



# ADRC Care Transitions Workgroup Call

January 23, 2011

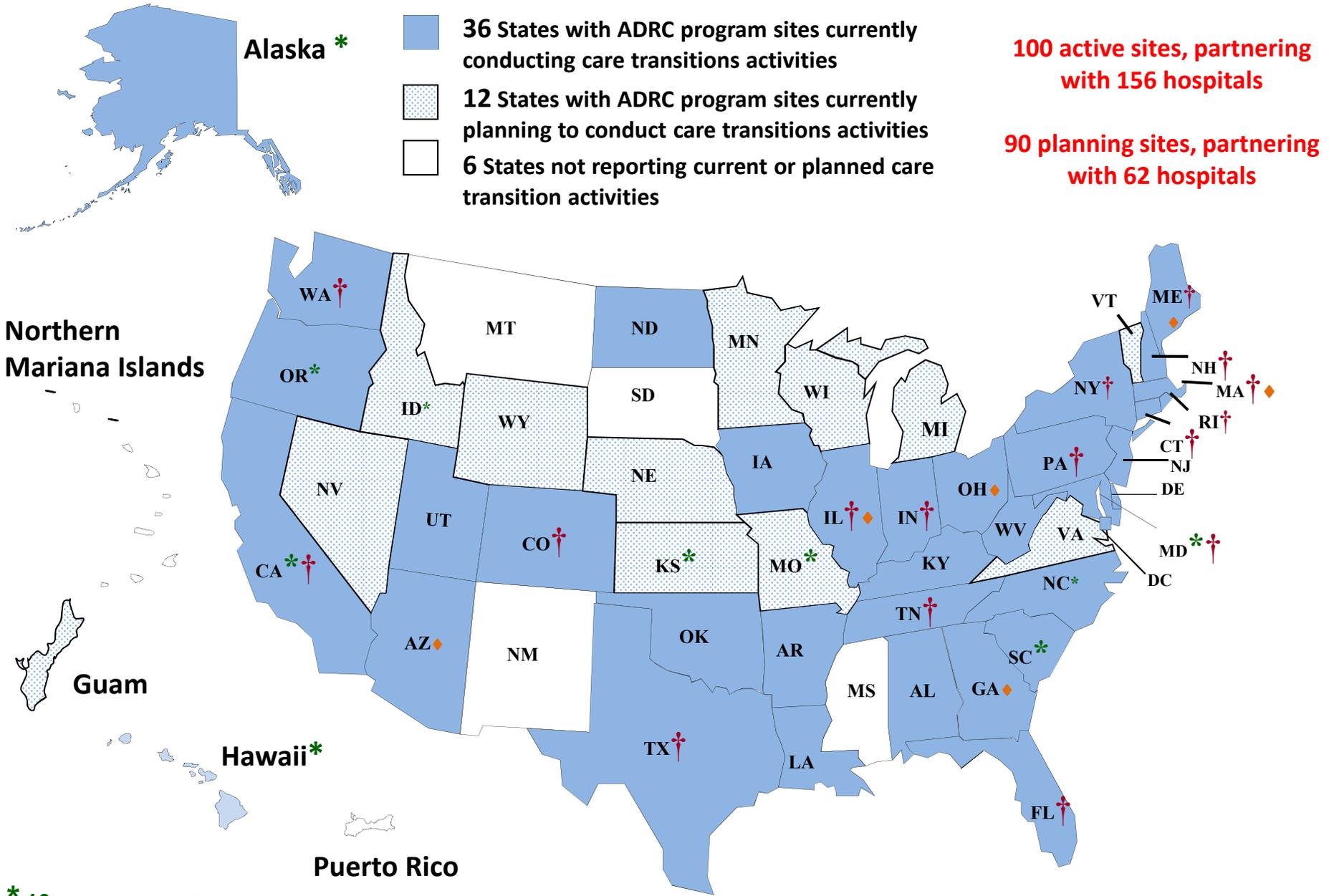
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ADMINISTRATION ON AGING, WASHINGTON DC 20201  
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# Agenda

- **Welcome and Introductions**
- Option D Grantee Spotlight: Massachusetts
  - Guest Speakers: Valerie Callahan and Emily Kearns
- Overview of Longitudinal Care Coordination Workgroup
  - Guest Speakers: Jennie Harvell (ASPE) and team
- ACA Update: Opportunities for the Aging Network
  - Guest Speaker: Abigail Morgan (AoA)
- Upcoming Events/Resources

# ADRC Care Transitions Activities



\* 10 states with CMS Hospital Discharge Planning Model grant

† 16 states with 2010 ADRC Option D Care Transitions grant

◆ 6 states participating in CCTP

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## The Massachusetts Context



**The Surprising  
Conundrum**

**Emerging role  
of AAAs**

**Changing  
Hospital  
Systems**

## The ADRC of the Greater North Shore



**Key Partnerships**

**Navigating Across  
Care Settings  
(NACS)  
Development**

## Safe Passages Collaboration



**Community  
Health**

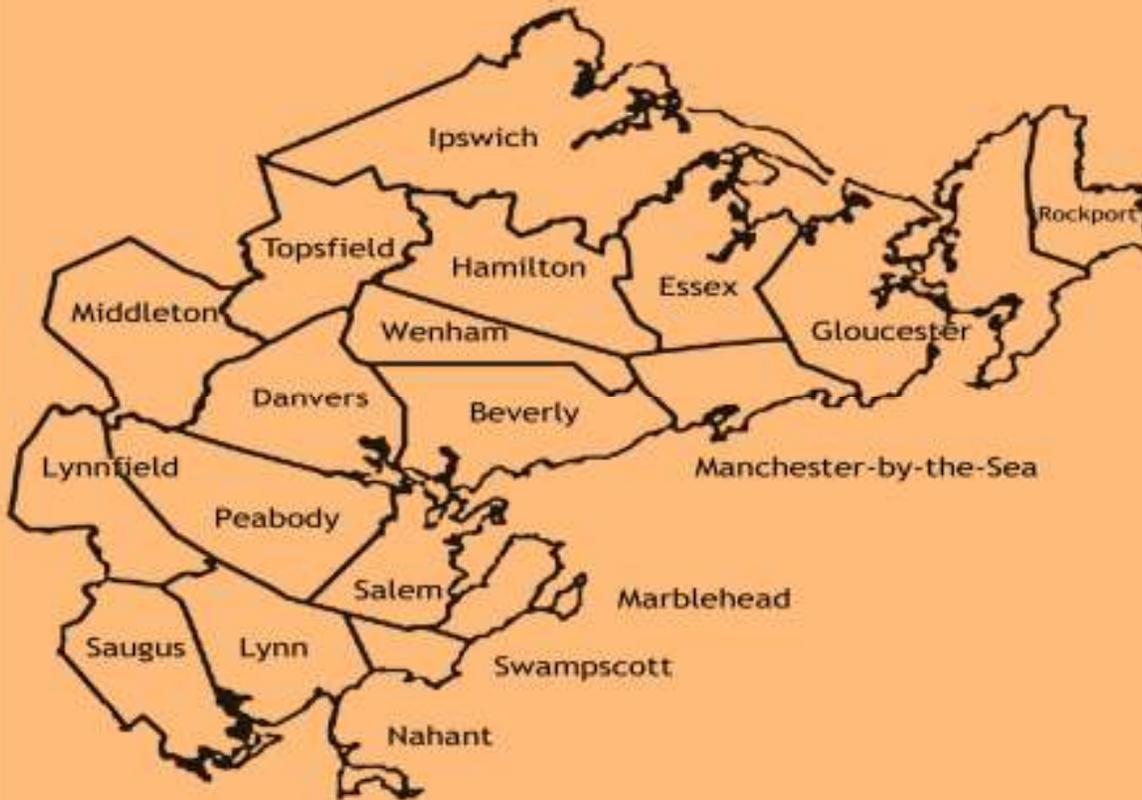
**Outcomes /  
Discovery**

**Care  
Transitions and  
Consumer  
Activation**

## The Massachusetts Context

- Massachusetts is home to some of the finest academic medical centers in the world but the state has some of the highest readmission rates in the country
- There are multiple research efforts to improve health outcomes and reduce costs at various hospitals
- Massachusetts is one of a handful of states participating in the *State Action to Avoid Re-hospitalizations (STAAR)* Initiative
- Massachusetts has an active AAA system invested in Care Transitions as well as a strong commitment to ADRC collaborations
- Two area hospital systems are now Pioneer ACOs

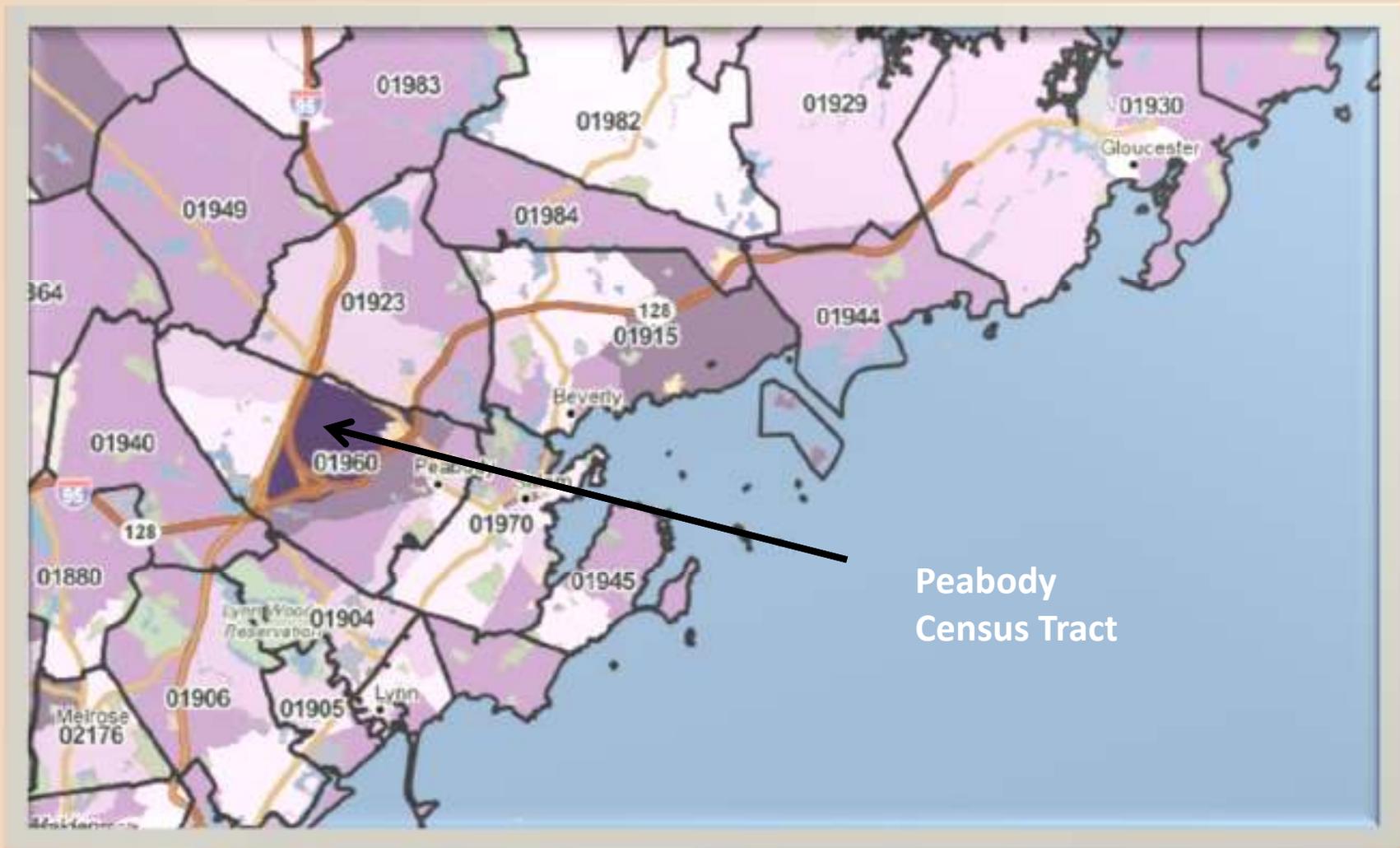
# The ADRC of the Greater North Shore



Goal: *Build ADRC partnership capacities to create community-centric triggers for consumer activation*

