Successful Aging: Transforming the Acute Care Continuum for Older Adults

June 20, 2023

California Hospital Association

westhealth

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Welcome

Carrie Harcharik
Education Program Manager
California Hospital Association

California Hospital Association

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2023 Post-acute Care Webinars

CHA is planning quarterly post-acute care webinars. Below are the remaining 2023 dates and times. We hope you'll mark your calendars to join us. You'll also receive emails as respective dates get closer.

- August 30 at 10 am
- November 8 at 10 am

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Continuing Education

Continuing education hours are being offered for this program in the categories of health executives and nursing.

Full attendance and completion of the online evaluation and attestation of attendance are required to receive CEs for this webinar.

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Questions

We have built-in time at the end of each section as well as at the end of the presentation for Q&A.

Please submit your questions using the Q&A box (usually located at the bottom of your screen) as they come to you throughout the presentation.

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Moderator

Pat Blaisdell, FACHA
Vice President, Policy
California Hospital Association
Pat Blaisdell provides membership support and advocacy for hospital-based post-acute care and case management services, including policy analysis and interpretation, communication with regulatory bodies and third-party payers, and planning and implementation of educational programs. Pat has more than 25 years of experience in hospital and health care management in acute and post-acute settings and has expertise in clinical operations and reimbursement across the post-acute continuum of care.

CALIFORNIA HOSPITAL ASSOCIATION 6

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West Health Team Introductions

Jon Zifferblatt, MD, MBA
Chief Strategy Officer

Amy Stuck, PhD, RN
Senior Director

Renee Tyska, RN
Director, Clinical

Chris Crowley, PhD
Program Manager

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Topics for Today

1. Who Is West Health
2. Rethinking Geriatric Care at Sharp HealthCare
3. The Promise of Value-Based Acute Care at Home
4. Sustainability of Home-Based Care Continuum

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About West Health

westhealth

West Health is charting a new course for aging and health care in America.

West Health is a family of three nonprofit organizations that combine applied medical research, advocacy, policy analysis, and high-impact grantmaking to improve care, lower costs, and enhance the aging experience for seniors and all Americans.

Gary & Mary West Foundation
High-impact grantmaking and investments

West Health Institute
Turning research and evidence into action

West Health Policy Center
Connecting best practices to public policy

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Rethinking Geriatric Care at Sharp HealthCare

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Sharp HealthCare: A Patient Case

"An 85-year-old man fell in his garden. He had four rib fractures. In medicating him for pain, he became too groggy and delirious to participate in PT, and we were essentially chasing our tails trying to get him enough pain management to actively participate. Ultimately, he was transferred to the ICU on comfort measures"

Diane Wintz, M.D.

A Sharp-affiliated critical care specialist and medical director of the Trauma Program at Sharp Memorial Hospital in San Diego

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The Urgency Is Here for All Hospitals

Supporting older adults through the care continuum can decrease patients' length of stay, ease care transitions, lower the cost of care, and reduce patient harm.

- Growing population creates an urgency to change how we care for older adults; the number of older adults in the U.S. is projected to increase from 54.1 million in 2002 to 95 million by 2060.
- Hospital-wide standards of care for geriatrics are not universally applied and many geriatric models of care work in silos.
- If not addressed, geriatric-specific needs can result in significant risk to the patient, decompensation, exacerbation of illness, and permanent consequences to mobility and functional status.
- The older-adult population requires standards of care, similar to pediatrics, due to factors such as: Geriatric syndromes, frailty, physiology, vulnerabilities and risk factors.

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Generational Health as a Model of Care

The "Generational Health" approach, inspired and developed by Dr. Diane Wintz, has guided Sharp Memorial Hospital in changing the culture of care for older adults.

By using existing resources and reworking care workflows, Dr. Wintz and her team proved they could reduce poor patient outcomes and optimize care without adding costs.

CORE TENETS OF GENERATIONAL HEALTH:

- Address and mediate the sometimes unintended functional or cognitive decline older adults experience while in the hospital.
- Prioritize the individual in the context of their illness or injury, one size does not fit all when you consider frailty and vulnerabilities.
- Recognize the medical inflection point, when a patient's treatment may cause more harm than healing.
- Embrace an anti-silo approach that brings interdisciplinary teams together, reducing hierarchy and focusing on what teams can do better together.

