Reducing Hospital Readmissions: Home Care as the Solution

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Kathy Duckett, Sutter Center for Integrated Care

“Transitions in Care” – The issues

The ACA provisions for Transitions in Care took effect Federal Year 2013

- Provides for penalties to hospitals whose re-hospitalization rates exceed levels as determined by CMS
  - Re-admissions are above national average for AMI, Heart Failure and Pneumonia beginning with discharges on or after Oct. 1, 2012.
  - The penalties are 1%, 2%, and 3% of Medicare payments graduated from 2013 to 2015
  - The penalties are separate from the lost revenue from uncompensated (vacated) days due to re-hospitalizations within 30 days of discharge for the same or similar diagnoses
  - Many hospitals have an exposure
  - CMS has stated that “64% of re-hospitalizations are patients discharged without a post acute referral”
Transitions - the Hospitals’ Issues

Inadequate discharge planning for significant numbers of patients

* Budget constraints – appropriate staffing
  o Inability to identify all “at risk” patients, regardless of “homebound status
  o Appropriate clinical and social service staffing components
  o Protocols
* Late day discharges by physicians without notification
* Lack of a post acute service component to prevent re-hospitalizations with 30 days of discharge
  o Can not provide free care to a patient using hospital employees
  o Violation of the “Stark” laws

Hospital Readmissions
Home Care’s Opportunity

A non-hospital-based agency can provide services to non-homebound patients paid for by the hospital

➢ Who gets a seat at the table?
  • Excellent Home Health Compare and HH-CAHPS scores
  • Avoidance of Adverse Events (drivers of hospitalization)
  • **Low re-hospitalization and ED incidents**
  • Patient transition protocols
  • Service plan design, including technology with the right pricing
Does Your Agency Deserve a Seat at the Table?

Looking at the Data

This is What You’re Competing Against

- Excellent Outcomes
- Low Hospitalization Rates
- Low Emergent Care Usage

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Your Actual</th>
<th>Your Risk Adjusted</th>
<th>SHP Database</th>
<th>Your % Ranking</th>
<th>Your Risk Adj % Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Improvement in Ambulation</td>
<td>PIP</td>
<td>68%</td>
<td>66%</td>
<td>60%</td>
<td>81% (Top 19%)</td>
</tr>
<tr>
<td>2 Improvement in Bed Transferring</td>
<td>PIP</td>
<td>61%</td>
<td>66%</td>
<td>50%</td>
<td>81% (Top 19%)</td>
</tr>
<tr>
<td>3 Improvement in Pain Interfering with Activity</td>
<td>70%</td>
<td>71%</td>
<td>66%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Improvement in Urinary Incontinence (not public)</td>
<td>52%</td>
<td>41%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Improvement in Bathing</td>
<td>PIP</td>
<td>77%</td>
<td>74%</td>
<td>67%</td>
<td>67% (Top 33%)</td>
</tr>
<tr>
<td>6 Improvement in Management of Oral Meds</td>
<td>PIP</td>
<td>59%</td>
<td>61%</td>
<td>50%</td>
<td>85% (Top 17%)</td>
</tr>
<tr>
<td>7 Improvement in Dyspnea</td>
<td>PIP</td>
<td>74%</td>
<td>72%</td>
<td>66%</td>
<td>81% (Top 19%)</td>
</tr>
<tr>
<td>8 Discharged to Community and public</td>
<td>PIP</td>
<td>73%</td>
<td>71%</td>
<td>71%</td>
<td>71% (Top 39%)</td>
</tr>
<tr>
<td>9 Improvement in Status of Surgical Wounds</td>
<td>PIP</td>
<td>94%</td>
<td>100%</td>
<td>69%</td>
<td>98% (Top 1%)</td>
</tr>
<tr>
<td>10 Ambul Care Hospitalization</td>
<td>PIP</td>
<td>21%</td>
<td>21%</td>
<td>25%</td>
<td>69% (Top 31%)</td>
</tr>
<tr>
<td>11 Emergent Care without Hospitalization (not public)</td>
<td>PIP</td>
<td>4%</td>
<td>3.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SHP National Database. Provider: VNA of Cape Cod
This is What You’re Competing Against

New CMS 60-Day Claims-based Hospitalization Metric

Source: SHP National Database. Provider: VNA of Cape Cod
This is What You’re Competing Against