- One of the first ADRCs in Massachusetts, also one of the most active:
  - ☒ Options Counseling
  - ☒ Mobility Management
  - ☒ Care Transitions and Health Self-Management
  - ☒ Networking and Advocacy
- Covers 19 communities, comprising 346,000 residents of whom 15% are over 65

## Percent of People 65 and older in the Root Cause Living in Poverty, 2005-2009



**Dark Purple section** indicates greater than 59% concentration

**Moderate Purple** = 40-59%

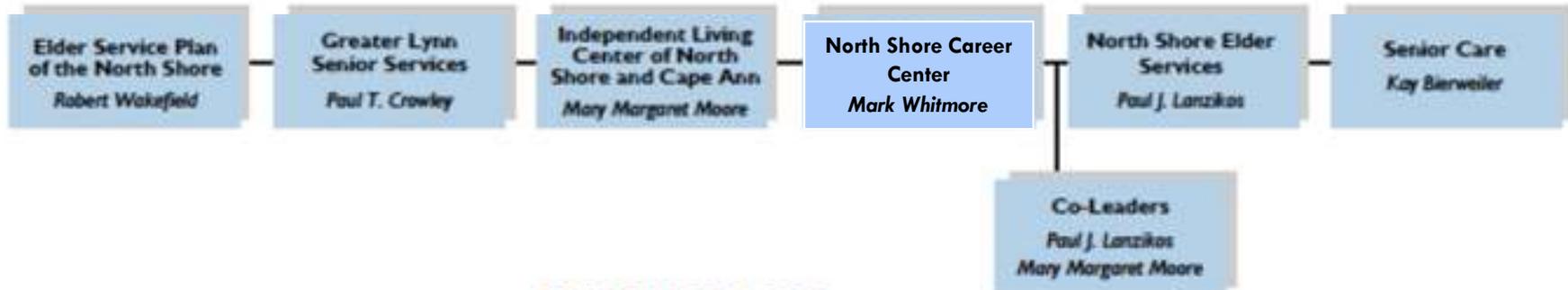
**Light Purple** = 20-40%



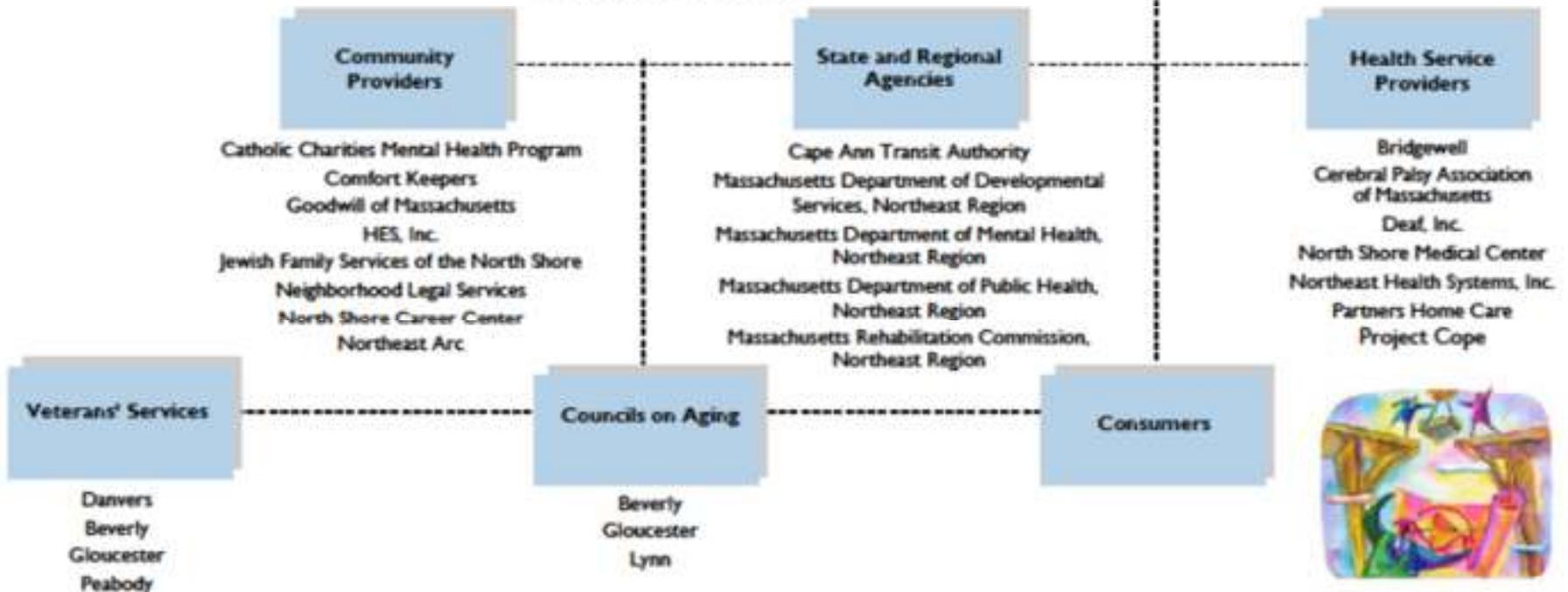
# AGING AND DISABILITY RESOURCE CONSORTIUM OF THE GREATER NORTH SHORE

## ORGANIZATIONAL CHART

### LEADERSHIP AGENCIES



### STAKEHOLDERS



## The ADRC of the Greater North Shore

ADRC member organizations have been developing care transitions capacities for several years:

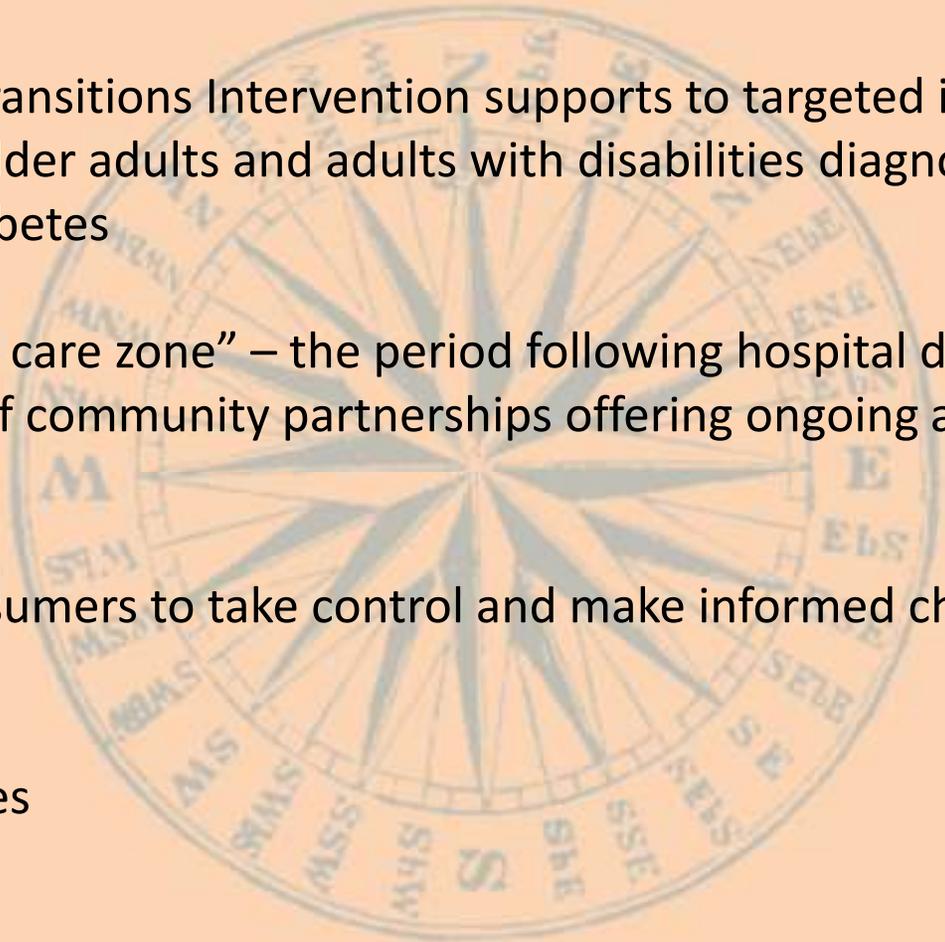
- ❖ Participation in the STAAR cross-continuum teams with Addison Gilbert, Beverly, Salem and Union Hospitals
- ❖ Small care transitions pilot at Union Hospital begun in 2010, but restricted by hospital research
- ❖ Agreement to collaborate on fuller care transitions work with Addison Gilbert and Beverly Hospitals



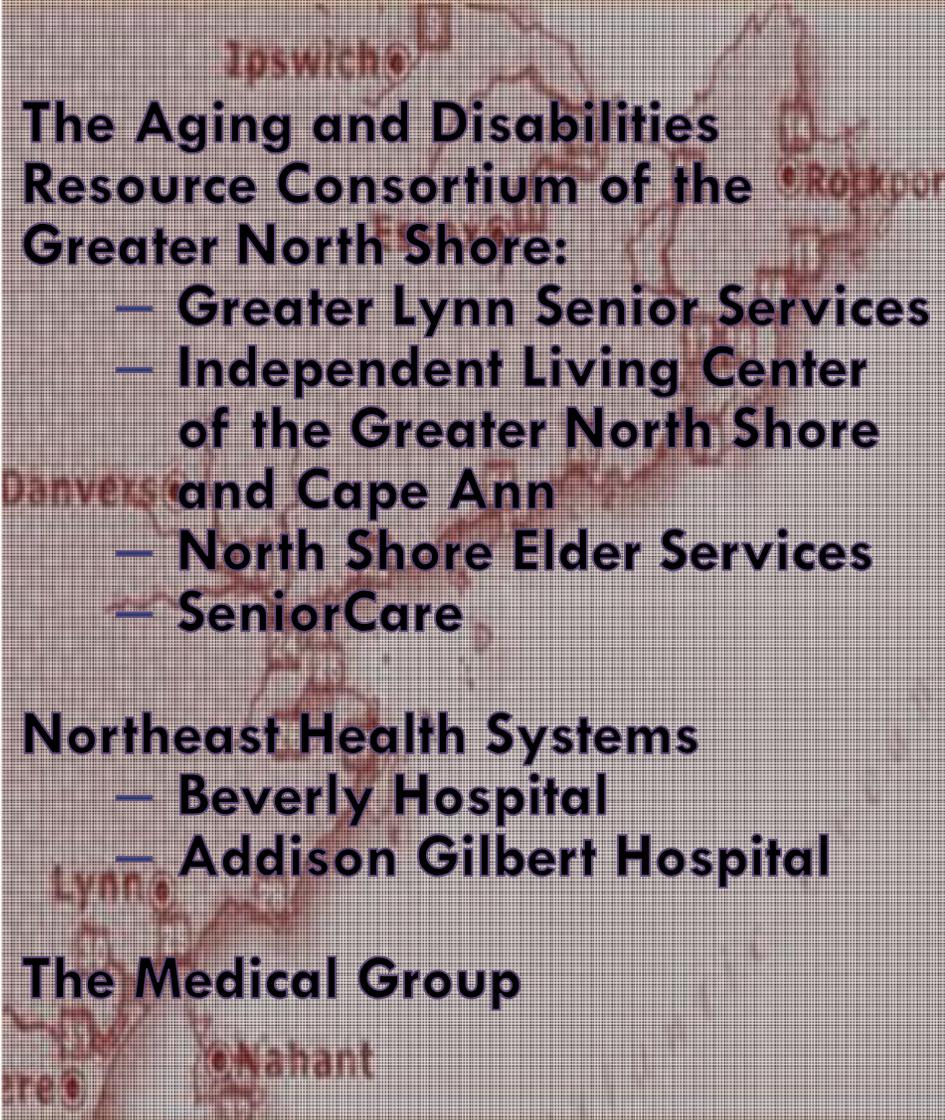
These 4 hospitals account for approximately 28,000 North Shore Area resident discharges each year

