Opportunities for ACO Partnerships with Geriatric Emergency Departments

Dr. Kevin Biese
MD, MAT

Megan Donovan
MBA

Dr. Stephen Meldon
MD, FACEP

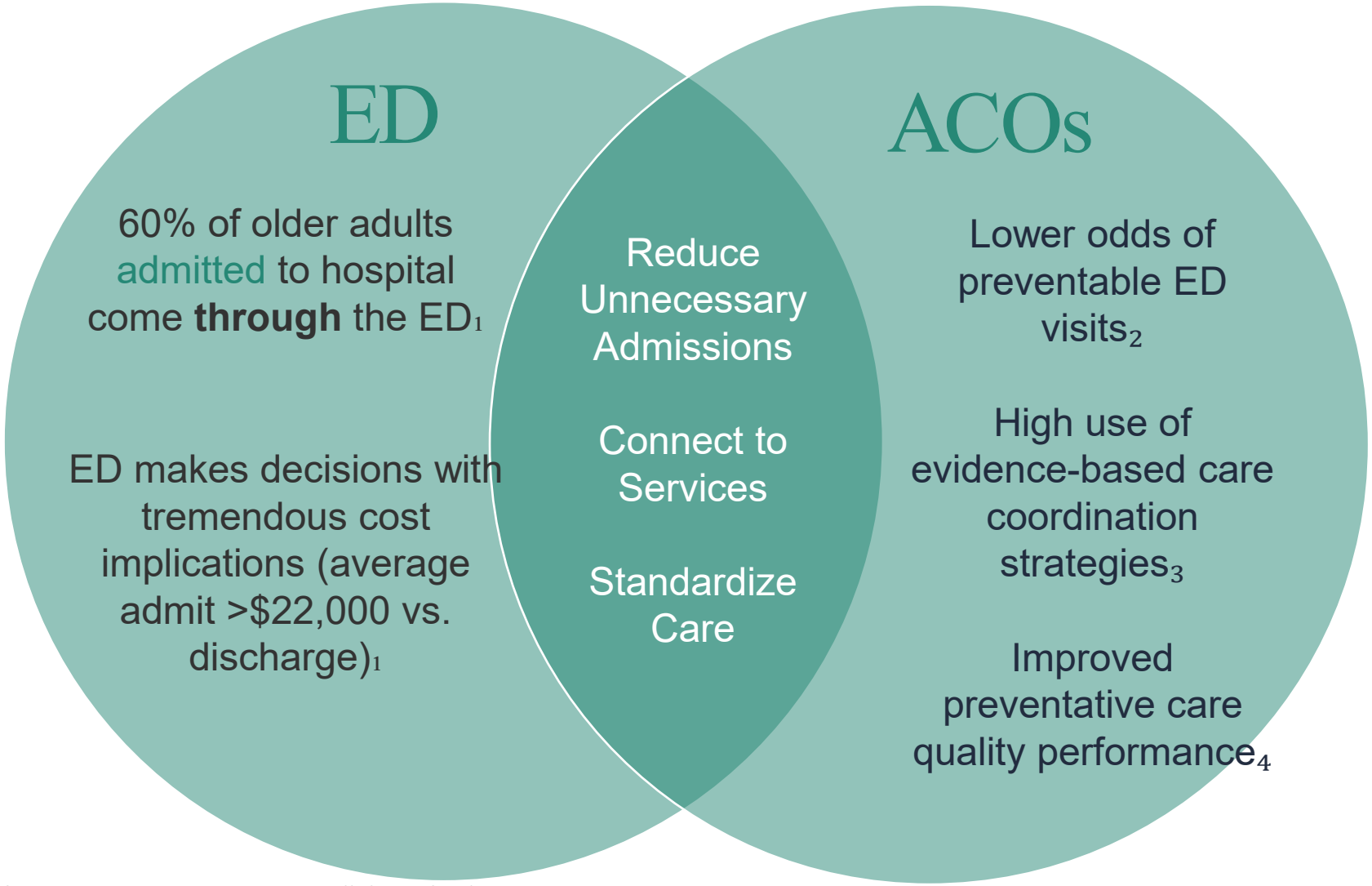
GEDC

Housekeeping

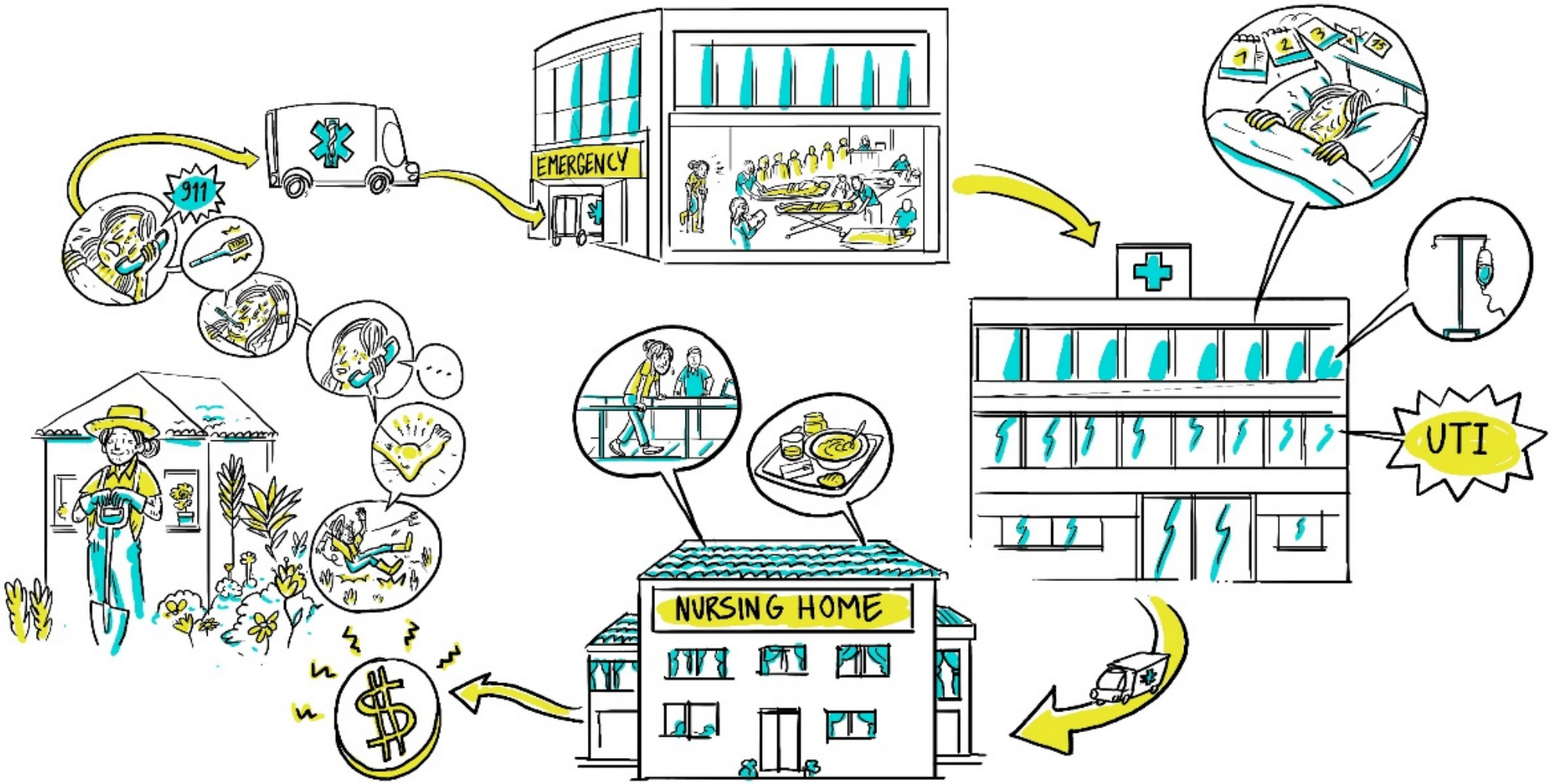
1. Speakers will present for approximately 50 minutes

2. Q&A will take the remainder of the time
   - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
   - During the Q&A session, you can use the “raise hand” feature on your dashboard to ask a live question.
3. Webinar is being recorded
   - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available.

