Innovative Projects for Assisting Patients Gain Access to the Appropriate Care Setting to Reduce Healthcare Cost & Reduce Hospital Readmission Rates

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Response to CHA: Health Efficiency Navigation Initiative (HENI)

James T. “Tyler” Lee
Community Healthcare & Development, Manager
Mission, Values, and Vision

Our Mission
- Improve the health of the communities we serve

Our Values
- **For Carilion Clinic:**
  - **CommUNITY:** Working in unison to serve our community, our Carilion family and our loved ones.
  - **Courage:** Doing what's right for our patients without question
  - **Commitment:** Unwavering in our quest for exceptional quality and service
  - **Compassion:** Putting heart into everything we do
  - **Curiosity:** Fostering creativity and innovation in our pursuit of excellence

Our Vision
- We are committed to a common purpose of better patient care, better community health and lower cost.
Let’s SBAR it!

SBAR = Situation, Background, Assessment, Recommendation
Situation - 2010

- Rapidly rising uncompensated care
- Rapidly rising healthcare costs
- Overutilization of services
- Cuts to Medicaid and Medicare
- Uncoordinated care among the uninsured, Medicaid, Medicare
- At CFMH, 62% of uncompensated care came through Emergency Services
- Only 17% of ED uncompensated care was primary care – Waiting too long for treatment
The **Emergency Medical Treatment and Active Labor Act (EMTALA)** is a U.S. Act of Congress passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It requires hospitals and ambulance services to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay.
No pay or less than cost forces providers to shift cost or close – Jobs lost

If Cost is shifted, employers pay or pass on to employees

Emptors lay off employees to pay for benefits or reduce benefits

Patients head to Hospital ER (Highest Cost Care)

Patients head to hospital ER (Highest Cost Care)

WHERE IT STARTS!

Govt. Cuts Safety Net Funding

S

Situation . . .

And the cycle continues . . .
Background:
Charity and Bad Debt as a % of Revenue

19% for September 2011
Translates to between $16-19M in Free Care/Year
Background:
Uninsured most likely to not have a medical home

Figure ES-3. Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care

Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

* Compared with insured with income at or above 200% FPL, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.
Assessment: Health Reform

- What it is not:
  - Raising taxes
  - Rationing care
  - Cutting payments to providers

- What it is: Lowering cost by
  - Coordinating care
  - Providing incentives to providers to keep patients healthy and manage chronic conditions
  - Providing patient incentives to keep themselves healthy and manage chronic conditions
Assessment: Healthcare Finance 101

Results in: Unaffordable Insurance for Business and Individuals, rationing, and increased taxes to keep up with it all.
Recommendation . . .

It’s primarily about reducing overutilization and employing good case management!

HENI: Every dollar saved drops to the bottom line and it is good for patients – a WIN-WIN!
Step 2: ED to PCMH Project 2010 - 2011

- Use Emergency Room as a point of Primary Care Education
- Get people connected with Patient Centered Medical Home
- Ensure we meet our EMTALA obligations
- Start with CMA Rocky Mount patients and expand as we have primary care options
| STATISTIC                        | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG* | SEP* | OCT* | NOV* | AVERAGE |
|---------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|------|------|--------|---------|
| Patients Screened               | 70  | 74  | 95  | 107 | 72  | 81  | 84  | 68  | 42  | 53   | 48   | 10   | 19    | 63      |
| Patients Diverted               | 38  | 48  | 73  | 80  | 51  | 57  | 54  | 57  | 31  | 35   | 32   | 5    | 14    | 44      |
| Diversion Rate                  | 54% | 62% | 77% | 75% | 71% | 64% | 84% | 74% | 68% | 66%  | 67%  | 50%  | 74%   | 68%     |
| Kept for Medical Reasons        | 8   | 3   | 4   | 3   | -   | 3   | -   | 1   | 1   | 2    | 3    | 1    | -     | 2       |
| Patient Refused Diversion       | 25  | 25  | 22  | 24  | 21  | 20  | 20  | 30  | 11  | 9    | 10   | 7    | 2     | 2       |
| Average Patient Age             | 26  | 26  | 22  | 23  | 26  | 22  | 31  | 31  | 26  | 34   | 22  | 24   | 22.8  | 16      |
| Pediatric Patients              | 27  | 27  | 41  | 49  | 26  | 37  | 24  | 20  | 15  | 7    | 14   | 2    | 6     | 23      |
| % Pediatric Patients            | 38% | 36% | 43% | 46% | 36% | 46% | 29% | 29% | 36% | 29%  | 29%  | 20%  | 23%   | 36%     |