HHCAHPS

<table>
<thead>
<tr>
<th>HHCAHPS</th>
<th>Your Actual</th>
<th>SHP Database</th>
<th>% Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Composite 1: Care of Patients</td>
<td>90%</td>
<td>85%</td>
<td>97% (Top 33%)</td>
</tr>
<tr>
<td>Composite 2: Communications Between Providers and Patients</td>
<td>81%</td>
<td>83%</td>
<td>86% (Top 34%)</td>
</tr>
<tr>
<td>Composite 3: Specific Care Issues</td>
<td>84%</td>
<td>84%</td>
<td>78% (Top 26%)</td>
</tr>
<tr>
<td>Universal 1: % of Patients who Rated Agency 9 or 10</td>
<td>87%</td>
<td>83%</td>
<td>87% (Top 22%)</td>
</tr>
<tr>
<td>Universal 2: % of Patients who would Recommend Agency</td>
<td>80%</td>
<td>79%</td>
<td>89% (Top 11%)</td>
</tr>
</tbody>
</table>

Source: SHP National Database. Provider: VNA of Cape Cod

The Whole Report Card
Hospitals and ACOs Want Data

When Do Your Readmissions Occur?
Emergent Care Tended by Month

### Emergent Care with Hospitalization

<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
<th>Total Patients</th>
<th>You Observed</th>
<th>SHP State (OH)</th>
<th>SHP National</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>194</td>
<td>1,236</td>
<td>15.70%</td>
<td>19.47%</td>
<td>17.01%</td>
</tr>
<tr>
<td>12 Months</td>
<td>2,074</td>
<td>13,109</td>
<td>15.82%</td>
<td>20.47%</td>
<td>17.67%</td>
</tr>
</tbody>
</table>

### Emergent Care without Hospitalization

<table>
<thead>
<tr>
<th>Date</th>
<th>Events</th>
<th>Total Patients</th>
<th>You Observed</th>
<th>SHP State (OH)</th>
<th>SHP National</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2012</td>
<td>59</td>
<td>1,236</td>
<td>4.77%</td>
<td>3.91%</td>
<td>3.77%</td>
</tr>
<tr>
<td>12 Months</td>
<td>543</td>
<td>13,109</td>
<td>4.14%</td>
<td>3.97%</td>
<td>3.82%</td>
</tr>
</tbody>
</table>

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Hospitalization Risk Factors

### Hospitalization Risk Factors (M1032)

<table>
<thead>
<tr>
<th>Risk for Hospitalization: What of the following signs or symptoms characterize the patient as at risk for hospitalization? (Mark all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Reduced food intake or need for tube feeding (5 or more in the past 30 days)</td>
</tr>
<tr>
<td>- Multiple hospitalizations (2 or more in the past 30 months)</td>
</tr>
<tr>
<td>- History of falls (2 or more in the past year)</td>
</tr>
<tr>
<td>- Incontinence of bowel or urine</td>
</tr>
<tr>
<td>- Fever of 38.5°C or above (or any fall within 8 days)</td>
</tr>
</tbody>
</table>
| - Frailty, weakness, other

### OASIS C to OASIS C1 Side-by-Side Comparison

(M1032) Risk for Hospitalization: What of the following signs or symptoms characterize the patient as at risk for hospitalization? (Mark all that apply)
Improving Interventions that Keep High Risk Patients from Readmitting

### Hospitalizations by Primary DX – 4/13 to 5/13

*Visiting Nurse Association of Cape Cod, Inc.*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Cases</th>
<th>Count</th>
<th>%</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infectious/Parasitic</td>
<td>83</td>
<td>22</td>
<td>26.51%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neoplasms</td>
<td>435</td>
<td>105</td>
<td>37.83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine/Nutrit/Immune (not Diabetes)</td>
<td>62</td>
<td>13</td>
<td>20.97%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>347</td>
<td>82</td>
<td>23.63%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood/Blood-Forming Organs</td>
<td>76</td>
<td>26</td>
<td>34.21%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>254</td>
<td>51</td>
<td>20.98%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>288</td>
<td>66</td>
<td>19.44%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulatory (not CHF or CVA)</td>
<td>764</td>
<td>164</td>
<td>21.47%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>251</td>
<td>46</td>
<td>16.69%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHF</td>
<td>542</td>
<td>180</td>
<td>32.03%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVA</td>
<td>240</td>
<td>43</td>
<td>17.32%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory (not COPD)</td>
<td>355</td>
<td>67</td>
<td>20.06%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>480</td>
<td>131</td>
<td>26.84%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Digestive</td>
<td>483</td>
<td>159</td>
<td>20.76%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Hospitalizations by Primary DX – 4/13 to 5/13 (Continued)
Visiting Nurse Association of Cape Cod, Inc.

