

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 at Home

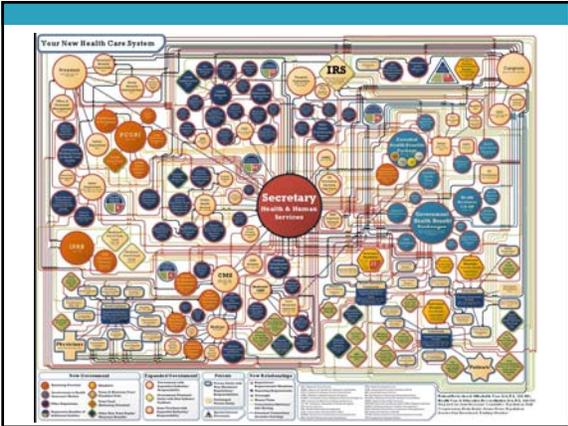
Community PCP doesn't know Mrs. Harrison was admitted to the hospital. Mrs. Harrison's primary care physician is overwhelmed and doesn't return to work. The Home Health Care agency is unable to get the medications to Mrs. Harrison. Mrs. Harrison is feeling depressed because she can't get around anymore like she used to. Mrs. Harrison is having difficulty coping with her mobility changes. Children can't agree how to help her. Mrs. Harrison is feeling isolated now that she's homebound. Mrs. Harrison's Community Services are delayed. Mrs. Harrison can't follow-up medical appointments.

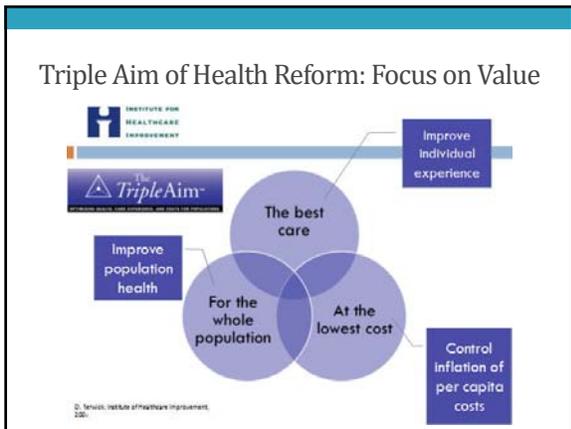
Is this the worst case scenario, or is it a typical transition?

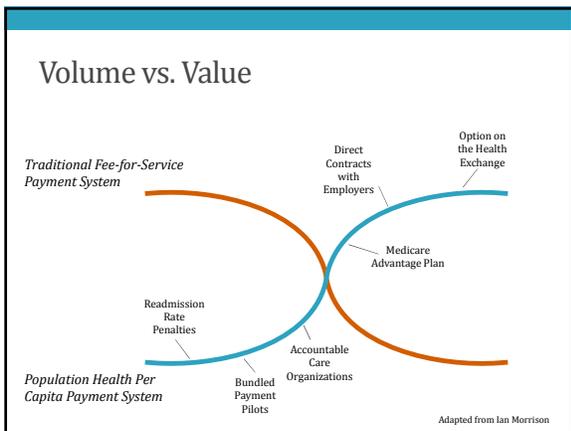
WHAT'S IN IT FOR YOU? WHAT'S IN IT FOR YOU? HEALTH REFORM LANDMARK HEALTH BILL HOUSE PASSES HEALTH REFORM

SETTING THE SCENE

The BridgeModel







Forces at Play

- Consumerism
 - CVS
 - Walmart
 - Immediate care
- Population health
 - Accountable Care Organizations
 - Managed Care
 - The ACA and the newly insured
 - Value-based Purchasing

Health Care Reform

Primary Care Clinic

What is Population Health?

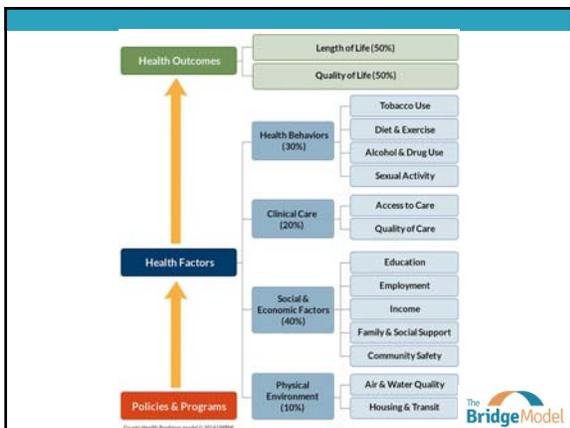
- The health outcomes of groups of patients served by a health system
- Inevitable in the current capitation environment
- Focus on entire health care trajectory
 - Moving from episodic to chronic
- Necessitates a comprehensive look at health
 - Ecological Systems Theory
 - Wagner's Chronic Care Model



