COORDINATING TRANSITIONS OF CARE ACROSS MULTIPLE CARE SETTINGS

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Learning Objectives

I. Describe the core components of the Bridge Model and its impact on healthcare outcomes
II. Highlight the important role of community-based organizations in meeting transitional care needs of older adults
III. Learn about quality measures and sustainability options for a transitional care program

Case Example

- Mrs. Harrison
  - Widowed
  - 75 years old
  - Has diabetes and CHF
- Admitted through the ED after a fall
  - Hospitalized for 5 days
  - Discharged with home health care
  - 10 medications prescribed
Mrs. Harrison's two children can't agree how to best manage their mother's medical needs.

Mrs. Harrison's primary caregiver is overwhelmed and has to return to work.

The Home Health Care Agency doesn't arrive on time.

Mrs. Harrison has no transportation to her follow-up medical appointments.

Mrs. Harrison doesn't know which medications to resume and which to stop taking at home.

Mrs. Harrison is feeling depressed because she can't get around anymore like she used to.

Mrs. Harrison is feeling isolated now that she's homebound.

Mrs. Harrison is afraid she will fall again and have to return to the hospital.

Is this the worst case scenario, or is it a typical transition?
Triple Aim of Health Reform: Focus on Value

- Improve individual experience
- Improve population health
- The best care
- For the whole population
- At the lowest cost
- Control inflation of per capita costs

Volume vs. Value

- Traditional Fee-for-Service Payment System
- Medicare Advantage Plan
- Accountable Care Organizations
- Bundled Payment Pilots
- Direct Contracts with Employers
- Option on the Health Exchange
- Population Health Per Capita Payment System

Forces at Play

- Consumerism
  - CVS
  - Walmart
  - Immediate care
- Population health
  - Accountable Care Organizations
  - Managed Care
  - The ACA and the newly insured
  - Value-based Purchasing
- Volume vs. Value
- Triple Aim of Health Reform: Focus on Value
What is Population Health?

- The health outcomes of groups of patients served by a health system
- Inevitable in the current capitation environment
- Focus on entire health care trajectory
- Moving from episodic to chronic
- Necessitates a comprehensive look at health
  - Ecological Systems Theory
  - Wagner’s Chronic Care Model

Hospital System Perspective

- Shift away from activity-based reimbursement
  - Toward payment that rewards providers
  - Care quality, outcomes, cost-effectiveness
- Infrastructure and cultural challenges significant both within and beyond hospital walls
- Hospital linkages to post-acute providers
  - Traditionally informal, unorganized
  - Effort needed to develop and support effective coordination with continuum of providers

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*Bridge Model*
Psychosocial Aspects of Transitions

- Older adults particularly vulnerable at times of transitions
- Literature highlights importance of social determinants in successful transitions
  - Cognitive decline while in hospital and post-discharge
  - Journal of General Internal Medicine
  - 40-50% of readmissions tied to psychosocial issues, lack of community resources
  - Health and Social Work
  - "Unplanned readmissions largely determined by broader social and environmental factors..."
  - Journal of the American Medical Association
- Racial and socioeconomic patterns in readmissions rates

Mrs. OG

- Was an avid fisher
- Die-hard Jeopardy fan
- Loves to give her Primary care Physician (pictured) a hard time
- Actively looking for husband
- Hates taking her insulin

TRANSITIONAL CARE
Where does transitional care fit in?
- Numerous "providers" – medical, psychosocial, community
- Little and flawed interdisciplinary and interprovider communication
- No single "owner" of a transition

Where do breakdowns occur?

"Rather than a one-size-fits-all approach, programs should be developed that address the specific needs of vulnerable patients and the hospitals that care for them. Hospitals in one area of the country may have different needs than hospitals in other areas, because of local infrastructure, resources, access to care, and integration of outpatient practices."

