CareForum 2022

The WellSky® Conference

Case Conference 2.0

Transforming performance and culture

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Today's speakers

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Objectives

The learner will be able to:

- Describe best practice methodology for home health interdisciplinary team meetings
- Summarize a method to enhance advancement of clinician skills in service of clinical outcome improvement and retention
- Identify methodology to use data to drive efficient and effective guidance of clinicians and IDTs toward compliant, best practice utilization management

Stack skills to serve and conserve

The new productivity

Achieving the best clinical outcome, within the most efficient use of visits and technology, is the new gold standard for home health productivity and value.

Clinical team processes which don’t directly contribute to gold standard often waste resources.

Within today’s growing demand and constricted supply of workforce, can you afford to waste resources?

Home health interdisciplinary case conference impact

Pros

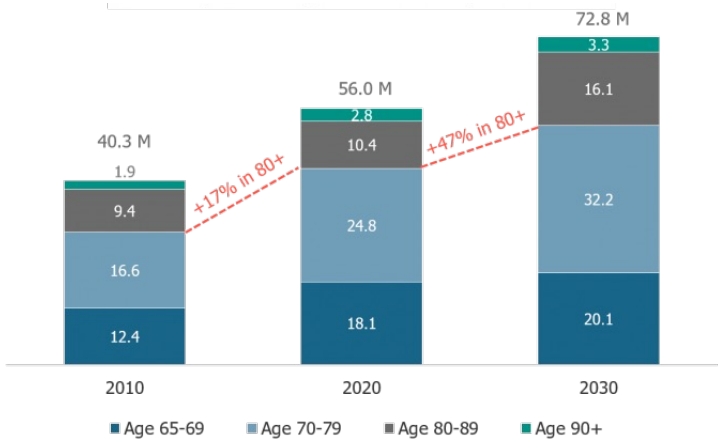
Cons

Set the stage for a new day in home health

Our industry faces a **historic inflection point**

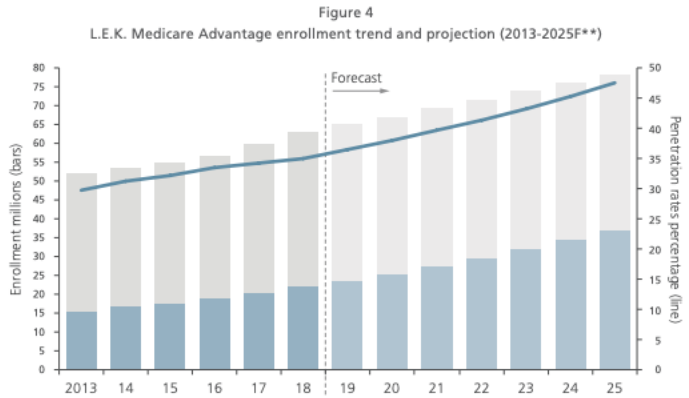
Increasing needs, limited staff

80+ population projected 47%+ growth in in the next 10 years



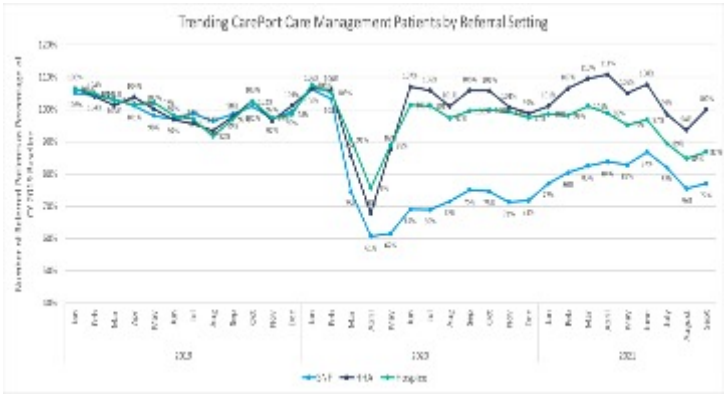
Shift in payer mix

"Medicare Advantage Heading Towards 70% Penetration"



Rise of home-based care

Transition to home was already underway, sped up by COVID



Building value is a team sport

Home Health Value-Based Purchasing

Anticipate vigorous competition based on outcomes:

- Focus: hospitalization and emergent care (claims), functional impairment (OASIS), patient satisfaction (HHCAHPS)
- 2022 — proposed baseline
- 2023 — first performance year
- 2025 — first payment year

Team behaviors are learned:

- What are you teaching them, and how?
- Consider how we have learned through PDGM

Wrap daily focus of care and IDT in a QAPI process

Consistency in outcome-driven performance, fed by a process:

- Comprehensive assessment performance and OASIS data capture *competence*
- Excellence in coding and OASIS review – fueling ongoing, data-driven micro-education and best practice, stacking skills
- Integration of performance data and predictive analytics into best practice care planning, utilization management model (Intelligent Care Management)
- Care planning aligned with patient's risk, acuity and goals – align right resource to need
- Best practice and top outcomes, fueled by:
  - ✓ Performance Improvement Project: reduce hospitalization and emergent care, root cause analysis
  - ✓ Diagnoses aligned analysis and resultant, targeted actions to focus approach to care
  - ✓ Education aligned and designed to stack skills, build confidence, competence and engagement, yielding top outcomes

- **Smart use of data – every day: 'Case Conference 2.0'**

Our teams need the right tools to meet the needs of today’s home health

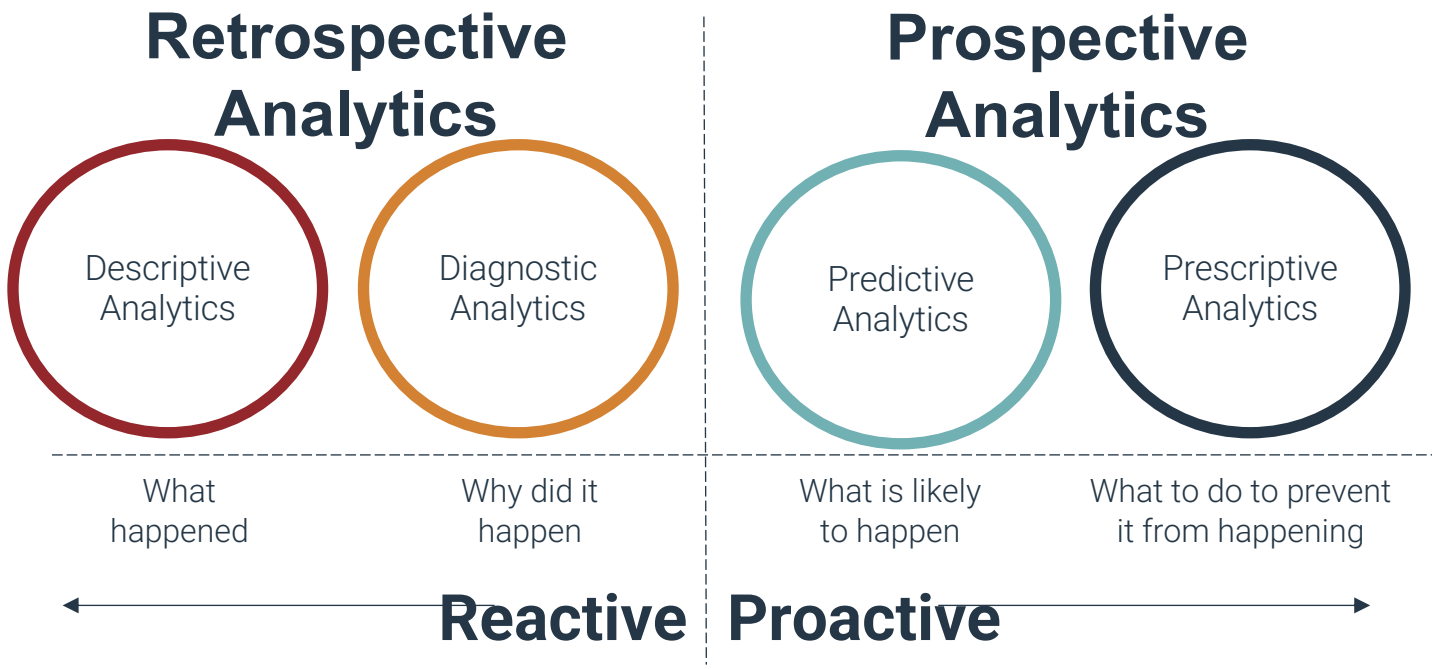
Before going deeper on case conference 2.0:
Quick comment on artificial intelligence in home health

