Care Transition Programs, Solution or Work Around

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Rebuilding the Airplane in Mid-air

1. Defining ‘The Triple Aim’
2. Pitchers; Catchers; Managers, Owners and The League
3. Care Management

Due to the sagging economy, rising fuel prices, the cost of maintenance and healthcare premiums; the light at the end of the tunnel has been turned off. We apologize of any inconvenience.
“Of all of the aims of the IOM, that healthcare should be safe, timely, effective, efficient, equitable and patient centered, our biggest priority for the immediate future is efficient.”

- Dr. Donald Berwick, former CMS Administrator, December 2011, IHI national forum

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The ‘Triple Aim’

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care
The Key: Co-Evolution

Delivery System Redesign and Alternative Payment Models must support each other and evolve in parallel.

**Non-Risk**

<table>
<thead>
<tr>
<th>Payment Methodology</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS</td>
<td>Single Payment</td>
</tr>
</tbody>
</table>

**Delivery System**

<table>
<thead>
<tr>
<th>Fragmented Care</th>
<th>Coordinated Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality &amp; Efficient Care</td>
<td></td>
</tr>
</tbody>
</table>

Clinical Integration: The High Value Network
Unsustainable Traditional Model

- **Hospital Stay**: $14,200
- **Home Care (1 to 6 visits)**: $870
- **Rehab / LTC Stay**: $11,190 (optional: $373/day × 30 days)
- **ER Visit**: $1516
- **Home Support**: Unpredictable

Total: $27,776
An estimated 70% of Americans ages 65 and older are projected to experience some level of need for long-term services and supports. (1) Those who survive to age sixty-five have a 46% chance of spending time in a nursing home. (2)

‘29% of the sample who lived alone, were in the worst health and had the highest prevalence of activity limitations of any group in the sample’

2. New estimates of lifetime nursing home use: have patterns of use changed? Med Care. 2002;40(10)
May 2015 GAO - Medicaid: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures

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Recovering from acute illness
- “perturbed physiologic systems”

Stress
- Sleep deprivation
- Disruption of normal circadian rhythms
- Poorly nourished
- Have pain and discomfort
- “…confront a baffling array of mentally challenging situations”
- Receive medications that can alter cognition and physical function
- Can become deconditioned by bed rest or inactivity

Lead to impairments in the early recovery period
- Inability to fend off disease
- Susceptibility to mental error

Adapted From: Rise of Post–Acute Care Facilities as a Discharge Destination of US Hospitalizations
JAMA Intern Med. Published online December, 14

Figure Legend:
Trends in Discharges to Post–Acute Care (PAC) Facilities and Home Trends in the percentage of patients discharged home or to PAC facilities are shown. Each year is compared with 1996 values to calculate a relative percentage change.
Variability Among US Intensive Care Units in Managing the Care of Patients Admitted With Preexisting Limits on Life-Sustaining Therapies

Joanna L. Hart, MD, MSHP; et al

*JAMA Internal Medicine Published online March 30, 2015*

TRIAD VI: How Well Do Emergency Physicians Understand POLST Forms?
TRIAD VII: Do Pre-hospital Providers Understand POLST Documents?

Ferdinando L. Mirarchi, DO, FAAEM, et al

*J. Patient Safety Volume 11, Number 1, March 2015*
CMS Penalty Matrix

<table>
<thead>
<tr>
<th>Program</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>FY 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital VBP Program</td>
<td>±1.25%</td>
<td>±1.50%</td>
<td>±1.75%</td>
<td>±2.00%</td>
</tr>
<tr>
<td>Readmissions</td>
<td>-1.0%</td>
<td>-2.0%</td>
<td>-3.0%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Reduction Program</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAC Program</td>
<td>-1.0%</td>
<td>-1.0%</td>
<td>-1.0%</td>
<td></td>
</tr>
<tr>
<td>Hospital IQR Program</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Max Penalty:</td>
<td>4.25%</td>
<td>6.5%</td>
<td>7.75%</td>
<td>8.0%</td>
</tr>
</tbody>
</table>

