Home Care’s Pivotal Role in Patient Transitions from Acute to Post Acute Care Settings:

Experiences of a Successful CCTP Program… And So Much More!

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A diversified provider of healthcare services

Tenet Healthcare
• MetroWest HomeCare & Hospice
  Touching lives... every day

  - Home Care, Hospice, Private Care and Transitions in Care / CCTP
    - Serving 67 communities in Metro Boston and Central MA
  - Home Care Elite
  - Average daily census is 470
  - Annual Revenue $13 million
  - Incorporated 1932
    - Rich history in the community
  - Affiliated with local Tenet healthcare system
    - 3 Hospitals
    - Physician Practices

Scope of Post Acute in a Patient’s Life
Post Acute Value Proposition

Triple Aim
Health system success will be defined by those that achieve The Triple Aim

A Post Acute Network can:
- Improve the patient experience of care
- Improve the health of populations
- Reduce the per capita cost of care

And...Enhance patient loyalty to your affiliated hospitals and markets

Example:
Comparing average payments across first post acute settings, it is clear that home health is the most cost-effective. For example, the average first setting Medicare payments for MS-DRG 470 (major joint replacement) are:

- Home Health $3,267
- Skilled Nursing Facility $8,981
- Rehab Facility $13,073
- LTACH $27,399

Population Growth and Utilization of Home Health

Population of age 65 and older to more than **double** between 2012 and 2065, from 43 mil to 92 mil. **

Home Health spending increased **5.1%** in 2012 to **$77.8 billion** (all payers).***

Approximately **45%** of Tenet Medicare patients are discharged from the hospital to home with no **services**.

Additional opportunity exists within our **growing OSD** to provide post procedure care in the home via Home Health.

**Source:** US Census Bureau  
***Source:** cms.gov/research- statistics-data
Hospitals and Health Systems Incentive to Partner with Home Health

CMS Readmission Penalties

The new healthcare reform law allows CMS to withhold a percentage of inpatient Medicare payments. These percentages will be calculated on a hospital’s aggregate Medicare payments for all discharges, not just heart failure, acute myocardial infarction, and pneumonia patients. The impact is as follows:

- Up to 1% in FFY 2013
- Up to 2% in FFY 2014
- Up to 3% in FFY 2015 and thereafter


FY 2015 - HF, MI, PN, plus THR, TKR, COPD
More than 2200 hospitals in 49 states are hitting the penalty

The Shift from Fee-for-Service to Value Base Purchasing - VBP

Medicare Spending Per Beneficiary (MSPB)

A measure in the Efficiency Domain

Claims-based measure that include risk-adjusted and price-standardized payments for all Part A and Part B services provided from 3 days prior to a hospital admission (index admission) through 30 days after the hospital discharge

41% of all spending that comprises the MSPB measure is accumulated outside of the inpatient hospitalization

Clinical integration and care coordination is vital!
Why is MSPB Important?

ACO Alignment

Goals:

- Supporting clinically integrated provider organizations that beneficiaries choose to manage their health and health care
- Bending the cost curve
- Improved access, patient safety, experience of care

Tom Cassels, ED of The Advisory Board

“The acid test for me is not whether the ACO program survives.”
Bundled Payment for Care Improvement (BPCI)

CMS Innovation Center
- Financial and performance accountability for episodes of care higher quality, more coordinated care at a lower cost

4 Models
- Model 1: Retrospective Acute Care Hospital Stay Only
- Model 2: Retrospective Acute Care Hospital Stay plus Post Acute Care
- Model 3: Retrospective Post Acute Care Only
- Model 4: Acute Care Hospital Stay Only

Participants enroll for diagnoses of their choosing; 48 eligible clinical conditions

Innovation

Readmission Reduction
ACO Alignment
BPCI Integration
Innovative Specialty Programs
Technology Solutions
CMS Community-based Care Transitions program (CCTP)
Transition Care Coaches
Telephonic Care Post Acute Care DC
Palliative Care
Leaders in market Transitions in Care and Community Collaborative Meetings
Transition in Care Timeline

- Telephonic Care
- Community Partners Collaborative
- Transition Care Coach
- Palliative Care
- CCTP

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CCTP Community-Based Organizations

102 Approved / 83 Active

Source: Centers for Medicare & Medicaid Services
Partner Organizations

MetroWest HomeCare & Hospice  UMass Memorial Medical Center
St. Vincent Hospital  Health Alliance Hospital
MetroWest Medical Center  Marlborough Hospital
Leonard Morse  Wing Hospital
Framingham Union  Clinton Hospital

Area Agencies on Aging
- Bay Path Elder Services
- Elder Services of Worcester

Lessons learned in CCTP
- Putting the patient first; adhering to the triple aim
- Many partners could work together successfully, a home health agency, 2 competing health care systems, 2 lead ASAPS, skilled nursing facilities, ACO, and physician group practices
- Collaboration, mutual respect, and sharing create a collegial environment
- Quarterly meetings with our CCTP leaders
- Weekly calls led by the Home Health Agency to coordinate care of CCTP patients
CCTP Program Components

- Transition Care Coach
- Telephonic Care
- Palliative Care
- Transitions in Care Pharmacy Intervention
- Care Transition Intervention®
- Care Transition Intervention® plus

Transition Care Coaches (TCC)

