At Home: Comprehensive Care of the Frail Elderly

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December 10, 2013

Presentation Objectives

- Develop, both culturally and operationally, an on-demand clinical model to respond to changes in clinical status.
- Utilize real-time analytics to coordinate care and identify patients in need of higher-intensity services.
- Leverage community paramedicine to assist with patient evaluation and triage during off-hours.
- Discuss the future use of advanced illness programs to manage the transition from volume to value
At a Glance: North Shore-LIJ Health System

NSLIJ Health System

- 16 hospitals
- 3 SNFs
- 400 ambulatory physician practices
- Emergency Medical Services
- Home Care Agency
- Hospice Care Network (affiliated)
- Feinstein Institute for Medical Research
- Center for Innovation and Learning, and Patient Safety Institute
- NSLIJ Hofstra School of Medicine

NSLIJ Care Solutions

- Care management Organization
- Helping NSLIJ make the switch from the "illness business" to "the health business"
- New entity to coordinate the resources within the Health System as we take on risk as an insurance company
- Focus on population management programs, such as Advanced Illness Management

NSLIJ CareConnect

- President – Alan Murray
- First provider-owned plan in New York
- Insurance license approved July 2013
- Enrolling individuals, families, and small and large business on Long Island, Queens, Staten Island, and Manhattan
- Available on the New York Health Benefit Exchange
- Emphasis on customer service and patient experience
Clinical Scenario

Clinical Imperative
The Clinical Imperative

- **Advance Directive**
- **Advance Care Planning**

<table>
<thead>
<tr>
<th>PHASE 1</th>
<th>PHASE 2</th>
<th>PHASE 3</th>
<th>PHASE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy or with reversible illness</td>
<td>Early onset, chronic conditions</td>
<td>Progressive, frequent complications</td>
<td>Hospice eligible</td>
</tr>
</tbody>
</table>

Disease Progression

Current

Chronic and Curative Care

Palliative Care

Hospice Care

Source: Advanced Illness Management Strategies, Part 1, American Hospital Association, August 2012.

The Financial Imperative

- Multiple hospitalizations, overtreatment, and “care transition” add up
- 5% (Tier 3 A) account for 50% of total costs

**Tier 3A Patients:**
This is who we need to target!

Clinical + Financial Imperative = Opportunity

Program Gap

CHRONIC DISEASE Case Management Medical Homes 2-20 Years

HOSPICE < 6 months

18-24 months

Advanced Illness Program

North Shore-LIJ House Calls, Advanced Illness Management’s foundational program, provides care to frail elderly patients with multiple chronic illnesses and functional impairments.

- Over 900 patients across Queens, Nassau and Suffolk
- Care team:
  - 7 medical doctors, 3 nurse practitioners, 2 social workers, 4 medical coordinators and administrative leadership
Clinical Team

Clinicians
- Establish relationship with new patients
  - Evaluation visit and 2-week follow-up visit
- Regular visits at clinically appropriate intervals
- Urgent same- and next-day visits
- 24/7 telephonic response:
  - Rotate “on call” coverage every night and weekend
  - Rotate NP “on call” coverage in the office M-F, 9-4:30PM
  - Remote access to EMR at all hours
- Social workers assist with psychosocial complexities

Support Team

Administrative Support
- Intake Nurse
  - Manages referrals and intake paperwork
- Medical Coordinators:
  - Schedule appointments and optimize providers’ calendar
  - Answer phone calls from patients/families and attend to administrative patient needs
  - Transfer clinical questions to providers
- Biller:
  - Answers billing questions and optimizes revenue capture
Patient Eligibility

- Homebound
- Prioritize referrals for patients by severity of medical necessity:
  - Referrals from hospital or hospice
  - Uncontrolled symptoms
  - No relationship with a primary care provider

Advanced Illness Patients

Demographics:
- Average Age: 85 yrs
- Gender:
  - Female: 72.4%
  - Male: 27.6%

Top 10 HCC Dx Condition Categories

<table>
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<tr>
<th>Condition</th>
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<td>Diabetes</td>
<td>25%</td>
</tr>
<tr>
<td>Protein-Calorie Malnutrition</td>
<td>24%</td>
</tr>
<tr>
<td>Decubitus Ulcer of Skin</td>
<td>24%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>17%</td>
</tr>
<tr>
<td>Specified Heart Arrhythmias</td>
<td>17%</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>14%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>12%</td>
</tr>
<tr>
<td>Ischemic or Unspecified Stroke</td>
<td>12%</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>12%</td>
</tr>
<tr>
<td>Parkinson's and Huntington's Diseases</td>
<td>9%</td>
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Independence at Home