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





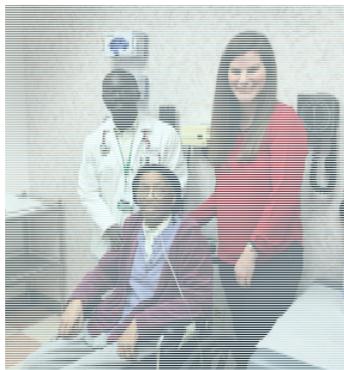
Psychosocial Aspects of Transitions

- 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

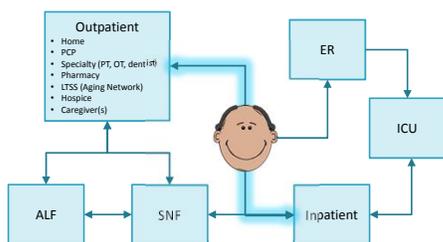


Where does transitional care fit in?

- Numerous “providers” – medical, psychosocial, community
- Little and flawed interdisciplinary and interprovider communication
- No single “owner” of a transition



Where do breakdowns occur?



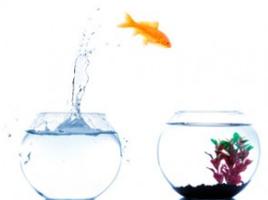
*Adapted from NTOCC

“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.”

– Adrian Hernandez and Lesley Curtis, “Minding the Gap Between Efforts to Reduce Readmissions and Disparities,” *Journal of the American Medical Association* 305(2011): 715-716, doi:10.1001/jama.2011.167

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...



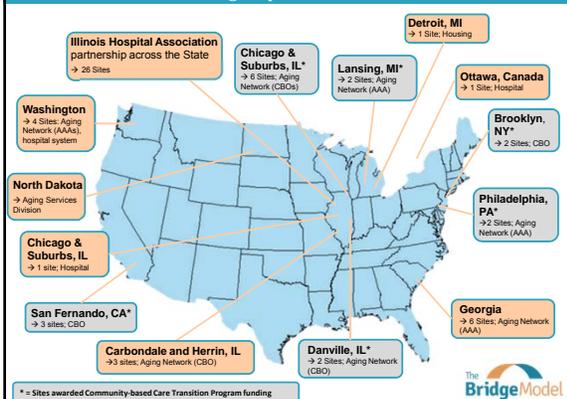
- Rush University's Enhanced Discharge Planning Program (EDPP)
 - 2005
 - Pilot started after discharge planner concerns
 - Approx. 2,500 clients served
 - 2009
 - Randomized Controlled Trial (n=720)
- Aging Care Connections' Aging Resource Center
 - A response to concerned field case managers meeting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