State of the State

- Funding opportunities in the ACA
  - Care coordination initiatives: ACOs, bundled payments
  - Transitions-specific: Community-based Care Transitions Program

- Models for transitional care emerging to address client and caregiver needs across the continuum
  - Care Transitions Intervention
  - The Transitional Care Model
  - Project RED
  - Project BOOST
  - Geriatric Resources for Assessment and Care of Elders (GRACE)
  - Geriatrics Floating Interdisciplinary Transitions Team
  - The Bridge Model

BRIDGE MODEL HISTORY

"If patient engagement were a drug, it would be the blockbuster drug of the century, and malpractice not to use it."
- Leonard Kish
In The Beginning...

- Rush University’s Enhanced Discharge Planning Program (EDPP)
  - 2005
  - Pilot started after discharge planner concerns
  - Approx. 2,500 clients served
  - 2009
  - Randomized Controlled Trial (n=720)
- Aging Care Connections’ Aging Resource Center
  - A response to concerned field case managers meeting with clients in need post-discharge
  - Successfully integrated the hospital INTO the hospital to capitalize on the “servable moment” and maintain a client-centered care transition

Highlights

- 2005: Enhanced Discharge Planning Program pilot begins; Aging Resource Center started
- 2009: Randomized controlled trial of EDPP model begins; Bridge Model National Office formed
- 2011: Aged Resource Connections Transitions Grant obtained by BMNO for Bridge Program
- 2014: Bridge Model Collaborative launched

Bridge Replication Sites

- Washington: 1 site; Aging Services
- North Dakota: 1 site; Aging Services
- San Fernando, CA*: 3 sites; CBO
- Danville, IL*: 1 site; Aging Resource Center
- Ottawa, Canada: 1 site; Hospital
- Columbus, OH*: 2 sites; Hospital
- Detroit, MI: 1 site; Housing
- Highland, MI: 2 sites; Hospital
- Philadelphia, PA*: 2 sites; Agency Services
- Chicago, IL: 1 site; Aging Services
- Chicago & Suburbs, IL*: 6 sites; Aging Services
- Lansing, MI*: 3 sites; Agency Services
- Chicago & Suburbs, IL*: 6 sites; Aging Services

* = Sites awarded Community-based Care Transition Program funding
Ms. KA
- Had 7 husbands (but says she shouldn’t have remarried after her first) and now single
- Felt extremely isolated until BCC
- Is learning how to speak up for herself
- Loves receiving volunteer visitors
- Starting to get to know her ALF neighbors

BRIDGE MODEL SPECIFICS

The Typical Transition
Hospital
Physicians
Discharge Planner
Nursing Staff
Other Services
Community
Home Health Providers
PCP Specialists
Community Based Services
Other Outpatient Care

Hospital and Community providers are fragmented across disciplines and settings
The “Quarterback”

Hospital and Community providers communicate across disciplines and settings under the facilitation of a care coordinator.

Bridge Model Phases

<table>
<thead>
<tr>
<th>Model Features (n ~ 3,000)</th>
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<tbody>
<tr>
<td>Readmission decrease</td>
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<tr>
<td>Mortality decrease</td>
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<td>Physician follow-up</td>
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Building Blocks of Bridge

- Continuous Quality Improvement
- Comprehensive Assessment
- Clinical Intervention
- Social Determinants of Health
- Community-specific Focus
- Hospital-Community Collaboration
Hospital-Community Collaboration

- Bridge Care Coordinator serves as primary care coordinator and extension of the inpatient clinical team
  - Conduit of information between inpatient and outpatient settings
  - Manages care coordination tasks
  - Facilitating inclusion of other team members
- Additional team members vary by client
  - Inpatient case manager and attending physician
  - Nurse
  - Primary care physician
  - Pharmacist, therapists, other medical providers
  - Home health and other community service providers

The Aging Resource Center (ARC)

- Symbol of a great partnership
- Physical office space for BCCs to receive referrals, access hospital and community records
- A library of resources
- Space for the BCCs to collaborate with the interdisciplinary team
- A location for the BCC to meet with Bridge clients and their families to discuss community-based resources available

Community-specific focus

- BCCs must be experts in the community
  - Aging network
  - Community organizations
  - Faith-based and volunteer groups
  - Non-traditional resources
- Cultural humility
  - Impact on treatment plan
  - Home remedies
  - Decision-makers
The Value of Partnerships