We have come a long way in ability to predict and manage clinical risk

Data has evolved – a key tool for clinicians and leaders in care at home

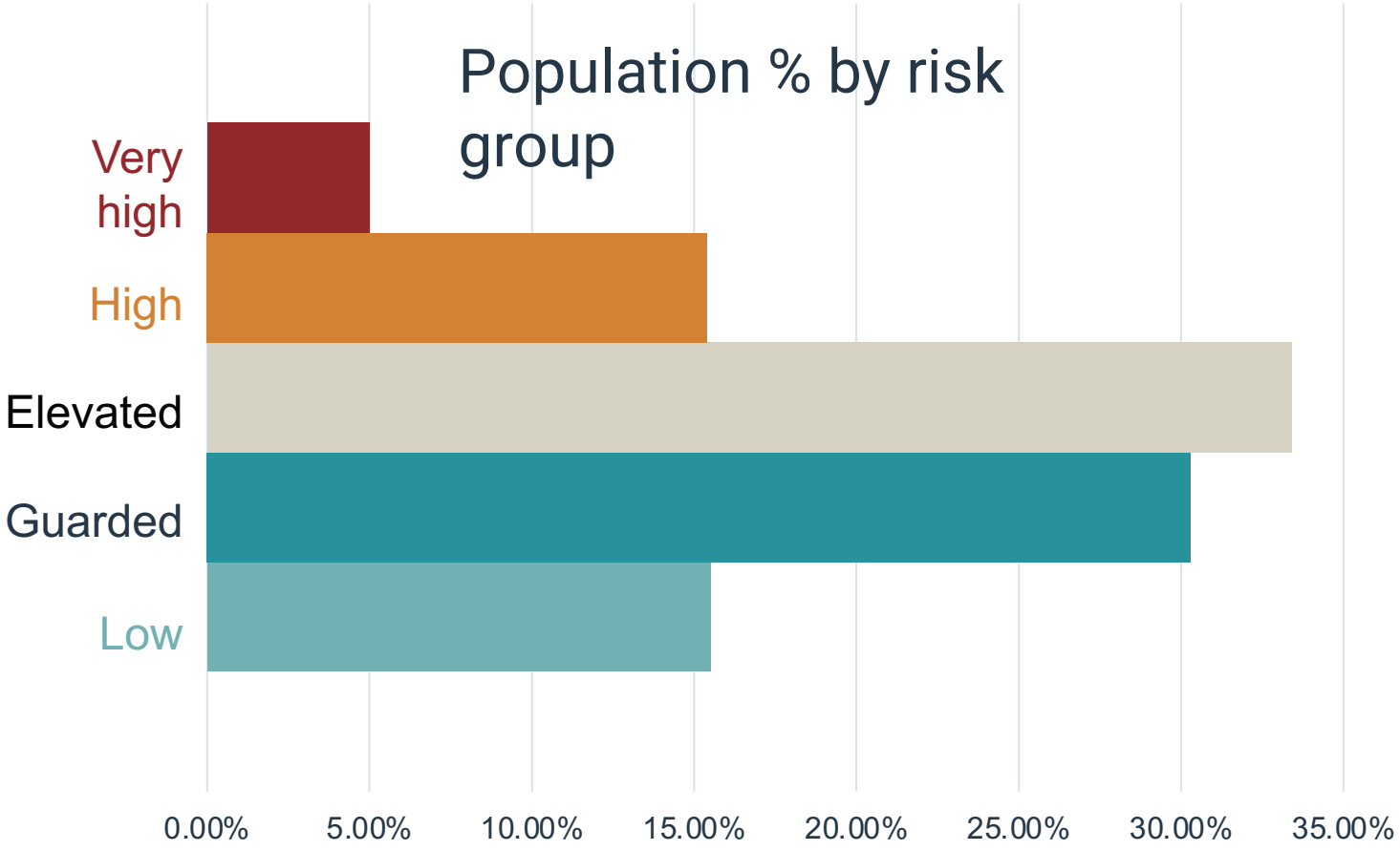
How are you leading the use of new tools which light the path to practice today?

Traditional view of analytics capabilities



Your analytics should cover the full spectrum of clinical care optimization, relationship management, & caregiver engagement analytics

Take advantage of algorithms that predict risk



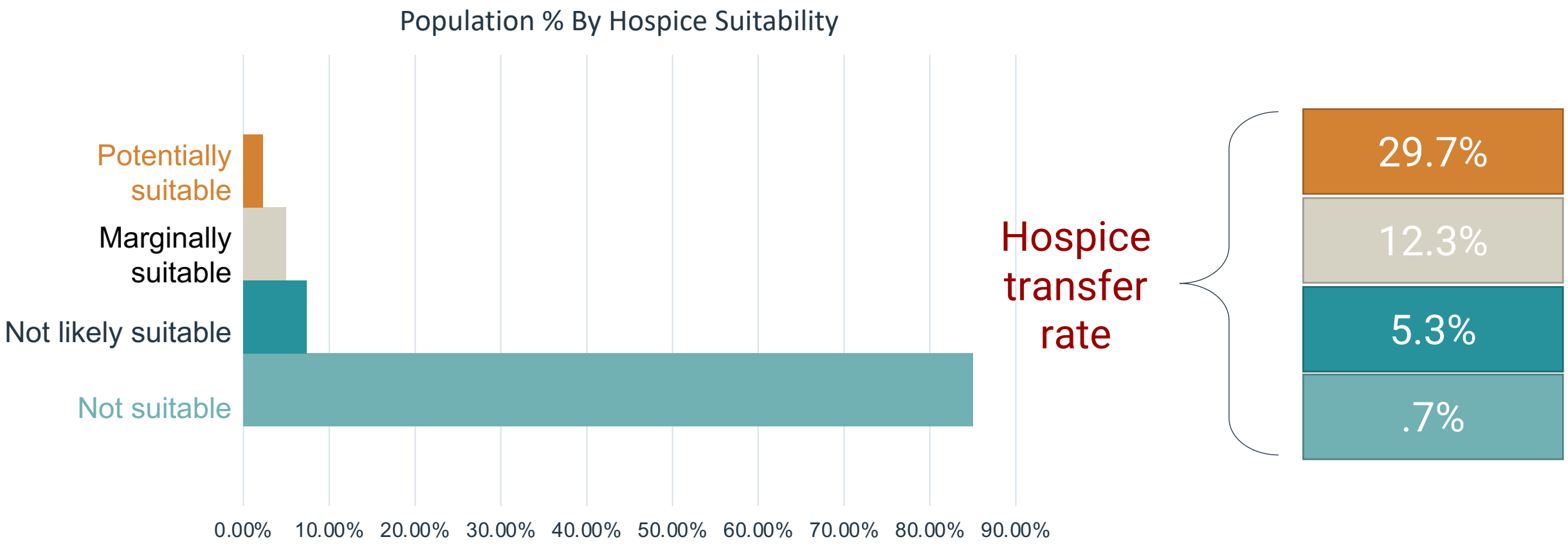
Hospital transfer rate

- 41.0% 60-day hospitalization
- 22.4% 60-day hospitalization
- 11.9% 60-day hospitalization
- 5.5% 60-day hospitalization
- 1.6% 60-day hospitalization

Identify patients at risk of hospitalization based on a predictive algorithm.
Patients are segmented into categories based on the estimated likelihood for hospitalization rate.

