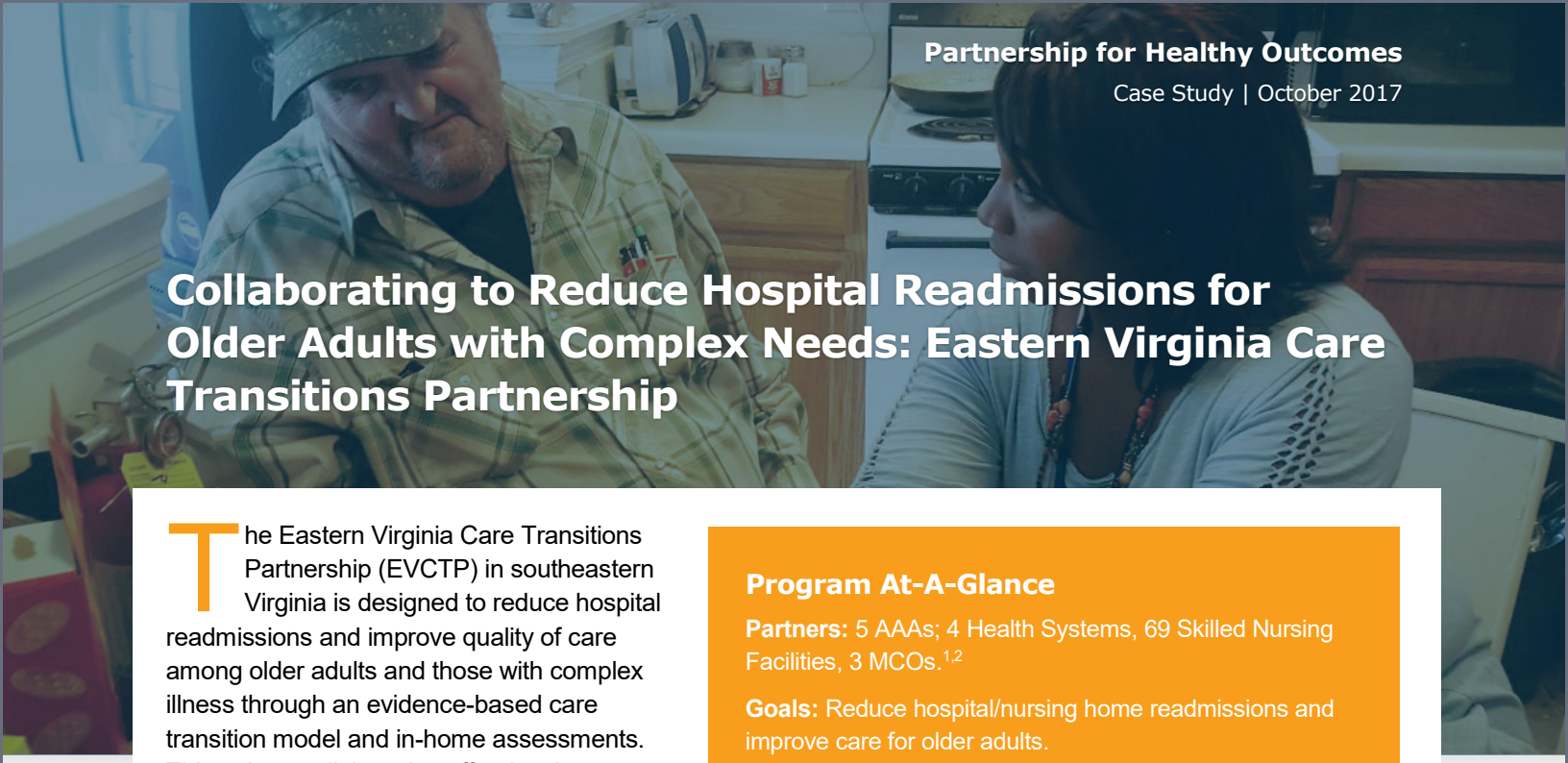


Collaborating to Reduce Hospital Readmissions for Older Adults with Complex Needs: Eastern Virginia Care Transitions Partnership

The Eastern Virginia Care Transitions Partnership (EVCTP) in southeastern Virginia is designed to reduce hospital readmissions and improve quality of care among older adults and those with complex illness through an evidence-based care transition model and in-home assessments. This unique collaborative effort is a large-scale partnership including Bay Aging and four other Area Agencies on Aging (AAAs),[1] four health systems,[2] three managed care organizations (MCOs), and other health care and human service providers.

