Aging Policy Briefing

4th Annual Managed Care Pre-Conference

Sponsored by: Humana®

April 20, 2015
Panelists

- **Moderator:** JoAnne Lynn, Director, Center for Elder Care and Advanced Illness, Altarum Institute
- **Joan Hatem-Roy**, Assistant Executive Director, Elder Services of the Merrimack Valley, Inc.
- **Sandy Atkins**, Vice President, Strategic Initiatives, Partners in Care Foundation
Using Quality Improvement to Drive Sustainability for AAA’s

Joan Hatem Roy, LICSW
Assistant Executive Director
Elder Services of Merrimack Valley, Inc.
jhatemroy@esmv.org
Capturing Data Depends on Setting

Who are the costliest patients?

Which neighborhoods have the highest readmission rates due to poor access to transportation?

Is the community-based transition program more cost-effective than our hospital-based program?

What day of the week is the safest to discharge someone to their home?

Does this patient need to be seen by a nurse or a community health worker today?
User experience – customers can’t wait for standards to evolve
Where to Start?

• Must Identify Aim Statement first:
  – Primary and Secondary Drivers
  – Change Strategies: Easiest, cheapest, fastest test of change
  – PDSA

• Figure out what data you can collect and analyze yourself without relying on healthcare system, CMS, etc

• Translate that into your value - Find their “Pain Points”
Analyzing data - Must start with an Aim

Quality Improvement

Aim
Measurement
Drivers

Adapted from Langley et al. The Improvement Guide

Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey
Rapid Cycle Testing = Quality Improvement
Why is rapid cycle testing so important?
Get to Better Outcomes Faster and Cheaper

Outcome

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Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey
<table>
<thead>
<tr>
<th>Aim Statement</th>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help AAA</td>
<td>increase hospital-based revenue</td>
<td>by 20%</td>
<td>by providing care transitions services</td>
</tr>
</tbody>
</table>

- Add new Aim
- Add new Primary Driver
- Add new Secondary Driver
- Add new change strategy

© Care at Hand
Help AAA | increase hospital-based revenue | by 20% | by providing care transitions services | at ½ the cost of traditional transition services | within 6 months

Showing value to hospitals

Providing transitions at lower cost than hospitals

Add new Aim   Add new Primary Driver   Add new Secondary Driver   Add new change strategy
**Aim Statement**
Help AAA | increase hospital-based revenue | by 20% | by providing care transitions services | at ½ the cost of traditional transition services | within 6 months

**Primary Drivers**
- Showing value to hospitals
- Providing transitions at lower cost than hospitals

**Secondary Drivers**
- Not enough business acumen
- No way to measure impact of transition program in real time
- No trust from hospitals
- No published data to show hospitals AAA impact
- Not enough experience doing transitions using non-clinical staff

**Change Strategies**

Add new Aim
Add new Primary Driver
Add new Secondary Driver
Add new change strategy

© Care at Hand
PDSA Wizard

Aim Statement
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Change Strategies
- Bootcamp and ongoing TA for biz acumen
- Use Care at Hand QI Dashboards and PDSA Wizard
- Submit for case studies like AHRQ innovations exchange, etc
- Bootcamp and ongoing TA on QI
- Real-time identification of knowledge deficits

Add new Aim
Add new Primary Driver
Add new Secondary Driver
Add new change strategy
Aim Statement

Help AAA | increase hospital-based revenue by 20% | by providing care transitions services | at ½ the cost of traditional transition services | within 6 months

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Change Strategies

- [COMPLETED – Scaled] Use Care at Hand QI Dashboards and PDSA Wizard
- [COMPLETED – Scaled] Real-time identification of knowledge deficits
- [COMPLETED – Squashed] Bootcamp and ongoing TA on QI
- [COMPLETED – Squashed] Bootcamp and ongoing TA for biz acumen
- [COMPLETED – Squashed] Submit for case studies like AHRQ innovations exchange, etc

Add new Aim
Add new Primary Driver
Add new Secondary Driver
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# Group Activity

<table>
<thead>
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<th>Primary Drivers</th>
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<th>Change Strategies</th>
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<td>Add new Secondary Driver</td>
<td>Add new change strategy</td>
</tr>
</tbody>
</table>

© Care at Hand
What Happens When the First PDSA Doesn’t Work

PDSA – 1

• **PLAN** – (hypothesis) if we increase our per diem hours on the weekend for coaches and nurses so that they are allowed to make home visits will it decrease our HV lag time to within 48 hours of d/c?