Bundled Payment

Types of Services by Model

<table>
<thead>
<tr>
<th>Type of Services</th>
<th>Model 1: Acute Hospital Stay Only</th>
<th>Model 2: Acute Hospital Stay + Post-Acute Care Services</th>
<th>Model 3: Post-Acute Care Only</th>
<th>Model 4: Acute Hospital Stay + Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Related post-acute care services</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-acute care services</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Related readmissions</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Other services defined in bundle (Part A &amp; Part B)</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Post Acute Care’s Impact

"Finally, our findings suggest that if the BPCI hospitals wish to find opportunities for savings, they would do well to look at post acute care services such as those provided by skilled nursing facilities, rehabilitation facilities, or home health agencies."

Deconstructing and Reconstructing the Care Continuum

View from the Hospital

- Admission criteria
  - Observation
  - 3 midnight rule
- Readmissions
  - Revenue vs penalties
- New payment schemes
  - Total medical expense
  - Pay for performance
- Length of stay
  - DRG
- Patient flow
  - High census
  - Case mix
Rebuilding the Airplane in Mid-air

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‘Shared’ Savings programs

- One of many value based purchasing initiative (e.g. hospital inpatient VBP)
- Promotes Accountability for care
- Coordinates items and services under Medicare Part A and Part B
- Encourages infrastructure investment and redesigned care processes for high quality and efficient delivery
- Intent is to promote accountability for a population of Medicare beneficiaries
- As an incentive, Medicare can share a percentage of the savings with the ACO
- This only occurs if the quality performance standards are met and sharable savings are generated
Misaligned Incentives

- Medicare Part A
  - FFS
    - Churning
  - Hospital DRG
    - Push out patients
  - SNF
    - Can't bill for both usual care and hospice care
    - Overuse of rehab services at EOL
  - Hospice
    - Benefit designed for home bound patients
    - Does not take into account acuity and resource needs
    - Not a fit for SNF due to costs of room and board
    - 6 mo designation deters patients

- Medicare Part B
  - Promotes over-testing and treatment.

CMS New Coordination of Care Codes

- Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:
  - communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care
  - communication with home health agencies and other community services utilized by the patient
  - patient and/or family/caretaker education to support self-management, independent living, and activities of daily living,
  - assessment and support for treatment regimen adherence and medication management,
  - identification of available community and health resources,
  - facilitating access to care and services needed by the patient and/or family
AND...

- Non-face-to-face services provided by the physician or other qualified health care provider may include:
  - obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents);
  - reviewing need for or follow-up on pending diagnostic tests and treatments;
  - interaction with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems;
  - education of patient, family, guardian, and/or caregiver;
  - establishment or reestablishment of referrals and arranging for needed community resources
  - assistance in scheduling any required follow-up with community providers and services.

AND

- TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. The first face-to-face visit is part of the TCM service and not reported separately.
- Additional E/M services after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.
- These services address any needed coordination of care performed by multiple disciplines and community service agencies.
- The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access.
CMS Chronic Care Management Payment Program

- Began CY 2015
- $40/pmpm
- $480/yr
- 200 qualified patients = $96,000/yr
- 20% co-insurance for patient = $100/yr if no supplemental insurance
- Minimum of 20 min devoted to care planning/month

Adapted from: Edwards and Landon NEJM 371:22 Nov 2014

To Do’s

- 24/7 Access to CCM services and a linked provider
- Primary provider with easy access
- Care Plan*
  - Physical, mental, social, functional and environmental assessments and actions.
  - Inventory of supports and resources
  - Patient document aimed at choice and values
- Chronic disease management
  - Systems based plan
  - Prevention
  - Medication management
    - Reconciliation
    - Compliance
  - Regular updates of plan with respect to physical, mental and social
- Care transitions management
- Coordination of home, HH and community based providers with plan
- e-Highway for patients and caregivers to communicate with team
*Care Plan Components*

