Parkview Health’s Population Health Journey

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Community Based Registered Nurse
Objectives:

• By the completion of the webinar the listener will be able to identify the work in development in Parkview Health’s high risk chronic disease and community based care:
  • How to identify high risk populations
  • Describe the correlation between chronic disease and community based care
  • Evaluate care strategies
  • Describe measurable outcomes
Parkview Regional Medical Center

Parkview Hospital

Parkview Whitley

Parkview Ortgo Hospital

Parkview Huntington

Parkview Noble

Parkview LaGrange

Parkview Behavioral Health

8 Hospitals
821 Beds
Annual Revenues: $1 billion
Inpatient Discharges: 35,266
Outpatient Registrations: 362,352
Service Area Population: 890,000
Co-workers: 8,000
Medical Staff: 870
“Real communities don’t just live with each other, they love each other.”
Sustaining Life

Life House provides immediate relief from hunger and homelessness. The Bible tells us whenever we feed the hungry, clothe the needy or help the poor, we’ve done it as unto the Lord. Life House lives out this biblical teaching every day. Here, transient men stay for the night or a few weeks, while the needy in our community find three free meals a day as well as clothing, hygiene products, referrals—or simply someone to listen.

BEDS

44+

IMMEDIATE HOUSING PROGRAM

Housing Program for men up to 30 days. Basic needs, case managers and ongoing spiritual support. Includes goal setting and referrals to other health and social service agencies. If The Rescue Mission determines a man needs more intensive services, he’s invited to enroll in one of the programs of Restoration House if eligibility requirements are met.

COMMUNITY MEALS PROGRAM

- More than 216,000 meals served each year.
- Breakfast, lunch and dinner open to Mission residents and the public 365 days a year.
- Special meals on Thanksgiving, Christmas and Easter. Free clothing and hygiene products as well as referrals to health and social service agencies.
Rescue Mission Key Statistics
2014

• Provided over 212,034 meals - residents and community members in need
• Provided over 56,436 nights of lodging
• Served more than 326 men, women, and children in our life changing ministries.
• Saw 604 reports of spiritual experiences
• Provided services for 149 children
• Had 129 men and women gain employment
• Had 156 men and women experience some form of life change in our life changing ministries.
Population Health - Alphabet Soup

The Buzz ...

- ACA
- ACO
- Clinical Integration
- HMO Risk
- Exchanges
- Payer Products
- Shared Savings
- Tiered Benefits
- Narrow Networks
Overview Clinical Integration Networks

- Clinical integrations networks ("CIN") are emerging across the country with goals that include:
  - Creating organized systems of clinically integrated care
  - Driving more members into organizations through value-based or narrow network contracts
  - Alignment strategy between hospitals and physicians
  - Managing patient leakage to influence quality and control costs
  - Creating contracts focused on reimbursement for quality (value-based care)
Progression of Risk Based Contracts

Progression of Risk-Based Contracts and Capabilities Required

<table>
<thead>
<tr>
<th>0-3 years</th>
<th>3-5 years</th>
<th>5-10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay for Performance</strong></td>
<td><strong>Care Coordination Fee/PMPM</strong></td>
<td><strong>Upside Shared Savings</strong></td>
</tr>
<tr>
<td>• Metric tracking, reporting</td>
<td>• Metric tracking, reporting</td>
<td>• Metric tracking, reporting</td>
</tr>
<tr>
<td>• Disease management, patient activation infrastructure</td>
<td>• Disease management, patient activation infrastructure</td>
<td>• Disease management, patient activation infrastructure</td>
</tr>
<tr>
<td>• Physician, other provider alignment</td>
<td>• Physician, other provider alignment</td>
<td>• Physician, other provider alignment</td>
</tr>
<tr>
<td>• Ability to share risk with other providers</td>
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<td>• Ability to share risk with other providers</td>
</tr>
<tr>
<td>• Utilization management</td>
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<td>• Utilization management</td>
</tr>
<tr>
<td>• Total cost-of-care measurement</td>
<td>• Stop-loss insurance</td>
<td>• Actuarial expertise</td>
</tr>
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</table>

