

## 3B Health Care Reform: Reconfiguration of Health Care Delivery to Seniors—Part Two

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2:00 pm–3:30 pm



*A Total Solutions Partner*

# Health Care Reform: Reconfiguration of Health Care Delivery to Seniors

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Connie March, CEO  
Provena Senior Services  
March 24, 2010

# Provena Senior Services

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- Peri-acute constellation of service and care options centered around elders
- Services include adult day, home health, hospice, AL, elder housing, nursing homes
- 26 locations
- Provide services in Illinois, Indiana & Wisconsin
- Member of Provena Health, a health care system with 6 hospitals in Illinois

# Reconfiguration

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- Merging senior services and home care
- Forming “peri-acute” constellation
  - Around or before and after acute episodes
- Embraced home/community-based care—desired by consumers—prevent hospitalizations—future growth area
- And institutional care—post-acute care—member of health system continuum
- Initiated July 2009

# Reconfiguration (continued)

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- Model:
  - One governance body
  - Parent corporation with subsidiary corporations
  - One corporate office/management structure
  - Integrated strategic plan
  - Integrated budget and financial statements
  - Integrated key documents and meetings
  - Re-naming to support positioning for future

# Reconfiguration (continued)

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## ■ Early Outcomes:

- Very high satisfaction of all key stakeholders
- Decreased out-migration across system
- No disruption of operations
- Improved financial results
- Removed competitive silos
- Best practices shared and adopted
- Elevated status of organization within the system
- Positioned for future changes—e.g., bundling

# Avoiding Re-hospitalizations Tool— Nursing Homes

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- Part of system—capture data across continuum for performance improvement
- Use computerized tool (Tech Tools) to track nursing home discharges to hospitals by admitting dx., admission dates & discharge dates (-30 days)
- Reconcile nursing home data with hospital re-admission diagnoses and re-admission dates
- Clinician prioritizes patients re-admitted to hospital from nursing home within 30 days by admitting diagnoses that could be avoidable—septicemia, dehydration, CHF, etc.

# Avoiding Re-hospitalizations Tool— Nursing Homes (continued)

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- Nurse performs chart audits to determine diagnoses with numbers and percentages that could have been avoided
- In test phase currently
- Results will be on dashboards for nursing homes, market and system re-admission committees
- Will be reviewed by nursing home teams and/or re-admission committees; & PDSA (performance improvement action plans) implemented and monitored for avoidable re-admissions

# Avoiding Re-hospitalizations

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- Partnered with system hospitals to identify top 3 re-admission diagnoses—selected CHF
- Began protocol development with home health
  - Adopted standardized best practice CHF protocol
  - Monitors put in place (slide 9)
  - Outcomes in 2009: very low re-admissions compared to benchmark of 27% (slide 10)
- Similar CHF protocol in development for nursing homes—first connecting system of care pathway for hospitals, nursing homes and home health

**Heart Failure Monitor**

Total Readmission for Heart Failure in 30 Days or Less (Numerator):

Total Number of Heart Failure Patients (Denominator):



**CLICK TO VIEW  
Heart Failure  
Readmission GRAPH**

**Service Monitor**

# of Service Recognitions (Numerator):

Census on Last Day of Quarter (Denominator):

# of Service Recoveries (Numerator):

Census on Last Day of Quarter (Denominator):



**CLICK TO VIEW  
Service Recognition  
GRAPH**



**CLICK TO VIEW  
Service Recoveries  
GRAPH**

**Infection Control Monitors**

Total # of BSI Infections (Numerator):

Device Days (Denominator):

Total # of SUTI Infections (Numerator):

Device Days (Denominator):

**Patient Client Infection Control Monitors**

\*\* Patients who received flu vaccination (Numerator):

\*\* Audit 10 charts per month (Denominator):

\*\* Patients who received the pneumococcal vaccine (Numerator):

\*\* Audit 10 charts per month (Denominator):



