ANKOTA
healthcare delivery management

Selling Care Transition Services to Hospitals

An Ankota White Paper

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How to Sell Your Care Transition Services to Hospitals

Introduction:

For several years, Care Transitions has been a hot topic in the healthcare conversation. In a nutshell, many preventable adverse medical episodes occur when a patient is in transition from one setting to another, such as transitioning from hospital to home. Medicare spends approximately $26 Billion per year on hospitalizations for patients who were readmitted within 30 days of a hospital discharge[1] and conservative estimates show that half of these readmissions are avoidable. Countless study programs are proving to reduce readmissions. But wide spread adoption has been slow because care transition services aren't reimbursed like other health services. The bottom line is that care transitions are the right thing to do, but "selling" these services is tough. This paper will help.

Estimates of Waste in US Health Care Spending in 2011, by Category

	Cost to Medicare and Medicaid[a]			Total cost to US health care[b]		
	Low	Midpoint	High	Low	Midpoint	High
Failures of care delivery	$26	$36	$45	$102	$128	$154
Failures of Care Coordination	21	30	39	25	35	45
Overtreatment	67	77	87	158	192	226
Administrative complexity	16	36	56	107	248	389
Pricing Failures	36	56	77	84	131	178
Subtotal (excluding fraud and abuse)	166	235	304	476	734	992
Percentage of total health care spending	6%	9%	11%	18%	27%	37%
Fraud and abuse	30	64	98	82	177	272
Total (including fraud and abuse)	197	300	402	558	910	1,263
Percentage of total health care spending				21%	34%	47%

SOURCE: Donald M. Berwick and Andrew D. Hackbarth, "eliminating Waste in US Health Care," JAMA 307, no 14 (April 11, 2012) 1513-6. Copyright © 2012 American Medical Association. All rights reserved.
NOTES: Dollars in billions. Totals may not match the sum of components due to rounding. [a]Includes state portion of Medicaid. [b]Total US health care spending estimated at $2.687 Trillion.

Why hasn't the readmission penalty solved this problem?

[1] http://www.chiamass.gov/assets/Uploads/A-Focus-on-Provider-Quality-Jan-2015.pdf

Starting in 2013, Medicare instituted a readmission penalty program to encourage hospitals to better manage care transitions and avoid readmissions[2]. In the first year, the max penalty was 1% of the hospital's Medicare revenue, and the hospitals were evaluated based on discharges for three diseases - Pneumonia, Congestive Heart Failure (CHF), and Acute Myocardial Infarction (heart attack). Penalties were assessed totaling $280 million to 2,217 hospitals[3]. By the third year, 2015, the penalty was increased to 3% of Medicare revenue and the total assessed grew to $428 million[4]. In most cases, this hasn't had much of an impact.

The reason is that the penalty, which averages $250 per readmission, is not large enough to motivate the hospitals to act. They're still able to bill thousands of dollars per readmission and the $250 penalty is not much more than a slap on the wrist. Looking at the math, the $400 million in penalties amounts to less than 2% of Medicare's cost and on an $8,000 readmission, it's simply not consequential to the hospital.

Don't give up - the tides are turning!

Despite the ineffectiveness of the readmission penalty programs there are still motivations for hospitals to work with you to solve this problem, as follows:

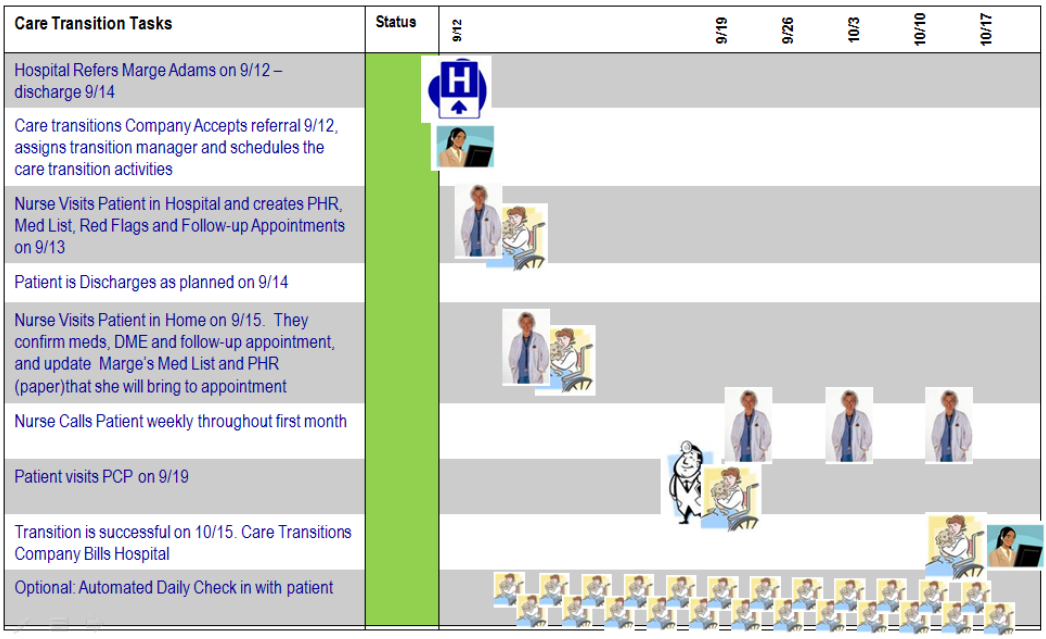
1. Medicare is moving to a new reimbursement approach called "Bundled Payments," where hospitals will not be paid anything for readmissions. Instead, they'll receive a fixed fee for the full episode (like $16,000 for the full 30 day costs of a knee replacement). In this case, the $8,000 readmission would be a total loss for the hospital.
2. The hospital can benefit from lower readmissions. Since instituting the readmission penalties, hospital readmission rates have become public information, and a high readmission rate can negatively impact consumer choice of the hospital. Also there are hospital ratings, such as the Star-Rating system[5] that reward hospitals with low readmissions.
3. Lastly, there are ways for you to offer programs that cost the hospital less than the $250 and are still profitable for your home care agency. If you can bring the hospital a way to reduce cost and increases their star ratings, they will be foolish not to consider it. This will be addressed in greater detail later in the paper.

An ideal, but perhaps hard to afford, Care Transition Program

The diagram below shows the steps in one of the popular evidence-based care transition programs. In a nutshell, there is a referral from a hospital resulting in scheduling a hospital visit

[2] http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/
3 http://khn.org/news/medicare-hospitals-readmissions-penalties/
[4] http://khn.org/news/medicare-readmissions-penalties-2015/
[5] http://www.hcahpsonline.org/StarRatings.aspx

(prior to discharge), confirming or providing transportation home, performing a home visit within 24-48 hours of discharge, ensuring there's a primary care visit (and perhaps providing transportation), making follow-up phone calls each week, and doing an "end-of care" visit to confirm the successful series. The diagram also shows telehealth check-ins.



These programs are proven to be effective (studies and journal publications have proven them to be "evidence based", but in general, they cost more than the hospital penalties so it's a classic case where it makes sense at the level of the overall US healthcare system, but there's no clear payer. Some of the programs and their associated costs are the Guided Care[6] program costing $1,732 per consumer per year, the Geriatric Resources for Assessment and Care of Elders (GRACE) program[7] at $1,432, the Transition Care Model[8] (Naylor Model) at $982, and the best known Care Transitions Intervention[9] (Eric Coleman Model), which has been reported to cost only $196 (but in our experience, care provider organizations are not consistently able to formulate profitable programs for that cost).

What type of care transition program should you offer?

There are numerous ways to formulate a care transitions program. Your offering should be based on the capabilities of your organization. Note that not having all of the required skills is not necessarily a bad thing and can in some ways be a benefit. For example, if you are a non-

[6] http://www.ncbi.nlm.nih.gov/pubmed/19670959
[7] http://medicine.iupui.edu/iucar/research/grace/
[8] http://www.transitionalcare.info/
[9] http://www.caretransitions.org/ Note: The Care Transitions Intervention® and all of its materials are the property of the Care Transitions Program®. The Care Transitions Program® is solely authorized to provide training on the Care Transitions Intervention®. Disclaimer: The Care Transitions Program and its personnel assume no liability or risk for use of model, materials or any advice explicit or implicit.

medical home care agency, or area agency on aging and don't have nursing skills, one solution is for the hospital to provide their nursing or pharmacy skills with staff that they already have. At Ankota, we're familiar with the following types of care transition services:

- **Private Pay Care Transition Service:** This is a service offered to patients or their family members for a fixed fee like $199 and includes transportation home, a home safety inspection (and for example discarding expired items from the refrigerator), medication pick-up and filling of a pill box, and an update to the family. This type of service is offered most frequently by non-medical home care agencies.

- **Check-In and Referral Service:** This service is offered by area agencies on aging and some independent referral organizations.

- **Care Transition Service Based on an Evidence-Based Protocol:** These services are more medically oriented and in many cases are grant funded. The programs are working, but in many cases they don't have a funding source when the grants run out.

