Engaging Effective Post Acute Partners in New Models of Care

A Transitional Care Model
Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
FirstHealth of the Carolinas

4 Hospitals
Hospitalist Services
Heart Center
Specialty Practices
Primary Care Practices
Inpatient Rehab
Outpatient Services
Hospice/Palliative Care
Care Transitions
Why Do We Need New Models of Care?

Demands of Health Care Reform
- Better health
- Better health care
- Lower cost

Care delivered across the continuum

Focus on high risk, high cost population

Move from fee for service to value based care
CMS Innovation Center

Created by Congress under the ACA

Fosters healthcare transformation

New ways to pay for and deliver care

Lower costs and improve care
7 Categories of Innovation Models

ACO’s

Primary Care Transformation

Medicaid and Chip

Dual Eligibles

New Payment and Delivery Models

Adaption of Best Practices

Bundled Payments
The Bundled Payments for Care Improvement
4 Models

Retrospective Acute Care Hospital Stay Only

Retrospective Acute Care Hospital Stay plus Post Acute Care

Retrospective Post Acute Care Only

Prospective Acute Care Only
Retrospective Acute & Post Acute Care Episode Model 2

Single/Double Hip and Knee Replacements

Includes physicians, hospital, SNF’s, home health, inpatient rehab

3 days prior; 30 days post

3% target savings to Medicare (over 2011)

>3% = gain share

Lowest cost, highest quality care
Key Cost Saving Opportunities

Cost of acute stay

Readmissions

ED utilization

Post acute level of care
Medicare Cost: Single Knee Replacement

- Hospital: $0, $2,000, $4,000, $6,000, $8,000, $10,000, $12,000
- Inpt Rehab
- SNF
- Home Health

Legend:
- Hospital
- Inpt Rehab
- SNF
- Home Health
Post Acute Disposition
January 2014-June 2014

- Home Health
- SNF
- IPR
<table>
<thead>
<tr>
<th>The RAPT Assessment Tool</th>
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</thead>
<tbody>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Ambulation</td>
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<tr>
<td>Assistive devices</td>
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</tbody>
</table>
Joint Replacement Pathways

Sets consistent care standards

Establishes milestones

Manages cost

Coordinates care from acute to outpatient

Standard/High Intensity
New Models of Care

*From volume to value*
Common to All Models

Move from fee for service to value based payment

Focus on high risk, high cost population

Care delivered across the continuum

Transitional care
# A Plethora of Transition Models

<table>
<thead>
<tr>
<th>Care Transitions Intervention</th>
<th>The Chronic Care Model</th>
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<tbody>
<tr>
<td><em>Eric Coleman</em></td>
<td><em>MacColl Center for Health Care Innovation</em></td>
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<tr>
<td><strong>Transitional Care Model</strong></td>
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<tr>
<td><em>Patricia Naylor</em></td>
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<tr>
<td><strong>Project BOOST</strong></td>
<td><strong>Project INTERACT</strong></td>
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<tr>
<td><em>Society of Hospital Medicine</em></td>
<td><em>Florida Atlantic University</em></td>
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<td><strong>Project RED</strong></td>
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<tr>
<td><em>Boston University Medical Center</em></td>
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<tr>
<td><strong>Guided Care</strong></td>
<td><strong>Project STAAR</strong></td>
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<tr>
<td><em>Bloomberg School of Public Health</em></td>
<td><em>Institute of Healthcare Improvement</em></td>
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<td><strong>The Bridge Program</strong></td>
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<td></td>
<td><em>Illinois Transitional Care Consortium</em></td>
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</tbody>
</table>
The Road to Transitions
HRSA Telehomecare Network Grant 2009

$750,000, 3 year study

Increase access to care

Improve the quality of care

Develop chronic disease pathways of care

Create a network leveraging Telehealth technology
Hospital to Home Pilot

Post Acute Care Workgroup

Skilled Nursing Facility Team

Reid Heart Center Project
Telehomecare Network Grant Results
Utilization Outcomes

-6% hospitalization all

-25% hospitalization Telehealth

-17% HF hospitalization
Telehomecare Network Grant Results
Clinical Outcomes

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Telehealth Benchmark</th>
<th>Telehealth</th>
<th>Non Telehealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvement in Ambulation</td>
<td>66%</td>
<td>68%</td>
<td>59%</td>
</tr>
<tr>
<td>Improvement in Transferring</td>
<td>60%</td>
<td>71%</td>
<td>59%</td>
</tr>
<tr>
<td>Improvement in Pain</td>
<td>71%</td>
<td>83%</td>
<td>77%</td>
</tr>
<tr>
<td>Improvement in Bathing</td>
<td>73%</td>
<td>75%</td>
<td>66%</td>
</tr>
<tr>
<td>Improvement in Mgt of Meds</td>
<td>57%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Improvement in Dyspnea</td>
<td>68%</td>
<td>79%</td>
<td>78%</td>
</tr>
</tbody>
</table>
Hospital to Home Pilot