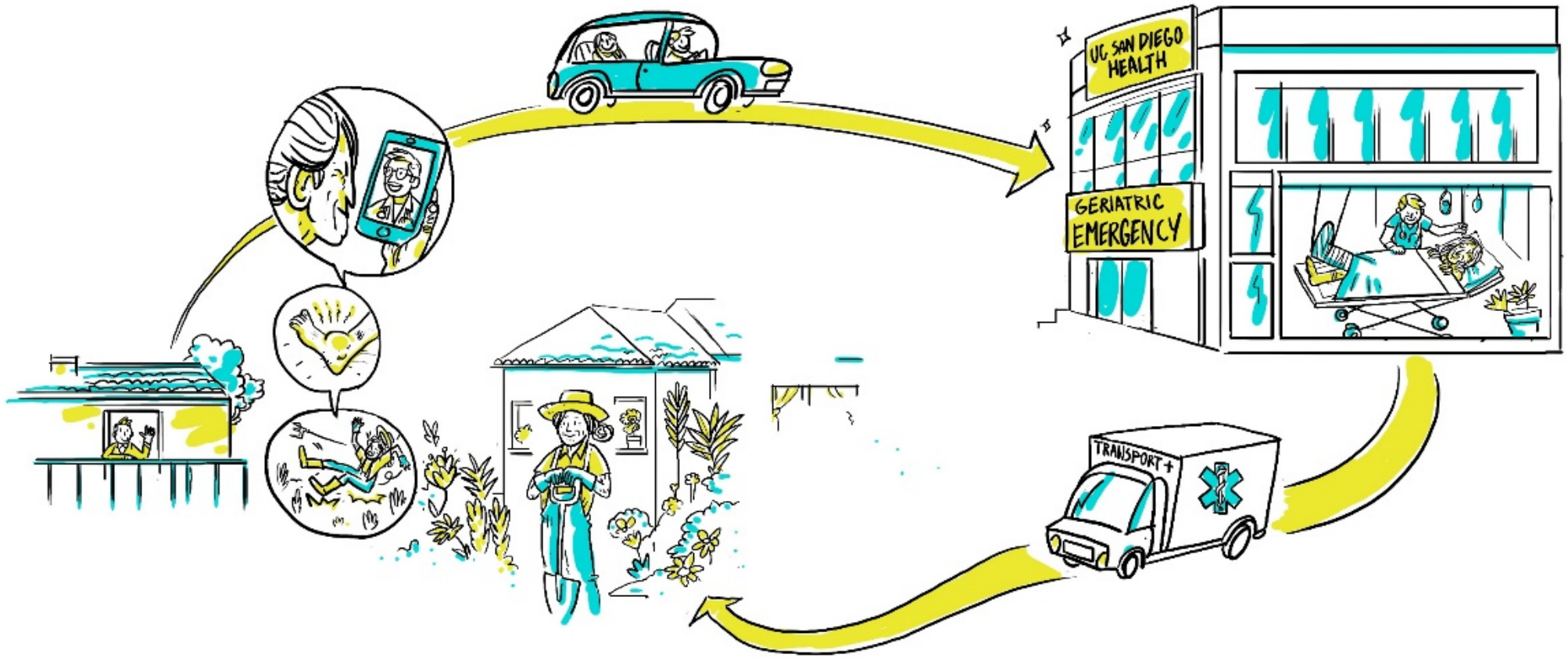
ACOs and GEDs can partner to improve the cost and care trajectory for older adults.



Traditional ED Pathway for Complex Medicare Patients



GEDC



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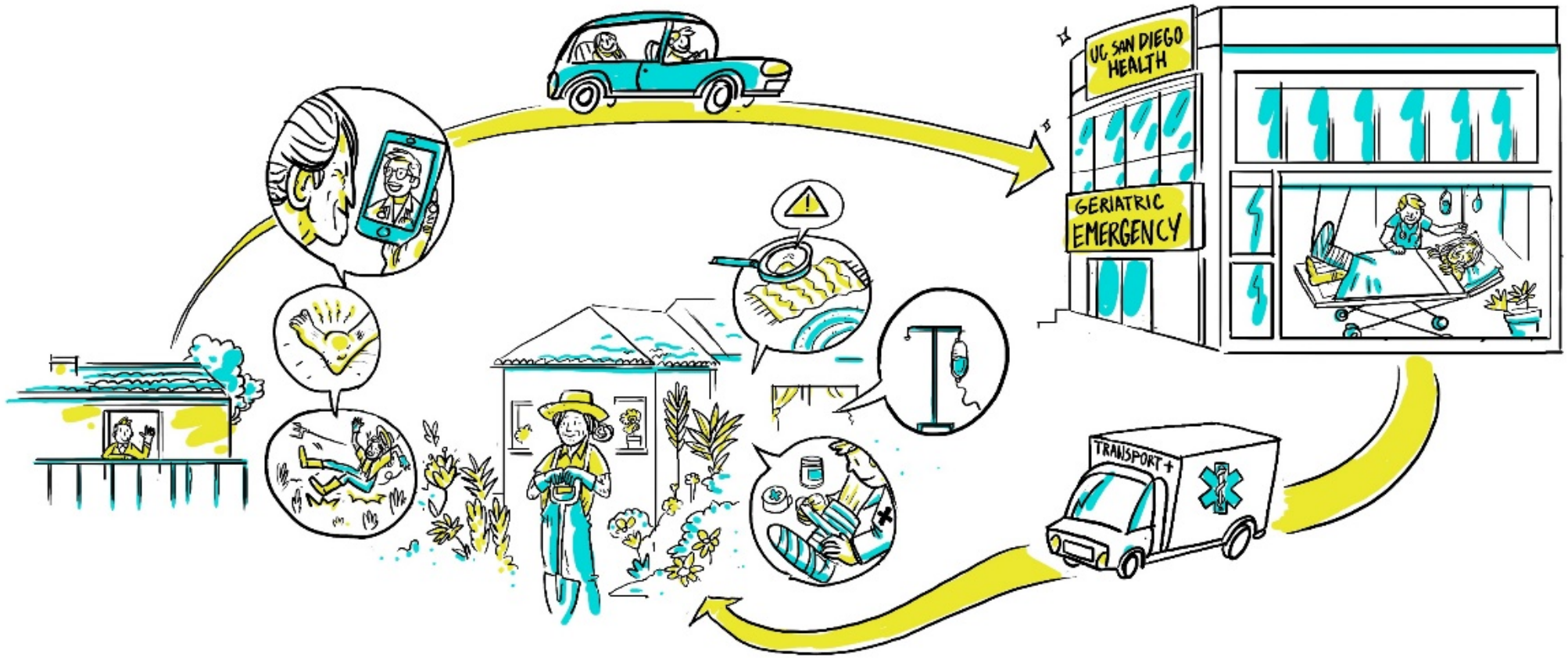

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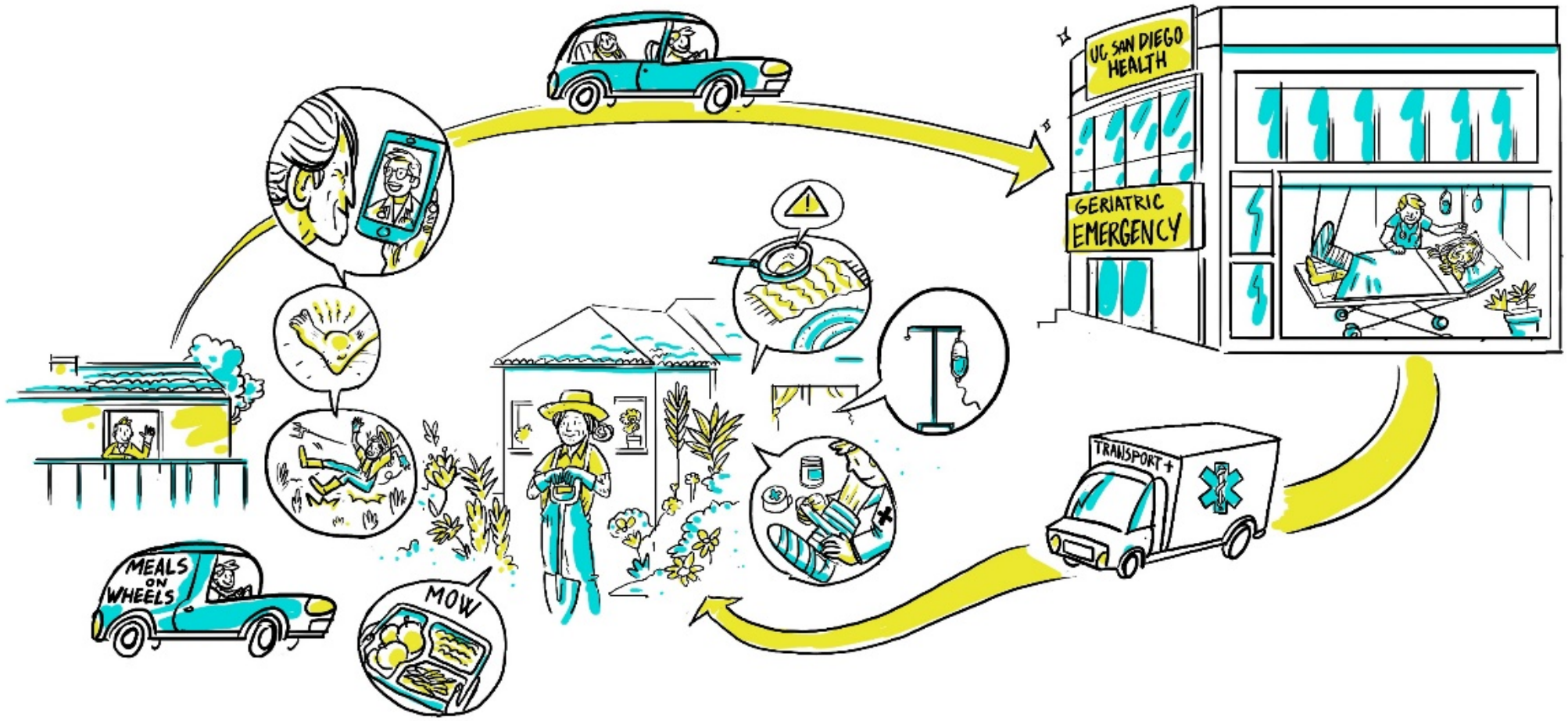
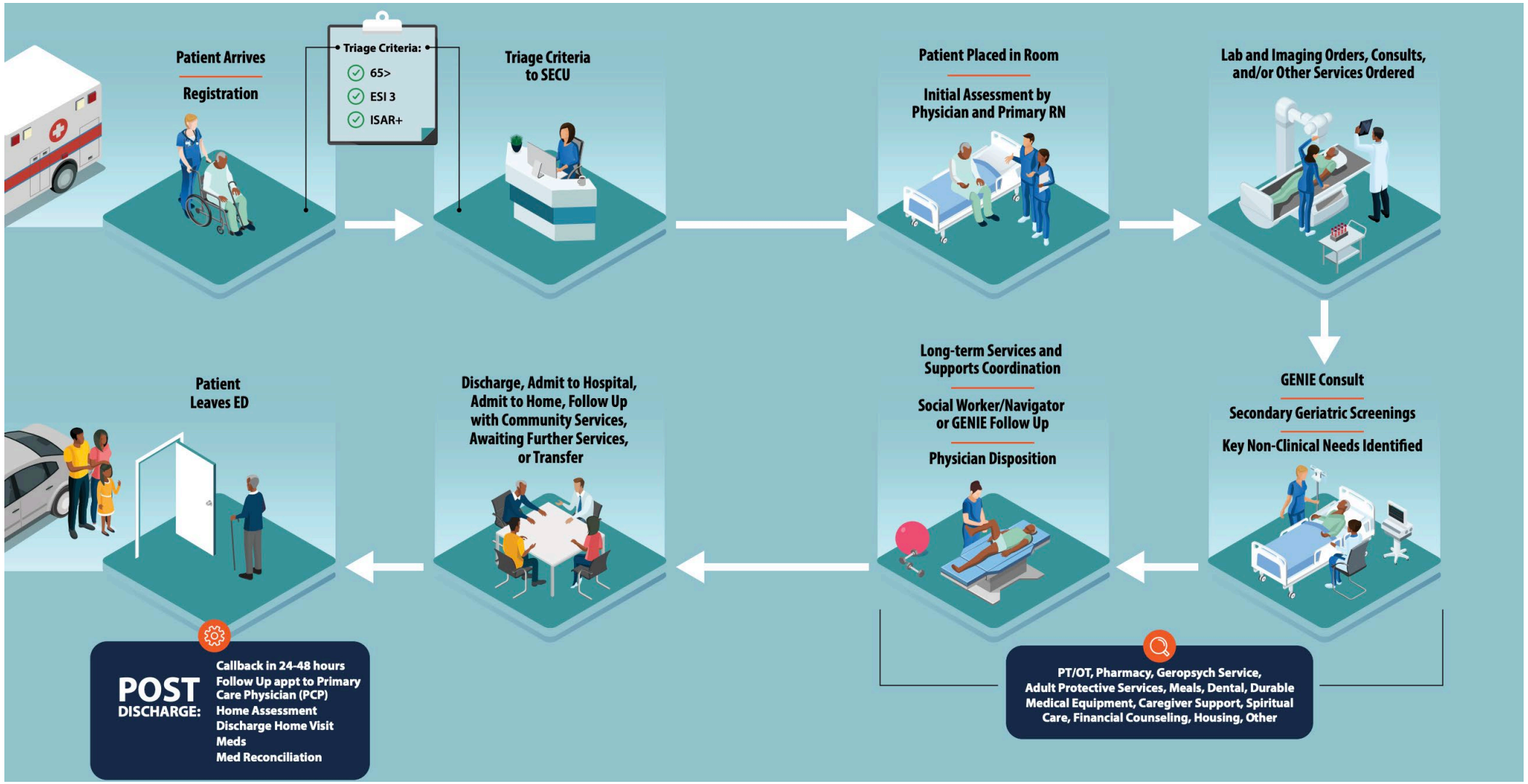
Alternative Geriatric ED Pathway for Complex Medicare Patients