Algorithms are built to identify hospice or palliative suitability

Review your patient's prognostic status in relation to their goals, to more effectively serve patients and families



Predictive analytics can help your team identify patients who may be suitable for hospice care.
Patients are segmented into categories based on the estimated likelihood for hospice transfer rate.

Data insights help us see patterns of need, and comparative best practices

Driving QAPI & Intelligent Care Management

Determined
- Patients with good health outcomes

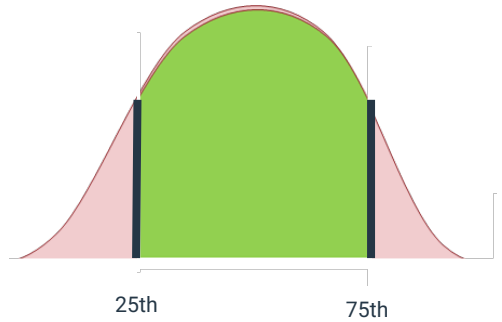
Segmented
- Patients into PDGM groups

Calculated
- Median number of visits by clinician type

Developed
- Percentile range of visits

Patient specific analysis

- Review your patient's expected utilization



- Assess visit utilization

Visit Utilization Insights

This Episode	PDGM Median	Assessment	LUPA Risk
5	22	Under	5/5
14	12	In Line	5/5
6	11	In Line	5/5
18	14	In Line	5/5
4	14	Under	4/5

Stack skills in today's home health

Integrate practices to build competence and confidence for high impact on retention and outcomes achieved

- Evaluate who is training and how you are training your teams in assessment technique, associated OASIS data capture, use of available analytics and best practice clinical decision support
- Expect, train, measure, and create accountability in **point of care documentation**
- Then integrate training of best practices in the care of specific patient cohorts
- Align this training to commonly served patient cohorts, think of PDGM clinical groupings
- Provide specific teaching of best practice utilization expectations – based on their great assessment skills and resultant, evidence-based predictive analytics
- Integrate skill stacking into daily practices to engage, build, and retain effective staff

Case conference 2.0 Disrupts

Do not use the team meeting **to work-around** core competencies of timely documentation

Do provide:

Training in expected use of available predictive analytics – providing context for *why* and teaching of *how*

Case conference 2.0 concepts:

-Daily virtual team triage, risk-informed
- Every visit clinician views risk-informed snapshot
-Skill-stacking educational format , grand rounds approach, integrating best practice EMR and analytic use into clinician tools for care

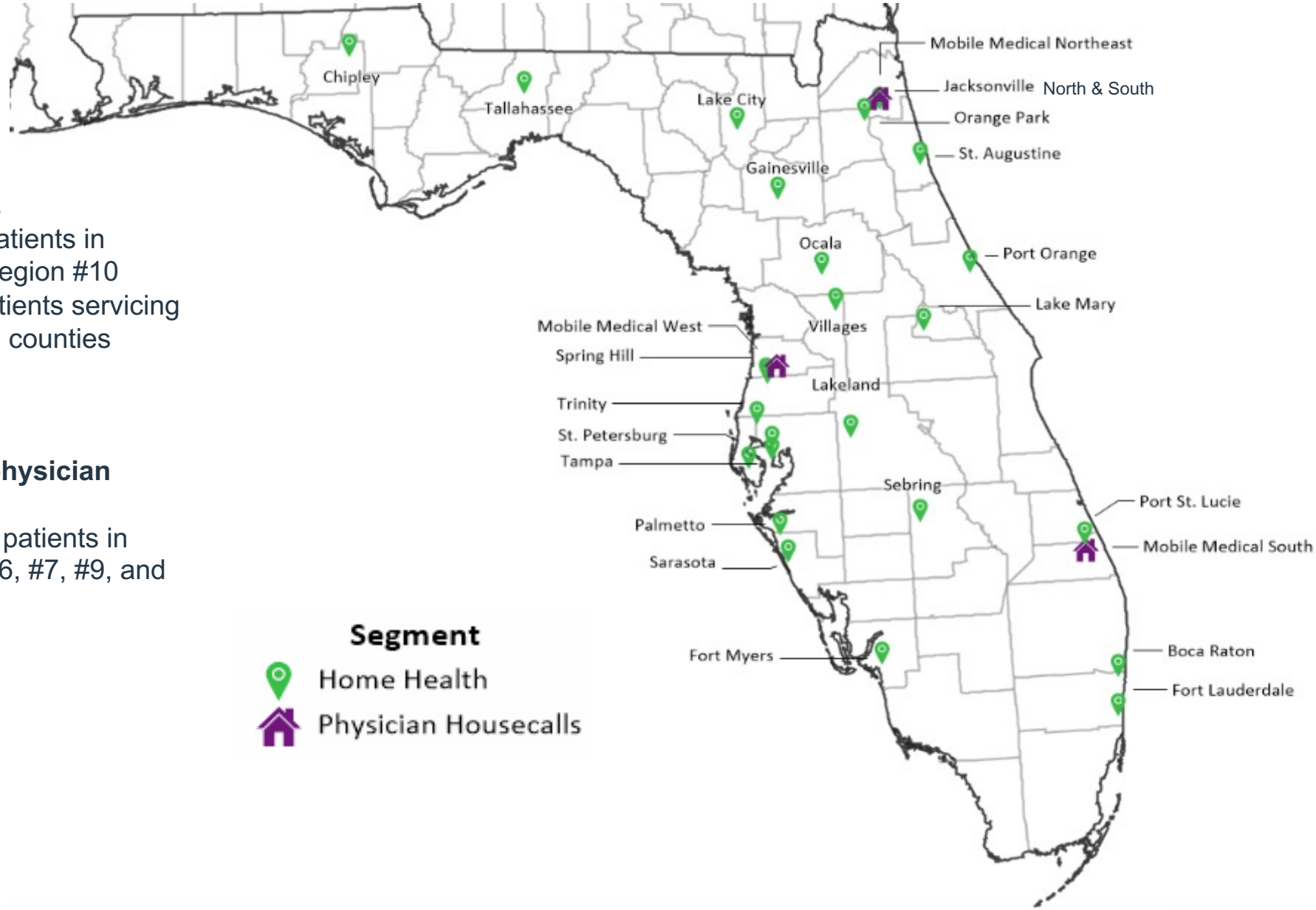
Making a difference

Concierge HOME CARE

We have been growing

- **26 home health locations**
  - Currently servicing patients in Region #2 through Region #10
  - Over 5,300 active patients servicing the majority of the 67 counties

- **3 in-home primary care physician locations**
  - Servicing over 6,600 patients in Regions #3, #4,#5, #6, #7, #9, and #10



Beyond PDGM 101

Next steps for home healthcare

Lose the waste – dare to disrupt!