Partnership Overview

In 2012, in response to a funding opportunity from the Centers for Medicare & Medicaid Services (CMS) Innovation Center's Community-Based Care Transitions Program (CCTP),[3] Bay Aging — an Area Agency on Aging [4] serving the southeastern region of Virginia — teamed up with five health systems to form the Eastern Virginia Care Transitions Partnership (EVCTP).

Program At-A-Glance

Partners: 5 AAAs; 4 Health Systems, 69 Skilled Nursing Facilities, 3 MCOs.[1,2]

Goals: Reduce hospital/nursing home readmissions and improve care for older adults.

Partnership Model: AAAs partner with hospitals to provide dedicated coaches to support in-home assessments and linkages to social services for post-discharged hospital patients.

Scope of Services: Direct referral assistance, case management, benefits counseling, family caregiver support, and other non-clinical services such as meals and transportation.

Funding: PMPM and episodic (per care intervention) reimbursement from Medicaid health plans; funding through hospital partners for specific projects.

Impact: Reduced 30-day readmission rate from 18.2 to 8.9 percent, from February 2013 to January 2015, resulting in estimated savings of more than $17M through 1,804 avoided readmissions.

Bridging Community-Based Human Services and Health Care Case Studies

Health care and community-based organizations (CBOs) across the country are increasingly working together to address social needs that may be contributing to poor health outcomes. These cross-sector relationships are occurring under a variety of models, yet little is known regarding the strategic, cultural, operational, and financial considerations that factor in their success. With support from the Robert Wood Johnson Foundation, the *Partnership for Healthy Outcomes* brought together Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities to capture and share insights for partnerships between health care organizations and CBOs, particularly those that serve low-income and/or vulnerable populations. This case study series highlights four partnerships illustrating diverse models between CBOs and health care organizations.

Support for this project was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Robert Wood Johnson Foundation

Since then, EVCTP's success in helping consumers transition from hospital (or another care setting) to home and reducing hospital and nursing home readmissions has led to the formation of a statewide coalition of 25 AAAs, known as VAAACares. The program serves as a one-contract, one-stop entity for comprehensive care coordination, care transitions, and other community-based services for Virginia's dually eligible Medicare and Medicaid beneficiaries. Results from the partnership have been impressive — the EVCTP program reduced the 30-day readmission rate from 18.2 to 8.9 percent, from February 2013 to January 2015, resulting in estimated savings of more than $17M through 1,804 avoided readmissions.[5]

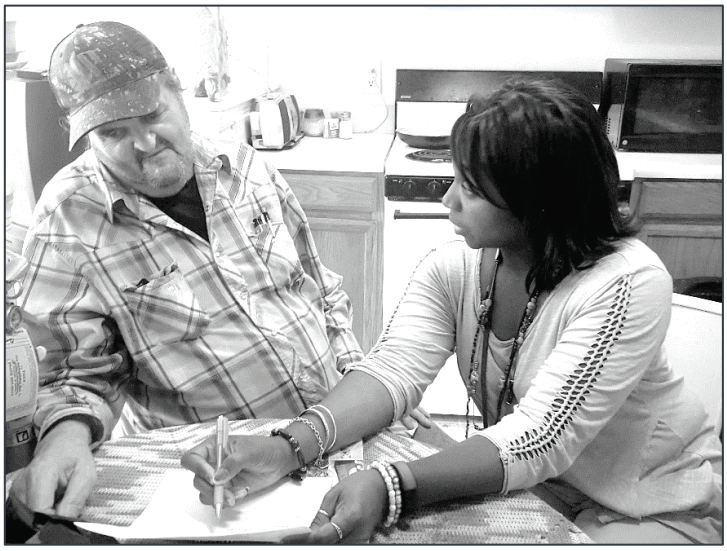
The Evolution of the Eastern Virginia Care Transitions Partnership

2012	2013	2015	2016	
CMS CCTP pilot partnership with Bay Aging and Riverside health system.	EVCTP's full launch with 5 health systems, 69 skilled nursing facilities, and 5 Area Agencies on Aging — covering 20% of the state.	Bay Aging initiated development of VAAACares statewide.	AAAs agreed on the structure and name of VAAACares for statewide contract opportunities. Local and regional health care providers continue business with EVCTP.	Based on Medicare savings and improved health outcomes, the VA General Assembly awarded funding to Bay Aging/ EVCTP to demonstrate impact in Medicaid.