**CLICK TO VIEW  
Flu Vaccinations  
GRAPH**



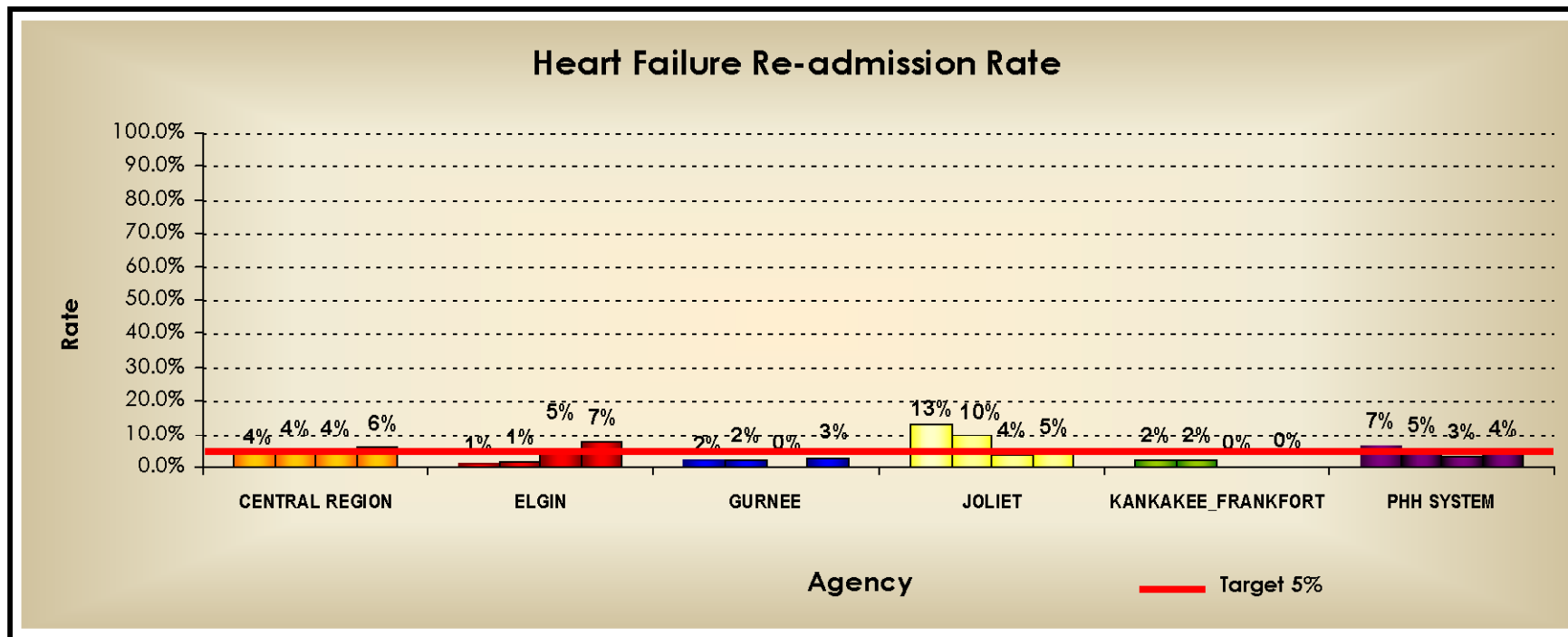
**CLICK TO VIEW  
Pneumococcal Vac.  
GRAPH**

***\*\* Please note: Monitor Oct, report in Jan and April***

**Employee Infection Control Monitors**

\* Employee TB Skin Tests Administered (Numerator):

**Title: Heart Failure Re-admission Rate**  
**Descriptor: Re-admission for Heart Failure within 30 days (total)**  
**Timeframe: 2009**



**RATE:** Total readmissions for Heart Failure in 30 days or less (Numerator)  
Total number of Heart Failure patients (Denominator)

# Stroke Management Pathway Planning

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## ■ Credentials

- Provena Hospitals—Joint Commission Stroke Certified
- Provena Nursing Homes—Evaluating CARF Stroke Certification & Joint Commission Certification
- Provena Home Health—Joint Commission Certified

## ■ System stroke pathway similar to CHF pathway under development

- Physician partnering with pathway development
- Information technology to support pathway

# William Casper

Vice President Residential Services

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## CJE SeniorLife Profile

- 39-year-old organization serving 18,000+ seniors and families annually
- 462 subsidized or affordable housing units in 7 sites
- 3 Adult Day Services sites
- 240-bed skilled nursing facility
- 160-apartment assisted living facility
- Full range of community-based services
  - Home health, consumer assistance, counseling and care management, Managed Care Community Program, transportation, home delivered meals
- Research and grants

