TRANSITIONING TO VALUE-BASED CARE

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Lake Region HEALTHCARE

OBJECTIVES

- Define Accountable Care Organizations
- Understand the impact of prevention and chronic disease management on the patient's quality of life and care experience as well as the health care organization's bottom line
- Identify issues and challenges of an ACO
- Explain the key role of technology in providing better care while lowering costs

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PATIENT PROTECTION AND AFFORDABLE CARE ACT

1. Achieve near-universal coverage
2. Improve fairness, quality and affordability of insurance coverage
3. Improve health care value, quality and efficiency while reducing wasteful spending and making the system more accountable
4. Strengthen primary care access
5. Strategic investments in public health

Source: Rosenbaum, S. (2011). The patient protection and affordable care act: implications for public health policy and practice. JAMA

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MEDICARE SHARED SAVINGS PROGRAM

- Established as part of the ACA
- Medicare delivery system reform initiative
  - Volume-Based → Value-Based
- Goal is to achieve the Triple Aim
  - Decrease Cost
  - Improve Care and Quality
  - Improve Population Health

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ACCOUNTABLE CARE ORGANIZATIONS

- Population-based Model of care and payment
- Group of doctors, hospitals and other health care providers, who come together voluntarily to provide coordinated, high-quality care to their Medicare patients to help them deliver better care at lower cost
- Goal: Patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors

CARAVAN HEALTH

- ACO Investment Model (AIM)
  - Pre-paid shared savings model
  - Encourage new ACOs to form in rural and underserved areas
  - If successful, Medicare shares up to 50% of savings
  - If not successful, no penalty
  - Existing reimbursement stays the same
- Minimum of 5,000 attributed Medicare beneficiaries
- MN Rural ACO
  - 2016: 4 facilities
  - 2017: 7 facilities

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FOCUS

- Prevention
- Chronic Care Management
- Transitional Care Management
- Coding and Documentation
- Quality

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PREVENTION & CHRONIC CARE MANAGEMENT

- Care coordination
- Million Hearts Initiative
  - Prevent 1 Million heart Attacks and Strokes by 2017
    - Improving the quality of care for the ABCS
      - Aspirin Use
      - Blood Pressure Control
      - Cholesterol Management
      - Smoking Cessation
- Minnesota Community Measures
  - Hypertension
    - Decreasing Gaps
  - Diabetes
    - Clinical Improvement Project 2017
- Annual Wellness Visits
  - Focusing on Dual Visits
- Clinical Health Coach
  - Motivational Interviewing
    - Partnerships for Health Grant

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CARE TRANSITION

- Transitional Care Management
  - Discharge Planning Committee
    - Starts at admission
      - Decrease in Gaps
    - 7 P's
    - Care Coordination Referral
  - Prompt In-person Office Visit
    - Follow- Up Phone Call

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CODING & DOCUMENTATION

- Chronic Care Management
  - Continues to require 20 minute minimum per month
    - New regulations
      - Billing Codes (99490, 99487, 99489, G0506)
- Transitional Care Management
  - Follow up phone call require within 48 business hours following discharge
  - Follow up face to face visit with set time frame depending on severity
    - High Complexity- 7 days
    - Moderate Complexity- 14 days

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

*(Annual Wellness Visit [AWV], Initial Preventive Physical Examination [IPPE], Transitional Care Management [TCM], or Other Qualifying Face-to-Face Evaluation and Management [E/M])

