Modern Healthcare

DECEMBER 8, 2014

PROVEN TECHNIQUES HOSPITALS ARE USING TO IMPROVE QUALITY, LOWER COSTS AND ACHIEVE BETTER OUTCOMES

Best Practices

CARE COORDINATION

Managing care between home and hospice

By Steven Ross Johnson

They call it the gray zone—the gradual deterioration of health experienced by many frail and chronically ill elderly people, the condition that lies between treatable disease and terminal illness.

More than a decade ago, Sutter Health recognized that aggressively treating such patients as their illnesses progressed raised troubling quality-of-life and cost issues.

"There was this frequency with which patients with advancing illness would come back to the emergency department or hospital for symptoms that seemed like they should be able to manage at home," Sutter Health Chief Hospice Executive Betsy Gornet said.

Such patients represent a disproportionate share of Medicare spending.

Elderly patients with four or more chronic conditions represented about 14% of Medicare beneficiaries in 2010, but accounted for 70% of the 1.9 million hospital readmissions, according to a 2012 CMS report. Nearly two-thirds of patients did not receive any home healthcare visits that year, and hospice care remained underutilized.

But when should providers switch from treatment to hospice, or even begin to dial back on the tests, drugs and procedures they prescribe for the frail elderly?

"This population is in the gray zone between treatable and terminal, and that gray zone is expanding really rapidly," said Dr. Brad Stuart, former senior medical director of Sutter Visiting Nurse Association and Hospice.

"In that gray zone, it's often not appropriate to just stop treatment and go straight to hospice," he said. "But at the same time, it's also not appropriate to just throw the whole nine yards of treatment at everybody every time, which is what we tend to do in traditional care."

Stuart was instrumental in helping Sutter develop its Advanced Illness Management (AIM) program, an integrated delivery model that advises patients and their families on how to make the transition to hospice while still delivering desired healthcare services in a home setting.

The program begins with a team of staffers consisting of home health and hospice nurses, physicians and social workers asking patients about their treatment.

Those targeted for entry into the program are usually chronically ill patients who have the possibility of dying within a year and have yet not chosen to enter hospice.

Once patients have been identified, AIM staff works on a plan for the next steps in managing their care. AIM's goal is to coordinate care for these patients before they reach the terminal stage to smooth the transition into hospice.

Eventually, the focus of treatment shifts from administering acute procedures to providing more palliative care. AIM staff also helps patients develop advance directives. As patients get sicker, the team helps them move into hospice.

Sutter expanded the pilot after early results showed the rate at which AIM patients entered hospice was 47% compared with 20% among non-AIM patients, according to a 2006 study published in the Journal of Palliative Medicine. A few years later, Sutter began investing $21.4 million into a system-wide rollout of AIM, which was helped along with a $13 million grant in 2012 from the CMS Innovation Center. The AIM model now serves 79% of Sutter's service territory: The program is in 14 out of 19 counties treating an average of 1,200 patients a day.

The program faces challenges, however. The current fee-for-service payment model used by private and public payers does not reimburse for all of the services AIM provides.

For example, while the Medicare-certified home healthcare service is reimbursed, any transitional care provided to a patient to enable entering hospice is not reimbursed.

It also sharply reduces revenue by reducing hospital admissions, which has turned AIM into a money-loser for the system.

"The rate of the spread of the program will be in direct proportion to the rate that our system converts from fee-for-service toward accountable care," Stuart said. "The quicker that transition happens, the quicker this (kind of) program will grow," he said.

MH RESULTS

Treatment in the gray zone

Since 2010, Sutter's Advanced Illness Management program has:

- **Reduced hospitalizations** by 60% in the first 90 days after enrollment.
- **Reduced emergency-room** visits by 30%.
- **Decreased days** in intensive care by 75%.
- **Saved payers** about $5,000 per patient enrolled over the first 90 days.
- **Generated** consistently high patient-satisfaction scores.

Source: Sutter Health

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Aging agencies help cut readmits

By Maureen McKinney

Three years ago, eight-hospital Riverside Health System faced looming federal penalties for excess readmissions, often the result of inadequate transitions from the hospital to home.

Thirty-day readmission rates varied widely across the Newport News, Va.-based system, with most above the national average. The system lacked a standardized way of ensuring that discharged patients had adequate supports in place, understood their conditions and saw primary-care physicians for follow-up care.

"We didn't really know what was going on in patients' homes," said Dr. Kyle Allen, Riverside's vice president for clinical integration and medical director, geriatric medicine and lifelong health. "We missed many of the issues that led them to be readmitted."

Hospitals such as those belonging to Riverside are under increasing financial pressure to smooth the post-discharge period and address patients' daily-life challenges, both to improve outcomes and protect hospital finances. One underused approach to reducing readmissions involves encouraging patient self-management and collaboration among providers and community-based organizations. Hospitals that forged such collaborations have rapidly reduced readmissions, experts say.

"Much of the time, people get readmitted because of the challenges they have in daily life, not because of their diagnoses," said Dr. Eric Coleman, director of the Care Transitions Program at the University of Colorado and a national thought leader in the field.

Recognizing it didn't have the tools to prevent readmissions and avoid the penalties, Riverside decided to try the partnership approach.

Beginning with a small pilot program, Riverside forged collaborative relationships with agencies on aging, which are community organizations that help older adults live independently.

"In healthcare, there's a tendency to do things on your own," said Allen, who began working with such agencies in the 1990s in private practice and later as chief of geriatrics at Akron, Ohio-based Summa Health System.

Under Riverside's program, hospitals enroll Medicare beneficiaries with chronic illnesses. Cases are given to trained transition coaches from community agencies who brief patients and their relatives on how to manage medications, watch for signs of worsening health and set goals to keep them out of the hospital.