## Subacute Services

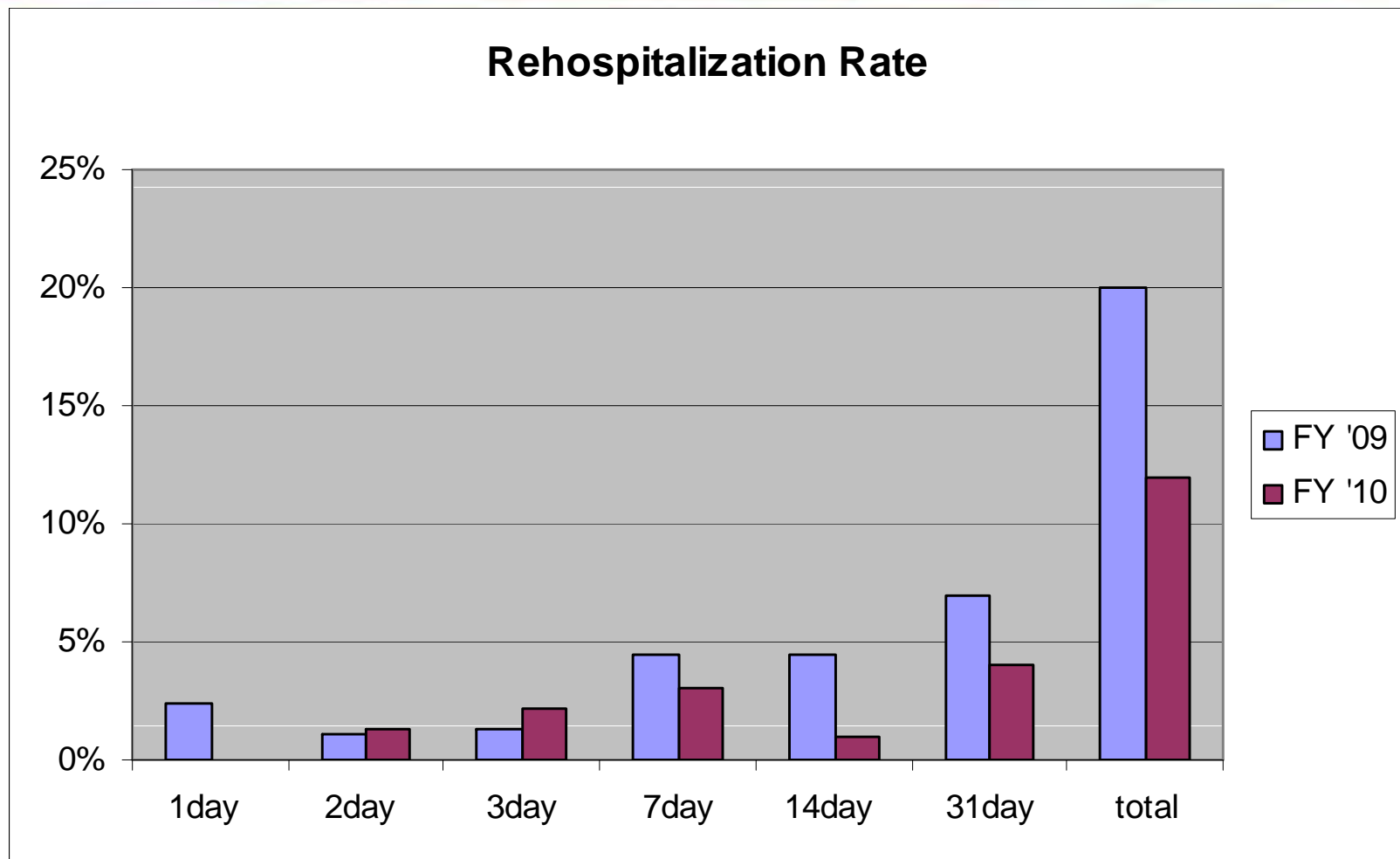
- Primary “front door” to skilled nursing and the “face” of the organization
- Positive net operating income
- Dependent on:
  - quality of care
  - customer satisfaction
  - outcomes
  - hospital and physician referral relationships