GEDC

GEDs provide standardized and integrated care.



GEDC

There are three levels of GED accreditation.

Each level has different staffing components.

ACEP Geriatric Emergency Department Accreditation

Staffing	Level 1	Level 2	Level 3
1 MD/DO with evidence of focused education for geriatric EM	✓		✓
1 RN with evidence of focused education for geriatric EM	✓		✓
Physician champion / Medical director	✓	✓	
Nurse case manager/transitional care nurse present > 56 hrs/week	✓	✓	
Interdisciplinary geriatric assessment team includes at least 2 roles		✓	
Interdisciplinary geriatric assessment team includes at least 4 roles	✓		
At least 1 executive / administrative sponsor supervising geriatric ED progra	✓	✓	
Patient advisor/patient council	✓		

GEDs and ACOs share similar goals.

Lower Costs

Improve Quality

Improve Experience

Up to 16.5% reduced risk of hospital admission[5] and 17.3% of readmission[6]

$3,202 savings per Medicare beneficiary after 60 days[7]

Decreased odds of 30 and 60 day fall-related ED revisit with PT services[8]

87.3% satisfaction with the clarity of discharge information and perceived wellbeing[9]

21 studies showcasing improved experience across a variety of interventions[10]

ACO beneficiaries are seeking care at all 250 accredited GEDs.

27%

- Median percent of GED Medicare patient visits that are ACO-attributed beneficiaries (For 332 ACOs with 11+ GED visits).

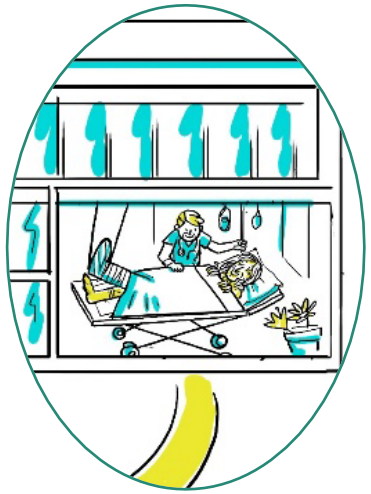
1.6x

- On average, ACO beneficiaries are visiting Emergency Departments at a GED accredited hospital multiple times.

21

- ACOs with at least 1,000 ED visits in 2019 in GEDs with Level 1 or Level 2 Accreditation

Make the connection between your ACO and local GED.



Identify

Download the "Geriatric ED Accredited List" located at: https://www.acep.org/geda/

Determine

Determine GED lead physician by contacting Nicole Tidwell, GEDA program manager at: ntidwell@acep.org or Amber Hartwell, GEDA program coordinator at: ahartman@acep.org

Ask

What are your current QI projects? What services would you like to add?

Partner

How can we help identify our ACO patients at the beginning of their ED visit? Where can we partner on QI or population health projects?

EHR GED/ ACO Integration

Mechanism to alert GED physicians that they are treating an ACO beneficiary

Creating Alignment between ACOs and Geriatric EDs

Stephen Meldon, MD

Emergency Services Institute,

Cleveland Clinic Health System

NAACO, September 2021

ACO ED to SNF Program

- August 2017 ask
- Waiver of 72-hour stay for SNF admission
  - Home/office, Inpatient, ED when clinically appropriate
- Discrete workflow teams
  - Develop/operationalize work flows, protocols
- Piloted June-Dec 2018

Direct to SNF Program (Provider 'Checklist')

- Be on the look-out for older patients with *acute functional or medical needs who aren't safe to go home* but don't need an acute care hospital admission
- Screen for acute medical conditions ("medical clearance") that would require an admission
- Notify care management if available
- Document any new medications (antibiotics, inhalers) on discharge
  - Write any new Rx as per usual for DC patients; this will populate AVS; ***discard*** hard copy **RX** (no need to send with patient)
- Complete brief DC to SNF 'orders' (EMR dot phrase)
- Complete patient's medical chart (EMR) *prior to transfer*
- If after-hours and patient is a possible SNF candidate, place in CDU (Main Campus) or in observation
- Geriatric consult (Main Campus) and PT evaluation (if applicable)

Email, staff meetings, 'road show'

