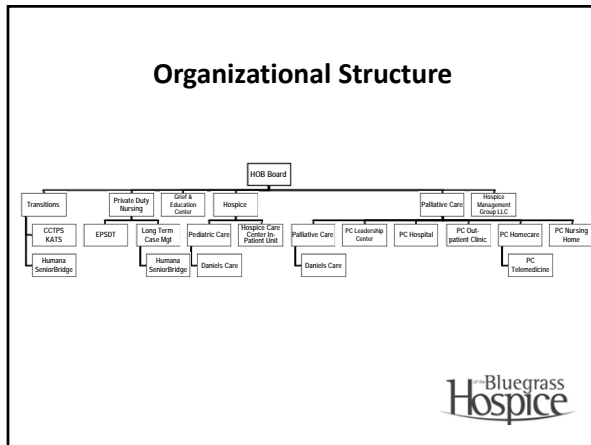




NHPCO Management Leadership Conference  
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### Objectives

- Components of developing a transition care service
- Funding sources available for transition programs
- CMS Innovation Community Care Transition Project



### The Human & Financial Cost of Unnecessary Harm

- Every day, 1 out of 20 US hospitals is affected by a hospital-acquired infection
- Among chronically ill adults, 22% report a “serious error” in their care
- 1 out of 7 Medicare beneficiaries is harmed in the course of their care, costing the federal government over \$4.4 billion each year
- CMS reports that each 30-day readmission costs \$9,600 per episode
- Despite pockets of success-CMS found massive variations in the quality of care, and not major change in the rates of harm and preventable readmissions over the past decade

### The Intolerable Condition: Causes of Hospital Readmissions


**Provider-Patient interface**

- Unmanaged condition worsening;
- Use of suboptimal medication regimens;
- Return to an emergency department

**Unreliable system support**

- Lack of standard and known processes;
- Unreliable information transfer;
- Unsupported patient activation during transfers

**No Community infrastructure for achieving common goals**



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### Rationale for Developing Transition Care Services

- Attractive program to offer new medical service delivery models
- CMS, Medicare Advantage Plans, Medicaid Managed Care Organizations, Commercial Insurers, ACOs, Medical Homes, hospitals and nursing homes’ area of focus is on avoidable 30-day hospital readmissions
- Expands corporation's lines of service further in the health care continuum

**Development Components**

- Business Plan
  - SWOT Analysis
  - Market Analysis
  - Organizational Structure
  - Financial Plan
  - Transition Clinical Model
  - Initial Pilot
  - Evaluation & Lessons Learned

**Transition Services Structure**

- Case management company filed as a HOB d/b/a—KY Appalachian Transition Services
- Utilize private duty PRN nurses for transition services
- Nurses are paid a per visit all-inclusive rate
- Administratively managed by existing private duty staff
- Payers: CMS & Humana Advantage pay a case rate based on the specific transition intervention

**Transitions of Care vs. Care Coordination**

- Transitions of Care
  - Range of *time limited* services & environments that complement primary care & are designed to ensure health care continuity & avoid preventable poor outcomes among at risk populations as they move from one level of care to another, among multiple providers across settings
- Care Coordination
  - Is a related by distinct concept that refers to the actual transition between 2 particular care settings. It involves the interaction of providers & health plan administrators across a variety of care settings to ensure optimal patient care.

**Partnership for Patients: Better Care, Lower Costs**

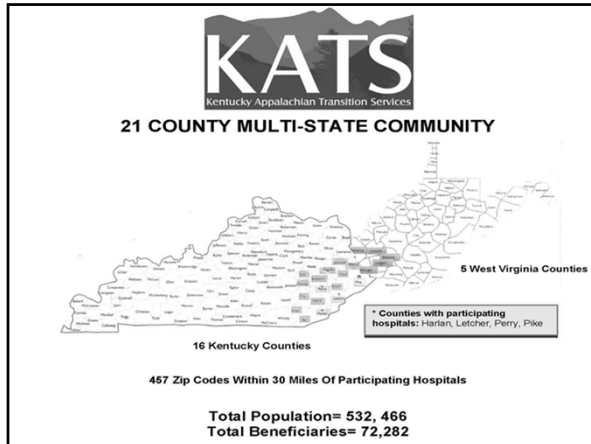
- The ACA directed the HHS Secretary to establish a 5-year community-based transitions program for eligible entities beginning January 2011--\$500 million is available for this demonstration project
- The innovation is the Community Care Transition Program (CCTP)
- The goals of the community-based transitions programs are to improve care transitions for high risk Medicare beneficiaries
  - Improve quality of care
  - Reduce readmissions
  - Document measurable savings to the Medicare program

