Achieving Scale with Care Transitions

Caroline Ryan, ADRC Care Transition Lead
Abigail Morgan, Social Science Analyst

Session Framework

I. Federal Level

II. State Level

III. Local Level

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Question to Run On:

What are you going to work on tomorrow?

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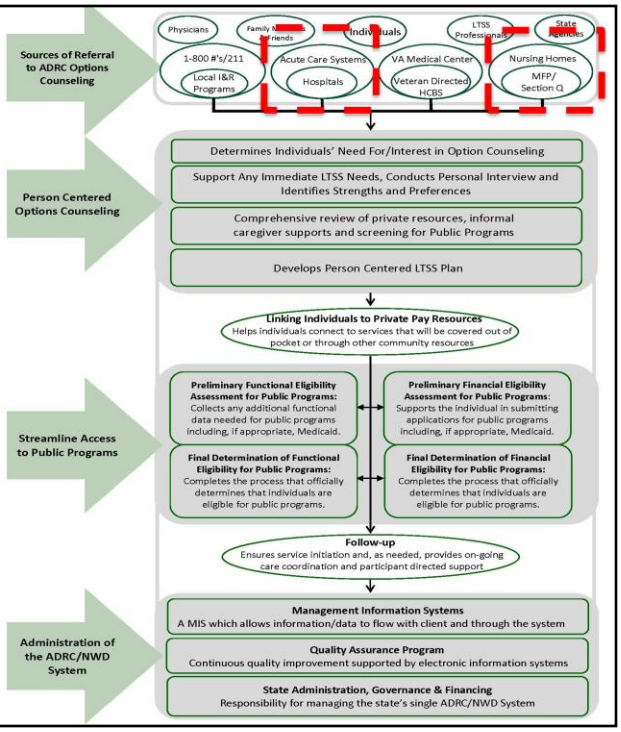
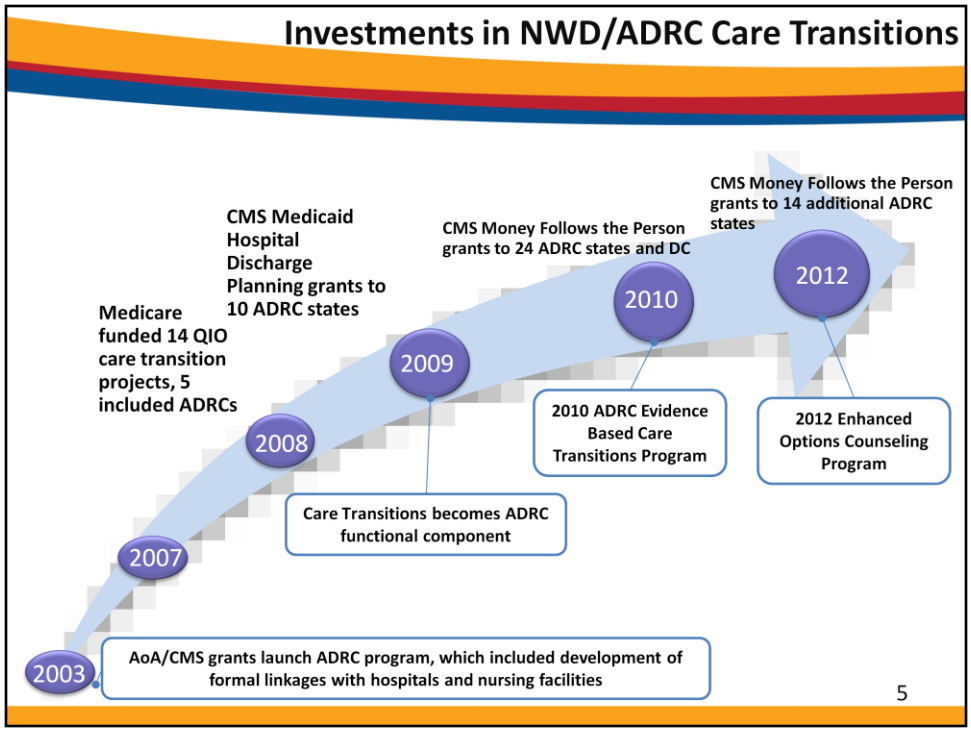
The NWD/ADRC System

