SUSSEX COUNTY TRANSITIONAL CARE PROGRAM

"Public Private Partnerships: A Unique Approach to Best Practices"

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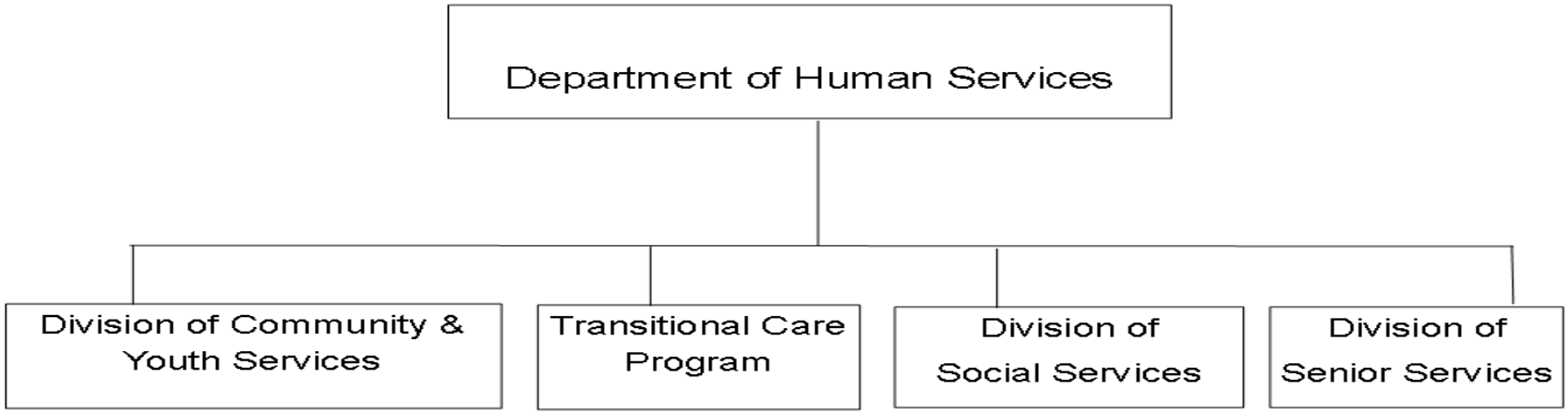
Sussex County Department of Human Services

Mission: To improve the quality of life of Sussex County residents through an integrated approach to comprehensive services that meets the needs of individuals, families and communities.



Transitional Care Program

Mission: To address the rising cost of healthcare, the growing number of Sussex County residents requiring community resources and to help citizens remain in their home

Program foundation – Preventable hospital readmissions are caused by:

- Confusion about/lack of compliance with medication regimen
- Lack of understanding of discharge plans
- Failure to follow up with primary care physician/specialist
- Inability to get timely assistance at local offices when in crisis

Program Development – Timeline

October 2011	– Partnership agreements with Sparta Medical Associates and Newton Medical Center signed
	– Application to CMS for Community Based Care Transitions Grant
	– Staff became Master Trainers of Take Control of Your Health
November 2011	– Staff completion of Transitional Care Nurse program, Transitional Care Management, University of Pennsylvania (Naylor Model)
December 2011	– Application not approved
January 2012	– Attended Care Innovations Summit, Washington D.C.
	– Presented to NJ Area Offices on Aging Directors
	– Presented to NJ Human Services Directors Association
February 2012	– Appointed as NJ Care Integration Advisory Council (NJCIA) Community Services Chair
	– Mary Naylor presents at Sussex County consortium
May 2012	– Risk Sharing Partnership with Premier Medical Associates
January 2013	– Newton Medical Center/Sussex County fund program in the amount of $200,000
May 2013	– Geriatric Center of Excellence invitation
	– Staff Certified Transitions Coaches, The Care Transitions Program (Coleman Model)

The Beginning

- Recognize the need for change
  - Understanding the services already in place in the public sector
    - Under-utilization by both patients and providers
  - Identifying the requirements of the private sector
  - Recognizing the changes required and opportunities provided by the Affordable Care Act
- Envisioning a system that accommodates these services, requirements and opportunities