• Partnerships a fundamental component of the Bridge Model
  • Clients do not live in the hospital or short-term rehabilitation facility
  • They live in homes, communities, long-term care SNF’s
  • The plan of care is only as good as the receiver’s ability to implement it
  • Partnerships, pre-established collaborative processes have a great impact on client outcomes
  • Meaningful partnerships allow for timely data transfer, expedited community service provision, and quicker problem solving
  • Paves the way for a Population Health/Bundled Payment approach

Community Partners

• BCCs skilled at:
  • Facilitating and maintaining relationships with interdisciplinary teams
  • Hospital
  • Community agencies
  • Skilled Nursing Facility
  • Home Health
  • PCP
  • Navigating community resources, particularly the Aging Network

Types of partnerships

• Informal
  • Nothing in writing
  • Can be strong or weak
• Memorandum of Understanding
  • Written agreement – no signature
• Business agreement
  • Contract
  • Recommended for working with larger entities/hospitals
Comprehensive Assessment

- Builds on 9 years of experience
  - Dozens of focus groups and individual meetings with Bridge Care Coordinators
- Biopsychosocial approach
  - Social determinants of health
- Root-cause analysis approach
  (5 Whys)
  - 29 Post-discharge need data points
  - 12 Discreet social work interventions
- Basis for ALL continuous quality improvement activities

Social Work Clinical Skills

- Bridge is led by master's-prepared social workers
  - Person-in-Environment perspective
  - Client-centered interviewing
  - Motivational interviewing, Acceptance and Commitment Therapy, CBT, etc.
  - Stages of change
  - Cultural humility

Motivational Interviewing skills

OARS

- Open-ended questions
- Affirmation
- Reflection
  - Key to accurate empathy
  - “Continue the paragraph”
- Simple reflections
- Repeating
- Rephrasing
- Complex reflections
  - Paraphrasing
  - Reflecting feelings or emotional content
- Summary

02/12/2016
Mrs. SM
- Huge Blackhawks fan
- 16 grandchildren
- Has painted her whole life (one of the few things she can still do)
- Loves learning new things (e.g., the word "empathy")

KNOWING YOUR WORTH
Quantifying and communicating the value of social work

The universe of administrative concerns

GUIDING QUESTION:
WHAT CAN I OPERATIONALIZE?
The letter and the spirit

- Quality assurance and improvement
  - Inherent challenges
  - Putting people and processes under a microscope
  - Understanding how to measure quality (the spirit)
  - Data availability
  - Data quality
- Significant payoff
  - Sustained quality (maintained fidelity)
  - Improved outcomes
  - Sustainability

Lean transitional care

The Power of Data

- Process
  - Quality assurance
  - Outcomes
  - Quality improvement
- Impact/Outcomes
  - Funders, ACOs, Bundles, Insurance
  - Revenue
  - Hospital support, self-sufficiency, business planning
Scope of Control

- Training
  - We have the ability to comprehensively map our operations
- Workflows
  - Swim lane flow charts
- Data collection
  - We can put parameters around data collection processes
  - Inter-rater reliability
  - Enough detail to tell a story without overwhelming staff
  - Note workload tracking and termination challenges
- Clinical supervision
  - We can provide consistent, helpful clinical supervision
- PDSA
  - We can conduct regular quality improvement activities
  - Readmission reviews (consistently strive to understand the population you serve)

Data Definitions

- Process data
  - Identified needs and interventions utilized
  - Number per case
  - Top three (or four, or five...)
  - Relationship status (Excel)
  - Most frequently utilized providers
  - Five best and worst
  - Cases per month
  - Length per case
  - Outcome data (know your data sources)
  - Readmissions
  - Physician follow-up
  - ER utilization
  - Mortality

Connecting Process and Outcome

- Limited by data availability, but is the gold standard
- Readmission example
  - Identify cases readmitted within 30 days
  - Identify process measures associated with those cases
  - Compare with cases that did NOT readmit and note differences – does anything stand out?
  - Shorter duration of intervention
  - Unique subset of identified needs
  - Demographic differences
Quality Improvement

