Florida’s Experience: Expanding the CMS Care Transition Demonstration into a Sustainable Care Transitions System

September 27, 2010
A Community Moved to Action

This material was prepared by FMQAI, the Medicare Quality Improvement Organization for Florida, under contract with the Centers for Medicare & Medicaid Services, an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy # FL2010F40012611906
Project Background

“Making the health care delivery system work reliably for very sick Medicare beneficiaries requires linking all clinical care providers and ensuring that transitions are thoroughly reliable. This work can only succeed when all of the community is engaged and working together, so the QIOs will serve to catalyze and coordinate the work across all care settings in the community.”

Barry M. Straube, M.D.
Director & Chief Clinical Officer
Office of Clinical Standards & Quality for CMS

The Medicare Quality Improvement Organization for Florida
## Provider-Associated Readmissions

<table>
<thead>
<tr>
<th>Provider</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>30.3% ↑</td>
</tr>
<tr>
<td>Home (including ALF) *</td>
<td>23.6% ↑</td>
</tr>
<tr>
<td>SNF</td>
<td>13.4% ↓</td>
</tr>
<tr>
<td>Outpatient</td>
<td>12.0% ↑</td>
</tr>
<tr>
<td>HHA</td>
<td>11.4% ↓</td>
</tr>
<tr>
<td>Other</td>
<td>9.3% ↓</td>
</tr>
<tr>
<td>Totals</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

*Physician claims assigned to associated category/provider
Framework

• Adapted Eric Coleman’s* Care Transitions Intervention℠ (CTI)

• CTI addresses patient empowerment through the intervention’s four pillars:
  – medication reconciliation,
  – physician follow-up,
  – disease management,
  – maintaining personal health record

* www.caretransitions.org
Interventions

• Provider-specific
• Collaboratives
• Coaching
  – 5th & 6th “Pillars”
• Educational Updates
  – Providers & Beneficiaries
Current Findings
Community 30-Day Readmission Rate
(12-month periods)

FL 30-Day Readmission Rate (3/08) = 18.8%

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Diagnosis-Specific 30-Day Readmission Rates
(12-month periods)

FL: AMI (3/08) = 20.1%              FL: HF (3/08) = 24.8%             FL: PNE (3/08) = 18.3%

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% Physician Follow-Up Visits After Discharge
(12-month periods)

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Beneficiary Satisfaction (HCAHPS)

(12-month periods)

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<thead>
<tr>
<th>Month</th>
<th>Medication Management</th>
<th>Discharge Information</th>
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<tbody>
<tr>
<td>Jun-08</td>
<td>74.14%</td>
<td>74.93%</td>
</tr>
<tr>
<td>Sep-08</td>
<td>74.14%</td>
<td>75.97%</td>
</tr>
<tr>
<td>Dec-08</td>
<td>74%</td>
<td>75%</td>
</tr>
<tr>
<td>Mar-09</td>
<td>73%</td>
<td>76%</td>
</tr>
<tr>
<td>Jun-09</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>Sep-09</td>
<td>71%</td>
<td>78%</td>
</tr>
<tr>
<td>Dec-09</td>
<td>70%</td>
<td>79%</td>
</tr>
<tr>
<td>Mar-10</td>
<td>73.14%</td>
<td>80%</td>
</tr>
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</table>

The Medicare Quality Improvement Organization for Florida

Information for Healthcare Improvement
Identified Best Practices

Physician Follow-Up Visit

- **Physician Follow-Up 30-Day Readmission Rate**
  - Yes: 15.08%
  - No: 35.01%
  
  N = 7,474

CTI - Coaching

- **Coaching 30-Day Readmission Rate**
  - Yes: 14.5%
  - No: 24.8%
  
  N = 945

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Miami Collaborative Findings
Proclamation for Safe Care Transitions

Existing to serve our patients in the Miami community, we commit to improving Patient-Centered Care Transitions, by affirming these shared beliefs:

- Collaborate effectively to develop a timely, comprehensive care transition plan for our patients.
- Empower patients/caregivers to participate in their care through access to understandable health information provided in the appropriate language.
- Provide patients and healthcare partners with timely, legible, accurate, and complete discharge information.
- Improve health care provider communication by seeking clarification of ambiguities/discrepancies in the patient’s discharge information.
- Assist patients and their families to expedite timely scheduling of their post-discharge physician appointment.
- Support patients in comprehending, maintaining, and sharing discharge information with their physicians and other involved healthcare providers.
- Encourage patients to proactively self-manage their care by sharing updated health information with their health care team.

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Community Activation Measure

• Allows any provider to assess its perceived frequency of the collaborative’s (community’s) commitment to improving care transitions.

• Incorporates the Proclamation’s seven shared beliefs.

• Measured using a 5-point Likert Scale
Alliance for Aging – Community Living Program
Alliance for Aging, Inc.

**Mission**

To foster optimal quality of life for elders and their families in Miami-Dade and Monroe Counties.
Community Living Program

Overview

- Funded through grant from AoA.
- Link services with Hospital Discharges.
- Services for up to 45 Days
- Level of care determined by CARES
- Referrals to Lead Agencies
## Community Living Program

### Data & Information

- Started July 2009 in several hospitals

<table>
<thead>
<tr>
<th>Figures &amp; Data</th>
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<tbody>
<tr>
<td>Individuals Assessed</td>
<td>372</td>
</tr>
<tr>
<td>CLP Grant-Paid Service Placements</td>
<td>43</td>
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<tr>
<td>Aventura Hospital Project (March 2010)</td>
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<tr>
<td>Individuals Assessed</td>
<td>128</td>
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<tr>
<td>CLP Grant-Paid Service Placements</td>
<td>35</td>
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<tr>
<td>Referred to Other Funded Services</td>
<td>75</td>
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<tr>
<td>Refused Services or Died After Assessment But Prior to Services</td>
<td>18</td>
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</table>
Community Living Program
Next Phase

Going Forward

- CLP Phase II Starts October 2010
- Services Funded through OAAIII – B
- Expanding to other Hospitals
- Referrals from other sources not only Hospitals
## CTI & Community Resources

<table>
<thead>
<tr>
<th>Coached &amp; Community Resources</th>
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<tbody>
<tr>
<td>Community Readmission Rate</td>
<td>22.1%</td>
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<tr>
<td>Verified Cases&lt;sup&gt;1&lt;/sup&gt;</td>
<td>27</td>
</tr>
<tr>
<td>Readmissions</td>
<td>0</td>
</tr>
<tr>
<td>30-Day Readmission Rate</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

1. Did not meet CLP criteria – referred for other resources.
The Role of Nutrition in Preventing Hospital Readmissions

ILSmeals

Nutrition Care Management & Meals Program
The Facts

Poor nutrition, or malnutrition, leads to poorer health outcomes including slower healing rates, increased risk for medical and surgical complications, delayed recovery, increased length of stay, and increased readmission rates and mortality.

## Nutrition Status of the Post Discharge Patient

- Patients are generally already malnourished upon admission.
- Continue to be malnourished or may develop malnutrition while hospitalized.
- Altered food intake, digestion and absorption issues and poor metabolism of food all contribute to the malnutrition.
- Other risk factors are socio-economic status, physiological disorders, chronic diseases, malignancies, alcohol or drug abuse, lower educational levels, and older age.
Nutrition Status of the Post Discharge Patient

- Older adults discharged from the hospital have a one in five chance of being readmitted within three months.
- Many of the most prevalent chronic conditions, such as diabetes, hypertension and/or a combination of these diseases, are those for which nutritional interventions have been demonstrated to be effective in improving health status and health outcomes.
## Specific Nutrients

- The most common form of malnutrition in the older hospitalized patient is:
  - Protein-Calorie Malnutrition (PCM)
  - Anemia
  - Vitamin Deficiencies:
    - Vitamin D
    - Calcium
    - Folate
Oftentimes, following a hospitalization, the elderly and disabled find themselves returning to an empty house or facing mobility or other issues that impede their ability to obtain or prepare nutritious meals for themselves.