# The ADRC of the Greater North Shore

## Navigating Across Care Settings: (NACS)

- Deliver Care Transitions Intervention supports to targeted individuals over two years -- older adults and adults with disabilities diagnosed with CHF, COPD, and diabetes
  - Bridge the “no care zone” – the period following hospital discharge – with a rich tapestry of community partnerships offering ongoing and diverse supports
  - Empower consumers to take control and make informed choices for using supports
  - Track Outcomes
- 

# The NACS Partnership



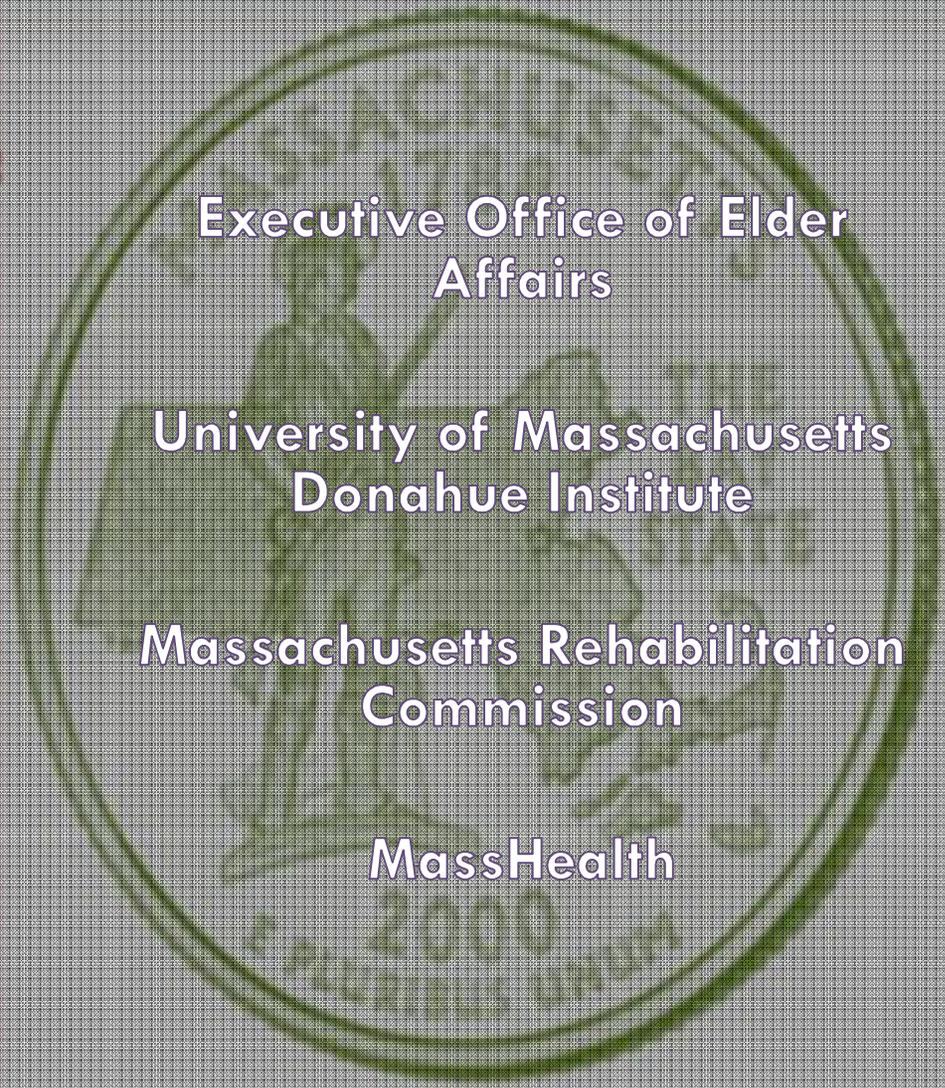
## The Aging and Disabilities Resource Consortium of the Greater North Shore:

- Greater Lynn Senior Services
- Independent Living Center of the Greater North Shore and Cape Ann
- North Shore Elder Services
- SeniorCare

## Northeast Health Systems

- Beverly Hospital
- Addison Gilbert Hospital

## The Medical Group



Executive Office of Elder Affairs

University of Massachusetts Donahue Institute

Massachusetts Rehabilitation Commission

MassHealth

# PROPOSED OUTCOMES

Consumers	Caregivers	Providers
*are less likely to be re-hospitalized within 30- and 90-day periods	*feel they have more supports for effective care-giving	*know about available Care Transitions supports in the community
*feel more in control of their health routines	*are aware of available supports and how they work	*make appropriate referrals to Care Transitions supports
*follow health regimens more effectively	*feel they can do more effective problem-solving	*believe communications with patients has improved
*feel they have more choices about how to effectively manage their health routines	*feel they can cope better with stress	*are more willing to participate in care transitions support programs and/or integrate care transition elements into their practices
*communicate more effectively with health providers	*believe they can better manage their own daily lives	
*are satisfied with their health management choices	*believe they can better manage the health routines of the care recipient	
*have identified and know how to use a wider range of supports for managing their health routines		
*feel more positive about their health and well-being		

# UNANTICIPATED CHALLENGES

- Hospital Merger
- Significant number of consumers discharged to rehab (not home)
- Consumers discharged before coaches could visit
- Some confusion around coaching referrals when hospital's community services (VNA) part of discharge plan

# COACHES' FOCUS GROUP FINDINGS

- Consumers are unable to commit to the coaching process if introduced to it while in the hospital: they are too sick; there are too many people coming in and out; they want to go home
- Before hospitalization and after discharge, while they are stable, is the ideal time to introduce coaching to consumers
- Creating a trusting relationship is key to successful coaching
- Role playing is an effective tool for consumers to develop self advocacy skills useful during physician visits

# RESPONSE TO CHALLENGES

- ◆ Continuing to work through multiple communications issues, many involving IRB
- ◆ Creating Hospital Liaison Position
- ◆ Merging NACS with a sister “Rehab” pilot following same protocols
- ◆ Cultivating stronger partnership with VNAs
- ◆ Developing “pre-hospitalization” marketing campaign – “Where’s My Coach??”

**Meet Shirley.  
She's part of a  
winning team.**

**The game plan?  
To help Shirley stay  
healthy and in charge.**



**NAVIGATING ACROSS CARE SETTINGS: CHOICES FOR SUCCESSFUL TRANSITIONS**

**A CARE TRANSITIONS INTERVENTION PROGRAM OFFERED TO YOU BY THE AGING AND DISABILITY RESOURCE CONSORTIUM OF THE GREATER NORTH SHORE IN PARTNERSHIP WITH NORTHEAST HEALTH SYSTEM**

Your health care and community providers working together for a healthier you.

## Shirley has a coach, a team, and a 30-day, potentially life-changing game plan.

If you have been admitted to the hospital with congestive heart failure, chronic obstructive pulmonary disorder (COPD), or a diabetes-related diagnosis, a trained, certified coach can guide you through the discharge process and your transition back home or to a skilled nursing or rehabilitation facility.



### SHIRLEY'S TEAM

- **STEPPING UP TO THE PLATE:** Shirley herself.
- **THE COACH:** Andrew.
- **IN CENTERFIELD:** Shirley's care team—her Physician and Endocrinologist.
- **THE PINCH-HITTER:** Gladys, Shirley's next-door neighbor, who helps out by driving her to medical appointments.
- **THE CHEERLEADER:** Shirley's daughter, Linda, who lives in another state.
- **THE GAME-CHANGER:** The "PLUS" Program's Diabetes Self-Management Workshop leader Shirley is about to meet.

### THE 30-DAY GAME PLAN

Andrew will meet with Shirley in the hospital and after discharge, then stay in touch to make sure she understands and is moving forward with her discharge plan. He'll give Shirley the tools, education, confidence, and supports she needs to better manage her own health and health care after discharge by walking her through a series of helpful steps:

- Get Shirley started on developing a detailed personal health record to take with her to all her doctor's or hospital visits.
- Make sure she understands why she is taking each medication and how much you should take.
- Remind Shirley to schedule a follow-up appointment with her physician.
- Make sure she recognizes the warning signs that her condition may not be getting better and what to do and who to call if that happens.
- Introduce Shirley to the PLUS Programs—healthy living workshops that can keep her moving in the right direction.

**Who's on your team? Get a coach: 1-888-499-5324.**

**"NAVIGATING ACROSS CARE SETTINGS" IS PROVIDED TO YOU BY THE AGING AND DISABILITY RESOURCE CONSORTIUM OF THE GREATER NORTH SHORE IN PARTNERSHIP WITH NORTHEAST HEALTH SYSTEM—WORKING TOGETHER FOR A HEALTHIER YOU.**

## The Safe Passages Collaboration

*Goal: Build ADRC partnership capacities to create community-centric triggers for consumer activation*

- *NACS as building block*
- *Merging with sister pilots (expanding diagnoses and including transitions from area rehabs to home)*
- *Focusing on prevention and shifting community norms around health self-management*

## The Safe Passages Collaboration

### The Collaborative Members:

- *ADRCGNS*
- *Two Hospital systems*
- *Medical Practices*
- *Health Centers*
- *Rehab/SNFs*
- *Home Health Agencies*
- *Visiting Nurse Associations*
- *North Shore Community College*

## The Safe Passages Collaboration

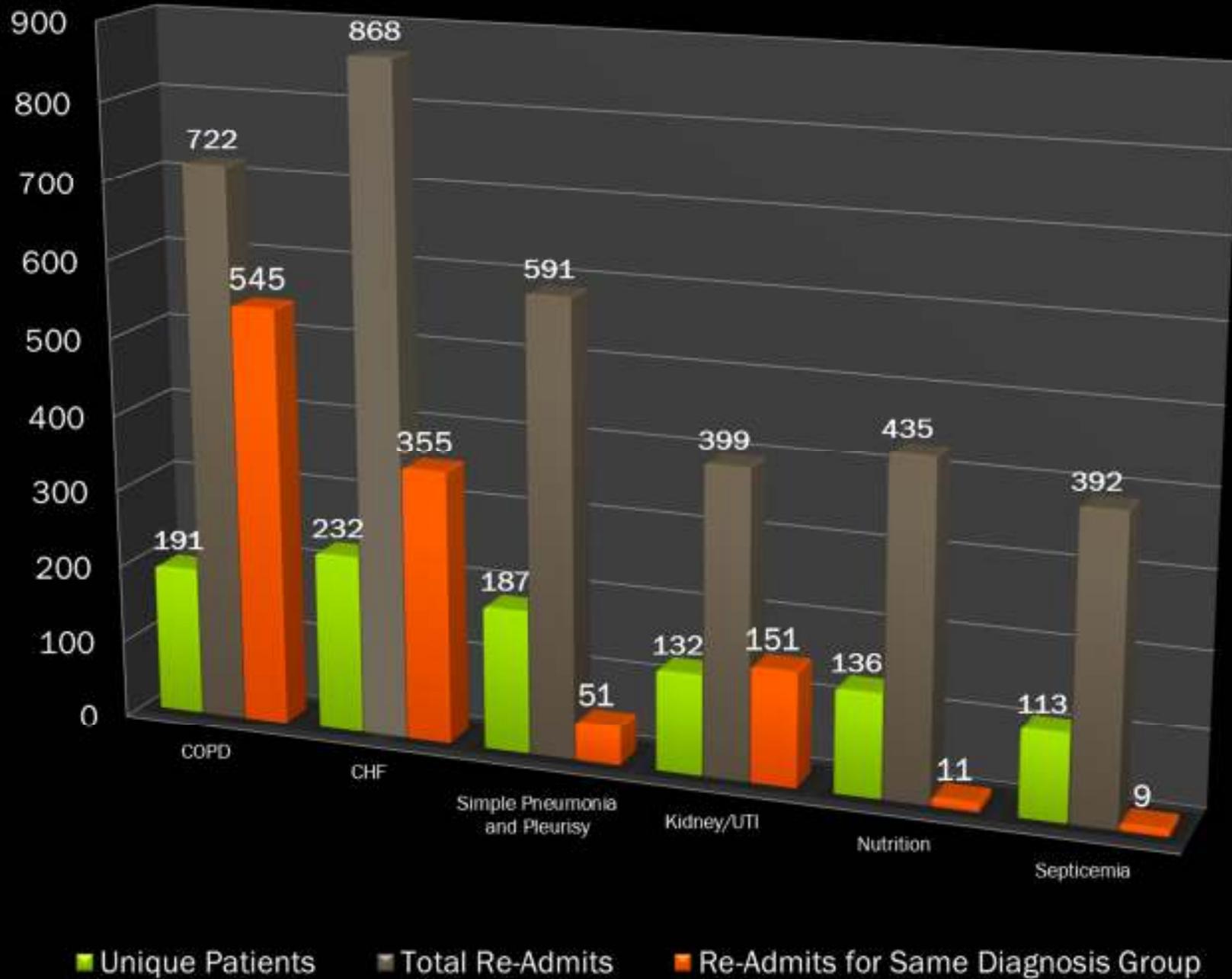
### Work to Date:

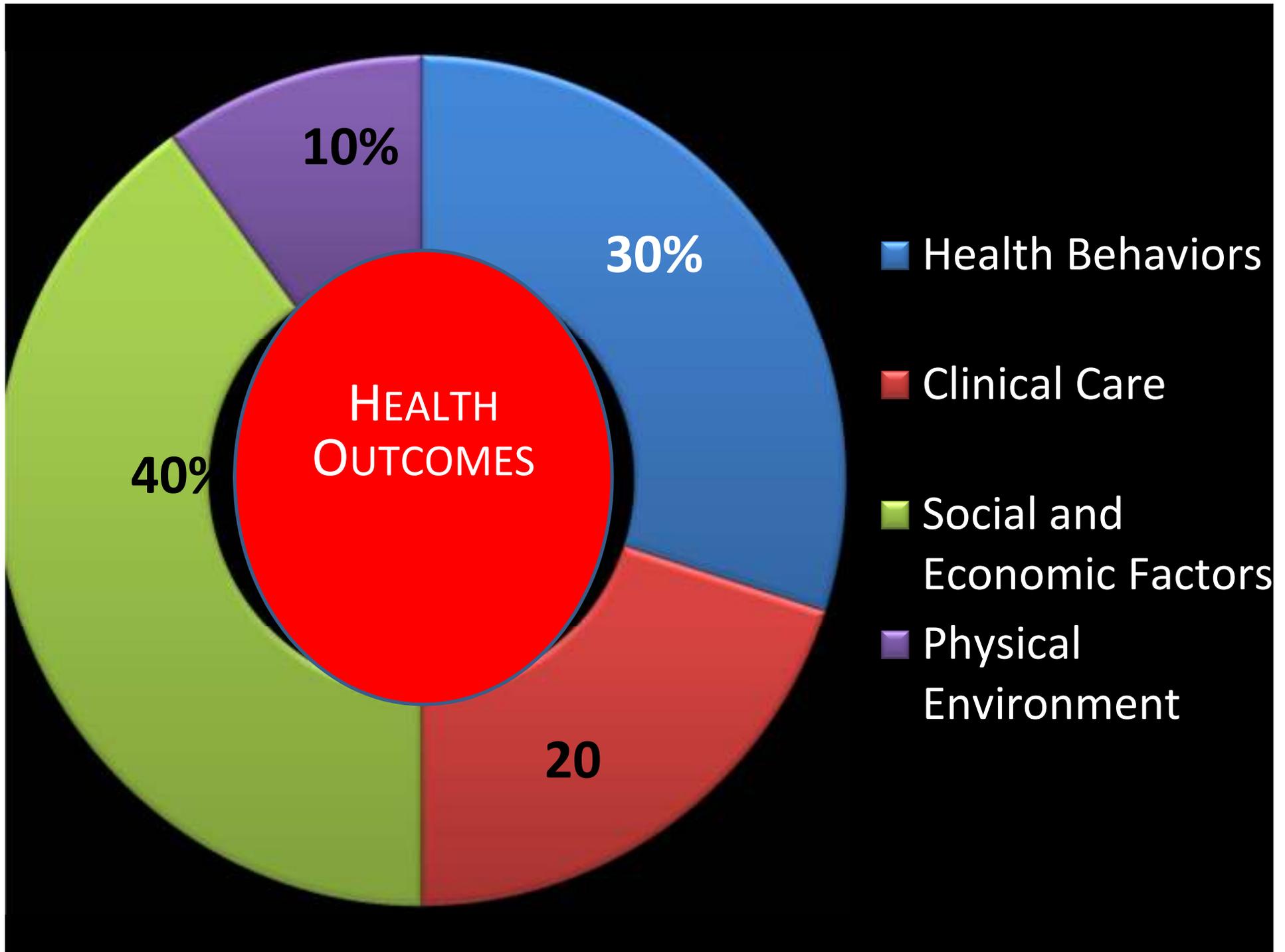
- *Two regional meetings – 30 area agencies*
- *Discovery – Root Cause Analysis*
- *Development of PLUS coordination and programming*
- *Three Care Transitions Projects*
- *Marketing Campaign Development*
- *Embedded Services*

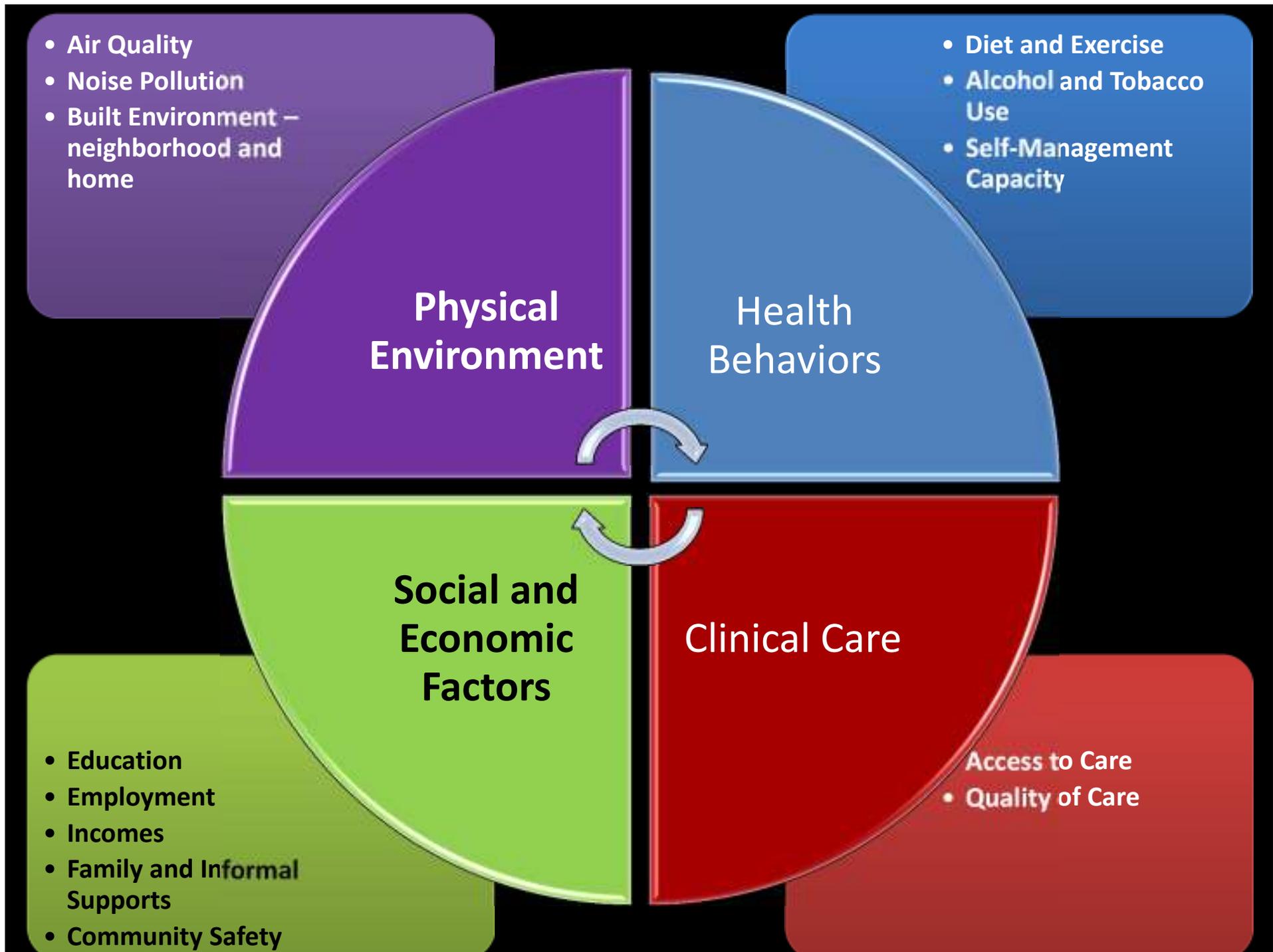
## The Safe Passages Collaboration

- Based on simple age-specific rates, residents in our catchment area who are over 50 are hospitalized at a rate almost 7% higher than the statewide average
- Age-specific (50+) hospitalization rates are 16% higher for mental health related disorders, and 10% higher for pneumonia diagnoses in our region compared to the state
- Age-specific (50+) hospitalization rates for COPD and kidney/UTI disorders are also significantly higher in Beverly, Gloucester, Peabody, and Lynn than for the region or state as a whole
- Significant numbers of consumers re-hospitalized have multiple co-morbidities

# Data Snapshot: Multiple Co-Morbidities







## The Safe Passages Collaboration

### **BOILS DOWN TO CONSUMER ACTIVATION: THE SOURCE OF HIGHER QUALITY CARE AT LOWER COSTS**

- Willingness and opportunity to learn about healthy behaviors
- Knowledge of what healthy behaviors are
- Willingness and opportunity to practice healthy behaviors
- Knowledge of how to practice and sustain healthy behaviors
- Willingness to find and use the motivation for sustaining
- Seeking and getting support to sustain

# The Safe Passages Collaboration

Activation  
Coaching –  
before, during,  
and after  
health crises!

## Consumer Activation

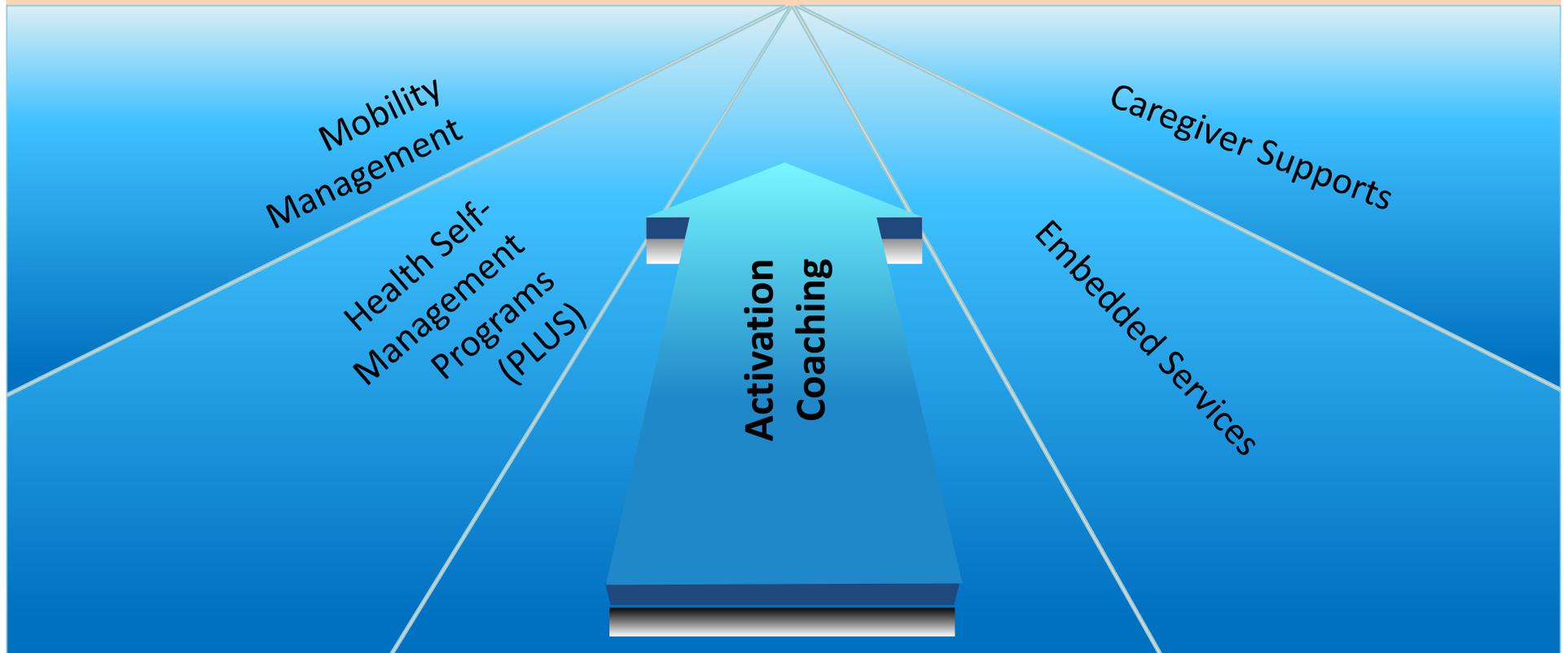
Mobility  
Management

Health Self-  
Management  
Programs  
(PLUS)

