A patient’s wife called us to let us know she needed to take her husband to the ER for shortness of breath. We got an order for a prn visit and had a nurse at the home in less than two hours. The nurse worked with the physician on medication changes and an ER visit was avoided.

Ashley Scales, LPN
Nashville, TN

Our patients have seen superior levels of communication between the members of their medical and clinical care teams... true integration of the PCP and post-acute provider. As a result, these patients have benefited from less fragmented care.

Katie Trevino, RN
Austin, TX

We re-engineered our practice to achieve better clinical outcomes. This partnership allows us to extend our care into the home and we have significantly reduced hospitalizations and ER utilization while improving our quality metrics and patient satisfaction.

Anas Daghestani, MD
Austin, TX

AccentCare®
Advanced Community Care Model
Optimizing the viability and results of healthcare in the home setting

AccentCare®
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Introduction

Health systems and physicians are being held increasingly accountable for patient outcomes... outside the four walls of their facilities and offices. Hospital re-admission penalties and risk-sharing models such as the Centers for Medicare & Medicaid Services’ bundled payments initiative and insurance plans’ population health incentives create demand for better integration across the continuum of care to help improve clinical outcomes and patient experience while reducing costs.

Summary

Fully integrating home care into a healthcare network helps improve care transitions, reduces avoidable hospitalizations, optimizes clinical outcomes, and lowers the cost of both acute and post-acute care. Home care represents the lowest cost-setting for care delivery and at the same time meets the personal preference of most seniors.

This paper will discuss acute/post-acute care partnerships utilizing a unique integrated home care model incorporating customized teams and protocols, disease- and patient-specific approaches, and technology to achieve better outcomes, and higher satisfaction while contributing to cost reduction.
Problem: Rising Cost

Unplanned re-hospitalizations and emergency department (ED) utilization are indicators of the need for integrated healthcare and are significant contributors to its rising cost.

According to a Medicare Home Health Claims-Based Re-hospitalization Measures Technical Report, “Avoidable hospital re-admissions are a national priority for Medicare beneficiaries. Research indicates that 20% of all Medicare beneficiaries who were hospitalized had a return hospital stay within 30 days. In 2004, this cost the Medicare program $17.4 billion.”

Seniors, age 65 and older, make nearly 22 million ED visits annually, at a rate of 485 per 1,000 persons. About 47% of these ED visits result in hospitalization.

These statistics are no surprise given the high rate of complex co-morbidities and incidence of behavioral health conditions among this age group. Three in four seniors has multiple chronic conditions, accounting for 93% of total Medicare spending. In addition, over 2 million suffer from depression and an estimated 5.3 million are diagnosed with Alzheimer’s or other forms of dementia. Such conditions further exacerbate lesser outcomes and higher cost of care due to non-compliance.
Background: CMS Studies

CMS identified studies which partnered healthcare providers to reduce re-hospitalization rates, suggesting that better coordination across the care continuum is beneficial for outcomes, as well as cost reduction related to avoidance of unplanned re-hospitalization.

Medicare cites a study demonstrating that when care coordination was utilized, the patients receiving such care had a lower hospitalization rate (15%), compared to the rate within the control group (20%). Similarly, in a CMS Care Transitions project, home health providers that employed specific strategies to care for patients (front-loading visits, identifying patients at highest risk, providing education and medication reconciliation), achieved a 4% absolute reduction in re-hospitalization rate. In yet another study in which a care transitions coordinator provided coaching, physician appointment scheduling, and patient/caregiver education, re-hospitalization rates decreased from 17% to 12%.¹

The AccentCare® Advanced Community Care Model (AACCM), in partnership with physician groups, exceeds outcomes and results of these studies.
Solution: New Care Model

In 2013, AccentCare®, Inc. worked with Dr. John Williams, internal medicine physician and President of Nashville Medical Group (NMG), who sought to create a streamlined process within his practice to extend the physician’s line of sight into the patient’s home. “As providers within a MSSP ACO, it is critical for our physicians to be able to manage both the quality and spend associated with post-acute care,” says Williams.