**Downside Shared Savings**

<table>
<thead>
<tr>
<th><strong>Capitation</strong></th>
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<tbody>
<tr>
<td>• Metric tracking, reporting</td>
</tr>
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<td>• Disease management, patient activation infrastructure</td>
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<td>• Stop-loss insurance</td>
</tr>
<tr>
<td>• Actuarial expertise</td>
</tr>
</tbody>
</table>
Conflicting Healthcare Paradigms

- Continued pressure to bring down healthcare costs and reduce reimbursement (volume-based model)
- Shift to accountable care and value-based reimbursement tied to performance of services
### 2012 Mean Annual Expenditures per Individual by Percentage Group

<table>
<thead>
<tr>
<th>Individual Spender Tier</th>
<th>Spending per Person</th>
<th>Percent of Total Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 1%</td>
<td>$97,859</td>
<td>21.8%</td>
</tr>
<tr>
<td>Top 5%</td>
<td>$43,038</td>
<td>49.5%</td>
</tr>
<tr>
<td>Top 10%</td>
<td>$28,452</td>
<td>65.2%</td>
</tr>
<tr>
<td>Top 30 %</td>
<td>$12,954</td>
<td>89.6%</td>
</tr>
</tbody>
</table>

Proactively Identifying the High Cost Population

Insights from the Health Care Transformation Task Force

July 2015
## Age Distribution of Persistent High Spenders

<table>
<thead>
<tr>
<th>Age range (in years)</th>
<th>Percent or Persistent High Spender Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+</td>
<td>42.9%</td>
</tr>
<tr>
<td>45-64</td>
<td>40.1%</td>
</tr>
<tr>
<td>30-44</td>
<td>10.6%</td>
</tr>
<tr>
<td>18-29</td>
<td>3.1%</td>
</tr>
<tr>
<td>0-17</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

Proactively Identifying the High Cost Population
Insights from the Health Care Transformation Task Force
July 2015
Clinical profiles of Persistent High Spenders

Chart 1. Clinical profiles of Persistent High Spenders: Prevalence of Clinical Conditions

Figure 6. Common Conditions among Elderly High Spenders, 2006

- Essential Hypertension
- Disorder of Lipid Metabolism
- Diabetes Mellitus
- Arthropathies NEC/NOS
- Ill-Defined Heart Disease
- Mood Disorders
- Neurotic Disorders
- Cardiac Dysrhythmias
- Allergic Rhinitis
- Cataract
- Glaucoma

Percent with Condition

Proactively Identifying the High Cost Population
Insights from the Health Care Transformation Task Force
July 2015
Medically Complex

• Psycho-social barriers
• Medicaid - 60% of patients in the top 10% spender tier remain in that tier the following year
• Medicare one third in top 10% spender tier and 40% of patients in the top 5% spender tier have persistently high costs over two years
Episodic High Spending

- 37% of patients in top 10% spender tier become “reverters” drop out of spender tier
- Not good candidates for long-term chronic care management
End of Life

• 28% of Medicare spending, $170 billion, occurs in last six months of life.
• 11% of patient in top 5% spender tier die within 1 year
• 28% of patient in top 10% spender tier died within two years
Medicare/Medicaid Population

- 11% die in 1 year
- 28% die in 2 years
- Medicare 5% - 2 years
- Medicaid 60% Medicare 33% 2 years
Clinical Disease Registry is Key to Connection

- Clinical Disease Registry (CDR) supports Clinical Integration goals of connecting care, tracking clinical outcomes and comparing against evidence-based protocols.
Disease Registries in 2014

Do you use a disease registry to manage gaps in care across a population?

- **ALL 2014**
  - No: 35%
  - Yes: 65%

- **MOST WIRED 2014**
  - No: 24%
  - Yes: 76%

How is the majority of data populated?