* Note: Beginning in August physician practice saturated with patients began on taking their patients whom they actually having open slots for which resulted in several documented patients not being diverted. When this happens in the day it alters the amount of patients screened which results in decreased screened and diverted total.

** In October, Dr. Sherrard reduced her hours at the practice and this has really affected our ability to divert patients. We need to increase provider supply to continue to make an impact here.
Help Improve Our Community’s Health

SHARE YOUR INPUT ON CURRENT HEALTH ISSUES AND CHALLENGES

Flip over for more information.
Major Needs and How Priorities Were Established

Upon compiling all primary and secondary data, a review was conducted to complete a list of health needs identified through the assessment process. The Management Team and the CHAT then met to prioritize the needs and narrow the focus to 3 to 5 areas of highest priority. These top areas were identified based upon community need, feasibility of addressing the need and potential impact. Similar categories were grouped, and four areas of priority became clear, based upon the four assessment activities performed (stakeholder survey, community survey, focus groups and secondary data). The Franklin County CHNA findings demonstrate the need for:

- Access to:
  - Mental health and substance abuse services
  - Primary care
  - Adult dental care
  - Specialty care
- Need for improved coordination of care across the health and human services sector
- General wellness:
  - Obesity
  - Chronic disease management
- Transportation
Step 3: Health Efficiency Navigation Initiative (HENI)
HENI - Purposes

1. Utilize the Emergency Department as a primary place of identification of patients with coverage issues;
2. Do our best to find and influence coverage for them;
3. Navigate them to appropriate care settings close to home; and
4. Utilize the full array of coordination services within Carilion Clinic and with safety net providers in our region to facilitate 1-3.
Major Needs and How Priorities Were Established

Upon compiling all primary and secondary data, a review was conducted to complete a list of health needs identified through the assessment process. The Management Team and the CHAT then met to prioritize the needs and narrow the focus to 3 to 5 areas of highest priority. These top areas were identified based upon community need, feasibility of addressing the need and potential impact. Similar categories were grouped, and four areas of priority became clear, based upon the four assessment activities performed (stakeholder survey, community survey, focus groups and secondary data). The Franklin County CHNA findings demonstrate the need for:

- Access to:
  - Mental health and substance abuse services
  - Primary care
  - Adult dental care
  - Specialty care
- **Need for improved coordination of care across the health and human services sector**
- General wellness:
  - Obesity
  - Chronic disease management
- Transportation
- Web-based – Focused on Social Determinants
- Connect to all HENI Members - MOAs
- Connect to other Community Agencies - MOAs
- HIPAA Compliant - Releases
- Easy to Use

Results November 15, 2016- June 6, 2018:
  - $725,737 in Community Benefit
  - 2,323 Individuals Served
  - 6,617 Acts of Kindness
HENI Effect on Outcomes: FY 2015-2016

