accountable aging CARE MANAGEMENT®

Making Sense Out of Eldercare Options
Managing the Eldercare Experience®

May 2012

In this issue: Care Transitions, Shared-Savings Programs, AACM News

AACM and You:
We can be the "glue"

Lack of coordination during care transitions is, unfortunately, quite frequent and can be disastrous for everyone involved. Medication errors and failure to transfer important information are two of the most common problems that occur during care transitions. These errors are easily preventable with better care coordination.

At AACM, we understand the value of coordinated and accountable care. The disease-centered model that dominates healthcare often results in communication gaps between different providers. The individual pieces have no perspective on how they fit together as a whole.

We can be the "glue" that connects all of the pieces in the puzzle. As a private company focused solely on our clients' best interests, we are agile enough to help bridge those gaps. We advocate for our clients, particularly when they cannot advocate for themselves, introducing a measure of continuity to an otherwise fragmented system.

Our approach aims to push the perspective from disease-centered to patient-centered. We are present at every stage along the way, building relationships and shoring up your "team". As a result, we are in a unique position to act as your "quarterback".

What is a Care Transition and Why does it Matter?

Margaret is an 82 year old senior with COPD and diabetes. Under the guidance of her Primary Care Physician, Margaret has managed to keep her health relatively stable during the past two years. Although Margaret occasionally receives some in-home assistance to help prepare meals and perform household duties, she remains mostly independent. Last month, Margaret lost her balance getting out of the shower, and the resulting fall broke her hip. She received surgery the following day in a hospital setting. One week later, she transitioned to a Skilled Nursing Facility to begin rehab. Last week, the nursing staff determined that her hip was stable enough to return home, provided that she receive care from a visiting nurse.

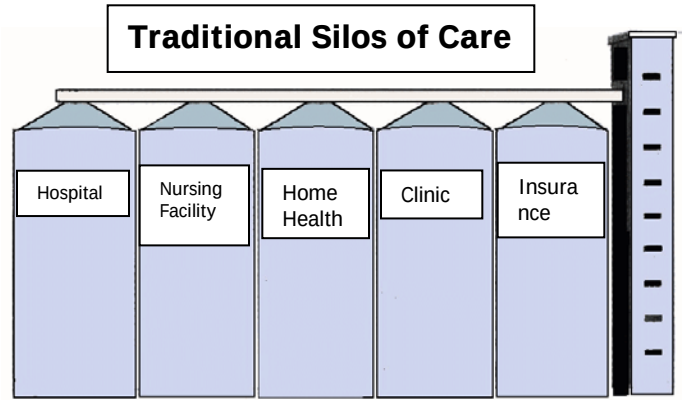
The term "care transition" refers to the movement patients make between health care providers and settings as their condition and care needs change following an accident or illness. Each of the "shifts" Margaret made – from home to hospital, hospital to nursing facility, and nursing facility to home – is by definition a care transition. The recovery process has been both stressful and painful for Margaret, and the added burden of a surgically-repaired hip has complicated her previously well-managed chronic conditions. Worst of all, she hasn't been allowed to return to her gardening – a passion that she enjoyed on a daily basis. Her doctors feel that the back porch steps are too precarious, and they fear she might put too much strain on her still-recovering injury.

From a healthcare provider's viewpoint, an individual's needs vary widely depending on context and setting. The surgeon who performed her hip surgery certainly had a different set of challenges and considerations than, say, the physical therapist who helped her strengthen that hip. Similarly, the visiting nurse approaches Margaret's care from a different viewpoint than the physical therapist. *It is unlikely that any of these three fully appreciates the link between her physical recovery and the emotional well-being she cultivates in her garden*.

Margaret is at risk of being a part of the 20% of Medicare patients who are re-hospitalized within 30 days following a previous hospitalization. Even though each healthcare provider along the journey has performed his or her role, the lack of communication between different care settings results in a fragmented model that is prone to risk and error. A successful care transition requires a team, yet in practice we don't always know what our teammates have done, what they are doing, or what they will do in the future.

Medicare Takes Notice

Hospital re-admissions can lead to a lower quality of life for patients and their families. They are also a tremendous financial strain on the Medicare system. These two considerations prompted the Center for Medicare and Medicaid Services (CMS) to investigate how to increase the quality of patient care while reducing wasteful, preventable expenditures.



