Developing a Program to Prevent Potentially Avoidable Hospitalizations

Preparing for ***Value Based Payment*** – Partnering With an MLTC

Able Health Care Service, Inc.

Revised 9/4/18

Understanding VBP, Aligning our Goals

- Overall goal for NYS Medicaid program/Able Health Care Service's goals:
  - Improve health outcomes for individuals and populations
  - Provide more integrated care and care coordination
  - Remain financially sustainable (maintain or reduce costs)
- How to accomplish this? VBP approach:
  - Holistic, all encompassing approach
  - Create a program where Home Care Providers partner with MLTCs to accomplish goals
  - NYS VBP will leverage managed care to:
    - Deliver payment reforms;
    - Change provider business models through positive financial incentives;
    - Allow maximum flexibility within a standardized framework and
    - Recognize importance of community level services and social determinant of health interventions

Selection of Quality Measure/MLTC contracts

- Able Health Care Service, Inc. staff tracks and reports hospitalizations at PI/PAC meetings
- Discussion and chart review revealed that our LHCSA population have multiple comorbidities with many chronic conditions (ex: CHF, HTN, COPD, seizures, DM, OA, Depression, Anxiety, History of UTI, PNA)
- These conditions often exacerbate and cause rehospitalizations
- Prevention may be possible by early recognition and reporting of symptoms, follow up with MDs and other community resources.
- MLTCs agreed to the importance of this outcome – the new VBP contracts included this quality measure, prevention of PAH.

Incorporating Quality Measure: PAH Into Our QAPI Program, Determining Interventions

- Instruction provided to all Administrative and Clinical Managers, Directors of Rehabilitation, to nurses, therapists, compliance staff, aide coordinators re: VBP and Quality Measure Prevention of PAH
- Discussion in meetings and chart reviews revealed need for:
  - Understanding of importance of aide as patient's first level of health care in LHCSAs - they are with the patient weekly to daily while nurse visits every 3 months and even if therapist visiting twice a week, visit is short while aide is there for hours
  - Improvement in communication between aides and nurses/therapists
  - Closer monitoring/supervision and instruction of aides- HHAs and PCAs
  - Creation of additional focused instruction for aides on PAH and incorporation as additional in-services for our aides
  - Revision of our Hospitalization Tool to help us obtain more data to explain reasons for hospitalizations and areas to improve to meet our goals

Carrying Out the Interventions

- A focused Communication In-service was created and provided to all aides providing care for Able Health Care Service, Inc.
- PAH program created with a template geared to aide thinking, questions including all tasks they perform – 6 modules, 1 for every DOH condition (attached)
- Program presented to agency staff in all boroughs, all levels to make them aware of the modules that are now presented to aides in two separate in-services
- Train the trainers then completed – Aide instructors were presented and trained on the modules which they would now be teaching the aides
- We also present a Sepsis handout at every aide in-service and discuss signs and symptoms of Sepsis.
- At meetings, discussed with staff need for more intensive monitoring/ supervision of aides, improved communication and follow up within and between all levels of staff

Revised/Updated Hospitalization Tool

ACUTE CARE HOSPITALIZATION TOOL

	1	2	3	4	5
Patient initials					
Patient's Age					
SOC date					
Hospitalization Date					
CHHA/LHCSA	CHHA	CHHA	CHHA	CHHA	CHHA
If LHCSA MLTC involved	MLTC	MLTC	MLTC	MLTC	MLTC
Is patient compliant with POC?	Y N	Y N	Y N	Y N	Y N
Does the patient live Alone, w Family, or Group Home?	Alone Family Group Home	Alone Family Group Home	Alone Family Group Home	Alone Family Group Home	Alone Family Group Home
Has the same clinician seen the patient from Start Of Care to Hospital episode?	Y N	Y N	Y N	Y N	Y N
Has there been any phone monitoring between visits if frequency is Monthly or more infrequent?	Y N	Y N	Y N	Y N	Y N
Is there evidence of ongoing education or reinstruction/monitoring related to disease processes?	Y N	Y N	Y N	Y N	Y N
Did family or group home notify patient's nurse or MD of worsening condition prior to hospitalization?	Y N	Y N	Y N	Y N	Y N
If not, did the aide notify the patient's nurse or MD of patient's worsening condition prior to hospitalization?	Y N	Y N	Y N	Y N	Y N

