Build a Care Management Connection to Your Post-Acute Partners

Share Actionable Information Across the Continuum with Crimson Care Management

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Road Map

1. The Post-Acute Data Gap

2. Requirements for a Best-in-Class Solution

3. Crimson Care Management Impact
Will Post-Acute Care Make or Break Your Population Health Strategy?

Outsized Impact from Post-Acute Providers

Post-acute care providers are in the spotlight, as population health managers learn how much their own performance depends on the post-acute period. A sprawling array of post-acute provider types, care settings, and business models exerts huge influence over patient outcomes and the cost of care.

**Post-acute care is expensive and complex:**
- Post-acute care cost growth has outpaced acute care growth, at over 6% annually through 2012.
- Over 70% of spending variation for Medicare patients is attributed to post-acute care.
- Advisory Board member organizations typically report that hundreds of unique post-acute care entities treat their patients in a single market.

**Population health managers bear the risk of adverse patient outcomes in post-acute settings:**

About 40% of Medicare inpatients are known to be discharged to post-acute care, including skilled nursing facilities, home health agencies, or inpatient rehabilitation. Roughly half of those patients enter a skilled nursing facility (SNF); researchers found that one-fourth of SNF patients were readmitted to acute care within 30 days.

Population health managers can’t succeed under value-based payment without influencing the performance of their post-acute partners. Where should you start?

Three Improvement Strategies Available

Efforts to boost post-acute care partners’ performance fall into three categories:

1) Incentive alignment
2) Network development
3) Cross-continuum care management

**Incentive alignment**, whether through bundled payments, outright acquisition, or an alternate integrative contracting strategy, does not assure success: creating motivation to improve does not assure expected outcomes.

**Network development** can be as simple or as complex as desired, ranging from a list of preferred post-acute providers to a more formal narrow network vetting process with contractual relationships. Understanding relative performance is useful but does not drive continuous care improvement over time and across patient populations.

**Only ongoing cross-continuum care management** can guide post-acute partners’ actions to drive efficient and effective care choices. Many organizations have invested heavily in expanded care management capacity; what blocks effective care management extension across post-acute care providers?

Post-Acute Providers Are Flying Blind with Your Patients

Data Gaps Make Effective Cross-Continuum Care Management Impossible

Cross-continuum care management requires that all care stakeholders follow a shared plan for an individual patient, responding to changing needs in real-time. In the post-acute care environment, most providers are missing both guidance from a shared plan and missing ongoing shared updates about actionable patient needs.

Patients entering post-acute care must transition from data silo to data silo as they move across providers and settings. Even if a retrospective care record is perfectly transmitted (unlikely in the complexity of the post-acute care landscape), care management guidance is not shared. Patient status changes are not reported across the entire care team. Patient information fails to trigger appropriate action to improve quality and cost.

The Moment the Patient Falls Off the Radar

We can identify the moment when vulnerable patients tumble into the post-acute data gap – it’s when they are loaded into an ambulette for transfer out of the acute facility, with a discharge summary in a manila folder shoved under their pillow. They fall right off of “the EMR cliff”, becoming invisible to EMR-dependent care managers and providers.

Carrie Kozlowski
General Manager
Crimson Care Management

Many organizations have attempted to solve post-acute data gaps (both during transitions and during ongoing care) with staff deployment or standardized transition tools. Unfortunately, manual efforts will not scale across the requirements of population health.

Workarounds Fall Short

- **Unscalable effort**: impact limited by manual processes, reliance on telephonic outreach, redundant forms, lagging or missing data
- **Limited connections**: information still not shared with all stakeholders (for example, qualified patients are not connected with local human service agencies for financial aid, nutrition services, non-clinical in-home help)
- **Opaque performance**: patient and provider progress towards goals is not captured

Expensive resources like an RN care manager tracks patients with weekly phone census

Standardized forms, tracking tools, handoff documents try to bridge the EMR boundary

Specialized transition managers attempt to solve one patient at a time
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Unlocking Collective Care Impact

Shared Insight Should Drive Coordinated Action

Cross-continuum care management should unlock collective care impact: improved clinical and financial outcomes, as each individual stakeholder plays their part well. No one stakeholder can identify all patient requirements; and no one stakeholder can provide all needed solutions. The entire care team – including providers, community agencies, families, and the patient themselves – must work from a shared playbook for patient care.

Applying Care Management Technology in Post-Acute Care

How can technology help all post-acute care stakeholders to work from a shared playbook?