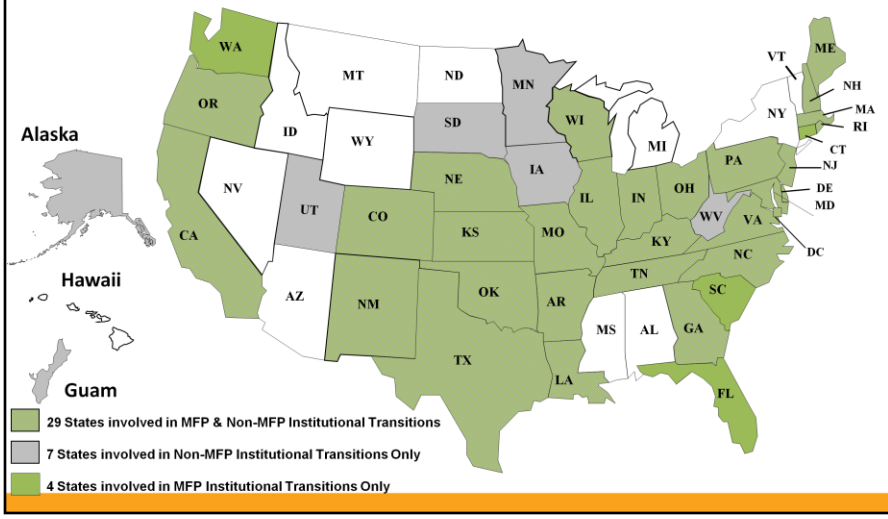
For All Populations and All Payers

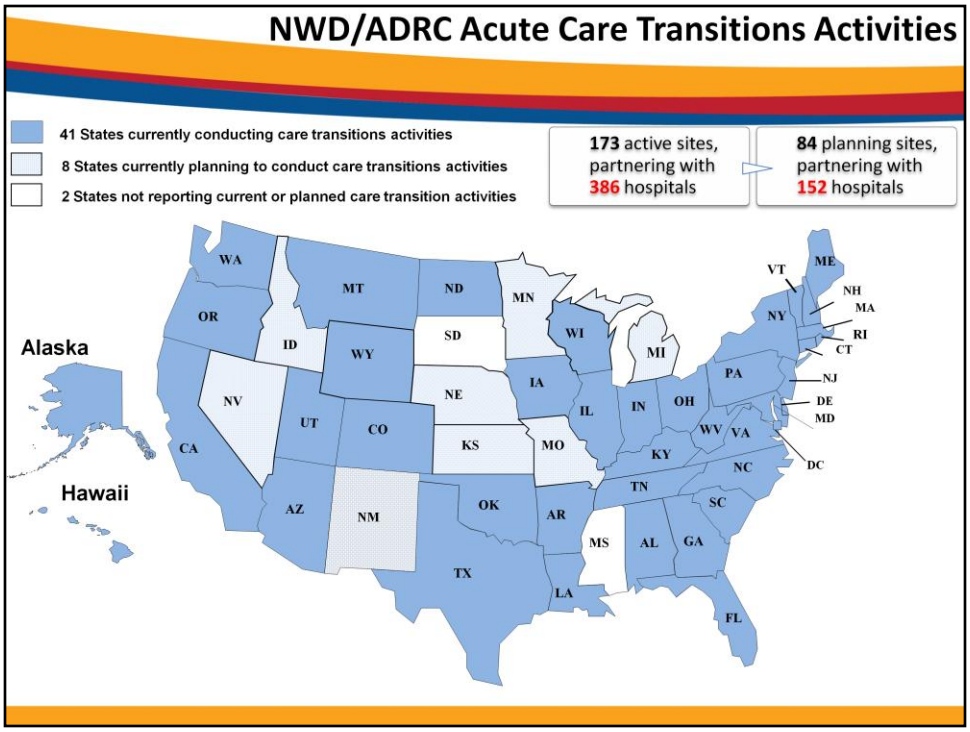



Investments in NWD/ADRC Care Transitions
CMS Money Follows the Person grants to 14 additional ADRC states
CMS Medicaid Hospital Discharge Planning grants to 10 ADRC states
CMS Money Follows the Person grants to 24 ADRC states and DC
Medicare funded 14 QIO care transition projects, 5 included ADRCs
2012
2010
2009
2008
2007
2003
2010 ADRC Evidence Based Care Transitions Program
2012 Enhanced Options Counseling Program
Care Transitions becomes ADRC functional component
AoA/CMS grants launch ADRC program, which included development of formal linkages with hospitals and nursing facilities
5

ADRC Institutional Care Transitions Activity

304 ADRCs in 42 states are involved in institutional transitions




NWD/ADRC Acute Care Transitions Activities
41 States currently conducting care transitions activities
8 States currently planning to conduct care transitions activities
2 States not reporting current or planned care transition activities
173 active sites, partnering with 386 hospitals
84 planning sites, partnering with 152 hospitals
Alaska
Hawaii
WA
OR
CA
ID
NV
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
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WI
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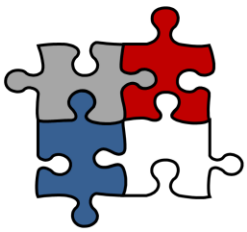
What is the Connection between Long Term Services and Supports and Hospital Readmissions?



Long Term Services and Supports and Hospital Readmissions

- In a study evaluating the home food environment of hospital-discharged older adults, 1/3 of participants reported being unable to both shop and prepare meals
- Greater volume of attendant care, homemaking services and home-delivered meals is associated with lower risk of hospital admissions

Anyanqu, Ucheoma O., Sharkey, Joseph R., Jackson, Robert T. (2011) Home Food Environment of Older Adults Transitioning From Hospital to Home. *Journal of Nutrition in Gerontology and Geriatrics* 30:105-121.
Xu, Huiping et al. (2010) Volume of Home-and Community-Based Medicaid Waiver Services and Risk of Hospital Admissions. *Journal of American Geriatric Society*

NWD/ADRC Care Transitions Preliminary Results and Lessons Learned

- Partnership
- Communication
- Sustainability

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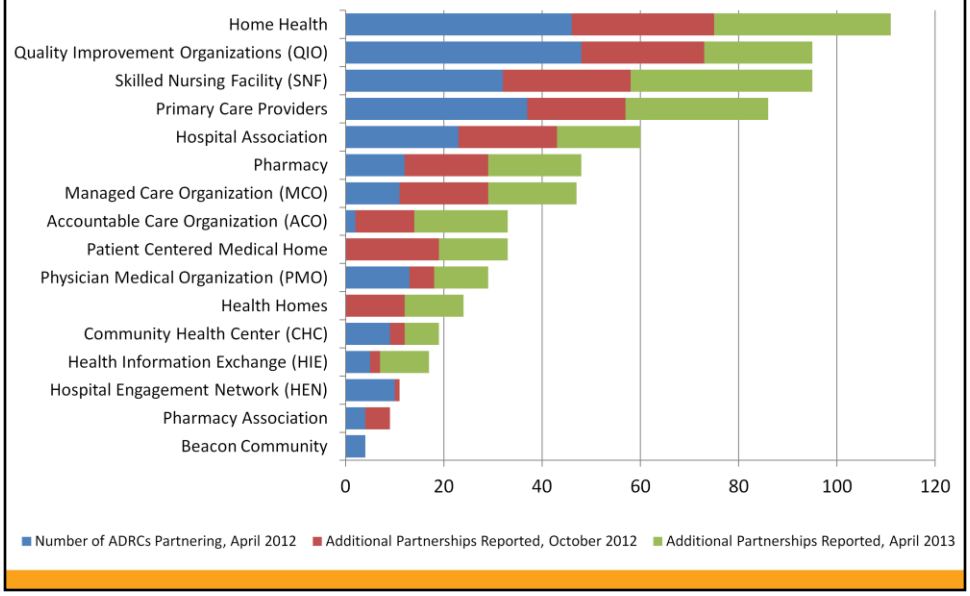
NWD/ADRC Care Transitions Partnerships



Preliminary Results and Lessons Learned

- Partnership
- Communication
- Sustainability

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Communication Strategies

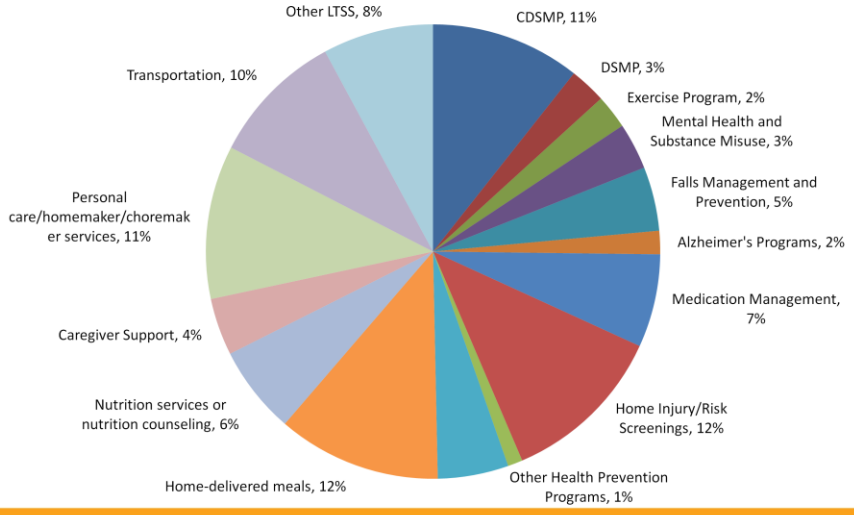
- In-person meetings/Rounds/Shared Space
- Success Stories
- Leveraging Technology
  - **Center for Technology and Aging (CTA)** Tech4Impact Diffusion Grants Program
  - EMR/HIE

Resources:
Care Transitions Success Story Template
CTA ADOPT Toolkit
Washington State's ADRC Care Transitions Intervention Toolkit

