AHA Post Acute Care Webinar

Allina Health – Redesigning Advanced Care

Paige Bingham, MBA
Navigating Serious Illness

Episodes of Care

LifeCourse

Health
LifeCourse Video

https://www.youtube.com/watch?v=i4AoFHBgPnc
LifeCourse Key Components

Care Guide
Whole Person
What Matters
Community
How Did We Find Care Guides?

• Education
  – Bachelor’s degree

• Skills
  – Communication

• Serious illness experience
  – Knowing or caring for someone with serious illness
LifeCourse Care Guide Training

- Palliative care domains
- LifeCourse visit framework
- Advance care planning
- Communication and collaboration
- Lay healthcare worker role and scope
- Professional boundaries
- Electronic health record

Footnote: 1. "Clinical Practice Guidelines for Quality Palliative Care", National Consensus Project for Quality Palliative Care
Integrating LifeCourse

Patient’s Care Team + Trained Care Guide
## LifeCourse Visit Framework

<table>
<thead>
<tr>
<th>Domain Question Sets</th>
<th>Visit #1</th>
<th>Visit #2</th>
<th>Visit #3</th>
<th>Visit #4</th>
<th>Visit #5</th>
<th>Visit #6</th>
<th>Ongoing</th>
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<tbody>
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<td>Physical</td>
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<td>Family/Caregiver</td>
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<td>Financial/Legal</td>
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<td>Spiritual</td>
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<tr>
<td>Legacy &amp; Bereavement</td>
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<td>End of Life</td>
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### Assessment Tools

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<tr>
<th>Assessment Tools</th>
<th>Visit #1</th>
<th>Visit #2</th>
<th>Visit #3</th>
<th>Visit #4</th>
<th>Visit #5</th>
<th>Visit #6</th>
<th>Ongoing</th>
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<tr>
<td>PROMIS-10</td>
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<td>PPS</td>
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<tr>
<td>Who’s At Your Table?</td>
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</table>

### ACP

| ACP | |
|-----|-----
|     | Advance Care Planning |
## How is LifeCourse Different?

<table>
<thead>
<tr>
<th><strong>LifeCourse</strong></th>
<th><strong>Other Supportive Care Programs</strong></th>
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<tbody>
<tr>
<td>• A longitudinal relationship, offering support through the last several years of life</td>
<td>• Time limited, many are 30-90 days and focused on a point in time such as post-hospitalization</td>
</tr>
<tr>
<td>• A continuum-based approach that follows the patient across settings</td>
<td>• Typically condition related, i.e. heart failure</td>
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<tr>
<td>• Balances medical and nonmedical focus, to promote a whole person approach</td>
<td>• Medically focused on improving specific outcome measures</td>
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<tr>
<td>• Trained lay healthcare workers, called care guides, as primary contact</td>
<td>• RN or SW as primary contact</td>
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<tr>
<td>• Visits are in-person</td>
<td>• Contact is primarily telephonic</td>
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<tr>
<td>• Supports a generalist approach to palliative care that does not require specialty training</td>
<td>• Supports a medical model of care requiring clinical training</td>
</tr>
</tbody>
</table>
LifeCourse Impact

- **Median Hospice Length of Stay**
  - **Usual care:** 17 days
  - **LifeCourse:** 28 days

- **Quality of Life**
  - Improved patient care experience
  - Increased use of palliative care

- **Better Outcomes**
  - 57% fewer ICU stays
  - 27% fewer inpatient days
  - 34% more advance care plans completed
## Reaching Patients

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Patient Profile</th>
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<tbody>
<tr>
<td><strong>Palliative Care</strong></td>
<td></td>
</tr>
<tr>
<td>Abbott Northwestern Hospital</td>
<td>Patients followed post-discharge</td>
</tr>
<tr>
<td>United Hospital</td>
<td>Patients followed post-discharge</td>
</tr>
<tr>
<td>Mercy/Unity Hospital Campus</td>
<td>Patients followed post-discharge</td>
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<tr>
<td>St Francis Medical Center</td>
<td>Patients followed post-discharge</td>
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<tr>
<td><strong>Specialty Care</strong></td>
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<tr>
<td>Minneapolis Heart Institute</td>
<td>Advanced heart failure</td>
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<tr>
<td>Givens Brain Tumor Center</td>
<td>Brain tumor</td>
</tr>
<tr>
<td><strong>Coordinated Care</strong></td>
<td></td>
</tr>
<tr>
<td>Advanced Care Team</td>
<td>At-risk for readmission</td>
</tr>
<tr>
<td>Complex Care for Seniors</td>
<td>Primary Care with IDT for Complex</td>
</tr>
<tr>
<td></td>
<td>High-risk ACO population</td>
</tr>
</tbody>
</table>
## Payment Mechanisms

