AdvantagePoint Health Alliance

Transitions of Care

Lifepoint Health

Local Market Resource Centralized Resource

Typical Network Support Model

Strategic Support

- Contracting subject matter expertise
- Contract negotiation support
- High-performing post-acute network support

Market Executive Director

- Business Development
- Relationship Mgmt.
- Contract Mgmt.
- Referral Mgmt.
- Board Meetings
- P&L Responsibility

Medical Director

- Clinical Oversight over Care Management and Quality Programs
- ACO/CIN Board Appointed

Population Health Advisors

- Physician Education
- Reporting
- Workflow Transformation
- Billing Support
- Referral Workflow
- Provider Relations
- Implement QI Program at the Market Level
- Roster Maintenance

Coding Documentation Specialist(s)

- HCC and RAF Program Ownership
- Practice Assessment
- Gap Reporting
- Chart Audits

Care Navigators

- Care Coordination
- Chronic Care Mgmt.
- Transitional Care Mgmt.
- Disease Mgmt.
- Utilization Mgmt.
- Remote Patient Monitoring

AWV Nurse support

- Workflow support
- Increase in RVUs without additional time spent

Healthcare Analysts

- Analysis of Referral Patterns
- Out-Migration Analysis
- Ad-Hoc Reporting
- Market-Level Reporting
- Total cost of care analysis
- Cross-contract opportunity trends
- Custom solutions

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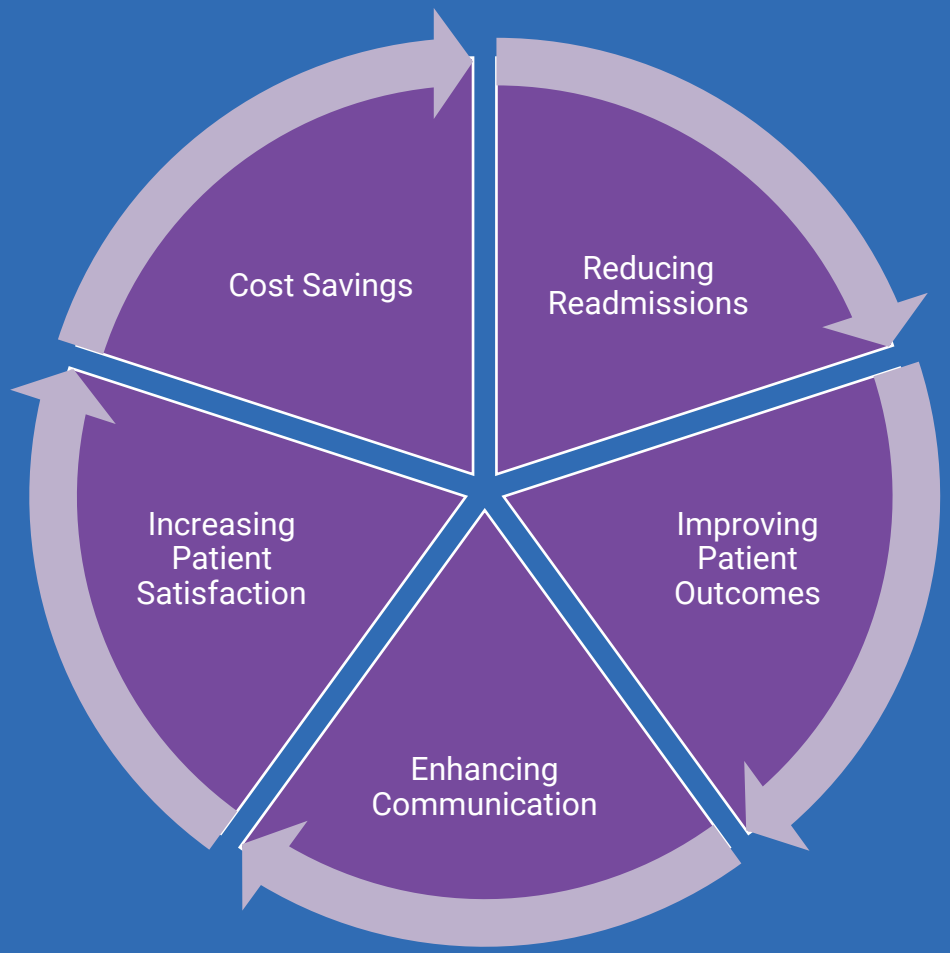
Managing Transitions of Care



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Significant Challenges in Transitions of Care

- Communication breakdowns
- Medication management
- Inadequate discharge planning
- Social determinants of health
- Technology gaps
- Behavioral and psychological factors
- Regulatory and financial constraints

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Addressing Challenges

- Importance of timely and efficient communication
- Building a network support system
- Enhanced access to data (Persivia)
- Multi-disciplinary teams (Care Navigators, CHWs, clinical pharmacists, etc.)
- Partnerships for ancillary services (CCM, RPM, TCM, CoCM)