- Created by Affordable Care Act as part of CMMI
- Shared savings model
- Rewards based on quality and utilization
- Home-based primary care teams directed by physicians and nurse practitioners

Independence at Home

- Follow-up within 48 hours after hospital admission, hospital discharge, and ED visits
- In-home medication reconciliation within 48 hours of hospital discharge and ED visits
- Annual documentation of patient preferences
- All-cause hospital readmissions within 30 days
- Hospital admission rate for ambulatory care sensitive conditions
- ED visit rate for ambulatory care sensitive conditions
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Care Team Engagement

Twice weekly meetings discussing significant patient events
- Reinforcement of shared vision and values
- Emphasis on return of calls same day
- Emphasis of reorganizing patient schedules to accommodate patient with urgent needs
Patient engagement

- Education of our on demand model
- Expectations that we will contact them or be contacted if they are admitted to hospital or ED

Clinician engagement

- Structured intake process with patients
  - MOLST and health care proxy discussed at first meeting with patient
  - Individual consent forms done by providers with patients or their health care proxies
  - Emphasis on shared decision making from day 1
MOLST

Medical orders for Life Sustaining Treatment

- CPR or allow natural death
- Treatment guidelines
- Mechanical ventilation
- Feeding tube
- IV fluids
- Antibiotics
- Keep at home or hospitalize

Community Paramedicine
Community Paramedicine

• Q4 2012 integration of call center with EMS
  - Calls from patients to our office are answered by EMS dispatch

• House Calls Providers credentialed as On Line Medical Control (OLMC) physicians
  - Can provide medical orders to paramedics, and orders to treat, orders to leave the patient home

• Paramedics provided Geriatric Training to address the needs of the frail elderly
  - Sensitive to patient wishes and MOLST

Community Paramedic Pilot

• Hipaa compliant video teleconference
Community Paramedic Pilot

Initial results
• 21 calls
• Only 1/3\textsuperscript{rd} transported to the ED
• Average response time
  – 25 minutes
• Average total time on scene
  – 63 minutes

Select Cases
• Hypertensive urgency
  – BP 214/130
  – Improved with IV labetolol
• Change in mental status
  – Symptomatic hypoglycemia
  – Improved with IV dextrose
• Shortness of breath
  – Improved with albuterol nebulizer
Results

- Care coordination
- Advanced Care planning
- LOS
- Admission Rate
- Deaths at home
- Patient satisfaction

Care Coordination

Post-Admission Contact

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Hospital Admissions</th>
<th>Post-Discharge Med Rec</th>
<th>Percentage Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 2012</td>
<td>94</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Q4 2012</td>
<td>108</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Q1 2013</td>
<td>109</td>
<td>100%</td>
<td>79%</td>
</tr>
<tr>
<td>Q2 2013</td>
<td>132</td>
<td>100%</td>
<td>88%</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>144</td>
<td>100%</td>
<td>85%</td>
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Care Coordination

Post-Discharge Medication Reconciliation

- Post-Discharge Med Rec Within 48 Hrs
- Percentage Met

Advance Care Planning

MOLST Questions Answered, Q3 2013

Percentage without question answered  Percentage with question answered

- Resuscitation Instructions: 43% 86%
- Intubation & Mechanical Ventilation: 46% 46%
- Treatment Guidelines: 46% 54%
- Hospitalization: 46% 50%
- Artificial Nutrition: 50% 49%
- Antibiotics: 50% 49%
A 37% reduction in hospital admissions after coming on to the program
Subset of 140 sickest patients new to program in the last year

Outcomes: Hospital LOS

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<th>Q1 2013</th>
<th>Q2 2013</th>
<th>Q3 2013</th>
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<tr>
<td>Admissions</td>
<td>110</td>
<td>114</td>
<td>133</td>
<td>144</td>
</tr>
<tr>
<td>Avg LOS (Days)</td>
<td>8.61</td>
<td>7.79</td>
<td>6.86</td>
<td>7.28</td>
</tr>
<tr>
<td>Avg LOS Reduction</td>
<td>0.82</td>
<td>1.11</td>
<td>(0.42)</td>
<td></td>
</tr>
<tr>
<td>Excess Days</td>
<td>94</td>
<td>148</td>
<td>(60)</td>
<td></td>
</tr>
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(Q4 2012 - Q1 2013)