Service Delivery Model

In preparation for the CCTP funding opportunity, which challenged awardees to reduce avoidable 30-day all-cause hospital readmissions by 20 percent, EVCTP conducted an analysis to identify diagnoses linked to the highest volume of readmissions within the aging population. EVCTP defined its CCTP population as Medicare and dual-eligible beneficiaries with at least one of the following: (1) congestive heart failure, (2) chronic obstructive pulmonary disease, (3) acute myocardial infarction, (4) pneumonia, or (5) septicemia.

As the lead organization for EVCTP, Bay Aging manages administrative functions including acting as the hub for electronic referrals across partner hospitals and AAAs and coordinating standardized staff training and reporting across EVCTP partners. A core component of this model is the Care Transitions Intervention (CTI) program,[6] which assists patients and their caregivers in taking a more active role in their care. EVCTP also provides advance care planning, motivational interviewing, fall prevention, and chronic disease self-management techniques.



CTI is embedded in EVCTP hospitals' intake processes. Inpatients who meet the high-risk program criteria and who consent to CTI, receive a bedside visit from an assigned AAA coach 24 hours prior to discharge to ensure successful transition from the hospital to home or a partnering skilled nursing facility. Within 72 hours of discharge, the coach conducts an in-home assessment and connects patients to needed services, including: transportation to medical appointments, home-delivered meals, and home repair to facilitate independent living.

Information Sharing and Reporting

To support effective information exchange, EVCTP established agreements with its partner hospitals for secure data-sharing systems, integration into health systems' electronic health records and health information exchanges, and a centralized source for billing and tracking readmissions.

AAA coaches can access a shared inpatient tracking system to prioritize hospital and home visits. AAA coaches and their supervisors attend hospital readmission meetings regularly to discuss patients who were recently discharged and information is shared with patients' primary care providers and health systems.

> *"You need to find an individual on the health system side, otherwise the CBO struggles. You have to find that key person inside who wants to make this happen. Someone has to "boundary span" to bring the CBO into the health care system."*
>
> *- Riverside Health System*

Bay Aging shares monthly trend reports with AAAs and partner health systems. Each hospital has access to two versions of monthly one-page reports and trend data — one for executives, which includes group-level data as well as hospital-specific readmissions rates, and a more detailed report to track individual care coordinator performance.

Shared Governance

Bay Aging serves as the official legal entity for the broader group of CBOs that are part of the statewide VAAACares program. Member AAAs have Business Associate Agreements with Bay Aging, but Bay Aging is the sole organization entering into indemnification arrangements with the health plans. This structure has evolved since EVCTP was first launched, at which time an independent board, led by Bay Aging, was in place. The board, which consisted of three executive designees from each of the original five AAAs and four health systems, facilitated dialogue across partners and helped to formalize existing relationships between the state's AAAs and health systems. The original EVCTP Board, which represented only 20 percent of the state, continues to work on regional health care improvement systems with the state's quality improvement agency.

Funding Model

AAAs were originally funded in part through federal OAA support and other local funding, including grants from local foundations. The CMS CCTP pilot provided new funding to support participating AAAs, although funding did not cover administrative overhead and infrastructure costs and the AAAs were only paid once per eligible discharge in a 180-day period for any given beneficiary.[7] As a result, the AAAs experienced significant challenges at the outset of CCTP and during the EVCTP ramp-up period, leading some AAAs to take out loans to cover administrative costs, including onboarding additional staff and contributing to software development for the partnership to support the enhanced analytics required by CMS.

Once the CCTP pilot ended, Virginia's General Assembly provided one-time bridge funding for EVCTP to pursue a Medicaid pilot. EVCTP also pursued new lines of Medicaid revenue from health plans. The majority of funding for VAAACares now comes from three health plans to cover care transitions, care coordination, and in-home assessment support for dual-eligible members through a fee-for-service model. Given EVCTP's success, additional funding is provided by the health systems for special projects, wherein EVCTP is included in their budgets. Based on the program's success, partner health systems are using hospital foundation funds to support a variety of new EVCTP projects, including: (1) an advance care planning initiative across EVCTP; (2) enhanced chronic disease care management; (3) emergency department diversion and alignment with new medical homes; and (4) telehealth efforts with Riverside Health System, funded by a grant from the Health Resources and Services Administration (HRSA).

Community and Patient Engagement

> *"It's about culture change — you can redirect a small boat better than a ship. AAAs are the smaller vessels and are better able to shift direction and take on new delivery system approaches."*
>
> *- Riverside Health System*

EVCTP conducts ongoing focus groups with patients at partnering hospitals and senior centers, and these have recently revealed that patients have gained the confidence to manage their health conditions independently based on their participation in the program. EVCTP also participates in annual community health needs assessments to inform community members regarding available services. EVCTP regularly shares community and patient feedback with partner hospital boards to promote the design and implementation of age-friendly services that enhance the quality of care for older adults.