• **DO** – RN to cover CAH from 8am to 2pm on Saturday and Sunday. Coaches will book up to 4 HV’s each per day.

• **STUDY** – Using the CAH time to first visit performance report we will measure the d/c to HV lag time from 2/8/15 – 2/22/15.

• **ACT** - HV lag time decreased from 10 days to 8 days. This PDSA cycle did not meet goal and is not scaled to program.

» But.. What did we learn?
What did we learn from PDSA 1?

Increasing per diem hours did decrease HV lag but did not make enough of an impact to meet goal.

PDSA 2

• **PLAN** – (hypothesis) if we keep the expanded weekend hours but add 3 nights a week that nurses and coaches can do per diem visits will it decrease our lag time to within 48 hours of d/c?

• **DO** – RN to cover CAH 3 week nights until 8 pm to allow coaches to do up to 3 visits per diem after workday complete.

• **STUDY** – Using CAH time to first visit performance report we will measure the d/c to HV lag time from 3/1/15 – 3/15/15.

• **ACT** – HV lag time decreased from 8 days to <2. This PDSA met our goal and is scaled to our program. Extended per diem hours are now permanent.
Completed and Upcoming PDSAs/Change Strategies

**Aim Statement**
- Help AAA | increase revenue for health homes program | by 30% ($7k) | by increasing productivity of care coordinators | using more effective triage | within 6 weeks
- Help AAA | secure contract | w/ at least 1 hospital | for providing care transitions services | cheaper than MCO-grown program | within 3 months
- Help AAA | secure contract | w/ at least 1 MCO | for providing care transitions services | cheaper than hospital-grown program | within 3 months
- Help AAA | increase billable patient rate | by 50% | by providing care transitions services | more efficiently | within 6 weeks

**Primary Drivers**
- Care coordinators don't bill enough for existing panel
- Care coordinators panels are not large enough
- Money wasted on admin FTE for inefficient administrative functions
- Need to show impact of care transitions program
- Inability to send and receive data electronically

**Secondary Drivers**
- Manually enrolling newly referred patients for each provider using xls is wasteful
- Time wasted finding forms & info about each client
- Filling in & filing paper forms from field wastes time
- No performance measures for program/ tracking operational analytics/MCOs want analytics
- Care coordinators get stuck doing care coordination b/c don't know when it's safe to empower consumer to do own care coordination
- No means of triage to escalate more time-intensive consumers
- No data standards for communicating between LTSS providers and Payers

**Change Strategies**
- CAH used as database management system to input referrals and manage patients
- Onboard all new staff w/ Jeff and get nurse buy in w/ Lori
- Send electronic forms/data from CAH into MCO case management systems via xls outputs
- Capture forms in CAH
- CAH dashboards (manual or auto) to capture operational performance
- Care at Hand risk stratification of consumers to identify those needing higher level care coordination
- Real time alerts facilitate patients that require more care coordination
- Use Care at Hand as means of connecting LTSS data to local HIE so hospitals and/or payers can access data in HL7 format
- Use Care at Hand to test use of FHIR as means of communicating with MCO case management systems

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Elder Services of the Merrimack Valley, Inc.
Choices for a life-long journey
Technology: Elder Services and CAH Partnership

- Precise allocation of resources for most at-risk patients to avoid preventable acute care utilization
- Building capacity of underutilized, inexpensive workforce
- Quick, inexpensive proof of value using rapid cycle approaches

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Data-driven decision support for right level of care at right time

Health Coach

Emergency Dept/Admission $$$$$$

Primary Care Provider Visit $$$

Home Visit by Nurse $$

Care coordination $$

Nurse Care Coordinator
Non-clinical workers reduce costs, predict readmissions

AHRQ. Service Delivery Innovation: Community-Based Health Coaches and Care Coordinators Reduce Readmissions Using Information Technology To Identify and Support At-Risk Medicare Patients After Discharge. Rockville, MD. 2014.