Activation  
Coaching

Embedded Services

Caregiver Supports



# Consumer Activation

Theory of Action	Inputs	Activities	Outcomes	Measures
<ul style="list-style-type: none"> <li>• Deviance Theories including Positive Deviance</li> <li>• Choice Theories</li> <li>• Engagement and Activation Theories, Relational Counseling, Situated Learning and Role Theories</li> </ul>	<ul style="list-style-type: none"> <li>• Coleman Coaches</li> <li>• Evaluation Team</li> <li>• Hospital data collection staff, IT, and IRB</li> <li>• Project Manager</li> <li>• Marketing Team</li> <li>• Consumers</li> <li>• Referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Coaching</li> <li>• Options/Travel Counseling</li> <li>• Health Self-Management Supports</li> <li>• Elder Mobile Mental Health</li> <li>• Caregiver Supports</li> <li>• QA / Evaluation</li> <li>• Marketing</li> <li>• Ongoing program integration</li> </ul>	<ul style="list-style-type: none"> <li>• Greater consumer awareness/ motivation</li> <li>• re: health self-management</li> <li>• Reduced health crises/ avoidable hospitalizations</li> <li>• Greater community livability and consumer satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>• Data gathering tool (including PAM)</li> <li>• Consumer satisfaction/well-being surveys</li> <li>• Hospital readmissions/ER Visits</li> <li>• Consumer use of health self-management techniques</li> </ul>

# The Safe Passages Collaboration

## **INFORMATION WON'T CHANGE UNHEALTHY BEHAVIORS OR PROMOTE ACTIVATION**

- Requires inspiration, effective rewards and positive meaning within daily life, and a perceived benefit greater than the cost
- Requires credible and accessible choices
- Requires willingness to accept role and responsibility for choosing
- Requires community oases or pulse points to reinforce and support choice and practice

## Current Care Transitions Projects: Building Relationships that Inspire

- NACS – Transition from Hospital to Home, 3 Diagnoses
- NACS “Sister Project” – Transition from Rehabs to Home, 5 diagnoses
- Union Hospital Project – Nurse Liaison at Hospital; includes both transitions from hospital and rehab to home; cannot include consumers in hospital-based care management pilot
- PLUS Programs
  - Health Self-Management
  - Mobility Management
  - Caregiver Supports

## Current Care Transitions Projects

### **To date:**

- 303 Care Transitions referrals
- 36% received home visit
- All completed PAM scores (baseline, 30, and 90 days) demonstrate increased activation
- Preliminary re-admissions reports are positive

Where can I get more information?

Your coach can help get connected with these and other community supports, as needed.

If you are no longer working with your care transitions coach, call 1-888-555-5555 to speak with a counselor and get more information about these programs.

Who provides this program?

This program is funded through the U.S. Administration on Aging and is a collaborative effort among Addison Gilbert and Beverly Hospitals—part of the Northeast Health System—and the Aging and Disability Resource Consortium of the Greater North Shore, working in partnership with your local health care provider.



“We were so anxious to get Mom home, we forgot to ask a few of the questions we meant to during the discharge process. Our Coach helped us ask the right questions of the right people.”

## NAVIGATING ACROSS CARE SETTINGS



**T**his program is designed to empower older adults, people living with disabilities, and their families and caregivers to be more knowledgeable and confident in self-managing their care and health after hospital discharge to prevent readmission.

Based on the Care Transitions Intervention Model developed by Eric Coleman, M.D., the program recognizes that people can become overwhelmed by or have questions about specific discharge instructions once they return home and are suddenly responsible for their own self-care. Our program features trained coaches and a “PLUS” program providing connections to ongoing community education and supports.

**You’re back home.  
We want to keep you  
healthy and in charge.**

**CALL TOLL FREE  
1-800-555-5555**

**You’re back home.  
We want to keep  
you healthy and  
in charge.**



**NAVIGATING ACROSS  
CARE SETTINGS:  
CHOICES FOR  
SUCCESSFUL TRANSITIONS**

**“PLUS” PROGRAM  
RESOURCE GUIDE**

Giving seniors, adults with disabilities, and their families and caregivers the tools, education, confidence, and supports to better self-manage their care and health after hospital discharge



“With PLUS, I learned to manage my chronic pain.”

Our “PLUS” programs keep you moving in the right direction by connecting you with the tools you will need to become a more knowledgeable consumer, self-confident user of the health care system, and independent person.

### Who is the “PLUS” program for?

It has been designed especially for you – as a participant in “Navigating Across Care Settings”(NACS) project – for residents of the North Shore age 60 and older or adults with disabilities age 22 and older hospitalized with chronic obstructive pulmonary disorder (COPD), congestive heart failure.

### What kinds of programs are available?

There are a number of tools that can help you, including:

•**OPTIONS COUNSELING** gives you access to trained counselors who provide unbiased information, support and follow-up to you and your family and caregivers about available options for long-term care, housing, services, and more.

• **“AT YOUR SIDE” MEDICAL ADVOCACY** provides trained volunteer medical advocates to accompany you to your medical appointments. We can help by asking questions, clarifying answers, and providing advocacy as needed.

• **CHRONIC DISEASE SELF-MANAGEMENT WORKSHOPS--** called “My Life. My Health”– are proven to help adults of all ages living with the challenges of one more chronic diseases to better manage symptoms, improve communication and generally feel better. – experiencing less fatigue, distress, and disability and fewer limitations on social and work activities



“The PLUS program helped me feel connected.”

• **A MATTER OF BALANCE** provides coaching around fall prevention, including strategies for controlling your fear, a plan for setting realistic goals for increasing movement and exercise, and concrete suggestions for changes to your environment that can reduce risk factors for falls.

• **PEER GUIDES** through the Independent Living Center of the Greater North Shore work with consumers with disabilities to build confidence and strategies to effectively cope with being "out there" in society and being constantly viewed as "different. Peer Guides assist the consumer to resolve family and personal issues, develop self-advocacy skills around a variety of issues including health supports, and sustain positive social connections.

• **CAREGIVER SUPPORTS** provides training and supports for caregivers or those assuming the caregiver role so they can provide assistance with knowledge and confidence. We offer free respite, support groups, and trainings, such as the *Savvy Caregiver Program*.



“Today I feel more in control , and I am less afraid of falling.”

# The Safe Passages Collaboration

## ***PLUS Coordination***

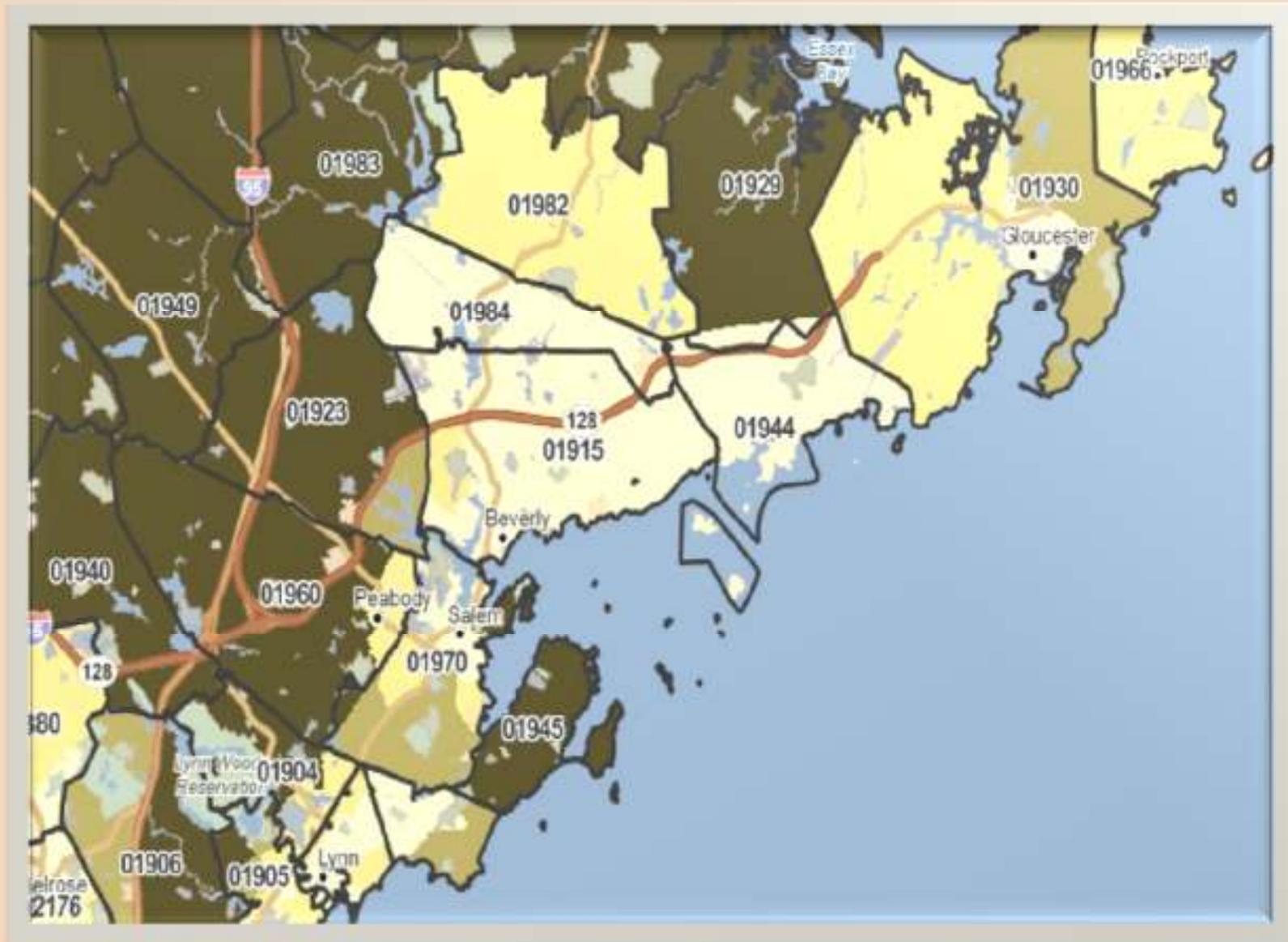
- ❑ An 800 centralized Counseling Line staffed by Options Counselors trained in decision supports
- ❑ Information about – and regional coordination for – caregiver support groups, education and interventions (REACH, SAVVY Caregivers)
- ❑ Regional coordination of and referrals to area health self-management programs and peer groups
- ❑ Seamless referrals to local care managers and the full range of at-home and community supports

