LEADINGAGE MAGAZINE · JULY-AUGUST 2018 • VOLUME 08 • NUMBER 04

The Technology of Integrated Services

JULY 18, 2018 | BY GENE MITCHELL

Integrated systems that bring acute-care and post-acute providers together into networks, offer strong care coordination and use alternative payment models rely heavily on technology. Here is a look at what some providers are using.

Providers in aging services have long understood that the long-term services and supports "system" they work in is inefficient, fragmented and hard to navigate for older adults and their families. It leaves too many of those individuals and families confused about their options and in financial jeopardy.

Developing a person-centered, comprehensive system is a priority for LeadingAge, as it is for payers, public and private, and other sectors of health care. Such a desire is the impetus behind the development of, for example, accountable care organizations (ACOs), PACE programs and bundled payment systems. Such integrated service models typically eliminate or minimize traditional fee-for-service payment arrangements, require significant care coordination efforts, and keep costs down by having providers share risk while offering financial incentives for efficiency and good outcomes.

All of these elements work best when paired with 21st-century technology. The sharing of information among payers, insurers and providers has been the area of greatest concern, and creating true interoperability between electronic health record systems has been a long and difficult process. Other

technologies for telehealth, medication management, and communication that enables care coordination are also growing more common.

We talked with a group of LeadingAge members who are, in one way or another, participating in various integrated health systems, and asked them to tell us about the technologies that help make those systems work.

Data, Shared and Analyzed

The Post-Acute Care Network (PACN) is a group of 11 Cincinnati-area organizations—7 long-term/post-acute providers and 4 home health agencies—brought together in 2011 to position members to participate in value-based payment models. Owned by Episcopal Retirement Services and Life Enriching Communities, PACN has been participating in the Bundled Payments for Care Improvement (BPCI) initiative since April 2015.

PACN serves more than 600 people per year in the bundled payments programs, but PACN CEO Tim Grimes notes that the systems put into place for those clients are also used for all others.

“We’ve been helping [our members] with care redesign, care transitions and [being] successful in value-based care,” says Grimes. “We’ve had great success: positive net payment reconciliation amounts every quarter we’ve been in bundled payments.”

PACN is using 2 products from Archway Health: its Carelink care transitions software, which it has used to track almost 2,500 episodes of care, and Archway Analytics, which provides performance data and cost breakdown for all of the bundled payment clients.

Archway is also a convener for bundled payments, providing tools, consultation and payment reconciliation services.

“Most of our sites are in a high number of bundles, so [Analytics] gives a good snapshot of the care they are providing,” says Julie Uhrig, RN, vice president, clinical operations and development. “We can run a lot of reports, do deep dives into the data, and select home health providers because we know, based on claims data, which providers [visited] the next day and which waited 72 hours to show up.”

CareLink doesn't interface with any electronic medical records, but PACN has been happy with the system, which provides better management and tracking of patients.

Uhrig says it's very simple to use: "When an episode is entered in Carelink, very little information has to be put in, just enough to create the episode and facilitate patient engagement. There's a modified LACE assessment built in to stratify their risk. Then after you answer 4 simple questions and identify the diagnosis-related group [DRG], it projects their length of stay based on state benchmarks. It allows providers to have a good conversation with families, telling them how many days they'll be in skilled nursing before going home."

Hospital discharge planners can see dashboards of the people they discharge to PACN; home health agencies have a dashboard for the patients that will come to them.

"We update patients by smartphone in 10 seconds," says Uhrig. "If a patient is listed as off-track, it sends alerts to anyone on that care plan, so they can see what's going on, and take steps to get the patient back on track."

Uhrig says Carelink enables aggregation of data between all providers to evaluate success on various DRGs. This, she says, enables PACN providers to "speak the language" of hospitals and help make the case for partnerships to help manage patients.

"From a non-clinician standpoint," says Grimes, "it also allows some predictive financial projections and modeling, based on historical data. If it's a BPCI patient we can see whether this will be a positive or negative for us."

Carelink also does robocalls or text messages that give the patient the option to say, "Yes, I am doing well," or "No, I'm not feeling well, and I'd like to hear from my care transitions coordinator."

TANDEM365 is a collaboration of 5 organizations—Clark Retirement Community, Holland Home, Life EMS Ambulance, Porter Hills and Sunset Retirement Communities & Services—based in Grand Rapids, MI. It serves about 715 older adults who need assistance managing medically complex health issues. All

clients are referred by Priority Health, a Michigan-based insurance company. Starting in January 2019, TANDEM365 will also serve clients of the Blue Care Network, a Medicare Advantage plan.

CEO Teresa Toland says that most of TANDEM365's clients are frail people with a projected longevity of about 2 years.

"If we can show savings for them and really help people, and understand disease prognoses, we're creating better value."