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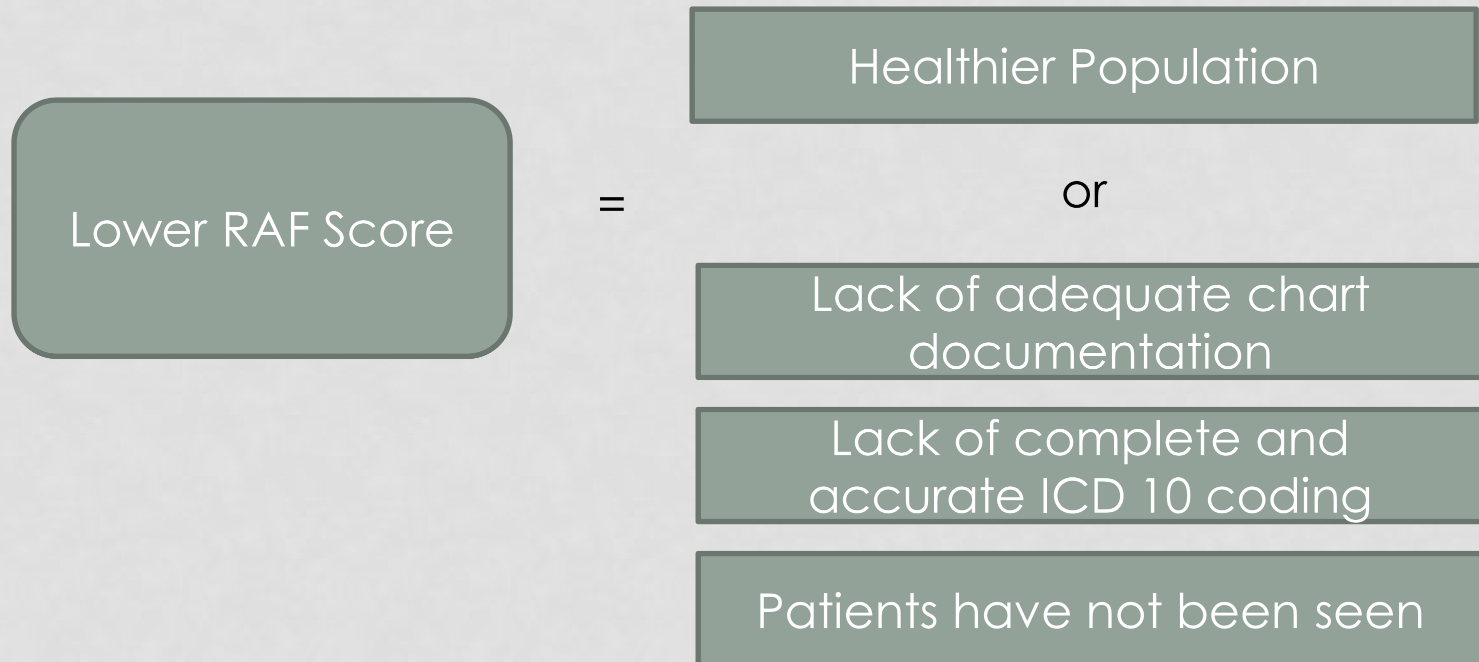
CODING & DOCUMENTATION

- Risk Adjustment Factor (RAF) – identifies the health status of patient population and drives reimbursement



Source: Banner Health Network

OPPORTUNITIES

- Improve patient care delivery and quality of care
- Improve financial performance
- No upfront investment – No financial risk
- Work with and learn from other organizations

CHALLENGES

- Change
- EHR and Data Analytics
- Coding and Documentation
- MACRA
- Uncertain future of health care

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HIE

- Current Status
  - Secure Direct Messaging
- In process
  - Testing e-Interact module within PointClickCare for transition from nursing home to hospital
  - ER reports this is providing them with information they need

Nursing Home to Hospital Transfer Form

Resident Name *(last, first, middle initial)* ______
Language: ☐ English ☐ Other ______ Resident is: ☐ SNF/rehab ☐ Long-term
Date Admitted *(most recent)* ___/___/___ DOB ___/___/___
Primary diagnosis(es) for admission ______

Sent To *(name of hospital)* ______
Date of transfer ___/___/___
Sent From *(name of nursing home)* ______ Unit ______

Contact Person ______
Relationship *(check all that apply)*
☐ Relative ☐ Health care proxy ☐ Guardian ☐ Other
Tel (____) ______
Notified of transfer? ☐ Yes ☐ No
Aware of clinical situation? ☐ Yes ☐ No

Who to Call at the Nursing Home to Get Questions Answered
Name / Title ______
Tel (____) ______

Primary Care Clinician in Nursing Home ☐ MD ☐ NP ☐ PA
Name ______
Tel (____) ______

Code Status ☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Comfort Care Only ☐ Uncertain

Key Clinical Information
Reason(s) for transfer ______
Is the primary reason for transfer for diagnostic testing, not admission? ☐ No ☐ Yes Tests: ______
Relevant diagnoses ☐ CHF ☐ COPD ☐ CRF ☐ DM ☐ Ca *(active treatment)* ☐ Dementia ☐ Other ______
Vital Signs BP ______ HR ______ RR ______ Temp ______ O2 Sat ______ Time taken *(am/pm)* ______
Most recent pain level ______ (☐ N/A) Pain location: ______
Most recent pain med ______ Date given ___/___/___ Time *(am/pm)* ______

Usual Mental Status:
☐ Alert, oriented, follows instructions
☐ Alert, disoriented, but can follow simple instructions
☐ Alert, disoriented, but cannot follow simple instructions
☐ Not Alert

Usual Functional Status:
☐ Ambulates independently
☐ Ambulates with assistive device
☐ Ambulates only with human assistance
☐ Not ambulatory

Additional Clinical Information:
☐ SBAR Acute Change in Condition Note included
☐ Other clinical notes included
For residents with lacerations or wounds:
Date of last tetanus vaccination *(if known)* ___/___/___

Devices and Treatments
☐ O2 at ____ L/min by ☐ Nasal canula ☐ Mask (☐ Chronic ☐ New)
☐ Nebulizer therapy; (☐ Chronic ☐ New)
☐ CPAP ☐ BiPAP ☐ Pacemaker ☐ IV ☐ PICC line
☐ Bladder (Foley) Catheter (☐ Chronic ☐ New) ☐ Internal Defibrillator
☐ Enteral Feeding ☐ TPN ☐ Other ______