1) **Identify patient needs**: to scale across populations, care managers need help to know where their patients are; care managers and providers need to know what the patient’s most-important clinical and psychosocial needs are. Patient needs can be determined by diagnosis, sub-population, or care setting but must be reassembled into a patient-specific care plan for use by the care team.

2) **Push actionable information to all members of the care team**: defined patient needs often require multi-stakeholder input for resolution (for example, a follow-up appointment can require transportation assistance). Successful technologies will coordinate extended care teams (including community-based agencies and services unable to join an EMR system) by automatically generating prioritized requests for action and pushing them to the correct actor.

3) **Track patient and provider progress**: continuous improvement and, for some organizations, network refinement is only possible with ongoing performance tracking.

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**Underestimating Post-Acute Potential**

Too many population health managers underestimate two things: the impact that post-acute care has on their outcomes and the ease with which they could apply technology to improve post-acute partnerships.

*Carrie Kozlowski*
General Manager
Crimson Care Management
Anatomy of a Shared Playbook: Crimson Care Management

Crimson Care Management helps organizations to expand the impact of their care managers by extracting actionable insight from comprehensive patient data. Crimson Care Management connects to post-acute care providers by offering an application to share the patient care playbook, coordinating activities and exchanging need-to-know updates about patients.

**Integrating Complex Data**

Cross-continuum data for the entire population is analyzed to tell you what your patients need. Crimson assigns patients into care programs that reflect specific diagnoses, social needs, care goals, sub-population membership, or status changes.

- ADT and HL7 feeds
- Discharge notes
- Medical claims
- Attribution
- EMR
- Lab systems
- Biometrics
- HRAs
- Risk scores

**Extracting Insight with Analytics**

Crimson assembles prioritized care guidance for individual patients based on current risk stratification, real-time data inputs, and care program assignment.

**Driving Collective Action**

Crimson guides care team workflow to meet prioritized patient needs quickly. To-do steps are pushed out and completion is tracked. Care notes and alerts can be shared across the team, including with post-acute care providers, community caregivers, family members, and social service providers. Progress is measured with configurable reporting.
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   - Case Study 1: HCA Capital
   - Case Study 2: Michigan Pioneer ACO/Detroit Medical Center
Case Study: HCA Capital

Building a Bridge from Care Managers to Post-Acute Providers Drives Readmissions Down

HCA Capital, sub group of 7 Hospitals in Southwest and Central Virginia

- **About:** In 2011, concerned about potential penalties due to impending changes to CMS’ Hospital Readmissions Reduction Program, HCA Capital Division leadership analyzed its markets and targeted seven hospitals for readmission improvements.

- **Challenge:** Heart Failure (HF) was a known driver increasing readmission rates for seven hospitals within two markets.

- **Solution:** Using Crimson Care Management (CCM), HCA Capital piloted a program using automated protocols to assist in providing support for discharged HF patients for at least 30 days and enabling better communication with post-acute and community-based providers to identify patient issues.

- **Impact:** HCA Capital decreased HF readmissions by 32.5% in its Southwest Virginia market, previously at risk for penalties. Its Richmond market, with historically low readmission rates but also with the biggest potential for large financial loss if national standards were to decrease, reduced rates by nearly 9.2%.

**Streamlining Care Coordination to Reduce Readmissions**

<table>
<thead>
<tr>
<th>Identify Patients</th>
<th>Focus Interventions</th>
<th>Drive Workflow</th>
<th>Track Results</th>
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<tbody>
<tr>
<td>• Discharged HF patients flagged for 30-day monitoring</td>
<td>• Custom care programs automatically generate tasks to address patient goals</td>
<td>• Sub-acute providers engaged to help complete interventions efficiently</td>
<td>• Overall patient outcomes analyzed to identify variations in care</td>
</tr>
<tr>
<td>• Risk indicators determine care navigators’ highest priority patients</td>
<td>• Programs align to meet financial and patient outcome goals</td>
<td>• Alerts ensure care team members are informed</td>
<td>• Caseload progress tracked across the entire team</td>
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**Impact Highlights**

- **32.5%**
  - Decrease in readmissions in rural, vulnerable market

- **9.2%**
  - Decrease in readmissions in larger market already performing well
Case Study: HCA Capital, continued

Community partners are eager to participate and collaborate with HCA Capital to provide better care.

Workflow technology enables care team coordination to effectively support HF patients in 30 day post-discharge period.

Seamless Communication Prevents Readmission

A home health worker noticed the status of one of my patients declining and sent me a Care Note Alert asking for immediate assistance. Quickly connecting, we determined that the patient had been doing better on a different diuretic during his hospital stay. Working together and with the patient’s physician, we were able to get the diuretic changed and saw an immediate improvement.

