Referral Partnerships: A Data-Driven Approach to Cross Continuum Care Coordination

Agenda

- Introductions
- Goals
- Why Referrals are Increasingly Important
- What Health Systems Want to See
- Use Your Data to Open Doors
Introductions

Jason Stevens, Vice President Post-Acute Care
Gregg Loughman, Vice President Strategy and Governance

Goals

• How and what to communicate to health systems for potential referrals
• Understand what your data is telling you
• Using your data to open referral doors
Why Referrals are Important

Hospitals Narrowing Their Referral Network

Previous Model
All providers in a geographic region

Future Model
Selected providers pre-screened for quality outcomes
Continued Evidence of an Inefficient and Ineffective System

- 1 in 3 hospitalized patients are harmed during stay
- 1 in 5 Medicare patients readmitted 30 days post discharge

Patients Reported Experience:
- 20% -- records not transferred
- 25% -- physician reorder tests for accurate information/diagnosis
- 50% -- problems with care coordination, notification of results and physician communication
- < 50% -- received clear information on benefits and trade-offs of treatment

1/3rd or $750 billion of health care expenditures don’t improve health

Institute of Medicine Best Care at Lower Cost, September, 2012

US Spending is Highly Concentrated

30% of people consumed 90% of cost
Per capita spend higher for ages 60+

Managing through the tipping point

Consider relevant Harris study* statistics:
- 38% of System level leaders anticipate “rapid integration” and…
- 47% would like to see “rapid integration”

*Source: Harris Interactive for KPMG LLP, 2012

Economic Triggers In Move From Volume to Value

Value-Based Purchasing
Readmissions Reduction
System Integration
Stronger Business Case and ROI For Our Services

Percentage of Hospital Revenue at Risk

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Accountable Care Organization Building Blocks

- ACO responsible for:
  - Clinical care management (clinical integration)
  - Capture data for continuum of care
  - Measure and monitor costs and quality

Clinical Integration/ACO: How Do You Generate Savings?

- Population management
- Well care
- Chronic disease management
- Effective use of appropriate clinicians
- Medical home
- Bundled payment

- 50% Care Management
- 15-20% Throughput (Volume)
- 15-20% Lower Cost Site
- 15-20% Generic use, GPO, standardization

- Post acute, outpatient, ER use
- Extended hours, higher occupancy, narrower network

Appropriate Economic Indicators
Do Your Patients Live in a Medical Home?

A Patient Centered Medical Home model delivers primary care that follows these basic tenets:

- Care must be comprehensive
- Care must be patient centered
- Care must be coordinated
- Care must be easily accessible
- Care must be safe and of the highest quality

Impact of Primary Care Medical Home

- 36.3 percent drop in hospital days
- 32.2 percent drop in emergency department use
- 9.6 percent decline in total cost
- 10.5 percent reduction of inpatient specialty care costs
- 18.9 percent reduction in ancillary costs
- 15 percent reduction of outpatient specialty costs

Medicare spending for the hospitalization episode

- Episode A (higher utilization)
- Episode B (lower utilization)

$6,500

Episodes A and B Have Same Bundled Payment

Hospitalization
Rehabilitation
Readmission

Acute Care Episodes

Source: Medicare Payment Advisory Commission (MedPAC)

How Hospitals are Measuring Quality
How Are Hospitals Measuring Quality Outcomes?

• Core Measures
  - AMI, CHF, etc.
• Readmissions < 30 days
• Mortality
• Inpatient Days /1000 cases
• HCAHPS
• Consumer Perception

“In God we trust. All others bring data.”
- W. E. Deming

Clinical Dashboards Link Clinical and Finance Outcomes
Understand The Impact Your Services Have on Quality, Cost and Patient Experience

Geographic Variation in Spending, MS-DRG 291
Heart Failure and Shock with Major Complications

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Source: CMS Office of Information Products and Data Analysis, Medicare Claims Analysis - 2010

Consumer Assessment of Healthcare Providers and Systems - CAHPS®

- Agency for Healthcare Research & Quality
  - Yale, Harvard & RAND
- NRC Early CAHPS Pioneer
- Pay for Reporting evolved to Value Based Purchasing
- Reimbursement Implications (e.g. 30% at risk)
- Broad Payor Adoption (e.g. Highmark BCBC)
- CAHPS Surveys with NRC Today
  - Hospital
  - CG CAHPS
  - Home Health
  - Nursing Home*
What Keeps Hospitals Up at Night?

- What do my patients do when they leave?
- What is influencing my scores that I cannot control?
- Is my data accurate?
- How are patient experiences different by clinical population? Socio-demographics?
- What is threatening my SL/M margin?
Example: HCAHPS Protocol

- When do residents get survey about inpatient stay (admissions to SNF are exempt)
  - Influence of transitions
  - Influence of home health provider
- Halo effect of Integrated Delivery System
  - Only as strong as weakest delivery point
- How will patient concerns be conveyed back to hospital?
  - Closing the loop

How Can You Educate Yourself on Local Hospital Performance?

www.whynotthebest.org
What to Present?

Data to Present to Potential Referral Sources

- Attention to Re-hospitalization
- Patient Experience Scores
  - Move-In to Move-Out
- Clinical Outcomes

Demonstrate:
- Peer group comparisons
- Trends

Be Specific:
- Results targeted to your audience
**Attention to Hospitalizations**

**PatientView**

**Patient List – Risk Overview**

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**Demonstrate your attention to potential hospitalizations at a patient level**
Attention to Hospitalizations

- **Discharge Calls**
  - Touch base within 48 hours of discharge
  - Quickly identify those who are “at risk”
  - Act on your findings
  - Track your results

**Educate your potential referral sources on the benefits of your discharge call program and your focus on hospitalizations**

Patient Experience Scores
Patient Experience Scores - Move In

- Satisfaction
- Recommendation
- Welcomed by Staff
- Ease of Move In
- Attention to Needs

Patient Experience Scores - Discharge

- Satisfaction
- Recommendation
- Care & Concern of Staff
- Answering Call Lights
- Quality of Care

DEMONSTRATE “EASE OF TRANSITION”

HIGHLIGHT THE VOICE OF YOUR FORMER PATIENTS
Overall Percentage of “Excellent & Good”

Be Specific

| 2013 Admissions from ABC Hospital |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Total           | Surveys Received| Overall Satisfaction | Overall Recommendation | Re-Hospitalization rate |
| 115             | 68              | 92%                | 94%                | 18.4%            |

Overall scores are good, specific scores by referral source are even better!
Know Your Star Ratings

Consumers aren’t the only ones looking at your ratings

Recommendation Scores Based on Overall Star Ratings
Wrap Up

• Hospital financial systems are evolving
• Referrals are increasingly important
• Use your data to open doors

Questions?
National Research Corporation

(800) 601-3884