The collaborative uses Netsmart as an electronic medical record. Health information exchange is done via Great Lakes Health Connect. Toland notes that not all physicians are loading all documents into the system yet, though the hospitals are uploading acute care information.

In Vermont, the SASH (Support And Services at Home) program is an innovative approach to providing coordinated care to older adults and those with special needs in affordable housing. Created by Burlington-based Cathedral Square Corporation, SASH is part of Blueprint for Health, Vermont's statewide health care reform initiative.

"Today, one of the big components of the SASH model is our collection of data," says Kim Fitzgerald, CEO of Cathedral Square, "and being able to run analytics and report back how we're doing, whether it's with falls, advance directives, or any number of health indicators. People like facts and data, and seeing results makes that easier to do."

SASH has recently transitioned from a state data system (which Fitzgerald says was more suited to analytics) to a care coordination data management system called Population Health Logistics (PHL), a cloud-based and HIPAA-compliant system. She says there are some growing pains, but is optimistic.

"I would say there have been issues, but they've been the typical conversion issues," Fitzgerald says. "We've had to tweak it to fit our needs. I believe PHL was originally written for area agencies on aging, so there's some differences between what they do and what we're looking for. The other big issue is that the amount of historical data we've had to transition from the old system to this one has been difficult because we're creating a new system while also trying to get a backlog of data into the system. We have

put off a big component of our historical data upload while working to get the [new] system where we want it."

Dunwoody Village, Newtown Square, PA, works with Delaware Valley ACO, according to Brandon Jolly, Dunwoody's director of health services. It is one of about 40 preferred providers the ACO contracts with.

Main Line Health, a nonprofit system in the Philadelphia area that supplies the great majority of Dunwoody Village's ACO clients, "just rolled out the Epic care system for their EMR, so now our physicians and nurses have access to the full hospital charts, which has been really nice," says Jolly. "Everyone had a lot of trepidation about that at first—HIPAA, training, getting the right access to the system."

Epic allows access to hospital records for Main Line patients. Dunwoody Village uses PointClickCare internally.

Integrated Services: LeadingAge's Vision and Resources for Members

Understanding integrated services, and helping members prepare to join networks and build partnerships to participate in such systems, is a priority for LeadingAge. In 2017, LeadingAge's Nicole Fallon, vice president, health policy & integrated services, wrote a white paper, "Integrated Service Delivery: A LeadingAge Vision for America's Aging Population." The paper offers a vision of how our fragmented system of health care and long-term services and supports for older adults might be reformed, and how aging services providers can be a valuable part of a comprehensive solution.

The link above will take you to the report, an executive summary, and a set of template materials to help disseminate the paper's arguments, including sample press releases, newsletter articles and social media posts.

LeadingAge spoke with Fallon to learn more.

LeadingAge: Why is the topic of integrated services so important to our field for the future?

Nicole Fallon: There is increasing pressure to control health care spending, and it is not an integrated system. It's very siloed—what I used to call "the conveyor belt of care," where every provider adds its piece to the widget. We have to go from thinking about the person in bits and pieces to thinking about the person as a whole.

We need a better way, but we have to articulate the future we want. We have to put it on paper, and it may be a big dream, but you've got to have that goal in front of you in order to achieve it.

LeadingAge: You've spelled out our vision with your 2017 white paper, but what are the next steps?

Nicole Fallon: We do not offer a single solution in the paper, but really a framework that includes the core, or essential elements of an integrated model. Now we're sharing it with our members, other provider groups and entities to refine the ideas.

If we're going to be successful in achieving this, it's really a 3-pronged approach.

First, we'll have to advocate for policies that change the way providers are paid and remove other policy barriers to collaboration; that seems obvious.

The second is innovating, which means helping members understand that the road to integration is a journey of incremental steps. It's about partnerships, about being person-centered and thinking about the whole individual and how we can serve them better. If we can help members see real-world examples of how this can be done, even within today's confines, and demonstrate to policymakers and the public that this can be done better, we will have greater success on the advocacy side.

The third prong is to educate other provider groups, other organizations and most importantly, consumers. I think the key is that consumers have to demand and expect that services will be integrated, and that providers will collaborate and share information to identify and problem-solve their particular needs.

If we come at it from those 3 angles, we'll have greater success than if we just try to push it from a policy-only perspective.

LeadingAge: Some LeadingAge members are participating in integrated care networks now. What are their keys to success?

Nicole Fallon: They are using technology as a tool to facilitate the essential communication and coordination among providers. What I also see is that some have developed care pathways that are what I call "site-agnostic." In other words, for each diagnosis, this is how we address the person's needs to achieve the outcomes we want, and monitor the changes in condition. These are best practices regardless of where the episode of care happens: at the hospital, in the assisted living community or in the person's home.