This approach has resulted in improved patient outcomes, cost savings, and reduced length of stay, with no additional staff hired. It's about working smarter.

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Inside the West Health-Sharp HealthCare Partnership

West Health Institute partnered in collaborative work with Sharp HealthCare to support their Generational Health Program.

Together we will identify and disseminate the key attributes of successful interdisciplinary team programs that unite the spectrum of hospital care.

OUR WORK ENCOMPASSES:

- **Research.** Evaluating the key components of the Healthy Aging Team program.
- **Case studies.** Share the value and ROI related to generational health programs.
- **Thought leadership.** Drive awareness of the need to support the older-adult population hospital-wide.
- **Generational health toolkit.** We seek to empower hospitals with a structured approach in applying geriatric models of care and supporting interdisciplinary culture of care.

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Creating a Generational Health Model

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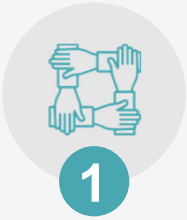

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Interdisciplinary teams collaborate and problem-solve to improve processes of care.

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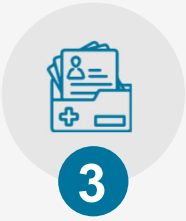
Recognize medical inflection point.



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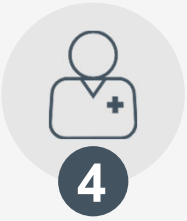
Match patients with a care plan that upholds their goals and values.



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Ensure patient and caregiver understanding of interventions and recovery.

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Connect back to the community and ensure appropriate resources are in place.

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Sharp HealthCare Continues to Expand the Reach of Generational Health to Benefit More Patients

Healthy Aging Team

Geriatric Emergency Department

Geriatric Surgical Verification

Advanced Illness Management

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In Focus: Healthy Aging Team

Began as a pilot in the geriatric trauma program focusing on home-based older adults with functional independence.

- To maintain functional status: Uses evidence-based approach to promote early mobility for older adults.
- To maintain cognitive function: Ensures care is provided in the best interest of the patient, not what is most convenient or standard for the hospital. Key examples: maintaining sleep hygiene (no labs or baths in the middle of the night), orientation to time and place (natural light and a clock in patients' rooms)

☑ **Results: Better patient outcomes, reduced costs of care**

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In Focus: Geriatric Emergency Department

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
ACCREDITED
GERIATRIC EMERGENCY DEPARTMENT

Sharp is upgrading to a Level-One GED, the highest standard awarded by American College of Emergency Physicians.

- Leveraging the observation unit to reduce inappropriate admissions and link to community resources.
- Implementing other components of program in the ED, further amplifying the benefits for patients. For example:
  - Early mobility in the ED/observation Unit
  - Delirium prevention measures from the start
  - Goals-of-care conversations to guide visit

☑ **Anticipated results: Improved census management and patient outcomes**

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In Focus: Geriatric Surgical Verification

Verifies that optimal geriatric surgical care standards are in place

- Ensures that tailored standards of care for older-adult patients are systematically implemented.
- Provides person-centered care that focuses on the patient's priorities and accounts for every individual's specific needs or vulnerabilities.
- Integrates with the Health Aging program to optimize post-surgical outcomes.

☑ **Anticipated results: Improved patient outcomes and increased surgical volumes.**

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In Focus: Advanced Illness Management

AIM nurses act as patient advocates and educators and offer consultations for advanced care planning and goals of care conversations.

- AIM nurses consult patients in the ED, and in-patient to support the care team in goals of care conversations
- Patient, caregiver, and clinical staff are supported by having a dedicated nurse who can navigate complex advanced illness management care.