- manually: 15%
- from practice-management data: 15%
- from a combination of electronic clinical and billing data: 14%
- from HIE or other multiorganizational effort: 56%

Source: 2014 Most Wired Survey
Data Sources for Risk Stratification

- Care Evolution - Historical
- Healthy Planet - Disease Based
- EPIC reports - ED, Admissions by payer
- Payer Sources - UR data
- Payer Sources - Claims data

Outcome Reporting
Rescue Mission at Risk Population

- Short Term program – work related
  - 2 weeks – multiple months
    - Stay longer than 2 weeks meet with nursing
- Long Term program – do not work
  - Connections program
    - See nursing immediately
- Parkview ED case management referrals
- Personnel referrals
- Care Advisor referrals
Living Environments
Care Advisor/Care Navigator
Scope of Service

PPG/Population Health Care Advisor will:

- Identify appropriate patients for services with PPG office staff and physicians
- Contact patient to assess understanding of health status and develop plan of care
  - Establish goals and interventions to achieve positive outcomes
- Coach on disease management needs
- Monitor adherence to prescribed medication
- Assist patient with navigating the health care system
- Conduct home visits to assess environment and social support/needs
- Accompany patient on office visits with patient to encourage compliance with plan of care
- Manage Referrals: medication assistance, dieticians, pharmacists, social work and other community resources
- Provide network steerage
- Facilitate follow-up appointments with provider
- Provide resources to assist the patient to reach his/her optimal state of health
- Encourage patient to have accountability for health care
- Encourage completion of routine health maintenance and disease specific care guidelines

Quarterly provider feedback to referring physician will be scheduled
Emergency Department Visits and Observation Care Advisor Services

- Observation Status discharges:
  - EPIC review to determine “severity” of the observation stay
    - Potential need to follow up
    - FU phone call
- Emergency Department Visits
  - Potentially avoidable admissions:
    - Call to see if ED issue has been resolved
      - Determine if an intervention is needed
      - Patients may need PCP follow up visit
        - Schedule appointment via the PPG Contact Center
  - Patients with frequent ED utilization
    - Review EPIC for a current “FYI” care plan
    - Contact patient to determine ED cycle triggers
      - Transfer care to Ambulatory Care Advisor if intervention is needed
  - Appropriate use of ED
    - Inquisitive interview of ED usage
      - Offer Walk In clinic option
      - PCP intervention – schedule appointment via Patient Contact Center
  - No “active” PCP provider
    - Schedule new patient appointment via Patient Contact Center
Key Components of Population Health Management

Key Elements of Population Health Management

- **Care Delivery**
  - Physicians at front line of care delivery across most specialties, sites of care

- **Care Planning**
  - Various levels of providers work with physicians to determine care plans, transitions

- **Care Coordination**
  - Communication between specialties essential to treating complex patients
Parkview Care Advisors

**PARKVIEW CARE PARTNERS’ APPROACH TO RISK CLASSIFICATION**

- **Catastrophic:** 1%
  - Integrated care management to deliver the right care, for the right person, at the right time and the right location.
  - No diagnosed chronic condition but with preventive service gaps.
  - Out of range biometric health factor(s).

- **High Risk:** 5 - 10%
  - Complex diseases, comorbidities
  - Chronic conditions with recent event(s), persistent gaps in care and/or out of range clinical values.

- **Rising Risk:** 15 - 35%
  - Conditions not under control
  - Focus on early detection and intervention.

- **Low Risk:** 60 - 80%
  - Minor conditions
  - Easily managed

Parkview’s care advisors work with patients in the “High Risk” category.
Care Advisor Team

- Intake Coordinator
- Social Work
- Nursing
- Medication assistance
- Analytics
Care Advisor Workflow

CARE ADVISOR WORK FLOW

INTAKE
Order
Disease Registry
Insurance Registry

IF Order
Notify MD of non engagement

Patient engagement

STOP

Patient Assessment of Needs

Acute Care Discharge

Medication Reconciliation
PCP visit within 7-14 days
Warning signs of disease
Social assessment

Yes

Social Assessment Flow chart

No

Issues

Resolved in one encounter

Yes

Close encounter

No

Graduate

30 Day acute care readmission

Hospital visit - reason for readmission

ED visits in one month

Phone Encounter Medication Reconciliation
PCP visit
Access to care

Yes

Issues resolved

Close encounter

No

Issue resolved

Log

ED visit

Phone Encounter Medication Reconciliation
PCP visit
Access to care

Yes
Care Management Assessment and Intervention Flow
### Care Advisor Story of Care

