HOME IS THE HUB
An Initiative to Accelerate Progress to Reduce Readmissions in Virginia
Webinar #7
Deep Dive Series: Insights from Anthem
February 22nd, 2017
• Slides were sent this morning
• Webinar is being recorded
• Please use the “telephone” option
  • Audio pin prompt
• All participants are muted
• Raise your hand
• Ask a question
• Warm up
WELCOME AND OVERVIEW

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An association of 30 member health systems representing 107 community, psychiatric, rehabilitation and specialty hospitals throughout Virginia.

Vision

Through the power of collaboration, the association will be the recognized driving force behind making Virginia the healthiest state in the nation by 2020.

Mission

Working with our members and other stakeholders, the association will transform Virginia’s health care system to achieve top-tier performance in safety, quality, value, service and population health. The association’s leadership is focused on: principled, innovative and effective advocacy; promoting initiatives that improve health care safety, quality, value and service; and aligning forces among health care and business entities to advance health and economic opportunity for all Virginians.
1. Hospital readmissions
   1a. Hospital-wide
   1b. Post-acute transfers
   1c. Total hip/Total knee Replacement 30-day readmissions

2. Clostridium difficile – Healthcare-acquired Infections
3. Patient Experience – HCAHPS
4. Serious Safety Events
Summary of Activities

• Introduced Dr. Amy Boutwell as strategic advisor
• Identified “High-Leverage Strategies”
  • Post-Acute Care
  • High-Utilizer/Multi-visit Patients
• Reviewed the importance of data and measurement
• Partnered with Virginia’s QIO, HQI (formerly known as VHQC)
• Partnered with SNF Association Leadership
• In-Person Shared Learning Session
HOME IS THE HUB: 2017

Activities
- Deep Dive webinars
- Special Topic webinars
- Office Hours for individual coaching
- State-wide SNF-Hospital “Sprint”
- Home is the Hub “Playbook”
- In-Person Meeting: Successes

Planned Events
- January 25: Deep Dive: ED-based Strategies
- February 22: Special Topic: Payer-Based Efforts
- March 15: Deep Dive: SNF Readmissions
- April 19: Virginia’s SNF-Hospital “Sprint”
- May 17: Special Topic: CHWs
- June 14: Office Hours with Dr. Boutwell
- July 12: Deep Dive: Post-Acute Care
- August 16: Home is the Hub Playbook
- October 18: Office Hours with Dr. Boutwell

*All webinars will be offered at 10am*
AGENDA

Anthem Goals:
- Transformation of health care via trusted and caring solutions
- Member-centric focus

Achieve Effective Inpatient Management:
1. Data driven
2. Enhanced processes and procedures
3. Communication
4. Barriers and Issues

Engage and Educate Members

Assure Quality

Partnership and Collaboration

Reimburse for Value

Recommendations
Anthem Inpatient Management
Strategies for Change, Innovation and Collaboration

Goals for IP Management:

▪ Reduce *unnecessary* admissions and readmissions:
  • Assure access to effective, comprehensive and ongoing OP care
  • Meet care needs in setting of lowest intensity

▪ Improve quality of care:
  • Timing and quantity of care = Appropriateness
  • Efficacy
  • Standards and guidelines

▪ Improve outcomes for our members:
  • Reduce condition complexity and severity
  • Reduce intensity of service necessary to maintain health and wellbeing
  • Focus on Quality:
    - Incentivize providers
    - Value Based
Institute for Healthcare Improvement
Triple Aim for Populations

Health care organizations that simultaneously deliver

- Excellent quality of care,
- Lower total costs, and
- Improve the health of their population

Reduce avoidable readmissions.

- Hospitalizations account for nearly one-third of the total $2 trillion spent on health care in the United States. Unplanned readmissions are costly, potentially harmful, and often avoidable:
  - The rate of avoidable re-hospitalization can be reduced by improving core discharge planning and transition processes out of the hospital;
  - improving transitions and care coordination at the interfaces between care settings; and
  - enhancing coaching, education, and support for patient self-management.
Quadruple aim

Outcomes
- Effective interventions
- Less preventable illness
- Decreased disparities

Patient Experience
- Satisfaction
- Quality
- Trust

Provider Experience
- Professionalism
- Joy at Work
- Recruitment & Retention

Costs
- Lower per-capita costs
- Appropriate spending & utilization

Equity
- Societal opportunity
- Decision making
- Structural Fairness

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QUALITY

Institute of Medicine – Six Dimensions of Quality:

1. Safe – Appropriate actions taken, not causing harm or injury
2. Effective – Science and evidence are applied to the care provided and serve as the standard in the delivery of care
3. Efficient – Avoids waste, cost effective
4. Timely – No delays in necessary/appropriate care
5. Patient centered – preferences, needs and values considered, patient informed and in control of decisions
6. Equitable – Reduce disparities
Anthem Admission Management

Admission Management Re-Design:

- Background
- Strategy
- Daily Census Report
- Readmission Risk
- Concomitant high ER utilization
- Grand Rounds
- HLOS and SLOS
Admission Management Foci

• Initiate review of cases through a proactive and comprehensive lens to anticipate the needs of the member.