The Partnership

- Recognizing the importance of the public-private partnership
- Convincing others of the value of this partnership
- Bringing the right public and private partners together
- Willingness of decision makers to give it a chance
  - Sussex County Board of Chosen Freeholders
  - Premier Healthcare Associates CEO and Board of Directors
  - Newton Medical Center leadership
  - Community

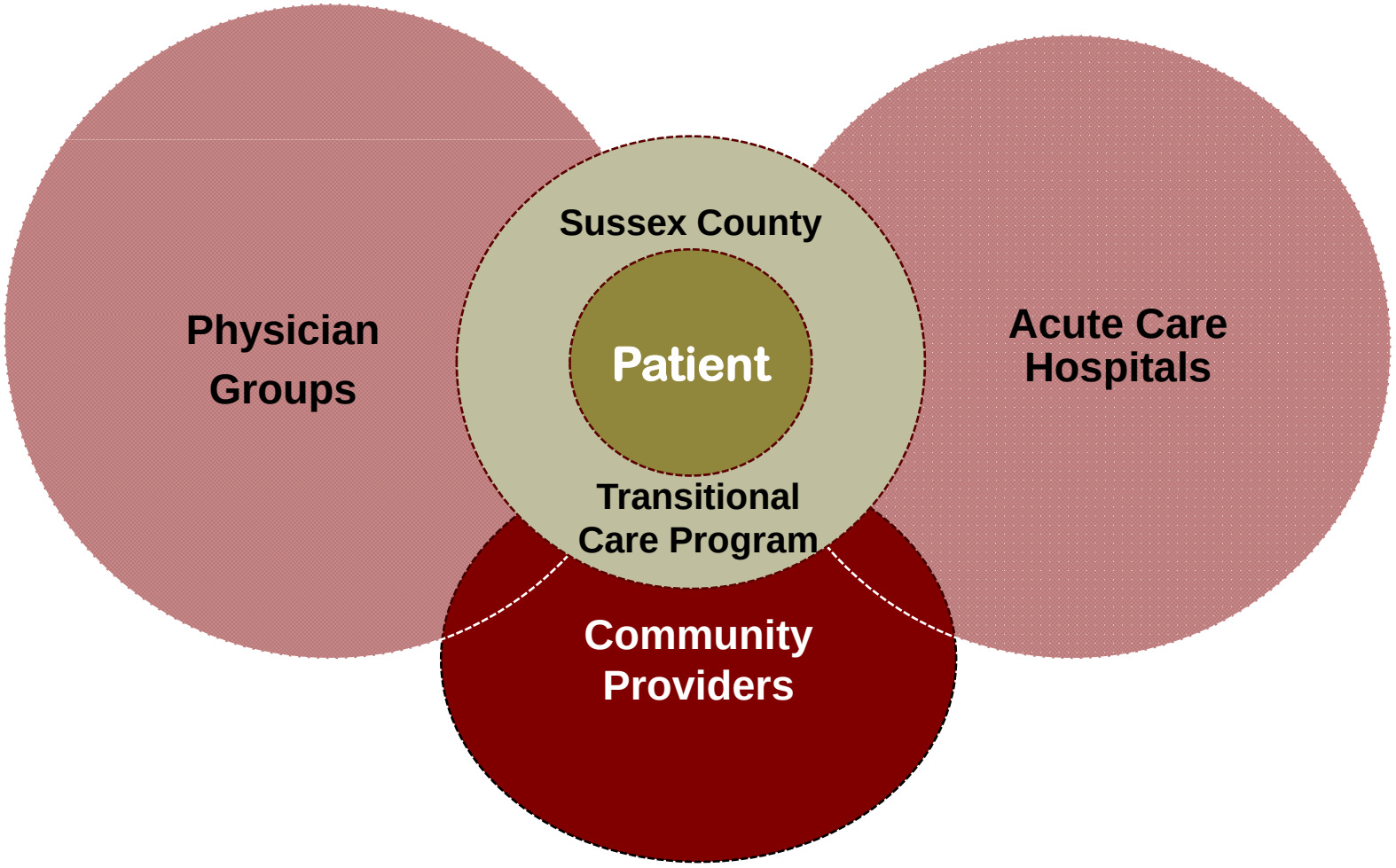
Putting It Together

- Understanding the importance of community, physician and hospital support
- Creating an environment that allows each partner to do what they do best
- Demonstrating the benefits of EMR access
- Utilizing the public sector to bridge the gap between patients, the hospital and the physicians
- Establishing trust among patients, providers & community