- Estimated Net Savings
  - 39.6% 30 day readmissions
  - $109 savings per member per month
  - $2.54 net savings for every $1 invested

AHRQ, Service Delivery Innovation: Community-Based Health Coaches and Care Coordinators Reduce Readmissions Using Information Technology To Identify and Support At-Risk Medicare Patients After Discharge. Rockville, MD. 2014.
Beyond Readmission
Results Show Value to Potential Health Care Partners

- Coaches are imbedded in hospital and WE know when “their patients” are admitted.
- Expansion to emergency department and observational status
- Neutral party – hospitals do not perceive us as vendors therefore accepted into the clinical care teams and rounds
- Appropriate leveling of MCO patients: “Community Well vs. Nursing Home Certifiable” = higher reimbursement for MCO
- Better care for patient
Data You Can Use... To Attract Contracts with Payers & for Contract Performance

Think like a geek!

Sandy Atkins, VP, Strategic Initiatives
Partners in Care Foundation
Part 1

Now – Showing Value

Straight from our Presentations to Healthcare
Data Collection – Now

• Write data exchange into every contract
  – Agree on approach & parameters (e.g., set up oversight & data committee)

• Good old Excel – lo-o-o-ong spreadsheets

• Fillable/Exportable PDF

• SurveyGizmo – HIPAA BAA

• Access on Office 365

• Legacy Waiver data system
Presenting Your Value

• Results
  – Your own
  – Research findings
  – Borrow ours and Joan’s

• Think Triple Aim
  – Better population health
  – Better patient experience of care
  – Lower Cost

• Quality metrics – HEDIS, Star, NCQA, etc.

• Member retention
Value Proposition: CBOs & Triple Aim

- Care Transitions Coaching
  - COST
    - ↓ ED
    - ↓ IP
  - HomeMedsPlus

- Stanford Self-Management Workshops
  - HEALTH
    - ↓ Pain
    - ↓ Falls
  - A Matter of Balance
  - Healthy Moves
  - HomeMeds

- Complex Community Care Management
  - QUALITY
    - ↑ Needs Met
    - ↑ Member Retention
  - Meals
  - Home visit
  - Transportation
Example 1 – Clinical Outcomes

- **Population:** 571 union members w/chronic conditions in MCO
- **Intervention:** CDSMP + monthly meetings + incentives
- **Outcomes:**
  - **Compared to baseline, after 12 months**
    - **Self-rated health** good or excellent: 60% vs. 32% at baseline
    - **BMI** ↓ 1 point
    - **A1C** ↓ 1 point
    - **Systolic BP** ↓ 11 points
    - **Depression** score ↓ from 5.8 at baseline to 3.2
    - **Pain** ↓ from 3.2/10 to 2.0/10
  - **Compared to baseline, after 12 months**
    - ↑ **aerobic exercise** from 51 to 75 minutes per week
    - ↑ **stretching/strength** exercise from 21 to 35 minutes per week
Example 2: Utilization

• Care Transitions Coaching & Social Services
  – On Westside, cut readmissions by more than half!
    • 10.1% readmission rate vs. 27.1% for those who met criteria but did not receive intervention

• HomeMedsPlus
  – Home visit, med rec, pharmacist, psychosocial/functional assessment, home safety evaluation
    • In physician group post-hospital – 13% lower rate of ED use & 22% lower rate of readmission w/in 30 days
    • Discovered medication-related problems in 63% per pharmacist...AFTER hospital medication reconciliation

• LTSS program for duals in California – MSSP
  – Keeps nursing-home eligible seniors at home avg. 5 years!
    • Cost? $357/month vs. $3,000+ for SNF
Example 3: Quality Measures

- Fall risk management
- Medication reconciliation post-discharge
- Potentially harmful drug-disease interactions
- Blood pressure control
- Antidepressant medication management
- Older Adults Received:
  - Advance care planning
  - Medication review
  - Functional status assessment
  - Pain assessment

"No risk factor for falls is as potentially preventable or reversible as medication use.
(Leipzig, 1999)"