Of the $2 trillion spent on healthcare in the US annually, hospitalizations account for about 33%. Nearly 20% of these hospitalizations are actually re-hospitalizations occurring within 30 days of discharge. One study found that around 75% of all re-hospitalizations are preventable. In 2004, the estimated cost of unplanned hospital readmissions accounted for an overwhelming $17.4 billion. The reasons range from basic to complex, but providers agree universally that **better communication between hospitals, nursing facilities, physicians and patients is the first step to reducing hospital readmissions**.

Since high readmission rates are often symptomatic of poor quality healthcare, hospitals with greater than expected readmission rates for certain chronic conditions will be subject to reimbursement penalties for ALL Medicare patients, beginning later this year. The Center for Medicare and Medicaid Services (CMS) was granted the authority to implement this provision as part of the Patient Protection and Affordable Care Act. But what good is a "stick" without a "carrot" ?

Shared-Savings Programs – the "Carrot"

The Center for Medicare and Medicaid Services (CMS) realizes that a paradigm shift must occur in order to bring the cost of healthcare down while simultaneously improving the quality of care. Currently, hospitals are rewarded for keeping their beds full, but this model does not best serve the needs of all parties involved. CMS is pushing for a merit-based model that rewards providers for the quality of care, rather than the quantity. The idea is straight forward – If a healthcare organization or partnership can meet certain quality benchmarks while demonstrating cost savings to Medicare, that organization or partnership will "share in the savings."

CMS has funded dozens of pilot programs across the country, including several here in the markets we serve – Austin, Dallas and San Antonio. Although it will likely be several years before success can be estimated, we applaud these organizations for their flexibility and willingness to assume risk for the cause of improving healthcare right here in Texas.

Independence at Home Demonstration

The Independence at Home Demonstration was created by the Affordable Care Act. According to the CMS website, the demonstration is designed to test a service delivery and payment incentive model that uses home-based primary care teams to improve health outcomes and reduce expenditures for Medicare beneficiaries. Among the 136 contenders nationwide, 16 organizations were chosen to participate in the demonstration, including 2 in Texas.

Higher Quality, Lower Cost Initiatives:

- Value-Based Purchasing (VBP) In Hospitals, Beginning October 2012
- Nonpayment of never events
- Hospital readmissions payment penalty of 1% beginning in 2012, increasing to 3% in 2014
- Accountable Care Organizations (ACO)
- Bundled Payments
- Community-Based Care Transitions Program (CCTP)

Texas Readmissions Learning and Action Network

The Austin-based National House Call Practitioners Group ("**House Call Doctors**") and the Dallas branch of the **Visiting Physicians Association of Texas** will have an opportunity to "share in the savings" with CMS, depending on their success at saving money and improving care to Medicare patients.

> *"It is the one thing ever in my life, and I'm 52, where I truly see all parties aligned — the patient, the physicians' group, Medicare as the payer, as well as the taxpayer"*
> - Julia Jung, House Call Doctors

Pioneer Accountable Care Organizations

"Accountable Care Organization" refers to a system where healthcare providers - including primary care physicians, specialists, and hospitals - work together and accept collective responsibility for the cost and quality of care delivered to a population of patients. The Pioneer ACO Model was designed specifically for organizations with experience offering coordinated, patient-centered care, and operating in ACO-like arrangements. 32 organizations were chosen to participate in the pilot program, including 2 in Texas.

Fort Worth-based **North Texas Specialty Physicians** and **Texas Health Resources** have partnered to treat Medicare patients in Tarrant, Parker, and Johnson counties. In Austin, the Seton Healthcare Family and Austin Regional Clinic (ARC) have formed the **Seton Health Alliance**. The Seton Health Alliance serves an 11-county area in Central Texas. Although it is part of the Medicare Shared-Savings Program, the Pioneer ACO model differs from other programs like the Independence at Home Demonstration in several distinct ways. The first two years of the Pioneer ACO Model are a shared savings payment arrangement with higher levels of savings and risk than in the Shared-Savings Program. Furthermore, Pioneer ACOs will be required to develop similar outcomes-based payment arrangements with other payers by the end of the second year and fully commit their business and care models to offering seamless, high quality care. We are anxious to learn whether or not these initiatives will help advance healthcare as a whole.

Educate and Engage: The Readmissions Learning and Action Network

TMF Health Quality Institute, a Quality Improvement Organization (QIO) funded by CMS, has formed a statewide Learning and Action Network with the ambitious goal of reducing avoidable 30-day readmissions in Texas by 20% over the next 2 years. This is a fantastic resource for anybody interested in the evolution of healthcare delivery systems. The network develops communities of directed learning through a broad range of educational opportunities, including free conferences, webinars and other structured exchanges of information. This network aims to educate and engage by dismantling traditional silos of care and connecting all community members to resources and opportunities. TMF has also compiled a vast library of educational resources for your perusal. Join the network to receive the latest news, as well as invitations to the many events being organized within the community.

