



Healthcare Leadership Council:
Care Transitions in Post Acute Care
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Golden Living
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Golden Living Profile



Golden Living Centers and Communities

- 296 skilled nursing facilities
- 15 assisted living communities
- Operates in 21 states
- 31,791 total licensed beds
 - 31,381 SNF beds
 - 410 ALF beds
- ~82,000 patients cared for in SNFs in 2012

Aegis Therapies

- Contract rehab therapy
- 38 states and D.C.
- 8,300+ employees
- 893 therapy contracts:
 - 303 affiliated
 - 713 non-affiliated

AseraCare

- 58 hospice locations
- Operates in 19 states
- 1,400+ employees

Golden Living Experience in Value Based Purchasing: ACO's and Bundled Payment Model's 2 and Model 3

- Awardee Convener in Model 3: with 5 Episode Initiating SNF's starting on Jan 1 of 2014
- Approximately 500 patients in the Model 3 program per year in 18 Clinical Diagnostic Categories (half rehab in nature and half Medical Subacute Chronic or Infectious conditions)
- In Model 3 program Gain Sharing with attending MD's and Hospitals
- Approximately 30 Model 2 relationships with participating Golden Living Centers
- Approximately 25 ACO's in the Next Gen, Pioneer and MSSP programs

CMS Medicare Proposes Changes in Rules of Participation for SNF's in 2016-Value Based Initiatives

Possible Clinical Dimensions of Change:

- a) Staffing based on acuity
- b) Physician/NP/PA
- c) Frequency of Assessments
- d) Staff training and competency
- e) Care Needs and Discharge Planning
- f) Infection Control Changes
- g) Specific Competencies to treat certain conditions
- h) Work Flow changes to support care redesign based on acuity
- j) Coordinating Care and Case Mgt of Traditional Medicare patients

Implications for SNF's

Reduce

- LOS
- Inefficiency
- Readmissions

Improve

- Transitions to and from other sites
- Capability to manage more complexity
- Ability to accept patients from new referral sources

Establish new relationship with referrers

- New Waivers including the Hospital 3 day stay waivers
- Telehealth and Case Mgt Waivers

Create new models for physician coverage

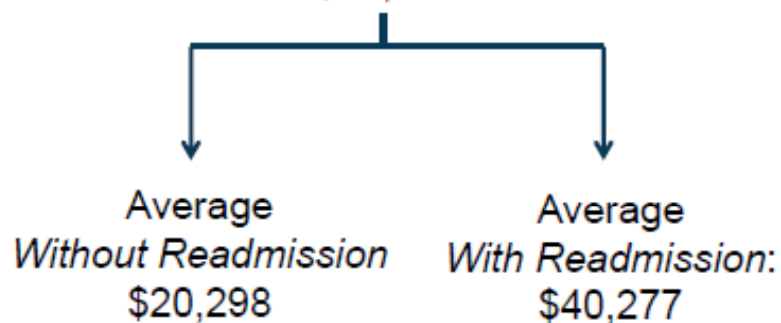
- Same day admission, increased involvement in discharge planning
- Increased intensity
- Seven days per week

Manage new reporting requirements in Care Mgt programs

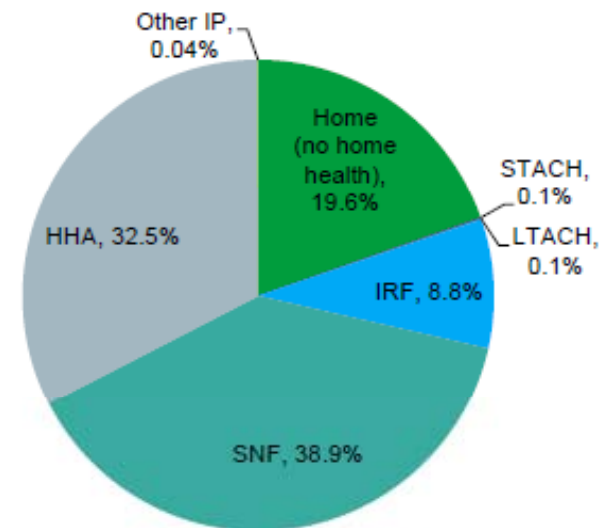
Utilization and Spending for National Medicare FFS Beneficiaries, Major Joint 90-day Episodes

Number of Episodes: 391,551 → % with Readmissions: 10.6%

Average Episode Payment:
\$22,416



Hospital Discharge Destination by Care Setting, Medicare FFS 2013



Source: 2012 and 2013 Standard Analytics Files (SAF) from Centers for Medicare and Medicaid Services (CMS). Data reflect 90 day episodes beginning between October 1, 2012 and September 30, 2013. Data excludes Part B services except for home health.