Cleveland Clinic

ED to SNF Playbook

Cleveland Clinic Emergency Services

July 2018

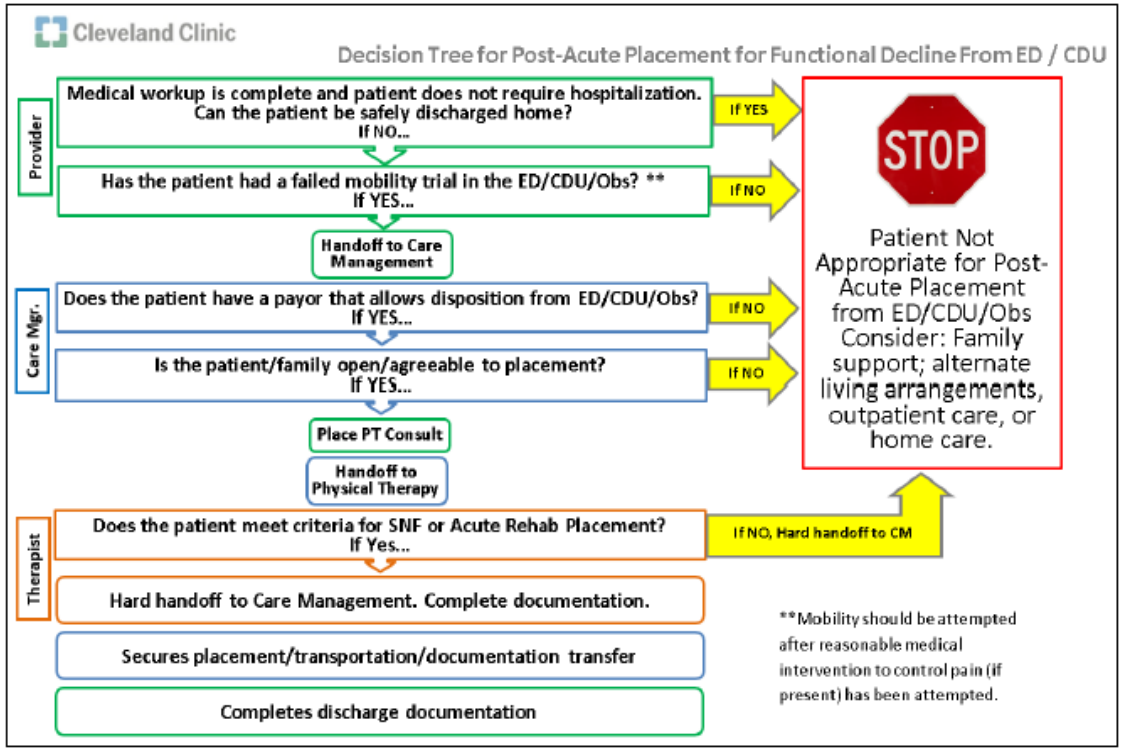
Cleveland Clinic

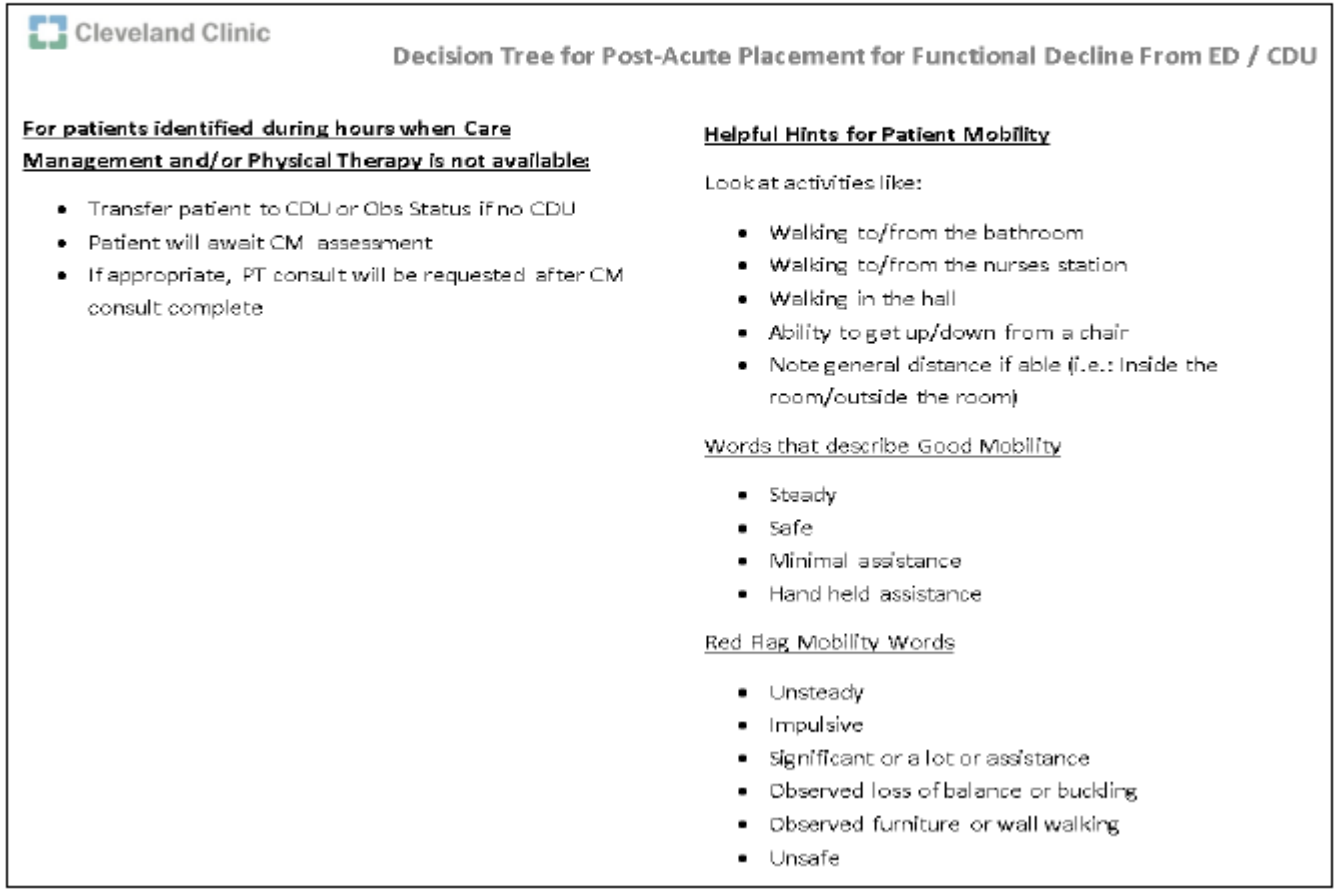
Table of Contents

PT Pocket Cards

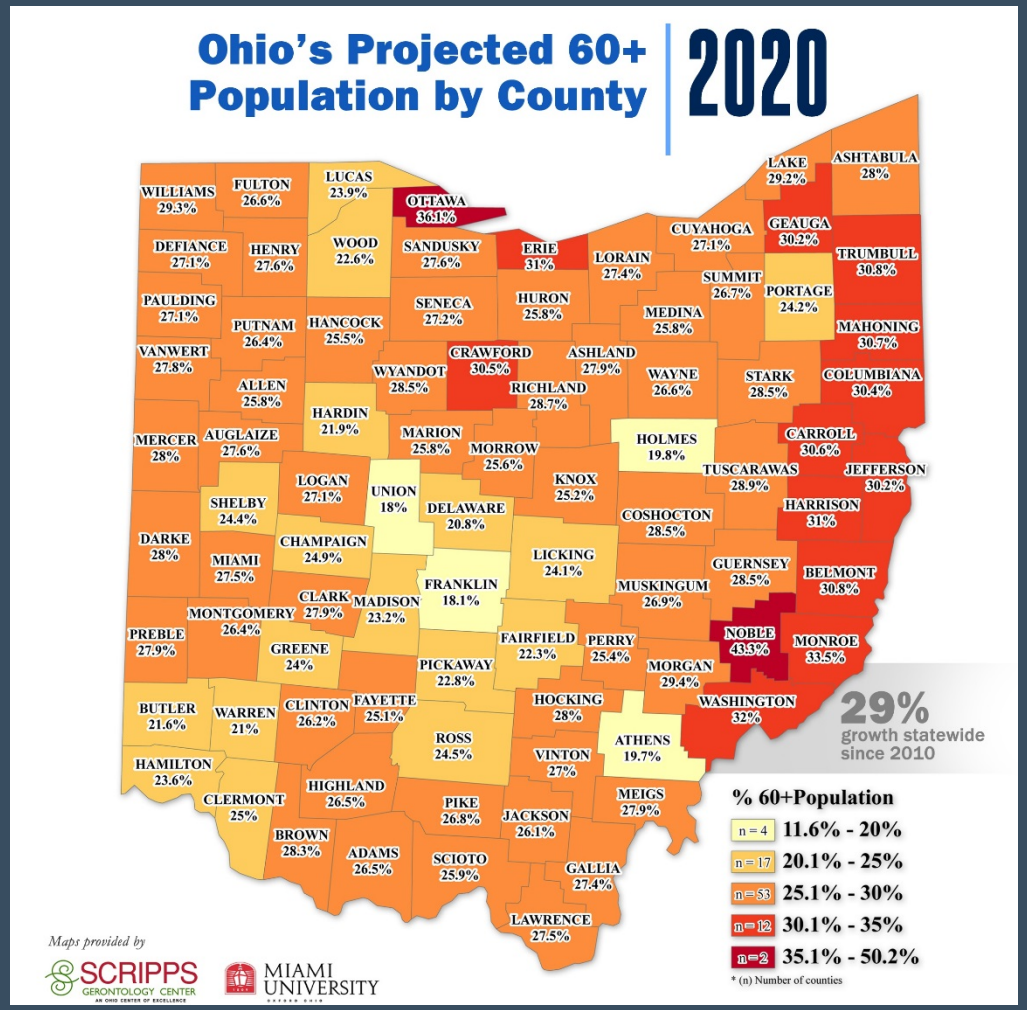
Front

Back





Why Geriatric EDs?



Geriatric Quick Stats

- In Ohio, **76%** have at least one chronic condition, and **43%** have two or more
- In Ohio, almost **35%** live with a disability
- Patients 65 and older represent nearly **40%** of hospitalized adults
- In the U.S., healthcare cost for recurrent falls and delirium is estimated to be **~$83 billion//year**
- The elderly were the smallest population group, nearly 15 percent of the population, and accounted for approximately **34%** of all spending in 2014 (CMS)
- FRAIL patients (~8% of Medicare population) accounted for **51.2%** of total preventable spending