<table>
<thead>
<tr>
<th>Statistics:</th>
<th>ED Visits One year prior to encounter</th>
<th>ED Visits One year after encounter</th>
<th>Difference</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Visits</td>
<td>366</td>
<td>253</td>
<td>-113</td>
<td>-31%</td>
</tr>
<tr>
<td>Number of Patients</td>
<td>124</td>
<td>124</td>
<td>124</td>
<td></td>
</tr>
<tr>
<td>Average Visits per Patient</td>
<td>2.95</td>
<td>2.04</td>
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<table>
<thead>
<tr>
<th>Gender:</th>
<th>Number of Patients</th>
<th>% of Patients</th>
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<tbody>
<tr>
<td>Men</td>
<td>57</td>
<td>46%</td>
</tr>
<tr>
<td>Women</td>
<td>67</td>
<td>54%</td>
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<table>
<thead>
<tr>
<th>Age Groups:</th>
<th>Number of Patients</th>
<th>% of Patients</th>
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<tbody>
<tr>
<td>0-26 years old</td>
<td>24</td>
<td>19%</td>
</tr>
<tr>
<td>27-40 years old</td>
<td>48</td>
<td>39%</td>
</tr>
<tr>
<td>41-50 years old</td>
<td>26</td>
<td>21%</td>
</tr>
<tr>
<td>51-65 years old</td>
<td>23</td>
<td>19%</td>
</tr>
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<table>
<thead>
<tr>
<th>Distribution of Utilization Variance:</th>
<th>Number of Patients</th>
<th>% of Patients</th>
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<tbody>
<tr>
<td>Increase of greater than 5 visits/year</td>
<td>4</td>
<td>3%</td>
</tr>
<tr>
<td>Increase of 1-5 visits/year</td>
<td>20</td>
<td>16%</td>
</tr>
<tr>
<td>No Change</td>
<td>21</td>
<td>17%</td>
</tr>
<tr>
<td>Decrease of 1-5 visits/year</td>
<td>73</td>
<td>59%</td>
</tr>
<tr>
<td>Decrease of greater than 5 visits/year</td>
<td>6</td>
<td>5%</td>
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# Enrollee Comparison
## 2015-2016 Open Enrollment

<table>
<thead>
<tr>
<th>Zip</th>
<th>2015 Enrollees</th>
<th>2016 Enrollees</th>
<th>Change</th>
<th>Area</th>
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<tbody>
<tr>
<td>24055</td>
<td>722</td>
<td>657</td>
<td>-65</td>
<td>Bassett</td>
</tr>
<tr>
<td>24065</td>
<td>341</td>
<td>366</td>
<td>25</td>
<td>Boones Mill</td>
</tr>
<tr>
<td>24067</td>
<td>152</td>
<td>174</td>
<td>22</td>
<td>Callaway</td>
</tr>
<tr>
<td>24088</td>
<td>236</td>
<td>240</td>
<td>4</td>
<td>Ferrum</td>
</tr>
<tr>
<td>24092</td>
<td>174</td>
<td>181</td>
<td>7</td>
<td>Glade Hill</td>
</tr>
<tr>
<td>24101</td>
<td>286</td>
<td>328</td>
<td>42</td>
<td>Hardy</td>
</tr>
<tr>
<td>24102</td>
<td>104</td>
<td>89</td>
<td>-15</td>
<td>Henry</td>
</tr>
<tr>
<td>24121</td>
<td>526</td>
<td>557</td>
<td>31</td>
<td>Moneta</td>
</tr>
<tr>
<td>24137</td>
<td>114</td>
<td>114</td>
<td>0</td>
<td>Union Hall</td>
</tr>
<tr>
<td>24151</td>
<td>908</td>
<td>960</td>
<td>52</td>
<td>Rocky Mount</td>
</tr>
<tr>
<td>24176</td>
<td>97</td>
<td>96</td>
<td>-1</td>
<td>Penhook</td>
</tr>
<tr>
<td>24184</td>
<td>240</td>
<td>245</td>
<td>5</td>
<td>Wirtz</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>3,900</strong></td>
<td><strong>4,007</strong></td>
<td><strong>107</strong></td>
<td></td>
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</tbody>
</table>
Significant Financial Improvement over time!

Tough Decisions to Make!
Service Utilization

CFMH - Self Pay (Rolling 12 Month's)

