Care Transitions:
Planning, Packaging,
A Provider’s Perspective

Karen Vance, OTR
Managing Consultant
BKD Health Care Group
kvance@bkd.com

Rhonda Dornbos, RN, BSN, COS-C
Clinical Operations & Quality Manager
Porter Hills Home Health Care
rdornbos@porterhills.org

‘Marketing Myopia’

- Theodore Levitt, lecturer at the Harvard Business School, introduced the famous question, “What business are you really in?”
- Levitt explained the railroads stopped growing because they assumed themselves to be in the railroad business rather than in the transportation business
- Are you in the home care business, or the health care business?
Inadequate management of care transitions was responsible for $25 to $45 billion in wasteful spending in 2011 through avoidable complications and unnecessary hospital readmissions.


*Care transition* describes a continuous process in which a patient’s care shifts from being provided in one setting of care to another.

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**Health Care Silos Deter Care Transition**
Supportive payment & regulatory environment → Organizations that facilitate the work of patient-centered teams → High performing patient-centered teams → Outcomes:
- Safe
- Effective
- Efficient
- Personalized
- Timely
- Equitable

REDESIGN IMPERATIVES: CHALLENGES
- Reengineered care processes
- Effective use of information technologies
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, sites of care over time

Policy Effect on Hospitals

- Section 3025 of the Affordable Care Act establishes the Hospital Readmissions Reduction Program
- Requires CMS to reduce payments to IPPS hospitals with excess readmissions
- The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).
**Policy Effect on Hospitals**

- Readmission is an admission to a hospital within 30 days of a discharge from the same or another hospital;
- Measures are used for Hospital Wide Readmission and applicable conditions of:
  - Acute Myocardial Infarction (AMI),
  - Heart Failure (HF)
  - Pneumonia (PN)
  - COPD (in 2015)
  - Elective THA/TKA (in 2015)

**Policy Effect on Hospitals**

- Excess readmission ratio calculated for each applicable condition,
- Used to calculate the readmission payment adjustment,
- Compared to the national average.
- Risk adjusted
- 3 year period assessed
- Penalties equal 1%, 2% and 3% from 2013 to 2015
Policy Effect on Health Care

- Exposure for hospitals is widespread
  - Exposure due to inconsistency in identifying ‘at risk’ population
  - Exposure due to lack of post acute service options for reducing re-hospitalization within 30 days

- Other ACA provisions more directly spread across the continuum of health care

Accountable Care Organizations (ACOs)

- Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care
- To ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors
- Will share in the savings it achieves for Medicare
  - Medicare Shared Savings Program helps a Medicare fee-for-service program providers become an ACO
  - Advance Payment ACO Model supplementary incentive program for selected participants in the Shared Savings Program.
  - Pioneer ACO Model a program designed for early adopters of coordinated care
### Bundled Payment for Care Improvement

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td>All acute patients, all DRGs</td>
<td>Selected DRGs, hospital plus post-acute period</td>
<td>Selected DRGs, post-acute period only</td>
<td>Selected DRGs, hospital plus readmissions</td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td>All Part A services paid as part of the MS-DRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All Part non-hospice A and B services (including the hospital and physician) during initial inpatient stay and readmissions</td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>

### Transitional Care Management (TCM)

- Services required during beneficiary’s transition to the community setting following particular kinds of discharges;
- Health care professional accepts care, takes responsibility of the beneficiary post-discharge without a gap
- Beneficiary has medical or psycho-social problems requiring moderate or high complexity medical decision making.
- 30 day TCM period begins day of discharge
Community-Based Care Transitions Program

- CCTP (§3026 of the Affordable Care Act), tests care delivery models for improving care transitions from hospitals to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- Goals of CCTP:
  - Improve transitions of beneficiaries from the inpatient hospital setting to other care settings
  - Improve quality of care
  - Reduce readmissions for high-risk Medicare beneficiaries
  - Document measurable savings to the Medicare program
- Funding for Community Based Organizations from 2011 through 2015

Physician Payment for CCM

- Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days
- CMS has proposed a payment rule of $41.92 per month per qualifying beneficiary
### Opportunities for Home Care

#### Partnering in care transitions
- Reduce hospitalizations
- Improve patient self-management/outcomes
- Provide cost-effective transition program
- Provide efficient care transition package
- Provide proof of value/worth of partnership

#### Proving worth as a partner
- Low hospitalization and ED rates
- Low adverse event rates
- Higher Home Health Compare scores
- Better HH-CAHPS scores
- To pursue partnership initially
- To prove ongoing value
Partnering in Care Transitions

- Use evidence based strategies/models for protocol development
  - Reducing hospitalization rates
  - Self-management/chronic care models
  - Care transition models
- Develop a culture of collaboration
- Data mine for capturing measures of value or worth of your partnership