Connection to LTSS and Supports During Transitions

8,801 people were connected to 15,892 services and supports

October 2012 – March 2013



Communication Strategies: Group Processing

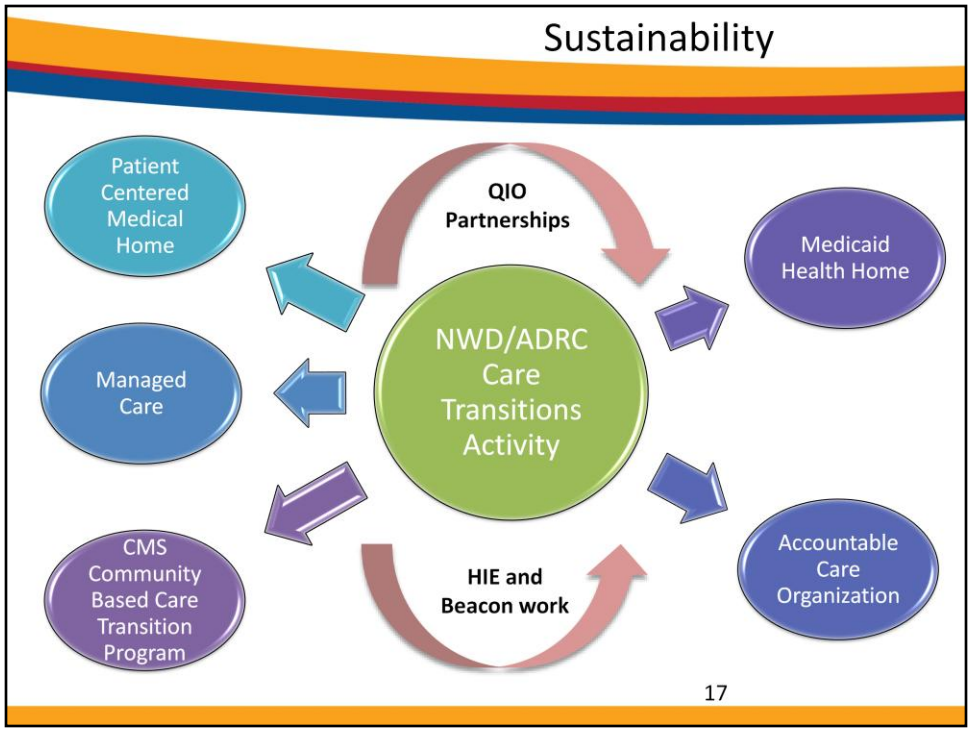
- What other communication strategies have led to success within your own transitions work?

15

Preliminary Results and Lessons Learned

- Partnership
- Communication
- Sustainability

16


Sustainability
Patient Centered Medical Home
QIO Partnerships
Medicaid Health Home
Managed Care
NWD/ADRC Care Transitions Activity
CMS Community Based Care Transition Program
HIE and Beacon work
Accountable Care Organization
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We get this question all the time. It's not too late.

Meet: Local Independent Physician

Similar challenges: everyone wants to collaborate, limited resources and time to devote attention, complexity of billing systems, access to data

Opportunities and similar goals: better care management, taking advantages of health reform changes, developing networks to maximize outcomes, etc.

Quotes below from online interview: http://www.californiahealthline.org/road-to-reform/2012/health-care-reform-driving-physicians-together and http://www.physicianspractice.com/mgma12/how-healthcare-reform-will-influence-private-practices

Meet: Local Public Health Dept.

similar challenges: ability to bill for services, ability to share data, health reform changes shifting service to other health care providers, services seemed outside the realm of traditional healthcare services, assume fully funded, etc.

Quotes from article: http://www.cdc.gov/nphpsp/essentialservices.html

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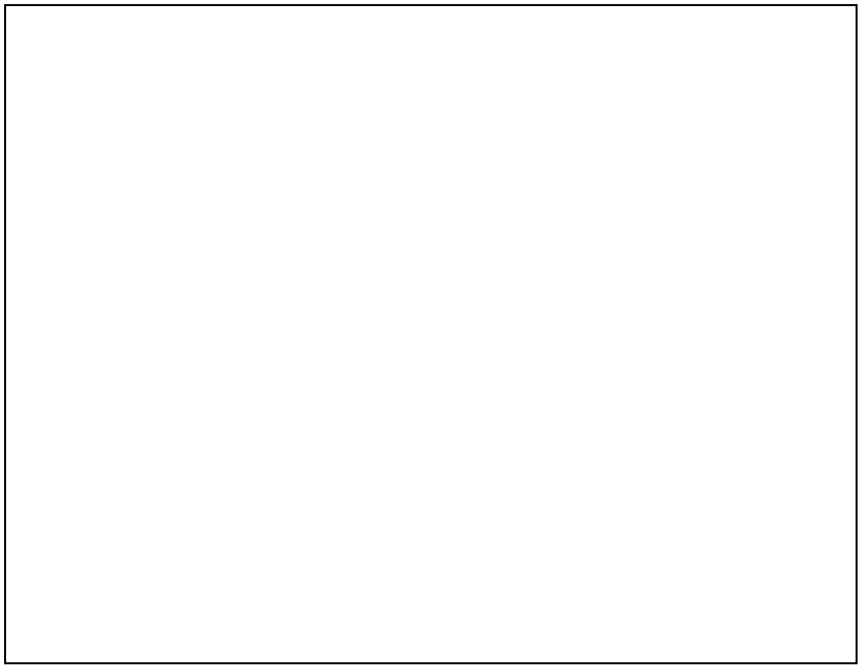
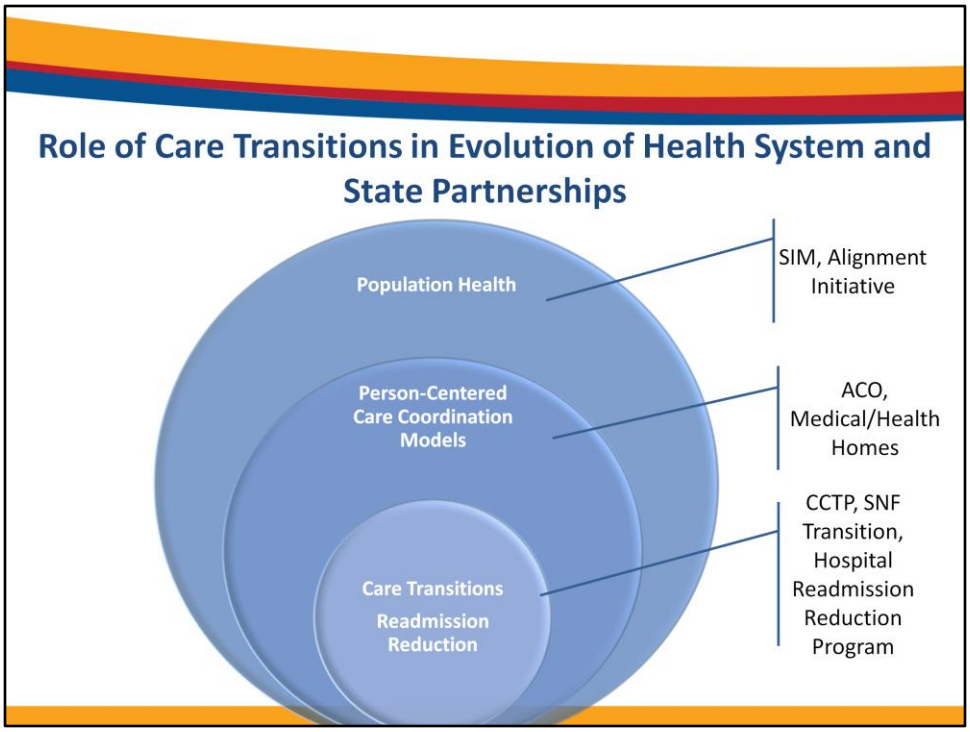


Financial Risk Of Care For Provider And Payer, By Payment Method



There is a role for care transitions and quick, appropriate access to LTSS in each of the cornerstone payment and care delivery models under health reform. As models move from concentrated, time-sensitive, to ongoing coordination and management of health and chronic conditions, populations, and individuals affected also expand.

