Rehab at Home ("PaCC")

Required from Hospital: Background Components	
Overview • Description of current or upcoming program/initiative which hospitals may be implementing to impact patient outcomes, population health and total cost of care performance under Global Budget Revenues (GBR).	The goal is to discharge the patient safely home following a Total/Revision of Hip, Knee, and Spine (note: Spine just began October 2018). Results show more patients able to go home following this service and less transferred to SNFs or CIRs. Patients are assessed after surgery to determine the next level of care the patient would best benefit from. Some require no follow up care. For the ones that require therapy, home heath physical therapy is provided if necessary but, most patients are transitioned to outpatient physical therapy. Home nursing is not typically required unless the patient has an open wound or other medical condition.
Defined Care Interventions • Briefly describe a standardized intervention pathway to address unmet clinical or social needs. • Identify care partners at the hospital, or in the community, who will implement the intervention.	**Interventions** • Proactively work with patients on discharge planning prior to surgery • Immediately after surgery, the PACC team coordinates with the entire hospital multi-disciplinary team (Surgeon, Physician Assistant, Nursing, Physical Therapy) to determine the best post-Acute plan. • The PACC team consists of patient care specialists and patient care coordinators. The specialists handle the post-acute insurance verifications/authorizations, scheduling, etc. The coordinators are a combination of RN's, Social Workers and Occupation Therapy which assess the patient's clinical needs. • When patients cannot be safely discharged home, the PaCC prepares the patient for the best step-down level of care until the patient can go safely home. They also follow the patient's while in those settings to ensure the discharge to home occurs as expected. • The PACC team also covers patients if they are readmitted to the Hospital. Those patients are automatically referred to the PACC team via the EMR. • The PACC team also follows the patient at lower levels of care (i.e. SNF's, CIR, etc.) until the patient is discharged home. They are often instrumental in

	facilitating a quicker discharge from some of the step-down settings due to their constant follow up with those teams. **Care partners**: The PACC Team coordinates the post-acute care utilizing Home Health (MedStar VNA and other agencies as necessary) and Outpatient Therapy Providers (MedStar NRH and other providers as necessary)
Required from Hospital: Analytic Components	
Identifiable Intervention Population • Medicare FFS beneficiaries only, until further payer data available • Must be identifiable in Medicare claims based on clinical condition, patient history and/or other criteria; cannot be identified with an EHR or clinical data point,	All MUMH surgeries on Total/Revisions of Hip, Knee, and Spine regardless of Payor Hip APR 301. Knee APR 302, and Spine APRs 023, 026, 303,304,310,320,321,850,950,951
Episode Trigger • A "trigger" event, or combination of factors, to identify when a beneficiary is enrolled in the intervention • Must be identifiable in Medicare claims; cannot be triggered with an EHR or clinical data point,	• Any surgery for one of the triggered conditions happening at MedStar Union Memorial Hospital. • Costs to be measured for procedure/hospitalization and 30 days post discharge •