# Subacute Services

- Key priorities
  - Relationship with key acute care hospital system
  - Relationship with targeted physician referrers
  - Diversification of referral sources
- Functional outcome measures
- Demonstrated medical competency
  - Key physician relationships
  - Psychiatry consultant
- Advanced Nurse Practitioner
  - Initial physician acceptance
- Meet the needs of hospital referral source
  - Reduction in 30-day re-hospitalization
  - Ease and efficiency of admission process
- Home Health Continuum of care



# Subacute Services



## Managed Care Community Program (MCCP)

- 11-year Pilot Program with Illinois DoA
- Capitated social model for clients at risk of nursing home placement
- Serves 500–600 persons per year
- Average payment of +/- \$1,000 per mo.
- MCCP clients have complex social and mental health issues
- CCP program is fee for service providing fragmented services

# Managed Care Community Program (MCCP)

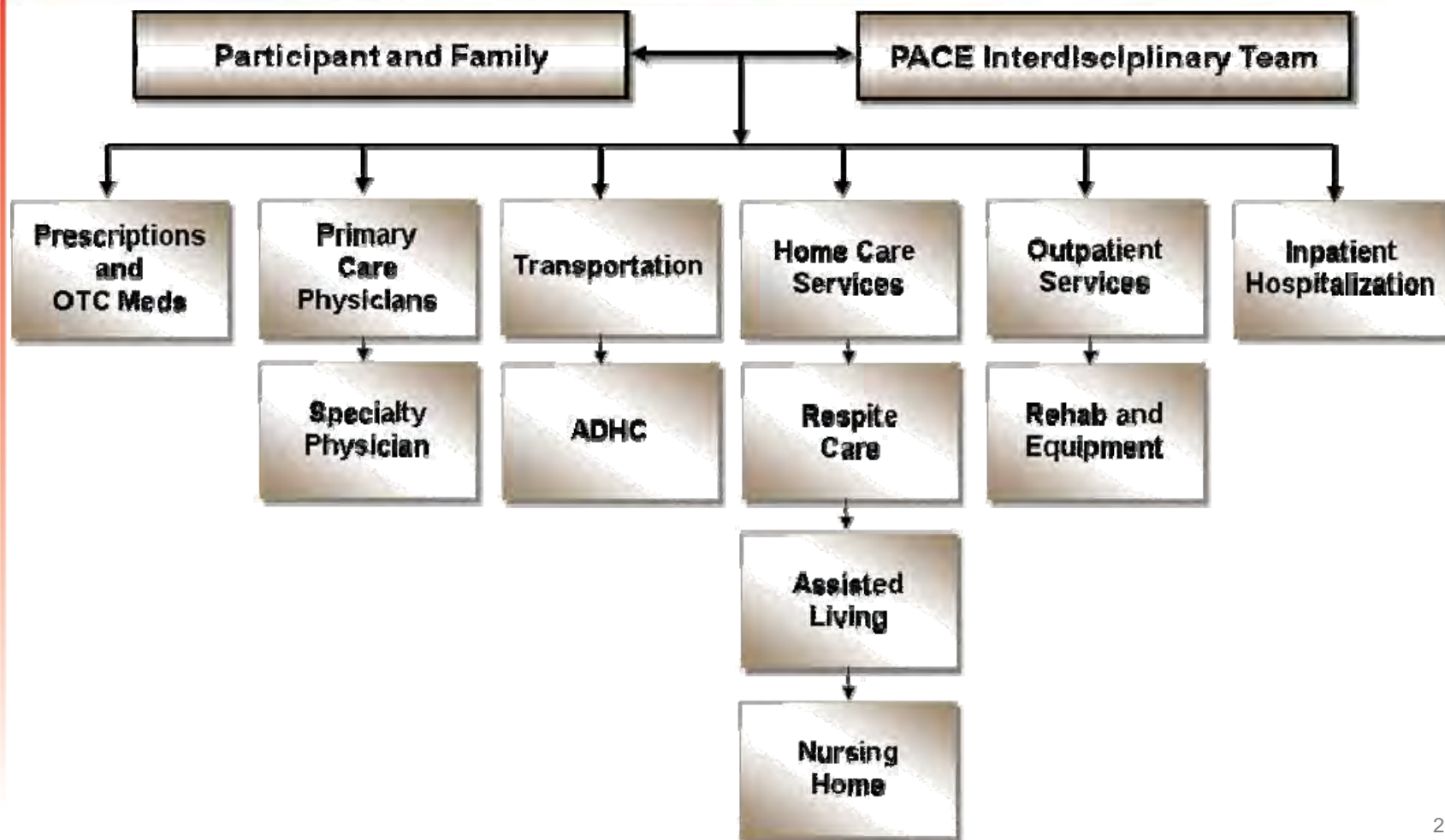
- CJE service package:
  - Geriatric Care Management
  - Personal care
  - Transportation
  - Adult Day Services
  - Home Delivered Meals
  - Bill paying
- State funding at risk
  - Program outcomes are positive but cannot be replicated
  - State funding crisis
- Transition to PACE???