<table>
<thead>
<tr>
<th>Type of Payment</th>
<th>Payment Source</th>
<th>Revenue</th>
<th>Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Risk</td>
<td>Medicare Advantage</td>
<td>$ Capitated</td>
<td>Allina/Aetna (in process)</td>
</tr>
<tr>
<td>Accountable Care Org</td>
<td>Care Coordination</td>
<td>$ PMPM</td>
<td>Care Management</td>
</tr>
<tr>
<td>Increased Hospice $</td>
<td>Medicare Part A</td>
<td>Contribution Margin $</td>
<td>Palliative</td>
</tr>
<tr>
<td>Philanthropy</td>
<td>Family Foundation</td>
<td>$50,000/yr</td>
<td>Givens</td>
</tr>
</tbody>
</table>
Challenges

• Financial sustainability
• Dosing around frequency and length
• Clarity on role during hospice
• Ideal panel size
THANK YOU

Paige Bingham  Paige.Bingham@allina.com

www.lifecoursemn.org
Innovative Approaches to Coordinating Post Acute Rehabilitation Services

Jill Henly
Manager, Care Management

September 19, 2018
AHA Webinar
We are guided by our vision that one day all people will live, work, learn and play in a community based on abilities, not disabilities.
CKRI Care Coordination Model

Sub-acute Rehab Beds

- IPRU
- TRP

Outpatient Program Populations

- Brain Injury
- Stroke
- Spinal Cord Injury
- Cancer Rehab
- Baclofen - Spasticity Management
- APCC

17
Handoff Process

Handoff Communication Guide
for Discharges from a rehab bed. (revised 5/4/18)

Discharge from IP Rehab or TRP with a diagnosis or condition that qualifies for CKRI Care Coordination
RN to RN Handoff (exception - BI)

- Stroke
  - Inbasket/email note: handoffStroke
- SCI
  - Inbasket/email note: SCI/Check WD
- BI
  - Inbasket/email note: handoffB1
- Cancer Rehab
  - Inbasket/email note: handoffCancerRehab
- Bicofen Pump
  - Inbasket/email note: handoffBicofenPump
- Advanced Primary Care Clinic - GV
  - Inbasket/email note: handoffAdvancedPCG

Discharge from IP Rehab or TRP to CKRI outpatient therapy without CKRI Care Coordination
SW Handoff to SW or Care Guide
* ANW IP Rehab Follow-up call sheet to Care Guide

- Stillwater
  - Inbasket/email: handoffSinclair
- Golden Valley
  - Inbasket/email: handoffSinclair
- ANW
  - Inbasket/email: handoffSinclair
- United
  - Inbasket/email: handoffSinclair

Discharge from IP Rehab to TRP

SW to SW Verbal Handoff
RN to RN email

- Phone call to Jackie Keller, MSW (Ground Floor) or Jaime Robertson (First Floor)
- Email note to Kristen Smude (Ground Floor) or Kim Peters (First Floor)

Route note to CC. TRP to Stephanie Ruland, Lynn Swenson, and Natalie Lenz; ANW to Heather Odeh

Route note to Anna Holland

If IP Rehab d/c - inbasket Sandy Schwalbe;
If TRP D/C with OP therapy, ask ANW notify Sandy Schwalbe at Stillwater notify Arnie Stanton, at GV notify Sarah Voeller and at United notify Ruth Mansev

Route note to CC: East metro to Andelle James, West Metro to Connie Brenna and at CKRI CREC-Pool (4037277).

Route note to Kristy Soloun

Route note to both Jenny Fransen and Kelly Wagner
Spinal Cord Injury Rehab

Followed by care team (RN CC/MSW/Care Guide) for two years post injury.
Spinal Cord Injury Rehab Care Coordination Outcomes
Discharge to 6 Months Post Discharge

- 68% decrease in ED utilization
- 67% decrease in hospitalizations
- 55% decrease mortality per 1,000 patients
- Outpatient therapy encounters increased from 6.36 encounters/individual to 19.04
- 70% increase in PMR follow-up visits
- 12% increase in PCP visits
Post Acute Stroke Care

Stroke order set populates case finding reports.