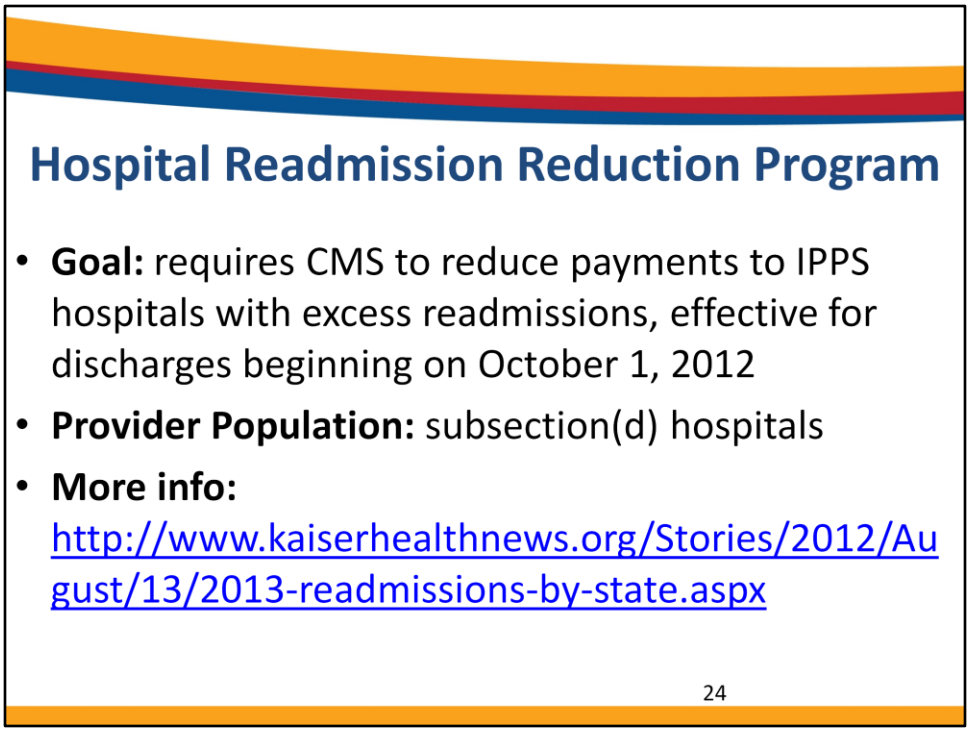
The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

Major themes of best practices:

Full hospital partnership—includes strategies such as CBO staff presence in the hospital, sharing access to hospital census and electronic medical records.

Proactive staffing models—regardless of which model or interventions sites use, states and sites can plan together for how best to develop a trained workforce. Sites find that staffing up quickly allow for quicker implementation of the program, care transitions referrals grow with the availability of staff to assess and follow up.

Full coordination with all programs/demonstration working to reduce readmissions—CCTP only targets Medicare FFS beneficiaries, but many programs and payers include performance metrics to reduce readmissions.



More than 2,200 hospitals faced some level of penalty in the first year. The penalties amounted to approximately $125,000 per hospital on average and $280 million total. Nine percent (278) of the hospitals were assessed the maximum penalty

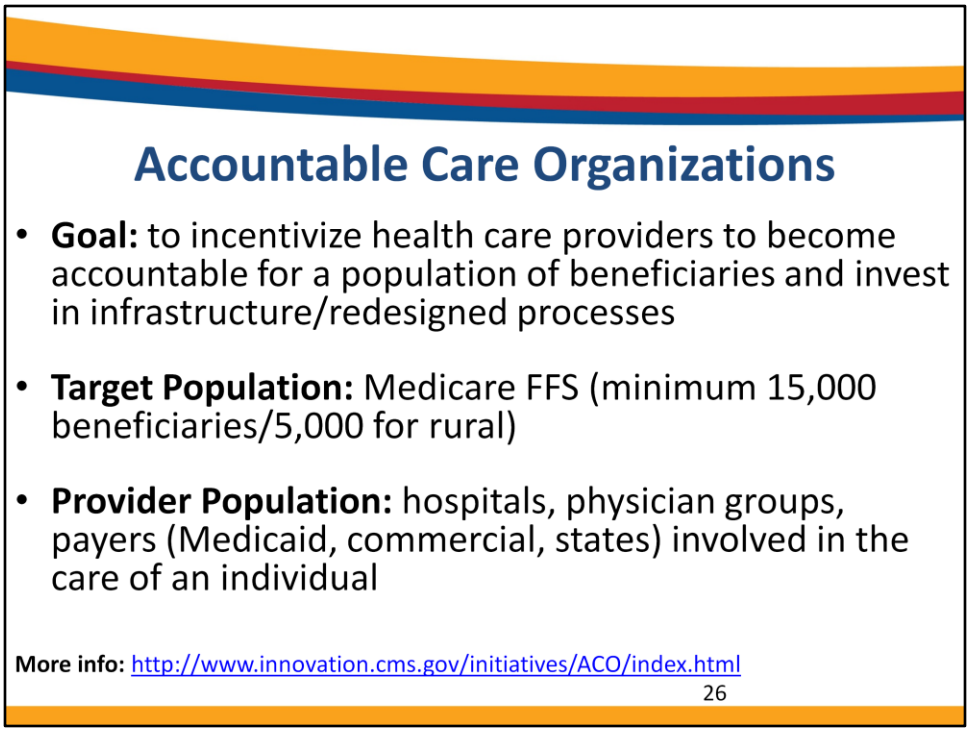
http://www.commonwealthfund.org/Blog/2013/Feb/The-Effect-of-Medicare-Readmissions-Penalties-on-Hospitals.aspx

26 Hospital Engagement Networks:
Develop learning collaboratives for hospitals;
Provide a wide array of initiatives & activities to improve patient safety;
Conduct intensive training programs to help hospitals make patient care safer;
Provide technical assistance to help hospitals achieve quality measurement goals;
Establish & implement a system to track & monitor hospital progress in meeting quality improvement goals.
Identify high performing hospitals and their leaders to coach and serve as national faculty to other hospitals committed to achieving the Partnership goals.
$218 million was awarded to 26 State, regional, national, or hospital system organizations to be Hospital Engagement Networks.

Areas of harm addressed by HENs: Adverse drug events (ADE), Catheter-associated urinary tract infections (CAUTI), Central line-associated blood stream infections (CLABSI), Injuries from falls and immobility, Obstetrical adverse events, Pressure ulcers, Surgical site infections, Venous thromboembolism (VTE), Ventilator-associated pneumonia (VAP), Preventable readmissions

Hospital Engagement Networks will address additional topics relating to organizational structure – such as leadership and culture change – to reduce all-cause harm and preventable readmissions.

CMMI and ACL are working together to develop targeted messages and resources for HENs to support additional coordination across CCTP and ADRC Care Transitions activities, including understanding performance metrics, supporting best practices such as access to hospital census and medical records, streamlining the referral process, etc.



