Increasing Profitability via Care Transitions

Is providing health care transition services a strategic fit for your organization?

Executive Summary:

While effectively managing health care transitions has long been a hallmark of excellent home health, home care and geriatric care management organizations, these transitions have traditionally been managed because it's simply "the right thing to do" and have not been rewarded with reimbursement. At the same time, the clear linkages between effectively managing care transitions and both improved health outcomes and reduced healthcare costs are well recognized. Case in point, on August 9th, 2013 the Office of the Inspector General (OIG) of the US Department of Health and Human Services issued Advisory Opinion No. 13-10[1], which authorizes hospitals to engage outside vendors to assist in avoiding preventable readmissions by managing care transitions and helping to insure that discharge plans are followed. This paper summarizes key content from the August 2013 OIG ruling to help home health, home care and geriatric care management agencies determine whether providing care transition services is a strategic fit for their organizations.

Why Are Hospitals Interested in Purchasing Care Transition Services?

The Hospital Readmissions Reduction Program (HRRP), established as part of the Affordable Care Act (Obama Care) and amended in the 2010 Health Care and Education Reconciliation Act, incentivizes hospitals to reduce avoidable readmissions[1]. HRRP became law in 2012 and imposes significant penalties on hospitals that have higher than average readmission rates for a variety of disease states. The initial program focuses on pneumonia, heart attack (Acute Myocardial Infarction), and heart failure and establishes the baseline against which extra readmissions are measured. According to an article in Kaiser Health News[1], Medicare imposed penalties of $227 million across 2,225 hospitals on October 1, 2013, making for an average penalty $102K per affected hospital for this first year of the program alone). Moving forward, the covered disease states and penalties are due to significantly increase each year. Bottom line, hospitals are highly motivated to improve care transitions and avoid readmission penalties.

Note that while the terms "hospital" and "hospitals" are used within this paper to describe the recipients of care transition services, the OIG ruling also states that patient-centered-medical-homes and managed care organizations can be customers as well, including Medicare and Medicaid managed organizations.

Establishing a Qualifying Care Transitions Program

The following paragraphs describe in detail what you must do to create a qualifying program in accordance with the OIG Ruling:

Package of services:

You must establish a package of services that help the hospital avoid payment reductions associated with excess readmissions. A typical set of services might be as follows:

- Visit with the patient in the hospital prior to discharge in order to prepare and establish an initial medications list.
- Visit the patient at home within 48 hours of discharge to ensure that discharge plans are understood and will be followed.
- Call the patient to ensure that key milestones are met, such as ensuring that requisite primary care physician visits have been made.
- Call the patient weekly, at a minimum, to check on red flags and ensure that things are well.[1]
- Perform a "completed transition" visit after the 30 day period is complete.

The ruling says that hospitals may also request additional services for which the vendor would charge separate or additional fees, based on an hourly basis plus expenses and a reasonable profit margin. The ruling refers to a "menu" of services. These services might include the following:

- Additional check in or medication reminder phone calls
- Home Health Aide visits
- On-site visits from a nurse or patient liaison (who does not have to be a nurse)

Although this is not specifically mentioned in the OIG ruling, some organizations have successfully negotiated their fee structure in a way that rewards successful completion of the transition (making their service more attractive to hospital payers).

Agreements:

The OIG ruling says the following with respect to agreements between the vendor and the hospital:

- An agreement spelling out the services to be provided must be signed by the vendor and the hospital.
- The vendor shall charge standardized fees for the services at fair market value[1].
- Fees charged by the vendor for these services will include an initial flat fee for implementation services.
- The vendor will also charge a per-patient fee. The ruling suggests that an "annual fee" can be charged for a census of patients and that additional fees can be charged if the actual services exceed the contracted amount.
- Hospitals may also request additional services for which the vendor would charge separate or additional fees, based on an hourly basis plus expenses and a reasonable profit margin.
- Agreements shall have terms of not less than one year.

Communications between the Hospital and Vendor

According to the ruling, the following items define the communications relationship between the hospital and vendor.

- The hospital will decide on a patient-by-patient basis whether a patient would benefit from a care transitions program. For example, hospitals may focus on the diseases that result in readmission penalties and may also consider whether the patient is being discharged to home or to a skilled nursing facility.
- The hospital will enter the patient demographic information and discharge plans into the vendor's software system. This implies that you need a HIPAA-compliant software interface accessible by your referring hospitals.
- Reports will be provided to hospitals regarding patients' medication adherence, post-discharge physician appointment completion, readmission rates, demographics, readmitting hospitals, and secondary diagnoses.