☑ **Anticipated results: Increase number of goals of care conversations, change of code status, increased advanced care directives, referrals to hospice, and reduction in ED readmission rates.**

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Bringing Generational Health to Your Hospital

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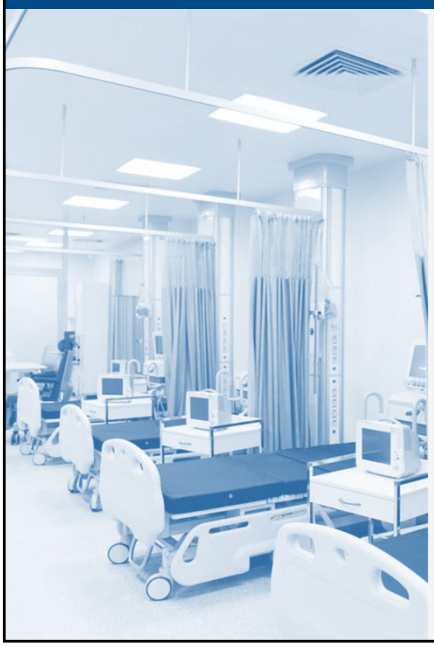

- Catalogue existing efforts or resources that can be leveraged.
- Find and take advantage of opportunities to strengthen or create connections between existing efforts.
- Identify key data points: what is your percentage of older-adult ED visits? Percentage of admissions? Percentage of positive delirium screens?

IMPORTANT QUESTIONS AS YOU EVALUATE YOUR PROCESSES

- Do you have protocols in place to identify frailty and vulnerabilities?
- Do you have hospital-wide efforts to support mobilization and mentation for older adults? Do teams work together to improve?
- Is sleep hygiene prioritized? For example, when does your units draw labs?
- How does your team handle transitions of care? Does your system have opportunity to improve care transitions for older adults?

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The Promise of Value-Based Care at Home: Geriatric Care Across the Continuum

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When Health Care Gets Personal: Meet My Dad, Jim

- 82-year-old retired engineer
- CKD with transplant
- Heart DX, 3 stents
- Parkinson's with dementia
- Aggressive advanced metastatic skin cancer

* Not connected to any provider or system with responsibility for the Total Cost of Care (e.g., ACO, MA, etc.)

BETWEEN MARCH 2020 AND APRIL 2022, JIM HAD 7 HOSPITAL ADMISSIONS (6 WITH ED VISITS)

- 3 cardiac related admissions
- 3 fall related admissions (two acute rehab stays)
- 1 admission for radical skin CA surgery w/complications
- 1 observation stay for hypotension and dehydration
- 2 additional outpatient surgeries (eye and skin)
- Discharged to ALF on hospice after contracting COVID in ARF

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Value-Based Care at Home: Empowering Providers to Succeed Through New Home-Based Alternatives

Lower costs from reducing hospitalizations. Efforts should focus on creating new options within a home-based care continuum.

Disrupting the traditional ED-to-admission trajectory by addressing unscheduled care in new ways—and with new roles and well-trained workforce.

Redesigning home-based care collaboratively with health system leaders, clinicians, and multidisciplinary team including patients and their families.

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Matching Care to Seniors' Needs Requires Strategies that Are Agile and Responsive

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LOWER INTENSITY OF CARE ⟷ **HIGHER INTENSITY OF CARE**

- Home-based Primary Care
- Skilled Nursing via Home Health
- Telemedicine
- House Calls
- Remote Monitoring
- Hospital Substitutes
- Community Paramedics
- Care Coordination

Building the Home-based Continuum of Care and Services

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High Cost Is Not Fiscally Sustainable for Medicare, the U.S. Federal Health Insurance Program for Those 65 and Older

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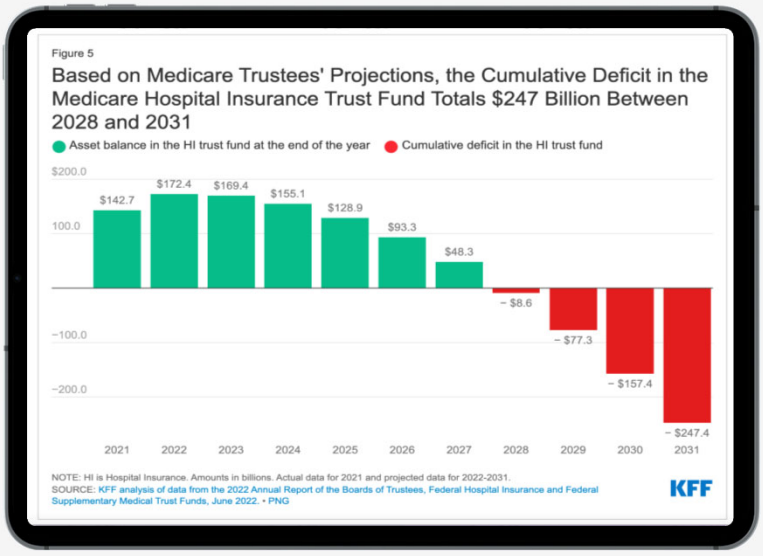

