Hospital Readmissions: Challenges and Opportunities for Catholic Senior Service Providers

Nov. 19, 2012
Noon – 1:30 p.m. ET

Reflection for Today’s Event:

God, Creator, Giver of Life,
For each of us here this day, you have inspired within our souls a desire to respond to the needs of others through ministry in healthcare, to seek ways of caring for ourselves and those we meet on our journey. Keep us resolute in our determination to further your healing mission in Catholic health care. We ask this through Christ, our Lord,

Amen
Hospital Readmissions: Challenges and Opportunities for Catholic Senior Service Providers

Your Presenters for Today’s Event:

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Urban Institute
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New York

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Hospital Readmissions: Challenges and Opportunities for Catholic Senior Service Providers

November 19, 2012

Howard Gleckman
Resident Fellow
The Urban Institute

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The Care Challenge

- 23.5 Percent Readmitted from SNF-Hospital within 30 days
  - 419,000 Medicare beneficiaries in 2006
  - 24 percent to 60 percent may be avoidable
  - Wide variation
    - Top 25 percent averaged < 10 percent
    - Bottom 25 percent averaged 25 percent
  - 80 percent for one of five conditions
    - Pneumonia, CHF, UTIs, dehydration, COPD/asthma

The Regulatory & Business Challenge

- Hospital Readmission penalties
  - 2200 hospitals penalized in Oct., 2012
  - Up to 1 percent this year--$280 million for MI, CHF & Pneumonia
  - Up to 3 percent of total Medicare revenues in 2015+ more conditions
  - Private insurers sure to follow

- SNF readmission penalties
  - Obama
    - MEDPac

- Long-stay nursing home penalties
  - On the way?
Causes?

- Lack of NF Resources
- Poor communication
  - Among NF staff
  - Between staff and other providers
- Little confidence in NH abilities from physicians and families
- Poor relationships w/ hospitals/discharge planners
- Family dynamics
- Poor advance care planning
- Liability worries
- Perverse incentives

Solutions

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of resources</td>
<td>Hire/reconfigure staff/culture change</td>
</tr>
<tr>
<td></td>
<td>Does it pay?</td>
</tr>
<tr>
<td>Poor internal communication</td>
<td>Training/technology/culture change</td>
</tr>
<tr>
<td>Low confidence by external physicians</td>
<td>Better communication/technology</td>
</tr>
<tr>
<td>Poor relationships w/ hospitals</td>
<td>Resident case managers</td>
</tr>
<tr>
<td></td>
<td>Communication w/ discharge planners</td>
</tr>
<tr>
<td>Family issues/liability</td>
<td>Better communication w/ families, EOL planning, POLSTs, DNH</td>
</tr>
<tr>
<td>Perverse Incentives</td>
<td>New payment &amp; delivery models: Maged care/ACOs/ bundled payment</td>
</tr>
</tbody>
</table>
Models for Success

- Hebrew Senior Life
  - 50-bed Recuperative Services Unit (RSU)
    - Standardized admissions document
    - Automatic palliative care consult and ongoing family communication
    - Team Improvement for the Patient and Safety (TiPs) conferences
    - RED for RSU discharges
    - Now expanding to long-stay

- Wheaton Franciscan Healthcare
  - Integrated hospital/SNF/long-stay nursing
    - Regular meetings w/ hospital and NH senior staff
    - Embedded NH admissions coordinators in partner hospitals
    - INTERACT
    - Hospital End of Life Program to increase mobility, reduce catheter and meds (hospital & NH)
    - Enhancing nurse training through NiCHE (hospital & NH)

- Archcare
ArchCare

ArchCare is the continuing care community of the Archdiocese of New York

- The system that serves frail and disabled individuals in New York City and the Hudson Valley.
- Encompasses 7 nursing homes, a long term acute care hospital, managed long term care plans, home care, and hospice.

### Consumer Demographics

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SNF Residents (Average Daily Census)</td>
<td>2,409</td>
</tr>
<tr>
<td>Number of New SNF Admissions Per Year</td>
<td>3,836</td>
</tr>
<tr>
<td>Managed Care Enrollment</td>
<td>1,511</td>
</tr>
<tr>
<td>Number of Consumers With Developmental Disabilities Served</td>
<td>2,145</td>
</tr>
</tbody>
</table>

### Managed Care Statistics

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-SNP Enrollees</td>
<td>1,236</td>
</tr>
<tr>
<td>PACE Enrollees</td>
<td>275</td>
</tr>
</tbody>
</table>

### Workforce

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of FTE’S</td>
<td>4,491</td>
</tr>
</tbody>
</table>
### ArchCare & Affiliate Services