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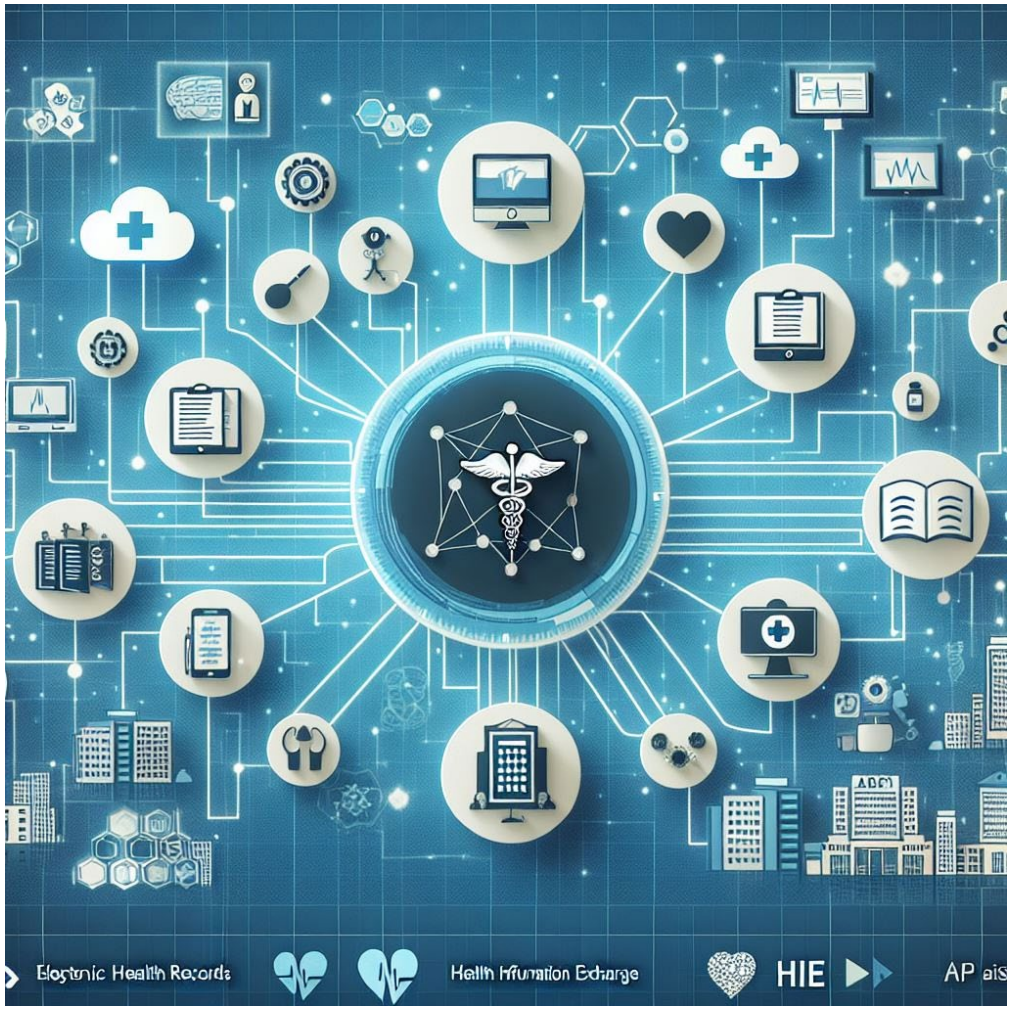
Ensuring Seamless Communication

Use of technology and existing features

Automated communication through HIEs and APIs



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Improving Patient Engagement and Empowerment

- Effective communication and patient education
- Involving patients in decision-making
- Simplifying discharge instructions
- Leveraging technology and engaging family/caregivers
- Addressing social determinants of health
- Continuous support and follow-up

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Role of Technology and Innovation

- Improving communication and information sharing
- Enhancing care coordination
- Reducing readmissions through predictive analytics
- Facilitating patient-centered care
- Addressing social determinants of health
- Streamlining administrative processes
- Real-time monitoring and feedback
- Innovations in collaboration

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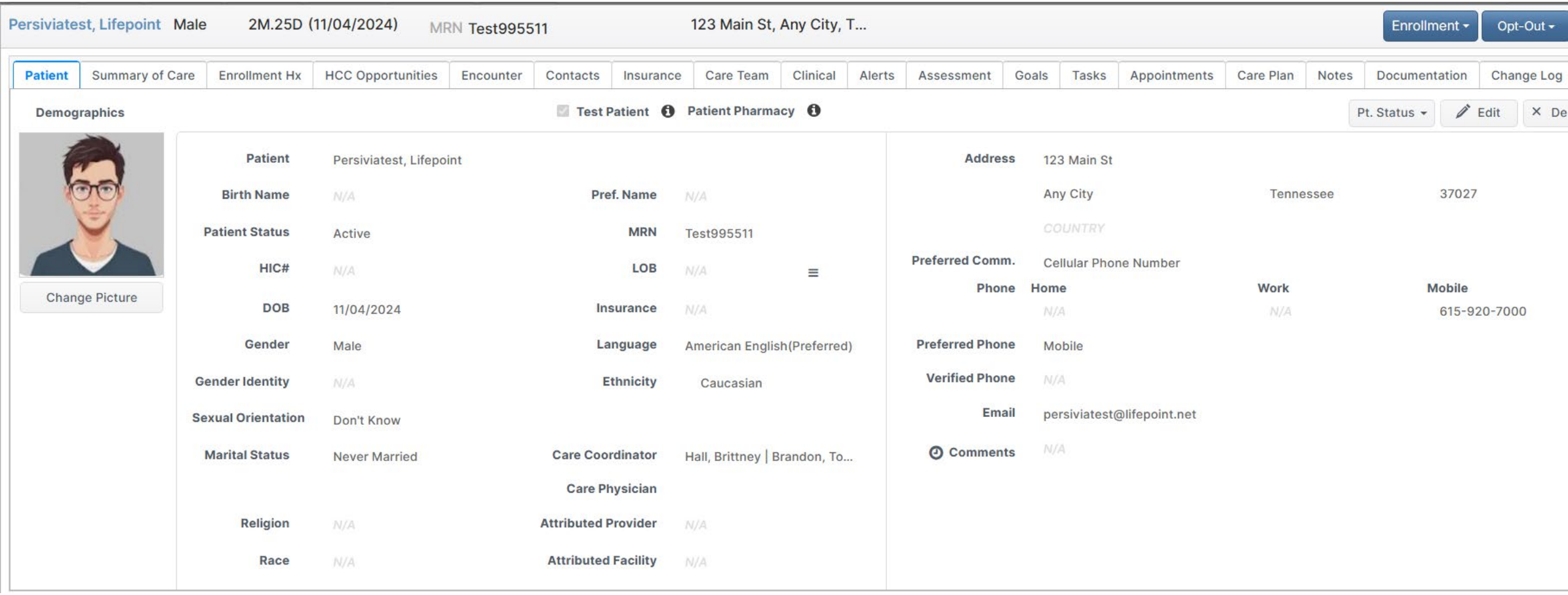
Consolidated Medical Record