Also known as the ACO – Accountable Care Organization
Reward ACOs that take responsibility for the costs and quality of their care for Medicare beneficiaries over time
Savings shared between ACO and Medicare

There are over 250 ACOs participating in partnerships with CMS, with high concentrations in the northeast and southeast regions of the country, as well as the Chicago region (including Region V states).

Over 50% of ACOs are made of networks of independent physician practices and group practices.

Rules have been published and details announced about ACO Models:

Pioneer ACO—32 participating in 2 yr demo
http://innovation.cms.gov/initiatives/aco/pioneer/index.html

•Targeted to groups of providers already experienced in this model, able to rapidly move from producing shared savings to population based payment (e.g. per beneficiary per month)

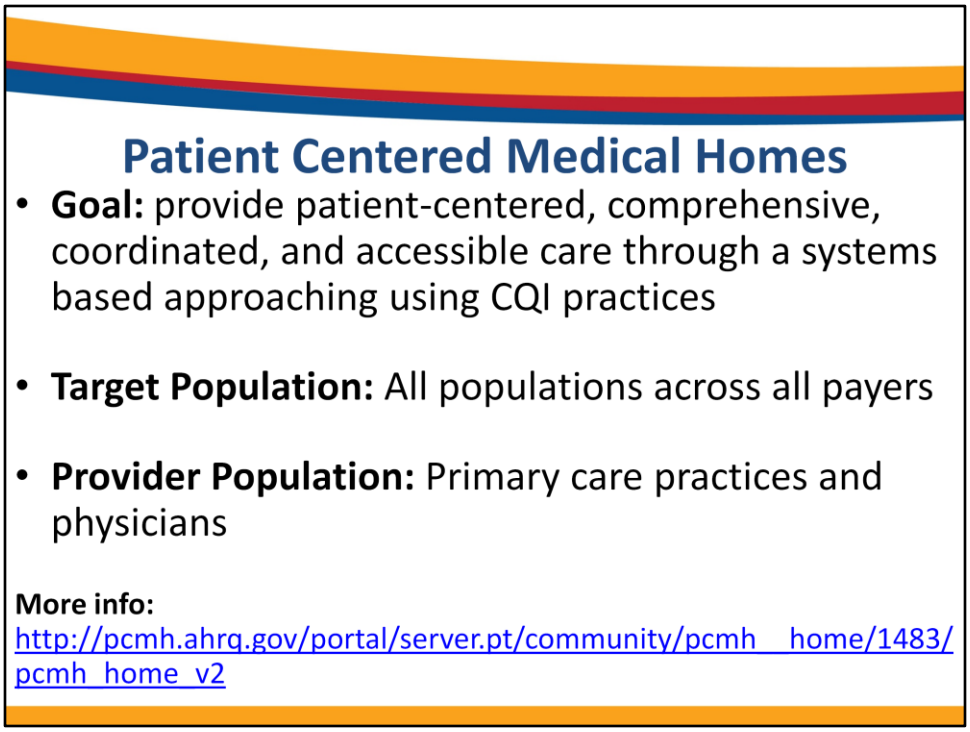
•UPDATE: 9 pioneers dropped out, 7 to MSSP, less risk, no downside.

Advance Payment Model—20 participating
http://innovation.cms.gov/initiatives/aco/advance-payment/index.html

ACOs are expected to also invest in infrastructure to support service coordination not traditionally reimbursed through Medicare FFS payments

Program monitoring includes service utilization patterns, audits and beneficiary surveys. ACO8-measure includes monitoring all-cause readmissions

There are many pages that outline not only the configuration of ACOs, but guidance on performance measurement and quality reporting. http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html



NCQA has rigorous certification process:
http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx
The CAHPS PCMH Survey assesses several domains of care:
Access, Information, Communication, Coordination of care, Comprehensiveness, Self-management support and shared decision making.

There's an excellent White Paper from AHRQ discussing challenges and solutions around PCMH for adults with complex care needs—AAAs specifically mentioned in conjunction with the administrative burden of PCMH to coordinate social services:
http://pcmh.ahrq.gov/portal/server.pt/gateway/PTARGS_0_11787_956295_0_0_18/Coordinating%20Care%20for%20Adults%20with%20Complex%20Care%20Needs.pdf

Other items of note:

Transitional Care Codes—77 FR 68978 through 6899
Payment for physician or qualifying non-physician practitioner care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization.

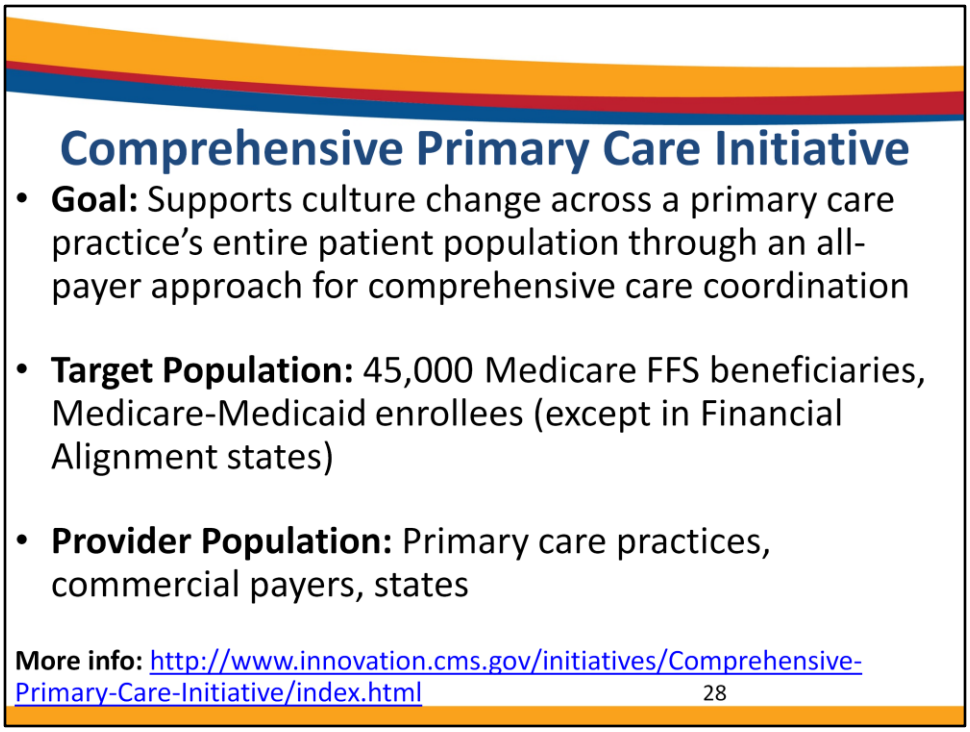
FAQs available here: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

Who can provide: This issue is addressed in greater detail in the Internet-only Benefit Policy Manual, Chapter 15, Section 60 available at: http://www.cms.gov/Regulations-and- Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html

More info: http://www.hospitalmedicine.org/AM/Images/Advocacy_Image/pdf/FAQ-CPT_Transitional_Care_Management_Final.pdf

Proposed Chronic Care Management Codes—proposed in physician fee schedule beginning 2015
- For patients with 2+ chronic conditions
- Must have medical home status, employ NP or PA
- Must offer 'complex chronic care management services' on 24/7 basis
- Must have received Medicare Annual Wellness Visit within last 12 months