• Implement management of member progression in accordance to appropriate Milliman Care Guidelines (MCG).

• Ensure timely referrals to Medical Directors and Grand Rounds when MCG criteria are not being met.

• Review the daily census report to monitor member care and progression through discharge.

• Use clinical expertise and judgment to provide evaluation and input on member’s specific needs.

• Enhance interaction between the UM Nurse, Medical Director, Case Manager, Discharge Planner and BH to manage member needs and next steps.
Key drivers of utilization:

- Members with 2-4 Admissions are very high users of ER
- Members at all levels of readmission (1 – 10+) had no physician visits within the preceding 90 days of admission
- 10% of admissions are readmissions
- Nearly 40% of readmissions (within 30 days) occur in 0-7 days
- BH co-morbidity increases risk for admission, readmission and increases LOS
Distinct Members by Number of Admits

% of Admit Category

- Members with 1 Admit: 1.43%
- Members with 2-4 Admits: 19.12%
- Members with 5-9 Admits: 79.32%
- Members with more than 10 Admits: 0.12%
Anthem Admission Management

Factors increasing medical admissions/readmissions are “impactable” by a variety of strategies/interventions:

- Leverage UM nurse and Medical Director expertise to proactively identify and manage all members
- Hospital census – “heads in beds”
- Intense focus on high-risk members:
  - Readmissions
  - ER utilization
- Grand Rounds

Key Opportunities:

- Timely clinical review and decisions communication
- Reduce delays in care
- Monitor - track and trend:
  - Non-DRG related
  - LOS
  - Potential outlier members
  - Early discharge planning and for
  - Case Management
Admission Management Strategies

Implement a **strategic data-driven review** of Admissions/Readmissions to:

- Focus on high risk members at the start of hospitalization (daily census to highlight)
- Timely clinical Grand Rounds with an interdisciplinary team
- Reinforced discharge planning
- Targeted Case Management
- Maximal engagement of PCPs:
  - EPHC
  - Value-based Arrangements
Daily Census Report

- The Daily Census Report has been developed to capture all members currently admitted (heads in beds).
- UM Nurses use clinical expertise to identify members requiring: Grand Rounds Presentation, Medical Director Consultation, CM referral, and/or Discharge Planning.

### Example of Daily Census Clinical

<table>
<thead>
<tr>
<th>DRG_DESC</th>
<th>TotalAdmits</th>
<th>TotalERVisits</th>
<th>ReadmitFlag</th>
<th>MostRecentOfficeVisit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Extremity and Humerus Procedures Except Hip, Foot, Femur without CC/MCC</td>
<td>2</td>
<td>2</td>
<td>RecentAdmit</td>
<td>9/26/2016</td>
</tr>
<tr>
<td>Trauma to the Skin, Subcutaneous Tissue &amp; Breast without MCC</td>
<td>1</td>
<td>0</td>
<td>NotRecent</td>
<td>9/28/2016</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction without CC/MCC</td>
<td>1</td>
<td>0</td>
<td>NotRecent</td>
<td>9/14/2016</td>
</tr>
<tr>
<td>Percutaneous Cardiovascular Procedure with Non Drug-Eluting Stent without MCC</td>
<td>3</td>
<td>0</td>
<td>NotRecent</td>
<td>9/29/2016</td>
</tr>
<tr>
<td>GI Hemorrhage without CC/MCC</td>
<td>5</td>
<td>2</td>
<td>NotRecent</td>
<td>9/31/2016</td>
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<tr>
<td>Major Small and Large Bowel Procedures without CC/MCC</td>
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<td>0</td>
<td>NotRecent</td>
<td>9/27/2016</td>
</tr>
<tr>
<td>Coronary Bypass without Cardiac Catheterization without MCC</td>
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<td>1</td>
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<td>9/16/2016</td>
</tr>
<tr>
<td>Major Small and Large Bowel Procedures without CC/MCC</td>
<td>1</td>
<td>0</td>
<td>NotRecent</td>
<td>8/25/2016</td>
</tr>
<tr>
<td>Bronchitis and Asthma without CC/MCC</td>
<td>1</td>
<td>0</td>
<td>NotRecent</td>
<td></td>
</tr>
</tbody>
</table>
Grand Rounds

Grand Rounds Case Selection Criteria:

High Risk Patients:
- Patient is high risk for readmission.
- Patient readmitted emergently within 30 days of prior discharge.
- Member’s condition is deteriorating and/or treatment goals are not being met in the rehab, SNF or LTACH and hospital readmission is likely.
- Members with high utilization who have not seen a provider in 90 days.
- Medical management and/or discharge issues that arise due to Behavioral Health/Medical co-morbidities.