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Addressing Social Determinants of Health

- Role of care navigators
- Identifying resources and assisting patients
- Comprehensive assessments and connecting patients with providers
- Monitoring utilization trends and targeted outreach

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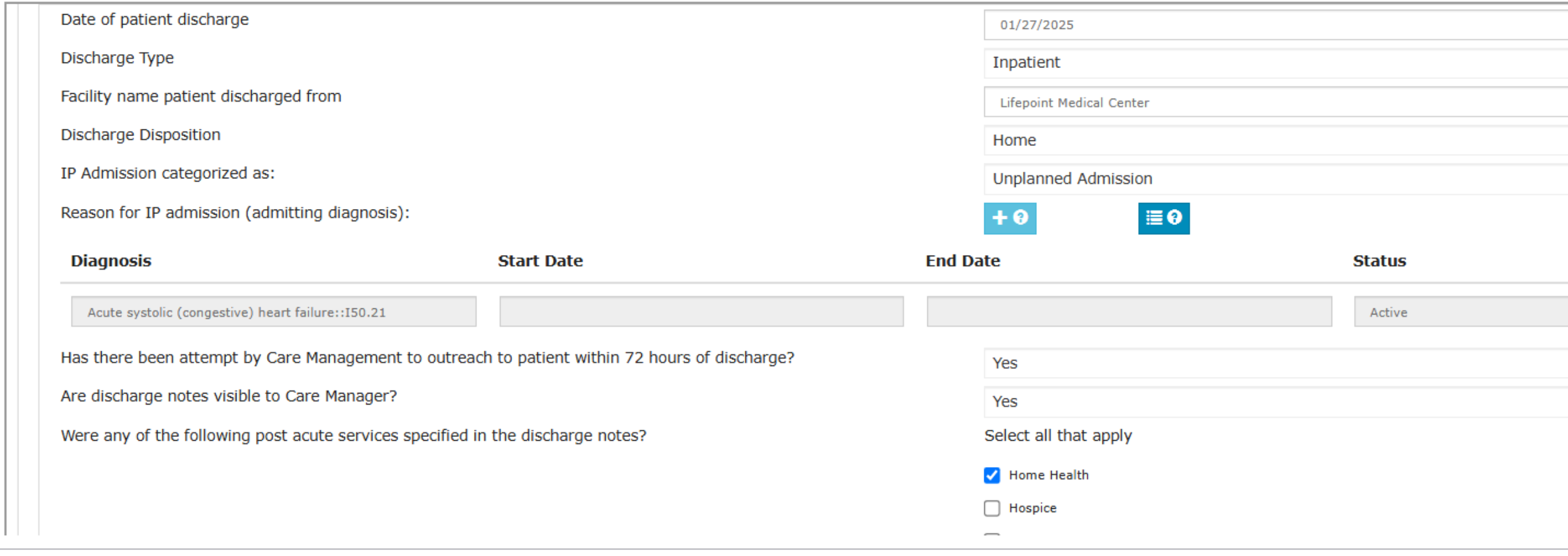
Care Navigator Assessment



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Facilitating Collaboration

- Patient-centric approach by care navigators
- Provider/practice-centric approach by population health advisors
- Communication with all entities on behalf of the patient

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Mission Moment: Compassionate Care Coordination

A patient, part of our readmission prevention program, was discharged after neck surgery. Despite having follow-up care arranged, the patient was emotionally distressed due to her husband's suicide on the day of discharge. A care navigator, unaware she was on speakerphone, provided compassionate support, which was deeply appreciated by the patient's family. The patient's son later expressed gratitude for the navigator's empathy and intentional focus on his mother's emotional well-being, highlighting the importance of compassionate care in improving patient outcomes.

