Risk Identification Assessment Tools and Care Coordination Risk Mitigation Strategies

The National ACO, Bundled Payment and MACRA Summit – June 2018

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Disclosure

Agenda

- About Brooks Rehabilitation
- Risk tools
- Risk mitigation care strategies
- Readmission results

Brooks System of Care – Overview

- Mission based non-profit post-acute health system
- Headquartered in Jacksonville, FL; service area includes Northeast and Central Florida
- Model 3 bundle awardee convener – starting October, 2013

Where We Are

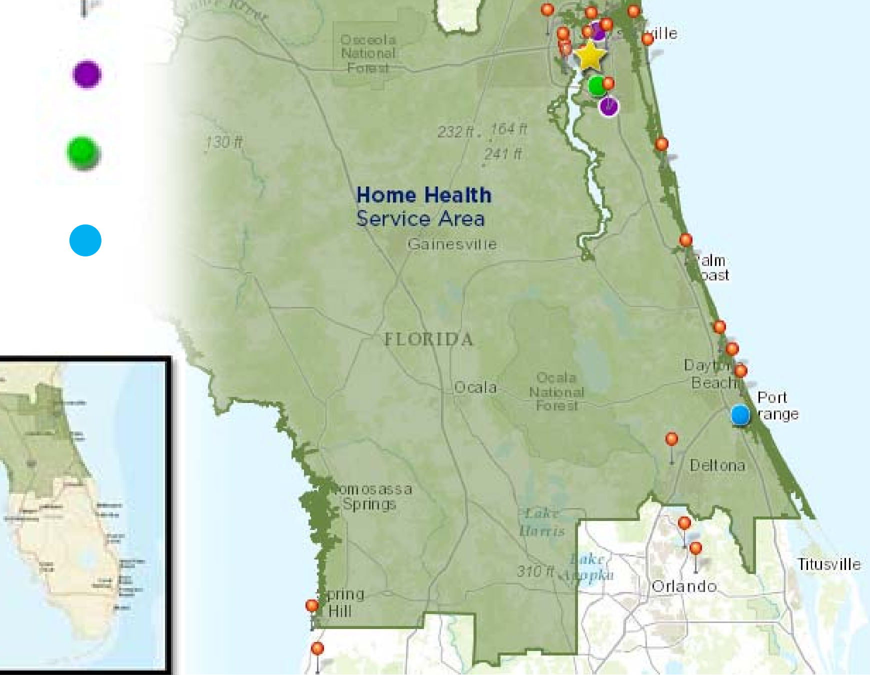
Brooks Rehabilitation Hospital/Corporate

Brooks Outpatient Clinics & Programs *(32)*

Brooks Owned Skilled Nursing Facilities *(2)*

Brooks Total Joint Rehabilitation Skilled Nursing Unit
(Partnership with St. Vincent's Southside)

Center for Inpatient Rehab
(Partnership with Halifax Health)



Current State of Bundles and Brooks Bundle Payment Model

CompleteCare BPCI Results Episodes (January 2014 – December 2017)

Clinical Episodes	Savings	Patient Satisfaction	Functional Improvement
Over 4,500+	**26%** savings	**94%** overall	**107%** average increase in function

Diagnosis	Start Period of Performance	Episode Length
Hip Pelvic Fractures, Total Knee and Hip Replacement/Revisions	October 2013	60 days
Congestive Heart Failure	April 2015	30 days
Non-Cervical Fusion, Cervical Fusion, Back & Neck Surgery	April 2015	60 days

Post-Acute Setting Utilization

Frequency Percent

100%
80%
60%
40%
20%
0%

Year 1 Year 2 Year 3 Year 4 Year 5

CC Year

InitialSite

BRH SNU SNF BHC

Risk Tools & Program Components

Resources and Tools Implemented

- Assure *"best"* 1st care setting
- Decision tool

Standardized evidence- based assessments

- Patient & Caregiver Engagement
- Activation Risk
- Care Navigators

<u>TOOLS</u>

- Care Compass
- Acuity Risk
- PRAISE

Poll Question #1

Is your system currently using any tools to identify patients that are at a higher risk for readmission?