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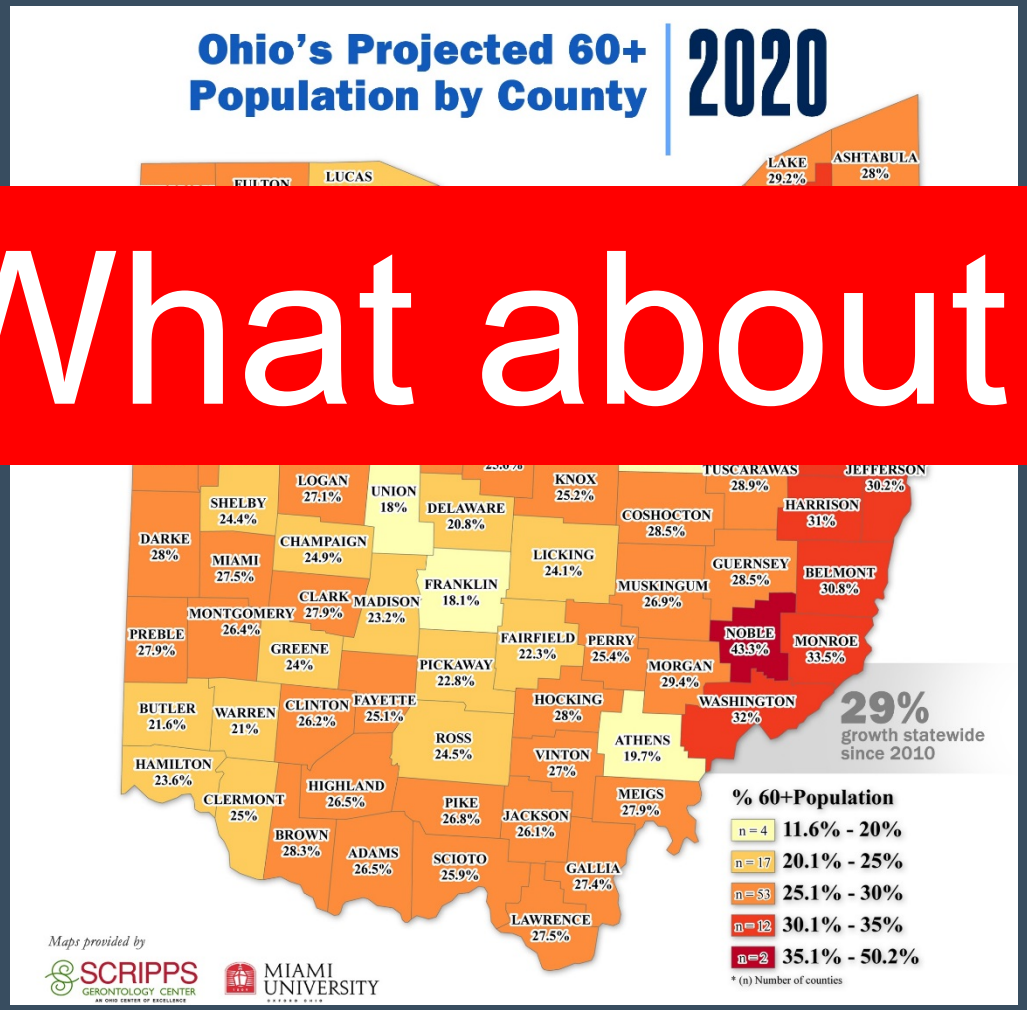

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What about the care?

Building the GeriED Program

- Enterprise and Institute/Department Support
- Philanthropic Support
  (Samuel H. and Maria Miller Foundation)
- Interdisciplinary team (Geriatrics, Case Management/LISW, ED Pharmacists, PT/OT, Nursing) – GeriED team
- GEDA Local Teams
  - Physician champion
  - Nursing champion
- ESI Administrative/Analytics support

GeriED Team Expertise

- Educational plan for Champions, Staff, & Nursing
- Policy, guideline, and protocol guidance
- High-risk criteria BPA development
- Screening tools/assessments
- Geriatric workflow integration
- Outcome metric tracking
- Referral offerings (e.g. Falls clinic, CC Successful Aging Program)
- GEDA Application Preparation

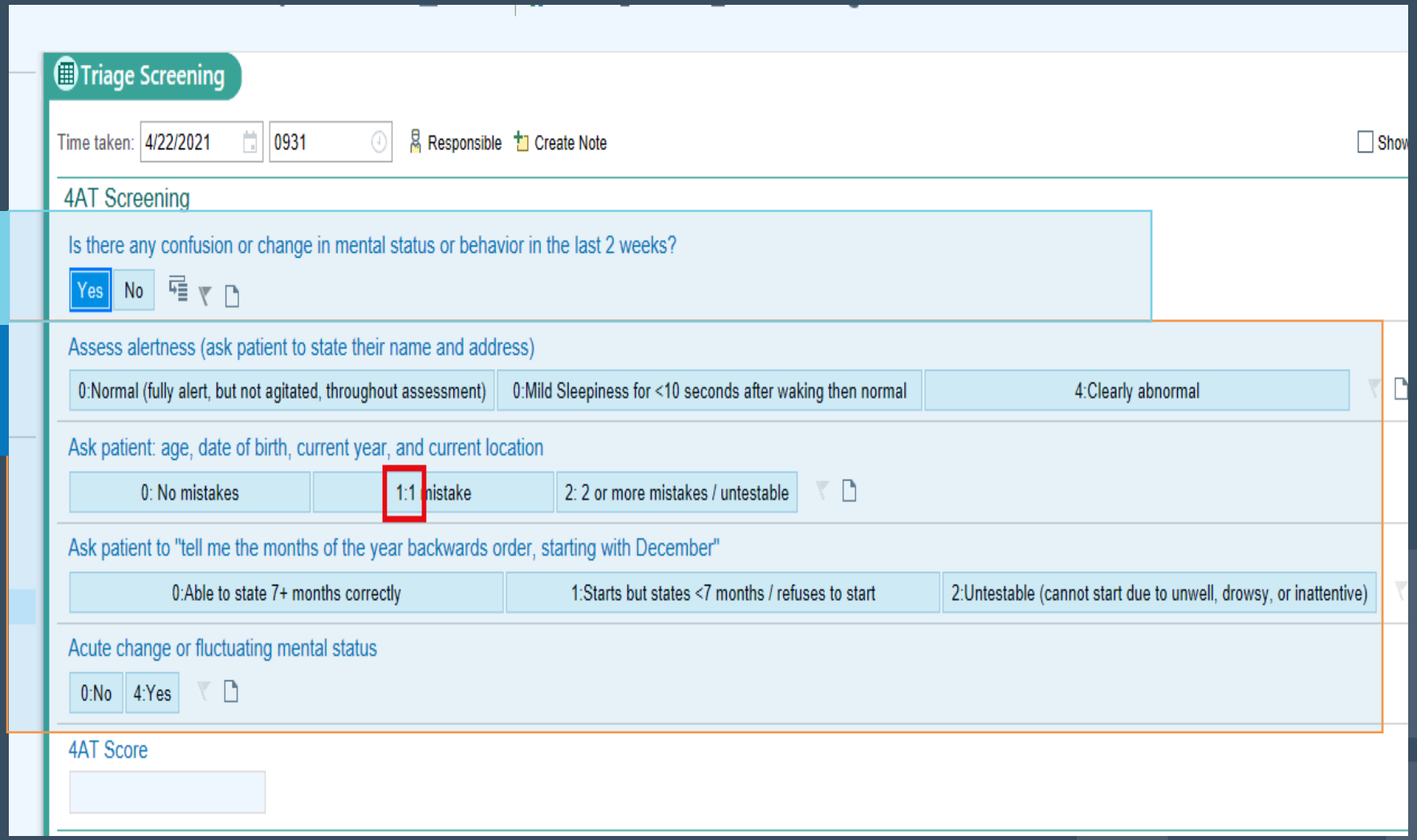
Geriatric Emergency Care Initiative Delirium Screening

Two-stage Screening

Stage 1: Assess Mental Status

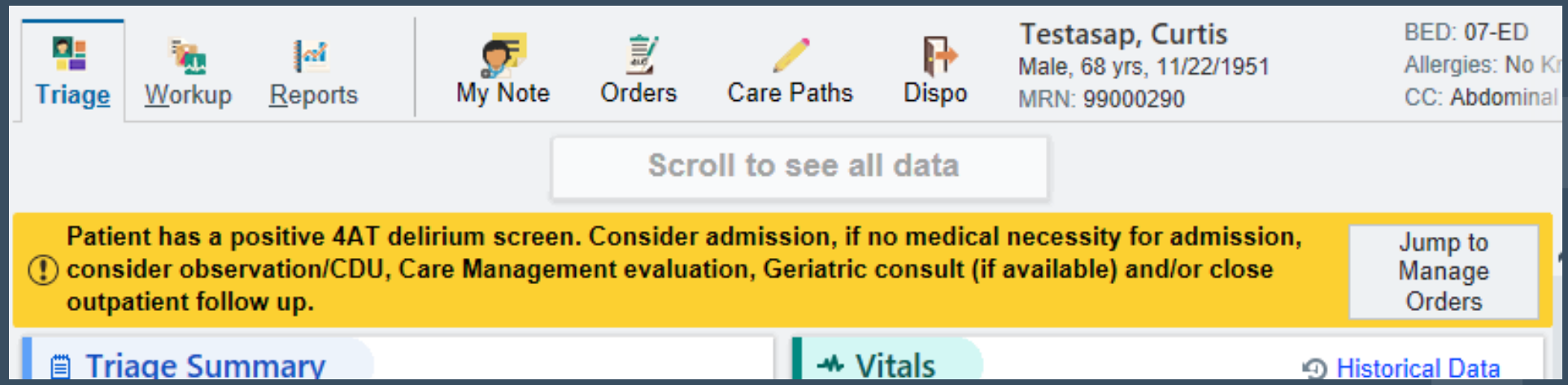
Stage 2: 4AT Screen

(If stage 1 = yes)