**Eligible Entities For the Demonstration Program**

- Hospitals with high readmission rates that partner with community-based organizations (CBOs)
- US hospitals with the highest % of readmission penalties
- CBOs that provide care transitions across continuum of care through arrangement with hospitals

**KATS Awarded CMS CCTP Demonstration**

- There are 100 CMS Innovation Community Based Care Transition Project awardees
- KATS received the demonstration project award in February 2013—in the 5<sup>th</sup> award round
- KATS is the only awarded site that is using the Transitional Care Model, which has a longer intervention than other programs are using



- ### ARH/KATS Partnership
- KY Appalachian Transition Services (KATS) is a case management company owned by Hospice of the Bluegrass that is not related to hospice services
  - ARH partner hospitals- Hazard ARH Regional Medical Center, Whitesburg ARH and Harlan ARH, Williamson ARH (all high readmission hospitals)
  - The Agencies on Aging in the KY River ADD and Cumberland Valley ADD are collaborating partners

- ### Root Cause Analysis of Why Patients are Readmitting Within 30-days of Hospital Discharge
- Medical Record Review
  - Analysis of admissions & discharge data
  - Process assessment including process owner interviews & direct observation
  - Focus groups with patients & providers
  - Identify patterns of readmissions
- All led to decision on the KATS clinical model—CMS mandated that all applicants chose one of the 6 offered evidenced based transition models to continue testing during the Innovation Demonstration

- ### Results of the Root Cause Analysis
- Poverty
  - Health literacy
  - Illiteracy
  - Poor home support
  - Lack of information on care—prior to and after discharge
  - Low compliance with appropriate care measures
  - Non-compliance with hospital process care measures
  - Non-compliance with discharge medication instructions
  - Emergency room usage
  - Few community-based services
  - Cultural preference of hospitalization vs. home care

- ### KATS Clinical Model
- Transitional Care Model © - University of Pennsylvania’s Ralston PENN Center— developed by Dr. Mary Naylor
  - An evidence-based alternative model of care that has been tested and refined over twenty years, has improved health outcomes, prevented avoidable re-hospitalizations, enhanced patient and family caregiver satisfaction & decreased health care costs.

- ### TCM Overview
- 6 week hospital-based care transitions that requires a nurse to do the following:
    - Conduct initial hospital visit and assessment
    - Subsequent home visits for 1 month
    - Detailed assessment of patient’s ability to conduct activities of daily living
    - Provide medication management
    - Coach patient for follow-up primary care visit
    - Accompany them to the primary care visit
    - Conduct follow-up phone calls for each week there is not a home visit

### TCM Protocols

- Every patient participating in TCM receives individualized care based on tested protocol.
- Standardized protocols-tailored specifically for the patient based on their unique circumstances
- In-hospital visits with patients and families within 24 of enrollment in TCM—comprehensive assessment, collaboration with physicians and other members of ARH team to streamline the plan of care and to design and coordinate inpatient and follow-up care based on the assessment and patient identified goals
- Home visits with patients- in home visit within 24 to 48 hours of discharge. After initial visit, a minimum of 1 home visit per week during the first month, followed by semi-monthly visits until discharge from TCM
- Telephone follow-up— as needed and in each week there is not a home visit—on-call availability 8am to 8pm Monday through Friday and 8am to noon on weekends.
- Nurse visit with physician—nurse accompanies the patient on their first visit to physician post-discharge and on subsequent visits if needed
- Transition from TCM—nurse assures continuity of care & ongoing commitment to the patient's self management goals through communication with the primary care provider—transition summary provided to patients and PCP— assists in transitions to other programs, e.g. palliative care, home health, hospice, etc.

### KATS TCM Risk Assessment Tool

Used in the hospital to screen for eligible at-risk FFS Medicare recipients

- Risk Factors to screen for eligibility:
- *Are the following statements true for the patient?*
- The patient was admitted to hospital within the last 24-48 hours?
- The patient is 65 years of age or older?
- Does the patient speak English?
- Is the patient reachable by telephone?
- Is the patient alert & cognitively intact?
- Is there a documented HX of a primary cardiovascular, respiratory, heart, and endocrine?
- Does not have end-stage renal disease?
- Does not have a major psychiatric illness?
- Does not have a primary diagnosis of cancer?
- Does the patient live within 30 miles of the admitted facility?
- Is the returning home after discharge (SNF/rehab stay <3 weeks?)