To achieve those pathways is a harder task than people might think, but the ones who have really been moving in that direction are starting with an episode or a diagnosis and asking, "What are the things that get us the outcomes we desire for these individuals?" It's about mapping out those best practices, and then it's repeat, repeat, repeat.

Data analytics is another thing providers are using: Here are our numbers today; let's do some root-cause analysis about why our outcomes are *x* instead of *y,* and then make changes to our practices using those [analytic] tools. Sometimes it's even identifying predictors from those tools.

Another thing is partnerships. I'm a big believer that if we're going to deliver integration, no provider organization can be an island any more. Even if it's as simple

as Medicare value-based payment, the expectation is that we're going to reduce readmissions, but it can't just be the nursing home working at it, or the home health provider. The doctor has to be part of these decisions, the hospital has to be part of these decisions. We have to talk to each other, work together and get our incentives aligned, or we can't get there.

LeadingAge: Do you have an "ask" for members?

Nicole Fallon: I want to continue to hear about examples of things they're trying and testing, even the things that don't work. It's kind of what we've been asking for in talking to outside groups beyond our members: "What are the little things we can do, what policy changes and barriers can we remove to get us closer to this goal?"

Members can contact me any time at NFallon@leadingage.org or 202-508-9435.

Telehealth Options

Ohio Living Home Health and Hospice, a subsidiary of Ohio Living, serves more than 67,000 older adults each year, offering 2 adult day programs along with the services in its name.

For several years, Ohio Living has been working with 2 ACOs, Northwest Ohio ACO and Mercy Health Select, and in the past year has participated in bundled payment programs.

Joyce Miller, Ohio Living's chief information officer, believes one long-time stumbling block for post-acute providers—implementation and full use of electronic health records—is no longer the roadblock it has been.

"To be up and running with a good system has been accomplished," Miller says. "So the big thing now is, where can we really direct efforts at the patient?"

To that end, Ohio Living has worked with the ACOs on a telehealth program using equipment from Health Recovery Solutions (HRS). With HRS software installed on iPads, home health workers can

review patients and use Bluetooth-enabled devices to measure blood pressure, heart rate, oxygen saturation, blood glucose, weight and more without having to visit the patient in their home unless indicated.

“You can get [those] with other packages out there,” says Miller. “What we like about this one is the 2-way video conferencing, encrypted for HIPAA, and a medication administration record tool so we can set up medications on the system and on a daily basis people can see which meds are due, and then they touch the screens to tell us they’ve taken that med.”

Melissa Puckett, director of nursing at Ohio Living Cape May, demonstrates a Triple Care telemonitoring unit on Abby Ellsberry, director of business development. Photo courtesy of Ohio Living.

Ohio Living has 20 iPads in use and has ordered 20 more.

Patient education modules cover conditions like congestive heart failure (CHF), COPD and diabetes. Workers set up the iPads and leave them with clients on the initial visit. Once the person is no longer in a range of high acuity and has stabilized, the iPads are removed, cleaned and given to the next client.

Ohio Living has a nurse whose primary role is to monitor the findings and follow up with the patient and the physician when indicated. “We get data from [the company] on the patients we’ve seen, and we interface the data into our EHR, so that our clinicians in the field are aware of results immediately,” says Miller.

Information exchange with the ACOs works well, says Miller. The ACOs are particularly interested in interventions for COPD/asthma, CHF and acute kidney injury.

"They're very focused on chronic illnesses today, because those are the things that people return to the hospital for," says Connie Tostevin, Ohio Living's chief nursing officer. "We're trying to bring the value proposition to the ACOs and others, hopefully insurance companies at some point."

The organization uses Homecare Homebase software for its hospice and home health clients. (In skilled nursing and assisted living it uses MatrixCare.)

"In a few nursing homes, we use a form of telemedicine, not telehealth, called Triple Care," says Tostevin. Triple Care provides physicians on call for off-hours coverage (overnights, weekends and holidays).

"They have a telemonitor on wheels you bring to the patient, and the doctor has a stethoscope and a high-resolution camera, and in conjunction with a nurse at the bedside, the doctors examine and talk to the resident," Tostevin says. Triple Care doctors will also talk to families and emergency room physicians as needed.

The organization is also preparing to launch a relationship with Philips for its Lifeline medical alert systems. "We would like to offer it to these high-risk people leaving our rehab centers and going home, and offering it to them for 60 days free of charge," says Miller. Part of the relationship involves Philips staff representing Ohio Living, asking patients to consent to Ohio Living knowing when they use their Lifeline.

"[Philips] also has analytics now that give you risk analysis and puts people at a red, yellow or green [designation], so we know who we have to be proactive with when they leave our building," Miller says. Eventually, she adds, Ohio Living will offer the same thing to home health clients with chronic illnesses.