## The Safe Passages Collaboration

### **Mobility Management: Not the Ride, But the Journey...**

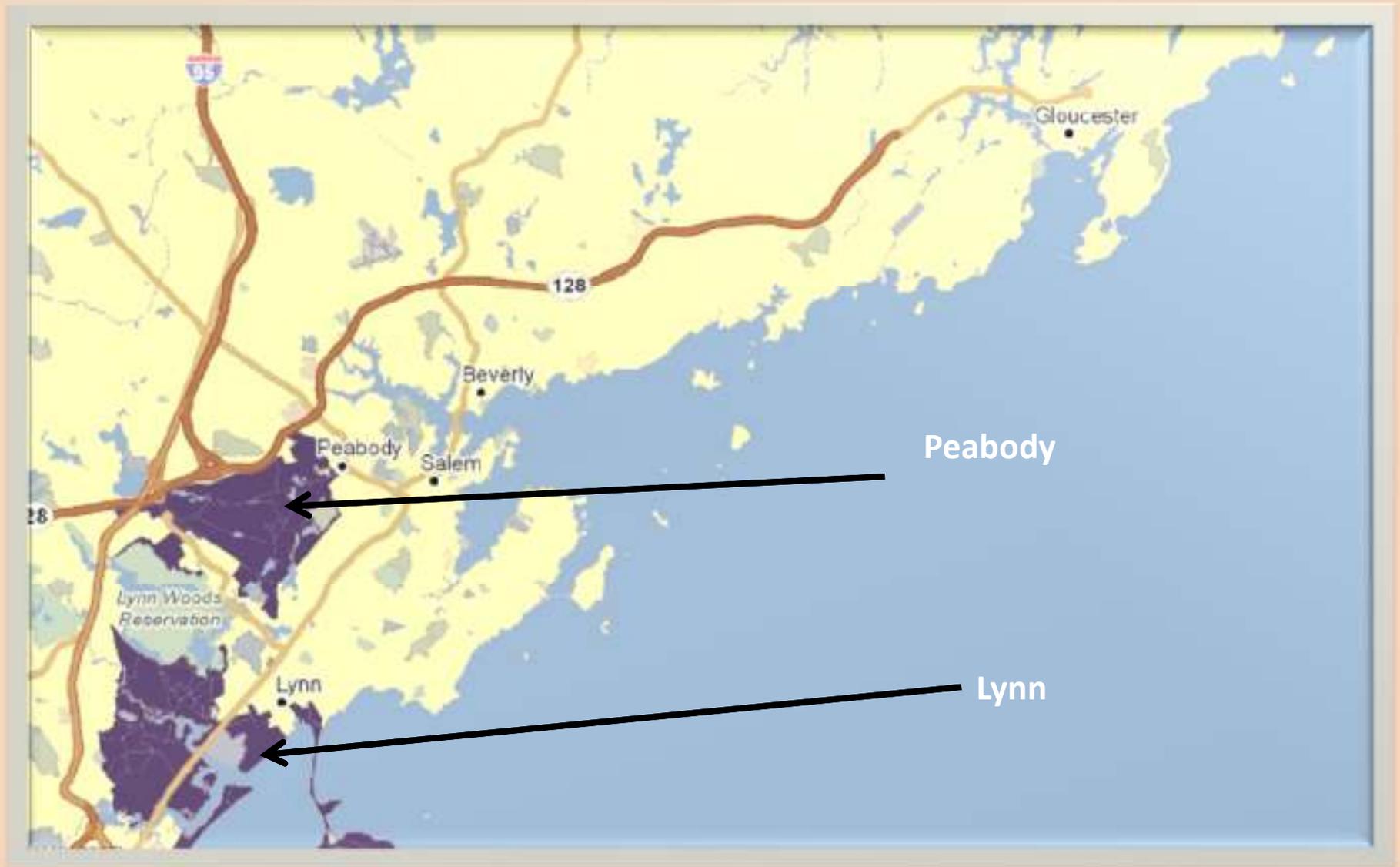
- ❑ Regional inventory of transportation resources, user friendly database, and centralized scheduling
- ❑ Travel Counseling Center staffed by Options Counselors who – trained in decision supports – provide information about transportation yet often end up in broader conversations about mobility, problem-solving, and managing care transitions
- ❑ Travel Counseling “800” line also connects with PLUS line and information resources
- ❑ Vigorous community education component promotes problem-solving around mobility reaches diverse consumers, including caregivers

## Distance up to 2 miles in closest public transit rail, 2009



Darkest brown sections are areas where distances exceed 2 miles

## Limited Supermarket Access of 2011



**Dark Purple section areas where there are significant barriers to supermarket access**

# The Safe Passages Collaboration

## *Embedded Services*

- ❑ ADRC staff trained in decision supports are embedded in local medical practices and Community Health Center
- ❑ Medical staff “hand-off” patients to ADRC staff when they wish to learn more about their community support options (often caregiver supports!), get transitions support, participate in health self-management programs, connect to people and places throughout the community, etc.
- ❑ Health self-management programs are held on-site at medical practices
- ❑ Elder Mobile Mental Health (home visits)
- ❑ ADRC staff help close the “communications loop” between patient and medical practitioners

# The Safe Passages Collaboration

## **SAFE PASSAGES IS ULTIMATELY ABOUT...**

- Creating the community pulse points that promote health and wellness/ livability
- Cultivating the community norms around healthy behaviors and choosing the healthier options
- Making the healthy choices more accessible to those at-risk
- Supporting the individual's self-management capacities

# Questions for Massachusetts?

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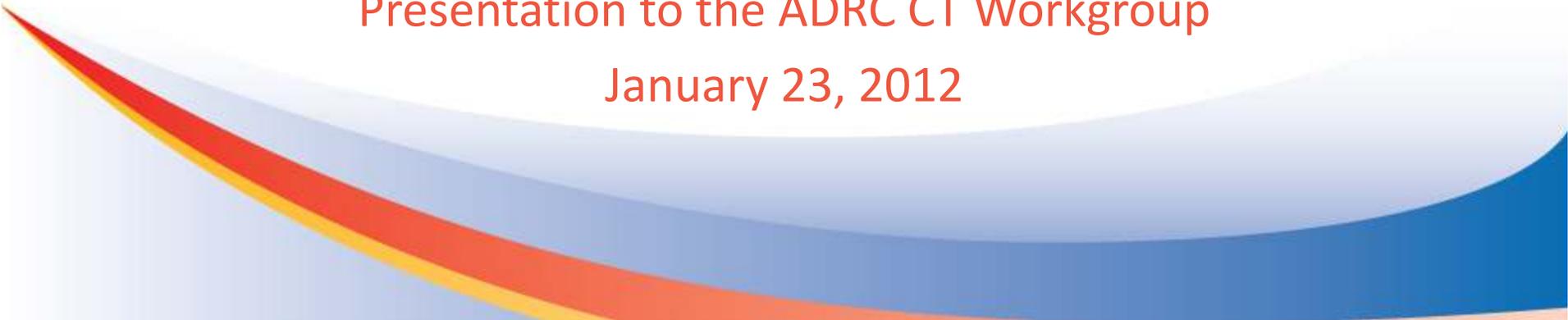


The Office of the National Coordinator for  
Health Information Technology

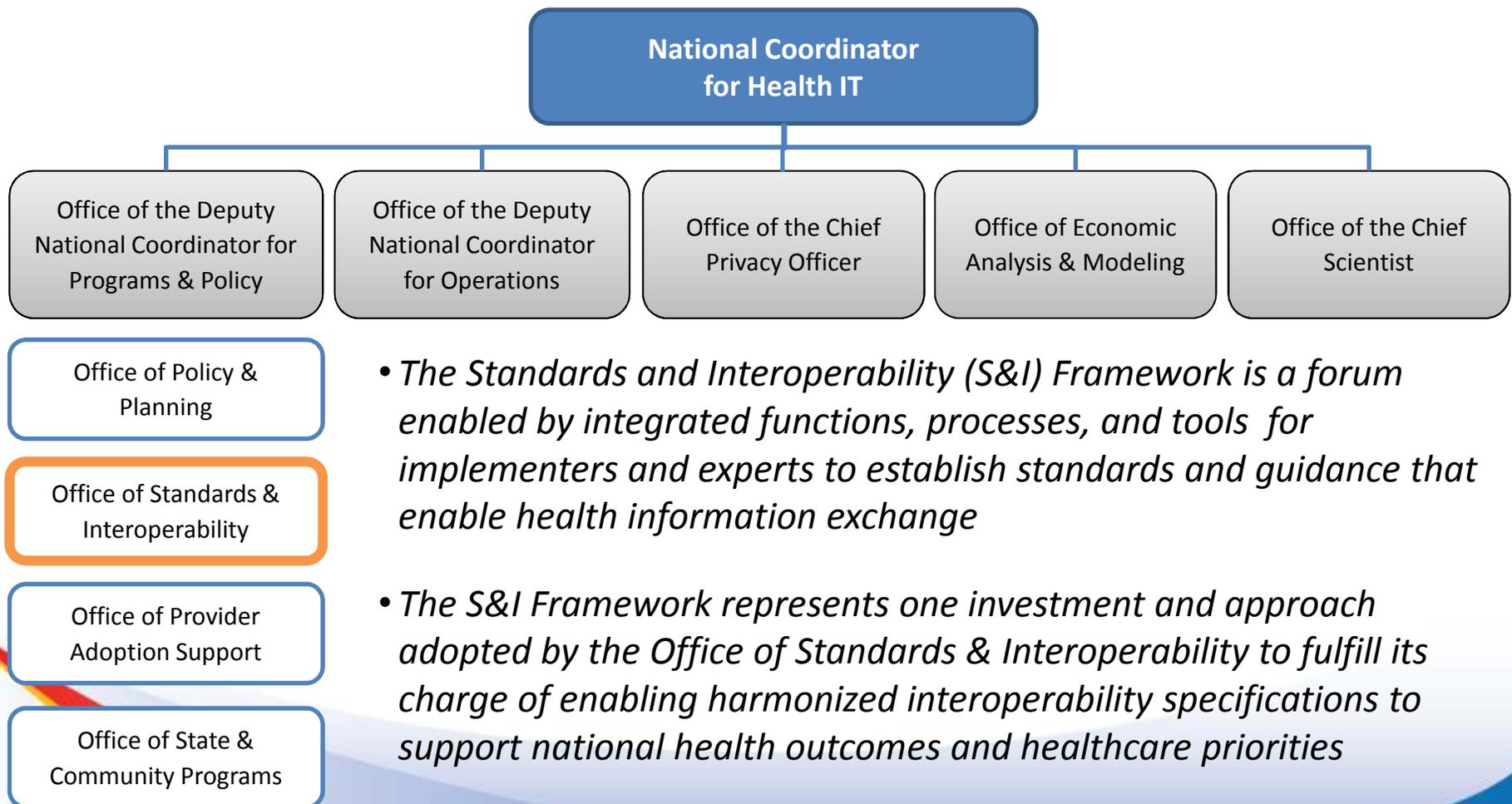
# Overview of Longitudinal Care Coordination Workgroup

Presentation to the ADRC CT Workgroup

January 23, 2012



# S&I Framework is a Key Tool in the Standards Toolkit



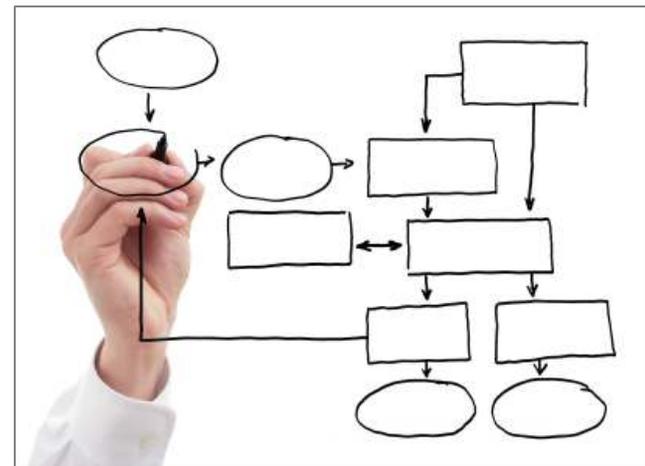
# S&I Framework Brings the Community Together to Solve Real-World HIE Issues