Key Attributes of Preparing a Patient for Discharge

Facility Work Flow Changes and Accelerated Processes

- Care Redesign such as Palliative Screenings
- Coordination with Emergency Depts. of Hospital Partners
- Arranged PCP first PCP appointment post discharge
- Meeting with Home Health team 3 days prior to discharge

Patient Ping in Mass and PA

- ACO patient identified upon admission
- Identification of PCP and contact information
- Ping the system at Discharge for PCP

48/72 hour Care Planning Conference

- Identification of Home Health Preferences
- Project the Length of the stay for the patient & family
- Use of LACE tool to stratify patient at high risk for readmission
- Home Visit by someone from therapy team

Types of Staff engagement in Care Transitions with ACO's and Bundling Model 2

- Transition Nurses at the Golden Living Center collaborating with ACO's
- Nurse Navigators involved in the Bundling Programs in Model 3 to coordinate care across the 90 day episode
- Nurse Navigators use an IT Tracking tool called "90 day tracker" (records certain quality measures, tracks DRG's, identifies patient work flow milestones, identifies Gain Share partner Hospitals and MD's on each episodes, status at any point in time of episode)
- Beneficiaries are automatically included in the model 2 and 3 without any opt in
- RNAC's supporting and fostering communication in Model 2 with the Awardee Conveners or episode initiating teams

Transition of Care Document; Used by Patient, Home Health and Provided to PCP

- Comprehensive tool and 6 page document
- Short Summary of Stay that identifies the patient functional mobility in ADL's
- Community Resources identified including Home Health agency or Outpatient provider, PCP Appointment day and time and how patient will get to the appointment, PCP name and phone number
- Medication information at Discharge, this supports Home Med Reconciliation
- Patients acceptance and execution/signature of the plan
Discharge Planning, Nurse Navigator, Transition Nurse follow-up contact at Golden Living

Partnering with Home Health Agencies: A key collaboration

- Work with Home Health partners willing to attend the 3 day planning meeting prior to discharge
- Key Home Health agencies can make first home visit next day after discharge
- Home Health Quality Measure experience
- Home Health agencies willing to communicate with nurse navigators at the Golden Living Centers
- Use Home Health agencies that work closely with the ACO's
- Review their Readmission rates to the hospitals
- Support the transition of care plan developed by the Golden Living Center including Medication Reconciliation and MD appointments

Bundling Nurse Navigator Patient Contact and Frequency; Follow-up in the home

- Communication is telephonic on a weekly basis in Model 3 using a script
- Bundling Patient population is not experienced in working with a Nurse Navigator and important to create a good working relationship during facility stay
- Often NN asking certain questions related to a disease process (weights in CHF or Blood Pressure in other conditions)
- In model 3 we have a Beneficiary Incentive Waiver to support care redesign initiatives
- Often through the Home Health agency or in a Model 2 Awardee convener navigator
- ACO's often have a disease state manager assigned to follow-up

The Electronic Exchange of Information

- **The success of every part of the “system” depends on the success of the entire care system**
- **Every part shares the risks and benefits of efficient care and optimum outcomes**
- **Information moves rapidly and is specifically tailored to meet the needs of the recipient**
- **Everyone contributes information to improve transitions of care**
- **Care is coordinated across entire episodes**
- **Health Information Exchanges**

Lessons Learned

Change is Hard: Share Best Practices

Align stakeholders	<ul style="list-style-type: none">• Organization scorecard
Patient care workflows	<ul style="list-style-type: none">• Keep it simple and centralized
Team based healthcare	<ul style="list-style-type: none">• Highest scope of license
Engage Patients	<ul style="list-style-type: none">• Measure
Use Technology	<ul style="list-style-type: none">• Integrate and leverage it
Engage Physicians	<ul style="list-style-type: none">• Address practice variation
Measure Effectiveness & Performance	<ul style="list-style-type: none">• Demonstrate the ROI