"We get a lot of referrals from hospitals that are in bundles. Starting in October we'll be penalized for our readmissions in the nursing home as well," says Tostevin. "People might have come to us and stayed only 2 weeks, and they have another 15 days to their 30-day readmission window, and we don't know what happens to them. We want to help them through that period."

"We feel like we've been around a long time and we're experts, and really want the acute providers to realize they do have expertise around them they can lean on," says Tostevin.

TANDEM365 also uses telehealth and medication dispensing equipment from Philips Healthcare, and encourages all clients to have personal emergency response systems (PERS). Toland says 50 clients are currently using telehealth, mostly people with COPD, CHF, high blood pressure and/or unstable vital signs. Such clients are monitored daily by the integrated care paramedics from Life EMS Ambulance. (Life EMS also has urgent response paramedics that can be in any home within 90 minutes.)

Toland says the medication management is crucial: "Without [it], our program would fail. The number of people needing medication setup is probably 30% out of 700 people."

Several members of PACN offer telehealth and remote monitoring services. Grimes says, "a lot of the home health agencies we work with use telemonitoring devices with regard to blood pressure, weight and more. We're integrating technology more and more into what we're doing. We're trying to pick and choose those that really move the needle in terms of improving care and decreasing costs."

Grimes is disappointed that this fall's change to BPCI Advanced model, the next generation of the bundled payment program, will end bundled payments for PACN, including coverage for telehealth.

"My hope is that telehealth as a whole continues to evolve, and payment continues to evolve from Medicare and other payers," says Grimes. He notes that the dwindling number of geriatricians—meaning fewer physicians visiting post-acute providers—will make telehealth even more useful in the future.

SASH has been piloting telehealth at 5 congregate housing settings for the last couple of years. Each site has a computer, Bluetooth stethoscope, digital scale, camera and speakers, and Zoom software (secure and HIPAA-compliant) to connect to the Internet. Each has a private room set aside for resident telehealth sessions, where a SASH wellness nurse accompanies the residents. "We originally talked about having carts and taking them to the residents, but we wanted to control all the variables from the start, so we're having residents come to a private room," Fitzgerald says.

She admits that not many telehealth appointments have taken place so far, but a much larger pilot is set to be launched. (Vermont has a waiver that will allow Medicare participants in urban areas to bill for telehealth originating from non-clinical sites.)

PatientPing is another technology SASH is using—sending real-time admission and discharge notifications to coordinators and wellness nurses when someone goes into the hospital or is about to be released.

(Ohio Living and Dunwoody Village also use PatientPing; all 3 providers are very happy with it.)

Finally, because SASH involves participants all over the state, training is always an issue. The organization contracts with Relias for online training and tracking. The system offers sessions in various media formats covering a wide array of topical training materials, both mandatory and optional.

Wish Lists

Ohio Living is considering use of a population health management system and is reviewing the options. "We're looking for a nice marriage between documenting and aggregating data and doing analytics," says Miller. Another item on the list is a resident portal.

Julie Uhrig of PACN has investigated a pharmacy platform that does robust medication reconciliation and education. "We don't feel we really need it," she adds, "because we have care transitions coordinators that go into the home and sort this out; even so we feel like it has some potential."

Finally, those providers participating in bundled payments wish they did not have to face a significant change on Oct. 1, when the new BPCI Advanced, the next generation of bundled payment models, will limit the role of post-acute care providers.

"It is a blow to lose the bundled payments," Grimes admits. But we'll stick together and keep doing what we're doing. We were formed to focus on being prepared for value-based care, so we'll keep working with sites to improve care and decrease costs, which will allow us to work with hospitals and group practices that may be working with BPCI Advanced. I believe CMS may come up with another alternative payment model for post-acute and we'll be prepared for that. We're not going to miss a beat."

Gene Mitchell is editor of LeadingAge *magazine.*

The Future of Aging Services Will Include Care Integration and Managed Care

In this LeadingAge Podcast, consultant Anne Tumlinson and Juniper Communities' Lynne Katzmann talk about why aging services providers must embrace integrated care and managed care.

LeadingAge Podcasts

The Future of Aging Services Will Include Care Integrat...

Share

0105: What pressures are payers feeling?

0215: What does this mean for LeadingAge members?

0323: Why aren't LTC providers sharing in the savings they produce?

0445: Why aging services providers must begin to integrate with the health care system, and why our field needs to begin to take on risk.

6:00 Lynne Katzmann introduces Juniper Communities

7:04 Description of Connect for Life program: importance of care transitions; electronic operating platform; creation of care transitions program; integrating service-enriched housing and clinical services for those with chronic illness and functional impairments

9:50 How Juniper Communities makes integration of care work

12:35 "Measurement of success" and cost savings

15:40 How can we build on this? What's next for our field?

2519 Connecticut Avenue NW Washington, DC 20008

202-783-2242

info@leadingage.org

Privacy Policy

©LeadingAge 2018. All rights reserved.