Caregivers are often strained meeting patients’ other health-related needs.

Home-delivered meals contribute to the improvement of health and emotional well being.

**Interventions**

- Often enough there are no coordinated, comprehensive systems in place to provide the wide range of nutrition services needed for older adults to remain at home safely after being discharged.
- Minor interventions can be effective in preventing re-admissions.
- These interventions may include coordinating follow visits with primary care providers, coordinating home-based services and ensuring nutrition support and meal planning.
Discharges to the home setting from acute care and long-term care facilities often take place before recuperation is completed and often without a plan for home and community follow-up services.

Nutrition is a critical component of the recovery and rehabilitation of patients discharged.
CMS Project: CTI & Nutrition

- ILS, through DOEA, provides nutrition Care Management:
  - 10 meals post discharge
  - Initial and follow-up surveys collected
  - Data is compared to those in the CTI program that do not take and nutrition support as part of the program
### Coached & Nutrition Program

<table>
<thead>
<tr>
<th>Metric</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Readmission Rate</td>
<td>22.1%</td>
</tr>
<tr>
<td>Verified Cases</td>
<td>237</td>
</tr>
<tr>
<td>Readmissions</td>
<td>18</td>
</tr>
<tr>
<td>30-Day Readmission Rate</td>
<td>7.6%</td>
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</table>
Post Acute Support System (PASS®)
Care Transition Intervention
# Post-Acute Support System

## About ILS

- Founded in 2001
- Health Care Management and Services Organization applying managed care concepts to the delivery of long-term care, and facilitates the use of home and community based services as an alternative to institutional care.
- Services individuals in: MAPD / SNP Plans (75,000), Managed Long-Term Care & Diversion (2,100), Pediatric Medicaid Plans (7,000), School & Community Programs (10,000)

## ILS Mission

The ILS Group’s mission is to provide services to individuals who are frail, elderly, underprivileged, or who may have chronic medical or mental health conditions or other special needs. ILS believes that these individuals can have significantly enhanced quality of life and health through a choice of cost effective home & community based resources and services.
Post-Acute Support System

The Problem

- 19.6% of Medicare; 16.5% of Medicaid\(^{(1)}\) patients are readmitted within 30 days, 28.2% within 60 days, 34.0% within 90 days, costing over $15bn annually.
- CMS guidelines have suggested that future reimburse will be reduced for readmission, especially those considered potentially avoidable
- Large percent of hospital re-admissions are “potentially” avoidable

<table>
<thead>
<tr>
<th>Conditions Related to Readmissions:</th>
<th>Factors Related to Readmissions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Heart Failure</td>
<td>▪ Medication Management / Access</td>
</tr>
<tr>
<td>▪ Pneumonia</td>
<td>▪ Nutrition</td>
</tr>
<tr>
<td>▪ COPD</td>
<td>▪ Access to care / outpatient services</td>
</tr>
<tr>
<td>▪ GI</td>
<td>▪ Access to support services &amp; resources</td>
</tr>
</tbody>
</table>

Avoidable Costs

<table>
<thead>
<tr>
<th>Factor</th>
<th>Average(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admits/1000</td>
<td>350</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td>15%</td>
</tr>
<tr>
<td>Cost of Readmission</td>
<td>$13,000</td>
</tr>
<tr>
<td>=</td>
<td>$56.80 pmpm</td>
</tr>
</tbody>
</table>

\(^{(1)}\) Rate for non-obstetric, 21 – 64 with 2 or more comorbidities
# Post-Acute Support System

## PASS Product

- The ILS Post-Acute Support System (PASS®) program focuses on the care transition between the institutional setting (Acute inpatient, Sub-Acute, Nursing Home) back to the home & community setting.
- Based on Care Transition Intervention (CTI<sup>SM</sup>) Program developed by Dr. Eric Coleman, University of Colorado.
- Care Transition program designed to coordinate and manage the transition of individuals from the Acute Inpatient setting to the Home & Community Setting.
  - PASS is <i>not</i> case management, discharge planning or home health.
  - PASS is <i>is</i> patient advocacy, education, communication and coordination.