<table>
<thead>
<tr>
<th>Category</th>
<th>Cases</th>
<th>Count</th>
<th>% with Visits</th>
<th>% with Home Visits</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric/Orthopedic</td>
<td>233</td>
<td>92</td>
<td>26.61%</td>
<td>31.31%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy/Childbirth/Disruptum</td>
<td>n</td>
<td>n</td>
<td>0.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue</td>
<td>244</td>
<td>44</td>
<td>18.03%</td>
<td>25.40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td>258</td>
<td>79</td>
<td>30.62%</td>
<td>37.34%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic</td>
<td>909</td>
<td>105</td>
<td>11.55%</td>
<td>14.12%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital Anomalies</td>
<td>3</td>
<td>0</td>
<td>0.00%</td>
<td>23.43%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms/Signs/Il Defined</td>
<td>266</td>
<td>73</td>
<td>27.44%</td>
<td>25.59%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury/Poisoning</td>
<td>1,254</td>
<td>184</td>
<td>14.57%</td>
<td>20.22%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V Codes (not Therapy or Aftercare)</td>
<td>243</td>
<td>48</td>
<td>19.75%</td>
<td>20.32%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aftercare</td>
<td>1,538</td>
<td>206</td>
<td>13.39%</td>
<td>16.40%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy/Rehab</td>
<td>484</td>
<td>63</td>
<td>10.88%</td>
<td>10.13%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>24.20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>10,080</td>
<td>2,039</td>
<td></td>
<td></td>
<td>0%</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
</tr>
</tbody>
</table>

*Note: Hospitalization can be in more than one DX category.*

---

### Emergent Care by Reason – 4/13 to 5/13
Visiting Nurse Association of Cape Cod, Inc.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>% with Visits</th>
<th>% with Home Visits</th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improper medication administration, side effects, toxicity, allergic reaction</td>
<td>39</td>
<td>0.17%</td>
<td>0.17%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iatrogenic injury</td>
<td>104</td>
<td>0.02%</td>
<td>0.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute respiratory failure, pneumonia, sepsis</td>
<td>206</td>
<td>0.18%</td>
<td>0.18%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other respiratory problem</td>
<td>252</td>
<td>0.34%</td>
<td>0.34%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart failure (e.g., heart attack)</td>
<td>177</td>
<td>0.20%</td>
<td>0.20%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac dysrhythmia (myocardial infarction)</td>
<td>69</td>
<td>0.11%</td>
<td>0.11%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction or chest pain</td>
<td>78</td>
<td>0.07%</td>
<td>0.07%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other heart disease</td>
<td>36</td>
<td>0.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke (CVA) or TIA</td>
<td>58</td>
<td>0.07%</td>
<td>0.07%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyper/hypotension, diabetes out of control</td>
<td>65</td>
<td>0.02%</td>
<td>0.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia, obstructive, aspiration, dysphagia</td>
<td>118</td>
<td>0.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demyelination, edema</td>
<td>116</td>
<td>0.01%</td>
<td>0.01%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>116</td>
<td>0.02%</td>
<td>0.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinary tract infection or complication</td>
<td>5</td>
<td>0.01%</td>
<td>0.01%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal failure or dehydration</td>
<td>414</td>
<td>0.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulceration, perforation</td>
<td>412</td>
<td>0.02%</td>
<td>0.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute mental/behavioral health problems</td>
<td>97</td>
<td>0.02%</td>
<td>0.02%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep vein thrombosis, pulmonary embolus</td>
<td>204</td>
<td>0.04%</td>
<td>0.04%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other than above reasons</td>
<td>248</td>
<td>0.09%</td>
<td>0.09%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poison inhalation</td>
<td>64</td>
<td>0.00%</td>
<td>0.00%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Eligible Cases (Denominator): 15,607
Do You Deserve a seat at the table?

Source: SHP National Database.
Competing for the Business Using Data

* Beat the scores of competitors in your area
* Focus on three metrics
  ➢ Former CMS hospitalization rate
  ➢ Current CMS hospitalization rate
  ➢ Readmits within 30 days
* Package data and share it
* Include physicians: show them data, not doughnuts

Transitions in Care Service Program
**Transitions in Care - Service Program**

- *Pure* transitions patients – not Medicare eligible
  - May not be homebound
  - May not have Medicare benefits
  - May not meet Medicare qualifying criteria
  - Always validate the criteria before enrollment!
- Create a separate “transitions” service/program within your organization
- Agency patient/client – **not** in certified home care program.