Plan of care developed with patient to achieve the above goals. Coaching continued with patient.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Beginning of Engagement</th>
<th>As of 4-1-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>218</td>
<td>181</td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td>203</td>
<td>159</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>328</td>
<td>193</td>
</tr>
<tr>
<td>A1C</td>
<td>8.1</td>
<td>7.0</td>
</tr>
<tr>
<td>FBS</td>
<td>200s</td>
<td>130s</td>
</tr>
<tr>
<td>Humalog</td>
<td>15u</td>
<td>None</td>
</tr>
<tr>
<td>Lantus</td>
<td>45u</td>
<td>10u</td>
</tr>
<tr>
<td>Exercise</td>
<td>Irregular</td>
<td>6 days week – cardio and weights</td>
</tr>
</tbody>
</table>
Care Advisor Story of Care

- 70 year old female
- Heart disease
- Lives with 88 year old mother
- Last few months 7 hospital admissions and CDU stays
- Skilled nursing stays
- Depression and frustration – living with mother
- Interventions in Care Advisor:
  - Depression assessment and coping mechanisms
  - Took patient to assess “Room and board assistance program”
  - Assisted Living placement
  - Behavioral Health evaluation
Healthy Planet Care Plan

Longitudinal Plan of Care report
You Might Want To...

Read your messages. You have 29 new messages.

View instructions for your appointment on Wednesday, August 5, 2015 with PRMC Radiation Oncology.

View your test results.  Send a message to your doctor's office.  Refill your medications.  Review your health summary.

MyChart News for You

Here is a link to our Proxy Access Updates MyChart Proxy Access Card.

Here is a link to our searchable Provider Directory.

Do you have a question about a recent bill or your insurance? Just Ask Customer Service!

Using the MyChart Message Center, you've been able to get medical advice from your clinic, but now you can also contact customer service. This new feature available through MyChart allows you to contact the clinic regarding non-medical concerns.

7 Tips for healthy living
- Move More
- Cut Fat
- Reduce Stress
- Wear Your Seat Belt
- Floss Your Teeth
- Keep a Positive Mental Outlook
- Drink Plenty of Water

7 Super foods for your health
- Salmon
- Yogurt
- Nuts
- Dark green leafy vegetables
- Beans
- Oats
- Blueberries
My Chart Patient Portal

The patient portal advances efficiency and engagement.

The patient portal is key to comprehensive virtual care. It enables providers to share information with patients before and after visits, and it creates a clear and easy access point for patients to contact providers.

In Spite of Patient Demand...

73%
Percentage of patients who would use portals to improve their access to care

50%
Percentage of patients who would consider switching to a physician who offered a patient portal

...Portal Adoption Still Lagging

5.5%
Percentage of patients who email with physicians

<25%
Percentage of patients registered for portal among majority of providers who have one
<table>
<thead>
<tr>
<th>ALL CLEAR</th>
<th>GREEN ZONE MEANS...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• No cough, wheeze, chest tightness, or shortness of breath during the day or night</td>
</tr>
<tr>
<td></td>
<td>• No decrease in your ability to maintain normal activity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CAUTION</th>
<th>YELLOW ZONE MEANS...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sputum (phlegm) that increases in amount or color or becomes thicker than usual</td>
<td></td>
</tr>
<tr>
<td>Increased cough or wheezing even after you take your medication and it has time to work</td>
<td></td>
</tr>
<tr>
<td>Increased swelling of ankles or feet</td>
<td></td>
</tr>
<tr>
<td>Increased shortness of breath with activity</td>
<td></td>
</tr>
<tr>
<td>Weight loss or gain of 3 lbs.</td>
<td></td>
</tr>
<tr>
<td>Fever of 100.5°F oral or 99.5°F under your arm</td>
<td></td>
</tr>
<tr>
<td>Increased number of pillows needed to sleep or need to sleep in chair</td>
<td></td>
</tr>
<tr>
<td>Anything else unusual that bothers you</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMERGENCY</th>
<th>RED ZONE MEANS...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unrelieved shortness of breath</td>
<td></td>
</tr>
<tr>
<td>Unrelieved chest pain</td>
<td></td>
</tr>
<tr>
<td>Wheezing or chest tightness</td>
<td></td>
</tr>
<tr>
<td>Increased or irregular heart beat</td>
<td></td>
</tr>
<tr>
<td>Change in color of your skin, nail beds, or lips to gray or blue</td>
<td></td>
</tr>
<tr>
<td>Mental changes</td>
<td></td>
</tr>
<tr>
<td>Chest pain or pain that worsens when you breathe or cough</td>
<td></td>
</tr>
</tbody>
</table>