System wide initiative

Hospital, Hospitalists, Outcomes Management, Corporate Quality, Pharmacy, Education

Community Care of North Carolina

100 HF and COPD patients x 1 year

Transition processes defined, gaps identified
Program Goals

- Facilitate collaboration across the system
- Standardize patient education
- Reduce hospital readmissions
- Reduce ED utilization
- Improve Quality of Life
- Identify care gaps
Lessons Learned

Significant reduction in ED utilization at 30, 60 and 90 days

20% improvement in PAM scores

30% improvement Quality of Life

Impact on 60/90 day readmits - but not 30

Rethinking that 30 days
Transitions Clinic

ANP led, multidisciplinary clinic follows high risk patients for 30 days post hospital discharge

3 clinic visits then transitioned to PCP

Available resources include:
- RD
- Health Coach
- Palliative Care
- Pharm D
- Complex Care Management
The Care Transitions Advisory Council

Leader representatives from across the system and community

Oversees all things “transitions”

Prevents duplication, confusion

Forum for program updates, results, new ideas
Forging New Internal Partnerships

Maximizing Assets
“Practically every health system I encounter is an aggregation of disparate assets: acute care hospitals, employed physicians, urgent care centers, ambulatory surgical centers, ambulatory clinics, skilled nursing facilities, and so on.”

<table>
<thead>
<tr>
<th>Post Acute Services Team</th>
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</thead>
<tbody>
<tr>
<td>Cardiac Rehab</td>
</tr>
<tr>
<td>Pulmonary Rehab</td>
</tr>
<tr>
<td>Diabetes Self Mgt</td>
</tr>
</tbody>
</table>
# FirstHealth of the Carolinas

## Post Acute Care Services

For information on Post Acute Care Services available from FirstHealth, select the symptom/diagnosis. Service details include locations, service areas, eligibility, referral process, service description, and contact information.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact</th>
<th>Phone</th>
<th>Locations</th>
<th>Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac Rehab</strong></td>
<td>Jean Barrett</td>
<td>(910) 715-1886</td>
<td>Pinehurst Centers for Health &amp; Fitness</td>
<td>Hoke, Lee, Moore, Richmond.</td>
</tr>
<tr>
<td><strong>Community Care of the Sandhills</strong></td>
<td>Tammie McLean / Vivian McInnis</td>
<td>910-246-9806</td>
<td>Rockingham Center for Health &amp; Fitness</td>
<td>Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Scotland</td>
</tr>
<tr>
<td><strong>FirstHealth Response</strong></td>
<td>Jackie Polston, Sherry Chaffield</td>
<td>(910) 715-1271</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FirstHealth Transition Care Clinic</strong></td>
<td>Cheryl Batchelor</td>
<td>(910) 715-8355</td>
<td>Specialty Centers Building, Entrance 135 Memorial Dr., Pinehurst, NC 28374</td>
<td>All</td>
</tr>
<tr>
<td><strong>HealthNet of the Sandhills</strong></td>
<td>Jenny Fitter</td>
<td>910-248-9806</td>
<td></td>
<td>Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Scotland</td>
</tr>
<tr>
<td><strong>Home Care Services</strong></td>
<td>Connie Christopher</td>
<td>(800) 876-2212</td>
<td></td>
<td>Hoke, Lee, Montgomery, Moore, Scotland, Richmond.</td>
</tr>
<tr>
<td><strong>Stanford Classes</strong></td>
<td>Amy Hamilton Forester</td>
<td>910-417-3735</td>
<td>Varies</td>
<td>Montgomery, Richmond, Hoke</td>
</tr>
<tr>
<td><strong>Valve Clinic</strong></td>
<td>Kathy Coon, RN</td>
<td>910-715-1868</td>
<td>Reid Heart Center-2nd floor, 120 Page Road North, Pinehurst, NC 28374</td>
<td>All</td>
</tr>
</tbody>
</table>

**CONTACT DATABASE COORDINATOR**
Cardiothoracic Surgery Pathway

Partnership between the Reid Heart Center and FirstHealth Home Care

Standardized clinical pathway
- Telehealth/Heart Center trained
- 8 structured home nursing visits
- Standardized patient education
- ECG capabilities
- Transitions the patient to cardiac rehab and cardiology follow up