**Written Contract**

- Must have a written agreement with hospital or Accountable Care Organization (ACO)
- Include written purpose and scope of transitions program
- Specific responsibilities of both the hospital or ACO and the agency
- Responsible parties – Who will you communicate with?
  - Contact information
  - Required hours of availability
  - Agreed upon payment rates
    - Include rates for all functions with inclusion of differentials and mileage (if indicted)
Written Contract

• Basic requirements of participation in the transitions program
  ➢ Physician participation and buy-in
    ▪ MD orders **required**
  ➢ Clients must be **willing** and **able** to participate
  ➢ Specify inclusion of Tele-monitoring or Telephone contact
  ➢ Frequency and type of contact – focus of care is “contact” **not** in-home visit
    ▪ Specify (few) circumstances that may require in-home visit
    ▪ Patient/client education materials/teaching/follow-up
• Agreement must specify that the program is for a minimum patient service period of 35 days from hospital discharge at no charge to the patient

Transitions in Care Service Program

* Identify patient enrollment exclusions:
  ➢ Strong history of non-compliance with meds, diet and physician appointments
  ➢ Evidence of unsafe/inadequate home environment – patient not safe at home

• Attending physician must agree to manage the patient care with **shared goals:**
  ➢ To maintain and improve patients health
  ➢ To prevent unnecessary re-hospitalizations and emergency room visits
  ➢ To provide patient education and support/mentoring regarding symptom and medication management
  ➢ To promote compliance with appropriate disease management principles
  ➢ Teach self care and independence to patients and families/caregivers
Remote Monitoring

• Tele-monitoring
  ➢ Monitor vital signs via tele-monitoring system
  ➢ Must have vital sign parameters for use of protocols and MD notification;
    ▪ Vital sign alerts
    ▪ Signs or symptoms indicating a potential problem
  ➢ Establish routine telephone contact with patient and attending physician
    ▪ Follow-up visit(s) not anticipated unless specifically ordered by attending physician and included in written contract

Telephony

• Establish routine telephone contact with patient/client
  ➢ Establish appropriate frequency for contacts
  ➢ Often daily calls
  ➢ Set goals for each call
  ➢ May include teaching patient to take, record and report vital signs daily
  ➢ Identification of other signs or symptoms indicating a potential problem
  ➢ Review medications, response and potential side effects

• Follow-up visit(s) not anticipated unless specifically ordered by attending physician and included in written contract
Referral Information

- Must include **complete** referral information;
  - Patient name
  - Address
  - Telephone and emergency contact
  - Hospital diagnoses
  - History and physical
  - Signed patient consent and willingness to participate
  - Responsible physician and transition services agreement (participation in transitions program)

Nursing Assessment Visit

- Non-OASIS clinical assessment RN visit
  - Complete necessary intake and clinical assessment information to manage (and monitor) the patient
  - Identify social service needs and safety issues that may require a PT, OT or Social Work evaluation
  - Reconcile Medications
  - Verify current medication orders
  - Schedule a physician follow-up appointment if not already scheduled
  - Verify vital sign parameters and when to notify physician
  - Review disease management education with patient/client
  - Reaffirm willingness of patient/client to participate in program
Home Care Programs to Reduce Rehospitalization

Kathy Duckett RN
Director of Training and Development
Sutter Center for Integrated Care
ducketk@sutterhealth.org

Facts About Who Sutter Serves

Sutter Care at Home

- 7 Service Lines
- 22 Locations
- 1,443 Employees
- 771 Volunteer
- 17,000 Average Daily Census

Sutter Center for Integrated Care

- 4500 Providers
- 46 States
- 1 Canadian Province
Living In Two Worlds At The Same Time

Fee for Service Value Based Population Reimbursement

Integrated Care Management: What is “It”?

1) A care delivery model
2) Based on Wagner’s Care Model (aka Chronic Care Model)
3) All patients across continuum
4) Defines key best practices and competencies for all providers

Bottom Line:
Defines care delivery redesign to achieve better health, better care, lower costs for today and for the future.
What is Different about ICM versus "Usual" Care?

- **Person Centered**
  - Dignity & Respect
  - Goals Drive Care
  - Member of the Team

- **Evidence Based**
  - Clinical Engagement
  - Self Mgmt. Support
  - Behavior Change

- **Coordinated**
  - Time/Settings/Providers
  - Meaningful & timely info exchange

Better Health, Better Care, Lower Cost

---

Coordinated Care Delivery: Two Models

* Sutter’s Community Based Transitions Model™

* Partners Healthcare at Home Connected Cardiac Care telemonitoring program
Alignment with the 7 Foundations For Safe Transitions

1. Patient/family action/engagement
2. Early identification for “at risk” patients
3. Transitions planning
4. Medication management
5. Multidisciplinary collaboration
6. Transfer of information
7. Leadership support

Source: HOT TOPICS IN HEALTHCARE, ISSUE #2, Transitions of Care: The need for collaboration across the healthcare continuum. The Joint Commission, February, 2013

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CMS Community-Based Care Transitions Program

**What will participation require?**
CBOs will be required to provide care transition services across the continuum of care, which may include at least one of the following:

- Care transition services that begin no later than 24 hours prior to discharge;
- Timely and culturally and linguistically competent post-discharge education to patients so they understand potential additional health problems or a deteriorating condition;
- Timely interactions between patients and post-acute and outpatient providers;
- Patient-centered self-management support and information specific to the beneficiary’s condition; and,
- A comprehensive medication review and management, including—if appropriate—counseling and self-management support.
Home Care's Unique Role in Transitions

- Comprehensive assessments including risk assessments
- Focus on medication reconciliation, signs & symptoms, MD Follow-up appointments
- Case management & care coordination
- ICM Training: Skills for effective health coaching in self management support & evidence-based guideline care

Community Based Care Transitions (CBTM)™ Objectives

- Expand the role of home health professionals
- Provide transition of care services in the hospital and home settings
- Restructure in-home care processes to optimally support transitioning patients
- Provide systematic approach for care of home health high-risk patients discharged from the hospital
**CBTM™**

How Is This Model Different?

* Care transition support begins in the hospital and continues in the home by same healthcare sector – home health

_The fewer the transitions the less the risk_

* No – one size fits all
* Patients have fewer layers of care providers
* Clinicians are trained to identify patients’ common barriers for self-care
* Clinicians provide care based on patient goals and aspirations

---

Community-Based Transition Model™ (CBTM)

- **Home Health in-Hospital Liaison**
  - Conducts assessment of risk
  - Functions as health coach
  - Informs high risk protocol
  - Ensures identification of care goals

- **Meaningful Data Exchange To Bridge Phases From Hospital To Home**

- **Home Care Delivery Re-Designed**
  - Home visit within 24 hours of hosp. d/o
  - First visit focus on care transition interventions
  - OASIS completed at second “next day” visit
  - Remote monitor deployed
  - Comprehensive assessment of barriers
  - Collaborative goal setting
**CBTM™: Practices within the Hospital**

- Hospital Case Coordinators screen all patients & identify “high risk”
- All high risk patients appropriate for home health seen by “home health coach”
- “Health coach”
  - determines homecare/hospice eligibility & which program may best meet patient needs
  - Schedules Home Care case manager & reserves telemonitoring equipment
  - initiates SCAH high risk transition protocol
  - Provides/instructs in red flag emergency plan
    - Patient activated learning and teach-back on symptoms to report and whom to report to
  - initiates meaningful data exchange

---

**CBTM™: Practices in the Home**

Key interventions in the home:
- First visit is initiation visit within 24 hrs d/c hospital
  - Follow up visit next day to complete SOC OASIS – same clinician
- Timely follow-up (in the home and with the PCP)
- Stoplight action plans – red flags teaching
- Medication Reconciliation
  - High risk medication teaching
  - Medication safe administration
- Initiation of personal health record
- Coordination with MDs / SBAR communication
- Presented in case conference
- Theory-based remote monitoring
SCAH
ICM Results to Date

30-Day Hospital Readmissions (Heart Failure)

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Santa Rosa HH - All</th>
<th>May 2011 - Feb 2012 Baseline</th>
<th>2012 all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 2012 (n=7)</td>
<td>33.3%</td>
<td>33.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Q3 2012 (n=12)</td>
<td>15.3%</td>
<td>15.3%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Q4 2012 (n=11)</td>
<td>13.9%</td>
<td>13.9%</td>
<td>13.9%</td>
</tr>
<tr>
<td>Q1 2013 (to date) (n=8)</td>
<td>10.8%</td>
<td>10.8%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

Care Transition Programs Utilizing ICM as Foundational Model

Results: Reduction in re-hospitalization rates for HF patients from 20% to 6% in one year

Results: Reduction in re-hospitalization rates for HF patients from 16% to 7.3%
Key Lesson Learned: Leadership Matters

1. Use “evidence-based leadership” principles (Kotter/ Studer) for transformational change.
2. Use behavior change techniques (e.g. motivational interviewing) to facilitate clinician behavior change.
3. Understand that behavior change takes time.
4. Make the right thing to do the easy thing to do- hardwire to promote consistent high quality care.

