Attachment A: **TEMPLATE FOR TRANSFORMATION PROJECT SUGGESTIONS**

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Project Title	***Implement care coordination through the development of a high-performing post-acute care network***

Rationale for the Project

   Readmissions are costly to the system and can indicate a need to have a post-acute care system and care transition that manages the unique needs of the patient. According to Health Affairs, Medicaid readmissions were both prevalent (9.4 percent of all admissions) and costly ($77 million per state) and that they represented 12.5 percent of Medicaid payments for all hospitalizations[i]. According to AHRQ, 14 percent to 46 percent of rehospitalizations could have been avoided[ii].

   Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicaid beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).

   For CHI's 43 current SNF providers, the 30-day re-hospitalization rates vary widely between 9.5% and 26.8% -- indicating a need to have consistent transition and management protocols to manage the readmission rates for these patients.

   To address this need, the Rainier ACO has developed the concept of a continuing care network for post-acute care (CCN). From a high-level perspective, the PAC-CCN encompasses an integrated group of post-acute providers that will accept patients discharged from health system hospitals who require rehabilitative, medical and post-surgical care following an acute inpatient hospitalization. The goal of the PAC-CCN is ultimately to ensure continuity of care and quality patient outcomes for the health system's patients. Continuing care networks (PAC-CCNs) represent one aspect of an evolving, clinically-integrated model of patient care for shared risk payment models, given a desire to achieve the generally-accepted goals of the "Triple Aim": better health, better care and lower cost.

Evidence-based support:

The development of post-acute care networks is supported by best practices and a strong evidence base. The following literature indicates the case for PAC networks:

- https://www.advisory.com/research/care-transformation-center/care-transformation-center-blog/2015/03/three-barriers-to-pac-network-performance
- http://www.beckershospitalreview.com/hospital-physician-relationships/post-acute-care-networks-the-key-to-success-in-accountable-care.html
- http://www.aha.org/research/reports/tw/15dec-tw-postacute.pdf
- http://www.aha.org/content/00-10/10postacutecasestudy.pdf

Benefit to Medicaid beneficiaries:

The Centers for Medicaid and Medicare Services has a vested interest in improving care transitions to post-acute services (see Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014). Medicaid beneficiaries would benefit immensely from an improved post-acute care network. There are many socioeconomic barriers to preventing readmissions after a hospitalization, and many providers will not accept Medicaid patients. The development of a high-performing, strong post-acute care network for Medicaid patients will help overcome many of these barriers and create partnerships between facilities.

Project Description

Which Medicaid Transformation Goals[iii] are supported by this project/intervention?

X Reduce avoidable use of intensive services

☐ Improve population health, focused on prevention

X Accelerate transition to value-based payment

X Ensure Medicaid per-capita growth is below national trends

This project supports multiple Medicaid Transformation Goals. Appropriate use of post-acute services and timely transition to post-acute services immensely reduces the use of avoidable services. By developing a high-performing post-acute care network, the system will be ready to transition to a value-based payment system because it can provide the value for Medicaid and patients.

Which Transformation Project Domain(s) are involved?

☐ Health Systems Capacity Building

X Care Delivery Redesign

☐ Population Health Improvement – prevention activities

Target population: Patients transitioning from an inpatient setting to a post-acute care setting

Project goals, interventions and outcomes expected during the waiver period, including relationship to improving health

equity /reducing health disparities.

