The Next Phase of Acute/Post Acute Partnerships: Not as Simple as 30 Day Readmissions

Heather Kirby, Assistant Vice President of Integrated Care Delivery

Frederick Regional Health System

Healthcare priorities today and tomorrow

- Nationally
  - Population Health
  - ACO
  - Medicare Shared Savings Programs (MSSP)
- Maryland
  - Reduction in Medicare spending by $320million
    - Hospital
    - SNF
    - Home Care
    - Hospice
  - HSCRC – New Waiver
  - Move to Global Budget Revenue

Moving from ARR to GBR

ARR (Admission/Readmission Revenue)

- Attempt to combine volume based revenue with quality based reimbursement
- Initial visit considered “Good” volume
- Focus on reducing 30 day readmissions for inpatients only
- Quality important but not a primary driver of financial results

GBR (Global Budget Revenue)

- Capitated Revenue
- Good volume
- Bad Volume
- PAUs -
  - Unnecessary admissions, ED visits, Observation, revisits
- PQIs
  - Chronic diseases that should be treated better outpatient reducing the need for hospital services

Preventable Quality Indicators (PQIs)

- HSCRC and CMS define as ambulatory conditions, which if treated appropriately in the outpatient setting should not require hospital care:
  - HF
  - HTN
  - DM
  - UTI
  - COPD
  - Asthma
  - Pneumonia
  - Ruptured Appendix

The Road Ahead

Care Management of Yesterday

- ED/Hospital focus
- Volume based revenue
- 30 Episodes
- Discharge planning
- Community referrals
- No intentional follow up post discharge
- Observation vs. Inpatient