### TCM Screening Tool continued

- *If yes to all of the above, does the patient have 2 or more of the following risk factors?*
- Age 80 or older
- Moderate to severe functional deficits (e.g., KATZ Activities of Daily Living <4)
- HX of mental/emotional illness (e.g. Geriatric Depression Scale >5)
- Four or more active co-existing health conditions
- Six or more prescribed medications
- Two or more hospitalizations within past 6 months
- Hospitalization in the past 30 days
- Inadequate support system
- "Poor" self-rating of health
- Documented history of non-adherence to therapeutic regimen

### Clinical Assessment Tools

- Subjective Health Rating
- Instrumental Activities of Daily Living
- Geriatric Depression Scale
- Short Portable Mental Status Questionnaire
- Rapid Estimate of Adult Literacy In Medicine-SF
- KATZ Activities of Daily Living
- Symptom Bother Scale
- Overall Life Rating
- Caregiver Assessment
- Medication Reconciliation

## 4 Key Performance Metrics

AIM of 20% reduction in all cause Medicare FFS 30 day readmissions requires:

**Full Enrollment**

100%

% of Target Enrollment

**Low CCTP Readmission Rate**

25% 18% 30%

Baseline Cr 1

**High Risk Target Group**

25% higher

All Cause FFS Readmission Rate CCTP Baseline Readmission Rate

**Sufficient Footprint**

30-60% of Medicare FFS Admissions

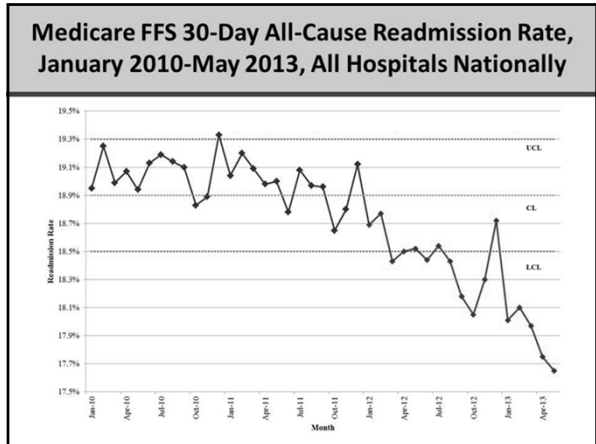
### Building on CCTP to Impact All Readmissions

Payer Type	Total Index Admissions (%)	Total Readmissions (%)
All Other	6%	5%
Uninsured	5%	4%
Privately Insured	25%	18%
Medicaid	18%	10%
Medicare Non-CCTP FFS	30%	40%
Medicare Advantage	5%	10%
Medicare CCTP	10%	6%

**42% of Readmits Among Payers Other than Medicare**

**CCTP Partnerships Account for 17% of Medicare FFS Readmits**

2010 Baseline for 32.9M Index Admissions and 4.7M Readmissions



### KATS Target Progress

- Average FFS Admits 663
- Potential Footprint 46% of FFS Medicare Admissions
- Monthly target enrollment-ultimately 308 per month
- 2014 1<sup>st</sup> Quarter monthly enrollment target: 200
- CMS' expected readmissions for the partner hospitals is 27%
- Current KATS readmission rate is 13.6%
- Patients admitted to KATS have had a 48% decline in readmissions
- March through October all-cause readmissions at partner hospitals decreased by 4%

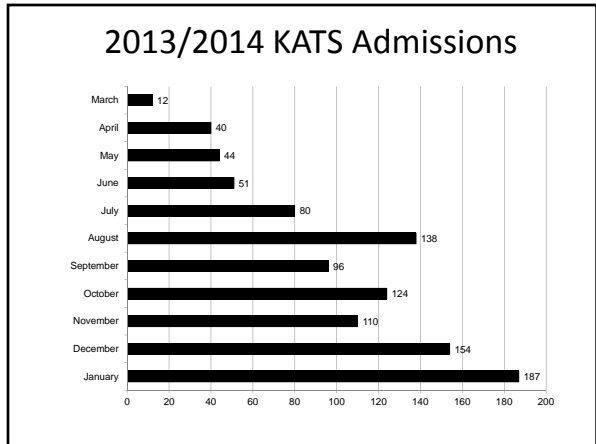
### KATS Financial Performance July-October 2013

- Avoided Readmission Savings -\$105,600
- CCTP Program Costs \$12,640
- Change in Medicare Spending -\$92,960
- Monthly Potential Lost Cash Flow Attributable to Completion & List Bill Submission Gap: \$12,640
- At Target Enrollment
  - Avoided Readmission Savings -\$364,800
  - CCTP Program Costs \$121,660
  - Change in Medicare Spending -\$243,140