Mission Moment: Complex TCM

A patient with chest heaviness and stomach pains was found to have significant ST elevation on an EKG and was transported to North Alabama Medical Center for cardiac catheterization and stent placement. Post-discharge, the patient faced challenges scheduling a cardiology follow-up and managing medications, as the referral needed to come from the primary care provider (PCP). Our care navigation team intervened, ensuring the patient received the necessary referral, 90-day medication supplies, and support for anxiety through Cardiac Rehab. This proactive approach highlighted the importance of timely communication and comprehensive care coordination, ultimately improving patient outcomes and satisfaction.

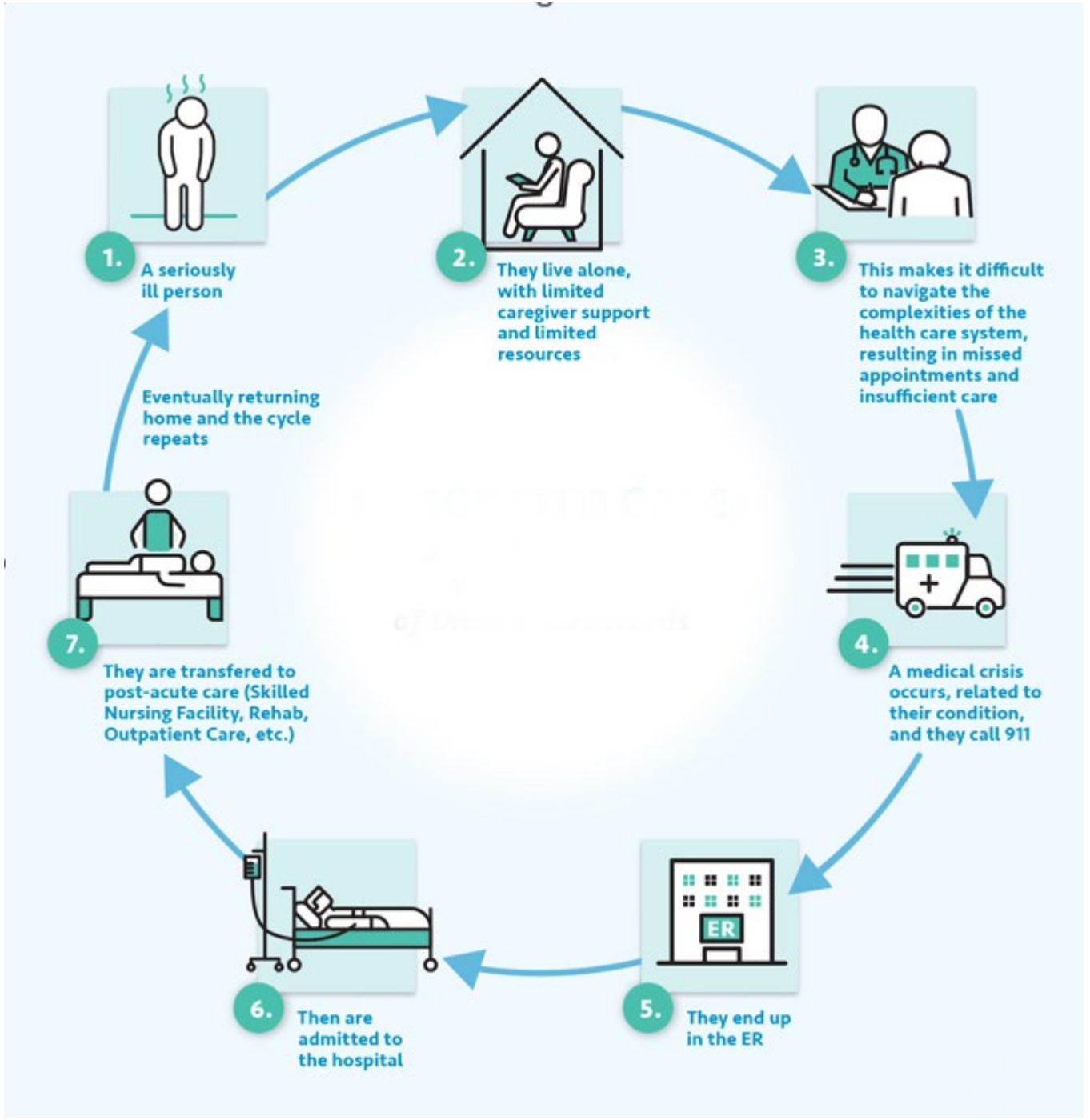
Innovations in Health Care Transitions
All Roads Lead Home.