KFF, July 12, 2022

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Traditional Care Continuum Options

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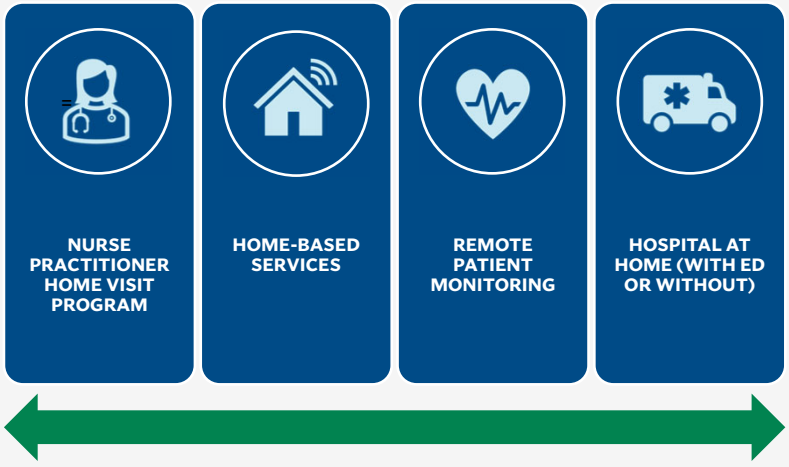
'Gap-Filling' Programs



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A Continuum to Match Needs to Services and Enable Aging in Place, Accounting for What Matters Most to Older Adults

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Exemplar: UnityPoint Health Care at Home (CaH) Outcomes

QI Intervention: Introduced 30-Day Ambulatory Care Bundle on October 1, 2019			
n(495)	Outcome Target	HTH Baseline (Pre-intervention)	HTH w. PCaH 30-Day Bundle (**Post-Intervention**)
Data Range		09/18 – 09/19	10/19 – 5/23
Number of patients served		59	436
7-Day ED Escalation Rate	≤ 10%	8.5%	3.5%
7-Day Hospital Admit Escalation Rate	≤ 10%	6.8%	5.3%
30-Day ED Escalation Rate	≤ 15%	27.1%	12.1%
30-Day Hospital Admit Escalation Rate	≤ 13%	22.0%	11.4%

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UC San Diego Health: Majority of Eligible Patients Needed IV Antibiotic Therapy and Were Successfully Treated at Home

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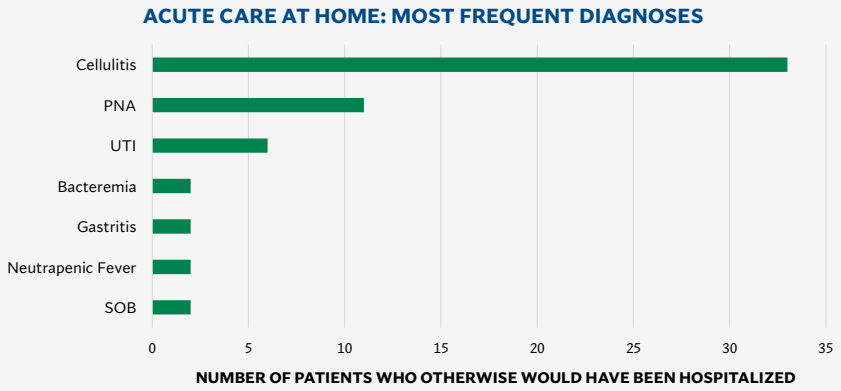
patients received acute care at home from the ED