Comment period until Sept 6th, Final rule expected around November 2013
https://www.federalregister.gov/articles/2013/07/19/2013-16547/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory



Part of the advanced primary care practice portfolio at CMMI, includes other medical home demonstration that emphasizes a team approach, prevention, HIT, care coordination and shared decision making

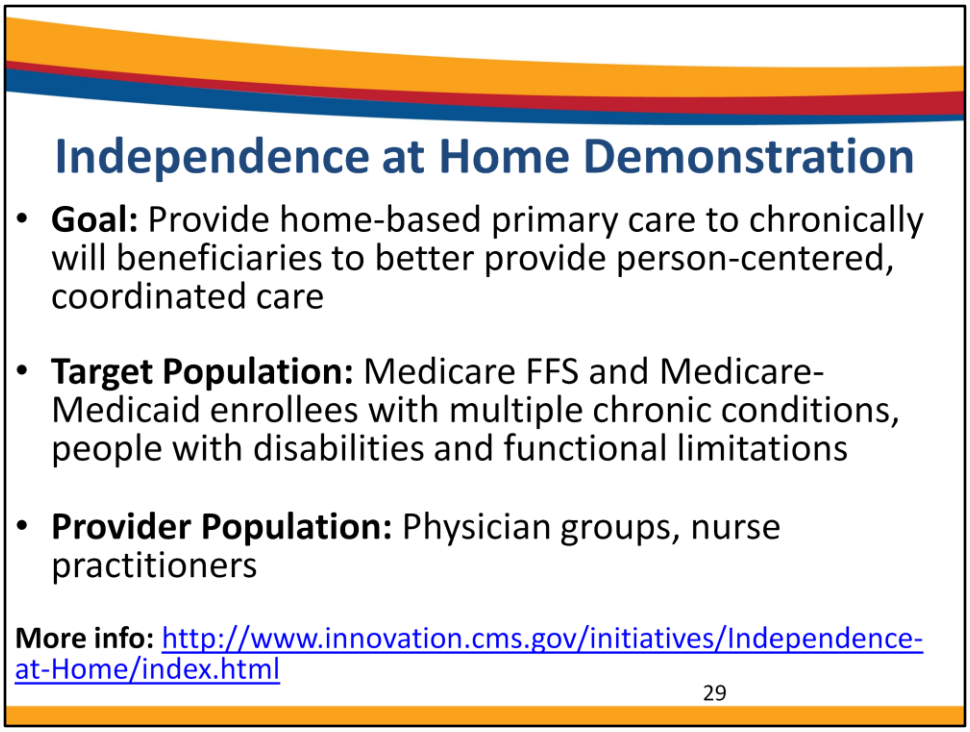
Services include risk stratification for care management
Identify needs for additional supports
•Includes evaluating MCC needs and complex acute care needs to support successful care transitions
Planned care for chronic conditions and preventive care
Coordination of care across the 'medical neighborhood' including 'community-based resources'

Markets: AR, CO, NJ, OR (all statewide); NY capital district/Hudson valley, OH/KY Cinncinati-Dayton area, OK Greater Tulsa = 500 total practices

Works with states, employers, health plans, purchasers to better invest and allow practices to better coordinate primary care services.

Other Medical Home Demos:

FQHC Advanced Primary Care Practice Demonstration- http://innovation.cms.gov/initiatives/FQHCs/
Multi-payer PCP demonstration: http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/

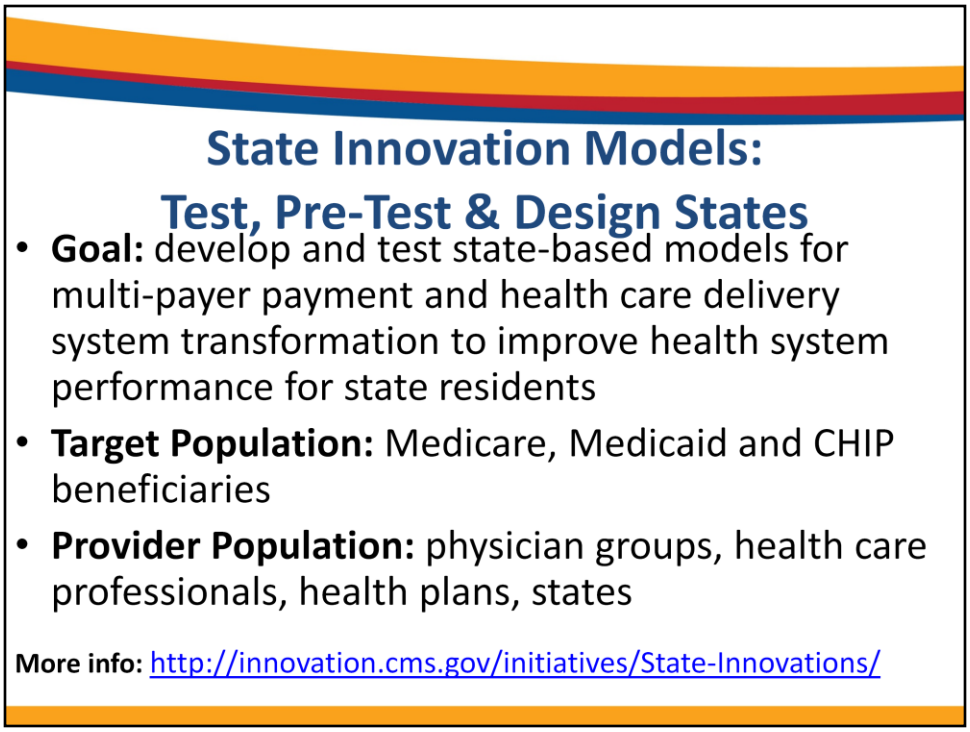


Establishes a payment incentive and service delivery system utilizing physician and nurse practitioner directed home-based primary care teams that improve health outcomes and reduce expenditures through care coordination in the home.

Overall goal is to test whether in-home primary care can reduce hospitalizations, hospital readmissions, emergency department visits, etc.

- Must serve at least 200 eligible beneficiaries
- Targets beneficiaries with multiple chronic conditions and functional limitations
- Cannot be in PACE or other shared saving demonstrations (e.g. ACOs)

Currently 15 practices, 3 consortia of practices in 14 states: MA, DE, OH, NY, NC, OR, KY, TX, FL, GA, MI, WI, IL, VA



Model test: 6 states including AR, ME, MA, MN, OR, VT ($250M over 3 years, approx $45M each)
Pre-test: 3 states including NY, WA, CO, (appxox $1-2M, six month planning period)
Design: 16 states including CA, CT, DE, HI, ID, IL, IA, MD, MI, NH, OH, PA, RI, TN, TX, UT (approximately $1-3M, six month planning period)