(Q2 2013 - Q3 2013)
Hospital Discharge Disposition

Discharge Disposition
- Discharges Home
- Discharges to Rehab
- Other Discharges

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<thead>
<tr>
<th>Quarter</th>
<th>Home</th>
<th>Rehab</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 2012, N=86</td>
<td>67%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Q4 2012, N=118</td>
<td>59%</td>
<td>20%</td>
<td>14%</td>
</tr>
<tr>
<td>Q1 2013, N=105</td>
<td>71%</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>Q2 2013, N=130</td>
<td>55%</td>
<td>27%</td>
<td>16%</td>
</tr>
<tr>
<td>Q3 2013, N=136</td>
<td>60%</td>
<td>29%</td>
<td>26%</td>
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Q4 2012, N=118
Q1 2013, N=105
Q2 2013, N=130
Q3 2013, N=136

Place of Patient Death

Patient Deaths
- Home
- Hospital
- Inpatient Hospice
- Rehab
- Unsure

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<tr>
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<th>Hospital</th>
<th>Inpatient Hospice</th>
<th>Rehab</th>
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<tbody>
<tr>
<td>Q4 2012</td>
<td>54%</td>
<td>22%</td>
<td>18%</td>
<td>5%</td>
<td>15%</td>
</tr>
<tr>
<td>Q1 2013</td>
<td>70%</td>
<td>18%</td>
<td>18%</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Q2 2013</td>
<td>67%</td>
<td>10%</td>
<td>10%</td>
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<td>22%</td>
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Sicker Patients

HCC Scores

Q1 2013, N= 819
- 0 - 1: 23%
- 1.01 - 1.99: 40%
- 2 - 2.99: 28%
- >= 3: 8%

Q3 2013, N=813
- 0 - 1: 18%
- 1.01 - 1.99: 27%
- 2 - 2.99: 37%
- >= 3: 19%

Patient Satisfaction

Q3 Your likelihood to recommend to family and friends: 100%
Q4 PCP reviewed your medications with you: 85%
Q6 Office staff treated you with courtesy and respect: 79%
Q7 PCP treated you with courtesy and respect: 95%
Q9 PCP explained things to you in a way that was easy to understand: 95%
Q10 PCP engaged your family and/or caregiver: 93%
Q11 Reduced your trips to the emergency room: 56%
Q12 Saw you within 36 hours for urgent medical problems: 45%
Q13 Received answer to your medical questions same day: 26%
Leveraging Informatics to Achieve High Reliability

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<td>• Care Coordination</td>
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Care Coordination: Decreasing the Unknown

- AIM patients admitted to 21 different hospitals in 2012
- Understanding the unknown
  - Patient and provider engagement – July 2012
  - Internal ADT Report - October 2012
  - Healthix Notifications - December 2012

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<td>Q1 2013</td>
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<td>Q2 2013</td>
<td>7%</td>
<td>Q3 2013</td>
<td>4%</td>
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Decrease in Unknown Admissions
Internal ADT Alerts
Real-time alerts received hourly via email

- Includes data from 9 NSLIJ hospitals
- Admission, discharge and transfer data

External RHIO Alerts
Healthix – largest RHIO for NYC and Long Island

- Receives data feeds from 48 hospitals, 18 SNFs, provider groups and home care agencies
- Receives real-time registration events for ER visits and hospitalizations
- Able to push real time notifications to end users
- Requires patient consent for care coordination activities
Healthix notifications

Care Coordination

A patient has a new notification from Flushing hospital Medical Center - Medsys available.

Please click on the following link to securely view this message:

Visit Clinical Links

To ensure secure mobile delivery of future emails, please see EventNotification@healthix.org to update sender list.
### Care Coordination

![Patient Search Interface](image)

#### Health IT Changes

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<th>New System</th>
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Leveraging the AEHR

• What defines a House Calls patient in the AEHR

• Enrollment Order
  • Allows us to define “active” patient census
  • Differentiate our patients within the EHR

Leveraging the AEHR

• Creation of specific orders based on metrics
• Develop analytics reports to extract data
  – Less manual chart review
• Create dashboards as a management tool
Care Team Engagement

- Share group metrics
- Share individual metrics

Advanced Illness: Taking Advantage of the Chasm
Payment Models Here and on the Horizon

Current Delivery System

- Fee For Services Payment
- Bundled Services Payment
- Episode of Illness Payment
- Upside Incentive Payment Model
- Shared Risk Model
- Global Market Risk Model

2012
$6.5 Billion

2020
$28 Billion

NSLIJ High Performance System

Increasing Accountability and Risk

Clinical + Financial Imperative = Opportunity

Program Gap

- CHRONIC DISEASE Case Management Medical Homes 2-20 Years
- HOSPICE < 6 months

18-24 months
What is your product?

What does your product cost?

Who is your audience?

Insurance Company

- What are their biggest risks?
- What are their benefit obligations?