Program Development – Phase I

- Analyze root causes
- Identify appropriate care model
  - Naylor Transitional Care Model
  - Project RED
  - The Care Transitions Intervention
- Match program elements with our county-specific root causes
- Create county-specific model
- Collaboration with community physicians for program design

Partnership Model



Program Development – Phase II

Partnership development:

- Premier Healthcare Associates and Newton Medical Center partnership provides Transitional Care Program:
  - Privileges to access patients and data
  - Inclusion in discharge planning
  - Inclusion of SCTCP staff in trainings and in-services
- Additional partners:
  - NJ State Department of Health and Human Services – Division of Aging Services
  - Health Care Quality Strategies, Inc. - NJ Care Integration Advisory
  - Bridgeway Rehabilitation Services
  - Karen Ann Quinlan Hospice
  - Compassionate Care Hospice

Funding:

- $200,000 matched cash investment by County and NMC, $200,000 in-kind investment by Premier and 3% Revenue Sharing Partner of their Sussex County Regional ACO contract, 3% of Per Member Per Month Incentive Payment
- $60,000 in grants from State of NJ, $15,000 Title III Funding
- In-kind Sussex County contribution for accounting, counsel and program administration

Transitional Care Service Goals

1. Decrease number of readmissions in Sussex County which cost an average of $9,692.00 each
2. Demonstrate that the TCP services provided by the County should be reimbursable by CMS and commercial insurers
3. Create Risk Sharing model in which Sussex County is a revenue sharing partner with ACO
4. Reduction in:
   - County funding through one-to-one case management
   - Number of office visits to Social Services and Senior Services
   - Number of rides requested through Skylands Ride
   - Number of information and referral calls

Transitional Care Benefits to Sussex County

- Access to services at the right place, right time, lower cost
- Ability to remain in home, part of community
- Assistance in navigating currently fragmented human service system
- Maximize efficient use of staff and other county resources through coordination across divisions and centralized referral process
- Reduce county cost of service associated with multiple trips and appointments to Senior and Social Services
- Reduce department data collection burden
- Benefit Sussex County businesses through:
  - Availability of Wellness Programs for employees
  - On-going business from residents who remain in community
  - Referrals to local businesses and service lines

Transitional Care Case Study-Barbara S. Hospitalization Admission

- Barbara S. is a 76 year old widow admitted to Newton Medical Center with a primary diagnosis of Atrial Fibrillation, Syncope and Collapse and Altered Mental Status, and secondary diagnoses of Diabetes Mellitus, Hypertension, Anxiety and Depression.
- She was confused and combative with hospital staff upon admission. This is her 3rd ER visit and 2nd hospitalization in 3 months, meeting the criteria for a high risk of re-admission within 30 days and generating a referral to the Transitional Care Program. Care Transitions coach visited her on day 2 of admission.
- Barbara's history:
  - Hospitalizations in the last three months
  - Leaving hospital AMA
  - Poor health literacy
  - Fragmented care with multiple providers
  - Frailty
  - Chronic disease
  - Depression
  - Uncontrolled symptoms of disease process
  - Availability of caregiver support not meeting patient's level of need
  - Medication non-adherence/difficulty managing medications

Transitional Care Case Study - Barbara S.
Discharge Preparation

Prior to discharge, Barbara demonstrated restored cognitive function and was anxious to return home.

Following discharge, the Care Transitions Coach visited Barbara on day 2 to assist with:

- Completing her Personal Health Record, identifying her personal goal: "To get my drivers license back." Coach breaks this goal down into smaller steps.
- Obtaining 4 newly prescribed medications and refilling others; also provided medication reconciliation.
- Making follow-up physician appointments (PCP, Nephrology, Neurology and Cardiology) and providing transportation.
- Completing paperwork (DMV, personal bills, insurance documents).
- Contacting and updating all physicians and care providers about her progress.
- Identifying red flags and warning signs.

Social worker called Barbara every week for 4 weeks.