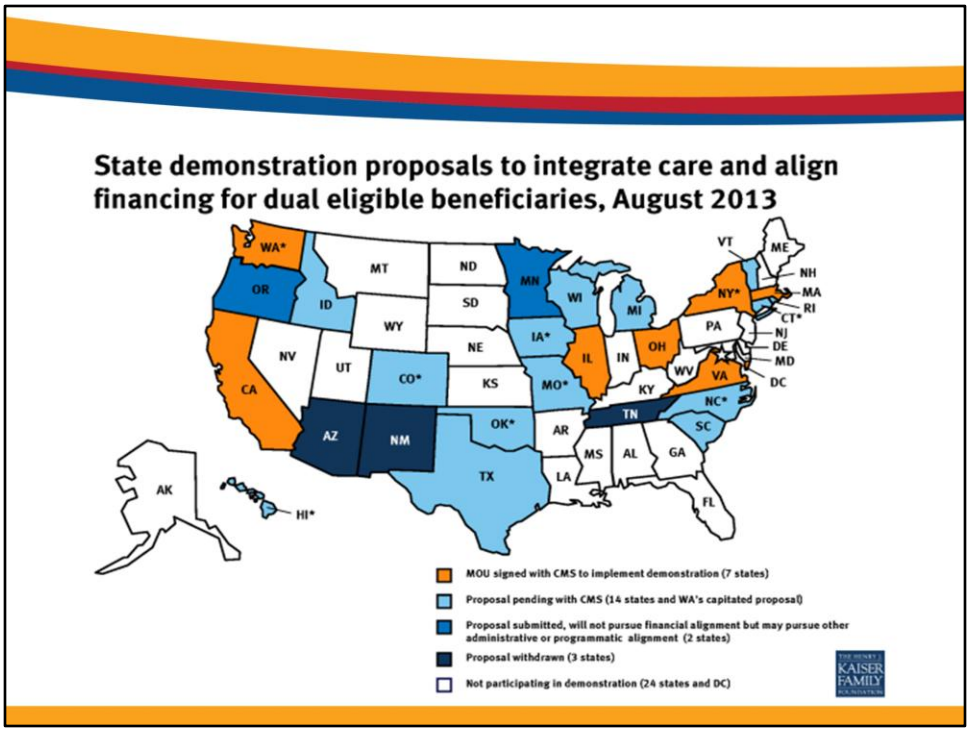
ACL part of CMMI technical assistance team for State grantees.

Comprehensive State-based Health Transformation Plans include:
Stakeholder engagement
Taking models to scale
Commitment to public health and LTSS
Building bridges across demonstrations

http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/

http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/

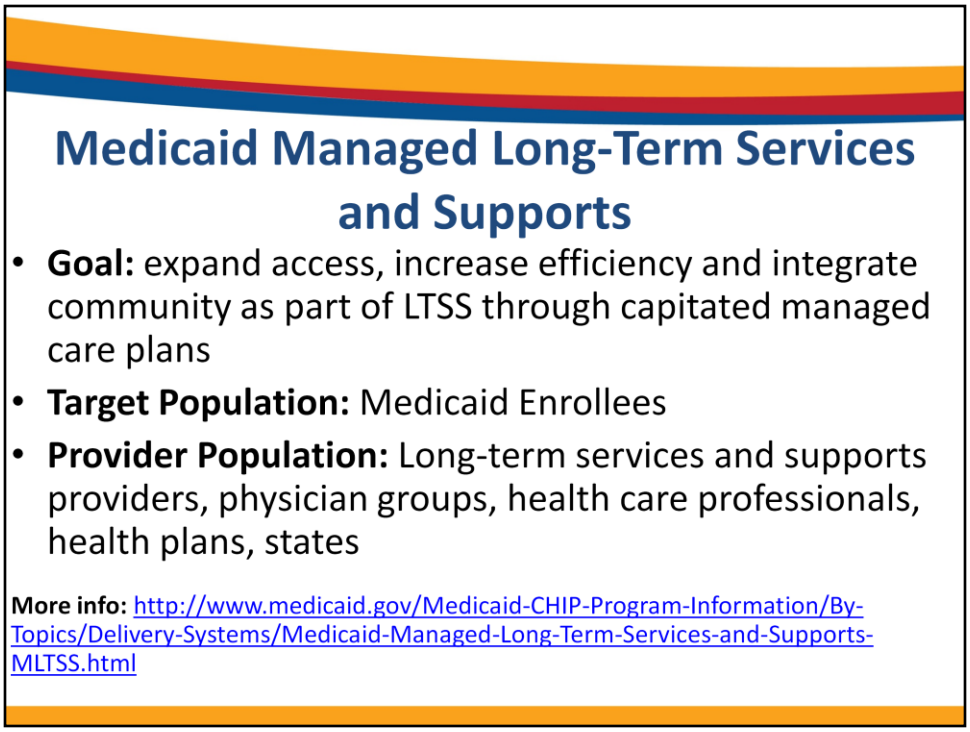
NOTES: *CO, CT, IA, MO, and NC proposed managed FFS models. NY, OK, and WA proposed both capitated and managed FFS models; however NY has withdrawn its managed FFS proposal. All other states proposed capitated models. WA's MOU is for its managed FFS model only; its capitated proposal remains pending with CMS. HI's proposal remains pending, but it does not anticipate implementation in 2014.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals, http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html, and state websites.



http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/

This map shows the current status of the state demonstration proposals to integrate care and align financing for beneficiaries eligible for both Medicare and Medicaid. Over 9.1 million seniors and younger people with significant disabilities are dually eligible for both programs, and as many as 2 million of them may be included in the demonstrations. Dual eligible beneficiaries are among the poorest and sickest beneficiaries covered by either program and consequently account for a disproportionate share of spending in both programs.

A number of states are working with the Centers for Medicare and Medicaid Services (CMS) to develop proposals to test capitated and/or managed-fee-for service models to integrate care and align financing for dual eligible beneficiaries, based on new demonstration authority in the Affordable Care Act. CMS is presently reviewing the states' proposals to determine which will be implemented. Enrollment in the first demonstration became effective in July 2013, with others expected to follow in late 2013 and in early 2014.
For more information see Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries. http://kff.org/health-reform/issue-brief/explaining-the-state-integrated-care-and-financial/