| | |
| | 24 hour phone number is: ________________ |
| | (Please notify your Home Care Nurse if you contact or go see your physician) |

| | |
| | Primary Physician: ________________ |
| | Phone Number: ________________ |
| | (Please notify your Home Care Nurse if you go to the emergency room or are hospitalized) |

CALL 9-1-1 IMMEDIATELY!
Community Resources
Person focused care

- Innovative approaches to prevention
  - Social
  - Environmental
  - Psychological
  - Cultural
- Faith based organizations
- Aging networks
- Home care based care
MEDICAL CARE

Question: What do you do if you need to go to a doctor or hospital for pain or other medical problems?

Answer: Tell the doctor or nurse who examines that you are in recovery!

Why? Most doctors and nurses these days will understand that a person in recovery must not take certain medications such as narcotic pain killers, certain cough syrups (with alcohol and codeine), muscle relaxants or tranquilizers. So make sure that you tell any medical professional who is treating you that you are in recovery. Explain to them that you cannot take any mood/mind altering substances as it will endanger your recovery and may result in a positive drug test. If you forget and your doctor gives you a prescription for a drug you are not allowed to take, you must contact that doctor, tell them you are in recovery and get a new prescription.

COMMON MEDICATIONS

Common medications that you should not take while in recovery include:

All Cough Medicine with Codeine, Alcohol or Dextromethorphan.

All Narcotic Analgesics (pain killers) Common brands include: Darvon or Darvocet (also known as Propoxyphene), Percocet or Percodan (also known as Oxycodone), Tylenol 3 (with Codeine), Vicodin (also known as Hydrocodone)

All Benzodiazeines (anti-anxiety drugs) Common brands include: Ativan (also known as Lorazepam), Librium (also known as Chlordiazepoxide), Valium (also known as Diazepam), Xanax (also known as Alprazolam)

All Amphetamines such as Adderall, Ritalin, Vyvanse, Concerta

Muscle relaxers such as Flexeril, Soma, Zanaflex

Antihistamines (Atarax, Vistaril) and Allergy/Cold Medication containing any of the following compounds: Pseudoephedrine, Phenylephrine, Dextromethorphan, Doxylamine

Examples: Actifed, Benadryl, Bexylin, Comtrex, Contact, Coricidin D, DayQuil, Dimetapp, Neo-Synephrine, NyQuil, Robitussin Sinus, Sine-Off, Sinutab, Sudaefed, Tylenol Cold, Vicks 44M, Zyrtec-D

READ YOUR LABELS AND ASK QUESTIONS

IMPORTANT POINTS TO REMEMBER
• **PERSONAL RESPONSIBILITY:**
  You, and you alone, are responsible for what goes in your body. Don’t come with an explanation that illegal or prohibited drug use is anyone’s fault but yours. **NO EXCUSES!**

• **OTHER PEOPLE’S MEDICINE:**
  Never, ever take any medication that has been prescribed for someone else (your mother, brother, boy/girlfriend etc.). Using medication prescribed to another person is a violation of federal law.

• **WHEN YOU ARE NOT SURE:**
  When in doubt, **DON’T TAKE IT!** Ask your doctor, treatment provider or case manager. If you have any questions at all about any medication you are taking; **ASK!**

• **READ THE LABEL:**
  Read the label when you buy cough syrup, cold medicine, mouthwash or other over-the-counter liquids. **MAKE SURE THEY DO NOT CONTAIN ALCOHOL!** Listerine contains alcohol. Dayquil contains alcohol. There are over-the-counter products available that do not contain alcohol.