Care Transition Model Elements

- Interdisciplinary communication and collaboration
- Transitional care staff
- Patient activation/participation
- Patient/caregiver knowledge/understanding
- Medication reconciliation/management
- Enhanced follow up
Care Transition Service Package

- Prepare a ‘Transitions’ product line outside of Medicare Certified program or all CoPs will apply to patient, including Comprehensive Assessment/OASIS
- Engage a contract agreement with the hospital or (TCM) physician
  - Scope of services (contact vs. visit)
  - Parties involved, protocols in place
  - 30 day Transition coverage period
  - Rates

Care Transition Service Package

- Implement/expand hospital liaison role
  - Identify at risk applicable conditions (AMI, HF, PN, COPD, Elective THA/TKA)
  - Readmission risk assessment

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has been admitted two or more times in the past year.</td>
<td>Patient has been admitted once in the past year. Based on Teach Back results, patient or family caregiver has moderate degree of confidence to carry out care at home.</td>
<td>Patient has had no other hospital admissions in the past year. Patient or family caregiver has high degree of confidence and can teach back how to carry out self-care at home.</td>
</tr>
</tbody>
</table>

How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations
Care Transition Service Package

- Screen for appropriate post-acute service
  - Home health or hospice eligibility
  - Transition service eligibility
- Obtain appropriate orders
- Exchange real-time handover data
- Schedule follow up according to risk level

How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations
Transition Services by Home Care

- Patient centered assessment within 24 hours
  - Identify necessary referrals for safety/follow up
  - Medication reconciliation and verify orders
  - High risk medication teaching
  - Verify parameters to notify physician
  - Red flag teaching/My Emergency Plan
  - Evaluate patient/caregiver confidence and activation with teach back
  - Initiate/reinforce personal health record

- Coordination with team and physician

Transition Services by Home Care

- Tele-monitoring
  - Integrate with Emergency Plan and teach back
  - Monitor vital signs/parameters as ordered
  - Relate change in condition to earlier teaching of signs and symptoms
  - Engage the 5 As as a protocol

- Patient self monitoring and reporting
- Assess the need for telephone contact versus a visit for successful self-management
Program Price Packaging

- Package Transition program balancing:
  - Covering costs
  - Market appeal
  - Avoid appearances of inducement

- Consider costs included
  - Liaison transition staff?
  - How much overhead
  - Anticipated average ‘contacts’
  - Cost per ‘contact’

Program Price Packaging

- Cost report provides direct and indirect costs per visit by discipline
- Per visit cost on cost report includes an aggregate of all types of visits
- Transition program initial visits not likely to emulate skilled home health admissions
- Average cost per visit per discipline used as starting point until further data gathered
- Paper trail for calculation if under scrutiny
Program Price Packaging

- Estimated average services per Transition patient might include:
  - 2 RN visits plus 4 phone calls
  - 1 SW visit plus 1 phone call
  - 1 therapy visit plus 1 phone call

- Possible inclusion:
  - Transition staff hospital liaison
  - Telemonitoring

Program Price Packaging

<table>
<thead>
<tr>
<th>Contact</th>
<th>Cost per contact</th>
<th>Average per 30 day</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN visit</td>
<td>$125*</td>
<td>2</td>
<td>$250</td>
</tr>
<tr>
<td>SW visit</td>
<td>$173*</td>
<td>1</td>
<td>$173</td>
</tr>
<tr>
<td>Therapy visit</td>
<td>$125*</td>
<td>1</td>
<td>$125</td>
</tr>
<tr>
<td>Phone call</td>
<td>$12^</td>
<td>6</td>
<td>$72</td>
</tr>
<tr>
<td>Telemotor</td>
<td>$80^</td>
<td>1</td>
<td>$80</td>
</tr>
</tbody>
</table>

$600 averaged total per various combinations of contacts

*Median total agency visit costs of all Ohio agencies based on 2011 FY cost reports.
^Portion of hourly RN rate averaged from Ohio agencies in NAHC 2012 Salary Report
^Anecdotal client experience
Prove Value to the Agency

- Transition package pricing must balance covering cost with market value
- Key to the home care agency is keeping costs down while achieving results
- Key performance indicators watch real time data for monitoring costs and outcomes
- Watch agency level numbers
- Sort to staff level performance

Key Value Performance Indicators
**Prove Value to Hospital**

<table>
<thead>
<tr>
<th>Midwest Rural Hospital Statistics</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of beds</td>
<td>149</td>
<td></td>
</tr>
<tr>
<td>Medicare discharges</td>
<td>3,415</td>
<td></td>
</tr>
<tr>
<td>Discharges to HH or Hospice</td>
<td>655</td>
<td>20%</td>
</tr>
<tr>
<td>Discharges to other post-acute</td>
<td>526</td>
<td>15%</td>
</tr>
<tr>
<td>Discharge with no post-acute care</td>
<td>2,234</td>
<td>65%</td>
</tr>
<tr>
<td>Total cost per bed day</td>
<td>$1,364</td>
<td></td>
</tr>
<tr>
<td>Total cost per ED visit</td>
<td>$168</td>
<td></td>
</tr>
</tbody>
</table>