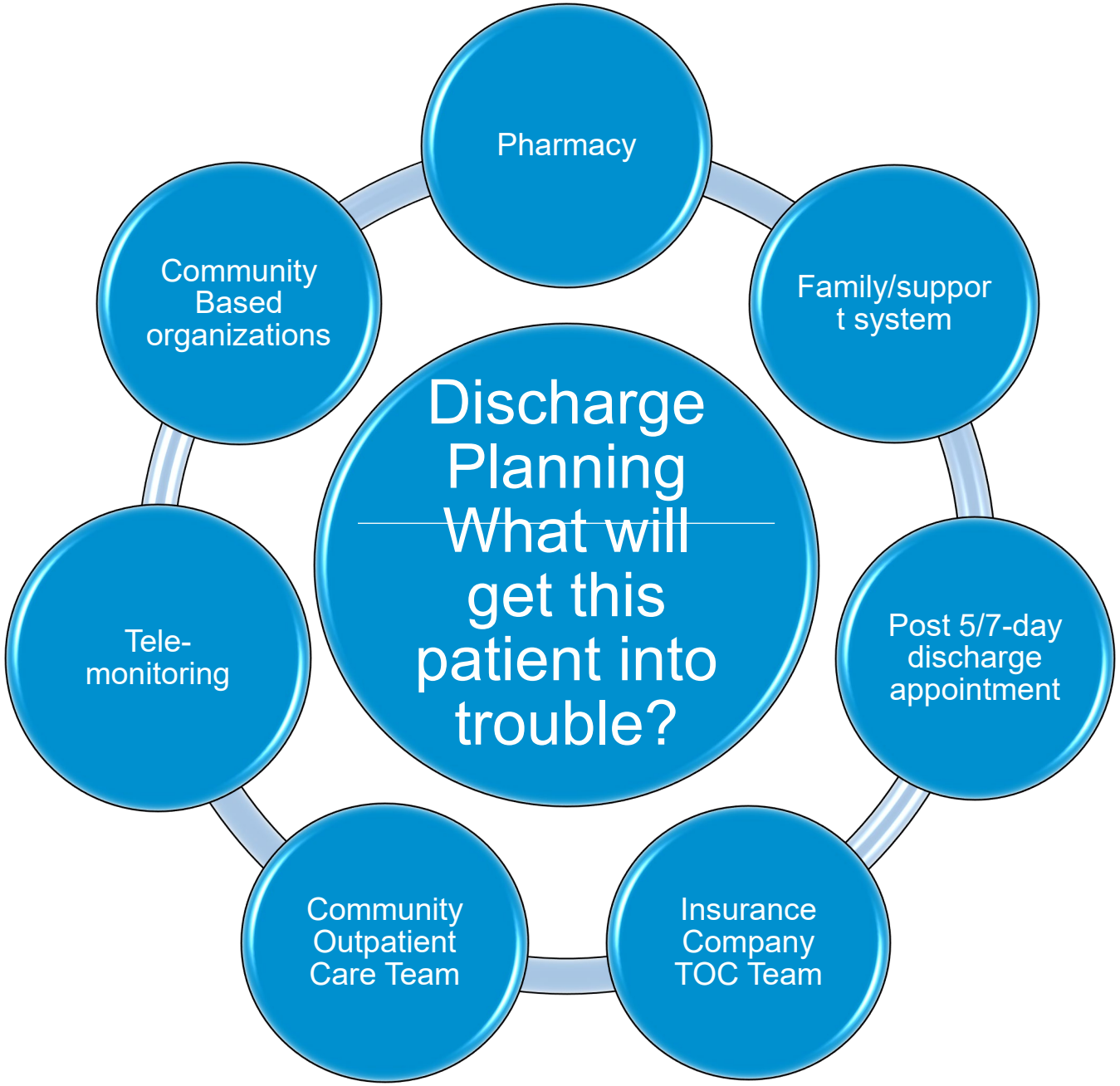
Geisinger

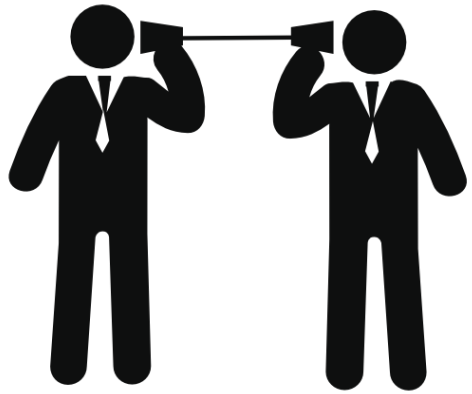
Keystone ACO

Joann Sciandra, MHA BSN RN CCM
Vice President, Care Coordination and Integration

The Complexity of the Healthcare Journey

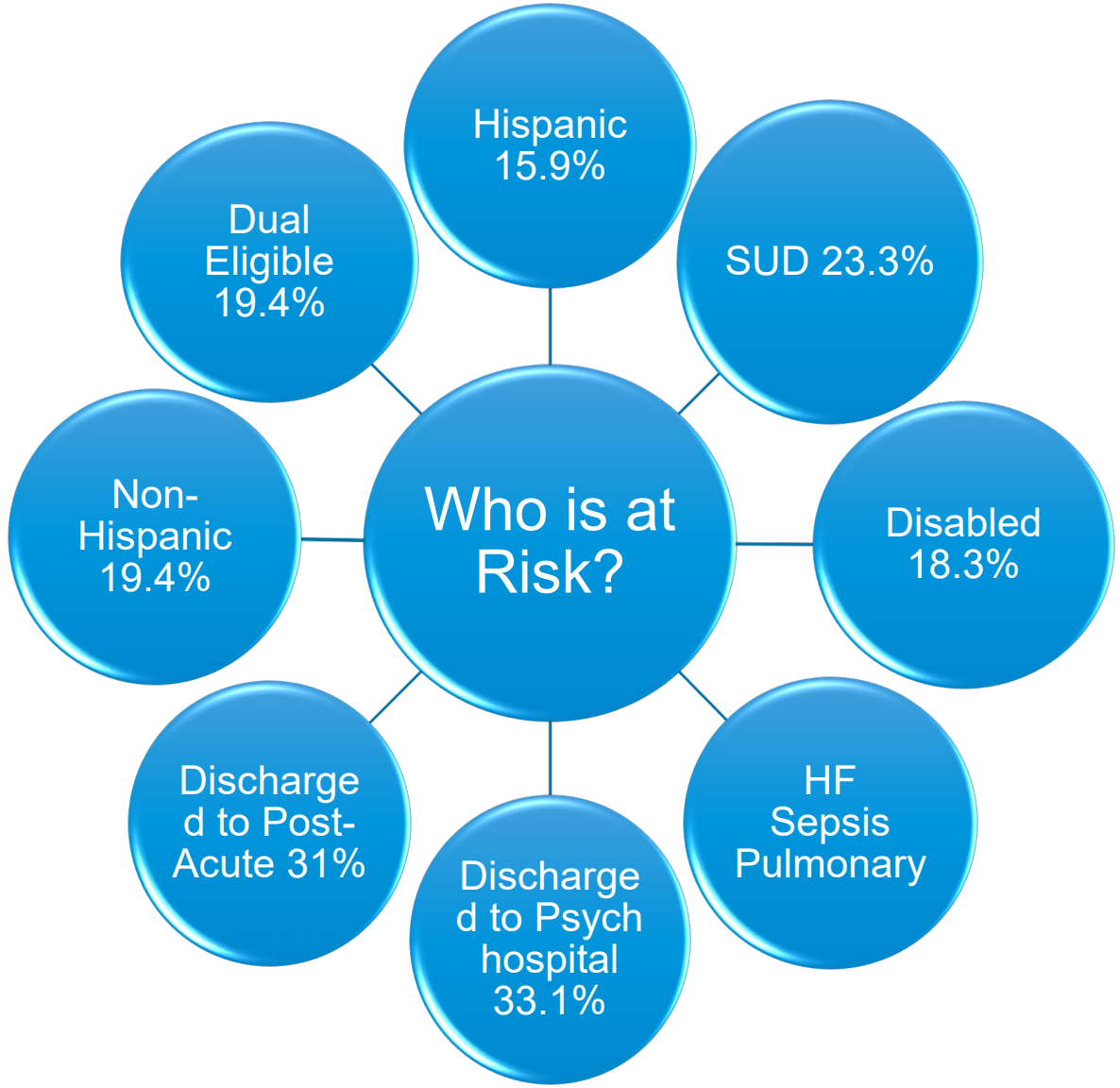






It's all about Communication

CMS Hospital Readmissions Vulnerable Populations



Care Model

Level 1

Home-Based, Highest Cost, and Predictive Risk

- Highest utilization/cost members requiring predominantly In-Home Care, such as patients at end of life, with severe progressive illness, and/or truly are homebound
- Complex post-discharge member needing in-home support

Level 2

Complex Case Mgmt.
Specialty Care Mgmt.
Complex Predictive Risk

- Advanced/critical illness/ complex co-morbidities, requiring intensive interventions but expecting progression
- Qualifying conditions requiring specialized interventions which fall within an established administered program (e.g., Nephrology, Cardiology, Pulmonary, 65 Forward)
- Stabilized exacerbation(s), but still requiring intervention
- Dual-eligible SNP

Level 3

Special Needs Unit (SNU) Peds

Women's Health

- High risk/ complexity to stabilized SNU/Peds patients requiring interventions or advanced interventions
- High, moderate, or low risk Women's Health patient with current pregnancy or post-partum

Level 4

Behavioral Health

- Primary behavioral health diagnosis, requiring intervention and Social Determinants of Health (SDOH) needs
- Stabilized behavioral health exacerbation(s), but still requiring intervention
- Early identification of primary behavioral health driver, and are at risk for future utilization (e.g., unnecessary ED visits, etc.)

Level 5

Transitions of Care (TOC)

- TOC cases are members recently discharged from inpatient stays with 1-2 conditions and high readmission risk, needing short-term care of 30-45 days, with routine discharge protocol
- Cases may need to be escalated based on need

Level 6

In progress: Condition Management (to be addressed by Chronic Disease Management Command Center (CDMCC)

- Members requiring education or training to self-manage chronic conditions and/or high-risk health behaviors
- RPM for patients that have graduated

Creating a Care Model in our Communities

Supporting those with serious & significant health conditions

Coordinated Medical Care

- Comprehensive assessment
- Condition optimization & management
- Close coordination with PCP/SCPs