<table>
<thead>
<tr>
<th>Services/Program</th>
<th>Capacity</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing Home Care</strong></td>
<td>2,331 beds</td>
<td>Manhattan (ArchCare = 25% of beds in the county), Bronx, Staten Island, Dutchess, Orange</td>
</tr>
<tr>
<td></td>
<td>- 431 subacute beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 48 Huntington’s beds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Approx. 100 dialysis beds</td>
<td></td>
</tr>
<tr>
<td><strong>AIDS Nursing Home Care</strong></td>
<td>156 beds</td>
<td>City-wide resource</td>
</tr>
<tr>
<td><strong>Long Term Acute Care Hospital</strong></td>
<td>225 beds (Calvary)</td>
<td>Regional resource</td>
</tr>
<tr>
<td><strong>Specialty Hospital</strong></td>
<td>50 beds (OPWDD – Article 16)</td>
<td>Regional resource</td>
</tr>
<tr>
<td><strong>ArchCare Senior Life (PACE)</strong></td>
<td>200 - 400 participants</td>
<td>Manhattan, Bronx</td>
</tr>
<tr>
<td><strong>ArchCare Advantage</strong></td>
<td>&gt; 1,236 enrollees</td>
<td>Manhattan, Bronx, Staten Island, Dutchess, Orange</td>
</tr>
<tr>
<td><strong>Outpatient Clinic (OPWDD – Art. 16)</strong></td>
<td>20,900 onsite visits; 40,300 off-site visits</td>
<td>City-wide resource</td>
</tr>
<tr>
<td><strong>Home Care</strong></td>
<td>&gt; 12,400 CHHA visits (Calvary)</td>
<td>North Manhattan, Queens, Bronx, south Westchester.</td>
</tr>
<tr>
<td></td>
<td>&gt; 820 CHHA census (VNR)</td>
<td>City-wide resource</td>
</tr>
<tr>
<td></td>
<td>~690 LTHHCP census (VNR)</td>
<td>Manhattan, Brooklyn, Queens</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>ADC: 206; Home Days: 73,726</td>
<td>Regional resource</td>
</tr>
<tr>
<td><strong>Adult Day Health Care</strong></td>
<td>30 slots</td>
<td>Staten Island</td>
</tr>
</tbody>
</table>

### Tactics To Minimize Hospitalizations

ArchCare has undertaken a number of efforts to reduce avoidable hospitalizations which include the following:

- Enrolling long term residents into ArchCare Advantage which is a Medicare Advantage Special Needs Plan (SNP).
- Implementing INTERACT and monthly analytics.
- Establishing clinical alliances between ArchCare skilled nursing facilities (SNFs) and hospitals.
ArchCare Advantage

- 2003 Medicare Modernization Act (MMA) authorized Medicare Advantage managed care plans focused on special needs populations

- Three types of SNPs based on defined populations
  1. Dual Eligibles
  2. Chronic Conditions
  3. Institutional

- In 2008, ArchCare launched its Institutional SNP (I-SNP)

I-SNP Performance: Percent of Beneficiaries By Number of Annual Inpatient Hospitalizations

<table>
<thead>
<tr>
<th></th>
<th>Zero</th>
<th>1</th>
<th>2</th>
<th>3 or 4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-SNPs nation-wide*</td>
<td>83.2%</td>
<td>12.1%</td>
<td>3.1%</td>
<td>1.1%</td>
<td>0.4%</td>
</tr>
<tr>
<td>ArchCare Advantage (I-SNP)**</td>
<td>82.1%</td>
<td>12.9%</td>
<td>3.4%</td>
<td>1.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Institutional Medicare FFS*</td>
<td>46.8%</td>
<td>24.4%</td>
<td>13.2%</td>
<td>10.9%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

* Source “SNP Alliance Annual Profile & Advanced Practice Report,” The Lewin Group, February 2012.
** 2011 data.
## I-SNP Performance (cont'd)

<table>
<thead>
<tr>
<th></th>
<th>National I-SNP</th>
<th>Institutional FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Median Risk Score</strong></td>
<td>2.14</td>
<td>1.84</td>
</tr>
<tr>
<td><strong>Hospitalization Rate per 1,000 Beneficiaries</strong></td>
<td>1,820 days</td>
<td>7,497 days</td>
</tr>
<tr>
<td><strong>Median ER Visits per 1,000 beneficiaries</strong></td>
<td>367 visits</td>
<td>714 visits</td>
</tr>
</tbody>
</table>

Source: “SNP Alliance Profile & Advanced Practice Report” prepared by The Lewin Group for the National Health Policy Group (February 2012)

## SNF Operational Tactics

- Implementation of INTERACT.
- Monthly quality reports.
  - Review of 25% sample of total transfers.
Clinical Alliances – Case Study

- Terence Cardinal Cooke Health Care Center (TCC)
  - 679-bed SNF
  - East Harlem, Manhattan
- Mount Sinai Hospital (MSH) - neighboring hospital.

- Formal clinical alliance agreement.
- Monthly meeting of joint management committee
- Clinical Transitions Manager
- Medical Director for TCC’s sub-acute unit
- Written transfer protocol
- Physician to physician contact
- Clinical rounding - AIDS

These collective efforts resulted in a 18% reduction of hospitalizations from 1,132 to 927 (2010 to 2011)

Summary

- ArchCare has sought to minimize potentially avoidable hospitalizations through a number of efforts on many fronts.
  - System-wide, hospitalizations declined 19% between 2010 and 2011.
  - This represents a reduction of 3.3 to 2.7 hospitalizations per 1,000 SNF resident days.
Reference Websites For Additional Information

National Health Policy Group (NHPG) and the SNP Alliance
http://www.nhpg.org/

“SNP Alliance Annual Profile & Advanced Practice Report”
The Lewin Group (February 2012)

INTERACT (Interventions to Reduce Acute Care Transfers)
http://interact2.net/index.aspx

Q&A