H-CAHPS scores all below national average

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**Prove Value to Hospital**

<table>
<thead>
<tr>
<th>Cost Benefit Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Revenue</td>
</tr>
<tr>
<td>[2013 1% penalty risk]</td>
</tr>
<tr>
<td>Estimated readmission rate = 20%</td>
</tr>
<tr>
<td>Average unpaid days/readmissions = 3</td>
</tr>
<tr>
<td>Total estimated cost for unpaid days</td>
</tr>
<tr>
<td>60% readmissions through ED</td>
</tr>
<tr>
<td>Total estimated cost of readmissions:</td>
</tr>
</tbody>
</table>

| Discharges to no post acute care               | 2,234    |
| Average Transition package cost                | x $600   | $1,340,400 |
| Estimated net savings to hospital for patients with no post acute care: | $1,523,316 |
### Outcomes Measures

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Ohio</th>
<th>Nat'l</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often patients got better at walking or moving around.</td>
<td>59%</td>
<td>59%</td>
</tr>
<tr>
<td>How often patients got better at getting in and out of bed.</td>
<td>55%</td>
<td>55%</td>
</tr>
<tr>
<td>How often patients got better at bathing.</td>
<td>63%</td>
<td>66%</td>
</tr>
<tr>
<td>How often patients had less pain when moving around.</td>
<td>64%</td>
<td>67%</td>
</tr>
<tr>
<td>How often patients' breathing improved.</td>
<td>64%</td>
<td>64%</td>
</tr>
<tr>
<td>How often patients' wounds improved or healed after an operation.</td>
<td>88%</td>
<td>64%</td>
</tr>
<tr>
<td>How often patients got better at taking their drugs correctly by mouth.</td>
<td>47%</td>
<td>50%</td>
</tr>
<tr>
<td>How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room – without being admitted to the hospital</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>How often home health patients had to be admitted to the hospital</td>
<td>18%</td>
<td>17%</td>
</tr>
</tbody>
</table>

### Process Measures

<table>
<thead>
<tr>
<th>Process</th>
<th>Ohio</th>
<th>Nat'l</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often HH began patients' care in a timely manner.</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>How often HH checked patients' risk of falling.</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>How often HH checked patients for depression.</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often HH checked patients for pain.</td>
<td>98%</td>
<td>99%</td>
</tr>
<tr>
<td>How often HH checked patients for the risk of pressure sores.</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often HH included treatments to prevent pressure sores in the POC.</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>How often HH gave foot care and taught patients about diabetic foot care.</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>How often HH treated their patients' pain.</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often HH treated heart failure patients' symptoms.</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>How often HH taught patients (or caregivers) about their drugs.</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>How often HH determined whether patients received a flu shot.</td>
<td>73%</td>
<td>70%</td>
</tr>
<tr>
<td>How often HH determined whether patients received pneumonia shot.</td>
<td>73%</td>
<td>69%</td>
</tr>
</tbody>
</table>
Prove Worth

<table>
<thead>
<tr>
<th>HH-CAHPS</th>
<th>Ohio</th>
<th>Nat'l</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often HH care in a professional way</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>How well did HH communicate with patients</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Did HH discuss medicines, pain, and home safety with patients</td>
<td>83%</td>
<td>84%</td>
</tr>
<tr>
<td>How do patients rate the overall care from the HH agency</td>
<td>82%</td>
<td>84%</td>
</tr>
<tr>
<td>Would patients recommend the HH agency to friends and family</td>
<td>76%</td>
<td>79%</td>
</tr>
</tbody>
</table>

Value in Care Transition Best Practice

- Effective patient and caregiver education and self-management training following discharge; anticipatory guidance for self-care needs at home post-discharge;
- Reliable referrals for home health care visits;
- Effective management and communication of medication regimens whenever changes occur;
- Timely and clinically meaningful communication (handovers) between care settings;
- Early post-acute care follow-up; and
- Proactive discussions of advance care planning and/or end-of-life preferences, and reliable communication of those preferences among providers and between care settings.

*How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations*
The Catalyst

• Hospitals preparing for readmission penalties
  – The collaborating hospital’s re-hospitalization rate for patients discharged to Skilled Nursing Facilities in 2010 was over 16%.
• Lack of communication and coordination between providers
• CMS Innovations Grant
What do we do?