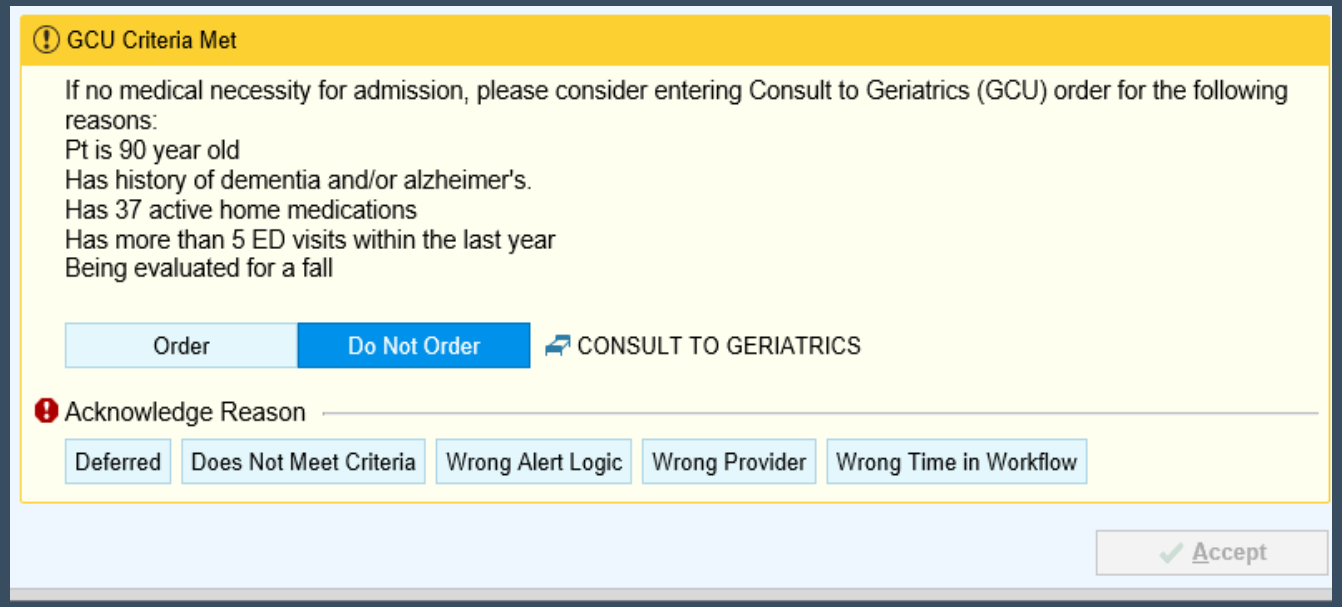


Delirium Screen Results

4AT Screening	
Is there any confusion or change in mental status or behavior in the last 2 weeks?	Yes EB
Assess alertness (ask patient to state their name and address)	4 EB
Ask patient: age, date of birth, current year, and current location	2 EB
Ask patient to "tell me the months of the year backwards order, starting with December"	2 EB
Acute change or fluctuating mental status	4 EB
4AT Score	12 EB

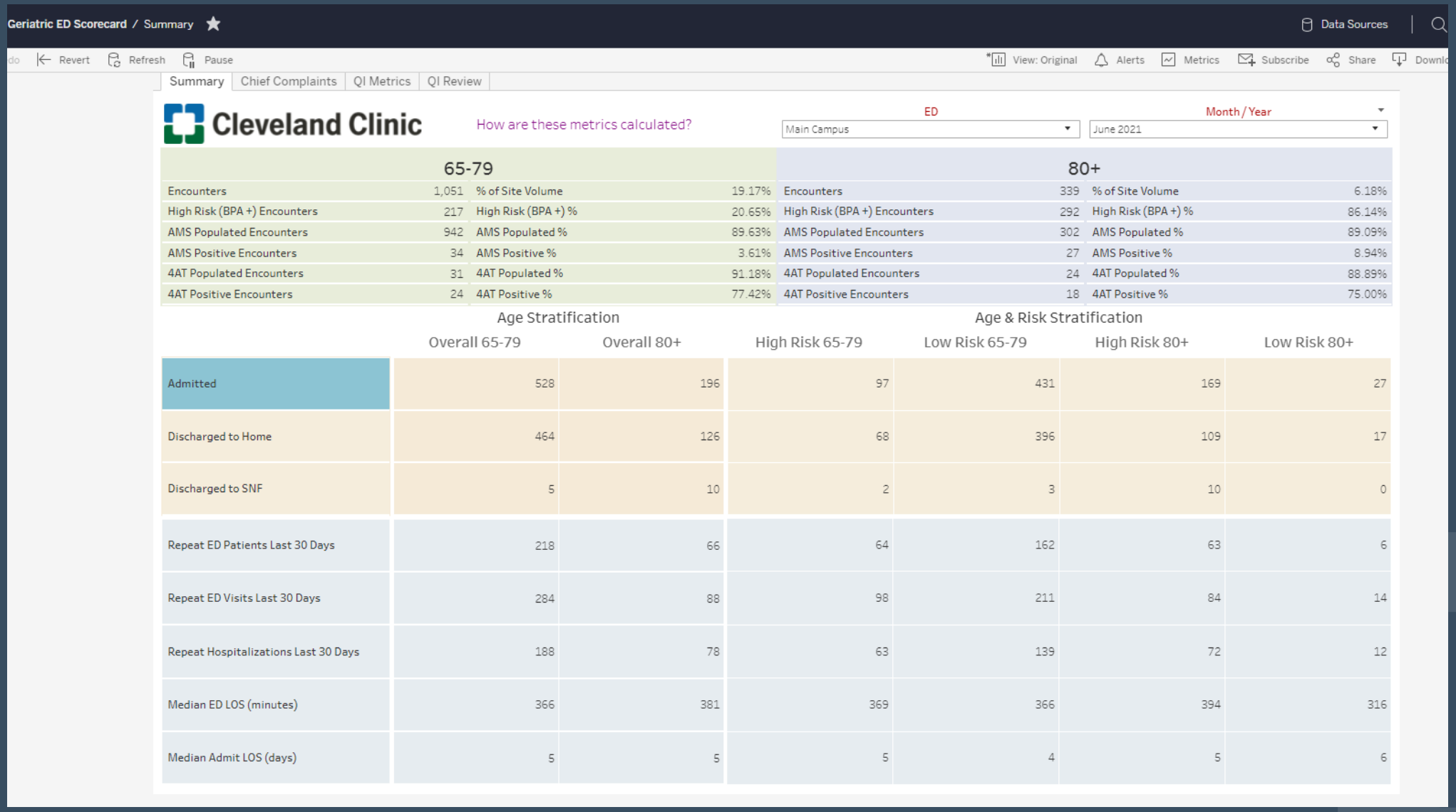


EMR BPA + Geriatric Patient List



ED Bed	Patient	Age	A	TT	Complaint	DOC	MID	4AT Score	OP Medication Count	ED Visits	Admit Count	Dementia Hx	Dispo
E12-20		♀ 76y	3	01:47	Shortness of Breath	DG	MA	⊠	17	9	3	—	—
E12-22		♂ 66y	3	03:14	Weakness	DG	DS	⊠	13	2	0	—	Admit - Clinical *
E14-12		♂ 65y	3	25:38	Syncope (while going down steps at church. + LOC, + hitting head. No blood thinners.); Headache (L sided)	—	TJ	⊠	6	1	0	—	CDU Observation - Clinical *
E15-04		♂ 69y	3	01:50	Fatigue; Abdominal Pain	EA	MW	⊠	23	2	2	—	Admit - Location:*
E18-01		♂ 82y		02:36	Refill Request	JK	JR	0	14	2	2	—	—
E18-06		♂ 73y	3	00:51	High Blood Sugar	JK	MH	⊠	21	1	0	—	—

Geriatric ED Dashboard



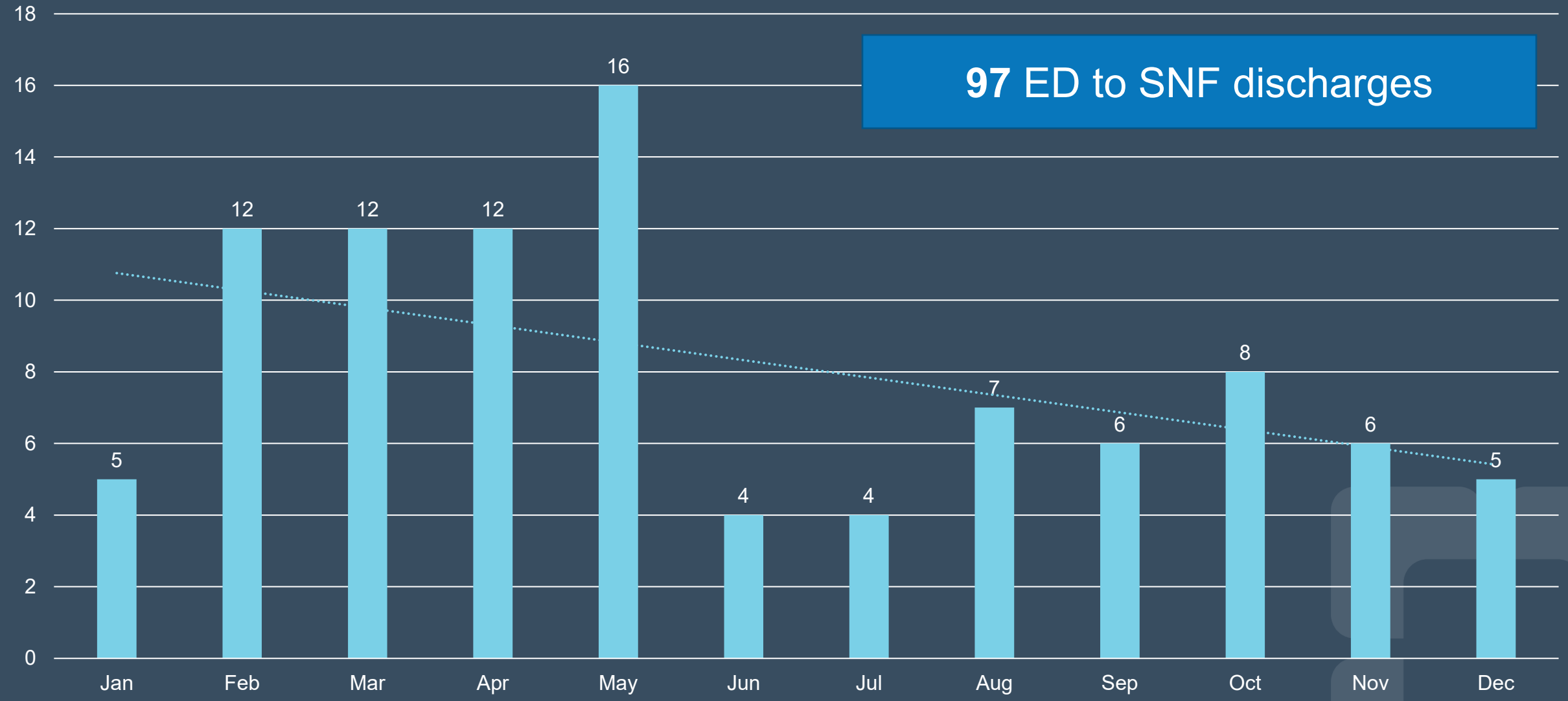
65-79				80+			
Encounters	1,051	% of Site Volume	19.17%	Encounters	339	% of Site Volume	6.18%
High Risk (BPA +) Encounters	217	High Risk (BPA +) %	20.65%	High Risk (BPA +) Encounters	292	High Risk (BPA +) %	86.14%
AMS Populated Encounters	942	AMS Populated %	89.63%	AMS Populated Encounters	302	AMS Populated %	89.09%
AMS Positive Encounters	34	AMS Positive %	3.61%	AMS Positive Encounters	27	AMS Positive %	8.94%
4AT Populated Encounters	31	4AT Populated %	91.18%	4AT Populated Encounters	24	4AT Populated %	88.89%
4AT Positive Encounters	24	4AT Positive %	77.42%	4AT Positive Encounters	18	4AT Positive %	75.00%