## Operation

- Driven by the PASS® Coach and supported by Care Support Representatives and PASS® system technology.
- Interaction with patient:
  - Face-to-face during inpatient admission
  - Face-to-face at Home post discharge (48 – 72 hours)
  - Telephonic, day 2, 7, 14 & 30 post discharge
Post-Acute Support System

**PASS Five Components**

**Medication Self Management** – patient is knowledgeable about medications & has a medication management system. *Home Visit:* Face-to-face medication reconciliation.

**Nutrition Management** – patient is knowledgeable about nutrition status, meal planning & diet as it relates to chronic conditions. *Home Visit:* Home based nutrition assessment, kitchen & environment evaluation, daily meal plan.

**Personal Health Record** – patient understands & utilizes a PHR to facilitate communication & ensure continuity of care plan across providers & settings. *Home Visit:* Reconciliation of PHR data, completion & education.

**PCP & Specialist Physician Follow-Up** – patient schedules & completes follow-up visits with PCP / Specialists & is empowered to be an active participant in these interactions. *Home Visit:* Schedule & coordinate PCP follow-up visit, direct coordination if necessary.

**Red Flags / Signs & Symptoms** – patient is knowledgeable about indicators that suggest his/her condition is worsening & how to respond. *Home Visit:* Education and coordination – recognition & response.

**PLUS…**

**Home & Community Based Services** – identification and coordination of home & community based services to assist in care transition and maintain patient independence. *Home Visit:* Identification & referral, coordination of services.
# Post-Acute Support System

## PASS Five Components – In Action

### Medication Self Management
Coach identifies medication discrepancies; contacts PCP → adjustment to medication dosage, d/c 2 unnecessary medications → **NO Readmission**.

### Nutrition Management
Patient lives alone and has no food in the home post d/c; Coach coordinates post d/c meals → **NO Readmission**. Care coordination provides ongoing home delivered meals program.

### Personal Health Record
Patient completes “Questions for my PCP” section and utilizes PHR to address issue related to his/her goals for returning home safely and remaining home → **NO Readmission**.

### PCP & Specialist Physician Follow-Up
Coach contacts PCP with patient and schedules follow-up visit within 3 days of discharge → treatment prescribed by Hospitalists adjusted → **NO Readmission**.

### Red Flags / Signs & Symptoms
Patient recognizes swelling in lower extremities and recalls education provided by PASS® Coach → contacts Plan’s nurse triage line, visits urgent care for treatment → **NO Readmission**. Patient referred to CDSMP / DSMP / MOB community programs.

### PLUS…

### Home & Community Based Services
Patient reports difficulty choosing between electricity, hot water and medications → Coach submits referral for Utilities Assistance program; Pharmacy Assistance Program → patient able to obtain medications → **NO readmission**.

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![PASS Five Components Diagram](image-url)
Post-Acute Support System

Fully Integrated Care Transition

Inpatient (Acute/Sub-Acute) Admissions:
- Medication Management
- Nutrition Management
- Personal Health Record
- Physician Follow-Up
- Red Flags Signs & Symptoms

Post Discharge - Home (48-72 hrs):
- Medication Management
- Nutrition Management
- Personal Health Record
- Physician Follow-Up
- Red Flags Signs & Symptoms

Follow-up Calls 2, 7, 14, 30 days Post Discharge:
- Medication Management
- Nutrition Management
- Personal Health Record
- Physician Follow-Up
- Red Flags Signs & Symptoms