Evaluation and Outcomes

Between 2013 and 2015, EVCTP completed home visits for 25,656 Medicare patients discharged from partner hospitals. As a result, the EVCTP enrollee readmission rate for 2016 decreased to 9.1 percent, significantly lower than the average target group readmission rate of 14.4 percent for that same year and the 2010 EVCTP enrollee readmission baseline of 23.4 percent.[8]

Similarly, through a recent 12-month pilot with 945 Medicaid patients, the average readmission rate dropped from 25 to six percent as a result of program participation. Assuming an average readmission cost of approximately $10,000, this correlates to savings of about $1.5 million, well beyond the $283,000 it cost EVCTP to implement the pilot.

Success Factors

EVCTP attributes its success to several factors, including:

- **Strong relationships among board members, health systems, health plans, providers, and patients.** AAAs have a long history of working in the community and leveraged these relationships to form EVCTP. AAA coaches, discharge planners and hospital care coordinators already had strong working relationships when EVCTP was launched, which facilitated handoffs, information sharing, and trust at the patient level.
- **Transparent reporting process across partners.** Bay Aging is accountable to organizational leadership and front-line staff through a transparent reporting process that shares data across partner organizations monthly. Building on its strong relationships and demonstrated achievements with health systems, EVCTP was also strategic in developing the business case and demonstrating value to health plans, which now provide the partnership with its main source of funding.
- **Experienced champions, particularly among health care organizations.** Riverside Health System was an early adopter among health care partners, and its participation encouraged other health systems to join the partnership. Kyle Allen, DO, AGSF, Vice President, Clinical Integration, Riverside Health System, who implemented the care transitions model successfully with Ohio AAAs, and Kathy Vesley, President/CEO of Bay Aging, recognized the potential of a partnership between AAAs and health systems and served as champions within their respective organizations. The involvement of hospital nursing staff, who were familiar with the operational issues of implementing such a model, was vital in keeping health care partners at the table.
- **Support from related federal and state initiatives**. CMS' CCTP opportunity propelled EVCTP forward with funding to support enhanced care transitions and in-home services. Concurrently, new value-based payment

regulations around Medicare hospital readmissions had been instituted,[9] presenting additional incentives for hospitals to join the partnership to avoid penalties for 30-day readmissions. With support from the Department of Aging and Rehabilitative Services, the Department of Medical Assistance Services, and the n4a Business Institute, Bay Aging also aligned with Virginia's State Innovation Model10 design efforts that contributed additional funding for EVCTP.

The state's move to managed long-term services and supports (MLTSS) now provides the partnership with an additional platform to market its services to Medicaid managed care plans. Commonwealth Coordinated Care Plus,[11] a statewide Medicaid MLTSS program that launched in August 2017, will serve approximately 214,000 Virginians with complex care needs through an integrated delivery model, with some support from VAAACares.

Success Story

Mr. Roberts, a 78-year-old widower, was admitted to the hospital with congestive heart failure, diabetes, and early stage renal disease. The AAA Care Transitions Coach met him in the hospital before discharge and enrolled him in the EVCTP program. Over the next 30 days, the coach put the following services into place, enabling Mr. Roberts to live comfortably in his home and avoid hospital readmission:

- Home-delivered, diabetic-compliant meals five days a week;
- Companion services six hours a week to help with errands, meal preparation for weekends, and household chores;
- Transportation to doctor appointments;
- Installation of a ramp by a local partner charity so that Mr. Roberts can use his walker to get in and out of the house;
- Weatherization of his home for the winter, including caulking all his windows; and
- Medication monitoring equipment and an emergency response alert system to remind Mr. Roberts to take his medications regularly as prescribed.

Challenges

Staff across the participating organizations described some key challenges, including:

- **Capacity building, both in terms of staff skillsets and bandwidth.** The AAAs faced staffing challenges when adapting to meet the new demands from growing patient populations through CCTP and supporting the necessary information technology infrastructure. Developing a business case was new territory for the AAAs and they struggled to articulate the investments needed to sustain the partnership. Enhanced marketing, communication, and negotiating skills were also necessary for the AAAs as EVCTP entered into arrangements with new partners, including health plans.
- **Conflicting business models for AAAs and health care partners**. There was misalignment at the outset between the health systems' and AAAs' business models. Acute care hospitals want to avoid penalties associated with avoidable readmissions, but are concerned about lowering other admissions that provide revenue. AAAs, on the other hand, aim to address the social service-related issues that are known to contribute to admissions, with PMPM and episodic reimbursement generally tied to in-home supports provided, not admissions. While AAAs continue to partner with the health systems for targeted projects, given ongoing differences in funding motivations, the AAAs have identified health plans as new partners, possibly with more aligned business models.