	Age Stratification		Age & Risk Stratification			
	Overall 65-79	Overall 80+	High Risk 65-79	Low Risk 65-79	High Risk 80+	Low Risk 80+
Admitted	528	196	97	431	169	27
Discharged to Home	464	126	68	396	109	17
Discharged to SNF	5	10	2	3	10	0
Repeat ED Patients Last 30 Days	218	66	64	162	63	6
Repeat ED Visits Last 30 Days	284	88	98	211	84	14
Repeat Hospitalizations Last 30 Days	188	78	63	139	72	12
Median ED LOS (minutes)	366	381	369	366	394	316
Median Admit LOS (days)	5	5	5	4	5	6

2019 ACO ED to SNF Goals

- Incorporate SNF partner feedback into processes
- Focus on Obs. to SNF handoff opportunity
- Tighter hand-offs across care continuum
- Greater ED CM involvement in work team planning
- Initiative integration into enterprise initiatives
- Launch program fully across *resource ready* hospitals

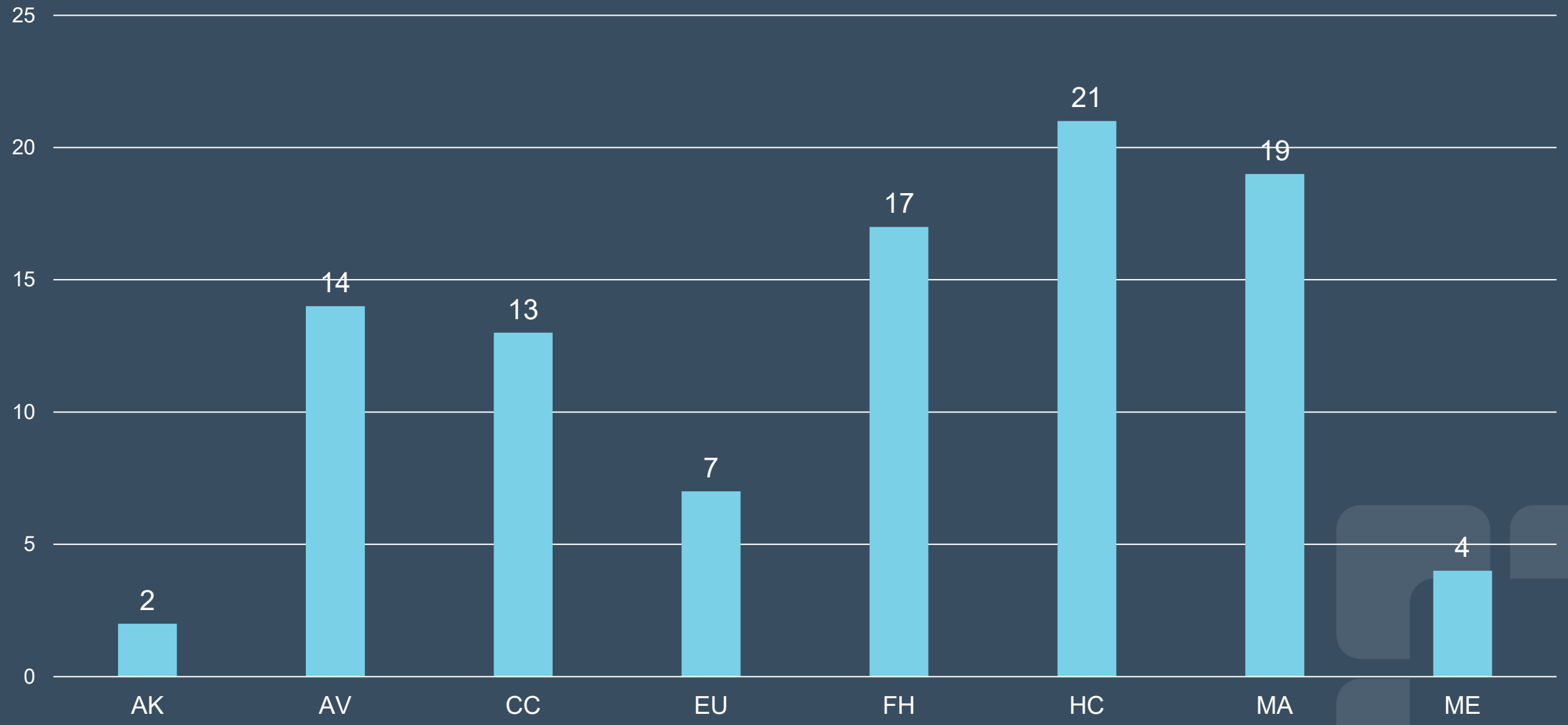
ACO ED to SNF Discharges
2019



97 ED to SNF discharges

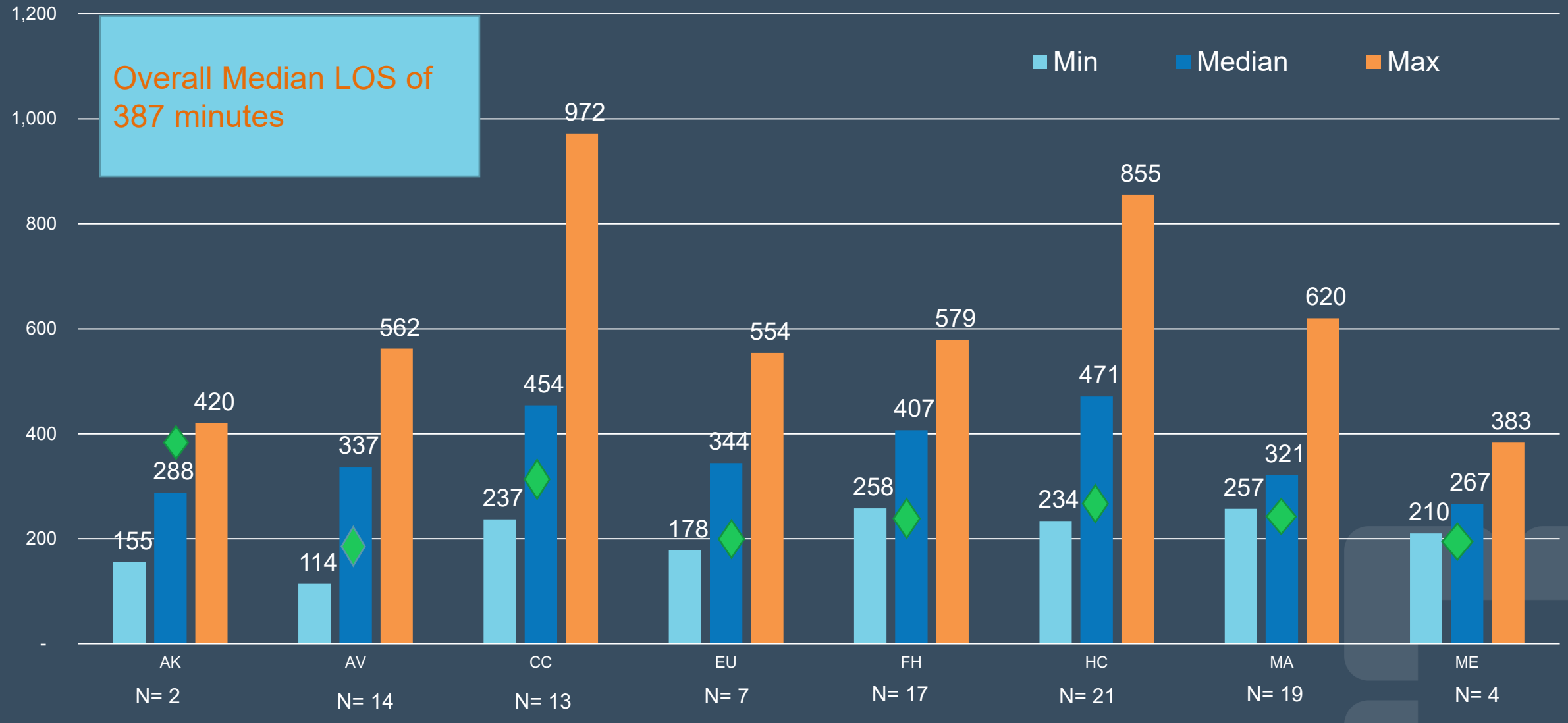
*Best estimate based on Allscripts care management data, LOS <3 days, discharged to Connected Care SNF for 2019.

