ND, SD...

**Payers**
- Medica
- BCBS
- DHS
- CMS
- UCare
- Preferred One
- Health Partners
- United Health Care

**Employers**
- Best Buy
- Target
- 3M

**Community**
- Wilder
- Pres Homes
- Cerenity
- Courage Center

**IHI**
- Quality
- Pat Sat

**BH**
- Time
- Trained Specialists

**Cost**
- Teamwork
- Specialists

**Time**
- Trained
- Specialists

**Teamwork**
- Trained
- Specialists
Transition IN

- STACH
  DRG Reimbursed

- Trigger Tool
  Earlier Identifiers/Prompts

- Bethesda
  - Right Care
  - Right Place
  - Right Time
  - Outcome Driven
Bethesda Hospital Admission Sources

- Twin Cities Metro Area (92%)
- Regional (5%)
- Out of State (3%)

Twin City Hospitals = 92%
- HealthEast (3) = 32%
- Allina Hospitals (5) = 14%
- Fairview Hospitals (4) = 11%
- Hennepin County Medical Center = 8%
- Regions = 7%
- North Memorial Medical Center = 5%
- Methodist = 1%
- SNF/NH/ALP/Other = 12%
- BH Outpatient Clinic = 3%

10+ Regional Hospitals = 5%
10+ Out-of-State Hospitals = 3%
Industry Statistics

• 3% of STACH Medicare D/C = appropriate for LTACH transfers
• Day 4-5 = National Average of when ICU refers to LTACH
• Day 17 = National Average of transfer from STACH to LTACH.
Triggers for Referrals to Bethesda Hospital

Does your patient need:

• Ongoing Hospital level of care?
• Daily Physician Visits?
• Prolonged (~5+ more) days in hospital?
• Unable to go to TCU or failed at TCU?
<table>
<thead>
<tr>
<th>Room</th>
<th>Patient Name</th>
<th>Acct Nbr</th>
<th>LOS</th>
<th>TCU Readmits</th>
<th>Vent/Trach Hrs (Extubations)</th>
<th>TPN Hours</th>
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2011 Innovation of the Year Award

Team
- Pulmonary Medicine
- Registered Nurses
- Nursing Assistants
- Clinical Education
- Central Stores
- Hospitalists
- Respiratory Therapy
- Occupational Therapy
- Speech Therapy
- Care Management
- Therapeutic Recreation
- Housekeeping
- Facilities Management
- Pharmacy
- Nursing Leadership

Methods
- Quality
- Vent Pathway
- Team Rounds
- Communication

Goal
- Liberation from Ventilator

HealthEast Care System
Transition Out

- SNF
- TCU
- IRF
- Group Home
- Home w
- Home Care

D/C Dispositions

Partnerships

Wound Care
- Vent/Trach Pathway
- Behavioral care
- Sharing staff and providers

Bethesda
Exciting times ahead

- 3 Pioneer ACOs in MN
- Medicaid ACO in MN
- Commercial TCOC contracts Increasing
- Partner with Payers to show and capture value
- Research focus
- Share best practices with others in nation
Transition Coach

Four Pillars

- Medication Management
- Personal Health Record
- Follow-up with PCP
- Education regarding Red Flags

Prescriptive Interventions

- Hospital meeting
- Post-Discharge Home Visit
- Post-Discharge 3 phone calls

Diagnoses:

CHF, CAD, Pneumonia, Arrhythmia, PVD, COPD, CVA, Diabetes, Hip Fracture & Joint Replacement
Transition Coach Results
March 2011 - March 2012

1114 persons enrolled

Quality

21.5% Medication Discrepancy Addressed

Percent of patients that found program to be helpful/very helpful with

- Managing Medications: 85%
- Better understanding on when to call PCP: 89%
- Better prepared to work with PCP: 85%
- Follow-up appointments: 69%
- Patient using the PHR: 70%
- Would recommend to family and friends: 95%

Cost

9.7% readmission rate 30 days post discharge
(for any level of intervention)
Compared to national average 20-25%

HealthEast Care System
Questions and Discussion