• ECHO group
• Internally

Creating ECHO

• Extended Care Health Organization

ECHO is focused on creating systems for best practices which lead to improving the overall patient experience.
Collaborative Model of Care

• Accomplishes the triple aim approach of CMS:
  – Better Care, Better Health, Lower Cost
• Recognizes the fragmentations in healthcare
• Understands the synergies gained from collaborating
• Addresses the gaps in communication and processes that occur when patients transition between health care settings and back into the community.
• Transformed friendly competitors to trusted co-collaborators
  – (“Co-opetition”)

Providers Include:

• Clark Retirement Community
• Holland Home
• Pilgrim Manor
• Porter Hills Retirement Communities and Services
• St. Ann’s Home
• Sunset Retirement Communities and Services

In partnership with the:
• Alliance for Health and Life EMS Ambulance
“Those who say it can't be done are usually interrupted by others who are doing it.”

James Baldwin

Prior State

- Functioned in silos
- Fragmentation for
  - Residents/patients
  - Families
  - Providers
  - Hospitals
  - Physicians
- Lack of Consistency, i.e. care, processes
- Lack of understanding of each other
- Recognized need for collaborative relationship with hospitals
ECHO

• Developing and becoming an effective team
  – forming, storming, norming, performing
• Creating best practices such as:
  – What do we want to focus on as a group?
    • LEAN Process Review
    • Asking hospitals what they want/need

ECHO

• Standardization
  – Developed/approved processes, procedures, tools including:
    • Advance directives
    • Emergency response directives
    • SBAR (Situation, Background, Assessment, Recommendation)
    • Diversion process
    • Standardized transfer forms such as:
      – Transfer to Emergency Department Form
      – Discharge Summary Form
  – Developed and implemented criteria and guidelines for conducting follow up phone calls
**ECHO**

- Clinical
  - Adopted clinical pathways

- Quality and accountability
  - Provide training and skill building for all provider staff; developed scripts for re-hospitalization education
  - Developing pathway for admission from Home Care directly to SNF
  - Developed dashboard report of all Post Acute providers

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**Dashboard**

Developed dashboard for all providers with information from Nursing Home and Home Health Compare along with reporting of the following criteria:

- **Home Care**
  - 60 day hospitalization rate
  - Availability of telehealth
  - % of patients definitely recommend agency
  - Counties served
  - Emergency Department visits without hospitalization (recent addition)

- **SNF**
  - 30 day re-hospitalization rate – LOS
  - % of patients definitely recommend SNF
Current State

- Root Cause Analysis of rehospitalizations
- Participating in joint leadership education
- Sharing tools and policies
- Presented a community Alzheimer’s conference
- Referrals to each other (yes really!)
- Considerate and respectful of each other
- ECHO aggregate SNF re-hospitalization rate for all hospitals dropped from 25+% to 9.9%

Rehospitalization Outcomes
Rehospitalization Outcomes

Unexpected Outcomes

• Higher cost to post acute providers to decrease rehospitalizations without shared benefits
• Increased shared awareness of acute and post acute care services
• Improved communication between acute care and post acute providers
• Hospital recognized areas for improvement, i.e. admission/discharge process to post acute care and services
• How well competitors can get along and work together
Future State

<table>
<thead>
<tr>
<th>Community Resource Deployment</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMS “drop in”</td>
</tr>
<tr>
<td>Increased physician involvement</td>
</tr>
<tr>
<td>Develop patient/family education regarding re-hospitalization and impact on patient and the healthcare system</td>
</tr>
<tr>
<td>Educators to develop shared education modules and training sessions</td>
</tr>
</tbody>
</table>

Future State

<table>
<thead>
<tr>
<th>Expanded Transition Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased ability to “care for all needs” to prevent re-hospitalizations</td>
</tr>
<tr>
<td>Joint Emergency Preparedness</td>
</tr>
<tr>
<td>Integration with Health Information Exchange</td>
</tr>
<tr>
<td>Preparation for Managed care</td>
</tr>
<tr>
<td>Inclusion of additional partners</td>
</tr>
<tr>
<td>Tandem 365—Integrated Care Model</td>
</tr>
</tbody>
</table>
Porter Hills

• What did we do specifically at Porter Hills?
  – Created HeartBeats
  – Focused on Outcomes
  – Provided Data

• Root Cause analysis on all re-hospitalizations
• Educated Sales force on outcomes
• Comprehensive 24/7 Care
  • Partnered with EMS to do after hours
  • Telehealth monitored by EMS
• Increased education to nurses to increase acuity
We must raise the bar

• There is opportunity to improve on care transitions
  – Determine the issue for your acute providers
  – Evaluate your agency: current and future
  – Know your data and *share it*
  – Find others who are like minded and work together
  – Tell the right people what you’re working on and how it will benefit them

Prove your worth

*BE SO GOOD THEY CAN’T IGNORE YOU*

~STEVE MARTIN