Transitional Care Case Study-Barbara S. Successful Outcome

Barbara was followed by TCP program for 30 days. During this time, Barbara:

- Worked with TCP social worker to organize medications so she can take them accurately and on a daily basis; she identified medication issues and follows her regimen.
- Made and completed all physician follow up visits and recommendations.
- Graduated from home health and physical therapy services and is now independent in all ADL's.
- Followed social worker's advice and met with a SHIP (State Health Insurance Assistance program) counselor to understand her Medicaid, Medicare and billing.
- Learned to identify warning signs of her low blood sugar. Barbara now calls her physicians office instead of 911. She has not had another syncopal episode.
- Regained her drivers license and accomplished her goal.
- Not returned to Newton Medical Center in over 6 months.

Transitional Care Components

- **Transitional Care Program Transitions Coach**
  - Hospital and Home Visits
  - Assistance with the completion of a Personal Health Record, identification of personal goal
  - Follow up phone calls weekly
  - Medication Reconciliation
  - Coordination of follow up visits to physicians and specialists
  - Assistance with identifying additional services needed to be successful at home and identify Red Flags
- **In-Home Services**
  - Home Health Assistance, Chore Services, Meal Delivery
  - Caregiver Support
- **Transportation**
  - Sussex County-provided transport
  - Community and Youth Services
- **Health Promotion and Wellness**
  - Chronic Disease Self-Management Programs
  - "Take Control of Your Health" and Diabetes Self-Management"

- **Benefits/Insurance Counseling**
  - SHIP (State Health Insurance Assistance Program)
  - Medicare (A and B), Secondary Insurance Counseling, Medicare Part D Prescription Benefit, Prescription Assistance to the Aged and Disabled (PAAD)
- **Hospice**
  - Options Counseling, Coordination of Services
- **Social Services**
  - Jersey Assistance for Community Caregiving
  - Global Options
  - Medicaid
  - Screenings for Supplemental Nutrition Assistance Program (SNAP)
- **Gerontology**
  - Dr. George Wang, MD , PhD.
  - Transitional Care Program Medical Director

Transitional Care Program in Action

Sussex County Transitional Care Program

Newton Medical Center

- TCP Coach positioned full time in hospital for direct patient access
- Coordination with hospitalists, social workers, case management
- Attendance at monthly TCP Six Sigma Committee Meetings
  Geriatric Center of Excellence
- HCAHPS, Press Ganey, hospital itinerary

Premier Health Associates

- Direct access to physicians, staff and patients
- EMR system access and documentation
- Community Education Partnership - Bimonthly Educational Series
- Dr. George Wang, MD, PhD
  Geriatrician, Medical Director for Transitional Care Program

- **Ardelle Bigos, Newton Medical Center**

The Value of the Sussex County Transitional Care Program for Patients and Newton Medical Center

Transitional Care Program
Preliminary Data

January 2013 – March 2013	
Patients enrolled into TCP (no.)	236
Home visits (no.)	157
Telephonic care management calls (no.)	471
Live discharges (no.)	232
30-Day readmissions (no.)	22 (14 readmitted from SAR/LTC – not followed by TCP; 8 readmitted from home)
30-Day readmission rate (%)	9.5% All DRG's

