

Community-Based Care Transitions and the Indiana AAA Network

*Reducing Hospital
Readmissions and
Improving Health Outcomes*

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Part One

What are Community-Based Care Transitions?

Jenny Hamilton, LifeStream Services

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Indiana

Community-Based Care Transitions

- Local networks of health, long-term services and supports and social services providers serving a specific geographic area.
 - Inclusive of multiple health systems.
 - Inclusive of facility-based and home/community-based settings.
 - Address both health and social supports needs.
 - Coordinate among primary, acute and long-term care.

Community-Based Care Transitions

- Facilitate the transitions of consumers from the acute care setting back to their homes.
- Improve continuity of care.
- Reduce avoidable hospital readmissions.
- Improve consumer health outcomes.
- Save on health care costs.



Community-Based Care Transitions

- Several evidence-based models of care transitions from which to choose, typically including:
 - In-hospital assessment and Options Counseling pre-discharge.
 - In-home assessments and multiple follow-ups post-discharge.
 - Medication reconciliation and management.
 - Care coordination across multiple settings.
 - Empowering consumer to take ownership of managing their health care, a theme among several AAA programs.
 - Assurance and provision of needed in-home medical and social supports.
 - Encouragement to engage with primary care physician.

Community-Based Care Transitions

- Local Coalitions May Target
 - Hospitals with high readmission rates.
 - Particular counties.
 - Conditions with higher rates of readmission.
 - Congestive heart failure
 - COPD
 - Pneumonia
 - Renal Failure
 - Myocardial Infarction
 - Consumers lacking natural supports.

Care Transitions vs. Case Management

Care Transitions

- See patient prior to and immediately following discharge from acute setting.
- Short term intervention.
- Specific goals: reduce readmit, improve transition of care.
- Improve transfer of information between settings as needed.
- Specific medical diagnosis at the time.

Case Management

- Case management is an ongoing collaborative relationship with quarterly and annual reassessment.
- Includes benefits counseling and connection to community resources.
- No diagnosis or age exclusion.
- Patient/client must have a need for services or assistance to remain in the community setting.

Community-Based Care Transitions

- Payor sources
 - No cost to patient.
 - Some local initiatives are funded through CMS' Community Care Transitions Program.
 - Some are funded privately/locally.
 - Some health systems are purchasing the service directly from AAAs.

Care Transitions Technical Assistance

- CMS has a vested interest in all local coalitions.
- Indiana's CMS-funded Medicare QIO (Quality Improvement Organization) provides technical assistance and data management to all local care transitions coalitions.
 - Health Care Excel based in Terre Haute.
- CMS has asked Indiana coalitions to educate other stakeholders about care transitions.

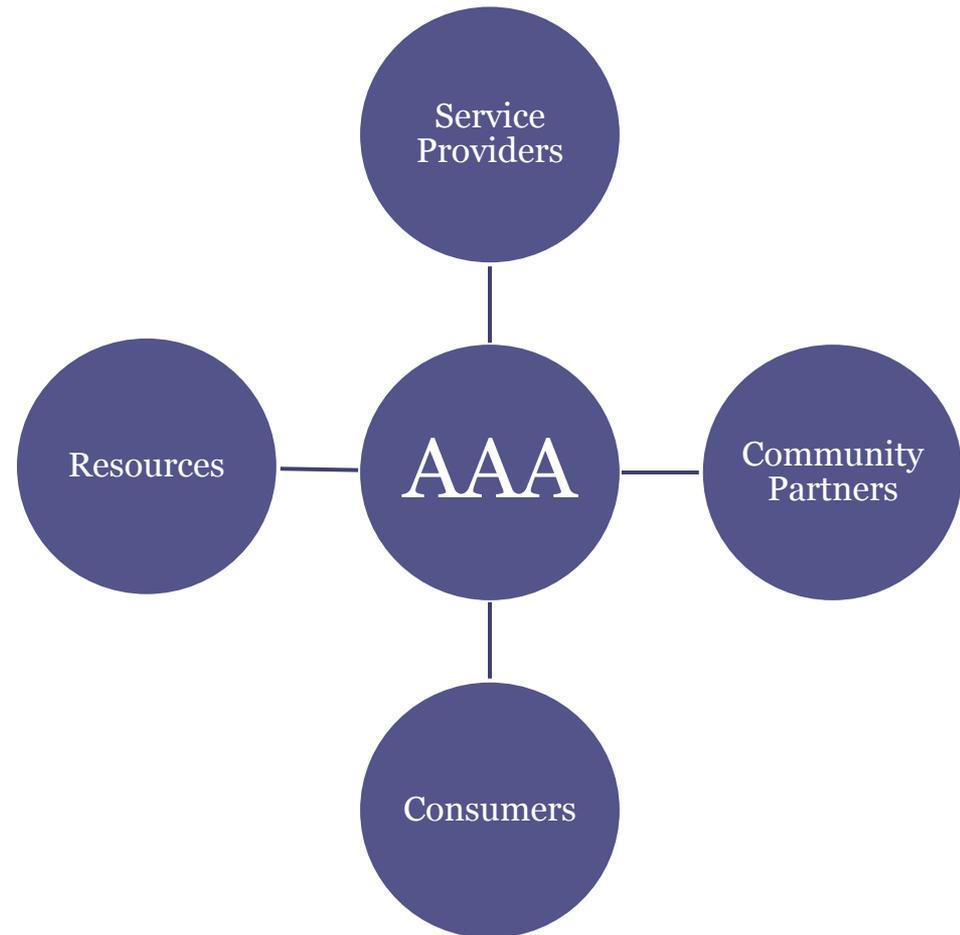
Part Two

How are Indiana's AAAs Involved?