Revised/Updated Hospitalization Tool

ACUTE CARE HOSPITALIZATION TOOL					
If nurse was notified, was a visit made the same day and visit freq. increased prior to the hospitalization?	Y N	Y N	Y N	Y N	Y N
Primary Diagnosis					
Reason for Hospitalization (M2430)					
Other Chronic Conditions	CHF	CHF	CHF	CHF	CHF
	COPD	COPD	COPD	COPD	COPD
	ANEMIA	ANEMIA	ANEMIA	ANEMIA	ANEMIA
	DIABETES	DIABETES	DIABETES	DIABETES	DIABETES
	Skin ulcers	Skin ulcers	Skin ulcers	Skin ulcers	Skin ulcers
	Seizures	Seizures	Seizures	Seizures	Seizures
	MR/DD	MR/DD	MR/DD	MR/DD	MR/DD
	h/o UTI	h/o UTI	h/o UTI	h/o UTI	h/o UTI
OTHER: ie, Neoplasms, HIV/AIDS, etc.					
For PT/OT/ST only cases – were nursing needs identified and referred for nursing visit?	Y N	Y N	Y N	Y N	Y N
Were complete medication reviews carried out by clinician or questioned re: med changes q visit?	Y N	Y N	Y N	Y N	Y N
Was caregiver oversight/participation in patient's care documented?	Y N	Y N	Y N	Y N	Y N
Did the patient go to ER or was hospitalized in the past 6 months?	Y N	Y N	Y N	Y N	Y N
COMMENTS					

Additional Interventions – Focus on Sepsis

- Able Health Care Service, Inc. set up a user agreement with HCA to utilize their Sepsis training, resources and SBAR tool.
- Agency staff provided with Sepsis training branch by branch starting with nurses and Clinical Managers, then therapists
- All were provided with the SBAR Tool for assessment and the Zone Tool for education and instructed on their use
- Aides, Coordinators and Compliance staff were already instructed on Sepsis when the PAH modules were rolled out
- An MVV app was set up with 6 Sepsis symptom identification questions for the aide to answer when they called out for the day
- Once answered they generate a report called Client Health Assessment
- Report is reviewed daily and any yes answers are followed up with the aide who reported them. So far, they have been found to be in error and aides were reinstructed on the questions

The Client Health Assessment Report

Client	Payer	Visit Date	Staff	Event	Comment
		08/17/2018		4. Is your patient suddenly complaining of extreme pain or discomfort (that they did not complain of before)?	No
		08/17/2018		5. Is your patient going to the bathroom less than usual even when drinking as usual and no diagnosis of Kidney Disease?	No
		08/17/2018		6. Is your patients skin more pale or discolored than usual?	No
	AGEWELL NEW YORK, LLC	08/17/2018		1. Does your patient have a fever of 100.9 or higher; or lower than 96.8?	No
	AGEWELL NEW YORK, LLC	08/17/2018		2. Is your patient having new symptoms of shortness of breath or fast respirations?	No
	CENTERLIGHT	08/17/2018		1. Does your patient have a fever of 100.9 or higher; or lower than 96.8?	No
	CENTERLIGHT	08/17/2018		2. Is your patient having new symptoms of shortness of breath or fast respirations?	No
	CENTERLIGHT	08/17/2018		3. Is your patient having new confusion or disorientation?	No
	CENTERLIGHT	08/17/2018		4. Is your patient suddenly complaining of extreme pain or discomfort (that they did not complain of before)?	No
	CENTERLIGHT	08/17/2018		5. Is your patient going to the bathroom less than usual even when drinking as usual and no diagnosis of Kidney Disease?	No
	CENTERLIGHT	08/17/2018		6. Is your patients skin more pale or discolored than usual?	No
	CENTERLIGHT	08/19/2018		1. Does your patient have a fever of 100.9 or higher; or lower than 96.8?	No
	CENTERLIGHT	08/19/2018		2. Is your patient having new symptoms of shortness of breath or fast respirations?	No
	CENTERLIGHT	08/19/2018		3. Is your patient having new confusion or disorientation?	No
	CENTERLIGHT	08/19/2018		4. Is your patient suddenly complaining of extreme pain or discomfort (that they did not complain of before)?	No
	CENTERLIGHT	08/19/2018		5. Is your patient going to the bathroom less than usual even when drinking as usual and no diagnosis of Kidney Disease?	No
	CENTERLIGHT	08/19/2018		6. Is your patients skin more pale or discolored than usual?	No
	CENTERLIGHT	08/20/2018		1. Does your patient have a fever of 100.9 or higher; or lower than 96.8?	No
	CENTERLIGHT	08/20/2018		2. Is your patient having new symptoms of shortness of breath or fast respirations?	No
	CENTERLIGHT	08/20/2018		3. Is your patient having new confusion or disorientation?	No