AACM Supports Team No MáS

Accountable Aging was a co-sponsor of Team "No MáS", which is a group of friends that love to ride and want to make a difference for folks living with Multiple Sclerosis. The team goals are pretty simple: make a significant impact for people living with MS and have fun doing it. **Mick Koffend** was one of the Team No MáS cyclists who participated in the 180 mile ride from Houston to Austin the weekend of April 21 & 22. Over $50,000 was raised (their goal was $30,000). If you've ever been curious what participating in one of these events is like, check out the team's video from last year's ride.

AACM Changes Faces

In this issue, we would like to introduce the latest addition to our team: **John Lloyd** has joined our Austin office as the new Client Coordinator. John is thrilled to be part of a team of dedicated, experienced and compassionate individuals. As such, he is constantly striving for better ways to manage all the little details so our Care Managers can spend more time working one-on-one with individuals. John is a National Merit Scholar who holds a B.A. from The University of Kansas and has plans to pursue a law degree in the future.

But with every new beginning comes an end. We would like to wish our friend and colleague **Jana Dodoo** a fond farewell as she transitions to her new life as a loving mother in California. Although Jana is leaving the team, her footprints will remain an integral part of AACM for years to come. We wish her all the best in this exciting new chapter of life.

As always, the clients of Accountable Aging Care Management are at the heart of everything we do, but our team is also dedicated to making an impact in the communities we serve.

Mary Pat Smith was recently appointed a representative to both the Health & Human Resources and Operations Committees of the **Texas Silver-Haired Legislature** in the Capital Area. The vision of the Texas Silver-Haired Legislature is that the applied wisdom, energy, and experience of aging will improve the lives of all Texans through education, knowledge, and involvement in legislation and governmental affairs. Part of her duties will involve writing and submitting resolutions to be presented to the Texas legislature later this fall. She feels this is a tremendous opportunity to advocate at the state level for the needs of older Texans. As if she weren't busy enough, Mary Pat also serves on the board of directors for Faith in Action Care Givers – Southwest Austin, as well as the Commission on Aging – Catholic Diocese of Austin.

Spencer Brown has been involved with the North San Antonio Chamber of Commerce since 2004 when he worked with a Chamber organization that sent him through an annual leadership development program. The North Chamber has been active in the San Antonio community building leaders, fostering productive business relationships, and promoting civic responsibility. The organization boasts a comprehensive membership crossing many industries and fields. A primary focus of the North Chamber is developing future leaders and empowering current ones.

In 2004, Spencer attended the North Chamber's nine month leadership development program to enhance his leadership skills. As a graduate, he served on the alumni board for two years, helping the association promote opportunities for continued growth among fellow graduates. Spencer has participated in a North Chamber program designed to provide regular coaching and perspective in leadership from professionals in many different fields. He also has developed strategic relationships with Chamber members through regular networking events. Being involved in this organization has proven valuable in connecting with key decision makers in the San Antonio community.

Because referrals are the lifeblood of our business, the best way you can thank us, as a satisfied client, is by referring a friend, neighbor or colleague to us! We appreciate all your referrals.

Accountable Aging Care Management Team

Mary Koffend, President
Mick Koffend, Director of Services
Spencer Brown, MSG, LNFA, Care Manager
Mary Cooper, BS, RN, Care Manager
Shannon Gray, Marketing Coordinator
Lindsey Hazlewood, Administrative Assistant
John Lloyd, Client Coordinator
Kathleen McClain, Care Manager
Meredith Patterson, RN, BSN, CRRN, Care Manager
Myra Richmond, MSG, CMC, Care Manager Consultant
Heidi Shanklin-Spock, LMSW, C-ASWCM, Care Manager
Mary Pat Smith, MSN, RN, CNS, Geriatric Nurse Consultant
Jennifer Tobey, Bill-Paying Clients & Resources Coordinator
Janet Troutman, Client Relations Manager

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Visit us online: www.accountableaging.com

Accountable Aging Care Management is an eldercare consulting and care management firm.

Accountable Aging is a single source for older adults and their families to attain knowledge, resources and on-going assistance with the challenges related to aging or caring for an elder loved one. We serve older adults in Austin, Dallas, San Antonio and the surrounding areas.

With this newsletter, our aim is to provide a trusted conduit for eldercare information and resources and to highlight the services we offer that meet the needs of older adults and their families.

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