- Break down the cultural walls of "it is ok if we do documentation later"…
- Identify other areas of waste and disrupt! Examples:
  - Coming to meetings absent preparation
  - QAPI that doesn’t find its way into practice
  - Nurses doing opens for therapy
  - Visits absent the right discipline/person/team/technology to make the greatest impact
- Elevate root cause analysis in QAPI through integrated use of data

Case conference 2.0 concepts: QAPI and clinical operations integration

Support QAPI and Performance Improvement Projects (PIPs) – root cause analysis:

- Reduce hospitalization
- Improve satisfaction
- Integrate data-driven guidance into new platform for dynamic education
- Improve utilization and capacity management – focusing care to need

Start with assessment approach/technique and data competence in OASIS capture

- Tie micro-education to real-time pattern of learning need
- Clinicians gain competence/confidence in assessment and **point of care data capture**
- Cycle of data informing risk-aligned and best practice thinking becomes a HABIT
- New habit serves patients more effectively

Patient acuity capture and data accuracy at SOC and end of care matter

- HHVBP is measures of magnitude of improvement, "dirty-data" can cloud outcome performance
- Data-gathering and point of care capture sets the stage for analytic engines to inform risk and utilization profiles
- Your process must reinforce this!

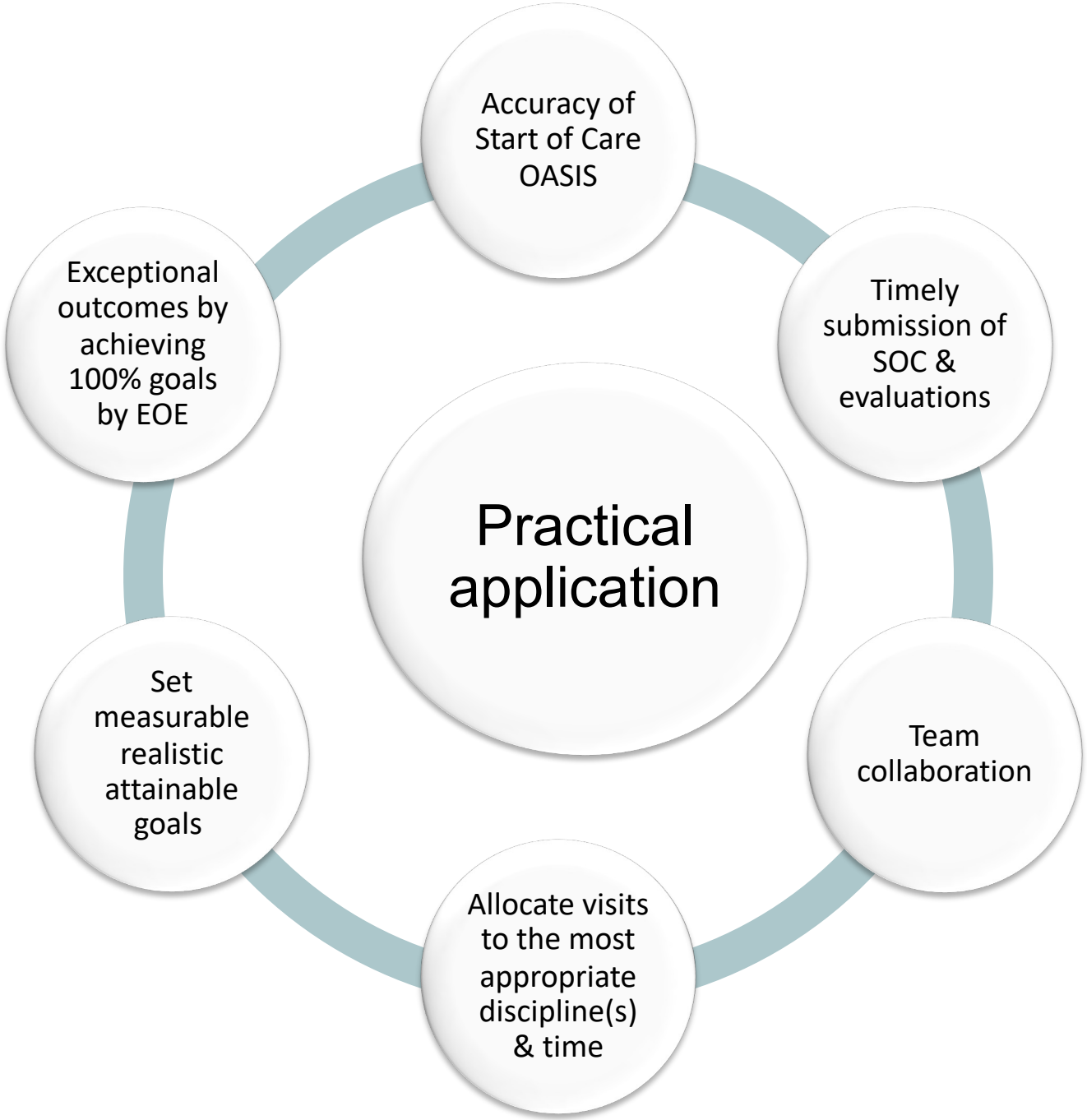
Focused method and discipline

Processes building performance:

- Daily case conference/virtual huddle:
  - New admits, recerts, and discharges, afterhours call log
  - Patients flagged as high-risk on CareInsights
    - Triage may initiate virtual visit
- Weekly clinician one-on-one with clinical manager, 15 min (virtual or in person – preferred)
  - Data-driven performance view
- Monthly staff education meeting — targeted education based on QAPI review, highlight HHCAPs and comments
- Quarterly incentive plans – report cards tying clinician performance, objective data with real time behaviors
- Quarterly QAPI review with each clinician to review their impact/opportunity

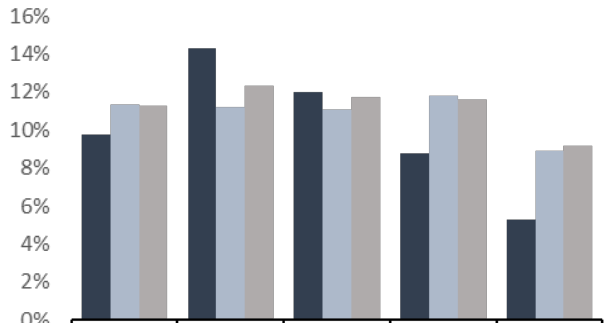
Growth of process, program, and people

- Build processes which build constructive feedback to staff
- Data informed feedback loops help managers who may lack skills in conflict management, also allows clear path for praise
- Clear objective data comparisons, takes away subjectivity
- Provide tools to allow review with clinician – talk about what is most meaningful – feeds data informed feedback and reinforces desired actions/behaviors
- Utilization Review team is embedded – from SOC – D/C goes to them; they give immediate feedback on items
  - UR does the coding and POC review/feedback on documentation
  - Ongoing OASIS training and Lunch and Learns, etc.