New pathway developed for Transmyocardial Revascularization and Transcatheter Aortic Valve Replacement
Cardiothoracic Surgery
Home Health Hospitalizations

Acute Care Hospitalization

2012  2013
Cardiothoracic Surgery Clinical Outcomes
Patient Centered Care Coordination
SNF Staff Education Project

- Pulmonary Rehab
- Cardiac Rehab
- Diabetes Self-Management
- Wound Care
- Infection Control
Transitional Care; What We Learned

Patient-centered, patient goal driven

Excellent communication across settings

Coordinated hand-offs/ transitions

Standardized education/consistent message

*Highly skilled nurse* to address patient’s complex needs and help navigate the care system

High risk patients identified/the PAM
Patient Activation Measure

The Universal Language of Care Transitions
The Patient Activation Measure
A Behavioral Concept

Measures the patient’s knowledge, skills and confidence essential to self management

Stratifies patients into one of four activation levels

Predicts healthcare outcomes including medication adherence, ER utilization and hospitalization

Creates a universal language across care settings
Level 1
Starting to take a role
Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.

Level 2
Building knowledge and confidence
Individuals lack confidence and an understanding of their health or recommended health regimen.

Level 3
Taking action
Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

Level 4
Maintaining behaviors
Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Increasing Level of Activation
The MORE ACTIVATED you are in your own health care, the BETTER HEALTH CARE you get...

<table>
<thead>
<tr>
<th></th>
<th>MORE ACTIVATED Patient</th>
<th>LESS ACTIVATED Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
<td>28%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
<td>48.6%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

Source: Adapted from AARP & You, “Beyond 50.09” Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved=Levels 3 & 4, Less Involved=Levels 1 & 2
Lowly Activated Patients
25%-40% of the Population

Feel overwhelmed with the task of managing their health

Have little confidence in their ability to have a positive impact on their health

Misunderstand their role in the care process

Have limited problem solving skills

Are passive in managing their health

Would rather not think about their health

*Hibbard et al 2005*
Lowly activated patients are less likely to:

- Play an active role in staying healthy
- Seek help when they need it
- Follow a Doctor’s advice
- Receive routine care
Principles of Coaching for Activation

Tailored support based on activation

Set small, simple, achievable steps

Realize success, build confidence

Develop awareness

Move from low to higher activation
<table>
<thead>
<tr>
<th>Health Plans and Hospitals</th>
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<tbody>
<tr>
<td>Blue Shield of California</td>
</tr>
<tr>
<td>Johns Hopkins Healthcare</td>
</tr>
<tr>
<td>Kaiser</td>
</tr>
<tr>
<td>Mayo Health Plan</td>
</tr>
<tr>
<td>United Healthcare</td>
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<tr>
<td>Well Care</td>
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</tbody>
</table>
Strategy by Payer

One Size Does Not Fit All
Medicare
55% of all readmissions

- Heart Failure
- Septicemia
- Pneumonia
- COPD
- Cardiac Dysrhythmias

Agency for Healthcare Research and Quality (AHRQ) Statistical Brief
Top 5 Conditions for Readmissions (2011)
Medicaid
20.6% of all readmissions

Mood disorders

Schizophrenia

Diabetes mellitus

Complications of pregnancy

Alcohol-related disorders

Agency for Healthcare Research and Quality (AHRQ) Statistical Brief
Top 5 Conditions for Readmissions (2011)
Private Insurance
18.6% of all readmissions

Chemotherapy or radiotherapy

Mood disorders

Complications of surgical procedures

Complications of device, implant or graft

Septicemia

Agency for Healthcare Research and Quality (AHRQ) Statistical Brief
*Top 5 Conditions for Readmissions* (2011)
Uninsured
4.9% of all readmissions

Mood disorders

Alcohol-related disorders

Diabetes mellitus

Pancreatic disorders

Skin and subcutaneous tissue infections

Agency for Healthcare Research and Quality (AHRQ) Statistical Brief
Top 5 Conditions for Readmissions (2011)
Care Transition Services

Managing Chronic Disease Across the Continuum
FirstHealth Care Transitions Services

Home Health

Complex Care Management

Care Transitions Nurses

Center for Telehealth
The FirstHealth Center for Telehealth

$1 million HRSA Telehomecare Network Grant

Provide remote monitoring for high risk patients

- Community Care Network
- PACE Program

Achieve economies of scale

Standardize practices and interventions

Develop cross setting communication strategies

Create sustainable payment model
Engaging Patients and Caregivers with Technology