Isolation Precautions
☐ MRSA ☐ VRE
Site ______
☐ C.difficile ☐ Norovirus
☐ Respiratory virus or flu
☐ Other ______

Allergies
______

Risk Alerts
☐ Anticoagulation ☐ Falls ☐ Pressure ulcer(s) ☐ Aspiration ☐ Seizures
☐ Harm to self or others ☐ Restraints ☐ Limited/non-weight bearing: (☐ Left ☐ Right)
☐ May attempt to exit ☐ Swallowing precautions ☐ Needs meds crushed
☐ Other ______

Personal Belongings Sent with Resident
☐ Eyeglasses ☐ Hearing Aid
☐ Dental Appliance ☐ Jewelry
☐ Other ______

Nursing Home Would be able to Accept Resident Back Under the Following Conditions
☐ ER determines diagnoses, and treatment can be done in NH ☐ VS stabilized and follow up plan can be done in NH
☐ Other ______

Additional Transfer Information on a Second Page:
☐ Included ☐ Will be sent later

Form Completed By *(name/title)* ______ **Signature** ______
Report Called in By *(name/title)* ______
Report Called in To *(name/title)* ______ Date ___/___/___ Time *(am/pm)* ______

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Nursing Home to Hospital Transfer Form *(additional information)*

Not critical for Emergency Room evaluation; may be forwarded later if unable to complete at time of transfer.
RECEIVER: PLEASE ENSURE THIS INFORMATION IS DELIVERED TO THE NURSE RESPONSIBLE FOR THIS PATIENT

Resident Name *(last, first, middle initial)* ______
DOB ___/___/___ Date transferred to hospital ___/___/___

Contact at Nursing Home for Further Information
Name / Title ______
Tel (____) ______

Social Worker
Name ______
Tel (____) ______

Family and Other Social Issues *(include what hospital staff needs to know about family concerns)* ______

Behavioral Issues and Interventions
______

Primary Goals of Care at Time of Transfer
☐ Rehabilitation and/or Medical Therapy with intent of returning home
☐ Chronic long-term care
☐ Palliative or end-of-life care
☐ Receiving hospice care ☐ Other ______

Treatments and Frequency *(include special treatments such as dialysis, chemotherapy, transfusions, radiation, TPN)*
______

Diet
Needs assistance with feeding? ☐ No ☐ Yes
Trouble swallowing? ☐ No ☐ Yes
Special consistency *(thickened liquids, crush meds, etc...)*? ☐ No ☐ Yes
______
Enteral tube feeding? ☐ No ☐ Yes *(formula/rate)* ______

Skin/Wound Care
Pressure Ulcers *(stage, location, appearance, treatments)*
______

Immunizations
Influenza:
Date ___/___/___
Pneumococcal:
Date ___/___/___

Physical Rehabilitation Therapy
Resident is receiving therapy with goal of returning home? ☐ No ☐ Yes
Physical Therapy: ☐ No ☐ Yes
Interventions ______
Occupational Therapy: ☐ No ☐ Yes
Interventions ______
Speech Therapy: ☐ No ☐ Yes
Interventions ______

ADLs Mark I = Independent D = Dependent A = Needs Assistance
Bathing ______ Dressing ______ Transfers ______
Toileting ______ Eating ______
☐ Can ambulate independently ______
☐ Assistive device *(if applicable)* ______
☐ Needs human assistance to ambulate ______

Impairments – General
☐ Cognitive ☐ Speech ☐ Hearing
☐ Vision ☐ Sensation
☐ Other ______

Impairments – Musculoskeletal
☐ Amputation ☐ Paralysis ☐ Contractures
☐ Other ______

Continence
☐ Bowel ☐ Bladder
Date of last BM ___/___/___

Additional Relevant Information ______

Form Completed By *(name/title)* ______
If this page sent after initial transfer: Date sent ___/___/___ Time *(am/pm)* ______
Signature ______

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- Future
  - Creating portals for each partner to place documents that would be of value to the community care team

  - Patient authorizes providers they want to access the portal

Minnesota Department of Human Services

PHR for LTSS *Demo*

Minnesota's Personal Health Record for Long Term Services and Supports Demonstration (funded by a CMS TEFT Grant)

Otter Tail PHR Data Views

DRAFT, updated 11/15/2016

HIE

- eLTSS Input
  - Federal demonstration with 9 states
  - Identifying data elements to create standards for Long Term Services and Supports
    - Demographics, Contact Information, Race/Ethnicity, AD, Residence, Community Support, Medications, Health & Wellness Information, ADLs/IADLs, etc

- Lessons Learned
  - EHRs do not capture some of the elements in a manner to populate this document
  - Until standards are finalized, vendors are not willing to change the product

ANY QUESTIONS ?