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Planned interventions
- Symptom management
- Medication management plan
- List of community and social services ordered
- Plan for directing and coordinating outside services
- List of responsible people for each intervention
- Requirements and schedule for plan reviews and updates

*More To Do’s*

- Authorizations
  - Regarding program and written agreement
  - To share PCHIS
- Documentation
  - That program fully explained
  - Accept or decline
  - Written care plan given to patient
  - Right to terminate
  - Explanation of benefit, in terms of sole provider overseeing and receiving payment
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Recent Negative Studies

  - "Perhaps most of the social risk factors that we identified are not useful for improving the prediction of stroke readmission, and other variables—such as living alone or social support which were unavailable for this analysis—are more important.”

- A Comprehensive Hospital-Based Intervention to Reduce Readmissions for Chronically Ill Patients: A Randomized Controlled Trial Am J Managed Care. 2014;20(10)
  - "we were not able to include—home visits and ambulatory follow-up care—were essential”

  - “there was no significant impact of the nurse telephone calls on 30-day readmission rates”

- Effect of a Post-discharge Virtual Ward on Readmission or Death for High-Risk Patients A Randomized Clinical Trial JAMA 312 (13) Oct 2014
  - “There are several potential reasons the virtual ward model of care we implemented did not reduce readmissions. First, it was difficult for virtual ward team members to communicate with many patients’ primary care physicians. Many primary care physicians were not easily available by telephone or e-mail, which made collaborative care difficult. Second, the multiplicity of different information technology systems available made it difficult for virtual ward team members to know what care had previously been provided to a patient”

- A Multidisciplinary Intervention for Reducing Readmissions Among Older Adults in a Patient Centered Medical Home Am J Managed Care Feb 2015: 21(2)
  - 572 patients with ED visit, unanticipated hospitalization or SNF stay. Pharmacist call within 2-4 day post d/c. Geriatric clinic visit within 1 wk. 21% readmit rate in intervention, 17% matched control group. Medication burden and HRDS correlated best. (21% success with both call and visit)

Recent Positive Studies

- Impact of an Integrated Transition Management Program in Primary Care on Hospital Readmissions JHQ Vol. 37 No. 1 January/February 2015
  - "Our TM program had several key features... Care Managers ...contacted by telephone to arrange timely outpatient follow-up."

- Medical Home Network announced today the results of a data review of its model of care program for Illinois Medicaid patients CHICAGO, Dec. 11, 2014
  - “One of the key strategies was creating a policy which made patients discharged from the hospital a top priority for scheduling follow-up appointments. By working together, in our first year we were able to achieve an average timely follow up rate of 47.2 percent with rates as high as 58.3 percent in some months.”

  - STAAR and H2H. Early PCP visit, communication with SNF, Med Reconciliation, incentives
“...high intensity transitional care interventions were associated with reduced readmissions in the short, intermediate, and long terms.”

1. TCI was far more efficacious in decreasing ED visits than in reducing hospital readmission: the NNT was 9 patients to avoid an ED visit vs 52 to avoid a readmission.
2. Our results suggest that high-intensity TCIs need be sustained for only a short duration (6 months or less) to be effective at reducing the risk of readmission, while moderate-intensity interventions need to be of a longer duration (more than 6 months) to have a similar effect.
3. Telephone follow-up used in isolation—the most frequently reported type of TCI (11 RCTs)—was not efficacious.
4. In all cases, low-intensity TCI should be avoided.
5. We found that follow-up in the outpatient clinic only, that is, the usual post-discharge arrangement, does not improve the outcomes studied.
6. A key element of TCI is follow-up of patients by a PCP within a week after discharge.
7. Successful communication between hospitals, in particular cardiology, and PCPs is also of paramount importance. Hospitals need to notify PCPs of patients discharged and send the summary for return visits.
8. The information on many discharge summaries is incomplete and inadequate.
Care Management

A comprehensive strategy for high quality, patient centered, cost effective care, aimed at restoration of function and independence.