Results of Tracking: Opportunities for Improvement, Further Research/Plans

- 100% of planned instruction has been completed
- When questioned and tested during aide classes, instructors have reported the aides understood questions and answered correctly
- Revised Hospitalization Tools consistently used for chart review during 2nd qtr of 2018.
- Results have indicated an opportunity for improvement in early identification and/or reporting of early s/s of change by aide and follow up with nurse/family/MD.
- Additional research is required to ensure that: timely communication to the clinical team and to MD is occurring
- Plan to hold additional clinical meetings to review findings from the Hospitalization Tools and obtain their input/feedback regarding future interventions
- Plan to continue meeting with MLTCs to discuss problems/needs/potential protocols to achieve goals

Results of Interventions - Positive Side A Success Story:

- After aide training on Sepsis, during care of a patient, one aide noticed symptoms
- The aide called the office and reported the changes to the Clinical Manager
- The Clinical Manager called the emergency contact (patient's son)
- The Clinical Manager also called the MD as patient was having bloodwork drawn at home by a lab that am
- She requested Urinalysis also be done and MD requested to see patient
- Aide called to schedule MD appointment and was told none available for four days
- Aide explained the serious symptoms and that MD wanted to see patient ASAP
- MD office said they could take her as a walk in that day
- As patient had a dental appointment for that day, aide called and rescheduled the appointment, then called MLTC to request change of location for transportation
- MLTC agreed, patient was seen as a walk-in, diagnosed with UTI and put on antibiotics
- All symptoms resolved without further progression to Sepsis

Current Added Costs of Interventions Towards VBP: None

- Incorporated into daily work schedule (CEO, Director of QI, Director of Education, Clinical Managers, nurses, therapists, aides)
  - Instruction of staff on VBP
  - Discussion and meetings with staff
  - Meetings with MLTCs
  - Revision of Hospitalization Tool
  - Creation of additional focused in-services for aides – Communication, PAH
  - Train the Trainer instruction
  - Provision of these additional in-services for our aides
  - Sepsis training to all staff, use of the SBAR tool (provided to us by HCA user agreement)
  - Review of new report added to our system – Client Health Assessment
- Addition of MVV – 6 Sepsis call-in questions and set up of report in our computer system (Sandata) – part of our contract, no added cost
- Continuous identification, tracking, trending and reporting on hospitalizations

Road Blocks to Successful Implementation of Value Based Payment program

- Unable to reach Care Managers at MLTCs
- Patients in Group Homes – difficult to reach their Case Managers
- Not always provided with contact information: Care Manager, CHHA nurse providing care aside from our LHCSA service, other community resources involved
- Noncompliant patients and caregivers
- MD mindset – sending patients to ER when symptoms reported rather than examining them first
- ERs occasionally don't admit patients who are clinically unsafe to remain in the home
- UAS attribution file data provided by DOH to MLTCs are not up to date
- Unable to enter into a VBP level 2 arrangement with MLTCs due to their inability to participate due to their challenges

Our Vision for VBP

- True partnership with MLTC and others to:
  - Identify patients who are "frequent flyers" to hospital and others at very high risk
  - Identify patients with poor health management and risk due to social/behavioral/ environmental issues
  - Set up mutual goals and protocols for prevention/minimization of hospitalization
  - Frequent and open communication regarding all services involved with patients: CHHA, Case Workers, Social Workers, Community Resources, Doctors
  - Discussion/case conference at interdisciplinary meetings with identification of community and other resources available to help the patient
  - Inclusion of patient/client representative in goal setting and individualized, focused plan/patient contract to improve patient health and reduce hospitalizations
  - Review of Quality data based on attribution files
- Set up of VBP roadmap through discussion of MLTC patient population, case mix data, concerns, focus
- Reduction of overall costs of care by preventing/minimizing hospitalization and ER/crisis visits for patient due to exacerbation of illnesses

Able Health Care Service, Inc. looks forward to working with our MLTC partners/others to enter the new age of Value Based Payment and achieve our goal of preventing potentially avoidable hospitalizations while helping our patients to achieve their optimum level of health and function through excellent, comprehensive home health services and care coordination!