Health System/Hospital

- How do they make money today?
- How could they make money tomorrow?

- How can you help reduce their risk/meet obligations?
- What existing programs align with your goals?
- Who are your potential allies?

What revenue or quality opportunity does your product solve?

Have they partnered with other programs already? How did it go?

Who are your potential allies?

Make your pitch

Make your pitch

51

52
Health System Case Study

What is your product

- Advanced Illness Management
  - Complex medical management for patients with multiple chronic illnesses and functional impairment
  - Palliative care focus
  - High quality care transitions
  - Admission abatement
  - Death at home
Care Coordination

Post-Discharge Medication Reconciliation

<table>
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<tr>
<th>Quarter</th>
<th>Hospital and ED Discharges Home</th>
<th>Post-Discharge Med Rec Within 48 Hrs</th>
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<td>55</td>
<td>63%</td>
</tr>
<tr>
<td>Q4 2012</td>
<td>111</td>
<td>90</td>
<td>83%</td>
</tr>
<tr>
<td>Q1 2013</td>
<td>112</td>
<td>96</td>
<td>86%</td>
</tr>
<tr>
<td>Q2 2013</td>
<td>103</td>
<td>186</td>
<td>97%</td>
</tr>
<tr>
<td>Q3 2013</td>
<td>125</td>
<td>94</td>
<td>94%</td>
</tr>
</tbody>
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Hospital Admissions

Pre- Post Hospital Admissions*

<table>
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<tr>
<th>Time Period</th>
<th>Pre-soc</th>
<th>Post-soc</th>
</tr>
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<tbody>
<tr>
<td>10 - 12 months</td>
<td>9.59%</td>
<td>5.33%</td>
</tr>
<tr>
<td>7 - 9 months</td>
<td>12.95%</td>
<td>3.37%</td>
</tr>
<tr>
<td>4 - 6 months</td>
<td>9.83%</td>
<td>11.97%</td>
</tr>
<tr>
<td>1 - 3 months</td>
<td>23.02%</td>
<td>13.05%</td>
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A 37% reduction in hospital admissions after coming on to the program
Subset of 140 sickest patients new to program in the last year
Place of Patient Death

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What does your product cost?

- Fixed costs
- Variable costs
- Step variable costs
- PMPM rate
Who is your audience?

- Health System Hospital

How do they make money today?

- Fee for Service
  - Quality
  - Pay for performance
  - Full Risk
  - Shared Risk
How Could They Make Money Tomorrow?

- Quality
- Pay for performance
- Shared Risk
- Full Risk
- Fee for service

What quality or revenue opportunity does your product solve?

- Revenue
  - Full or partial risk
  - P4P
  - Hedis/Star ratings
- Quality
  - Mortality
  - Readmissions
  - Efficiency
Have they partnered with other organizations? How did it go?

- Third party vendors
- Other clinical groups
- Other health systems

Who are your potential allies?

- Senior leadership
- Contracting
- Quality
- Finance
- Post acute services
Make your pitch

- Who is in the audience?
- Stay flexible
- Don’t overpromise

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**Decrease in Unknown Admissions**

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Care Coordination

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- Share individual metrics
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- Fee For Services Payment

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Make your pitch

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Hospital Admissions

Pre-Post Hospital Admissions*

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- 7 - 9 months pre soc: 12.95%
- 4 - 6 months pre soc: 9.83%
- 1 - 3 months pre soc: 23.02%
- 1 - 3 months post soc: 13.05%
- 4 - 6 months post soc: 11.97%
- 7 - 9 months post soc: 5.33%
- 10 - 12 months post soc: 3.77%

A 37% reduction in hospital admissions after coming on to the program
Subset of 140 sickest patients new to program in the last year
What does your product cost?

- Fixed costs
- Variable costs
- Step variable costs
- PMPM rate
Who is your audience?

• Health System Hospital

How do they make money today?

• Fee for Service
  • Quality
  • Pay for performance
  • Full Risk
  • Shared Risk
How Could They Make Money Tomorrow?

- Quality
- Pay for performance
- Shared Risk
- Full Risk
- Fee for service

What quality or revenue opportunity does your product solve?

- Revenue
  - Full or partial risk
  - P4P
  - Hedis/Star ratings
- Quality
  - Mortality
  - Readmissions
  - Efficiency
Have they partnered with other organizations? How did it go?

• Third party vendors
• Other clinical groups
• Other health systems

Who are your potential allies?

• Senior leadership
• Contracting
• Quality
• Finance
• Post acute services
Make your pitch

- Who is in the audience?
- Stay flexible
- Don’t overpromise