HomeMedsPlus visit helps meet all measures!
### Example 4: Cost Avoidance/ROI

<table>
<thead>
<tr>
<th></th>
<th>N=</th>
<th># 30-day readmits</th>
<th>% readmit rate</th>
<th>Readmits Avoided</th>
<th>$ saved @ $16,000/readmit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>253</td>
<td>23</td>
<td>9.1%</td>
<td>6.3</td>
<td>$101,333</td>
</tr>
<tr>
<td>No intervention</td>
<td>69</td>
<td>8</td>
<td>11.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>ED visits Avoided</th>
<th>$ saved @ $3,500 per ED visit</th>
<th>Total Saved by Medical Group</th>
<th>Total Spent by Medical Group</th>
<th>ROI</th>
</tr>
</thead>
<tbody>
<tr>
<td># ED visits</td>
<td>ED use rate</td>
<td></td>
<td>Total Saved by Medical Group</td>
<td>Total Spent by Medical Group</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>25.3%</td>
<td>9.3</td>
<td>$32,367</td>
<td>$134,000</td>
<td>51.3%</td>
</tr>
<tr>
<td>20</td>
<td>29.0%</td>
<td></td>
<td></td>
<td>$88,550</td>
<td></td>
</tr>
</tbody>
</table>

**Calculating avoided utilization:** Difference in utilization rates X intervention N
2.5% readmission rate reduction X 253 patients = 6.3 readmissions avoided
# HomeMeds-Plus Example

<table>
<thead>
<tr>
<th>Service</th>
<th>Outcomes &amp; Experience</th>
</tr>
</thead>
</table>
| **HomeMeds with In-Home Psychosocial and Home Safety Assessment** | - 280 post-hospital patients from large medical group  
- 63% of had med-related problems determined by PharmD to require prescriber action.  
- 77% had a service need or home safety issue  
- 9% had depression identified through PHQ-9.  
- 12.7% lower rate of ED use  
- 21.6% reduction in readmission rate compared to patients **not** receiving home visit & HomeMeds.  
- ROI >50% @ $350/home visit |

**MSSP**, Multipurpose Senior Services Program, is California’s Medicaid 1915(c) Home and Community-Based Services waiver for nursing home eligible older adults (aged 65+).
In Medicaid MCO, Partners’ transition coaches achieved the following outcomes:

- 11.7% readmission rate for intervention group.
- 19.8% Readmission rate for those who met referral criteria but didn’t receive home visit.
- Readmission rate was by 41% vs. baseline.
- ROI was 90%

Coleman RCT: 30% lower readmission rates at 30 days (8.3 vs. 11.9) v. controls

Over 5,000 interventions complete in 2 years
Leveraging CCTP (CTI+Bridge)

<table>
<thead>
<tr>
<th>Care Transitions @ UCLA under CMS</th>
<th>n=</th>
<th># 30-day readmits</th>
<th>% readmit rate</th>
<th># Readmit Averted</th>
<th>$ saved @ $16,000/ readmit</th>
<th>Total Spent by CMS</th>
<th>ROI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>400</td>
<td>47.2</td>
<td>11.8%</td>
<td>66.4</td>
<td>$ 996,000</td>
<td>$172,000</td>
<td>480%</td>
</tr>
<tr>
<td>No intervention</td>
<td>400</td>
<td>113.6</td>
<td>28.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

UCLA ran the numbers themselves. Guess what UCLA said once they saw the results...

*Give us a price for doing this in our Medicare Advantage plan!*
<table>
<thead>
<tr>
<th>Risk Criteria/Needs</th>
<th>Tier 1</th>
<th>Tier 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute/LTPAC Use</td>
<td>Primary care only</td>
<td>2+ ED visit or unplanned hospitalizations or SNF stay in past year</td>
</tr>
<tr>
<td>Medications</td>
<td>&lt;5 prescribed meds</td>
<td>9+ prescribed meds</td>
</tr>
<tr>
<td>Functional Impairment</td>
<td>None known</td>
<td>Daily hands-on assistance needed</td>
</tr>
<tr>
<td>Cognitive Impairment</td>
<td>None known</td>
<td>Moderate to severe</td>
</tr>
<tr>
<td>Social factors</td>
<td>Any or none</td>
<td>Likely caregiver issues</td>
</tr>
<tr>
<td>Literacy/ health literacy</td>
<td>Speaks English; understands healthcare</td>
<td>Not able to understand or act on instructions</td>
</tr>
<tr>
<td></td>
<td>instructions</td>
<td></td>
</tr>
<tr>
<td>Self-management</td>
<td>Clinical signs outside of goal</td>
<td>Clinical signs significantly outside goal/deteriorating</td>
</tr>
</tbody>
</table>
Part 2