Smart phone enabled

Caregiver/ provider alerts

Medication adherence

Virtual visits

Video delivered disease specific education
Complex Care Management
The Missing Link in the Care Continuum

High risk, lowly activated, not homebound

3 activity specific home visits

Weekly virtual video visits

Telehealth monitoring

Standardized education

Build knowledge, skills and confidence
# Complex Care Management Pilot

FirstMedicare Advantage

<table>
<thead>
<tr>
<th>30 high risk patients</th>
<th>Patient Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost of care</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>Patient Activation</td>
</tr>
<tr>
<td>ED utilization</td>
<td>Payment Model</td>
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</table>
Care Transitions Nurses

Specially trained nurses embedded in different care settings

Report under one organizational structure

Consistent approach across care settings

Community not hospital focused

Goal is to improve activation and change behavior
Chronic Disease Transitions Nurse
Emergency Department

Rural Health Grant

Coordinates care

Provides education

Initiates referrals

Focus on heart failure, COPD, diabetes and HTN
Transitions and the ED Revolving Door
Results

Reduced repeat ED utilization

Increased referrals to PCP

Increased referrals to Home Health

Increased access to medication assistance

Increased referrals to Community Care Network
Heart Failure Transitions Nurse
Acute Care

Duke Foundation Grant

Inpatient education

Follow up telephone calls for 30 days

PAM; PHQ2

Sets meaningful, patient centered goals

Principles of Coaching for Activation

Recommends appropriate post acute referrals and transitions to the next level of care
Heart Failure 30 Day Readmissions Intervention Group

2013 vs 2014
Heart Failure 30 Day Readmissions
Usual Care

2013
2014
Country Ham and Fried Bologna

“I think what you have done for me with the teaching and the phone calls has done more for me than any pill I am taking.”
Hospital Based Transitions Nurses vs Community Based Care Managers

Limited resources

Biggest bang for the buck

Hospital setting not conducive to learning

Transition from hospital to home fraught with risk

PAM risk stratification identifies where resources needed
Home Health

Pathway Driven Care
Post-Hospital Syndrome
An Acquired, Transient Condition of Generalized Risk

“During hospitalization, patients are commonly deprived of sleep, experience disruption of normal circadian rhythms, are nourished poorly, have pain and discomfort, confront a baffling array of mentally challenging situations, receive medications that can alter cognitions and physical function, and become deconditioned by bed rest or inactivity.”

1. NEJM 368;2 January 10, 2013, Harlan M. Krumholz, M.D.
Why Pathways?

*Chronic Disease Pathways provide a road map for the clinician and ensure that patients and their caregivers receive consistent, standardized and evidence based care.*
New Models Require New Competencies

Cross continuum view

Advanced clinical skills

Integrated Care Management

Care coordination as a skill set

Critical thinking is essential

Patient-centered holistic care
Care Delivery Redesign

Results
Home Health 30 Day Rehospitalization
All Cause

Year: 2011 2012 2013 2014

FHHC Benchmark
Home Health All Hospitalization
All Cause

<table>
<thead>
<tr>
<th>Year</th>
<th>FHHC</th>
<th>Benchmark</th>
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</thead>
<tbody>
<tr>
<td>2011</td>
<td>28.5</td>
<td>27.0</td>
</tr>
<tr>
<td>2012</td>
<td>25.0</td>
<td>24.5</td>
</tr>
<tr>
<td>2013</td>
<td>22.5</td>
<td>22.0</td>
</tr>
<tr>
<td>2014</td>
<td>22.0</td>
<td>21.5</td>
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</table>
Home Health CAHPS

2011 2012 2013 2014

FHHC

SHP Benchmark

2014

2013

2012

2011

FHH CSHP Benchmark
Home Health
The Transitional Care Partner

Highly functioning, multidisciplinary, patient centered team

Clinical expertise in chronic disease management

Sees the patient in the most challenging environment- their home
Principles of the Transitional Care Model

System-wide strategy based on a vision for care navigation

Capitalizes on the strengths of home health and a specially trained workforce

Driven by Patient Activation

Influenced by the Coleman, Wagner and Naylor models

Transitions patients from the acute care setting to home health and beyond
Where Vision and Value Merge

FirstHealth Care Transitions offers a patient centered, evidence based and technology infused approach to chronic disease management that works in partnership across the continuum of care for the benefit of the health care system, the community, our patients and their families.
“Care transitions is a team sport, and yet all too often we don't know who our teammates are or how they can help.”

-Eric A. Coleman, MD, MPH
Questions

Patty Upham, RN
Director FirstHealth Care Transitions
FirstHealth of the Carolinas
pupham@firsthealth.org