* 66 patients avoided hospitalization for at least 30-days

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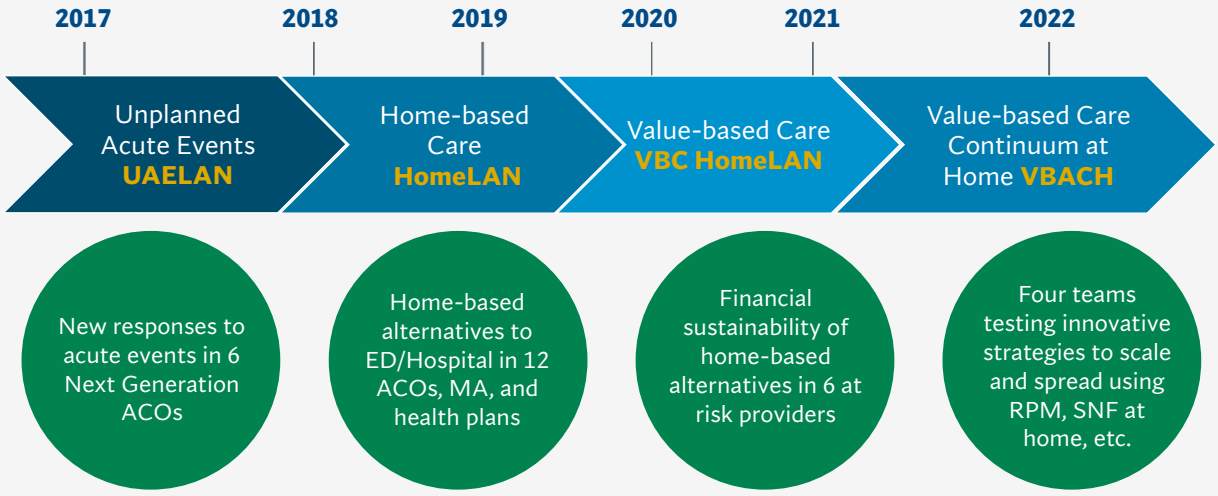
Evolving Learning & Action Networks: Prototyping, Testing, and Sustaining Programs



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Learning and Action Network Results: Fewer ED Visits and Hospitalizations

UAELAN. Six organizations stood up new responses to unplanned care needs.

HomeLAN. Twelve organizations averted >1120 ED visits and >550 hospitalizations; achieved $8 million in top-line savings.

VBC HomeLAN. Six organizations averted >800 ED visits and >470 hospitalizations; $7.5 million in top-line savings.

VB-ACH. Three organizations averted >300 ED visits, >330 hospitalizations; $4.1 million in top-line savings

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West Health/IHI Getting Started Guide

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Sustainability of Value-Based Geriatric Care Across the Continuum

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Sustainability in Medicare Payment: Value-Based Payment

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What Are Value-Based Programs?

Reward health care providers with incentive payments for the quality of care they give to people with Medicare.

Programs are part of a broader quality strategy to reform how health care is delivered and paid for. Value-based programs also support these three aims:

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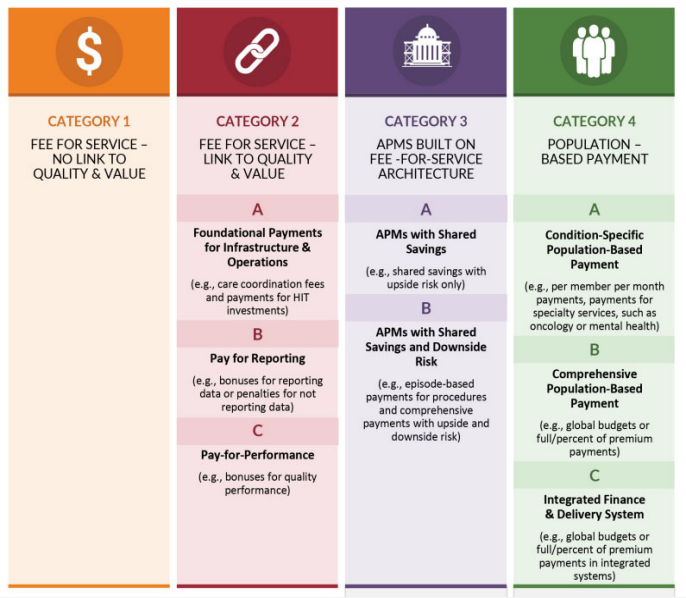
A Taxonomy of Medicare Value-Based Payment Models



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For Members and Affiliates of the California Hospital Association: History of Payment Reform Experience

DHCS

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Diagnosis Related Group Hospital Inpatient Payment Methodology

Payment by Diagnosis Related Group (DRG) encourages access to care, rewards efficiency, improves transparency, and improves fairness by paying similarly across hospitals for similar care. Payment by DRG also simplifies the payment process, encourages administrative efficiency, and basis payments on patient acuity and hospital resources rather than length of stay.