Accuracy of Start of Care OASIS
Timely submission of SOC & evaluations
Team collaboration
Allocate visits to the most appropriate discipline(s) & time
Set measurable realistic attainable goals
Exceptional outcomes by achieving 100% goals by EOE
Practical application

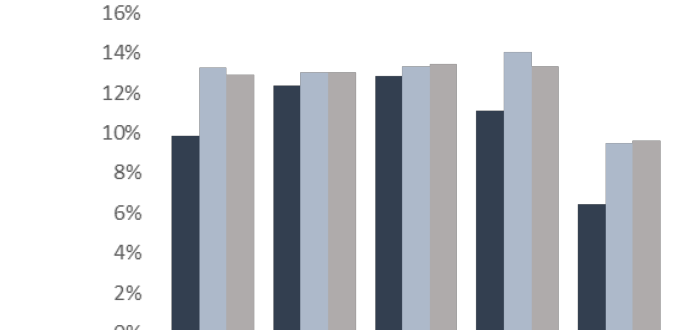
Results – changing behaviors

30-Day Re-hospitalization



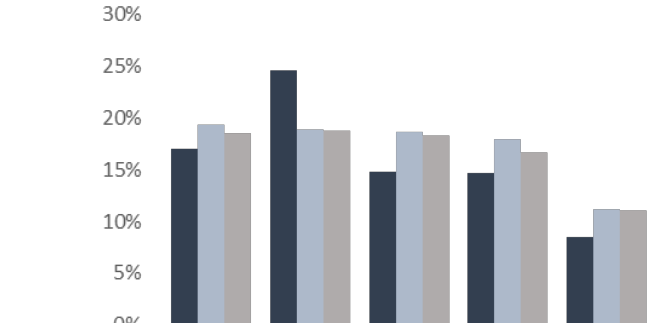
	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022
Ocala	10%	14%	12%	9%	5%
National Avg.	11%	11%	11%	12%	9%
State Avg.	11%	12%	12%	12%	9%

60-Day Re-hospitalization



	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022
Ocala	10%	12%	13%	11%	6%
National Avg.	13%	13%	13%	14%	9%
State Avg.	13%	13%	13%	13%	10%

All cause hospitalizations



	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022
Ocala	17%	25%	15%	15%	8%
National Avg.	19%	19%	19%	18%	11%
State Avg.	18%	19%	18%	17%	11%

- As we work to continuously improve, we have learned to value methods to use real-time, risk-informed data to drive clinical decision support, in every-day processes for case conferencing
- Consistent process allows us to assimilate acquisitions into our culture

Real-time patient insights into case conference 2.0

Case conference 2.0

- Stack clinician skills – build confidence and engagement
- Triage daily focus, reinforcing skills learned in team meetings
- Focus care through evidence-based, data-informed clinical decision support and align the schedule
- Use data for best practice utilization and capacity management
- Feed the right data into your QAPI process
- Keep on evolving as our learning and technology capacity grows

Serving patients, clinicians, and agencies

Case conference 2.0 – in three parts
Each building top performance

Monthly QAPI-fueled IDT grand rounds

QAPI/Clinical operations/IDT collaborative

- PIPs fueled by root cause analysis – data informed
- PIP aligned education, bringing protocol-controlled, risk and goal informed best practice teaching
- Reinforce how each member of the team contributes to picture of effective, lower cost, satisfying care
- Actively involve team in collective QAPI and PIPs – bringing them to life in the care of patients they know

Daily team huddle

Virtual & data-informed

- Identify patients with high and/or rising risk, service need
  - Prioritize scheduling of aligned resource
  - Realign discipline need to best coordinate care
- Review new admits from day before, reinforce risk-aligned initial care plan
- Confirm discharges/recertifications

Every visit preparation

Take 5 in Drive

- IDT member reviews predictive analytics shaping their observations, interventions, and approach.
  - Hospice suitability
  - ACH risk
  - Current orders
  - Last visit team notes
  - Patient goal

HHVBP Total Performance Score

Fueling your QAPI PIPs and education

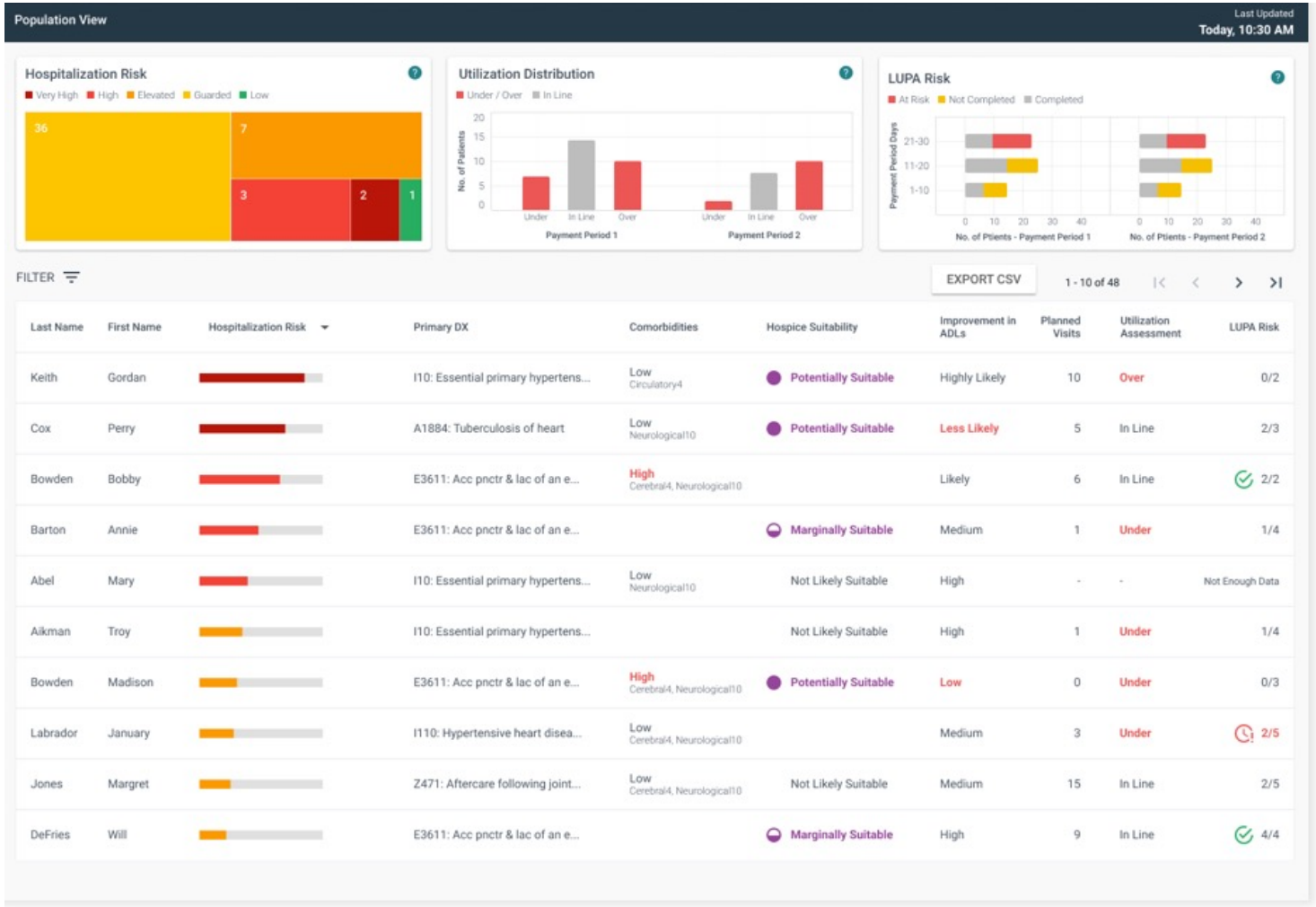
TN - Memphis

Medicare Certification:	Cohort Size:	Quality Episodes:	Est.Total Perf. Score:	WS National:	Est. Final % Payment Adjustment:
05/23/2015	Large	327	66.783 ↗	59th	+3%