24% increase in ACA paid cases from 2014 to 2015
Service Utilization 2016

CFMH ACA Patient Utilization

CFMH ACA Pts  Linear (CFMH ACA Pts)
Decline in ER Visits

Emergency Room Visits, July 2011 – September 2016

Axis Title
## Improved ER Acuity

<table>
<thead>
<tr>
<th></th>
<th>Full Year FY2006</th>
<th>Full Year FY2007</th>
<th>Full Year FY2008</th>
<th>Full Year FY2009</th>
<th>Full Year FY2010</th>
<th>Full Year FY2011</th>
<th>Full Year FY2012</th>
<th>Full Year FY2013</th>
<th>Full Year FY2014</th>
<th>Full Year FY2015</th>
<th>May YTD Annualized FY2016</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>953410 - Level 1 ED Visits</td>
<td>348</td>
<td>234</td>
<td>241</td>
<td>188</td>
<td>281</td>
<td>279</td>
<td>184</td>
<td>171</td>
<td>125</td>
<td>154</td>
<td>143</td>
<td></td>
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<tr>
<td>953411 - Level 2 ED Visits</td>
<td>5,402</td>
<td>4,963</td>
<td>4,568</td>
<td>4,167</td>
<td>3,437</td>
<td>3,250</td>
<td>3,927</td>
<td>3,447</td>
<td>2,920</td>
<td>2,599</td>
<td>2,448</td>
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</tr>
<tr>
<td>953412 - Level 3 ED Visits</td>
<td>10,216</td>
<td>11,972</td>
<td>12,917</td>
<td>12,394</td>
<td>8,594</td>
<td>7,380</td>
<td>7,955</td>
<td>7,405</td>
<td>7,193</td>
<td>7,937</td>
<td>8,175</td>
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<tr>
<td>953413 - Level 4 ED Visits</td>
<td>4,636</td>
<td>5,711</td>
<td>5,720</td>
<td>6,050</td>
<td>6,960</td>
<td>7,909</td>
<td>7,561</td>
<td>7,018</td>
<td>6,958</td>
<td>6,756</td>
<td>6,551</td>
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</tr>
<tr>
<td>953415 - Level 5 ED Visits</td>
<td>2,972</td>
<td>2,154</td>
<td>1,983</td>
<td>2,914</td>
<td>4,069</td>
<td>4,260</td>
<td>4,188</td>
<td>4,235</td>
<td>3,869</td>
<td>3,675</td>
<td>3,384</td>
<td></td>
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<tr>
<td>953416 - Level 6 ED Visits</td>
<td>157</td>
<td>166</td>
<td>179</td>
<td>134</td>
<td>37</td>
<td>33</td>
<td>30</td>
<td>36</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>953417 - LWBS</td>
<td>490</td>
<td>617</td>
<td>577</td>
<td>732</td>
<td>444</td>
<td>596</td>
<td>636</td>
<td>632</td>
<td>489</td>
<td>752</td>
<td>759</td>
<td></td>
</tr>
</tbody>
</table>
A “subsidiary” of Bay Aging

Eastern Virginia Care Transitions Partnership (EVCTP) is the regional division of VAAACares®

Kathy Vesley
President/CEO
Bay Aging dba VAAACares®
About Us

- VAAACares® is a Statewide collaboration of the Virginia Network of Area Agencies on Aging.
- A subsidiary of Bay Aging, it serves as the ‘one-stop-shop’ for Area Agencies on Aging in the provision of community-based care management services.
- It serves as the Hub for care transitions, chronic care management, and behavioral health integration across the State of Virginia.
Past Performance

CMS – CMMI funded Community Care Transitions Provider: Eastern Virginia Care Transitions Partnership (EVCTP)

EVCTP: Year 2 Performance Analysis:

- Visited 90% of chronically ill target group (high utilizer) patients from partner hospitals in their homes
- Total Home Visits to all Hospital Patients 25,655
- Target Group Readmission Reductions (Hospital Data)
  - 2010 Baseline 23.4%
  - Enrollee Readmission Rate 8.7%
  - Reduced ED Utilization of “Self Insured”
  - Increased PCP Utilization

In-home environmental assessment is key to identifying needs: beyond ‘health’ and discharge plan; what is needed for “well-being.”
EVCTP Quarterly 30-Day Readmission Trends
September 2013 - December 2015

*Readmission rate refers to Q9 only.