- Abbott Northwestern, Minneapolis, MN
- United Hospital, St. Paul, MN
- Mercy Hospital, Coon Rapids, MN
- Mercy Hospital-Unity Campus, Fridley, MN
Stroke Rehab Care Coordination

Follow care for up to one year post stroke – first 45 days most clinically intensive

Is it a stroke?
Check these signs BE FAST!

BALANCE – Look for changes in your balance. Do you feel dizzy? Having trouble walking?

YES – Look for changes in your vision. Do you have blurred or double vision?

FACE – Try to smile. Does one side of your face droop?

ARMS – Try to raise both arms. Does one arm drift down?

SPEECH – Try to repeat a simple sentence. Are the words slurred? Can you repeat the sentence correctly?

TIME – Call 911 immediately if you think you are having a stroke!

Your stroke rehab care coordination team

Heather Odell, RN
nurse care coordinator
612-863-4872

Julie Gebhardt
care guide
612-863-4317

Ruth Monson, MSW
social worker
612-863-4574

Making lives work

Please contact us with all your recovery questions and concerns.
Stroke Rehab Care Coordination Outcomes Discharge to 365 Days Post Discharge

ANW
- 29% decrease in ED utilization
- 15% decrease in hospitalizations
- 34% decrease mortality per 1,000 patients
- Outpatient therapy encounters increase from 6.45 encounters/individual to 12.81
- 17% increase in PCP visits

United
- 58% decrease in ED utilization
- 14% decrease in hospitalizations
- 31% decrease mortality per 1,000 patients
- Outpatient therapy encounters increase from 2.57 encounters/individual to 12.13
- 6% decrease in PCP visits
Baclofen Care Management

• **265** Individuals receive care at **3** CKRI clinic locations

• Concern was overdose or withdrawal due to difficulty managing battery life and refill schedules along with standardized documentation.

• Redesigned work to bring all care documentation into unique fields in the EMR to allow care management reports to guide needed follow-up care.

• Six months after implementing a care coordination program:
  - No ED Visits (2017= 4 ED Visits)
  - 2 Hospitalizations ( 2017 = 11 admissions)
  - 47% reduction in complications
Brain Injury Care Coordination

- RN CC Requisition pending approval
- Current state: For 30 days, a Care Guide follows up with individuals discharged from IP or Transitional Rehab bed following a brain injury.
  - Focus is caregiver support and patient supervision needs, therapy attendance, outpatient follow-up, med management, behavioral health needs, return to school/work.
  - Currently tracking volumes
Cancer Rehab Care Coordination

Focus on fall prevention, dressing and ADLs, cognition, activity goals, swallow

• 2018 targeted intervention for two populations:
  – Head and Neck Cancer (follow care until 6 months post completion chemo/radiation treatments)
  – Brain Cancer or Tumor (follow care until 9 month PM&R post treatment check)
Advanced Primary Care Clinic

• Serves patients with disabilities and complex health conditions. These individuals often have difficulty accessing primary care, and often end up using more expensive health care services, such as emergency room or hospitals. On average, the APCC patients have an average of 11 secondary health conditions, in addition to their disabling condition.

• Outcomes:
  – Reduction in hospitalizations by 53%, and a reduction in hospital days by 78%, from an average of 12 days per year to 2.76 days per year, and an average of .86 hospitalizations a year to .4 a year.
  – In contrast, emergency department visits have increased, from .45 per year to .9 per year.
Thank you

Jill Henly

jill.henly@allina.com

612-863-0884
Questions?
Identifying Patients

Provider Referral

Future State:
EPIC Case Finding Report
Core Tools

• PROMIS-10+1
  – Quality of Life assessment

• ESAS (Edmonton Symptom Assessment System)
  – Self-report tool designed to assist in assessment of symptoms

• PPS (Palliative Performance Scale)
  – Helps assess functional performance and decline over the course of an illness

• Who’s At Your Table?
  – An exercise that can be used to better understand a patient’s social network.
Social Determinants of Health

SDOH

Neighborhood & Built Environment

Health and Health Care

Social and Community Context

Education

Economic Stability

“... we can use her [the LifeCourse care guide] as a resource. We don’t have to figure everything out on our own. Plus, she is an excellent listener. She not only listens, but she has great empathy for some of the stuff we run into, pointing out different resources that are available to us.” – LifeCourse Patient

“... if I had to trust anybody besides my family, she [the LifeCourse care guide] would be the next person that I’d be able to trust because of what we’ve talked about, and ... what she’s helped me out with.” – LifeCourse Patient