ED to SNF Discharges by Hospital 2019



*Best estimate based on Allscripts care management data, LOS <3 days, discharged to Connected Care SNF for 2019.

Median LOS in ED



*Best estimate based on Allscripts care management data, LOS <3 days, discharged to Connected Care SNF for 2019.

Median ED LOS admitted patients

SNF Placement Overview

- 64% of ED waiver patients were placed at a Connected Care SNF

ED to SNF Waiver placement breakdown by geography:

ACO SNF Facility Geography	# of ED to SNF Waiver Discharges	% ED to SNF Waiver Discharges
East	51	53%
West	27	28%
South	19	19%

Estimated Savings

Bed Days

Assuming 3 days saved per waiver patient, a total of **291** bed days saved on Medicare ACO SNF 3 Day Waiver program over 97 placements in 2019.

Estimated Financial Savings

Over the 97 placements through August 2019, these avoided admission represent $931K[1] in savings to the ACO – NOT including costs of SNF care and downstream services.

[1] Medicare Revenue Savings per Admission Avoidance is $9,594 based on 2017 CC ACO data.

Medicare ACO ED to SNF Program

Stephen Meldon, MD[1], Lauren Delaney RN, MSN[2], Kristine Adams, MSN, CNP[2], Michael Levinson, MD[1], Mary Stilphen PT, DPT[3], Karen Green PT, DPT[3], Rachelle L. Brenner, MBA[4]

Cleveland Clinic

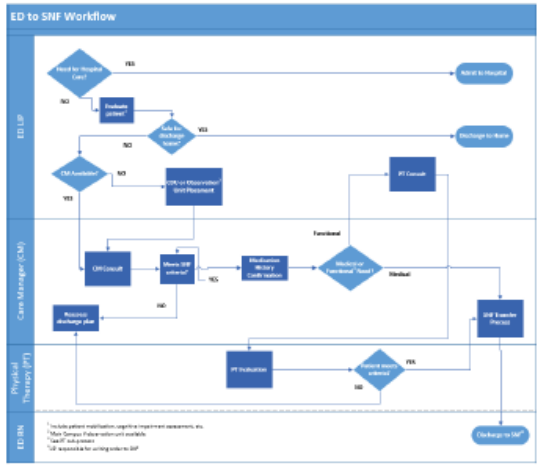
[1]Emergency Services Institute, [2]Care Management, [3]Physical Therapy, [4]Payment Innovation
Cleveland Clinic, Cleveland, OH

Introduction

The SNF 3-Day Rule requires that Medicare beneficiaries have an inpatient hospital stay of at least three consecutive days within the past 30 days to be eligible for coverage of Skilled Nursing Facility (SNF) admission. The Centers for Medicare & Medicaid Services (CMS) Shared Savings Program allow waiver of this rule for eligible beneficiaries who are prospectively assigned to an ACO and receive care from an eligible SNF. The CMS Shared Savings Program rewards ACOs for lower costs and enhanced quality in Medicare Parts A and B fee-for-service (FFS) costs (relative to their ACO-specific benchmark). The goal of our program was to develop and standardize the ED to SNF program and implement across the enterprise to reduce the total cost of care and avoidable admission days in our ACO population.

Key Actions

- Identification of appropriate and ACO eligible patients
- Care team process and communication across ED physician, care management, physical therapy, pharmacy, and SNF partners
- SNF Network quality, communication and feedback processes
- Development of playbook and process resources
- Expansion of ED based program across enterprise
- Expansion of eligible SNF Network



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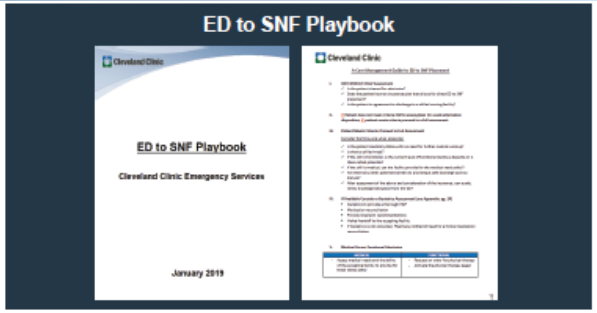
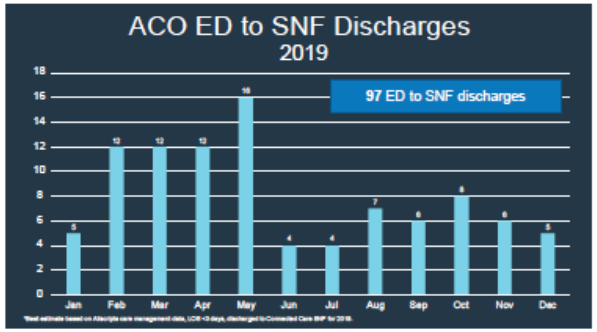


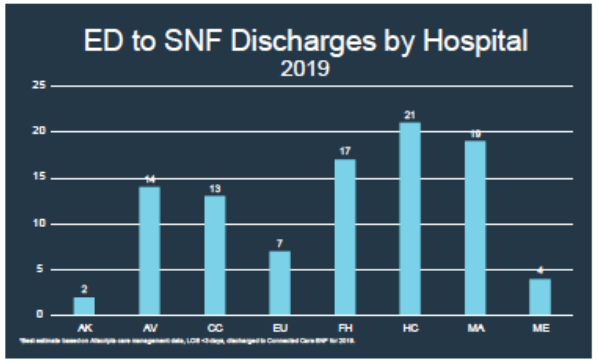
Outcomes

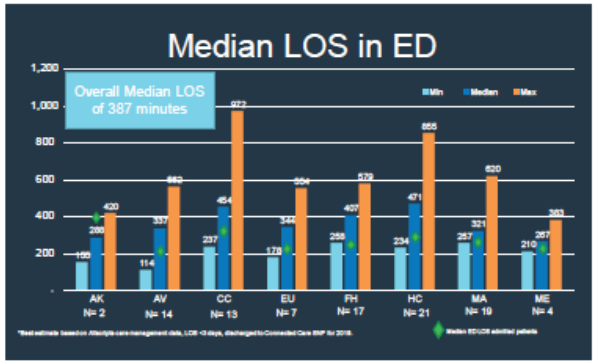
- 27 patients identified and transferred in 2018 pilot year and 97 patients identified and transferred in 2019
- Per avoided admission, there is the potential cost savings of $9,594 assuming downstream costs remain manageable (i.e. LOS). Based on 27 transfers in 2018 and 97 transfers in 2019 this amounts to potential savings of $259,038 and $930,618 respectively.
- If all patients received a 3 day qualifying stay, bed days saved from avoided admissions in 2018 was 81 days (27 transfers x 3 days saved) and 291 days in 2019 (97 transfers x 3 days saved)
- Median LOS in the ED for patients transferred under the program was 360 minutes in 2018 and 387 minutes in 2019



1 Medicare Revenue Savings per Admission Avoidance is $9,594 based on 2017 Cleveland Clinic Medicare ACO data.

Outcomes





Conclusion

The key to successful design and implementation of the ED to SNF program requires the following factors:

- Shared vision across all stakeholders
- Coordination of efforts across a multi-disciplinary team (Emergency Medicine, Care Management, Physical Therapy, Connected Care)
- Process and playbook development and implementation
- Market and Network Services and clinical services partnership

2020 ACO ED-SNF Goals

- Broaden team focus from ED to SNF → ED to Alternative Destination
- Document and publish value created by program and related efforts
- Initiative integration into enterprise initiatives

Cleveland Clinic

ED to SNF Playbook

Cleveland Clinic Emergency Services Approach to Emergency Department Transitions of Care

April 2020

Main Campus ED

- *All* avoided admissions
  - June-Dec 2017 :12
  - 2018: 70
    - (ED►SNF 50)
  - 2019: 90
    - (ED►SNF 72)
  - 2020: 57
- ACO ~25% of avoid admissions

Challenges

- COVID
  - Patient/family *and* SNF concerns
- Case management priorities
- SNF LOS once placed

Program Benefits

- Targeted care with improved outcomes for complex Geriatric patients
  - Appropriate level of care
  - Improved continuity of care
  - ACO cost savings – ED to SNF; possible linkage to Hospital at Home
  - Improved inter-institutional communication to care for complex Geriatric patients (ESI/4C or CGM)
- Enhanced patient and caregiver experience
- Potential telehealth services
- Marketing from GEDA accreditation

Key Takeaways

- Natural synergy between ACO ED-SNF and Geriatric ED programs
  - Geriatric ED (GCU): same people & processes
- Collaborative approach
  - CM key
- Buy-In

Key Takeaways

- Sustainability (not just financial)
- Enterprise integration of all clinical services key
  - CC Hospital at Home; CC SNF at Home
- Design/develop an adaptable program

Questions

If you did not get a chance to ask your question, or if you have additional questions in the future, please email info@institute4ac.org.

Generously supported by

GEDC

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