Value-Based Purchasing Quality Measure	Agency Performance (Improvement Threshold 2019)	All Agency Median (Achievement Threshold 2019)	All Agency 95th Percentile (Benchmark 2019)	Current Value	Achievement Score (Compared to All Agencies, 0-10)	Improvement Score (Compared to Self, 0-9)	Performance Score (Highest, 0-10)	Performance Score WS National Percentile	Weight
TNC Self-Care	2.122	1.683	2.344	2.218 ↘	8.104	3.903	8.104 ↗	85th	8.8%
TNC Mobility	0.690	0.582	0.829	0.721 →	5.638	2.008	5.638 →	76th	8.8%
Improvement in Management of Oral Medications	89.3%	72.1%	92.8%	83.9% ↘	5.694	0.000	5.694 ↘	75th	5.8%
Improvement in Dyspnea	88.3%	80.8%	95.9%	87.2% ↗	4.212	0.000	4,212 ↗	60th	5.8%
Discharged to Community	89.2%	82.7%	94.0%	76.6% ↘	0.000	0.000	0.000 ↘	0th	5.8%
60-Day Hospitalization	18.1%	15.0%	8.3%	16.2% ↘	0.000	1.782	1.782 ↗	48th	26.3%
60-Day Emergency Department Use	12.7%	12.8%	5.6%	1.6% →	0.328	3.146	3.146 →	36th	8.8%
HHCAHPS Professional Care	89.0%	86..0%	93.9%	89.0% →	3.786	0.000	3.786 →	47th	6.0%
HHCAHPS Communication	89.0%	86.0%	93.9%	89.0% ↗	3.786	0.000	3.786 ↗	63rd	6.0%
HHCAHPS Team Discussion	82.0%	84.0%	93.5%	82.0% →	0.000	0.000	0.000 →	0th	6.0%
HHCAHPS Willingness to Recommend	85.0%	80.0%	92.4%	85.0% ↗	4.028	0.000	4.028 ↗	71st	6.0%
HHCAHPS Overall Rating	90.0%	85.0%	95.7%	90.0% ↗	4.672	0.000	4.672 ↗	69th	6.0%

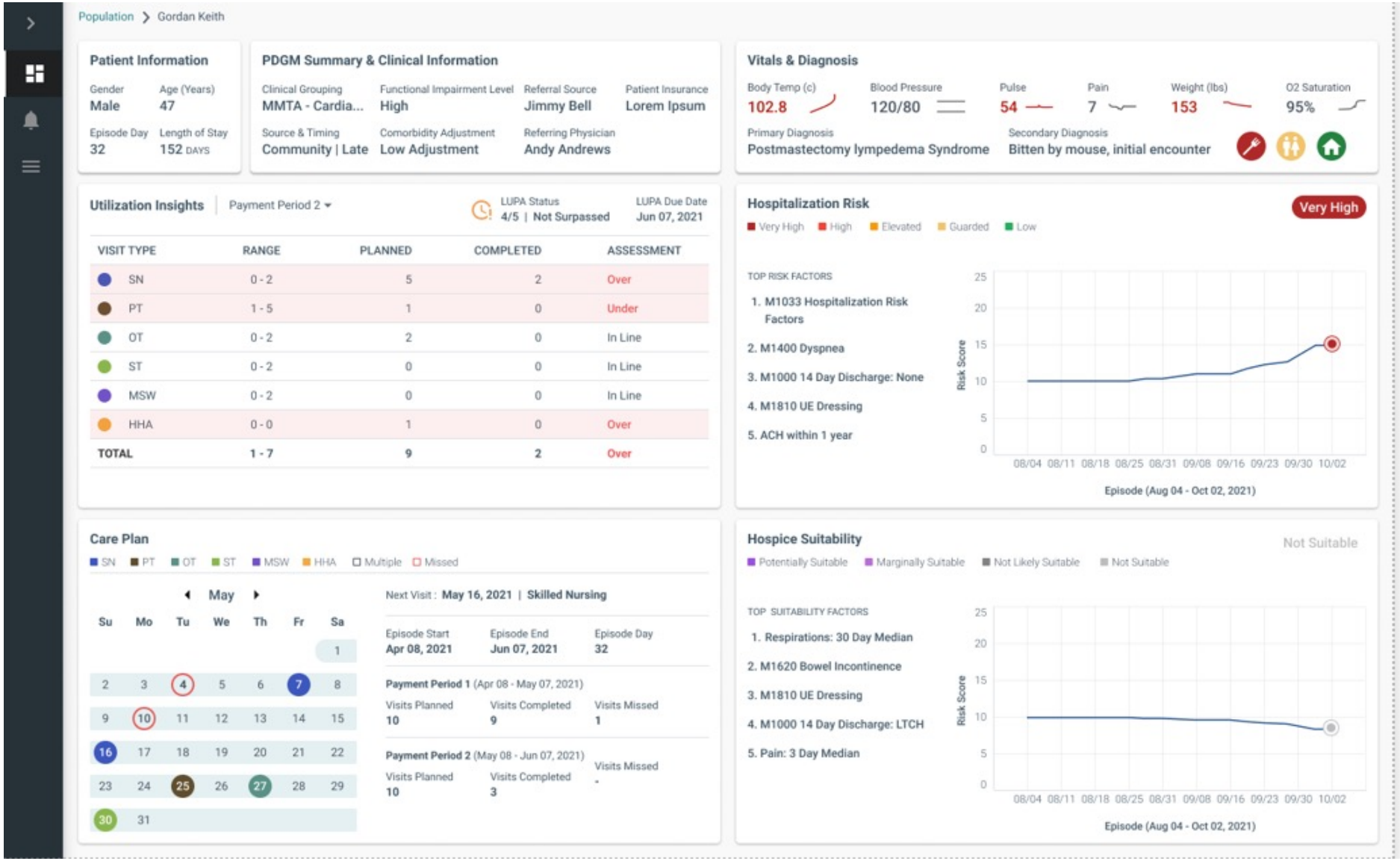
Daily virtual huddle

Triage team caseload – team view of risk



Last Name	First Name	Hospitalization Risk	Primary DX	Comorbidities	Hospice Suitability	Improvement in ADLs	Planned Visits	Utilization Assessment	LUPA Risk
Keith	Gordan		I10: Essential primary hypertens...	Low Circulatory4	Potentially Suitable	Highly Likely	10	Over	0/2
Cox	Perry		A1884: Tuberculosis of heart	Low Neurological10	Potentially Suitable	Less Likely	5	In Line	2/3
Bowden	Bobby		E3611: Acc pnctr & lac of an e...	High Cerebral4, Neurological10		Likely	6	In Line	2/2
Barton	Annie		E3611: Acc pnctr & lac of an e...		Marginally Suitable	Medium	1	Under	1/4
Abel	Mary		I10: Essential primary hypertens...	Low Neurological10	Not Likely Suitable	High	-	-	Not Enough Data
Aikman	Troy		I10: Essential primary hypertens...		Not Likely Suitable	High	1	Under	1/4
Bowden	Madison		E3611: Acc pnctr & lac of an e...	High Cerebral4, Neurological10	Potentially Suitable	Low	0	Under	0/3
Labrador	January		I110: Hypertensive heart disea...	Low Cerebral4, Neurological10		Medium	3	Under	2/5
Jones	Margret		Z471: Aftercare following joint...	Low Cerebral4, Neurological10	Not Likely Suitable	Medium	15	In Line	2/5
DeFries	Will		E3611: Acc pnctr & lac of an e...		Marginally Suitable	High	9	In Line	4/4