- ❑Yes; tools are in place and embedded in program
- ❑Somewhat; tools in place but are inconsistently used for care decisions
- ❑No; not at this time

3 Risk Tools

Patient Activation Measure – Individual's knowledge, skill and confidence to manage his or her own health and care

Acuity Risk Tools – LACE

Self Reported Tools

- Patients Perceived Readmission Risk – of readmission in 30 days.
- Health Literacy – confidence in ability to complete medical forms

Patient Activation Measure (PAM)

PAM is a 10 question survey that determines a patient's ability and willingness to manage their health

Low PAM	High PAM

Level 1 – Overwhelmed & disengaged

Level 2 – Becoming aware, but still struggling

Level 3 – Taking action

Level 4 – Maintaining behaviors and pushing further

1 2 3 4 5 6 7 8 9

0-100 point scale

Patient Activation Measure Survey

- ❑ I am the person who is responsible for my health.
- ❑ I know what each of my medications do.
- ❑ I can tell a doctor my concerns.

When adjusting for diagnosis, initial care setting, age, gender and race:

•Patients with a low PAM (low engagement) are over **2.5X** more likely to be readmitted compared to patients with a high PAM (high engagement)
(OR=2.73, $p<0.0001$)

LACE Components

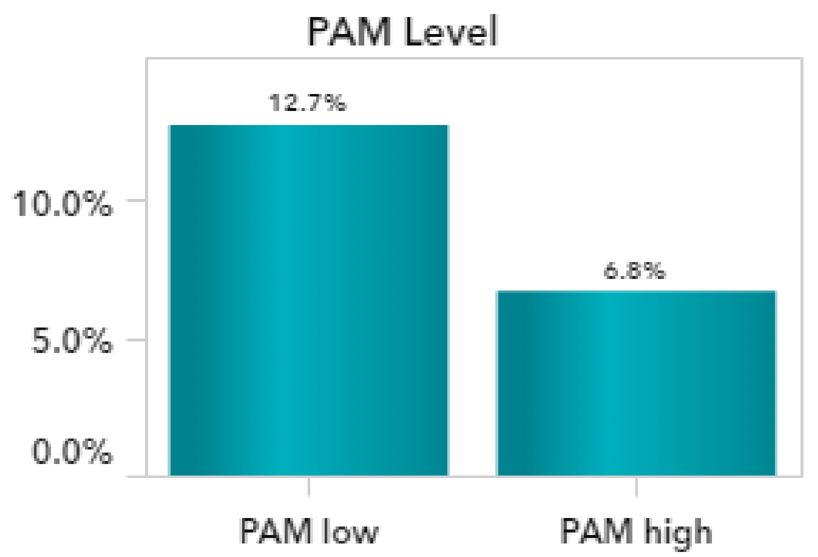
L = Acute Length of Stay

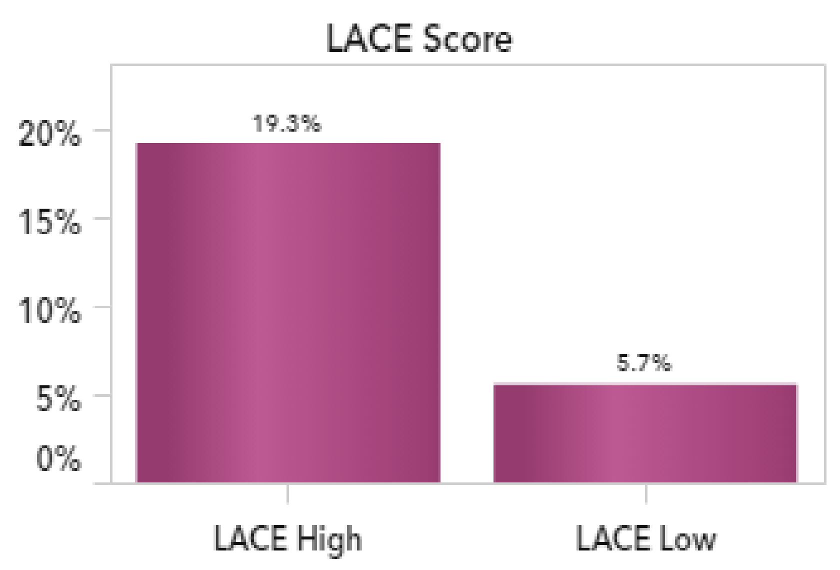
A = Acute Admission Emergent or Planned

C = Comorbidities

E = Emergency Room Visits (past 6 months)