1. Develop an organizational structure, including committees and a care coordination advisory committee
2. Develop a post-acute care selection and credentialing process.
3. Develop and implement a process, including utilization of data and information technology, to reliably identify hospitalized patients at high-risk for readmission.
4. Create a SNFist program. A SNFist program involves a physician and extenders (nurse practitioners and physician's assistants) who make daily rounds on short term patients discharged from hospitals to SNFs within the PAC network. The SNFist also engages in "warm hand-offs" (telephonic discussions) with hospitalists for patients newly admitted to the SNF, and with primary care physicians (PCPs) during the patient's stay in the SNF as well as at the time of discharge from the SNF to home.
5. Inpatient and outpatient teams will collaboratively develop standardized transition workflows:
    a. Develop mechanisms to support patients in establishing primary care for those without prior primary care affiliation
    b. Develop process for warm hand-off from hospital to outpatient provider, including assignment of responsibility for follow-up of labs or studies still pending at the time of discharge.
6. Develop standardized workflows for inpatient discharge care:
    a. Optimize hospital discharge planning and medication management for all hospitalized patients.
    b. Implement structure for obtaining best possible medication history and for assessing medication reconciliation accuracy.
    c. Develop and use standardized process for transitioning patients to sub-acute and long term care facilities
    d. Provide tiered multi-disciplinary interventions according to level of risk
        i. Involve mental health, substance use, pharmacy and palliative care when possible
        ii. Involve trained, enhanced IHSS workers when possible
        iii. Develop standardized protocols for referral to and coordination with community behavioral health and social services (e.g., visiting nurses, home care services, housing, food, clothing and social support). Identify and train personnel to function as care navigators for carrying out these functions.
7. Ensure connectivity between the hospital and post-acute care providers through health information technology
8. Establish or expand on a system to track and report readmission rates, timeliness of discharge summaries, and other transition processes, and investigate system-specific root causes /risk factors for readmission, using quantitative and qualitative information to identify the key causes of readmissions, including physical, behavioral and social factors.
9. Develop a care transitions program or expand a care transitions program to additional settings (e.g., emergency department), or to additional populations, using or adapting at least one nationally recognized care transitions program methodology[iv].
10. Develop standardized workflows for post-discharge (outpatient) care:
    a. Deliver timely access to primary and/or specialty care following a hospitalization
    b. Standardize post-hospital visits and include outpatient medication reconciliation.
11. Support patients and family caregivers in becoming more comfortable, competent and confident in self-management skills required after an acute hospitalization.
12. Engage with local health plans to develop transition of care protocols that ensure: coordination of care across physical health, substance use disorder and mental health spectrum will be supported, identification of and follow-up engagement with PCP is established, covered services including DME will be readily available; and a payment strategy for the transition of care services is in place.
13. Increase multidisciplinary team engagement by:
    a. Implementing a model for team-based care in which staff performs to the best of their abilities and credentials
    b. Providing ongoing staff training on care model.
14. Implement a system for continual performance feedback and rapid cycle improvement that uses standard process improvement methodology and that includes patients, front line staff and senior leadership.
15. Create a pipeline of workforce talent trained in providing care coordination

Links to transformation initiatives: Tangentially, this will work with the CMS post-acute quality initiative to improve data, Improving Medicare Post-Acute Care Transformation Act of 2014.

Potential partners: It will be important to partner with organizations doing similar work, to ensure continuity of efforts and reducing overlap of work. This may include organizations such as Qualis Health.

Core Investment Components
Proposed activities cost estimates: The primary costs of this program will be in developing the care transitions protocols and network management, as well as care managers. The FTE costs will range in the 100s of thousands per year per project. The scale of the project will apply to any patients who are discharged from the participating entities, so the scale may vary.   **Length of implementation:** 6-9 months   **Return on investment:**   Both CMS and the hospital systems will see a return on investment for a relatively low-cost intervention. Readmissions penalties are significant (in the hundreds of thousands) for any hospital who cannot manage care after the initial discharge. Additionally, readmissions cost payors (CMS) and the system for a utilization that could have been avoided ($77 million in Medicaid dollars per year per state). Every time a patient is readmitted, that is another discharge and another use of post-acute care services.
Project Metrics

Metric	Measure Steward	Benchmark data
30-Day All-Cause Hospital Readmissions*	NCQA	Suggest that a state benchmark be set
Potentially Avoidable ED visits*	3M	Suggest that a state benchmark be set
All ED visits	TBD	Suggest that a state benchmark be set
Observation admissions	TBD	Suggest that a state benchmark be set
Average length of stay	Premier	Suggest that a state benchmark be set
H-CAHPS: Care Transition Metrics	AHRQ	Suggest that a state benchmark be set
Reconciled Medication List Received by Discharged Patients	AMA-PCPI	Suggest that a state benchmark be set
HCAHPS Discharging Information	AHRQ	Suggest that a state benchmark be set
Average Lengths of Stay inside SNF	TBD	Suggest that a state benchmark be set

* From the Washington State Common Measure Set for Health Care Quality and Cost

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[i] http://altarum.org/publications/medicaid-admissions-and-readmission-understanding-the-prevalence-payment-and-most-common-diagnoses

[ii] http://www.ihi.org/Engage/Initiatives/Completed/STAAR/Documents/STAAR%20State%20Based%20Strategy.pdf

[iv] E.g., CMS Discharge Planning Hospital Conditions of Participation, AHRQ Hospital Guide to Reducing Medicaid Readmissions, Coleman Care Transitions Intervention-CTI, Project BOOST, STAAR, Project RED