Eastern Virginia Care Transitions Partnership
EVCTP

Old Friends Bringing New Opportunities for Successful Care Transitions from Hospital to Home

Area Agencies on Aging and Health Care Systems

Bay Aging, CBO dba EVCTP
Eastern Virginia Care Transitions Partnership: GOALS –

1. Introduce Eastern Virginia Care Transitions Partnership – EVCTP
2. Brief Overview of Goals and How We Operate
3. Current Status and Results
4. How We Can Partner to Enhance Ability to Reduce Readmissions
Eastern Virginia Care Transitions Partnership:

A community partnership of health systems, area agencies on aging, independent physicians’ groups and other public and private health and human service providers.

**HEALTH SYSTEMS**
- Bon Secours
- Mary Washington Healthcare
- Rappahannock General Hospital
- Riverside Health System
- Sentara Health Care

**AREA AGENCIES ON AGING**
- Bay Aging – Lead Community Based Organization
- Eastern Shore Area Agency on Aging and Community Action Agency, Inc.
- Peninsula Agency on Aging, Inc.
- Rappahannock Area Agency on Aging, Inc.
- Senior Services of Southeastern Virginia
1. Stafford Hospital
2. Mary Washington Healthcare
3. Riverside Tappahannock Hospital
4. Rappahannock General Hospital
5. Riverside Shore Memorial Hospital
6. Riverside Walter Reed Hospital
7. Sentara Williamsburg
8. Bon Secours Mary Immaculate Hospital
9. Riverside Regional Hospital
10. Sentara Care Plex
11. Riverside Doctors'
Community Care Transitions Program Purpose:

• Reduce unnecessary 30-day all-cause hospital readmissions by 20%
• Improve quality of life and healthcare for patients from the in-hospital setting to home or other care settings as community, not medical, partners
• Use evidence-based program to improve patient health outcomes and document measurable savings to Medicare
• Activate the patient to ensure PATIENT CENTERED practices
“Capitalizing” EVCTP Growth

• Centers for Medicare and Medicaid Services (CMS)
  • 2 years of funding Community Care Transitions Project (CCTP)
  • 3 additional years if EVCTP is successful

No charge to hospitals, health care provider partners, other care facilities or the patient for care transitions services.
How Did We Get Started?
Using Root Cause Analysis to Drive Intervention

• Hospitals identify high risk readmission beneficiaries through their Root Cause Analyses (RCA)

• Key findings determine/confirm the intervention selection

  • What hospitals say . . .
    • medication mismanagement
    • no follow-up
    • non-compliance

  • What patients say ...
    • cannot afford medications
    • lack transportation
    • confusing directions

• Care Transitions Intervention directly addresses root causes identified
Care Transitions Using the Coleman Model

• EVCTP AAAs use transitional coaching for reducing readmissions using the Coleman model – Four Pillars of Care Transitions

• Coaches are professionally trained and certified through the Coleman Institute Developed by Eric A. Coleman, M.D., M.P.H.

A proven, evidence-based model of reducing hospital readmissions.

FOUR PILLARS

• Medication Self-Management where the patient becomes knowledgeable about medications and has a medication management system

• Dynamic Patient-Centered Record so patient understands and uses a Personal Health Record to improve communication with primary care provider and/or specialist

• Follow-Up where the patient schedules and completes follow-up visit with primary care provider and/or specialist

• Red Flags alert a patient about indications that their condition is getting worse and how they should best respond
What is Care Transitions Intervention (CTI)?

CTI by Dr. Eric A. Coleman is designed to empower adults and people living with disabilities, their families and caregivers.

- Coaches begin working with patients before they leave the hospital
- Within first 30 days of discharge
  - assigned Coach conducts a home visit within 72 hours of discharge and
  - follow-up with phone calls to continue coaching patients
  - if necessary, Coaches will also work with families/caregivers to ensure a successful transition from the hospital to other care facility or home
- Planning for the Future: Services to Managed Care Organizations
  - Dual Eligible Demonstration
Who Qualifies for CTI?

- People of all ages admitted to the hospital
  - not emergency room
  - not observation
- Medicare Parts A & B
  - not Medicare Advantage (Part C)
  - not Hospice
- Medicare/Medicaid (dual eligible individuals)
- Skilled nursing facilities qualify
Target Enrollment

• Highest risk of readmission: reduce all-cause by 20%
  • Primary or Secondary Diagnoses: only eligible diagnoses
    • CHF, COPD, AMI, PNEU and Septicemias
      • other secondary cognitive or functional impairment with active caregiver participation
  • Can expand diagnosis with data justification
    • diabetes, renal failure, multiple emergency room visits, surgical patients, etc.
CTI Work Flow:

• **CTI is part of the hospital’s intake process**

• Hospital completes a risk assessment upon patient admittance and determines if the patient has one of the identified high-risk, chronic illnesses that frequently result in 30-day readmission

• If patient meets the criteria and consents to CTI, the patient is placed in a referral queue for Coaching

• EVCTP will dispatch the appropriate Coach to initiate a hospital visit 24 hours before the patient is discharged

• Some patients may need enhanced home and community based services

• Some patients may refuse Coaching
Enhanced Services:

• Some patients may need enhanced services to improve quality of life
  
  • **funds from CMS for transportation and pharmacy needs**

• Coaches may recommend home and community based services from Area Agencies on Aging

  • Meals on Wheels
  • Caregiver Support
  • Chore Services
  • Education for patients and caregivers for chronic disease self-management
Privacy, Confidentiality, Security:

Required of all EVCTP Members

- All patient information protected and not divulged
- All patient information securely stored at all times whether digital or physical
- Any proprietary partner information considered confidential unless otherwise agreed to in writing
BAY AGING – In Home Project

- 2011 – Partnered with hospitals to improve hospital to home patient outcomes
- Goal - Reduce hospital readmissions for Dual Eligible (Medicare/Medicaid) people 60 years and over and nursing home eligible
- Included enhanced services to improve quality of life – transportation, Meals on Wheels, chore services and other supports, advanced care planning supports
- Outcomes -
  - 265 patients referred
  - 2 readmissions within 30 days of discharge

Veterans Directed Home and Community Based Services – 37 of 38 people averted
Adult Day Health Services (day care) – 72 of 73 people averted
EVCTP Referrals By Diagnosis: January-February 2013

Total Number of Referrals: 139

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EVCTP Not Readmitted vs Readmission: January – February 2013

- 95% Not Admitted in 30 Days
- 5% Readmitted
Next Steps – What We Can Do Together

• Expand diagnosis focus – enlarge footprint
• Improve Stratification
  • capture secondary diagnosis
  • improve targeting such as frequent emergency department visits and prior hospitalizations
• Weekly goals for coaches and feedback to hospitals
• Improve informational materials and Coaches’ script
• Expand to other hospitals

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What Will It Take To Be A Success?

• Referrals - 1/2 of Fee For Service Medicare clients to get 20% all cause

• In-Hospital
  • Becomes part of physicians’ orders/nurses explain
  • Electronic Medical Records – reduce errors by 60%
  • Need executive and physician buy-in
  • Weekly meetings with clinical teams
  • Monthly readmission team meetings

• Message: part of doctors’ treatment plans, free service, part of Medicare benefit

• Shared optimism for the future

• Utilizing evidence based practices to meet bold goals
QUESTIONS & ANSWERS
OPEN DIALOGUE
Eastern Virginia Care Transitions Partnership (EVCTP)
A Collaboration of Mary Washington Healthcare, Rappahannock Health System, Riverside Health System, Sentara Health Care, and Bon Secours Health System
AND
Bay Aging, Eastern Shore AAA & Community Action Agency Inc., Peninsula Agency on Aging Inc., Rappahannock Area Agency on Aging Inc., and Senior Services of Southeastern Virginia

OUR COLLABORATION
EVCTP, led by Bay Aging, is a formal coalition of five health systems, eleven hospitals, and five Area Agencies on Aging.

HOSPITALS
Mary Immaculate Hospital
Mary Washington Hospital
Rappahannock General Hospital
Riverside Doctors’ Hospital
Riverside Regional Medical Center
Riverside Shore Memorial Hospital
Riverside Tappahannock Hospital
Riverside Walter Reed Hospital
Sentara Careplex Hospital
Sentara Williamsburg Regional Med. Center
Stafford Hospital Center

OUR PREVIOUS EXPERIENCE
EVCTP has over forty years experience collaborating among health care systems, Area Agencies on Aging, and senior service provider networks in Eastern Virginia. In mid 2011, EVCTP successfully collaborated with acute care medical facilities to improve patient post discharge outcomes (Home Instead Program). EVCTP conducted pilot programs using an enhanced Coleman Model intervention during 2012. Numerous other successful programs continue to be managed by EVCTP improving the long term care of seniors in our region.

OUR COMMUNITY

OUR IMPLEMENTATION STRATEGY
Three Root Cause Analysis tools were used – Hospital Readmissions Review, Physician and Staff Expert Panel Review, and Consumer Focus Group Surveys. The key findings contributing to readmissions included end stage disease/co-morbidity, lack of patient compliance with discharge plans, medication mismanagement, lack of follow up with the patient’s PCP, and patient acuity. These findings dovetailed with the Four Pillars of the Coleman Model, leading to CTI, supplemented with enhanced services. 40% of patients are expected to require enhanced services. EVCTP partnering hospitals will screen their Medicare patients and refer eligible participants to the serving Area Agency on Aging for coaching including a hospital visit, home visit, follow up phone calls, and coordination of any enhanced services that will improve after hospital care.

OUR COMMUNITY

OUR TARGET POPULATION
Experience as well as Root Cause Analysis (RCA) results indicates a need for a CTI model that employs the Four-Pillars approach as well as enhanced services such as transportation, Meals on Wheels, etc. to address root causes of hospital readmissions. The RCAs also highlighted the disproportionate amount of post discharge issues for those with diagnoses falling in five categories of chronic disease, specifically CHF, COPD, AMI, PNEU, and Septicemia. The target population for our interventions is therefore Medicare FFS beneficiaries (Part A&B) with one or more of the above five diagnoses.

Strategic Design Model
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