Where We’re Going:
Data for Performance Management & Contract Retention
Straight from our Presentations to Healthcare
## Pilot Metrics – Required Dashboard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Home Evaluation &amp; Needs Assessment</th>
<th>Care Transitions Home Visit</th>
<th>EBSMP</th>
<th>Complex</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals</td>
<td>19</td>
<td>12</td>
<td>6</td>
<td>39</td>
<td>79</td>
</tr>
<tr>
<td>Contacts attempted</td>
<td>42</td>
<td>31</td>
<td>14</td>
<td>156</td>
<td>243</td>
</tr>
<tr>
<td>Successful contacts</td>
<td>29</td>
<td>21</td>
<td>6</td>
<td>138</td>
<td>194</td>
</tr>
<tr>
<td>Unique members contacted</td>
<td>19 (100%)¹</td>
<td>12 (100%)</td>
<td>4 (67%)</td>
<td>36 (92%)</td>
<td>71 (90%)</td>
</tr>
<tr>
<td>Cases opened</td>
<td>18 (95%)²</td>
<td>11 (92%)</td>
<td>1 (25%)</td>
<td>36 (100%)</td>
<td>66 (93%)</td>
</tr>
<tr>
<td>Cases closed</td>
<td>13</td>
<td>10</td>
<td>1</td>
<td>28</td>
<td>52</td>
</tr>
<tr>
<td>Home visits conducted</td>
<td>20</td>
<td>18</td>
<td>N/A</td>
<td>72</td>
<td>110</td>
</tr>
<tr>
<td>EBSMP class enrollment</td>
<td>N/A</td>
<td>N/A</td>
<td>1</td>
<td>3-Pending</td>
<td>1 plus 3 Pending</td>
</tr>
</tbody>
</table>

¹ % = Unique Members contacted/Referrals  
² % = Cases opened/unique members contacted
Health Happens at Home
Top Needs/Problems Found

- Medication Issues
- Depression
- Community resources
  - Meals
  - Transportation
- Need for self-care/health coaching
- Eligibility for benefits
  - Financial assistance/SSI
  - Legal, VA benefits, Disability Assistance
- Need for caregiver/supervision
- Assistance with DME
Med-related problems identified for 82% of Members

HomeMeds Alert Types - 56 assessments

- Antihistamine Use w/fall, dizziness, or... 2%
- Elevated Blood Pressure/ sub-optimally... 4%
- Fall & Antipsychotic Use: 7%
- Low Systolic Blood Pressure with... 2%
- Dizziness & Medications 48%
- Confusion and Psychotropic Drug Use 13%
- NSAIDS & Anticoagulant, Steroid Use 2%
- NSAIDs and Age 80 or Older 5%
- Falls and Psychotropic Medication Use 11%
Medication review revealed significant issues, Potentially preventing costly avoidable care.

**Pharmacist Recommendations from Medication Review (n=56)**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggest revised dosage</td>
<td>52%</td>
</tr>
<tr>
<td>Adverse drug reaction</td>
<td>21%</td>
</tr>
<tr>
<td>Therapeutic duplication</td>
<td>11%</td>
</tr>
<tr>
<td>Indication w/o drug...</td>
<td>9%</td>
</tr>
<tr>
<td>Drug interaction</td>
<td>7%</td>
</tr>
<tr>
<td>Issues taking med</td>
<td>7%</td>
</tr>
<tr>
<td>Improper drug selection</td>
<td>2%</td>
</tr>
<tr>
<td>Sub-therapeutic dosage</td>
<td>2%</td>
</tr>
<tr>
<td>Adherence - Behavior</td>
<td>2%</td>
</tr>
<tr>
<td>Adherence - Access</td>
<td>2%</td>
</tr>
<tr>
<td>None</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Potential Impact from Recommendations per PharmD**

<table>
<thead>
<tr>
<th>Impact</th>
<th>ER Visit Avoidance</th>
<th>Hospital Avoidance</th>
<th>Physician Visit Avoidance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30</td>
<td>27</td>
<td>26</td>
</tr>
</tbody>
</table>
8/23 (35%) Had Moderate to Severe Depression
**Partners/Health Plan Home Visit Pilot**