Value to Stakeholders Across the Healthcare Continuum

1. Innovative care delivery model for ALL home health patients
2. Practices/competencies for partnering
   a. Care Transitions Coach
   b. Proactive Practice Team (PCMH) and CPCI initiatives
   c. Post acute partner for payment reform initiatives: MSPB, Bundled Payments, CBTM, ACOs
3. Systems approach to health care delivery reform
The Role Of Telemonitoring

* Effective in decreasing unnecessary rehospitalizations/ED visits
  * VA, PHH, Pinnacle, VNA Care Watch, Jewish Home Life, Vidant Health care etc
* Commonality – successful PROGRAMS

Partners Health Care at Home: Connected Cardiac Care Program (CCCP)

* Partners Healthcare System (PHS) sponsored program
* Utilization of Partners Healthcare at Home (PHH) telemonitoring program for high risk heart failure patients
* Aimed at reducing readmissions at Partners Healthcare System hospitals
* Administered in partnership with the Center for Connected Health during pilot and development phases
* Now fully integrated into PHH.
CCCP Essentials

* 4 month home Telemonitoring of heart failure patients by PHH Telemonitoring Nurse.
* Interventions by Telemonitoring nurse based on physician orders.
* Regular clinical reports as directed by Referring Physician.
* No cost to patient.
* Strong educational component
  * 1 Nurse visit to establish clinical status and knowledge deficits, medication reconciliation, then no further nursing
  * Bi-weekly telephonic educational phone calls
  * Encourage direct patient/PCP relationship

Partners Healthcare at Home:
2 Case Studies

<table>
<thead>
<tr>
<th>Heart failure and shock</th>
<th>Location</th>
<th>30-day Hf Readmit %</th>
<th># of IPPS claims</th>
<th>ALOS</th>
<th>Average Payment</th>
<th>Average Cost</th>
<th>Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Massachusetts General Hosp</td>
<td>23.7%</td>
<td>375</td>
<td>6.30</td>
<td>$10,114</td>
<td>$12,277</td>
<td>$7,095,972</td>
</tr>
<tr>
<td></td>
<td>Newton/Tufts</td>
<td>26.9%</td>
<td>15</td>
<td>3.53</td>
<td>$5,772</td>
<td>$8,784</td>
<td>$351,829</td>
</tr>
<tr>
<td></td>
<td>Newton Wellesley</td>
<td>23.8%</td>
<td>176</td>
<td>3.90</td>
<td>$7,042</td>
<td>$8,654</td>
<td>$2,986,599</td>
</tr>
<tr>
<td></td>
<td>Brigham &amp; Women's Hosp</td>
<td>22.7% 3</td>
<td>488</td>
<td>5.76</td>
<td>$9,744</td>
<td>$13,028</td>
<td>$5,706,264</td>
</tr>
<tr>
<td></td>
<td>Faulkner</td>
<td>27.0%</td>
<td>170</td>
<td>4.75</td>
<td>$6,895</td>
<td>$9,408</td>
<td>$1,599,360</td>
</tr>
<tr>
<td></td>
<td>Martha's Vineyard</td>
<td>22.2%</td>
<td>52</td>
<td>3.46</td>
<td>$8,562</td>
<td>$9,873</td>
<td>$513,292</td>
</tr>
<tr>
<td></td>
<td>Subtotal</td>
<td>34.5%</td>
<td>1,526</td>
<td>4.62</td>
<td>$8,018</td>
<td>$10,997</td>
<td>$17,433,215</td>
</tr>
</tbody>
</table>

* Mr. I – HC &TM
  * Prior to program: 3hosp/4mos
  * HC &TM – 117 days
  * Cost Savings: $26,500

* Mrs. G - CCCP
  * Prior to program: 5hosp/5 mos
  * In program 7 months with 0 rehospitalization
  * Cost savings: $52,725
Visit Pricing to be developed:
1. Skilled Nursing – evaluation and follow up
2. Occupational Therapy
3. Social Work
4. Telehealth
Price Point Development

Pricing Considerations
1. Based on full cost including allocated overhead?
2. Default to managed care visit prices? Do they constitute the pricing floor?
3. Visit costs per your Medicare cost report Worksheet C Part I?
4. Is a specific cost finding more appropriate?

Price Point Development

Calculation of cost of an evaluation and follow up nursing visit:
Direct cost per RN visit averages $68.37 per visit overall.
Total visits were 8157. Total direct costs were $557,723.
Here is how to isolate the cost per type of RN visit:

<table>
<thead>
<tr>
<th>Type</th>
<th>Visits</th>
<th>Ind. Visit Weight</th>
<th>Total Visit Weight</th>
<th>Ind. Visit Cost</th>
<th>Total Visit Cost</th>
<th>Direct Cost</th>
<th>Cost Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>783</td>
<td>1.90</td>
<td>1,487.70</td>
<td>$90,913</td>
<td>$116.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharges</td>
<td>500</td>
<td>1.25</td>
<td>625.00</td>
<td>38,194</td>
<td>76.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recerts</td>
<td>404</td>
<td>1.25</td>
<td>505.00</td>
<td>30,861</td>
<td>76.39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resumption</td>
<td>131</td>
<td>1.30</td>
<td>170.30</td>
<td>10,407</td>
<td>79.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow up</td>
<td>6,339</td>
<td>1.00</td>
<td>6,339.00</td>
<td>387,348</td>
<td>61.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$557,723</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation</td>
<td>1.60</td>
<td></td>
<td>9,127.00</td>
<td>97.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td>0.25</td>
<td></td>
<td></td>
<td>15.28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using 20% mark-up of the direct cost per visit to a 20% contribution margin for overhead, the visit prices would be:
- Evaluation: $117.34 up to $118.00
- Follow-up: $73.33 up to $74.00
- Telephone Visit: $18.34 up to $18.50
What cost do you use for pricing an RN visit?