A 2012 pilot program with Bay Aging, Urbanna, Va., and three Riverside hospitals led to a 20% drop in all-cause readmissions among 140 patients, and more than $900,000 in estimated savings.

Based on that success, in 2013 the CMS funded the Eastern Virginia Care Transitions Partnership, which expanded the pilot to include five area agencies on aging and 11 hospitals, including five Riverside hospitals. The system has seen its overall readmission rate drop to 16% from 23% in 2012, Allen said. The national readmission rate hovered just below 18% during the first eight months of 2013.

Recently, Allen said, a 56-year-old man with a history of emphysema and pneumonia was discharged from one of Riverside's rural hospitals after a stay for respiratory distress. The transition coach arranged transportation, contacted a food bank, got fuel assistance and helped the patient understand how to manage his condition.

Riverside is performing deep data dives to analyze transitions of care that don't go well. It is measuring criteria such as medication reconciliation and successful transfer of advanced directives, said Pat Russo, vice president of care management.

Partnering with outside agencies and other community-based groups presents challenges, such as confusion over who does what, reimbursement and physician hesitation.

"Riverside's biggest success is creating a trusting environment where people can come together and find solutions," said the University of Colorado's Coleman. "If you want to be a player, you have to be in the room."

MH STRATEGIES

Partnering with community groups

- **Reach out** to a local area agency on aging and suggest collaborating to improve the health of older patients.
- **Contact** the National Association of Area Agencies on Aging or the Administration on Aging for support.

- **Seek out advice** from places that have successfully implemented these programs, including recipients of grants under the CMS' Community-Based Care Transitions Program.
- **Be humble.** "Come in with a blank slate free of any stereotypes," Dr. Kyle Allen said. "Keep the patient at the center and think about how different skill sets can come together to make care safer."

Targeting the right patients for support

By Maureen McKinney

Dr. Ralph Fillingame was fed up. The family physician's aging patients had complex healthcare needs, including multiple chronic illnesses such as hypertension and diabetes, but progress in managing those illnesses was slow.

Some patients at the Santa Clara PeaceHealth Medical Group clinic, in Eugene, Ore., part of Vancouver, Wash.-based PeaceHealth, seemed unable or unwilling to take an active role in their own care.

"I realized it didn't matter how accurate the diagnoses were or how good the medications were," he said. "If the patient was not confident enough or willing to carry out those interventions themselves, we were just fooling ourselves."

Studies have demonstrated the critical role that patient engagement plays in medication adherence, healthy eating and other components of disease management. "These patients see a doctor once in a while, but they live with their chronic diseases 24/7," Fillingame said.

Some hospitals and health systems are using the Patient Activation Measure, or PAM, as a tool to help predict which patients are best equipped to engage in their care and which ones will be in need of additional support.

Developed by a team led by Judith Hibbard, a professor of health policy at the University of Oregon, PAM is a 10- or 13-item survey that assesses activation by measuring patients' agreement with simple statements such as, "I know what my prescribed medications do."

Based on their answers, patients receive a score on a 100-point scale and are placed into one of four levels, with lower scores indicating less activation. Research led by Hibbard and others has shown low PAM scores are associated with poorer health outcomes, higher costs, greater emergency-department utilization and higher readmission rates.

"We have found that people who measure low on the scale often don't understand their role in the care process," Hibbard said.

Many insurers have adopted the PAM assessment as a way to identify high-risk patient groups and control utilization, Hibbard said.

One such insurer was Regence Blue Cross and Blue Shield, which approached Fillingame in 2008 with a proposition: Regence would provide grant funding for an 18-month medical-home pilot using the PAM tool. Fillingame agreed and the project kicked off in October of that year.

Fillingame used the PAM assessment to customize his team's approach to each patient's care. Low-scoring, less-activated patients with more-complex healthcare needs, for instance, received more-intensive care coordination and coaching services, while high-scoring patients received a more hands-off approach. He used the grant funds to hire a full-time medical office assistant who helped with coaching, as well as a half-time behavioral health specialist.

Fillingame gave the example of a former male patient who suffered from a number of chronic illnesses, including hypertension and early diabetes, and who was a Level 2 on the PAM scale. "He was overwhelmed, but we worked with him to set small, attainable goals, which we kept modifying as he made progress," Fillingame said, adding that the patient lost 40 pounds and saw improvement in his health.

During the pilot, the average number of quarterly ER visits dropped more than 40%. Fillingame's team also saw improvements in patient-satisfaction scores and in the percentage of patients with controlled hypertension.

Unfortunately, when the pilot concluded, the practice didn't have the resources to keep the intensive approach in place, said Fillingame, who has since left for a job in public health.

That's not surprising, said Chris Delaney, CEO of Insignia Health, Portland, Ore., which has exclusive licensing rights for the PAM tool and has 130 clients, including 40 to 50 hospitals and health systems. He says PAM is a difficult sell in a fee-for-service environment where keeping patients well reduces revenue. Still, he expressed optimism that the move to value-based care will heighten the focus on activation.

"Raising a PAM score by just 1 point is worth a 2% decline in ER use, a 2% improvement in A1c levels and a 2% improvement in medication adherence," he said. "It's a very powerful metric."

MH STRATEGIES

Activating patients

- **Work with insurers:** Reach out to commercial insurers to see if they're open to arrangements that incentivize wellness.
- **Define pathways:** Outline which interventions and supports patients will receive based on their level of illness and their Patient Activation Measure score.
- **Measure, measure, measure:** Re-measure PAM scores every six months. Patients who score low can move up fast if they receive support. That translates to better outcomes.