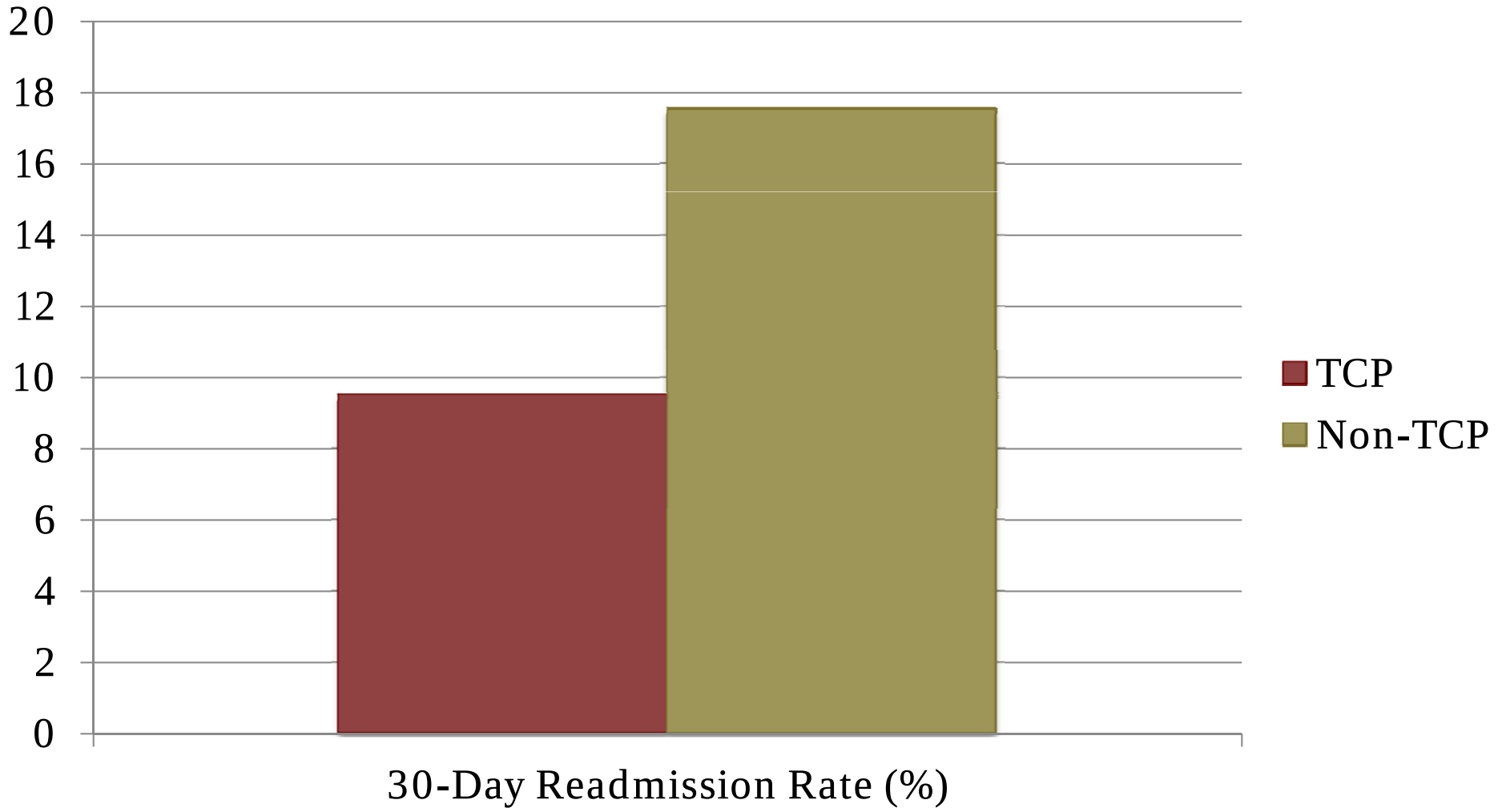
Transitional Care Program
Preliminary Data

January 2013 – March 2013	
30-Day readmissions for same diagnosis (no.)	7
30-Day readmission rate for same diagnosis (%)	3%
CHF (no.)	2
Renal disease/failure (no.)	1
Shortness of breath (no.)	1
COPD (no.)	1
Stroke (no.)	1
Abdominal pain (no.)	1

Sussex County Control Group Data

April 2012 – September 2012	
Live discharges (no.)	2,346
30-Day readmissions	410
30-Day readmission rate (%)	17.48

TCP-Associated Patient Outcome - (Estimated)*



*Comparison is not based on the same time period

Assessing the Effect of TCP on Outcomes: It's All in the Control Group

- Observational, non-randomized
  - Selection bias
    - TCP patients' PCPs were all in PHA (initial phase)
    - Differences in practice habits or quality of care between PHA providers and other practice groups?
  - Differences in patient populations (TCP group vs. control group)
    - Demographics
    - Baseline characteristics (comorbidities, risk level)
  - Goal: Maximize the causal inference that differences in patient outcomes is due to the effect of the TCP, rather than due to differences in the patient populations

Ideal Control Group

- Patients admitted to Newton Medical Center during the same period of time
- Patients with similar demographics as TCP patients
- Patients from same geographic region, with same access to health care
- Patients with similar comorbidities and risk level

Partnership with HQSI

- Select optimal control group of non-TCP patients
- Compare patient outcomes TCP vs. non-TCP

THANK YOU
Question and Answers

For Additional information please contact:

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