Highlights



Bridge Replication Sites



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





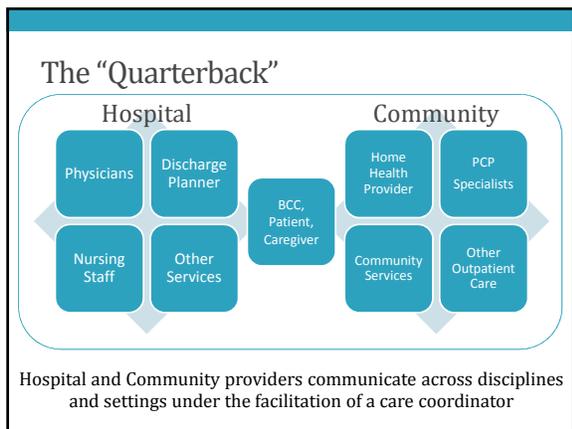
BRIDGE MODEL SPECIFICS

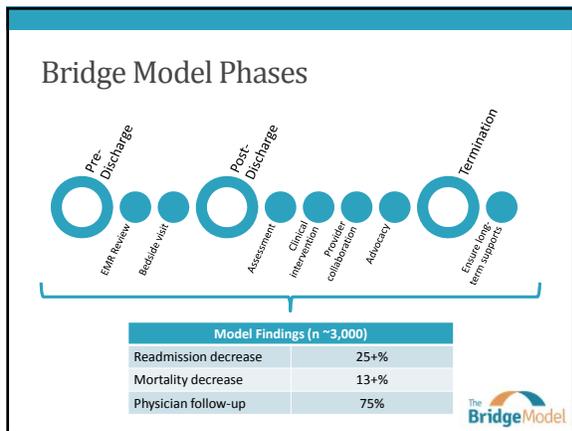


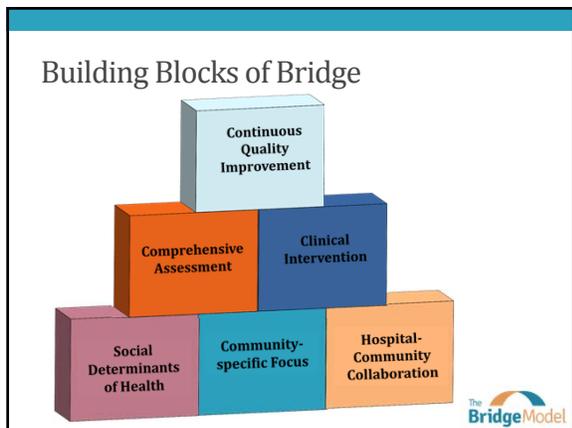
The Typical Transition

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

Hospital and Community providers are fragmented across disciplines and settings







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



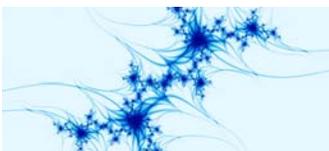
Comprehensive Assessment

- 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



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:
Sustainability
**WHAT CAN I
OPERATIONALIZE?**



The letter and the spirit

• Quality assurance and improvement

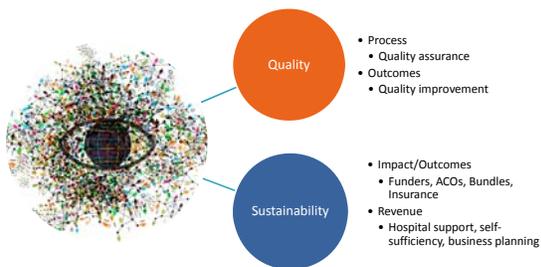
- Inherent challenges
 - Putting people and processes under a microscope
 - Understanding how to measure quality (the spirit)
 - Data availability
 - Data quality
- Significant payoff
 - Sustained quality (maintained fidelity)
 - Improved outcomes
 - Sustainability



Lean transitional care



The Power of Data



Scope of Control

- Training
- Workflows
 - We have the ability to comprehensively map our oper
 - 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 caseload 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, CLABS1
 - Efficiency
 - MSPB (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
 - http://www.aafp.org/dam/AAFP/documents/practice_management/payment/TCMFAQ.pdf



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
 - <http://www.pyapc.com/resources/collateral/white-papers/Chronic-Care-Whitepaper-PYA.pdf>

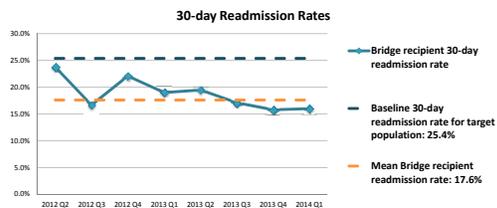


Bridge Impact

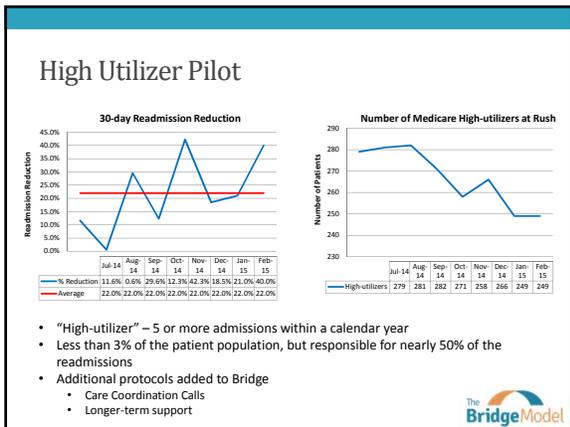


Community-based Care Transitions Program (2012-2014)

- Impact of Bridge on readmissions at six sites in Chicago area (n=5,753)
 - **30-day:** 30.7% fewer (vs. baseline)
 - **60-day:** 9.4% fewer (vs. weighted hospital average)
 - **90-day:** 13.9% fewer (vs. weighted hospital average)



*CMS disclaimer: The readmission data presented here are calculated using raw, unadjusted Medicare claims for the specified periods of time. They do not indicate impact or take trends or other initiatives into consideration. These metrics are provided by CMS for performance monitoring purposes only and while they inform evaluative results, they do not constitute the entirety of the program evaluation.



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