## What is PACE?

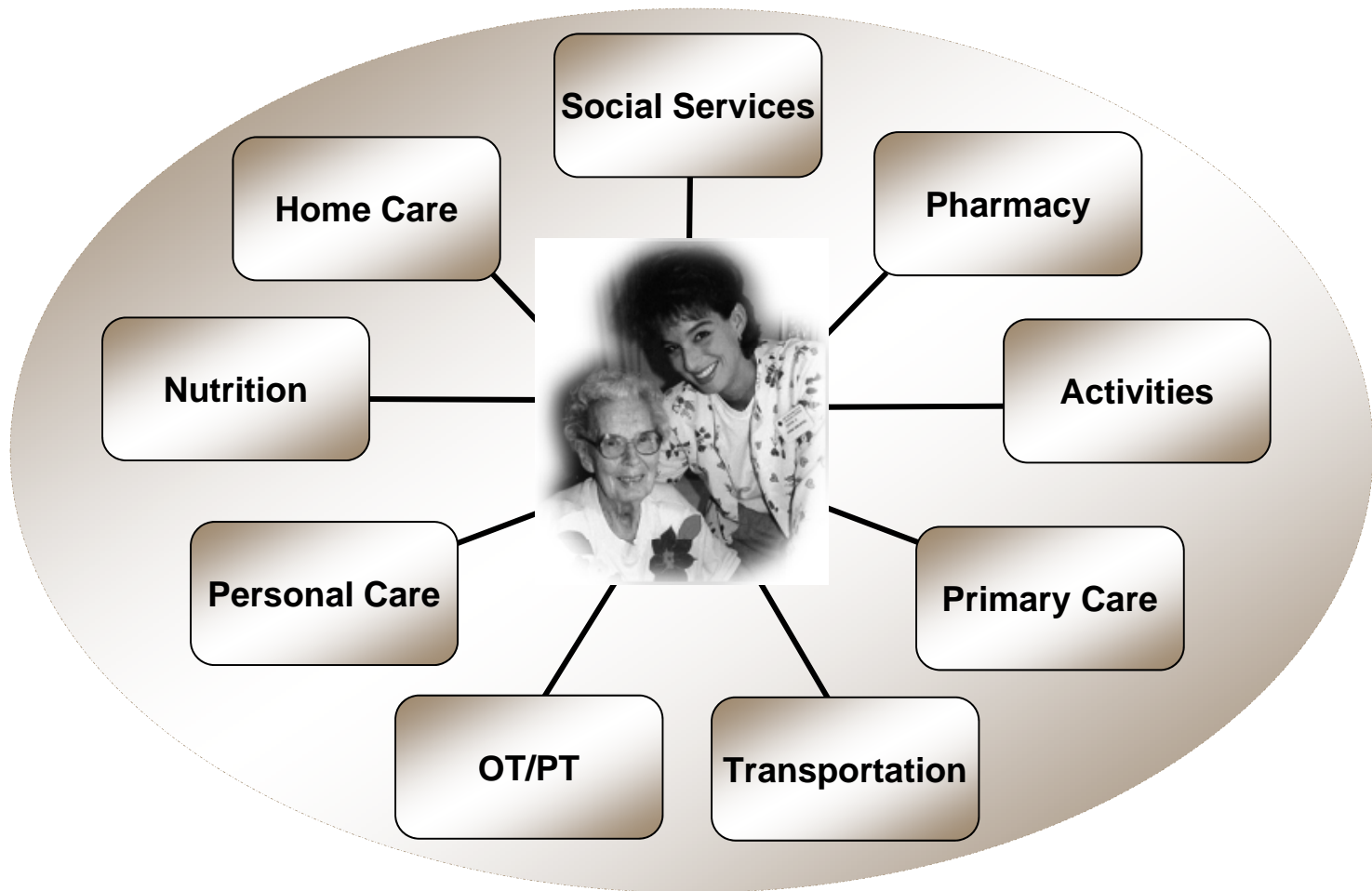
- Program of All-inclusive Care for the Elderly (PACE) is a model of care built on the foundation that seniors with complex health care needs should be able to live in the least restrictive environment for as long as possible
- PACE participants must be:
  - 55 years old and older
  - Certified to need nursing home care
  - Able to live safely in the community at the time of enrollment
  - Live in the catchment area
  - Agree to receive services from PACE network