- **Pharmacy-Driven Programs:** Some studies have shown that more than half of the preventable readmissions are due to medication errors. In fact, there are cases where the patient doesn't pick up their meds because they don't want to burden someone to do it, or sometimes don't want to pay their co-pays. There are also situations where the patient has all the right meds but doesn't know how to take the new ones so they go back to taking the old ones.

- **Tech-Enabled and Tele-Health Offerings:** There are a number of services where, for example, a Congestive Heart Failure (CHF) patient is given an Internet-connected or Telehealth-connected scale and asked to stand on the scale each day, and the weights are monitored for sudden spikes (indicating a recurrence of the CHF episode). These programs also suffer from the question of who shoulders the cost (including the telehealth equipment and deployment costs, plus the services to monitor the results).

- **Hybrid offerings:** Lastly, there are hybrid offerings where, for example, the hospital staff provides the "medical portion" of the care transition service, like identifying the red-flags and reconciling the medications, and the home health aides provide the in-home care services. This solution works quite well for all parties. For example, if the homecare agency offers the transportation, home safety inspection, and follow-on phone calls (or live check-in visits) and charges $25 per hour for those services (generally higher than their standard rate), they can earn $125 for the care transition episode, and the hospital generally already has the staff and skills for the other steps.

So, the bottom line is that you should formulate a program based on the skills that are available in your organization and look to the hospital or other partners to fill in any gaps. Let's think through the ingredients and who can fulfill the roles:

- Nursing: if your organization doesn't have sufficient nursing skills, perhaps the hospital can provide these skills or you can partner with home health in your region to get them.

- Pharmacy: Often, medical reconciliation is performed by nurses, but of course pharmacists are ideally suited for this work. Your local pharmacy may be willing to partner with you on this at low cost or no cost if you can get the prescriptions sent to them. Also, Walgreens has a care transitions offering (although it may be hard for a small agency to partner with a big company like Walgreens) and there's a new service called Pillpack (www.pillpack.com) that may be interested in partnering with you.

- Aides and companion services: if you don't have aides on staff you can likely partner with the non-medical home care staff in your area. It's also possible that this work can be done by social workers or community based organizations.

- Follow-up phone calls: Keep in mind the possibility that the hospital might have staff capable of doing follow-up phone calls with their patients. So you might go in thinking that you'll provide transportation home, home safety inspection, transportation to primary care, and the follow-up phone calls, but be flexible.

- Intake: Intake is an area that might result in some contention. Hospitals have focused a lot of their efforts and capital budgets on implementing Electronic Health Record (EHR) system, and as a result, they've been trained and conditioned not to be open to sending the referral into another software system. Even if your care transition software can accept referrals electronically, this can require effort on the part of the hospital's IT department and that can be a showstopper or cause a delay. Our advice, like everything else, is to be flexible. If you have to check for referrals in some online hospital system and do double data entry into your tracking system, this may still be better than not being part of the program. Once you're up and running and you have a successful track record, you may be able to reintroduce the idea of a direct connection to the hospital's EMR.

As in any sales situation, you are at the mercy of what your customer wants, and although you can try to design a perfect solution based on your perception of their strengths and how they complement yours, it's always good to listen to their needs and be flexible.

Selling your Service to Hospitals:

So far we've focused on preparation, which of course is the prerequisite to sales. Now that you're armed with the ability to provide care transition services, here are the steps that we recommend for selling your service to hospitals:

1. **Consider training on an evidence-based methodology**: Although the steps required for managing a care transition are not difficult, and are listed in this paper, there are benefits to training on an evidence-based methodology for care transitions like the Care Transition Intervention® (Eric Coleman Model). In this case, the program was designed to be delivered by paraprofessional care providers and social workers. An important note: a lot of this training is about how to transfer knowledge to your patient and teach them to better advocate for themselves. Lastly, when you are a trained partner using an evidence-based methodology, you can use the program's success metrics as part of your marketing.

2. **Establish Proof that your solution works**: Even though you won't be paid on day one, hospitals will want to see proof that your program works. The best way to establish this proof is to start performing care transition services for the patients/clients that you already have. If you're able, for example, to go to the hospital with evidence that you've managed care transition for 54 patients with only two readmissions for an overall 3.7% rate of readmissions, you will catch their attention.