The resulting program launched as the AccentCare® Advanced Community Care Model (AACCM) at NMG’s Midtown practice in 2014. To date, AccentCare and NMG have served 1,078 patients (912 home health, 166 hospice), achieving significantly lower 30-day re-hospitalization rates and greater improvement in ability to transfer, than national averages, by a margin of 2.5 and 21 percentage points, respectively.6

The program was later expanded to Austin, TX where it reduced re-hospitalizations for the partner health system by 29%,7 and to Los Angeles where it achieved emergency care utilization rates 3.1 percentage points below the national average.8

AACCM achieves results by establishing protocols and workflow in five key areas:

1. Communication for faster admission and order processing
2. High-risk patient identification
3. Disease-specific programs
4. Behavioral health recognition and accommodation
5. Technology in the home

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* AccentCare® Data from SQL server Nashville program data pull 8/25/17. National data from medicare.gov Home Health Compare Oct 15 – Sep 16 for patients rehospitalized within 30 days of SOC. All data rounded to nearest whole percent

* AccentCare® Data from SQL server Austin program data pull 10/4/17

* AccentCare® Data from SQL server Los Angeles program data pull Jul 16 – Jun 17. National data from medicare.gov Home Health Compare Oct 15 – Sep 16. All data rounded to nearest whole percent
Communication

The AACCM simplifies communication by dedicating a Clinical Liaison to coordinate care, with the physician, across home health/hospice service lines, acting as the single point of contact for the physician practice. This decreases the time from referral to admission with 89% of patients admitted within 24 hours or less. The Clinical Liaison also streamlines the communication process to provide the physician with greater insight into the patient’s ongoing clinical status, as well as the ability to more swiftly address a change in condition with real-time order processing and same-day prn visits.

The speed with which orders are processed can also impact ED utilization. Often when a clinician sees a change in patient condition, a physician order can be obtained by the Clinical Liaison while the clinician is still in the patient’s home. This reduces the time to address critical needs such as lab draws and medication changes that may help to avoid an ED visit.

High-risk Patient Identification

The AACCM Clinical Liaison and other dedicated AccentCare team members, along with the partner practice, together identify high-risk patients, who could benefit from increased oversight to prevent hospitalizations and decline, based on the medical practice’s knowledge of the patient and the AACCM risk-ranking tool.

AccentCare has identified factors that increase patient risk for hospitalization and that should be considered when determining appropriate levels of care:

- Multiple hospitalizations within the last 6 months
- Multiple falls within the last 12 months
- Multiple new medications
- History of patient compliance issues
- Newly diagnosed and/or unstable cardiac condition
- Newly diagnosed and/or unstable diabetes
- Psychosocial concerns in the home
- Late life depression

Physician feedback has indicated that this risk classification system is useful for all high-risk patients, including those for whom a skilled nursing or rehabilitative facility would be recommended were it not for the patient’s strong desire to be home.

(continued)
The robust structure of the care model helps to ensure patient safety and that appropriate levels of care needs are met in the home setting. AACCM services include:

- Nurse case conference (weekly or more frequently if indicated)
- Front-loading multi-disciplinary visits
- Tele-monitoring (as clinically appropriate)
- Proprietary RightPath® disease management and Palliative Care programs
- Weekly chart reviews
- Follow-up reporting on any missed visits
- Check-in calls
- Assistance with timely scheduling of follow-up physician visits

This care model has demonstrated success by exceeding national benchmarks in key functional improvement outcomes by as much as 21 percentage points.9

![Patient Improvement Chart]

Risk-stratification not only helps determine the appropriate home healthcare plans, but it also helps to determine the most appropriate level of care across the continuum, as patients approach end of life. Evidence shows that patients who are identified early as being appropriate for hospice have a better experience than those entering hospice care closer to end of life.10 AccentCare uses Medalogix predictive modeling to identify home health patients who may qualify for palliative care or hospice services. The Clinical Liaison shares such findings with the physician to determine any appropriate changes in the patient’s care plan or service.
3 Disease-specific Programs

AccentCare provides proprietary disease-specific pathways through its RightPath® programs for cardiac, COPD, diabetes, joint replacement, late life depression and palliative care. Each is evidenced-based with adherence to expert clinical guidelines that complement physician orders to optimize outcomes including not only re-hospitalization, but other measures such as improvement in transfer, dyspnea, and ambulation.

4 Behavioral Health Recognition and Accommodation

One of AccentCare’s core competencies is behavioral healthcare. Traditional home health focuses on a singular disease process or post-acute procedure, typically treating the physical symptoms that manifest as a result. While this remains a concentration of most treatment plans, the additional layer of AccentCare’s certified behavioral health nurses allows a truly holistic approach to patient care.

It is rare that a patient can self-identify a behavioral health problem and physicians are usually focused on specific physical ailments, with only an office-visit for behavioral observation. It is no surprise that behavioral symptoms are often overlooked. Due to the difficulty in identifying behavioral conditions, AccentCare trains its clinical home care staff to recognize common signs such as:

- Learning difficulties
- Pacing
- Tearfulness
- Headache
- GI symptoms
- Difficulty complying with healthcare instructions

Addressing these barriers results in safer and happier patients, allowing them to take a more active and compliant role in their healthcare.
The AACCM leverages technology to closely monitor patients, track performance, and communicate with physicians to enhance the delivery speed and value of clinical information.

