Is the Perfect Organizational Structure Just a “PIPE DREAM”?  
Carol Quiring  
President/CEO  
Saint Luke’s Health System Home Care and Hospice

What’s Your Point of Reference?  
- Health System owned  
- Core Services:  
  - Home Health  
  - Hospice  
  - Home Infusion  
- 240+ employees  
- 4 Branches and a Parent office  
- Cover Kansas and Missouri (All or parts of 29 counties)  
- 950-1000 patients served daily  
- Telehealth since 2001  
- EMR since 2002
Our Culture

- Accept all System referrals regardless of ability to pay
- System patients are our priority
- Health System is our Partner
  (THIS IS A KEY TO OUR FUTURE)
- Promote from within
- Transparency
- Shared Governance
- Innovation

Why are we here??

- Between now and 2050, the elderly population will double
- 1 in 5 people could fall in the category known as “elderly”
- 2.3M or nearly 20% of hospitalized beneficiaries will be readmitted
- Federal government cost = $17.4Billion

Do you understand the data??

- According to AHRQ, of the 40M hospitalizations in 2008, 1 out of 10 were avoidable
- Rural hospitals saw twice as many avoidable readmissions as urban hospitals
- Medicare beneficiaries with disabilities saw 53% readmissions within one year of their hospitalization
- 50% of all patient readmitted in 2008 did not visit a physician prior to readmission
- The likelihood of readmission increased with the number of chronic illnesses of a patient
Rehospitalizations

*In 2011
- 3.4M beneficiaries received home care by over 11,000 agencies (Medicare Certified)
- Home Health Compare reports the national readmission rate is 26%
- That means approximately 918,000 home health patients are hospitalized annually
- Med-Pac estimates 1 avoidable Rehospitalization cost $7,200
- Annual cost of home care patients being hospitalized: $6.6 Billion

In order to understand Home Care you must understand Health Care

Acute care providers are our Partners VBP Model
- Value Based Purchasing
  - Reimbursement Model for Acute Care Hospitals
- Quantity to Quality
- Start date: October, 2012
- Based on performance standards for “clinical process of care and patient experience”
- Conditions targeted: AMI; Heart Failure; Pneumonia
- Improvement vs. Achievement
Acute Care Providers are our Partners

- Patient experience: HCAPS
  - Communication
  - Pain Management
  - Cleanliness and Quietness
  - Overall rating
  - Discharge Instructions

How Does VBP Work?

- Score for Outcomes
- Score for Patient Satisfaction
- 2014 Score for Efficiency
- CMS is withholding 1-2% of the allowed DRG
- In order to receive the withheld $$'s the hospitals must demonstrate a curtain threshold
- Repayments will begin 1/1/2013

Efficiency Domain

- Cost of Care 3 days prior to hospitalization and including 30 days after
- All Medicare Part A & B
- Some risk adjustment will be applied
NOW Is Your Time To Build Your “App” For Success

- Patient Satisfaction: 70% (2012)
- Readmissions: 30% (2012)
- Efficiency

Start with your LEADERSHIP

Leadership

“The greatest barrier to success is the fear of Failure”
Sven Goran Eriksson
Visionary Leadership is a strategy to success.

"The one thing that distinguished successful projects from less successful projects was not money, the idea or importance of the project. IT WAS THE LEADER."

Dr. Steven Schroeder
President/CEO
Robert Wood Johnson Foundation
1990-2001

Bass’ Transformational Leadership Theory
- “Drive for Quality and Focus on Results”
- “No-secrets” culture
- Communication—speak from the heart, keep lines open
- Empowerment, innovation, and agility
- Responsibility to patients, employees, and communities
- Encourage new ways of looking at old problems
- Challenge status quo

Look Outside The Home Care Industry For Leadership
- The Spider and the Starfish
- Peak Performers
- Monday Morning Leadership
- Switch
- Motivational Interviewing
- The Innovator’s DNA
Look Outside The Home Care Industry For Leadership

- 2008 IOM Report
- January 2012 Report to Congress:
  - Post Acute Care Payment Reform Demonstration
  - January 2012 Delta Study to Reduce Rehospitalizations

Building Your Agency “App” For Success Chronic Model

- Wagner Chronic Care Model
- Guided Care
- Robert Wood Johnson: Chronic Care Model
- Stanford Model

Alternate Operating Strategies: Thinking Outside the Box

- What have you done to position your organization for “chronic care”?
  - Diabetic Educators
  - WOCN's
  - Nurse Practitioners
  - Cardio-pulmonary certified physical therapists
  - Lymphedema certified therapists
  - Other Discipline Specialties
- Do you recruit and hire or train your own???????????
Transitional Care