PAM & LACE Risk Prediction



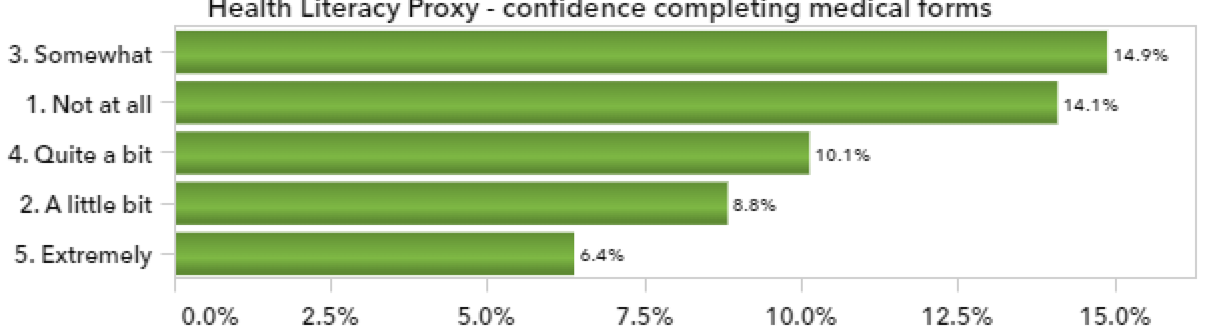


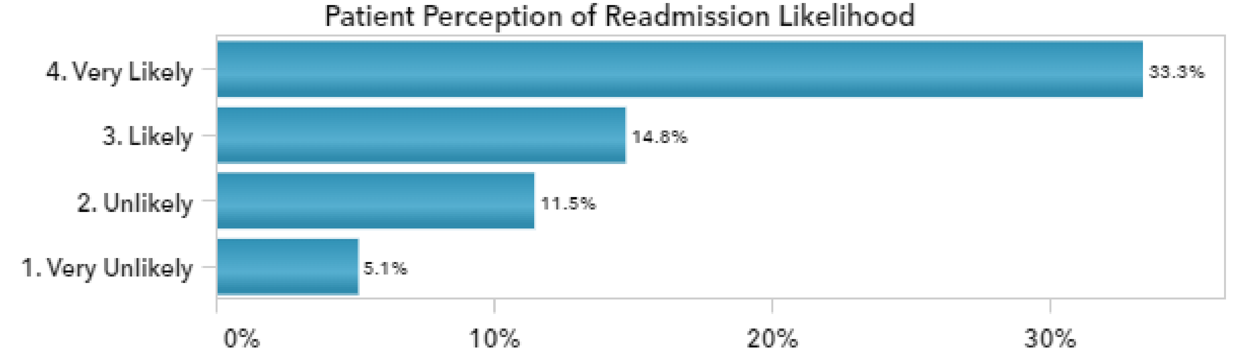
Risk Index Level

Risk Index Level	Percentage
1. High Risk and Low Activation	19.2%
2. High Risk and High Activation	14.9%
3. Low Risk and Low Activation	7.2%
4. Low Risk and High Activation	4.4%

0% 5% 10% 15% 20%

Health Literacy & Readmission Likelihood Predictors of Readmission





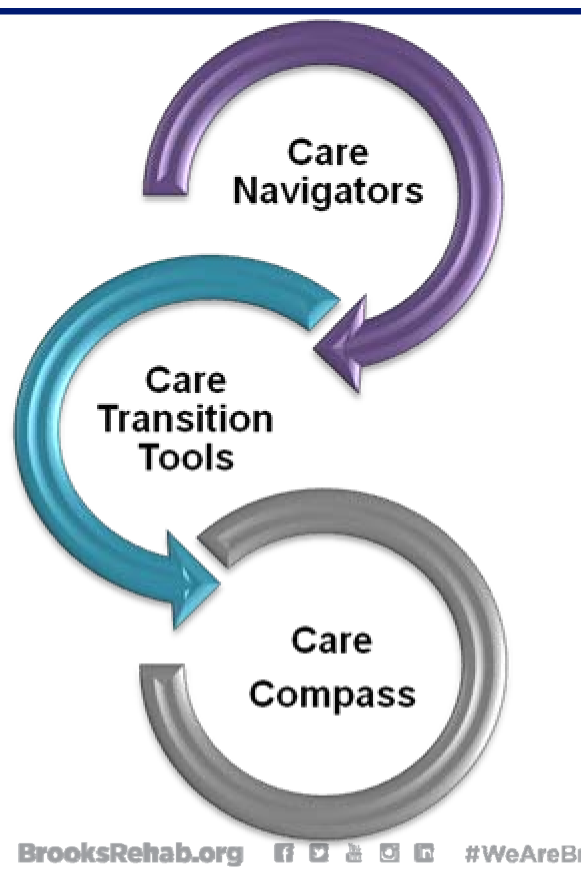
Risk Mitigation Strategies

Poll Question #2

Does your organization utilize Care Navigators or other staff to support patients after discharge from your acute hospital?