Barriers to Discharge
- Demonstrate socio-economic barriers.
- Inadequate post-discharge care giver support; no care giver, caregiver has not reported for required training or caregiver refuses to take member home.
- Transfer to a lower level of care is declined because a facility will not accept patient based on constraints (e.g. BMI >40, IV Drug Cost, etc.).
- Lack of a discharge plan when there is a need for a SNF, Rehab or LTACH.
- Inadequate patient post-discharge plan e.g. SNF instead of home IV therapy.
Hospital Strategies to Reduce Readmissions

- Increase coordination of care and communications between providers and patients.
- Improved discharge planning, education and follow-up for discharged.
- The use of electronic medical records -- easily shared and to provide continuity of care.

Other efforts include:

- Increased coordination with other providers and care settings to ensure that discharged patients receive the level of care they need for a safe transition out of the hospital.
- Prior to discharge, hospitals are using RNs, case managers and discharge planners to assess high-risk patients, identify patient needs and make sure there is a plan for meeting each need, and provide education and meet other discharge planning needs.
- Post-discharge, hospitals are coordinating with community resources such as physicians, home health agencies, etc. Some hospitals are calling patients within hours after discharge to ensure that they understand their plan for continued care, have access to needed resources, medications, etc. and answer any questions the patient might have.
- Implementation of policies and procedures to notify physicians of their respective patient’s discharge, follow-up on test results, and checks on patient progress.

Courtesy of ACEP.ORG
Hospital Strategies to Reduce Readmissions

Project BOOST (Better Outcomes by Optimizing Safe Transitions):

- Toolkit that includes medication reconciliation forms
- Checklist for discharge patient education
- Checklist for post-discharge continuity checks

Results:
A semi-controlled pre-post study in 11 hospitals showed a 2 percent drop in 30-day readmission rates after one year for units that participated in BOOST, compared to a slight increase in rates for units that did not participate.
Hospital Strategies to Reduce Readmissions

Yale University researchers identified six strategies that were modestly successful in lowering readmission rates for patients with heart failure:

1. Partnering with community physicians
2. Partnering with local hospitals
3. Having nurses reconcile medications
4. Arranging follow-up appointments prior to discharge
5. Sending discharge papers to patients' primary care physicians
6. Assigning staff to follow up on test results after discharge

Results:

Hospitals that implemented more of these strategies had substantially lower readmission rates. However, the study also found that several strategies intended to reduce readmissions actually increased readmission rates, potentially because they reduced informational and logistical barriers to hospitalization.
Readmission Reduction Insights Medicare and Medicaid Plan (MMP)

Jeff Lesesne, MD, Medical Director, Health Care Management, Government Business Division
Medicare Advantage and Medicaid Plan (MMP)

MMP is designed to provide integrated and coordinated benefits for dual eligible beneficiaries.

- Enhancing member experience and health outcomes

Includes members who are:

- Community well
- Waivered (receiving LTSS)
- Long Term Care residents

MMP utilizes a Case Management model to provide services across the spectrum of care.

- 100% of members have an assigned Case Manager for care coordination
MMP Universe of Services

Federal Medicare
- Medical model
- Episode care
- Disease oriented

State Medicaid
- Functional model
- Long-term care
- Support oriented

- Duals with multiple chronic conditions
- Duals with complex illnesses
- Duals with serious mental illness
Anthem MMP Plan in Virginia

Anthem HealthKeepers

• Go-live date of 4/1/2014
• Phased in regionally
• Plan termination 12/31/2017

Focus of initiatives

• Address avoidable, unnecessary hospitalizations related to Ambulatory Sensitive Conditions (ASC)
• Discharge management support to prevent complications leading to readmissions
Reducing Readmissions
Interdisciplinary Team Rounds

The interdisciplinary rounds process provides a forum for a member-centric dialogue to ensure coordinated, collaborative care.

Members of the interdisciplinary care team include:

• Health Plan Medical Directors, Nurse Case Managers and Pharmacy
• Member, Caregiver(s) and the member’s Primary Physician

Care Team members utilize the interdisciplinary rounds process to:

• Review results of health risk assessments completed by Case Managers
• Evaluate high-risk members and individuals recently admitted to the hospital
• Coordinate care with Behavioral Health
• Arrange and reinforce outpatient treatment and interventions
House Calls Program

House Calls program targets:

- Functionally home bound members
- High ED utilizers
- Members transitioning to a different level of care
- Members with conditions not well controlled
- Members with chronic conditions that are well controlled but require continuous treatment and careful monitoring (ESRD)

Vendor-based program deploying physicians and Nurse Practitioners able to write prescriptions
The Skill in Place initiative is a partnership between Anthem and Skilled Nursing Facilities (SNF) within the network.