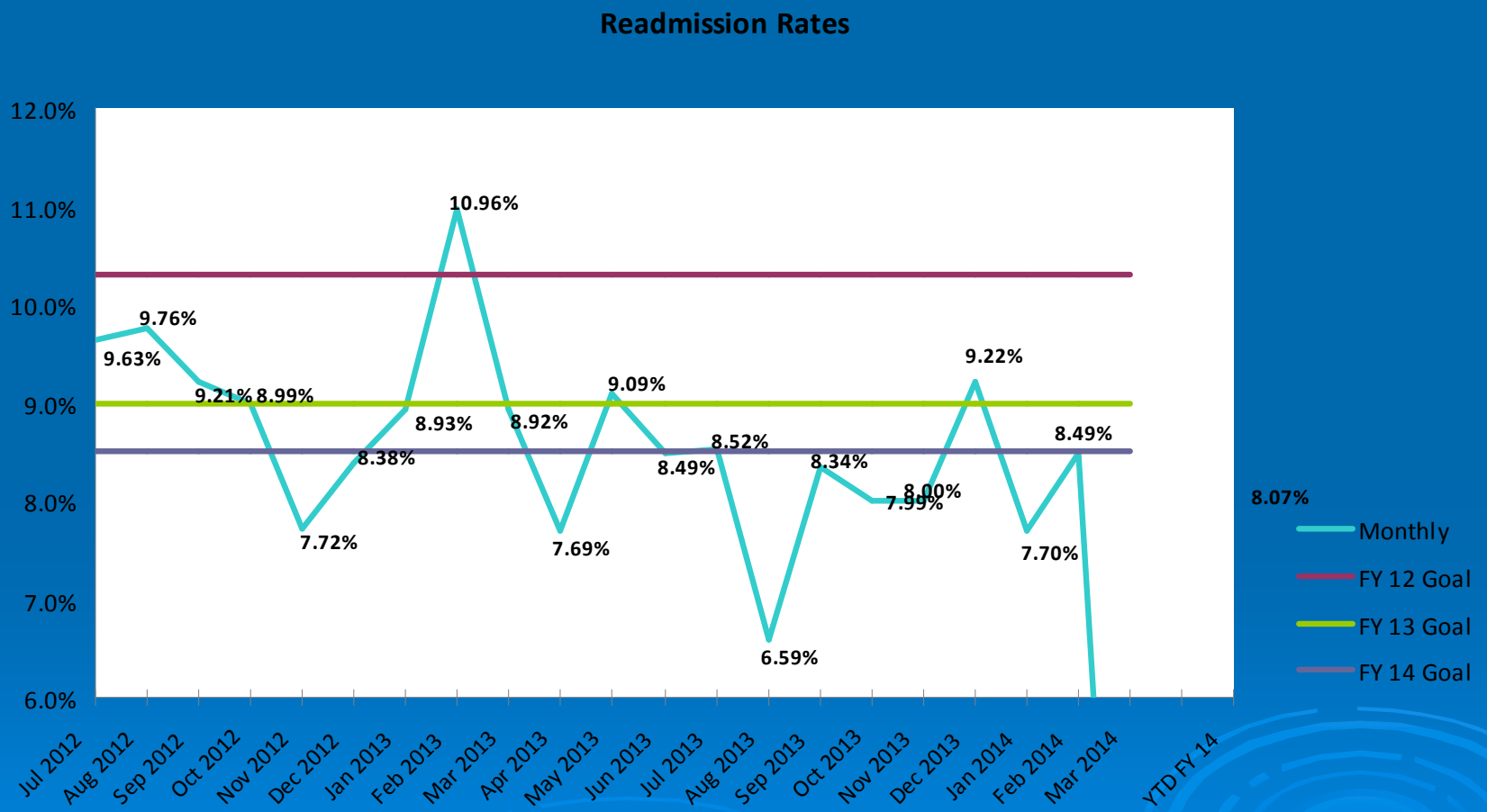
Care Management 2015

- Bundled payments
- Quality based care affiliations
- Home based care
- Community focused
- Long term accountability for the health of a population
- Transition planning/continued support
- Right service in right setting
- End of life planning
- Employee Health Plan
- Wellness/Health Coaching

Care Transitions at FRHS

- Dedicated team focused patients most at risk for readmission
- Focus on All Cause 30 Day Readmissions
  - Heart Failure, COPD, Diabetes, Behavioral Health
    - Year 1 (FY 12) - RA Rate = 10.2%
    - Year 2 (FY 13) - RA Rate = 9.03% (↓ 12%)
    - Year 3 (FY 14) - RA Rate = 8.44% (↓ 7%)
    - Year 4 (FY 15) - RA Rate = 8.00% and 9.68%

Readmission Rate Trend Overtime



2015 Broadening our Focus

- Expanding Care Transitions to Integrated Care Management
- Community based
- Segmenting our population
  - 5-10% highest risk
  - 20-25% rising risk
  - 70-75% low risk
- Identifying key tactics and partners to address unique needs of diverse community needs

2015 Metrics

- 30 Day All Cause Readmission (potentially avoidable utilization)
  - Revisits to the ED
  - Revisits as Observation
  - Observation revisits
- Preventable Quality Indicators
- HCAHPS
- Length of stay
- Transfers to other acute hospitals
- Post acute partner outcome metrics

Engaging Post Acute Partners

- Establish a relationship with Emergency Department
- Continuing Care Networks (quality, metrics, reports)
- Clinically Integrated Network
  - Shared Savings Programs
  - Bundled Payments
  - Purchased services
- Standardized care across the entire continuum
- Resource sharing, expertise, capital, technology
- Medication reconciliation across all settings
- Follow up phone calls
- Home visits
- The Conversation Project
- Use data to support continuing strategy or change direction

Quality Based Alignment

- Post Acute Partner Outcomes
  - 30 Day All Cause Readmission (potentially avoidable utilization)
    - Revisits to the ED
    - Revisits as Observation
    - Observation revisits
- Quality outcomes related to Preventable Quality Indicators
- CMS Compare scores (SNF and HHC)
- HH-CAHPS

The Challenge Ahead

- Flexible, nimble and data driven
- Increasing our comfort-”ability” with risk taking
- Patient / community needs driven
- Cultivating a creative, highly engaged environment
- Identifying and removing barriers
- Linking to partners – sharing the vision
- Shared best practices in a competitive environment

“When the winds of change blow; Some build walls, others build windmills”

Chinese Proverb

Questions?

Heather Kirby

hkirby@fmh.org

240-566-3679