- Supervisor leads the quality improvement effort
  1. Documentation quality
  2. Documentation consistency
  3. Data export
  4. Data analysis
  5. Communication back to the team
- All QI efforts focus on either process or outcome data
- Clinicians need to care about data (as hard as that can be)

PDSA and RIE

1. Identify variable(s) to track
   a. Case quantity: # of referrals, cases completed per month
   b. Case processes: contacts per case (calls, home visits), duration of case
   c. Client information: assessment results, referrals, provider relationships, readmissions, patient satisfaction
2. Select a time frame
   a. Must be long enough to avoid misreading trends (2-3 month minimum)
3. Collect data
4. Analyze data
5. Brainstorm corrective actions
6. Implement corrective actions
7. Repeat

Social Work Sustainability in Health Care

- Value-based purchasing
- Readmission reduction
- Downstream revenue
- Population health
  - Accountable Care Organizations
  - Managed Care Organizations
  - Bundled Payments/Shared Savings
- CPT codes
- Grant funding
VBP and Readmissions – What can we impact?

- Value-based Purchasing
  - 1.5% of DRG payments (competing against other hospitals, not a baseline)
  - Process
  - 12 clinical process measures
- Outcomes
  - HCAHPS
  - Mortality within 30-days (AMI, HF, PN)
  - PSI-90, CLABSI
- Efficiency
  - MIPR (Medicare Spending per Beneficiary)
- www.qualitynet.org
- The Hospital Readmission Reduction Program (HRRP)
  - 3.0% in 2015
  - Numerous factors outside of the hospitals control
    - Psychosocial, resource, patient activation

Downstream Revenue and Population Health

- Hospital systems vs. disconnected “systems”
  - Decreased readmissions lead to cost shifting
- Population health
  - Accountable Care Organizations (ACOs) – 3 types
    - Medicare Shared Savings Program (MSSP)
    - Advance Payment Program (subset of MSSP)
    - Pioneer ACOs (closed)
  - 33 quality measures (overlap with VBP)
    - Patient experience
    - Care coordination
    - Preventive Health
    - At-risk Population
- Managed Care Organizations
  - Common element - networks

TCM and CCM CPT codes

- Transitional Care Management (TCM)
  - 99495 – PCP visit w/in 14 days
  - 99496 – PCP visit w/in 7 days
  - Billed by PCP as part of the visit
- TCM and CCM CPT codes
  - Reimbursement range is between approx. $160 - $230 depending on setting and other considerations
  - Communication with patient or caregiver within 2 days of discharge
    - Non-face-to-face with:
      - Home health
      - Patient/family education to support self-management, ADLs/IADLs
      - Treatment regimen adherence
TCM and CCM CPT codes (cont.)

- Chronic Care Management (CCM)
  - 99490
  - 20 minutes non-face-to-face, once per month
  - 2+ chronic conditions
  - Consent
  - Co-pay
  - Reimbursement: $41.92
  - Vague service requirements, including:
    - Medication reconciliation
    - Patient education
    - Communicating with home health, etc.
  - Electronic care plan updated annually


Bridge Impact

Community-based Care Transitions Program (2012-2014)

- Impact of Bridge on readmissions at six sites in Chicago area (n=5,753)
  - 30-day: 20.7% fewer (vs. baseline)
  - 60-day: 9.4% fewer (vs. weighted hospital average)
  - 90-day: 13.9% fewer (vs. weighted hospital average)

![](chart.png)
High Utilizer Pilot

Questions?

Thank you!

- Interested in learning more about Bridge or being trained in it?
- Contact us!
  - Jessica Grabowski: jgrabowski@agingcareconnections.org
  - Walter Rosenberg: walter_rosenberg@rush.edu
  - info@transitionalcare.org
  - www.transitionalcare.org

- "High-utilizer" = 5 or more admissions within a calendar year
- Less than 3% of the patient population, but responsible for nearly 50% of the readmissions
- Additional protocols added to Bridge
  - Care Coordination Calls
  - Longer-term support