2010 Baseline Target Group FFS Rate
Target Group FFS Rate
EVCTP Enrollee Rate

*Readmission rate refers to Q9 only.
Eastern Virginia Care Transitions Partnership (now d/b/a VAAACares®)
Outcomes and Cost Savings

**CMS Medicare Demonstration**
- Total Enrollments: 23,278
- Expected Readmissions Prior to Enrollment: 2,221
- Enrollee Readmissions: 2,221

**Other Medicare**
- 2/2016 – 12/2017
- Total Enrollments: 3,474
- Expected Readmissions Prior to Enrollment: 145
- Enrollee Readmissions: 145

**General Assembly Funded Medicaid Pilot**
- 7/2016 – 6/2017
- Total Enrollments: 1,046
- Expected Readmissions Prior to Enrollment: 40
- Enrollee Readmissions: 40

**Managed Care Organization Duals Demo**
- 4/2016 – 12/2017
- Total Enrollments: 893
- Expected Readmissions Prior to Enrollment: 68
- Enrollee Readmissions: 68
VAAACares® Evidence-Based, Care Transitions Intervention (CTI)

- 30-Day intervention targeted to patients with one or more acute hospital admissions – based on a modified Coleman CTI model
- VAAACares® places embedded care coordination staff at participating hospitals.
  - Participants are targeted based on a defined inclusion and exclusion criteria and supported by available data sources
  - Patients consent to participate and the intervention becomes part of the hospital discharge process
- A person-centered intervention plan is developed based on assessment findings.
  - Discharge Planning Assessment
  - In-Home Assessment
  - Medication / Reconciliation post-discharge /Management Plan
In-Home Assessment Components

- Post-Discharge each participant receives an In-Home Assessment
- In-Home Assessment includes the following topics:
  - Nutrition Risk Screen
  - Medication Reconciliation/Management
  - Home Environment Safety Scan
  - Knowledge of Red Flags
  - Plan for Follow up Care
Medication Reconciliation / Management Plan

• Medication Review occurs in the home, post-discharge.
• Review begins with an analysis of discharge medication orders.
• Confirmation of medications that have been filled, as compared to discharge orders.
• Identification of other medications or OTCs taken in addition to the discharge medications ordered.
• Ensures a management plan includes when and how to use Rx.
• Discrepancies are reviewed and reconciled with the support of partnering Hospitalist / Primary Care Providers, appropriate nursing staff, and pharmacy.
  • Meets current HEDIS Measure requirement
Home Environment Safety Scan

- Identification and reduction of the number of home hazards
- Fall and Safety Risk Reduction to include a review of safe railing, flooring, clutter/hoarding at key access points
- Social Determinants Risk Screening
  - Medication co-payment / co-insurance barriers
  - Access to food / Food insecurity
  - Transportation
  - Other Services, if warranted
Target Population

- **Inclusion Criteria**
  - Patient with one or more chronic conditions and/or a recent hospital admission or Emergency Dept. encounter
  - Any “high utilizer”
  - Special targeted program “add ons”
    - Healthy IDEAS reduces anxiety (COPD)/ depression – PHQ 2 & 9
    - CDSMP, Fall Prevention and Advance Care Planning in the home, as needed

- **Exclusion Criteria**
  - Patients that will require long-term total care in a nursing facility that will not have capacity to return to a community setting
  - Patients with advanced dementia, severe mental illness, and active substance abuse without caregiver – referred to other services
# Program Goals

## Triple Aim

<table>
<thead>
<tr>
<th>Better Health</th>
<th>Better Health Outcomes</th>
<th>Lower Cost</th>
</tr>
</thead>
</table>

- Strategy 1: Reduction of 30-day Readmissions (90 days for bundled)
- Strategy 2: Increased Medication Adherence
- Strategy 3: Reduction of Ambulatory Sensitive Hospital Admissions
- Strategy 4: Reduction of Ambulatory Sensitive Emergency Department Visits
Terms of Engagement: Discussion

- Inclusion Criteria
  - CHF, COPD, Diabetes, Septicemia, AMI, Pneumonia, and other High Utilizers

- Exclusion Criteria
  - Active Substance Abuse, Serious Mental Health Issues without Caregiver, Hospice, and LTC

- Referral Process
- Data Access/Agreements
- Reporting/Billing
Thank you!

Questions?

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