**Patient Satisfaction Surveys (10-pt. scale; n=18)**

<table>
<thead>
<tr>
<th>Category</th>
<th>% in 8-10</th>
<th>% in 6-7</th>
<th>% in 4-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Satisfaction</td>
<td></td>
<td>9%</td>
<td>1%</td>
</tr>
<tr>
<td>Staff Respectful</td>
<td></td>
<td>92%</td>
<td>0%</td>
</tr>
<tr>
<td>Staff Helpful</td>
<td></td>
<td>81%</td>
<td>16%</td>
</tr>
<tr>
<td>Staff On time</td>
<td></td>
<td>54%</td>
<td>42%</td>
</tr>
<tr>
<td>Comfortable Discussing Needs</td>
<td></td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Would Recommend to...</td>
<td></td>
<td>62%</td>
<td>32%</td>
</tr>
</tbody>
</table>

8-10 - High  
6-7 Mod. Satis  
4-5 neutral/somewhat Dissatis.

**Emerging issue:** Confidentiality prohibits identifying individual problems to fix
Satisfied Members ➔ Member Retention

Main complaint in NON-Medicaid members <65:

“I can’t afford the services you recommended”

Rating of Effectiveness of Services (n=18)

- Received Recommended Services: 50%
- Visit Was Helpful: 72%
- Recommendat. helpful: 78%
- Advice discussed w/ MD/CM: 78%
- Discussed meds w/ MD, Pharm, CM: 83%
- Made changes to home: 40%
Data for Improving Referral Rate:

**Measure against goal/target**

- Dear hospital partners:
  - Here are this week’s referral metrics:

<table>
<thead>
<tr>
<th></th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>25</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Actual</td>
<td>22</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td>% of Target</td>
<td>88%</td>
<td>113%</td>
<td>33%</td>
</tr>
</tbody>
</table>

- Congratulations to hospital B for exceeding goal!!
### Data for Improving Referral Rate: Show Improvement

<table>
<thead>
<tr>
<th></th>
<th>Hospital A</th>
<th>Hospital B</th>
<th>Hospital C</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Quarter</td>
<td>25</td>
<td>15</td>
<td>18</td>
<td>58</td>
</tr>
<tr>
<td>Second Quarter</td>
<td>28</td>
<td>15</td>
<td>25</td>
<td>68</td>
</tr>
<tr>
<td>Third Quarter</td>
<td>32</td>
<td>15</td>
<td>38</td>
<td>85</td>
</tr>
<tr>
<td>% improvement</td>
<td>28%</td>
<td>0%</td>
<td>111%</td>
<td>46%</td>
</tr>
</tbody>
</table>

*Denominator is Quarter 1: Q3-Q1/Q1*

Congratulations to Hospital C for greatest improvement!!
Volume will make or break you

- On case rate, sustainability requires breakeven volume

- **Volume** = Plan Referrals x % Member Acceptance
  - Successful contact prerequisite to acceptance
    - Correct communication medium (phone, visit, email...)
    - Correct contact info (data service)
    - Correct time/day (working people, parents, retirees)
    - Correct approach (your doctor asked me to call...)

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Volume will make or break you

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Caveat Vendor:

Data-related contract requirements

• Must have data disaster recovery plan (backup & restore)
  – Tested annually and test results submitted to plan
• “Physical Security & Environmental Controls”
  – Limit access to those who need it; secure environment
• No data on laptops or mobile devices
• Must provide documented data security plan including diagrams, info architecture, risk assessment, policies
• Annual security audit & report
• Insurance – Privacy Liability and Network Security Insurance
More data requirements

• Same-day documentation of every attempt to contact member
  – Date, time, notes, plan
• Document supervision/monitoring
• Provide access for Plan to internal record-keeping systems related to Plan members
• Provide monthly summary of services delivered (and not delivered...with explanation)
• Maintain data system compatible with Plan’s and capable of data exchange
• Secure File Transfer Protocol (SFTP) & Secure Email required
Better IT – Seeking Solution(s)

• Meet all health plan security concerns
• Easy portal for use on both sides of contract
• Collects data through normal workflow
• Logic & structured meds database to integrate HomeMeds
• NCQA-friendly: assessment ➔ problem ➔ care plan ➔ care monitoring
  — Work process alerts — due dates
• Data exchange with contracting partners
• Service authorization
• Invoicing, billing
• Analytics for quality and performance improvement
• Central Intake
• Support population management – 50,000 members to engage
• Support evidence-based program management
• OUTCOMES!
Want to chat?

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- www.picf.org; www.homemeds.org