Medicare cost report: Total Cost $ 162.66

Specific visit cost finding:

Initial $ 118.00
Follow up $ 74.00
Telephone Follow-up $ 18.50

Largest managed care contract rate: $ 100.00

Calculation of cost of an evaluation and follow up OT visit:

Direct cost per OT visit averages $92.64 per visit overall.
Total visits were 889. Total direct costs were $83,287.

Here is how to isolate the cost per type of RN visit:

<table>
<thead>
<tr>
<th>Type</th>
<th>Visits</th>
<th>Ind. Weight</th>
<th>Total Visit Weight</th>
<th>Ind. Visit Cost</th>
<th>Total Visit Cost</th>
<th>Direct Cost</th>
<th>Cost Per Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluations</td>
<td>201</td>
<td>1.60</td>
<td>321.60</td>
<td>$ 26,532</td>
<td>$132.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow up</td>
<td>688</td>
<td>1.00</td>
<td>688.00</td>
<td>82.50*</td>
<td>56,755</td>
<td>$ 82.50</td>
<td>$ 83,287</td>
</tr>
<tr>
<td></td>
<td>889</td>
<td>1,009.60</td>
<td>1,009.60</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using 20% mark-up of the direct cost per visit to a 20% contribution margin for overhead, the visit prices would be:

Evaluation $ 154.80 up to $155.00
Follow-up $ 99.00 up to $ 74.00
Price Point Development

* Calculation of Cost for a Social Work Visit:
  * Social Worker costs from the cost report are generally greatly distorted due to fewer actual visits being made--- much, if not most, of the cost reflects non-visit indirect time.
  * Need to do a cost finding on actual cost per visit:
    * Agency separated it’s direct visit cost and indirect Social Worker cost!
    * Total direct costs were $2,047 and the Visits were 32.
    * As a result, direct costs were $39.37 per visit.
    * Using 20% mark-up of the direct cost per visit to a 20% contribution margin for overhead, the visit prices would be $47.24 rounded up to $48.00.

Price Point Development

The actual costs for Telehealth monitoring are:
The annual equipment depreciation and communication fees were for 62 monitors @ $77 per month would be $57,288.
Costs of a RN to perform Central Station functions, including telephone contacts with patients and the Primary Care Case Manager RNs in the field were $7,525.
Costs of staff to clean-up and prepare equipment for new installation were $2,508.
Based upon total costs of $67,321 divided by average number of monitors on hand, we have an annual cost of $1085.82 per monitor or $2.9748 per calendar day.
Applying 120% of direct cost formula to account for overhead, we arrive at a daily charge of $3.57 rounding up to $3.60 per day.
Price Point Development

Recap of per visit charges:

<table>
<thead>
<tr>
<th>Service</th>
<th>Evaluation</th>
<th>Follow-up</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>$118.00</td>
<td>$74.00</td>
<td>$18.50</td>
</tr>
<tr>
<td>OT</td>
<td>$155.00</td>
<td>$74.00</td>
<td></td>
</tr>
<tr>
<td>MSW</td>
<td></td>
<td>$48.00</td>
<td></td>
</tr>
<tr>
<td>Telemonitoring- per day</td>
<td></td>
<td></td>
<td>$3.60</td>
</tr>
</tbody>
</table>

Cost / Benefit to the Hospital

Variation and costs of services for 35 days:

<table>
<thead>
<tr>
<th>Patient Variation</th>
<th>RN Assessment</th>
<th>RN Follow-up Calls</th>
<th>Social Service Visit</th>
<th>OT Evaluation</th>
<th>Tele-health Monitoring</th>
<th>Total Cost Per patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Only</td>
<td>$118</td>
<td>$74</td>
<td></td>
<td></td>
<td></td>
<td>$192</td>
</tr>
<tr>
<td>Monitoring</td>
<td>$118</td>
<td>$74</td>
<td></td>
<td>(35) $126</td>
<td></td>
<td>$387</td>
</tr>
<tr>
<td>OT</td>
<td>$118</td>
<td>$74</td>
<td>$155</td>
<td>(35) $126</td>
<td></td>
<td>$473</td>
</tr>
<tr>
<td>Soc. Work</td>
<td>$118</td>
<td>$74</td>
<td>$48</td>
<td>$155</td>
<td>(35) $126</td>
<td>$521</td>
</tr>
</tbody>
</table>
Cost / benefit to the hospital