Stacey Kahre, Generations

AAA Involvement

- Nationally, AAAs are often the nexus of community-based care transitions coalitions
 - Neutral third-party convener among competing health systems and providers.
 - Ability to follow consumers across settings.
 - Experience in managing in-home services.



Indiana AAAs Involved

- CMS Community Care Transitions Programs
 - Aging and In-Home Services of Northeast Indiana and LifeStream Services (3 and 6)
 - Lifespan Resources (14)
- Local Initiatives
 - CICOA Aging and In-Home Solutions (8)
 - SWIRCA & More (16)
 - REAL Services (2)
 - Generations (13)



Health Care System Involvement

- Indiana University Health
- St. Vincent Health
- Community Health Network
- Deaconess Health System
- Parkview Health System
- St. Mary's Health System
- Trinity Health
- Veteran's Administration



Hospital Involvement

- Good Samaritan Hospital
- Daviess Community Hospital
- Memorial Hospital Health Care Center
- Deaconess Hospital
- Heart Hospital at Deaconess Gateway
- St. Mary's Medical Center
- Floyd Memorial Hospital and Health Services
- Clark Memorial Hospital
- Parkview Huntington Hospital
- Parkview Noble Hospital
- Parkview Hospital Randalia
- Parkview Regional Medical Center
- Parkview Whitley Hospital
- Bluffton Regional Medical Center
- Community Hospital of Anderson and Madison County
- DeKalb Health
- Henry County Memorial Hospital
- Indiana University Health Call Memorial Hospital
- St. Vincent Anderson Regional Hospital
- St. Joseph Regional Medical Center – Mishawaka
- Elkhart General Hospital
- Wishard/Eskenazi Hospital
- Methodist Hospital
- Indiana VA Medical Center

Indiana AAAs as Nexus

- Core services established and available in all 92 counties – boots have been on the ground for a long time.
- Established local brand identity with consumers and community partners as the single-point of entry to long-term services and support.
- Established processes for in-home assessment, and both face-to-face and telephonic Options Counseling.

Indiana AAAs as Nexus

- Established, extensive existing information and referral systems, many in partnerships with local 211 services.
- Deep and long-lasting local community partnerships to draw on to meet unique consumer needs.
- Proven ability to work one-on-one and face-to-face with a fragile consumer population.

Indiana AAAs Expanded Capacity

- All Indiana care transitions coalitions have built out new capacity to provide the service.
 - Purchased evidence-based care transitions models.
 - Made extensive monetary investment in training.
 - Hired care transitions coaches.
 - Established forums for successful collaboration among competing health systems and local health care providers for care transitions and beyond.
 - Effected data sharing agreements among competing health systems and local health care providers.

Indiana AAAs Expanded Capacity

- Established new business models and skills that enhance AAAs ability to expand traditional services and engage in new partnerships with health care providers.
- Improved ability to measure impact of consumer services, disease management and health care outcomes, health care cost savings, and quality of service related to all AAA programs.



Part Three

What are Results to Date?

Kelli Tungate, CICOA Aging and In-Home Solutions

Evansville Results

- Program started July 2012.
- 83 completed referrals vs. a control group of 150.
 - Control group members were referrals that either refused the intervention or the program was unable to contact.
- 9.6% 30-day readmission rate among completed referrals vs. 16.0% among the control group.
- 16.9% 60-day readmission rate among completed referrals vs. 26.7% among the control group.

Indianapolis Results

- Made 568 referrals in FY 2013.
 - Education, linking clients, caregivers, and professionals to community resources, professional consultations, and assessments for Home and Community Based Services such as Medicaid Waiver(MAW) programs.
- For FY 2013, estimated \$800,000 savings to Indiana Medicaid by diverting \$2.9 million in medical care costs for Medicaid Waiver recipients to \$2.1 million in LTSS costs.

Northeast Indiana Results

- CMS funded CCTP just began in April 2013.
- 309 consumers have started transitions services.
- 186 consumers have completed transitions services thus far (60.0%).
 - 86 additional in pipeline for completion
- 14.9% 30-day readmission rate among starters thus far, compared to a pre-intervention coalition average of 21.0%.

South Bend Results

- Pilot began in January 2012.
- 133 program graduates did not readmit within 30-days.
- 30-day readmission rate surpassed the national average 30-day readmission rate of 50% and the project goal of 33%.

Vincennes Results

- Pilot project implemented Nov 2012
- Admitting diagnoses included MI, CHF, PNEU, COPD and ESRD
- 49 referrals to date with 18 meeting pilot criteria
- 13 were considered successful transitions with no 30-day readmission (72%)
- 5 were re-admitted
 - 27.8% 30-day readmission rate compared to pre-intervention rate of 29.0%

Part Four

Impact of Managed Care

Kristen LaEace, IAAAA

Managed Care Impact

- The imposition of managed care threatens the ability of care transitions initiatives to continue operating.
 - Typically, consumers are excluded from care transitions program participation if they are in formal management plans elsewhere.
 - Vertical integration within one health system negates existing regional, multi-system coalitions.
 - Traditional managed care lacks experience with both LTSS and social (non-medical) supports, critical to care transitions success.
- Capacity and programs are in place now. Why build out a duplicative system?

Thank You!

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