Integrated Social & BH

- Social determinants of health
- Behavioral health

Acute Care

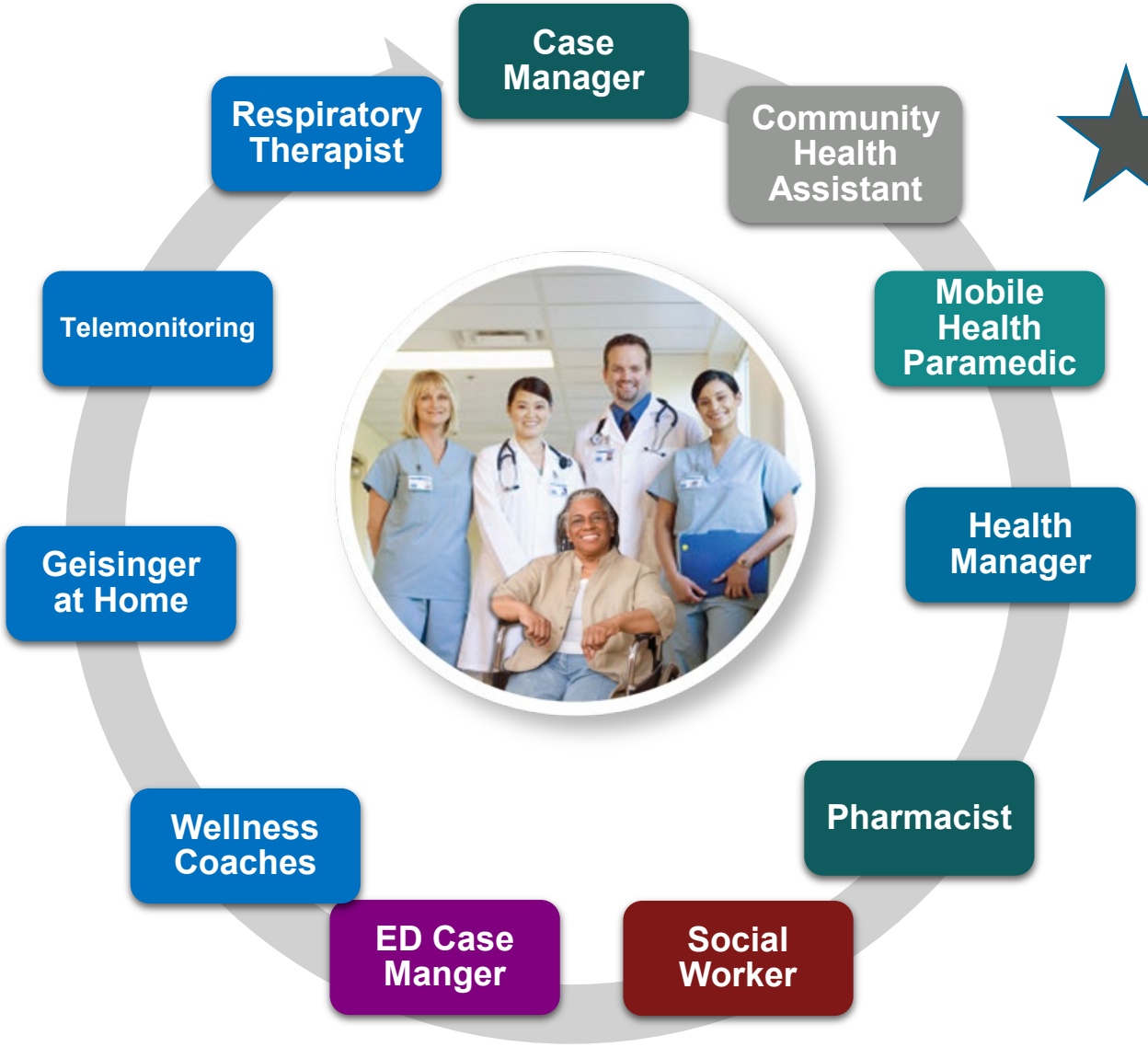
- Mobile paramedics
- Case Management
- Home Health
- AP/CHW Virtual Visits
- ER Case Managers

Advanced Illness

- Plan of care
- Symptom management
- Palliative care
- Timely transition to hospice

Ambulatory Care Team

- Social Determinants of Health
- Benefit Management
- Chronic Condition Management
- Transitions Of Care



Member Management in the Community

HOW?

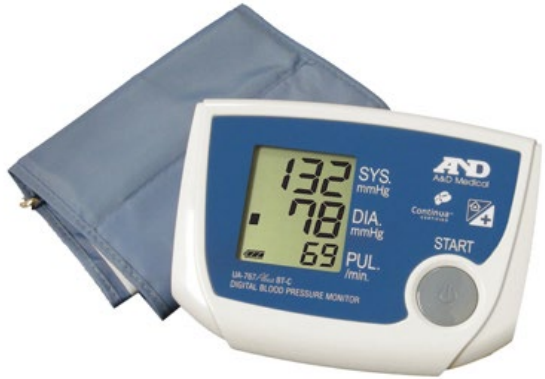
Deployment of a Plan of Care

- Community Service (aging, DME, HH)
- Triage to appropriate Care Team Members
- Dosing
  - Home vs Telephonic Visits
  - Care Team Member
- Telemonitoring
- Telehealth visits with accessories
- Connection with Nurse Triage
- Exacerbation management plan and deployments
- Mobile Health Paramedic
- PCP/Specialist Collaboration
- Deployment
- Care Gap Closure

Admission Prevention

Complex Care Management Care Team	• Chronic Condition Management • Care Transitions • Exacerbation Management • SDOH
* Advanced Practitioner	• Virtual visits • Post-discharge follow-up • Exacerbation Management
Mobile Heath Paramedic	• Intervention i.e. IV Lasix • Check-ins
* Embedded RN Case Manager	• High-Volume Emergency Rooms • Focus on complex patients with chronic conditions
Remote Patient Monitoring (RPM)	• Exacerbation monitoring • Trending • Readmission prevention

Remote Patient Monitoring Devices



Leveraging telehealth tools

- CHW does home visit in place of licensed staff
- Connects to our “Remote Medical Collaborator”
- High patient and provider satisfaction
- Some connectivity issues in rural areas
- Early use for acute care as well
- Use of peripherals to enhance visit impact

Case Review
Admission Diversion

70-year-old male, lives with wife, drives, is active

- Presents to ER with of shortness of breath for one week, +2 bilateral pedal edema. Complaining of inability to sleep. Shortness of breath increased with little activity. Denies chest pain. Complains of a productive cough with tan secretions
- Pulse ox at rest 87%, HR 115, temp 98.6, BP 138/82
- Past Medical history
  - COPD
  - Hypertension
  - 50-year smoker, quit 5 years ago
  - Applied 2L O2, pulse ox increased to 92%
  - HR 90
  - Upon ambulation pulse ox 90-92%

Does this patient need to be admitted?