* Large 500 bed teaching hospital in the Philadelphia metropolitan area
  * Total of 4,627 Medicare Fee for Service discharges in fiscal year 2011
  * 1,074 (23.21%) discharged patients referred to Homecare
  * 1,079 (23.32%) discharged patients referred to other post acute settings
  * 162 (3.50%) discharged patients expired
  * 2,312 (49.97%) discharged patients not referred to any post acute settings
  * Hospital does not track its re-admission data!
  * Hospital's variable cost per Bed Day is $1,130 and likely a $1,950 total cost
  * Hospital's variable cost of an Emergency Room visit is $124.30 and likely a total cost of $214.31
  * Hospital's re-admission rate on Hospital Compare is above the national average for all reported measured diagnoses!
  * Hospital's H-CAHP scores are all below national averages!

Cost / benefit to the hospital

* The Hospital's 2011 Medicare revenue was $101,000,000.
* If this was 2013, the Hospital's 1% penalty risk is $1,010,000
* The Vacated Days and ER visits are estimated:
  * Assuming an average of 3 re-hospitalized days for each patient and a 50% patient usage of an emergency room visit (actual data unknown)
  * Estimated variable cost:
    2,312 patients discharged x 23.07% readmission rate =
    533 patients x 10 re-hospitalized days = 2,665 days
    @ $1,130 = $3,011,450
    50% of 2,312 patient admitted through ER @ 124.30 = $143,691
    $3,155,141
Cost / Benefit to the Hospital

- Assumed cost of Vacated Days and ER Visit Costs $3,155,141
- Cost of Services – 2,312 patients
  - 30% RN only: 694 @ $192 = $133,248
  - 25% RN & Monitoring: 578 @ $387 = 223,866
  - 20% RN, Monitoring and OT: 462 @ $473 = 218,526
  - 25% RN, Monitoring OT & SS: 578 @ $521 = 301,138
- Net Savings to Hospital $2,278,363

Hospital Readmission Study
Within the 30-Day DRG Period

Suburban-rural 109 bed Regional Medical Center in the Minneapolis Metro area
- 179 Readmits (single and multiple) of Medicare Patients within the DRG Period resulted in 621 inpatient days for FY 2012
- 12.35% re-admission rate (2,890 Medicare discharges)
- 3.47 average days per readmitted patient!
- 82% (147) admitted through the Emergency Department
- Loss of $1,543,185 @ $2,485 per Bed Day Cost
- Loss of $28,077 @ $191 per Bed Day Cost
- Only 37 of the Readmitted Patients were referred to Home Care and 3 were referred to Hospice
- Tele-health was not available at the Hospital-based Home Health Agency
Hospital Readmission Study Within the 30-Day DRG Period

External Review of Readmission DRGs
* 139 Readmitted Patients (77.65%) should not have been referred to Home Care or Hospice
* Could have been eligible for a “Transitions in Care” program
* Potential savings of a significant portion of the $1,571,262 in vacated days cost!

Large Regional Medical Center in a Western State
* 680 Readmits (single and multiple) of Medicare Patients within the DRG Period resulted in 8,214 inpatient days for FY 2003
* 23.53% re-admission rate (2,890 Medicare discharges)!
* 12.08 average days per readmitted patient!
* Loss of $15,072,700 @ $1,835 per Bed Day Cost
  * Not including ER or any other Department Costs
* Only 80 of the Readmitted Patients had ever been Referred to Home Care
* Tele-health was not available at the Hospital-based Home Health Agency
Hospital Readmission Study Within the 30-Day DRG Period

External Review of Readmission DRGs
- 231 Readmitted Patients (34%) should have been in Home Care
- Only 34 of the Readmitted patient were referred to home care
- Potential Savings to Hospital of 2,752 days (33.50%) @ $1,835 = $5,049,900
- Additional Revenue to Home Care Agency = $482,650
  - Estimated 197 Episodes @ $2,450

Hospital Readmission Study Within the 30-Day DRG Period

External Review of Readmission DRGs
- 449 Readmitted Patients (66%) should not have been referred to Home Care
- Could have been eligible for a “Transitions in Care” program
- Potential savings of a significant portion of the $10,022,800 in vacated days cost!
Financial Management Conference
July 30, 2013

Reducing Hospital Readmissions:
Home Care as the Solution

Pat Laff & Lynda Laff, Laff Associates
Barbara Rosenblum, Strategic Healthcare Programs
Kathy Duckett, Sutter Center for Integrated Care