AccentCare uses tele-monitoring to recognize condition change in near real-time to enable preemptive intervention. By collecting biometric data, and monitoring symptoms and compliance with evidence-based guidelines between in-person visits, AccentCare arms its patients, clinical teams and physician partners with data to drive effective and timely decision-making. Collected data includes blood pressure, heart rate, peak expiratory flow, oxygen saturation, blood glucose, and weight. The AACCM Clinical Liaison reviews the data and appropriately alerts the physician by immediately sharing any data that may be indicative of needed action.

AccentCare utilizes a customized electronic medical record (EMR) platform to track AACCM program performance. Patient progress data is reported on an individual and aggregate basis. Individual patient information is shared with physicians by the Clinical Liaison, in accordance with physician preference. In addition, program level information is monitored on an ongoing basis and shared with physician practice stakeholders, at least quarterly, in joint operations committee meetings.
Conclusion: AACCM Optimizes Post-acute Care

AccentCare recognizes the importance of home care and the opportunity it presents to the healthcare industry. The AccentCare Advanced Community Care Model (AACCM) reflects our commitment to the continuous improvement of post-acute care.

We offer expertise, experience, and moreover, proven success as evidenced by lower re-hospitalization, reduced ED utilization, improved patient outcomes, and a better patient experience delivered in a lower cost setting.

Home care is a lower cost setting than facility-based care*

The AACCM has served more than 2,500 patients to date and continues to expand across the country.

To learn more about how we address the unique goals of each of our partners, contact us at partnerships@accentcare.com

RESOURCES

3. Chronic Disease Prevention and Health Promotion: Multiple Chronic Conditions, Centers for Disease Control and Prevention, www.cdc.gov/chronicdisease/about/multiple-chronic.htm
4. www.valleybehavioral.com/depression/seniors/signs-symptoms-causes#Statistics
5. www.alz.org/facts/
6. AccentCare® Data from SQL server Nashville program data pull 8/25/17. National data from medicare.gov Home Health Compare Oct 15 – Sep 16 for patients rehospitalized within 30 days of SOC. All data rounded to nearest whole percent
7. AccentCare® Data from SQL server Austin program data pull 10/4/17
8. AccentCare® Data from SQL server Los Angeles Program data pull Jul 16 – Jun 17. National data from medicare.gov Home Health Compare Oct 15 – Sep 16. All data rounded to nearest whole percent
9. AccentCare® Data from SQL server Jul 16 – Jun 17, Nashville AACCM teams. National data from medicare.gov Home Health Compare calendar year 2016. All data rounded to nearest whole percent
COMMITMENT TO COMPLIANCE

A culture of compliance promotes transparency and integrity to better protect patients, customer partners and healthcare providers. In addition to addressing the “7 Elements of Compliance,” AccentCare, Inc. utilizes:

- Third party monitoring of an alert/hotline
- Mandatory training for all employees and contractors
- Routine internal and third party audits of staff and processes
- Systematic QAPI programs, including tracked plans for corrective action

ABOUT ACCENTCARE, INC.

AccentCare®, Inc. is a nationwide leader in post-acute healthcare as well as specialized care management prior to acute episodes. Its wide variety of innovative services ranges from personal, non-medical care to skilled nursing, rehabilitation, hospice, and care management. Headquartered in Dallas, Texas, AccentCare has over 20,000 compassionate professionals in more than 150 locations across 11 states serving over 17,000 physicians and 2,000 facilities, regionally branded as AccentCare®, AccentCare® of New York, Alliance For Health®, Guardian Home Health & Hospice, Nurses Unlimited, Sta-Home, or Texas Home Health.

In addition, the company has over 30 regional strategic partnerships with insurance companies, physician groups, and major health systems, including joint ventures with Asante®, Baylor Scott & White Health, UC San Diego Health, and UCLA Health. AccentCare is the operator for these joint ventures under the brand names of AccentCare® Asante® Home Health, Texas Home Health Group, AccentCare® UC San Diego Health at Home, and AccentCare® UCLA Health, respectively.

AccentCare is committed to improving the quality of living with a mission to deliver consistently exceptional care for over 90,000 individuals, and their families, each year. Its approach to care, including proprietary RightPath® disease-specific programs, leads the industry in avoidance of unplanned re-hospitalizations, faster starts of care and quality performance. Among its distinctions, AccentCare has a 4.2-star quality rating for legacy home health agencies, many of which have earned the HomeCare Elite® distinction. All hospice locations are CHAP accredited, with designations from the We Honor Veterans program.