Home-Based Primary Care Model

- Comprehensive, longitudinal primary care
- Patients are visited monthly, more often as medically necessary
- **Team-Based approach**: Physicians collaborate with NPs/Pas; nurse clinical coordinators support team
- Model has been associated with strong quality and financial outcomes (cost savings)
HBPC: Quality and Cost Outcomes

Keeping Readmissions Low…

30-Day Readmission Rates:

- Mean Medicare 30-Day Rehosp. Rate
- Kindred HBPC

Empowering Seniors with End of Life Decisions…

Percent of Deaths at Home:

- Kindred HBPC 86%
- Approx General Medicare Population 25%

While Reducing Costs

- VA 89%
- JAGS 2014 83%
- Prelim IAH 75%
- Prelim KND 33%

Key Elements of A Care Transitions Program

<table>
<thead>
<tr>
<th>Identify Patients At High Risk for Readmission</th>
<th>Deploy Care Transitions Managers to ensure smooth transition</th>
<th>Coordinate Patient Access to PCP/Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assessment Tool</td>
<td>Patient Choice</td>
<td>Schedules follow up appointment within 7 days of transition home</td>
</tr>
<tr>
<td>External Referrals</td>
<td>Assesses patient for transition readiness (Teach Back)</td>
<td>Attends appointment(s) when indicated</td>
</tr>
<tr>
<td>Internal Referrals</td>
<td>Present on the day of transition - ensures thorough handoff</td>
<td>Review Medications/Treatment Plan pre and post PCP visit</td>
</tr>
<tr>
<td>Interdisciplinary Collaboration</td>
<td>Transitional Care Pharmacist Referral</td>
<td>Ensures additional follow up appointments are made and kept</td>
</tr>
<tr>
<td>Internal Data Trigger Reports</td>
<td>Transitional Care Rehab Specialist Referral</td>
<td>Obtains new provider for patients without a PCP</td>
</tr>
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</table>
Care Transitions Program Data 2014

- Readmission rate 30 days post discharge from a Kindred site of care = 6.1%
- Patient Satisfaction with Transition score = 3.6 (1-4 scale)
- PCPs were notified of admission and transition 97% of the time
- 93% of patients kept their scheduled PCP appointment within 7 days of discharge to home
- 98% of medications were administered as scheduled on the day of transition
- 98% of patients did not miss a meal on the day of transition

YTD Boston Market 09/2014

Key Elements of ‘Tier 2’ Program

<table>
<thead>
<tr>
<th>Identify Patients At High Risk for Readmission</th>
<th>Deploy Home Health Nurse to ensure smooth transition</th>
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<tr>
<td>Risk Assessment Tool</td>
<td>Early Visits</td>
<td>Schedules follow up appointment within 7 days of transition home</td>
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<tr>
<td>External Referrals</td>
<td>Medication Reconciliation</td>
<td>Make sure patient attends visit</td>
</tr>
<tr>
<td>Internal Referrals</td>
<td>Environment Prepared DME, Meals, Support, etc</td>
<td>Review Medications/Treatment Plan pre and post PCP visit</td>
</tr>
<tr>
<td>Interdisciplinary Collaboration</td>
<td>Education and activation</td>
<td>Ensures additional follow up appointments are made and kept</td>
</tr>
<tr>
<td>Internal Data Trigger Reports</td>
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Who’s on First?

- The home team ‘owns’ the ball
- The other players assist the catcher
- The manager provides the necessary equipment
- The owner rewards the players based on successful pitching, catching and fielding
- The league makes the rules fair and allows the teams to have enough resources to play the game

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Thank You!!!