History of DRG

Senate Bill 853 (Statutes of 2010) added Section 14105.28 to the Welfare and Institutions Code which mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon Diagnosis Related Groups (DRGs).

DRG Payment Method

The DRG reimbursement methodology replaced the previous payment method for all private hospitals with admissions on or after July 1, 2013, and for non-designated public hospitals with admissions on or after January 1, 2014.

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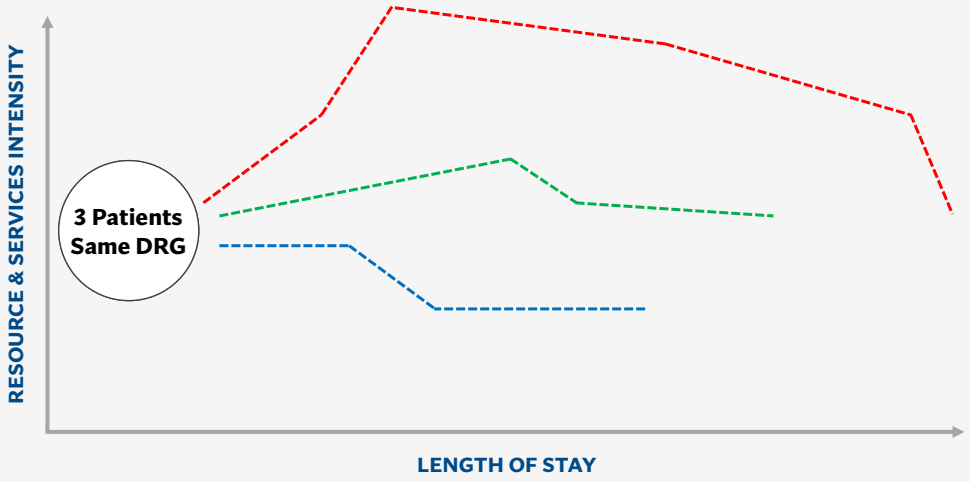
CHA Experience: Reconciling Homogeneity in Prospective Payment with Heterogeneity in Patient Care Needs



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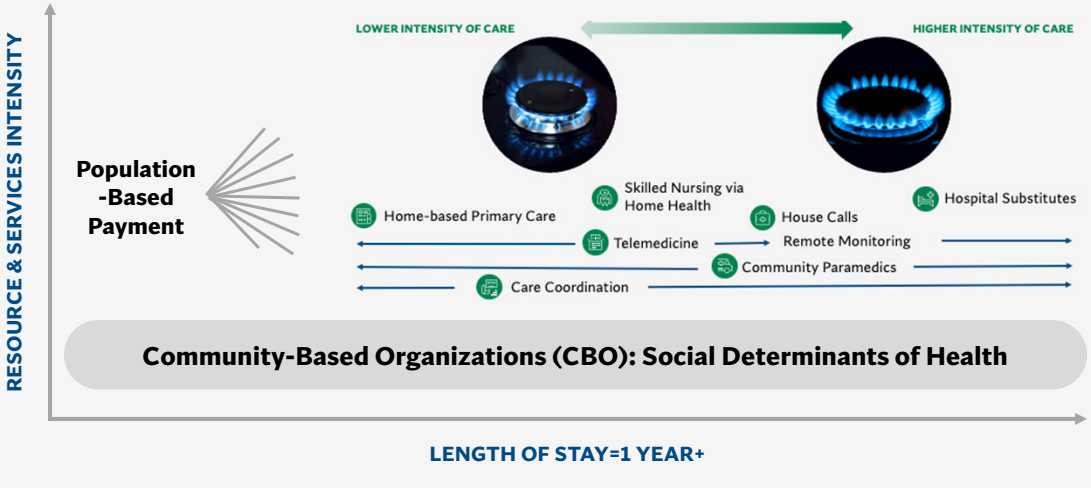
It May Take a Village: Reconciling Homogeneity in Capitated Payment with Heterogeneity in Population Needs



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Questions

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Thank You

Thank you for participating in today's webinar.

An online evaluation and an attestation of attendance will be sent to you shortly.

For education questions, contact:
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Thank you

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