Care Transition Delivery Requirements:

The ruling stipulates the following regarding care delivery:

- Patient liaisons, which are not necessarily clinicians, will contact participating patients within forty-eight hours of discharge to ensure that they understand and will follow discharge plans.
- Thereafter, patient liaisons will contact participating patients daily or at intervals selected by contracting hospitals to administer questionnaires about participating patients' health and compliance with discharge plans.
- Participating patients may also answer questionnaires via the Internet or through telephone interactive voice response systems.
- Patient liaisons will ask participating patients about medication compliance, remind them about refills, and add newly prescribed medication to their electronic health records.
- Patient liaisons may also assist participating patients with various tasks, such as the following:
    - Scheduling follow-up appointments
    - Reminding patients about scheduled appointments
    - Helping patients obtain transportation at participating patients' own cost
    - Providing patients with unbranded educational materials intended for general audiences
    - Providing updates to participating patients' caregivers and primary care providers.

Phone Support for Patients:

Another requirement is to provide phone support for your patients. If you are a home health agency or home care provider, you may already have these services available. Otherwise you will need to make plans to provide them, according to the following guidelines:

- Participating patients must have access for a twelve-hour period each day to a patient liaison that will help them understand and follow their discharge plans.

- For the remaining twelve-hour period each day when patient liaisons are unavailable, participating patients are to be automatically transferred to a twenty-four-hour nurse hotline. One suggestion made in the OIG ruling is that the nurse hotline might be a service that the contracting hospital can provide.

Providing Services After the Hospital Transition Period Ends

The ruling states that the vendor can contract directly with the patient for a more limited set of services after the hospital ceases providing the services. Thus the care transitions program may also serve as a marketing vehicle for private care practice.

Preparing your organization to offer Care Transition Services

The proceeding paragraphs describe the criteria necessary for your care transitions service offering, but in addition to these requirements, you need to be equipped and trained to provide care. To that end, there are resources and training programs available to you. Two such resources are as follows:

NTOCC

- The National Transitions of Care Coalition (NTOCC www.ntocc.org) is dedicated to improving care coordination and the quality of transitions of care. Since 2006, NTOCC's Advisors Council of over 30 organizations has shared a common goal of improving the quality of Transitions of Care. Working in association with over 3,000 individual professional subscribers, NTOCC has developed tools and resources available on-line and also offer conferences, webinars and memberships. To contact NTOCC, call toll-free at (888)562-9267 or via email at support@ntocc.org.

Care Transitions Program:

- One of the most widely recognized care transitions methodology in use today is the Care Transitions Program, under the leadership of Dr. Eric Coleman. The Care Transitions Program (CTP) is an evidence-based methodology for care transitions and as such, participating organizations must become partners and participate in the CTP training and transformation process. Note that while the CTP website provides sample materials online to provide insight into the methodology, it is not sufficient to simply download items from the web site. For more information, contact Susan Rosenbek ,RN MS with the Division of Health Care Policy and Research by email at susan.rosenberg@ucdenver.edu or by calling 608-831-2365.

Conclusion:

Successful management of health care transitions has been clearly recognized as a way to improve healthcare in the US. Hospitals are motivated by significant penalties if they have excess readmissions. Home health agencies and home care organizations are strategically well suited to provide care transition services. An August 2013 ruling by the OIG establishes the basis for vendors to contract with hospitals to provide these services. In addition to growing revenue via this approach, it is also logical to conclude that vendor organizations that minimize readmissions will gain more referrals. Your organization should strongly consider whether a care transitions offering would be a strategic addition to your services mix.

Bibliography:

[1] The August 2013 OIG ruling is available at http://oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-10.pdf

[2] See http://www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

[3] See http://kaiserhealthnews.org/stories/2013/august/02/readmission-penalties-medicare-hospitals-year-two.aspx

[4] Note: OIG ruling requires patient contact daily or at intervals agreed with the contracting hospital.

[5] Though not covered in detail in this paper, note that the OIG ruling discusses in length concepts that are necessary to ensure program compliance with anti-kickback and discount safe-harbor provisions. See Section II Legal Analysis within the ruling for further details.

About Ankota (www.ankota.com)

Ankota provides an online HIPAA-compliant solution for managing transitions of care in accordance with the
August 2013 OIG ruling.

Key features of the Care Hub Software system are as follows:

- Web-based Portal for hospital referrals, data entry and tracking
- Simple, easy to use intake process
- User configurable program templates
- User configurable additional services
- Fully configurable billing and payroll
- Low start-up cost / fast implementation
- System is preloaded with standardized forms for common agency transactions
- Forms may be customized for an additional fee
- Forms run on tablet (e.g. iPad) or PC
- Care providers see only assigned patients
- Hospitals and other authorized care participants (e.g. primary care physicians) can access patient charts

For more information on the Ankota Care Transitions Solution,
see www.ankota.com

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