• **POPPY SEEDS:**
  **Never, ever eat poppy seeds or “everything bagels”** because they can give a false positive for morphine. Don’t every try to explain away a positive drug test by saying you ate poppy seeds. **IT WILL NOT WORK!**

• **MAKING RECOVERY MORE DIFFICULT:**
  Taking prohibited drugs can only make your recovery harder.

• **IN CASE OF EMERGENCY:**
  Carry this notice in your wallet or purse so you can show it to any medical personnel in case of an emergency or when you go to the doctor.

Signature acknowledges that you have received a copy of this document and a copy will be placed in your file.

______________________________  ______________________  ______________________
Signature of Participant Date Signature of witness

Print Name Participant__________________________________________

Print Name/Title Witness__________________________________________
Rescue Mission Needs

• Community Partners
  • Behavioral Health
  • Medications
  • Dental
  • Housing
  • Clinics
  • Insurance Coverage
  • Transportation
  • Phone contact for appointments
Rescue Missions follow up clinic care

- Open door visits
  - Blood pressure checks
  - Oxygen saturations
  - Blood sugars
  - Defib. Vest
  - Dressing changes
  - MD appointments
  - Medication – pill boxes
Rescue Mission Case Study
Challenges

- Inpatient/community communication
- Physician communication
- Physician Access
- Behavioral Health
- Indiana insurance communication
Hip 2.0 MD Wise – Plan Choices

**Hoosier Healthwise**
A health plan for children under the age of 19.

**Healthy Indiana Plan (HIP)**
A health plan for uninsured adults ages 19–64.

**Hoosier Care Connect**
Hoosier Care Connect is a new coordinated care program for Indiana Health Coverage Programs (IHCP) members age 65 and over, or with blindness or a disability who are residing in the community and are not eligible for Medicare.

**Indiana Care Select**
A health plan for people who have special health needs or benefit from specialized attention.

**MDwise Marketplace**
A health plan for individuals and families in need of affordable health insurance.

HIP 2.0 now includes HIP Link, a new **premium-assistance program** that helps eligible, working Hoosiers afford their employer-sponsored health insurance plans. Employees who qualify for HIP Link must have a household income at or below approximately 138 percent of the federal poverty level ($16,436 per year for an individual and $33,865 for a family of four) and meet HIP eligibility requirements.

**Not sure what plan you have? Call customer service.**
CLINICAL OUTCOMES
## Rescue Mission Volumes

<table>
<thead>
<tr>
<th>Indicator</th>
<th>June 2015</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td># appts. to medical home</td>
<td>17</td>
<td>148</td>
</tr>
<tr>
<td># connections to resources</td>
<td>54</td>
<td>435</td>
</tr>
<tr>
<td># new residents</td>
<td>43 new/171 unique</td>
<td>217 new/609 unique</td>
</tr>
<tr>
<td># people seen within 2 weeks of programing</td>
<td>17 appointments</td>
<td>69</td>
</tr>
<tr>
<td># who lack providers</td>
<td>7</td>
<td>108</td>
</tr>
<tr>
<td># requiring medication assistance</td>
<td>10</td>
<td>61</td>
</tr>
<tr>
<td># actual touches</td>
<td>237 touches (69 men)</td>
<td>1583</td>
</tr>
</tbody>
</table>
Behavioral Health

Medical and Behavioral Illness Comorbidity

Medical Conditions

Behavioral Health Conditions

68% of adults with behavioral health conditions also have medical conditions

29% of adults with medical conditions also have behavioral health conditions

Primary care behavioral health screenings are your first opportunity to address behavioral health needs. If you invest in a way to identify problems early on, you can improve care planning and avoid unnecessary ED utilization or hospitalization down the road.
## Rescue Mission
Clinical Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>June 2015</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease in ER visits</td>
<td>15 visits (1 man x 3, 2 men x 2) 4 admitted</td>
<td>130</td>
</tr>
<tr>
<td># ER visits related to medication noncompliance</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>CIT calls</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>Program vs. Life House</td>
<td>6 programming (1 man x 3)/9 no programming</td>
<td>16 programming/94 no programming</td>
</tr>
<tr>
<td>Cholesterol within normal range</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>
Rescue Missions
Outcomes needs