- **Developing cross-partner analytics that resonate.** Over the past five years, Bay Aging has developed solid metrics and analytics to drive shared decision-making across EVCTP partners. This process was particularly challenging in the first few months of EVCTP's launch. The AAAs did not typically interact with the hospital leadership prior to the partnership, and there was a learning curve in identifying the data that resonated most with them. One of the key learnings for Bay Aging has been the importance of refining and simplifying reports, particularly for partner executives, to keep them engaged.

Looking Ahead

Informed by EVTCP's experiences in Virginia, health plans and health systems in several other states, including Maine[12] and Ohio,[13] are partnering with local AAAs to coordinate and deliver in-home and community-based services. In support of EVCTP and other emerging partnerships with AAAs, the recently established National Aging and Disability Business Institute[14] provides technical assistance to enhance the capacity of AAAs and other community-based organizations to scale their services in communities nationwide. EVCTP plans to continue to expand its partnership across geographic regions in support of a national partnership with leading AAAs and health care providers.

Partnership for Healthy Outcomes: Bridging Community-Based Human Services and Health Care

This case study is based on the Partnership for Healthy Outcomes, a year-long project of Nonprofit Finance Fund, the Center for Health Care Strategies, and the Alliance for Strong Families and Communities with generous support from the Robert Wood Johnson Foundation, which captured and shared insights for partnerships between health care and community-based organizations, particularly those that serve low-income and/or vulnerable populations.

Author: Deborah Kozick, MPH, Center for Health Care Strategies

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Endnotes

[1] Partner Area Agencies on Aging: Bay Aging, Eastern Shore Area Agency on Aging, Peninsula Agency on Aging, Rappahannock Area Agency on Aging and Senior Services of Southeast Virginia.

[2] Partner health systems: Bon Secours Health System, Mary Washington Healthcare, Riverside Health System and Sentara Healthcare.

[3] Centers for Medicare & Medicaid Services (CMS). Community-Based Care Transitions Program (CCTP) Fact Sheet. Available at: https://innovation.cms.gov/Files/fact-sheet/CCTP-Fact-Sheet.pdf.

[4] Area Agencies on Aging (AAAs) help vulnerable older adults live independently in their homes and communities. For more information, see K. Collelo. Older Americans Act: Background and Overview. Congressional Research Service (Mar. 2016). Available at: https://fas.org/sgp/crs/misc/R43414.pdf.

[5] N. Super. "Virginia finds better ways to transition patients from hospital to their homes." America's Health Insurance Plans (AHIP) blog (Jan 2017). Available at: https://www.ahip.org/virginia-finds-better-ways-to-transition-patients-from-the-hospital-to-their-homes/.

[6] For more information about the Care Transitions Intervention Model, visit: http://caretransitions.org/about-the-care-transitions-intervention/.

[7] CMS CCTP Fact Sheet, op cit.

[8] N. Super, op cit.

[9] The Affordable Care Act (ACA) established the Hospital Readmission Reduction Program (HRRP) in 2012 whereby hospitals are financially penalized if they have higher than expected risk-standardized 30-day readmission rates for acute myocardial infarction, heart failure, and pneumonia**.** More information available at: https://www.medicare.gov/hospitalcompare/readmission-reduction-program.html.

[10] Virginia Center for Health Innovation. The Virginia Health Innovation Plan + SIM (State Innovation Model). Available at: http://www.vahealthinnovation.org/what-we-do/the-virginia-health-innovation-plan/.

[11] Virginia's Department of Medical Assistance Services. Overview of Commonwealth Coordinated Care Plus. Available at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

[12] American Society on Aging/n4a. Webinar, Sept. 2016. Tapping into new payment and delivery models: An innovative AAA-ACO partnership to improve care and reduce costs. Available at: http://www.aginganddisabilitybusinessinstitute.org/resources/tapping-new-payment-delivery-models-innovative-aaa-aco-partnership-improve-care-reduce-costs/.

[13] G. Cook, "Integration: An AAA Experience." Available at: http://ohioaging.org/PDFs/COOK%20AAA%20Integration%202012.pdf.

[14] For information about the National Aging and Disability Institute, visit: http://www.aginganddisabilitybusinessinstitute.org/.