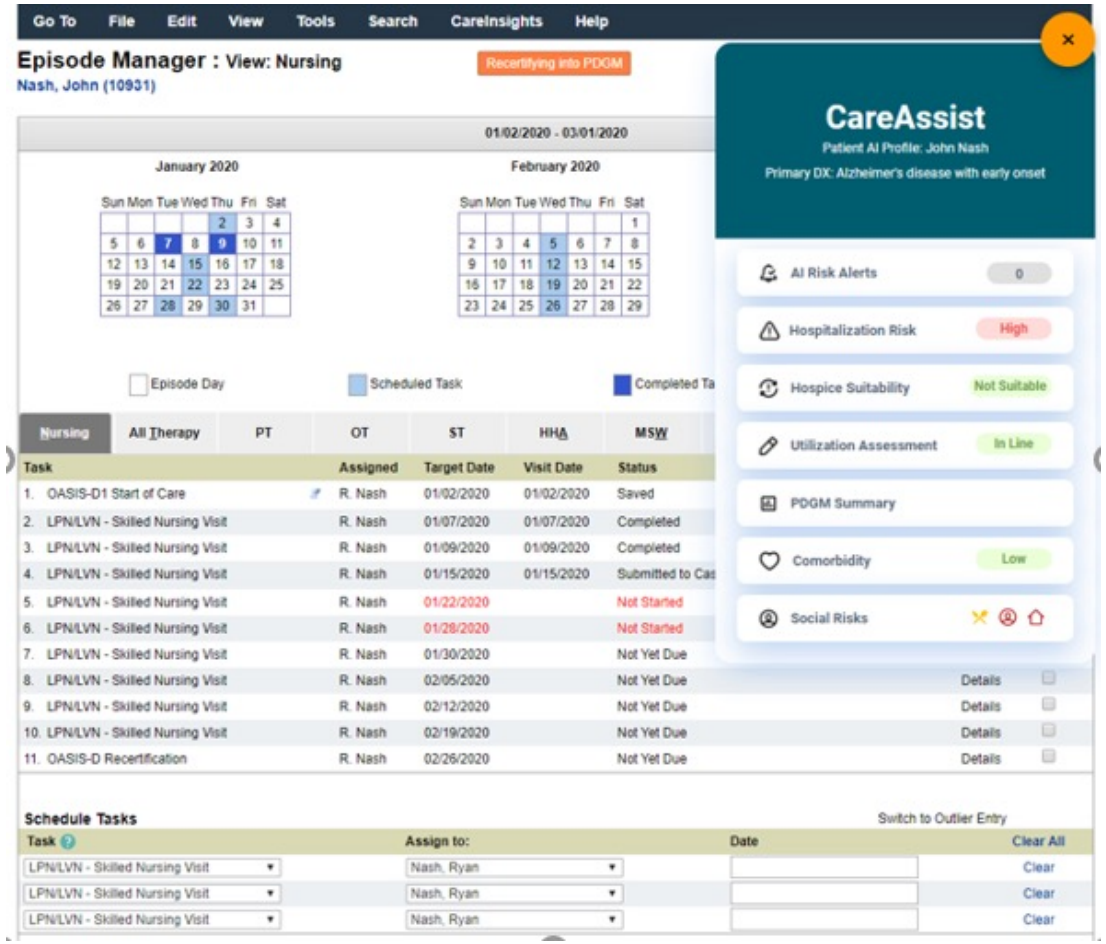
Drill down to patient level



Review of predictive analytics: every-visit

- Bring analytics to the field, just like taking a stethoscope to work
- Teach your teams to "take five in the drive" to review:
  - The most current risk profile (predictive analytics)
  - Current orders and patient-centered goal
  - Last SBARG /last note

- Reinforce authentic advocacy through point of care documentation/capture of patient status
  - Strong support for on-call teams
  - Serve teammates with real-time, risk-informed view
  - Helping the clinician maintain better work-life balance
  - Serving the patient best through evidence-based clinical decision support and guidance



When analytics are embedded into a clinician's EMR workflow

The whole team, including the patient, will use the power of artificial intelligence to improve care

Patient information	Click on the patient's name to find more detailed information about their risk profile
AI risk alerts	Review any alerts that have been triggered for the patient and click on the alert to review more detail
Hospitalization risk	Understand the patient's hospitalization risk and the associated top risk factors
Hospice suitability	View the patient's potential suitability for hospice and the associated top risk factors
Utilization assessment	Compare your schedule for the patient to other very similar patients with good health outcomes
PDGM summary	See the patient's clinical grouping, functional impairment level, admission source and timing
Comorbidity	Learn if the patient has a comorbidity adjustment under PDGM, and what clinical categories contribute to that adjustment
Social health indicators	Revisit a patient's social health status in each category based on their initial assessment

Recommend analytics become normalized in team culture and work process

QAPI fueled grand rounds IDT

- 2023 HHVBP reinforcing PIP – reduce ACH and Emergent Care
- Root cause analysis: what is driving the most hospitalization?
- Derive education, grand rounds based, teach on common themes
- Reinforce full IDT value – and build skills to enhance collaboration

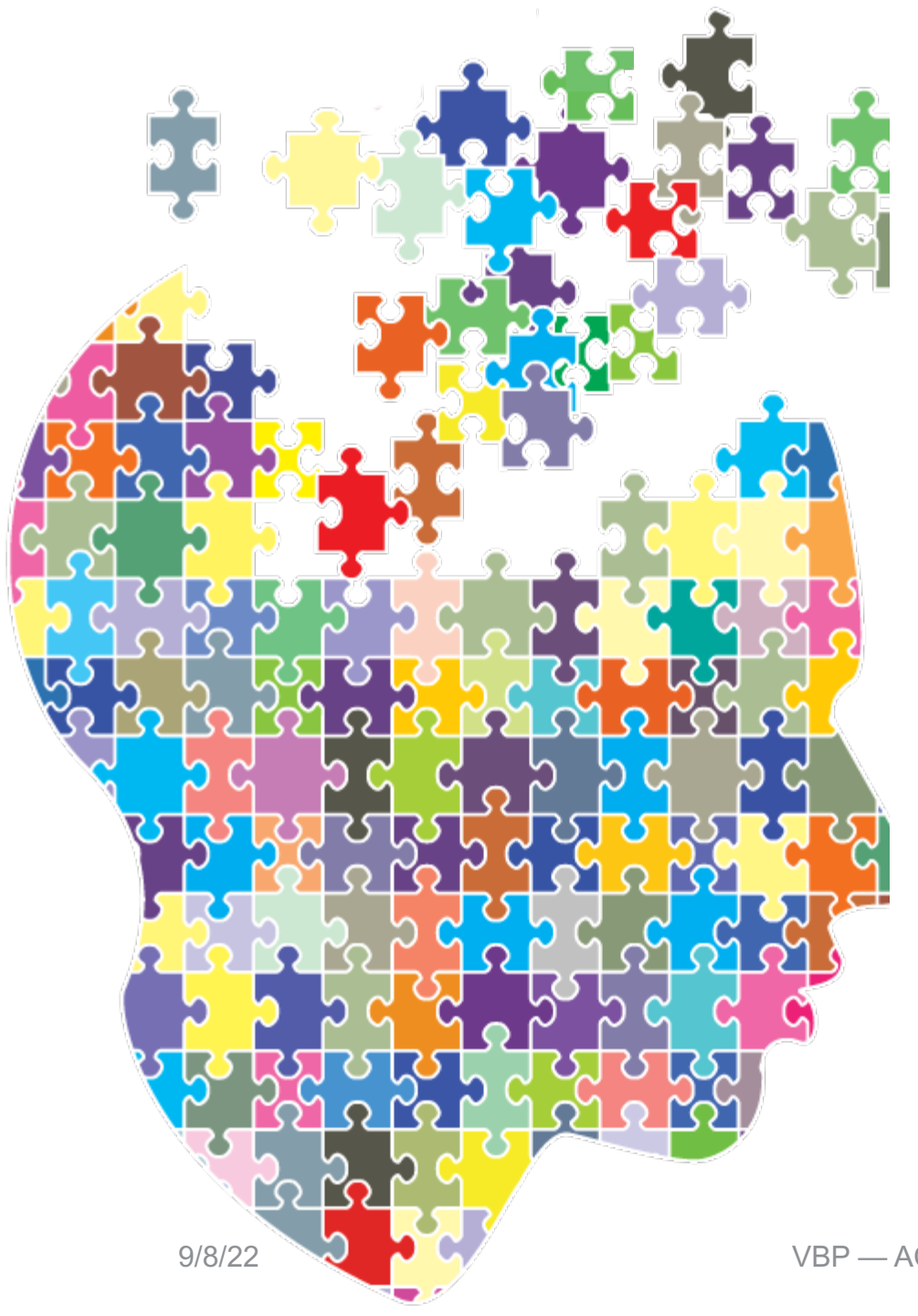
Monthly meeting: educative

- **Stack skills**, integrating key stakeholders into process of grand rounds discovery/education and discussion:

  -Integrate risk-informed data and aligned approach

  -Continuously improve approach to clinician support, team learning, care planning and best practice visit utilization and care delivery

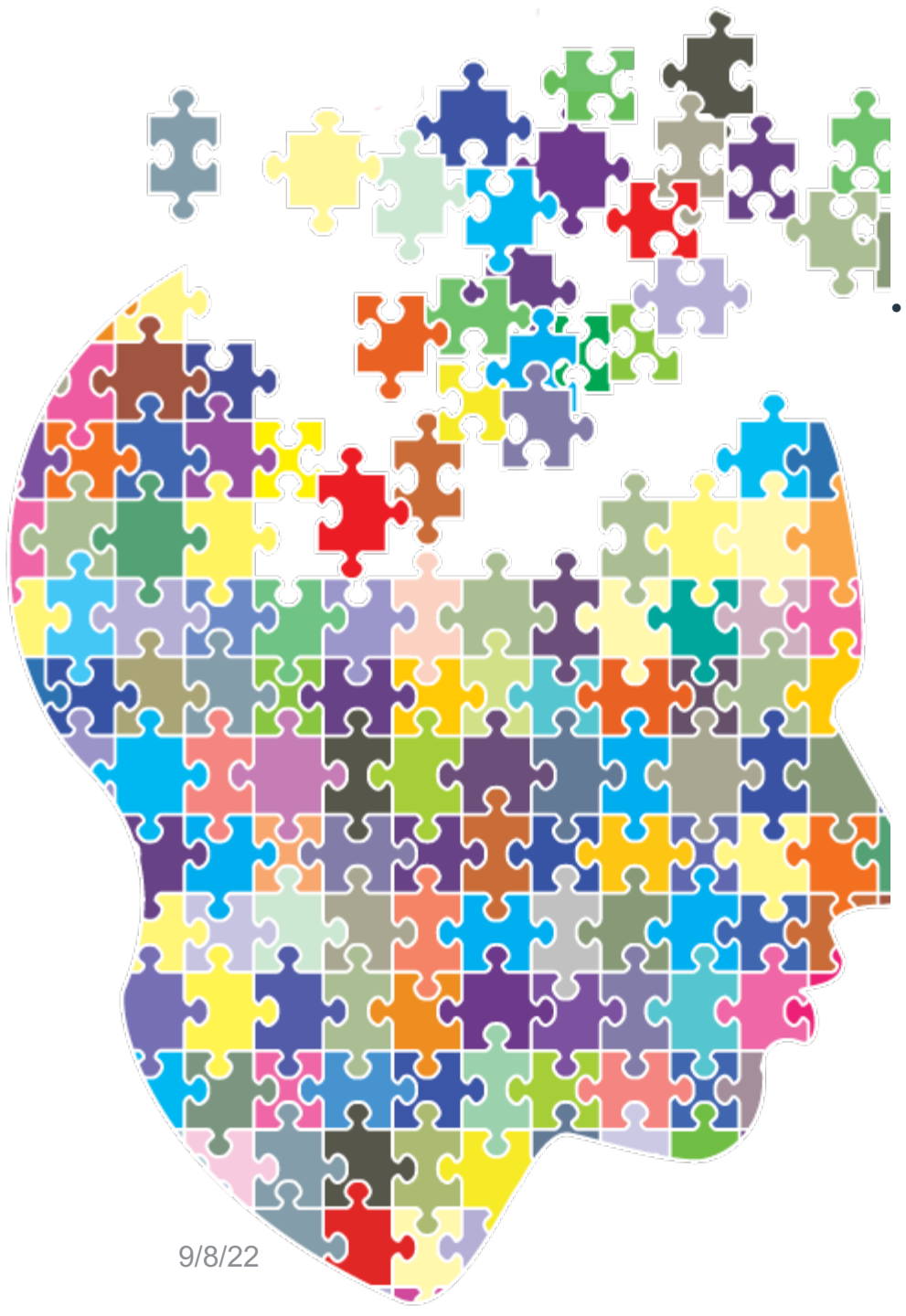
- Reinforce use of risk-informed data advocacy within discussion
- Give life to your PIP process – provide data-driven feedback on team results of efforts/learning and individual feedback



Put the pieces of the puzzle together

- Example of grand rounds approach to case conference:
  - Continuum-based care at home agency, operating at 2.5 stars, focused on QAPI initiatives of OASIS competence and new care management/case conference model
  - Data-dive found hospitalizations or ER trips leading to direct admit to hospice a large opportunity to lower hospitalization through effective transition, earlier, to palliative or hospice care
  - Integrated study of a few cases, with hospice APNs or Medical Director attending as SME
    - Reviewed cascade of disease, aligned data indicators and LCDs
    - Initiated training in advanced care planning
    - Home health clinicians received training in the LCDs for hospice and common disease trajectories
  - 18 months after initiating process at 4 stars, lower ACH, higher patient, family, and clinician satisfaction, and longer hospice median LOS

Arm home health clinicians with advanced care planning tools



Put the pieces of the puzzle together

- Another example of grand rounds approach to case conference:
  - Continuum-based care at home agency, operating at 2.5 stars, focused on QAPI initiatives of OASIS competence and new care management/case conference model
  - Data-dive found hospitalizations or ER trips were high for heart failure patients. Integrated study of a few cases revealed a lack of frontloading of care, no predictive diuretic protocol and low remote patient monitoring (RPM) adoption, trended by practitioner/team
    - SME reviewed cascade of disease, aligned data indicators **and LCDs**
    - Initiated training for how IDT can cover multiple frontloaded touch points for patient observation and careful tracking of transition to uncontrolled setting of the home
    - Reinforced training on efficacy of RPM with an anticipatory diuretic protocol, and how to initiate RPM with the patient/family
    - Integrated motivational interviewing process, elevating patient-centered goals, increasing patient satisfaction – buy in to self-management of disease
    - Home health clinicians also reviewed the LCD for heart failure, the diuretic protocols desired, and learned to better recognize advanced disease and how to advocate for patient wishes
  - 6 months after initiating process: higher adoption of RPM, lower ACH and ED use, higher patient satisfaction and clinician engagement

Case conference 2.0

- Disrupt non-value-added behaviors
- Stack clinician skills – build confidence and engagement
- Triage daily focus, reinforcing skills learned in team meetings
- Focus care through evidence based, data-informed clinical decision support and align the schedule
- Use data for best practice utilization and capacity management
- Feed the right data into your QAPI process
- Keep on evolving as our learning and technology capacity grows

Everyone wins

Questions?

CareForum 2022

The WellSky® Conference

Thank you.

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Learn more about
WellSky software & analytics solutions for home health

Request a consultation today!

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