# PACE Service Delivery Model



# Well-Functioning IDT is Key to PACE Success



# Overview of PACE Payment Structure

- Payment features are unique
- Combines funding from multiple payor sources to meet all participant needs:
  - Medicare
  - Medicare Part D
  - Medicaid
  - Private Pay
- Capitated payment system (per member per month)

PAID

## PACE

- Key issues for CJE
  - Community service infrastructure in place
  - Requires start-up capital
  - Requires management of medical services

# Geriatric Care Management

- Services
  - ADL assessment
  - Care plan and referral to medical, personal care, legal resources
  - Bill paying
  - Records organization and management
  - Coordinate caregiver assistance
  - Transportation to medical and dental appointments
  - 24/7 emergency access
- Focus on adult children as customer
- Private pay market

# Geriatric Care Management

- Expertise and credentialed staff
  - RN or Social Work
- Marketing plan and strategy to reach out-of-town adult children
- Productivity standards for staff
- Contract for services
- Hourly rates
  - Care management \$95/hour
  - Bill paying/insurance assistance \$60/hour

# CovenantCare *at Home*

*A service of Covenant Retirement Communities*



# CHANGING RESIDENT EXPECTATIONS



## **The Traditional Model:**

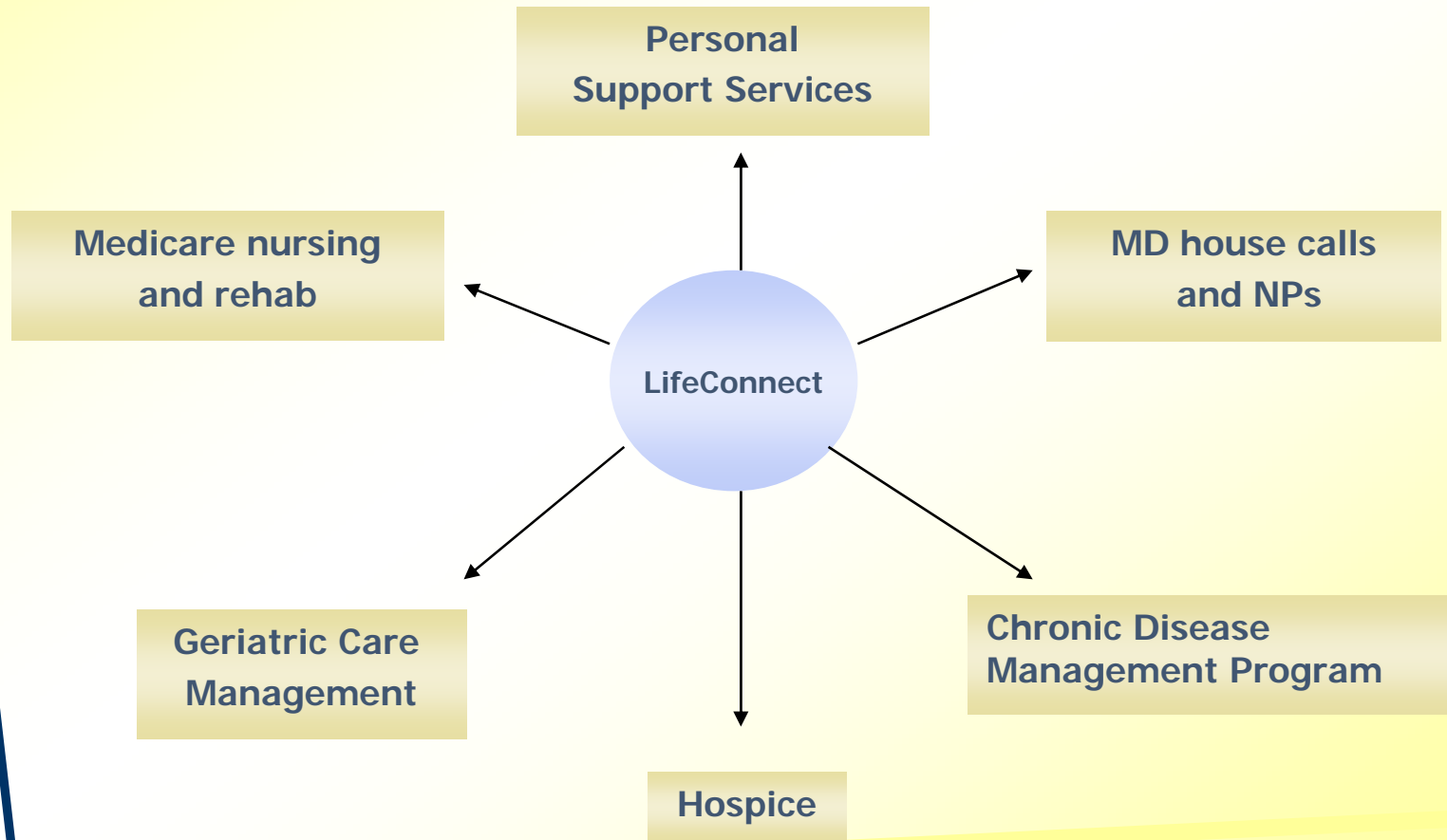
Need for more support & care?

**MOVE** to Skilled Nursing  
Facility or Assisted Living

# WHY WOULD CRC EMBRACE HOME HEALTH?

- \* Offer campus residents the options
- \* Maintain occupancy
- \* Building on the trust already established by Covenant services—  
Extend & **EXPAND** ministry into community
- \* New revenue streams

# CRC HOME HEALTH CORE PROGRAM



# MEDICARE A HOME HEALTH SERVICES

- ★ Direct discharge from hospital to campus
- ★ Post-acute care after SNF discharge
- ★ Medical stabilization without hospital stay
- ★ Flu shots
- ★ No charge to resident with traditional Medicare benefit

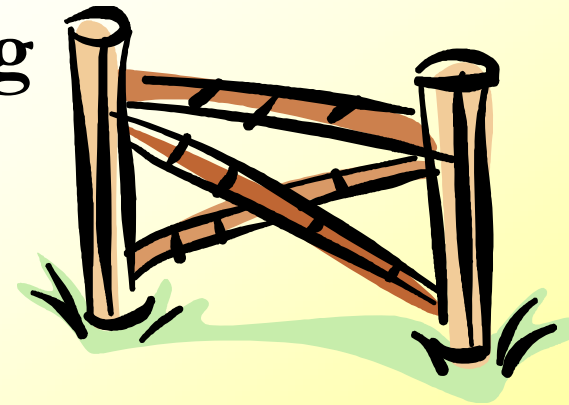
# INVESTMENT

- ★ \$500,000 to break even in 3 years
- ★ Medicare home health or hospice required
- ★ Private duty cannot \$ stand alone
- ★ Acquisition desirable but difficult



# OBSTACLES FOR HOME HEALTH

- ★ High levels of competition
- ★ Small Medicare patient loads on campus and in community
- ★ Entrenched thinking
- ★ Managed care



# HOUSE CALLS SUPPORTS HOMEBOUND

- ★ Pair NP and collaborating MD
- ★ Supplement PCP
- ★ CCRCs ideal: 7–8 visits/day
- ★ Medicare payment 25% higher than office

# Thank You

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