Referrals to Community Resources:
- CDSMT, Community Living

PASS Coach & Care Support & PASS System

Independent Living Systems, LLC – All Rights Reserved
## Post-Acute Support System

### PASS Tools

- **Nutrition Assessment** – comprehensive evaluation of nutrition status and education.
- **Personal Health Record** – concise but comprehensive summary of health information including demographic, emergency contact, medical history, medication records & provider information.
- **Medication Discrepancy Tool** - identifies & communicates transition-related and historic medication problems.
- **Home & Community Resource Tools** – database of resources; BenefitsCheckUp\(^{(1)}\); partnerships with AAAs/ADCs/ADRCs, etc.

### PASS System

Secure HIPAA compliant, web-based, real-time system providing:

- **Patient Tracking** – tracks client through the various interactions and components for each episode.
- **Electronic PHR**
- **Data Collection & Reporting**
- **Care Plan Management** – tracks interventions identified for a clients care plan and additional services coordinated including transportation, home physician visits, telemedicine, etc.

\(^{(1)}\) [www.benefitscheckup.com/ils](http://www.benefitscheckup.com/ils)
Pilot Outcomes

| Coached, Nutrition Program & CLP |  
|-------------------------------|---|
| Initial Readmission Rate      | 23.1% |
| Verified Cases                | 37 |
| Readmissions                  | 1 |
| 30-Day Readmission Rate       | 2.7% |
# Post-Acute Support System

## PASS Pilot Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Community / Population Rate</th>
<th>PASS Coached Rate</th>
<th>Non-Coached Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td>20.26%</td>
<td>7.03%</td>
<td>17.20%</td>
</tr>
<tr>
<td>Health Plan 1&lt;sup&gt;(1)&lt;/sup&gt;</td>
<td>19.60%</td>
<td>8.80%</td>
<td>13.60%</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>19.37%</td>
<td>10.10%</td>
<td>35.30%</td>
</tr>
<tr>
<td>MSO 1&lt;sup&gt;(2)&lt;/sup&gt;</td>
<td>21.73%</td>
<td>6.90%</td>
<td>8.93%</td>
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</tbody>
</table>

## Other Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in SNF Utilization (transfers; discharge to SNF)</td>
<td>22%</td>
</tr>
<tr>
<td>Reduction in Rx cost / utilization</td>
<td>30%</td>
</tr>
<tr>
<td>Member Retention</td>
<td>Unmeasured</td>
</tr>
</tbody>
</table>

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<sup>(1)</sup> Non-coached members still receive CTI follow-up calls and post-discharge meals.

<sup>(2)</sup> All patients receive PCP follow-up visit scheduled *before* discharge.
# Contact Information

<table>
<thead>
<tr>
<th>Susan Stone, MSN, RN</th>
<th>Peggy O’Neill MS, RD, LD/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Transitions Project Director</td>
<td>Vice President of Nutrition Services</td>
</tr>
<tr>
<td>FMQAI</td>
<td>Independent Living Systems</td>
</tr>
<tr>
<td>Office: (813) 865-3435</td>
<td>Office: (305) 262-1292</td>
</tr>
<tr>
<td><a href="mailto:sstone@flqio.sdps.org">sstone@flqio.sdps.org</a></td>
<td><a href="mailto:poneill@ilshealth.com">poneill@ilshealth.com</a></td>
</tr>
<tr>
<td>Horacio Ferrer</td>
<td>Jeffrey T. King, RN, MBA</td>
</tr>
<tr>
<td>Vice President</td>
<td>Vice President Clinical Services</td>
</tr>
<tr>
<td>Alliance for Aging</td>
<td>Independent Living Systems</td>
</tr>
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<td>Office: (305)670-6500</td>
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<td><a href="mailto:ferrerh@elderaffairs.org">ferrerh@elderaffairs.org</a></td>
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