3. **Offer a Private-Pay Care Transition Offering**: There's a private-pay care transition service described above that can potentially be beneficial to the hospital. Think of the situation where an elderly patient presents with a broken hip and their adult daughter flies into town to make sure that everything is ok, but can't stay (because she has to go home and take care of her kids or go back to work). If the hospital has a brochure from your agency for a $199 service that will get her mom home safe, she's very likely to call, and it's very likely that you'll be able to provide ongoing in-home care services. From the hospital's perspective, having your brochure takes a burden off of them and builds a reputation for you as a value-added partner to the hospital.

4. **Use your network to get introduced to hospital discharge planners**: As you know, people buy services from people they know and trust. The most successful private care agencies get most of their referrals from home health agencies, CCRCs, SNFs and other organizations (like hospitals) where they have grown and maintain relationships. Hospitals work the same way. If you're already getting referrals for home health or a private-pay care transitions offering, make sure that you or your marketer are maintaining the relationship by visiting every couple of weeks. Thank them for their business. Share updates and success stories on their more memorable patients who you served. If the relationship is strong, offer to help them lower their readmission rates.
5. **Understand the readmission rates, by disease, of the hospital**: Knowledge is power, but with this one, you have to be a little bit careful. You want to make the case that the hospital's readmission rates can be improved, and that their penalties can be reduced. You need to come to your discussions with the hospitals armed with this data. At the same time, you need to be careful not to insult the hospital personnel with this data. There is a lot of supporting evidence that readmission rates (when there is not a care transition program in place) generally correspond to the demographics of the community surrounding the hospital, and sometimes the better hospitals have higher readmission

rates because they take the more complicated cases.

6. **Identify the decision makers and request a meeting**: The good news is that as of this writing (July 2015), reduction of readmission rates and managing care transitions is a top-of-mind concern for virtually all hospitals. Having prepared your program, gathered evidence of its success, and having built a relationship with the hospital, you've earned the meeting. Meetings can go in a variety of ways. Believe it or not, some of the best meetings happen when the customer is not at all interested in your PowerPoint slides and is ready to tell you their pain and the services that they need, but make sure to be well-prepared. The data that you should have is as follows:
    - Information about your agency and the services you've provided to the hospital
    - Evidence about your care transition success rate
    - Knowledge of the hospital's readmission rates and penalties they've paid
    - Understanding of bundled payments (most importantly that readmissions will not be reimbursed in the future)
    - Services that you're able to provide: our recommendation is to have a program to offer plus the willingness to offer ingredients. For your program offering, describing what services you provide and what services the hospital provides, and list the price of the service (remembering that your success rate will go up if your services are under $250). Regarding the ingredients that you're willing to provide, be prepared to offer the services "a la carte."

7. **You want a "Yes," but be prepared for a "Maybe"**: It is very unlikely that the meeting will result in a decision to proceed with a program, but if things go well, there will be a set of action items that can lead to a favorable conclusion. For example, they may ask the discharge planner to define the program steps based on a combination of internal processes and the ingredients that you've proposed. This would be a strong sign that they're interested. Our advice is to take the lead on the actions that you are a part of and to commit to achievable dates. Then, as you complete the actions, communicate the results.

8. **If at first you don't succeed…**: By 2017, virtually all hospitals will have a care transition program in place, so the time to start is now.

The Question is Not "If" you should offer Care Transition Services, but "When"

Tim Rowan, the publisher of *Home Care Technology Report*[10], holds an annual conference called Health Care in Transition and the narrative is ominous. The discussion starts with the indisputable evidence that health care is changing and that many existing home care agencies won't survive. Then, the conference proceeds to highlight the actions of home health and home care agencies that are poised to win. These agencies are strengthening relationships with

[10] www.homecaretechreport.com

health systems in their areas and finding ways to participate in the forthcoming bundled service initiatives that are now being piloted and will shortly be the new way Medicare reimburses. When I was a child, patients were treated and recovered in the hospital before discharge. Now they are treated in the hospital and recover outside, and as a result, care has gotten better. Home health agencies who will survive are starting to determine how they can offer shorter episodes at lower cost. Their revenue per episode is going down, but their star ratings and referrals are going up, and they are thriving. With regards to home care, the shift will come soon as well. Today, most home care agencies describe themselves as helping their clients stay in their homes and avoid nursing homes. The successful agencies are the ones whose objective is to help their clients avoid preventable hospitalizations. The time is now for your agency to position for a successful future, and the next step is to begin offering a successful care transitions program.

About Ankota

Ankota provides advanced yet accessible, HIPAA-compliant software solutions for managing home care and care transitions. We are dedicated to dramatically improving the quality, efficiency and coordination of care delivered at home. We believe that the home care industry is a key foundation for health care reform. Please learn more about Ankota's software for private duty non-medical care and care transitions at http://www.ankota.com

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