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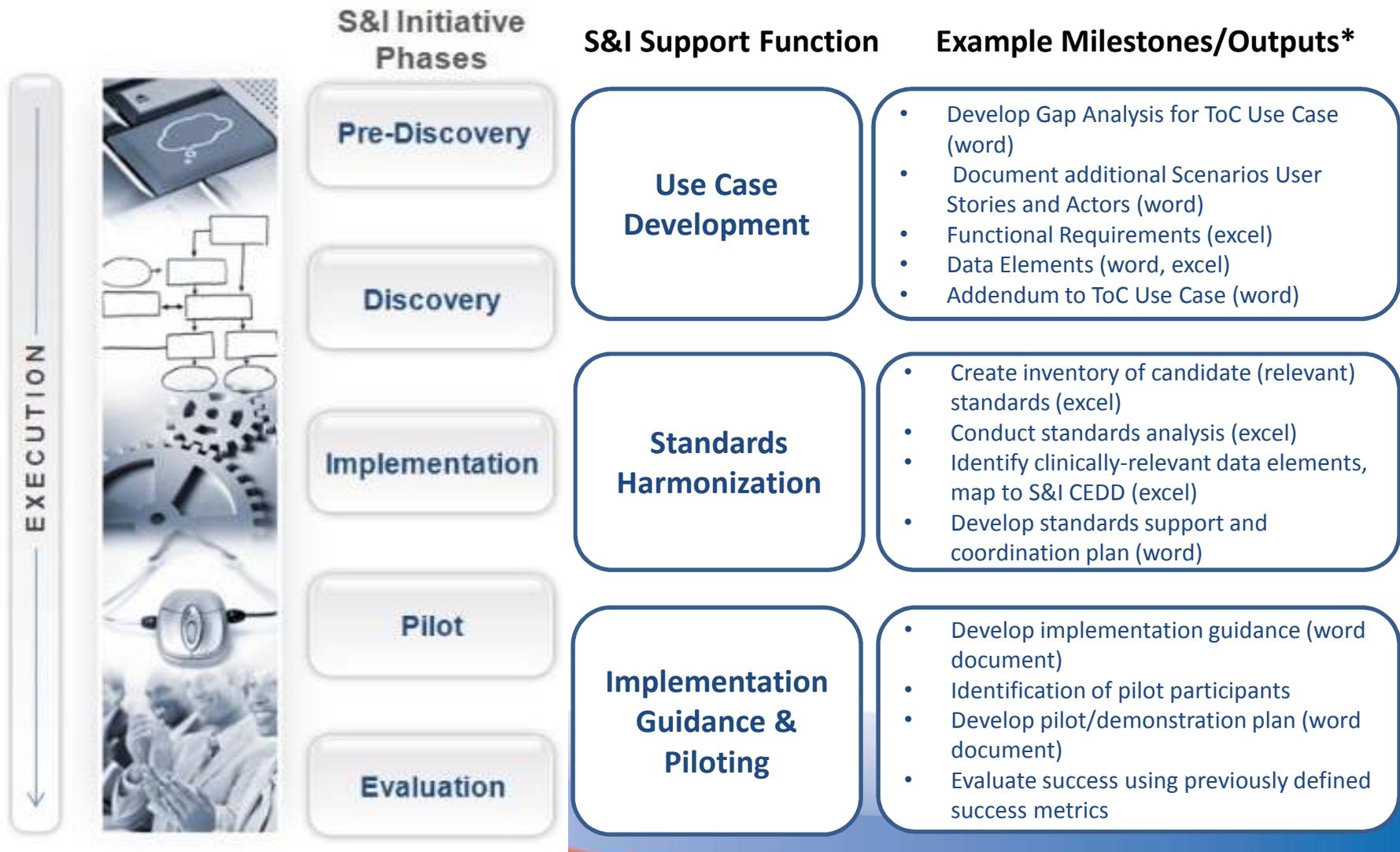
- S&I Framework Approach:
  - Create a collaborative, coordinated incremental standards process,
  - ... guided by ONC, with input from Federal Advisory Committees (e.g., Health IT Policy and Standards Committees)
  - ... enabled and led by an open community of industry participants
  - ... who are interested in solving real-world problems
- The Benefits:
  - Empower the community: give people a means to create the solutions rather than be “victims” of trends and mandates
  - Harness talent: attract a broad base of experts, implementers and other passionate healthcare community members
  - Enable Government as a Platform: provide tools, coordination, and harmonization to help the community drive solutions and adoption
  - Supports identification, piloting and use of standards for future stages of Meaningful Use

# S&I Framework Overview

- Specific health interoperability initiatives guide the design and development of a fully integrated and connected health information system.
- An **S&I Initiative** focuses on a single challenge with a set of value-creating goals and outcomes, and the development of content, technical specifications and reusable tools and services.
- **Call for Participation:** The overall success of the S&I Framework is dependent upon volunteer experts from the healthcare industry and we welcome any interested party to get involved in S&I Framework Initiatives, participate in discussions and provide comments and feedback by joining the Wiki:  
<http://wiki.siframework.org>



# S&I Initiative Phases, Support and Output



# Reusing Artifacts: Transitions of Care – Summary of Scenarios and User Stories

Scenario	User Story/Stories	Setting
<b>Scenario One: The Exchange of Clinical Summaries from Provider to Provider</b>	The Exchange of Information to Support the Transfer of Patient Information from One Provider to Another	<ul style="list-style-type: none"> <li>• Hospital or Emergency Department from where patient is discharged (sends discharge summary to PCP or Care Team)</li> <li>• Patient's PCP or Care Team (receives discharge summary from Hospital or ED clinical system)</li> </ul>
	Closed Loop Referral	<ul style="list-style-type: none"> <li>• PCP's office (sends consultation request clinical summary to specialist)</li> <li>• Specialist's office (receives referral request clinical summary from PCP; send consultation summary to PCP)</li> </ul>
	Complex Series of Care Transactions	<ul style="list-style-type: none"> <li>• Emergency Department</li> <li>• Hospital</li> <li>• Rehabilitation Facility</li> </ul>
<b>Scenario Two: The Exchange of Clinical Summaries between Provider to Patient in Support of Transitions of Care</b>	The Exchange of Discharge Instructions and Discharge Summary between a Provider and Patient to Support the Transfer of a Patient from One Care Setting to Another	<ul style="list-style-type: none"> <li>• Hospital or ED from where patient is discharged (sends discharge instructions to patient).</li> <li>• Patient</li> </ul>
	The Exchange of Clinical Summaries between Provider and Patients to Support the Closed-loop Transfer of a Patient from One Care Setting to Another Consultation Referral.	<ul style="list-style-type: none"> <li>• PCP's Office</li> <li>• Specialists Office</li> <li>• Patient</li> </ul>

# What is Longitudinal Care?

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- The sum of an individual's experience across multiple sites/ providers of care during an episode of care

## **Challenges:**

- Communicating among different sites of care and different health and human service providers
- Exchanging information with individuals and family members
- Assessing individual's status to support care planning across multiple sites/providers of care
- Coordinating care across all sites/providers of care each with their own care plans.
- Ensuring that each site that receives the individual receives needed clinical information for safe and efficient care
- Lacking interoperable communications standards to support the exchange of assessment, care plan, and transfer information needed during multiple transitions and instances of shared care.



# Establishing a Vision for Interoperable Longitudinal Care Coordination

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## Starting with Persons who Receive Long-Term and Post-Acute Care

### Vision

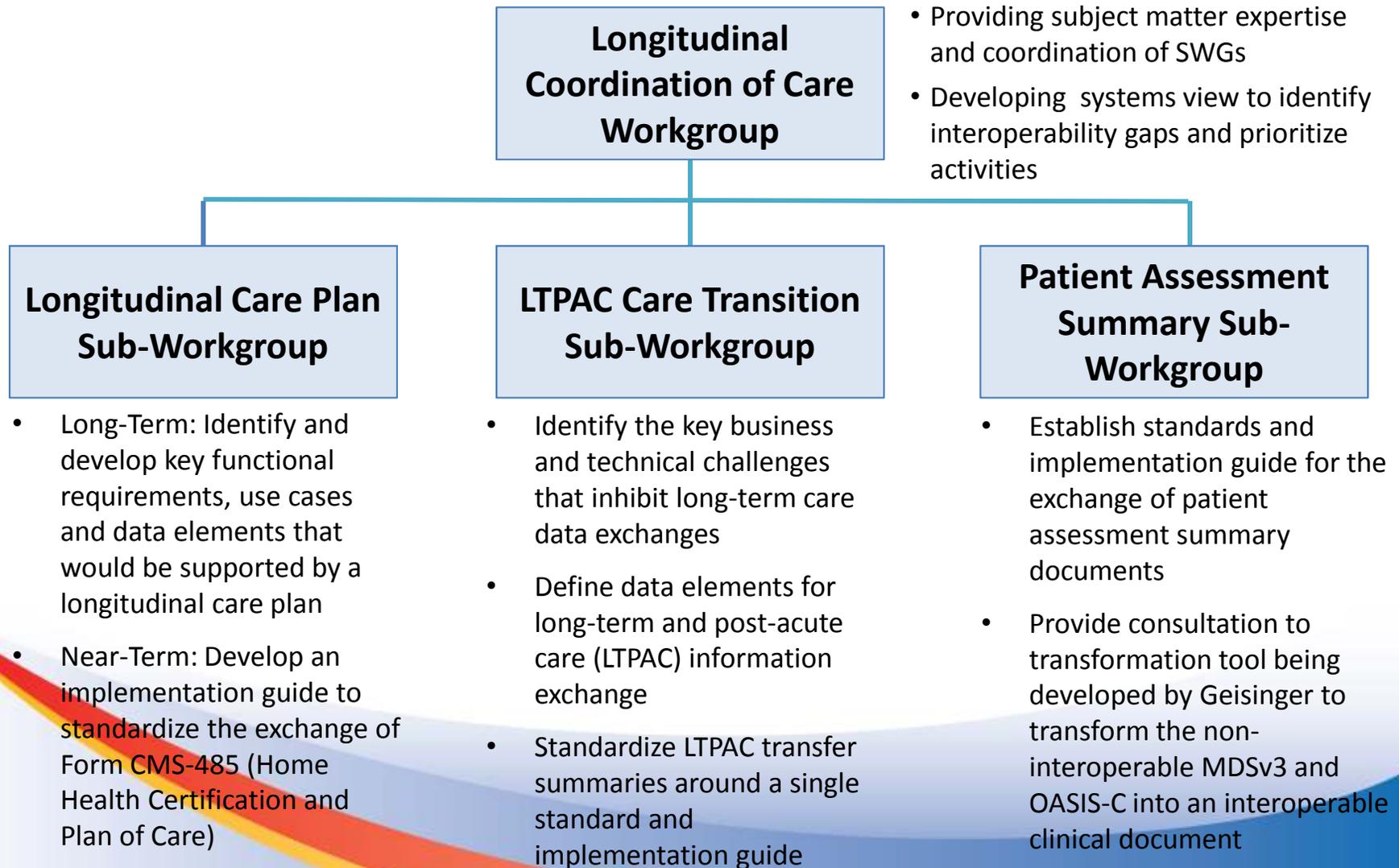
- Support and advance interoperable electronic health records systems across the long-term and post-acute care spectrum with the ability to electronically exchange clinical information with other providers
- Support and advance patient-centric interoperable health information exchange across the long-term and post-acute care spectrum
- Promote Longitudinal Care Management between all relevant sites and providers built around the needs and experiences of the patient
- LTPAC influences in Meaningful Use Stage 3

## LCC Sub-Workgroups

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- Three Sub-Workgroups (SWGs) are seeking to advance HIE across the longitudinal care space, focusing particularly on LTPAC.
- The 3 SWGs and Co-Leads are:
  1. **Longitudinal Care Plan:** Dr. Bill Russell and Sue Mitchell
  2. **LTPAC Care Transitions:** Dr. Terry O'Malley and Dr. Larry Garber
  3. **Patient Assessment Summary:** Leigh Ann Campbell and Sue Mitchell
- The SWGs aims to: identify the standards and services necessary to enable interoperable health information exchange of assessment content, care plans, and transfer documents; and ensure that there are forums for involved stakeholders to address these needs.