Case Review
Admission Diversion (continued)

- On-site RN Case Manager collaborates with Emergency Room Physician, patient and At-home Medical Director.
- Plan:
  - Discharge pt to home, O2 2L to be delivered today
  - 24-hour monitor, Pulse Ox, respirations, temp, steps/movement
  - PO antibiotic and prednisone ordered
  - Provider virtual visit in the am with Community Health Worker (CHW)
  - RN home visit within 24-48 hours
- 24 hours post discharge CHW/provider in home visit,
  - Medication reconciliation
  - Cardiovascular Pulmonary Assessment completed
  - Home safety
  - DME reviewed with patient and spouse
  - Pulse ox 93% at rest, Temp 98.4, patient states slept the best he has in weeks. 24-hour Trending
  - Pulse ox >90, no triggers identified

Case Review #2
3-Day SNF Waiver

75-year-old female, diagnosis of colon cancer

- Prior to this diagnosis, she was active in her community, went to church every day, lived alone and was independent
- Completed treatment, lost 30 pounds, complaining of weakness, had a fall, struggling to get back to her baseline
- Managed by Case Manager. CM ordered home health, PT/OT recommends admission to rehab for more challenging therapy.
- CM collaborates with a SNF that meets the criteria of Keystone ACO's 3-day waiver, patient is admitted to facility and discharged after 17 days.
- After meeting established goals, patient returned home and continued therapy as an outpatient.
- Patient is now going out with friends for lunch and starting to get back to previous level of functioning

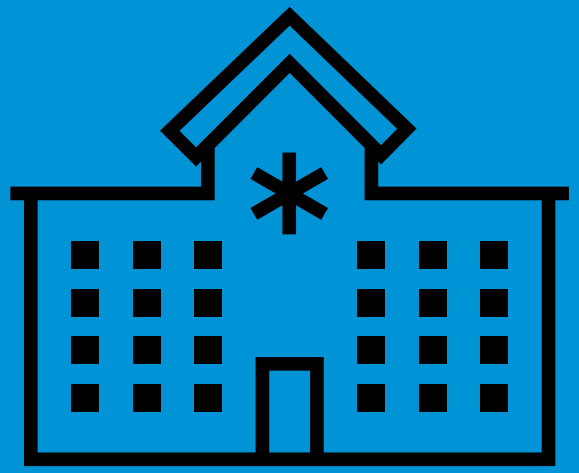
SNF 3-Day Rule Background

- The Medicare Fee-For-Service (FFS) Skilled Nursing Facility (SNF) benefit is for beneficiaries who require skilled nursing and/or skilled rehabilitation care resulting in a short-term intensive stay in a SNF.

- According to section 1861(i) of the Social Security Act, FFS beneficiaries must have a prior inpatient hospital stay of no fewer than three (3) consecutive days, within the past 30 days, to be eligible for Medicare coverage of inpatient SNF care.

KeystoneACO

SNF 3-Day Rule Waiver



It may be medically appropriate for some patients to receive skilled nursing care and/or rehabilitation services provided at SNFs **without prior hospitalization or with an inpatient hospital stay of fewer than three consecutive days.**

The waiver permits reimbursement under Medicare for beneficiaries that were approved by an **ACO provider/supplier Who is a Physician,** to receive skilled nursing and/or rehabilitation care at a **Centers for Medicare and Medicaid Services** (**CMS) approved SNF and contracted with KACO** without having been hospitalized for three days previously.

KeystoneACO

Case Study
Brad Core, 45 yo male

Employed in the manufacturing industry. Smoked for 20 years. Lives in rural area. Marital status married but unsure if living together. 2 children, boy age 10, girl age 12. Newly diagnosed throat cancer. Post op modified radical neck dissection. Tracheostomy and feeding tube. LOS 5 days. Discharge plan - Home Health, DME referrals placed. Bedside education completed.

- Mary, Outpatient Case Manager calls Brad several times, no answer
- Sends CHW out for cold call visit next day
- CHA knocks on door Brad yells “come in”
- Brad hasn’t heard from Home Health, no supplies, SOB and coughing, Pulse ox in the 80’s. CHA calls CM. Directed to call 911
- Brad readmitted to hospital with diagnosis of pneumonia, weak and deconditioned. Plan is d/c to SNF
- LOS 3 days, d/c to SNF
- 8 hours into d/c develops chills, temp, now sent back to ER

Case Study
Brad Core, 45 yo male.

Readmission review

- Brad's readmission reviewed by readmission committee
- Info sent to Home Health, no confirmation they received.
- No contact with outpatient care team
- Teaching was competed with Brad. Per the note in chart there was no discharge support. No one spoke with wife prior to d/c.

What could have been done different?

Thank you

Geisinger

Keystone ACO