Higher-risk model
Target patient population – HF, AMI, pneumonia, COPD
TCC RN meets with patients bedside
- Develop coaching relationship
- Assessment of post discharge needs
- Extensive teaching utilizing Teach-back and standardized teaching tools
- Scale, 24/7 Med Planner, Personal Journal, HF Advanced Management Guide

Calls/visits on day 1 at home then 2x per week for 30 days
Telephonic Care

Post hospitalization telephonic care system – lower risk patients

Partner with calling center – days 1, 5, 14, and 30

Target patient population – HF, MI and PN and any Medicare patient

Standardized electronic scripts based upon evidenced-based research

Assessing for gaps in care
- Lack of meds and/or equipment
- No PCP visit scheduled
- Unrecognized symptomatology
- Knowledge gap - Diet

Palliative Care

Goal is an emerging cultural shift regarding approaches to chronic illnesses and end of life care

Offer options

To begin modeling ‘the difficult conversation’

Inpatient, bedside consults by CHPC clinicians
CTI Model

- Transfer skills to a patient
- Help patient become more in control of their own health and medical conditions
- Focus on patient’s goal and center changes in behavior around that goal
- 4 pillars: Personal Health Record, Follow-Up Physician Appointment, Symptom Warning Signs, Medication Discrepancies

CTI Plus

Coach identifies need for Support Service

Examples:
- Transportation to physician appointment
- Someone to pick up medications
- Heavy chore to do temporary heavy lifting
- Someone to get groceries
- Case manager to help with applications or referrals
Our Tools Include

Success!

CMS recognized our project as one of the **top performing** projects across the 102 nation-wide approved sites.

Top Performers in:

- Reaching our Enrollment Target
- Reduced Readmission by **50%** for patients receiving a CCTP Intervention
- Reduced All-Cause Medicare Readmissions by **7.7%**
Results (June 2012- April 2014)

• Population Size = 7087 patients
• Baseline readmission rate for target high risk population = 31%
• Reduced readmission rates by 50% for patients receiving a Transition Intervention
• Readmission rate for patients who have received CCTP = 14.5

Re-Admission Rate by Intervention (June 2012 – April 2014)

Transition Care Coach
Palliative Care
Telephonic Care
Coleman Coach
Overall re-admission with Coleman

Community Collaboratives

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<tr>
<th>Purpose</th>
<th>Process</th>
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<tr>
<td>Decrease readmissions</td>
<td>Invite Post Acute Providers to the table to create partnerships and provider networks around patient care</td>
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<td>Maximize patient loyalty to our health care systems</td>
<td>• Identify barriers to successful transitions</td>
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<td>Enhance patient experience</td>
<td>• Share perspectives regarding challenges</td>
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<td>• Provide educational opportunities</td>
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<td>• Provide targeted resources</td>
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<td>• Develop cross-continuum protocols</td>
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<td>• Innovation/Program Development</td>
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Membership

Skilled Nursing Facilities – Med Dir, DON, Administrator, Clinical Liaisons
Home Care – Exec Dir, Clinical Director, Medical Director
Hospice – Exec Dir, Clinical Director, Medical Director
Transition Care Coaches, Coleman Coaches
Palliative Care Clinicians
LTACs - Med Dir, DON, Administrator, Clinical Liaisons
Rehabs - Med Dir, DON, Administrator, Clinician
Elder Service Agencies (Area Agencies on Aging) – Admin, Clinical Liaison
Quality Improvement Organization (QIO)
ACO/PCP Offices – Admin, CMO, Complex Care Managers
Hospital Leadership – CMO, CNO, DCQM
Hospital Case Management/ Social Work
Emergency Department – Med Dir and Clinical Director
Hospitalists / SNFists
Patients/ Family Members
Dialysis Centers
EMS Partners

Quarterly Meeting Sample Agenda Items

- Review of Quality Metrics / Report Card
- INTERACT III
- Treat in Place Protocols
  - IV Lasix, lab draw, x-ray availability and timeframe, physician cross-coverage, availability of APRN
- SBAR – use of form and/or verbal report
- Warm Hand-off and other transfer of patient info
- Role of Transition Care Coaches/ Coleman Coaches
- Advance Care Planning Communication
Components of Mini-RCA

- Chief complaint
- Reason for initial admission and reason for readmission
- Time of day for readmission, day of week
- What services were in place prior to readmission – LTAC, SNF, HH, Transition Coach, Telephonic Care, AAA, community services
  
  *Include reports from these providers as appropriate*
- Who was contacted /involved prior to the call to the MD?
- Did you follow a protocol, if so which one?
- What interventions were provided prior to sending to the ED?
- Did you use an SBAR with the MD?
- What specifically happened prior to patient coming to the hospital

Components of Mini-RCA (cont.)

- Was it a 911 call?
- Was PCP Follow up Visit completed prior to the readmission? If yes, # days post initial hospital DC
- Med reconciliation, discrepancies, Rx filled
- What support person does the patient have? Does the family understand the needs of the patient?
- Did you ascertain the wishes of the patient at the time, Palliative Care discussion / consult?
- Code status
- Is patient appropriate to return to the prior level of care? Is a higher level of care indicated?
- Was readmission avoidable? If yes, what are recommended actions to prevent this in the future?
Tools


SBAR
[http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx](http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx)

Advance Care Planning Tools (Five Wishes, Advance Directives, POLST)
[https://www.agingwithdignity.org/index.php](https://www.agingwithdignity.org/index.php),  

Ascertain if your community partners have tools they are using that can be shared with the group

Questions & Reflection