- Rescue Mission case managers better communication and identification of needs
- Men with medical issues identified to see nursing next day
- Hand off from other facilities to the Mission (Mental health, hospital, DOC etc)
- Increased health education access
Patient Perception of Illness
Care Advising outcomes
June /July 2015  N = 266

Advanced Directives

- Yes: 96%
- No: 4%
Medication Related issues

Interventions:
Physician contact = 10
Medication reminders = 5

Medication Assistance interventions:
Physician communication
Alternative selections
Medication Assistance

6-8 hours
Sample of Risk/Intervention

Diabetes Risk N = 12
June - July

Interventions:
A1C related = 7
General Mgt = 2
Eye care = 1
Foot Care = 3
100% Intervention

Fall Risk Assessment N = 29
June - July

Interventions:
Education = 19
PT/OT/fall clinic referral = 2
72% intervention
Post Acute Care

Nationally, 14% of patients in the acute care setting are discharged to a SNF, although that number grows to 23% when excluding patients younger than 65 years of age and to 28% when accounting for patients with lengths of stay above six days. Readmission penalties and moves toward bundled payment for full episodes of care will require hospitals to more actively oversee services their patients receive after transfer to a SNF. A number of the most common diagnoses (eg, congestive heart failure, joint replacements) related to SNF admissions are among targets for penalties and risk-sharing projects.

Hospital Discharge Disposition by PAC Site
US Market, 2014

- <1% LTACH
- 3% Transfer
- Home Health 14%
- Hospice 2%
- IRF 2%
- SNF 14%
- Other 3%
- 62% Home

Top 10 Reasons for SNF Admissions, by Discharge DRG

- Major joint replacement or reattachment of lower extremity, without MCC
- Septicemia or severe sepsis without mechanical ventilation 96+ hours, with MCC
- Kidney and urinary tract infections, without MCC
- Hip and femur procedures except major joint, with CC
- Heart failure and shock, with MCC
- Heart failure and shock, with CC
- Simple pneumonia and pleurisy, with CC
- Intracranial hemorrhage or cerebral infarction, with CC
- Renal failure, with CC
- Septicemia or severe sepsis without mechanical ventilation 96+ hours, without MCC

Note: Percentages may not total 100% due to rounding.
CC = complications and comorbidities; LTACH = long-term acute care hospital; MCC = major complications and comorbidities.
Sources: NIS Database, 2014; Sg2 Performance Database, 2014; Sg2 Analysis, 2014.
Long Term Care Preferences

- Avg Readmit Rate
- Avg In-House Wound Rate
- Avg Medicare ALOS (Days)
- Avg Falls with Injury Rate
- Avg Nosocomial Infection Rate
- Avg MA Plans ALOS (Days)
Post Acute Considerations

- **Living Arrangements:**
  - Private duty nursing
  - Custodial care
  - Adult day care
  - Assisted Living
  - Memory Care
  - Long term care

- **Skilled Care:**
  - Home Health Care
  - Skilled Nursing Facility
    - Procedures
    - Rehabilitation
  - Hospice

- **Alternative Options:**
  - Tele-monitoring
  - Palliative Care
9. Secure upfront financing for population health infrastructure

**Population Health Requires Extensive Investment**

External Funding Helps Ease the Burden

**An Undeniable Financial Burden**

$12M
AHA’s¹ estimate of ACO start-up costs for a 5-hospital system

$14.1M
AHA’s estimate of ongoing annual ACO costs for a 5-hospital system

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**Common Areas of Investment**

- Care management staffing
- Disease Registry
- Electronic Medical Record
- Post-Acute Care network
- Patient-Centered Medical Home
- Management resources
- Legal and consulting support
- Predictive analytics
- Health Information Exchange
- PCP recruitment
- Specialist network
- Patient engagement tools

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¹AHA: American Hospital Association
Review

• How to identify high risk populations
• Describe the correlation between chronic disease and community based care
• Evaluate care strategies
• Describe measurable outcomes