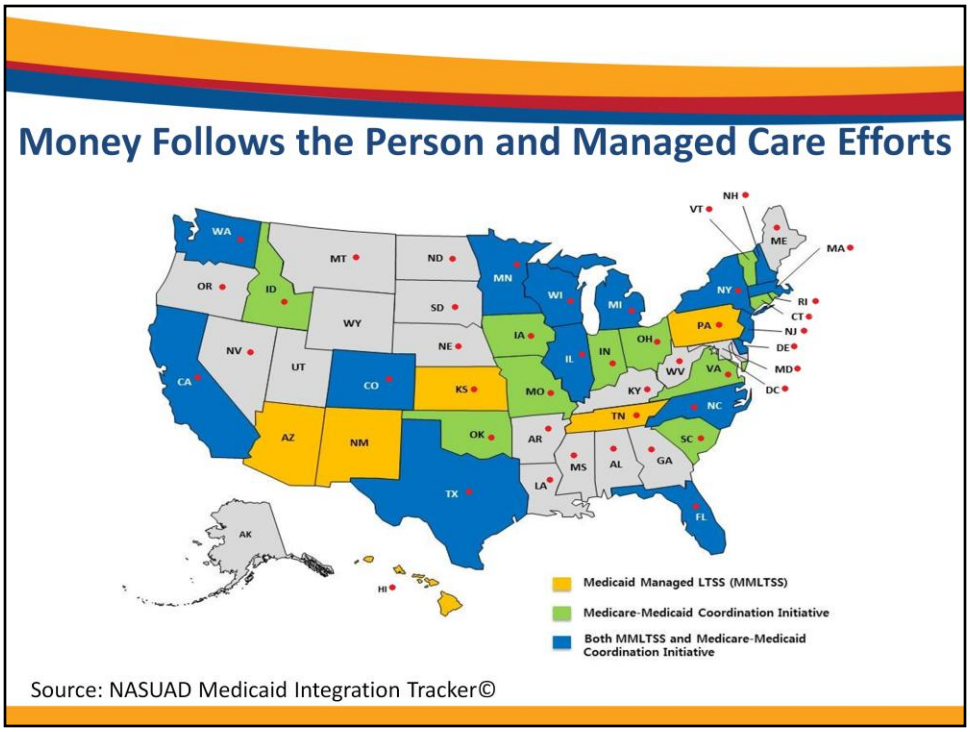


CMS Informational Bulletin that includes links to CMS guidance to states about 10 key areas adequate planning, stakeholder engagement, enhance provision of HCBS, alignment of payment structures and program goals, support for beneficiaries, person-centered planning, comprehensive integrated service packages, qualified providers, participant protections, quality: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-21-2013.pdf

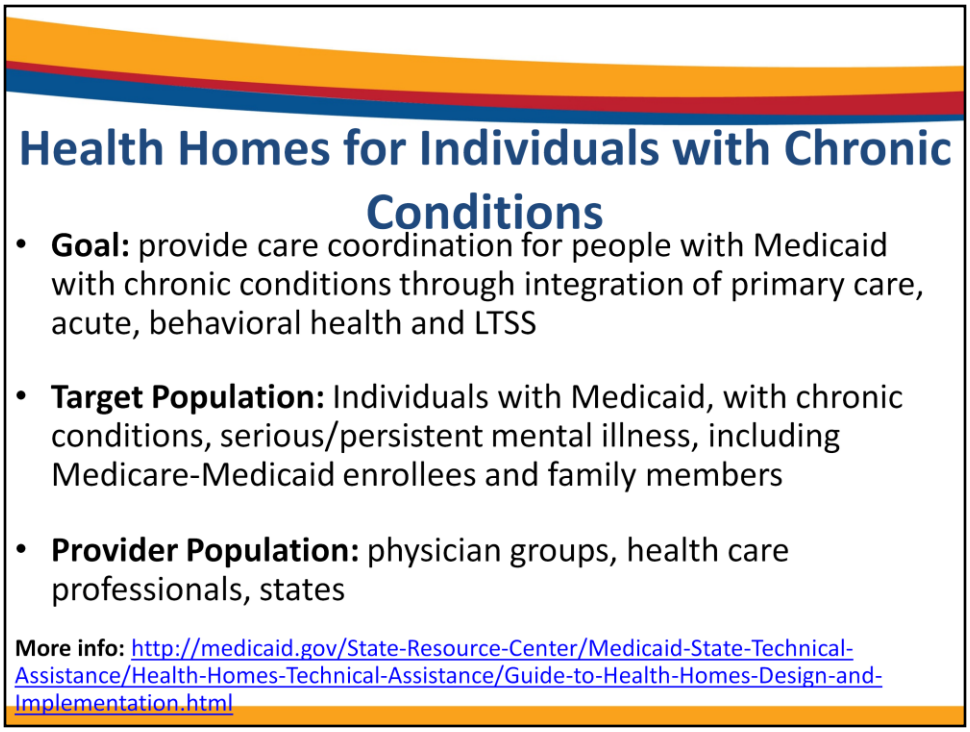
An online curriculum* offering states guidance on program design, Medicaid authorities and other information relative to the effective management of MLTSS. http://www.medicaid.gov/mltss/

A timeline for optimal planning and implementation of MLTSS programs. http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSS-Timeline.pdf

A paper identifying the concerns and considerations in incorporating traditional LTSS providers into a managed care program. http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/Transitioning-LTSS-.pdf



Issue brief from Mathematica discussing key areas of coordination for MFP and MLTSS. http://www.mathematica-mpr.com/publications/pdfs/health/MFPfieldrpt11.pdf



This is an example of a state plan option where partnerships with provides will provide better access and opportunity to play a full role on the team. Provide example from WA presentation—Washington's Dual Demonstration program is using the Medicaid Health Home to test a managed fee-for-service model

24 ADRC communities in **14** states are partnering with Health Homes

States are able to offer health home services for individuals with multiple chronic conditions or serious mental illness effective January 1, 2011
Coordinated, person-centered care
Primary, acute, behavioral, long term care, social services = whole person
Enhanced FMAP (90%) is available for the health home services (first 8 quarters)

25 states are actively planning for or implementing Health Homes

Website on slide outlines guidance for defining HH populations, core services, quality measures and payment methodologies. Some suggested quality measures include:

1. Adult Body Mass Index (BMI) Assessment,
2. Ambulatory Care - Sensitive Condition Admission,
3. Care Transition – Transition Record Transmitted to Health care Professional,
4. Follow-up After Hospitalization for Mental Illness,
5. Plan- All Cause Readmission,
6. Screening for Clinical Depression and Follow-up Plan,
7. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,
8. Controlling High Blood Pressure.

Links to National Care Transitions Event that discusses decline in readmissions across different measures

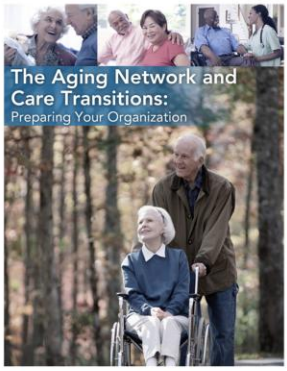
Recording with slides:
http://qualitynet.webex.com/qualitynet/playback.php?First=No&FileName=http://www.cfmc.org/integratingcare/files/F-CONATIONALCARETRANS072213.wrf

Slides:
http://www.cfmc.org/integratingcare/files/ICPC%20LAN%20KickOff_Final_072113_to%20post.pdf

Question to Run On:

What are you going to work on tomorrow?

Resources



Administration on Aging Care Transitions Toolkit

- Chapter One: Getting Started
- Chapter Two: Taking Time to Plan
- Chapter Three: Developing Effective Partnerships with Health Care Providers
- Chapter Four: Measuring for Success
- Chapter Five: Building Organizational Capacity
- Chapter Six: Implementation and Day-to-Day Operations

- **ADRCs and Care Transitions**
- **Template for Developing Care Transitions Success Stories**

Other ACA Resources

- Healthcare.gov (U.S. Dept. of Health and Human Services)
- State Refor(u)m (National Academy for State Health Policy)
- Health Reform Source (Kaiser Family Foundation)
  - Health reform summary; Implementation timeline; ACA federal funds tracker; Statehealthfacts.org
- Health Reform Central (Families USA)
- Health Affairs blog
- Health Insurance 101 (Community Catalyst and Georgetown University)
- Center for Medicare and Medicaid Innovation
- Federal Register: Health Care Reform

Find State Specific Resources:

- Where Innovation is Happening (The Innovation Center)
- State Medicaid Integration Tracker© (NASUAD)
- Integrated Care Resource Center
- State Resource Center (Medicaid)

Contact Information

Abigail Morgan
abigail.morgan@acl.hhs.gov

Caroline Ryan
caroline.ryan@acl.hhs.gov