- Coleman Model
- Naylor Model
- Project Red
- Boost

Models

- Care Transitions Program
  - Dr. Eric Naylor
  - Centered around the 4 pillars:
    - Medication Self Management
    - Follow-up appointment with PCP and Specialists
    - Knowledge or red flag symptoms of illness
    - Patient Centered Medical Records

- Transitional Care Model
  - Dr. Mary Naylor
  - Key Aspects:
    - Transitional Care Coach
    - Screening prior to discharge
    - Home visits within 24-48 hours
    - Frequent telephonic visits
    - Ensure appointments with health care providers including transportation
    - Personal emergency care plan
    - Records questions for doctor & attends appointments as needed
    - Patient Centered Goals
Models

- **Project RED / Re-Engineered Discharge**
  - Developed by a research based group out of Boston University Medical Center
  - Key Aspects:
    - Patient Education
    - Follow-up Medical Appointments
    - Medication reconciliation at discharge
    - Evidence based treatment
    - Expedite communication to key providers upon discharge
    - Telephonic re-assessment 2-3 days following discharge

- **Project BOOST: Better Outcomes for Older Adults through Safe Transitions**
  - Created by the Society of Hospital Medicine
  - Key Aspects:
    - Generalized Assessment of Preparedness
    - Medication reconciliation and teaching "Teach-back" approach
    - Discharge communication to health care team members
    - Telephonic communication with patient/caregiver within 72 hours of discharge

Hybrid

- Patient Focused Goals
- Using Motivational Interviewing techniques
  - "Motivational Interviewing in Health Care: Helping Patients Change Behavior"
- Palliative Care in the home
- Hospice Home Care
- Hospice Inpatient Care
A Different Kind of Hospice Home Care

Now Is Your Time To Experiment With Care Delivery Models

- Internal Case Management
  - 1 RN = 60 to 70 patients
  - Utilizing a tool at discharge (LACE) to stratify the risk for readmission
  - ICM visits high risk patients in the hospital and conducts assessment and teaching
  - Collaborates with field nurse to develop Plan of Care
  - ICM makes telephonic visits in-between field visits
  - Continues collaborative management of patients
  - Conducts post-episode telephone visit to assess satisfaction and ensure patient’s ability to maintain health status quo or improvement

Use Of Predictive Modeling

- LACE
- PARR
- HUM
- CPM
- Charlson Comorbidity Index
Other Models

- Teams
- PODS
- Clinical Resource

Operating “Apps” Goal

- Are you ready to participate in Bundled Payment Initiatives?

Bundled Payment Initiative Partner to Play

- Model 2 or Model 3
- Prepare your network
- Identify your collaborators
- Target your population
Model 3

- Target to reduce readmissions and improve post acute care to patients with Congestive Heart Failure or Diabetes
- Incorporate “transitional coaching” principles
- Deploy “telehealth monitoring”
- Utilize “motivational interviewing” techniques
- Perform “best practice-disease management” guidelines
- Establish long term relationship with physician providers of patient
- Jointly develop a “shared care plan”

Monitor each patient for the following:
- OASIS outcomes
- Rehospitalization rates
- ER visits
- HHCAHP scores
- Cost of episode

Patient Centered Medical Home Models

Accountable Care Organizations

Population Management
Are You A Vendor Of Low Margin, High Volume Services?

OR

Are You A Solutions Provider?

“App” For Sustainable Model

- People:
  - Right staff
  - Highly Productive
  - Accountable Staff
  - Staff Specialties

Sustainable Model?

- Customer service
  - Who are your customers?
  - Do you meet their needs?
  - Are you strategically positioned to be a partner to your key customers?
    (Physicians, Case Managers, Administrators, in Hospitals, LTC facilities, Rehab hospitals, Medical Practices)
  - Does your staff know who your top customers are?
Sustainable Model?
• Clinical Quality
  o Outcomes in the top decile
  o Measure and compare your outcomes by clinician
  o Share your clinical outcomes with your strategic partners

Have you built a Sustainable Model?
• Revenue Cycle Management
  o Cash is King
  o Audit, audit, audit!
  o What business has the highest margins?
  o Do you know the cost of doing business?

Have you built a Sustainable Model?
• Growth
  o Acquisition of additional geography
  o Additional Managed Care contracts
  o Solutions to Health Issues
  o Does your growth mirror your #1 Customer
Keys To The Operating Model Of the Future
- Staff with highly skilled critical thinking skills
- Partnerships with acute care and physician providers
- Chronic Care Management
- Seamless transitions from one care setting to the next
- Reduction in Rehospitalizations
- Visionary Leadership

3 Things You Should Do Everyday
- Laugh
- Think
- A passion that brings you to tears.

What’s in your App for your Future??
“Excellence is the result of caring more than others think is wise, risking more than others think is safe, dreaming more than others think is practical, and expecting more than others think is possible”
The future of home care is in our hands, don’t let others take it from us!
Questions???