- Risk sharing arrangement utilizing capitation, case rates and/or incentives models

SNF provides increased level of medical management services on site or “in place” reducing the need for unnecessary admission and/or readmissions.

- Includes services such as on-site laboratory, radiology, therapy, wound care
- Prior hospitalization is not required

SNF practitioner extender model is used to ensure care is available when needed.

- Physician Assistants and Nurse Practitioner s work in conjunction with Medical Doctors providing on-call availability
Nursing Facility Incentive Program

Anthem’s Nursing Facility Incentive program seeks to:

• Reduce potential, avoidable hospitalizations and ED visits
• Improve health outcomes and enhance quality of care
• Enhance opportunities for collaboration
• Improve member outcomes

Incentives are based on engagement, performance and quality.

• Engagement includes maintaining certification and coordinating care with the Health Plan (10%)
• Performance is based on avoiding hospitalization and ED visits at or below the control group (70%)
• Quality includes maintaining a 4 or 5 Medicare STAR rating (20%)
Advanced Illness Support

End-of-life care is highly variable and often fragmented leading to increased ED usage and hospitalization.

Anthem provide members with unique solutions throughout the advanced illness process.

Results promote a better quality of life and reduce preventable, unnecessary and/or non-beneficial services.
Advanced Illness Support: One Goal, Two Approaches

24/7 Care Provided in the Home
- Staff Includes MD’s to Diagnose, Treat and Manage Symptoms

Close Coordination with Member’s PCP
- Interdisciplinary Team (NPs, RNs, SWs and Chaplains)

Telephonic Outreach
- Helps the Member Clarify Preferences and Communicate Them Confidently

Transtheoretical Model of Change
- Advanced Care Planning
- Transtheoretical Model of Change

Anthem, Vital Decisions and Aspire work collaboratively to ensure members receive the most appropriate level of care. Members may be transferred within the programs as needs change.
Vital Decisions seeks to improve communication and shared decision making between members and their families and physicians.

Counselors are Masters educated professionals specially trained in advanced illness and end of life care.

56% of members eligible for the program have engaged with a Vital Decisions Counselor.

Anthem has evaluated outcomes using an intent-to-treat methodology comparing pre to post period differences.*

“My counselor is great and helps me be objective and thoughtful about health issues.”
- Anthem Member

*Treatment and comparison members were statistically matched to minimize baseline differences. Claims were adjusted for significant independent variables.
Aspire establishes a partnership with the health care team to co-manage needs in accordance with the member’s wishes.

Aspire provides members with relief from the symptoms, pain and stress of serious illness.

- Assistance navigate the health care system
- Guide members and caregivers through difficult and complex treatment choices
- Provide emotional and spiritual support
- 24x7 availability to members and caregivers

49% of members eligible for the program have engaged in Aspire Health.

Early, projected results demonstrate positive impacts on health outcomes and a reduction in preventable episodes of care.
Post-Discharge Stabilization (PDS)

The PDS model offers a continuum of services to promote coordinated care including intensive coordination with inpatient and outpatient providers.

• Connect with members prior to discharge to initiate the plan of care

• Ensure a clear understanding of the discharge plan

• Reconcile medications

• Prepare members for follow-up appointments

• Provide education regarding triggers and actions required to prevent exacerbations

Members who receive PDS services experience fewer readmissions, ER visits and are more likely to complete follow-up provider visits.
HealthKeepers Plus
Care Transition:
Reducing avoidable readmissions

David Buchsbaum, MD MSHA
Managing Medical Director, Medicaid
February 22, 2017
Key Issues facing our Medicaid Members

• Highly Vulnerable populations with extraordinary barriers to care: TANF and ABD
  ▪ Members often experience high rates of Behavioral Health Comorbidity
  ▪ Members have limited resources
  ▪ Members often experience unstable housing
  ▪ Members often live in challenging living environments
  ▪ Members often have Inconsistent phone service
  ▪ Members often have “Blocked” phone service
Managing Readmissions: Model and Issues

• Coleman’s 4 pillars of Care transition
  ▪ Medication self-management
  ▪ Use of a patient-centered health record that helps guide patients through the care process
  ▪ Primary care provider and specialist follow-up
  ▪ Patient understanding of "red flag" indicators of worsening condition and appropriate next steps

• Speed bumps to effective and efficient delivery of Care Transition
  ▪ Member outreach: pre vs post discharge
  ▪ Coordination between hospital and health plan
  ▪ Redundant care coordination activity
  ▪ Timely Access to PCP or specialist care.
Opportunities to improve Care transition

• Single point of hospital contact for CM team
• Single and shared discharge plan of care
• Enabling health plan contact with member pre discharge
• Clarity in hospital-health plan Care Coordination roles
Questions?