Care Navigator
Chippenham-Johnston Willis Medical Center

Stronger Provider Relationships, Enhanced Patient Engagement Reduces Readmissions

<table>
<thead>
<tr>
<th>Underperforming, Rural Market¹</th>
<th>9.2% Decrease in Readmission Rates Also Achieved in Large, Previously Well Performing Market²</th>
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<tbody>
<tr>
<td>Decreases Readmission Rates by 32.5%</td>
<td>30-Day Heart Failure Readmission Rate</td>
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<tr>
<td>Before CCM Q4 2011 - Q3 2012</td>
<td>22.3%</td>
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<tr>
<td>After CCM Q4 2012 - Q3 2013</td>
<td>15.1%</td>
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<tr>
<td>Before CCM Q4 2011 - Q3 2012</td>
<td>18.2%</td>
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<tr>
<td>After CCM Q4 2012 - Q3 2013</td>
<td>16.5%</td>
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¹ Pilot in Southwest Virginia market included LewisGale Medical Center, LewisGale Hospital Alleghany, LewisGale Hospital Montgomery, and LewisGale Hospital Pulaski.
² Pilot in Richmond, Virginia market included Chippenham-Johnston Willis Medical Center, Henrico Doctors’ Hospital, and John Randolph Medical Center.

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Case Study: Michigan Pioneer ACO

Hardwiring Better Care Management Across the Continuum

Michigan Pioneer ACO/Detroit Medical Center• 8-hospital center in Detroit, part of Tenet Healthcare Corporation

Impact

42% Drop in readmissions

3rd
Ranked 3rd in Shared Savings earned in the Pioneer Program, 2013

95% Patients Followed Up Within Fourteen Days of Discharge (70% within 7 days)

Challenge in Brief

- **Under Pressure for Rapid Results:** The risk/reward structure of the CMS Pioneer program demanded population-wide impact on an accelerated timeline.

- **Limited Data Visibility:** The ACO needed to quickly understand and act on patients’ needs after receiving attribution information from CMS. Approximately 70% of the population received care outside of the ACO, requiring tight connection with partner organizations. Changes to patient information and the right clinical playbook needed to be shared with all providers, both inside and outside the ACO.

- **Care Management Capacity Expansion:** The ACO needed to serve patients with a care strategy based on each patient’s current risk to provide cost-effective care management across the population. The organization also extended care management to new populations.

Up-to-Date Risk Scores Drive Segment and Partner Assignment

The ACO used Crimson to determine each patient’s individual risk (constantly updated as new data flows in from many sources). Patient risk scores incorporate both clinical and psycho-social data, carefully weighted to reflect the importance of the social determinants of health in their market. The highest-risk patients receive intense home-based services from an in-system partner. Rising-risk patients are helped with customized care plans coordinated by the ACO’s own care management staff. Low-risk patients are assigned to contact by the local agency on aging.
Case Study: Michigan Pioneer ACO, continued

Crimson Care Management Enables Coordination Between Many Organizations

How Need-to-Know Information Is Shared

Alert system notifies care team members of specific patient trigger events including care note alerts, transitions in care, visits to the ED, and expiration.

Custom-built care programs guide the task engine using protocols based on care coordination best practices and health system priorities.

Task lists are automatically populated by care program protocols and influenced by patient’s risk stratification.

Who Is Connected?

ACO Care Managers
Real-time patient data updates trigger their actions; platform provides a link to care managers for secondary populations.

Area Agency on Aging
Discharge “transition coaches” for low-risk patients document in CCM.

DMC Personalized Care at Home
Intense home-based care for highest-risk patients documents care in CCM and relies on multiple alerts.

Skilled Nursing Facilities
ACO care managers use CCM to track SNF population and care across many facilities.

Home Health Agencies
Use CCM to:
- Capture the start date of care
- Complete medication reconciliation
- Share assessment notes
- Create symptom management guides and share care goals

From Joan Valentine, RN, BSN, MSA, Corporate Director, Transitions in Care:

We are proudly cutting edge, and we want to remain a national leader in designing future health care delivery models. **We are a very well-wired system within our network, but delivering the promise of the ACO model meant expanding our reach** in order to get our arms around many thousands of attributed patients.”

It was **insanely crazy** how hard our team worked to provide the system-wide performance data every Friday. They had to create a line for each patient in a spreadsheet. Each patient had 18 fields. Multiplying that for each patient encounter (about 10 per patient) meant that we had enormous spreadsheets, which we scrambled to fill every week by chasing down doctors, typing in discharge notes, etc. **Now we have it all automatically.**