### KATS Progress 2013 March-December

- KATS is now implemented in all 4 partner hospitals
  - Hazard & Whitesburg March 2013
  - Williamson May 2013
  - Harlan July 2013

Hospital	Admission to Date
Whitesburg ARH	287
Hazard ARH	454
Harlan ARH	112
Williamson ARH	127
<b>Total</b>	<b>980</b>



### KATS January 2014 Results


Hospital	Hazard	Whitesburg	Harlan	Williamson
Total FFS MC admissions	450	140	186	128
Screened	308	141	114	89
Ineligible	186	94	80	66
Admitted	97	42	27	21
Refused	25	5	7	2

**KATS Community Referrals**  
March – October 2013

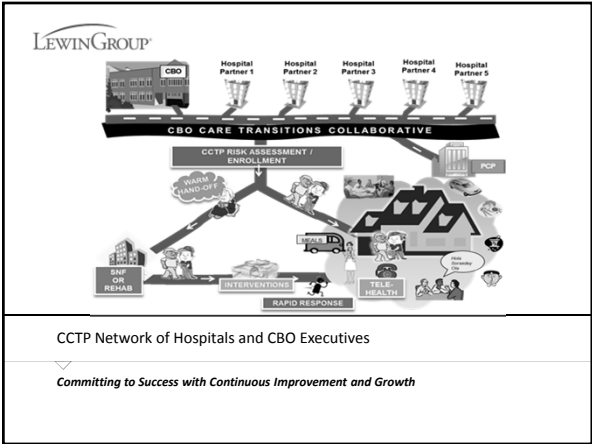
• Home Health	24
• DME	76
• Hospice	19
• SNF	11
• PT/OT	3
• Adult Day	2
• Home Meals	5

- CMS Mandated CCTP Patient Experience Survey**
- The survey contains three modules and 21 questions
  - Questions in each module are drawn from 3 existing instruments:
    - 5 Questions from the Hospital Consumer Assessment of Healthcare Providers & Systems (H-CAHPS) Survey
    - 3 questions from the Care Transitions Measure (CTM-3)
    - 13 questions from the Patient Activation Measure (PAM-13)
- Studies demonstrate that these questions provide valid & reliable information with similar patient populations

- Overview of Survey Administration**
- The Patient Experience Survey is administered either once or twice with each CCTP patient, depending on the type of intervention model used
  - First Administration: completed within four days after hospital discharge
  - Includes all 21 items
  - Second Administration: should be included at the end of the intervention
  - Includes only 13 questions in the last module (PAM-13)
  - KATS is mandated to do both questionnaires

- Challenges**
- Patients refusing the program
  - Hiring & training sufficient number of nurses
  - Strengthening Community Partnership
  - Educating physicians
  - Engaging our partners
  - Expanding the footprint
    - NH / Dementia / UMWVA
- 

- Strategies for Improvement**
- KY Medicare Quality Improvement Organization is showcasing KATS in their 10<sup>th</sup> Scope of work with CMS
  - Hospital Education Networks have been asked to assist CCTP awardees in fully engaging our partner hospitals
  - Scripting to improve acceptance rates
  - Activate the KATS Coalition!





**KATS Community Coalition**

- CMS stresses successful programs must have strong community collaborations
- All downstream providers should be involved in the development of processes to avoid re-hospitalizations
- Develop communication processes with other insurers & providers
- Referral & education sources for Transition Nurse Coaches

**CMS Mandated Contracts With Other Payers**

- All CCTP Awardees are expected to propose contracting for transition services with other payers
- KATS currently contracts with Humana Advantage
- Proposals to United, MCOs and hospitals
- KATS works closely with United Mine Workers of American in transitioning their members

**KATS Transition for Humana Advantage Members**

- Humana SeniorBridge contract to transition Advantage patients for 30-day 3 visit RN intervention—August 2012
- SeniorBridge contract for long-term case management- 1 visit per week—ongoing – November 2012
- Transition from hospitals in Central KY, Northern KY and Eastern KY

**Humana Advantage/SeniorBridge Admissions**

Short-term 30-day transition intervention	Long-term case management
<ul style="list-style-type: none"> <li>• 2012 August-December                             <ul style="list-style-type: none"> <li>– Central KY 71</li> <li>– Eastern KY 5</li> <li>– Northern KY 61</li> </ul> </li> <li>• 2013 January-September                             <ul style="list-style-type: none"> <li>– Central KY 282</li> <li>– Eastern KY 50</li> <li>– Northern KY 98</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 2013 January-October                             <ul style="list-style-type: none"> <li>– Central KY 88</li> <li>– Eastern KY 72</li> <li>– Northern KY 49</li> </ul> </li> </ul>

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