# Addressing the Challenges



# LTPAC Transitions, Care Plans, and Assessments

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- **Issue:** Elderly and disabled persons receive care from and transition to/from a wide range of health and human service providers.
- **Issues to clarify:**
  - Range of Transitions in care and disciplines involved in shared care
    - Types of health and human service providers
    - Types of settings that provide care to elderly and disabled persons
  - Prioritize providers/settings by volume, clinical instability and the “time-value” of the information
  - Data elements required for the elderly and disabled populations for safe and efficient care:
    - at each transition
    - for care planning
    - for assessments
  - Flagging privacy/security issues in documents





# LTPAC Transitions: Priorities

Transitions From (Senders)	Transitions to (Receivers)											
	In Patient	ED	Out patient Services	LTAC	IRF	SNF/ECF	HHA	Hospice	PCP PCMH	CBOs	Patient/ Family	
In patient				ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC
ED				ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	Out of Scope	ACH to LTPAC	Out of Scope	ACH to LTPAC	ACH to LTPAC
Out patient services				ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	ACH to LTPAC	Out of Scope	ACH to LTPAC	Out of Scope	Out of Scope	Out of Scope
LTAC	LTPAC to ACH	LTPAC to ACH	LTPAC to ACH	Out of Scope	Out of Scope	LTPAC to LTPAC	LTPAC to LTPAC	Out of Scope	LTPAC to LTPAC	LTPAC to LTPAC	LTPAC to LTPAC	LTPAC to LTPAC
IRF	LTPAC to ACH	LTPAC to ACH	LTPAC to ACH	LTPAC to LTPAC	Out of Scope	LTPAC to LTPAC	LTPAC to LTPAC	Out of Scope	LTPAC to LTPAC	LTPAC to LTPAC	LTPAC to LTPAC	LTPAC to LTPAC
SNF/ECF	LTPAC to ACH	LTPAC to ACH	LTPAC to ACH	Out of Scope	Out of Scope	Out of Scope	LTPAC to LTPAC	Out of Scope	LTPAC to LTPAC	LTPAC to LTPAC	LTPAC to LTPAC	LTPAC to LTPAC
HHA	LTPAC to ACH	LTPAC to ACH	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
Hospice	LTPAC to ACH	LTPAC to ACH	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
Ambulatory Care (PCP)	LTPAC to ACH	LTPAC to ACH	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
CBOs	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope
Patient/Family	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope	Out of Scope

LTPAC to ACH

ACH to LTPAC

LTPAC to LTPAC

Priority

Out of Scope

## Teaser Topics Being Discussed by LCC SWGs

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1. **Longitudinal Care Plan SWG:** What domains, services, goals, etc. need to be included in a longitudinal care plan? What are the range of service providers that should be considered by the LCP SWG?
2. **Patient Assessment Summary SWG:** What types of assessment items should be included in Assessment Summary Documents? Have all assessment question and answer patterns been identified?
3. **LTPAC Care Transition SWG:** What is the universe of health and human services providers that are involved in transitions of care? What transitions in care will be prioritized for the LCC WG Initiative?

## Where to Learn More

- S&I Framework Wikispaces and Webex have been set-up to facilitate collaboration between volunteers in diverse geographical locations
- Longitudinal Coordination of Care Wiki Page:  
<http://wiki.siframework.org/Longitudinal+Coordination+of+Care+WG>
- The LCC WG page contains the following information:
  - ✓ Logistics and Scheduling
  - ✓ List of Committed Members
  - ✓ Reference Materials
  - ✓ Discussion Boards



# How to Get Involved

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- Share what you learned during today's presentation
- Participate in one or more of the SWGs
- Sign-up as a Committed Member (guidance available on wiki)
- Help identify health and human service providers, and transitions in care, including those that will be in scope now
- Identify content and standards needed for care planning, transitions in care, and assessment summaries
- Ask for help by contacting the S&I LCC WG Support Co-Leads:
  - Meredith Lewis: [melewis@deloitte.com](mailto:melewis@deloitte.com)
  - Kris Cyr: [kristopher.cyr@accenture.com](mailto:kristopher.cyr@accenture.com)

# Discussion



# LCC Points of Contact

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- S&I LCC Steering Committee: [jennie.harvell@hhs.gov](mailto:jennie.harvell@hhs.gov)
- LCC SWG Leads:
  - Longitudinal Care Plan:
    - Bill Russell: [drbillrussell@verizon.net](mailto:drbillrussell@verizon.net)
    - Sue Mitchell: [suemitchell@hotmail.com](mailto:suemitchell@hotmail.com)
  - LTPAC Care Transitions:
    - Terry O'Malley: [tomalley@partners.org](mailto:tomalley@partners.org)
    - Larry Garber: [Lawrence.garber@reliantmedicalgroup.org](mailto:Lawrence.garber@reliantmedicalgroup.org)
  - Patient Assessment Summaries:
    - Leigh Ann Campbell: [lacampbell@geisinger.edu](mailto:lacampbell@geisinger.edu)
    - Sue Mitchell: [suemitchell@hotmail.org](mailto:suemitchell@hotmail.org)

# Agenda

- Welcome and Introductions
- Option D Grantee Spotlight: Massachusetts
  - Guest Speakers: Valerie Callahan and Emily Kearns
- Overview of Longitudinal Care Coordination Workgroup
  - Guest Speakers: Jennie Harvell (ASPE) and team
- **ACA Update: Opportunities for the Aging Network**
  - **Guest Speaker: Abigail Morgan (AoA)**
- Upcoming Events/Resources



# ACA UPDATE: Opportunities for the Aging Network

Building on Care Transitions as a Foundation for Aligning Program Opportunities

Abigail Morgan

Office of Policy, Analysis and Development, AoA



# The *Affordable Care Act* and the Aging Network

- Care transition activities are firmly rooted in ADRC core functions and in programs within the Aging Network
  - ADRC Critical Pathways and Evidence-Based Care Transitions Grants
  - Money Follows the Person
  - MDS 3.0 Section Q
  - Hospital Discharge Planning Grants
- Through different demonstrations and programs authorized by the ACA, there are opportunities for the network to be full partners in reforming our health care system
  - Delivery system redesign
  - Quality
  - Payment reform

# Section 3026: Community-based Care Transition Program (CCTP)

- The CCTP, mandated by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries
- Part of larger Partnership for Patients initiative through the U.S. Department of Health & Human Services

# The First CCTP Participants

7 Sites, 9 States, 38 Hospitals, 34,000 Beneficiaries



# Section 3021: Center for Medicare and Medicaid Innovation

- **Incentives**

Test models that align payment and administrative approaches that support delivering three part aim outcomes

- **Improvement and Spread**

Support development and diffusion of three part aim knowledge, models and operational activities

- **Ideas**

Drive development of new ways to deliver three part aim outcomes

# CMMI Initial Work and Models

- Partnership for Patients: (1) Patient Safety and (2) Care Transitions
- Imaging Demonstration
- Medicaid Emergency Psychiatric Demonstration
- Bundled Payments for Care Improvement
- Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP)
- ACO: Pioneer and Advanced Payment
- Comprehensive Primary Care Initiative
- Duals: Skilled Nursing Facility Demonstration (with Medicare-Medicaid Coordination Office)
- Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration.
- Physician Practice Group Demonstration Extension
- Million Hearts
- Healthcare Innovation Challenge

# Section 3022: Medicare Shared Savings Programs and ACOs

- Also known as the ACO – Accountable Care organization -- provision
- Reward ACOs that take responsibility for the costs and quality of their care for Medicare beneficiaries over time
- Savings shared between ACO and Medicare
- Rules have been published and details announced about ACO Models:
  - Pioneer ACO
  - Advance Payment Model

# Section 3024: Independence at Home Demonstration

- Establishes a payment incentive and service delivery system utilizing physician and nurse practitioner directed home-based primary care teams that improve health outcomes and reduce expenditures through care coordination in the home.
- Overall goal is to test whether in-home primary care can reduce hospitalizations, hospital readmissions, emergency department visits, etc.
  - Must serve at least 200 eligible beneficiaries
  - Targets beneficiaries with multiple chronic conditions and functional limitations
- Applications or Letters of Intent (as appropriate) are due to CMS by February 6th

# Section 2602: Federal Coordinated Healthcare Office -or- Medicare-Medicaid Coordination Office

The mission of the Medicare-Medicaid Coordination Office is to:

- Ensure Medicare-Medicaid enrollees have full **access** to the services to which they are entitled.
- Improve the **coordination** between the federal government and states.
- Develop **innovative** care coordination and integration models.
- Eliminate financial **misalignments** that lead to poor quality and cost shifting.

<http://www.cms.gov/medicare-medicaid-coordination/>

# Current and Ongoing Work within the Coordination Office

- The Medicare-Medicaid Coordination Office is working on a variety of initiatives to improve access, coordination and cost of care for Medicare-Medicaid enrollees in the following areas:
  - Program Alignment –29 misalignments published in the Federal Register-public notice for comments closed 7/11/11
  - Data and Analytics
  - Models and Demonstrations (through partnership with the Innovation Center)

# Medicaid and Care Transitions

- Section 2401: Community First Choice
- Section 2403: Money Follows the Person
- Section 2703: Health Homes
- Section 10202: Balancing Incentives Program

# Section 2401: Community First Choice Option

- Adds Section 1915(k)
- Optional State Plan benefit to offer Attendant Care and related supports in community settings, providing opportunities for self-direction
- Does not require institutional LOC under 150% FPL
- Includes 6% enhanced FMAP

# Section 2401: Community First Choice Option (cont'd)

## Implementation status

- Notice of Proposed Rulemaking published February 25, 2011 – Comment period closed April 26, 2011
- Final regulation coming soon

# Section 2703: Health Homes for Individuals with Chronic Conditions

- States are able to offer health home services for individuals with multiple chronic conditions or serious mental illness effective January 1, 2011
- Coordinated, person-centered care
- Primary, acute, behavioral, long term care, social services = whole person
- Enhanced FMAP (90%) is available for the health home services (first 8 quarters)

# Section 2703: Health Homes for Individuals with Chronic Conditions (cont'd.)

## Implementation Status

- Two states are actively implementing Health Homes (MO, RI)
- Draft Health Home State Plan Amendments have been submitted by 4 other States (North Carolina, Iowa, New York, Utah).
- Resources, state materials, data, sample templates, FAQs for Health Homes are available at the Integrated Care Resource Center:  
<http://www.integratedcareresourcecenter.com/healthhomes.aspx>

# Section 2403: Money Follows the Person

- Now extends through 2019-transitions individuals from institutions to community based care and adds resources to balance LTC
- Enhanced Federal match for community services for first year following transition from facility
- 43 States and the District of Columbia now participating in the demonstration

# Section 10202: Balancing Incentive Program

- Designed to help states balance their system of long-term services and supports (LTSS)
- \$3B awarded through increased Federal matching payments of 2% or 5% to States that:
  - Currently spend less than 50% or less than 25% of long-term care budgets on home and community-based services (HCBS)

# Section 10202: Balancing Incentive Program (cont'd)

- Participating States must commit to three structural changes:
  - Implement a No Wrong Door/Single Entry Point system
  - Use a Core Standardized Assessment Instrument
  - Implement Conflict Free Case Management standards

# AoA Contacts and Resources

- AoA Health Reform Page:  
[http://www.aoa.gov/Aging\\_Statistics/Health\\_care\\_reform.aspx](http://www.aoa.gov/Aging_Statistics/Health_care_reform.aspx)
  - Highlighted programs
  - Webinars
  - Toolkit
- AoA ACA Emailbox: [AffordableCareAct@aoa.hhs.gov](mailto:AffordableCareAct@aoa.hhs.gov)
- [Abigail.Morgan@aoa.hhs.gov](mailto:Abigail.Morgan@aoa.hhs.gov)

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# Upcoming Events

- **Register for AoA webinar: *Transitions and Long-Term Care: A Look at the Minimum Data Set 3.0 Section Q and Money Follows the Person***
  - January 30, 2012 from 3:00-4:30 pm Eastern
- **Next Care Transitions Work Group Call**
  - March 12, 2012 from 1:00-2:30 pm Eastern
- **Interest in an ad hoc call on rural issues?**
  - See post-webinar survey

**Questions?**  
**Contact Caroline Ryan:**  
**[caroline.ryan@aoa.hhs.gov](mailto:caroline.ryan@aoa.hhs.gov)**

Email resources to: [adrc-tae@lewin.com](mailto:adrc-tae@lewin.com)