- ❑Yes; staff are in place to perform routine follow up and support for all patients after discharge from acute
- ❑Somewhat; the PCP or Specialist is primarily responsible for follow up care
- ❑No; not at this time

3 Risk Mitigation Strategies



- Care Navigators assignment and touchpoints based on risk tools
- Care Transitions Tools connect the system of care
- Care Compass wrap around care management solution

Fostering Clinical Collaboration

Risk Identification Tools

Longitudinal Care Plan & Virtual Handoffs

Patient dashboards

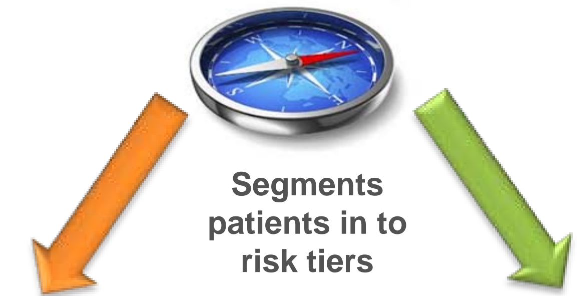
Predictive care path/cost

Standard process for care transitions

Tools Supporting Care Navigator Efficiencies

Navigator Placement Methodology

Care Compass Risk Measures

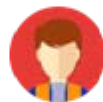


Segments patients in to risk tiers

Non-Clinical Navigator

New Alert: Pass to RN

Longitudinal Care Plan and Soft Hand Off Using PRAISE™


Person

Readmission Risk

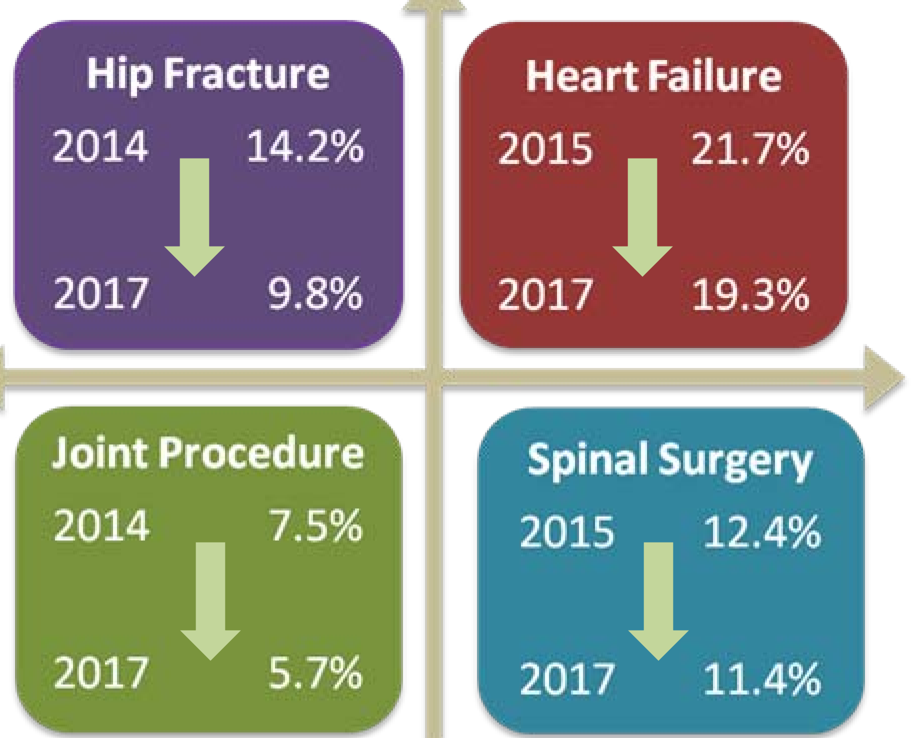
Alerts and Precautions

Interests

Social Factors

Expected Plan of Care

Readmission Rate *Reduction* 30-Day Rate by Diagnosis Group



Reduction Rate

Hip Fracture: 31%
Heart Failure: 11%
Joint Procedure: 24%
Spinal Surgery: 8%

Thank You
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