Meritage ACO Care Transitions: Coaching, Management, and Coordination

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At any level of track and field, even the Olympics, the most dangerous moment in a relay race is when one runner hands the baton to the next. Even if the team includes the four fastest humans on earth, if there is a problem transitioning the baton (as happens surprisingly often among top-level athletes), there is little chance of victory.

The same goes for the healthcare continuum. A provider network or accountable care organization (ACO) may include the best hospitals, skilled nursing facilities (SNFs), primary care physicians and specialists, home health nursing, and hospices, but if fragmented care and miscommunication result from poor transitions of patients from one care setting to another, the risk of mishaps increases. There can be medication errors, missed appointments with primary care and specialists in the outpatient setting, duplication of resources and increased costs, inconsistent care continuity, poor patient understanding of self-care needs, poor awareness of red flags among patients regarding their conditions, and other implications. The impending outcome is an avoidable hospital readmission and increased financial burden to the healthcare system.

The importance of good transitions and collaboration between acute and post-acute care providers was underscored by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 (H.R. 4994) signed into law on October 6, 2014. The bill is focused on improving Medicare's post-acute care (PAC) services, standardizing reporting measures for PAC providers, and ensuring data interoperability to facilitate coordinated care and improve Medicare beneficiary outcomes, including preventable readmissions.

According to the Centers for Medicare and Medicaid Services (CMS), 17.5% of Medicare fee-for-service beneficiaries discharged from hospitals are readmitted within 30 days (U.S. Department of Health and Human Services, 2014). Approximately 75% of those readmissions are preventable (Medicare Payment Advisory Commission, 2007). Total preventable readmissions across all patients add up to a cost of approximately $25 billion per year (PricewaterhouseCoopers, 2008). With that comes the human cost, in terms of harm to patients that could have been prevented.

These ramifications would be of concern under any conditions. They become far more painful to healthcare organizations, however, as the industry moves from a fee-for-service model to pay-for-performance. With options such as ACOs and bundled payments, where fees are paid based on the expected cost of an episode rather than services rendered, preventable readmissions cut into the bottom line. Kaiser Health News reports that CMS will assess an estimated $428 million in fines to 2,610 hospitals between October 1, 2014, and September 30, 2015, for failure to reduce preventable readmissions (Rau, 2014).

With these factors in mind, Meritage ACO of Novato, California, developed a model of care that combines care transitions coaching, complex care management, and care coordination. It was designed to achieve the Triple Aim: improve population health (as well as the care of each individual it touches), reduce per capita costs, and improve the care experience for patients.

The goals of the hospital- and community-based program were to:

- reduce preventable hospital readmissions among Meritage ACO's highest-risk populations,
- improve patient safety through medication reconciliation,
- improve patient satisfaction by providing better communication and coordination between providers and care settings, and
- ensure that patient end-of-life preferences are taken into account.

This article describes the journey Meritage ACO took to build a comprehensive care transitions program and the outcomes achieved to date.

Leading the Transition in Transitions

Meritage ACO is the first healthcare organization in the North Bay Area of California to be designated a Medicare Shared Savings Program ACO by CMS. The Shared Savings Program was created to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. An offshoot of the Meritage Medical Network, an Independent Practice Association (IPA), Meritage ACO encompasses 250 physicians and 21,000 beneficiaries, and covers a 2,600 square-mile service area spanning Marin, Sonoma, and Napa counties. Unlike most ACOs, which are hospital-driven or partnerships between physician groups and hospitals, Meritage ACO is physician-owned and governed.

One of the challenges ACOs face is not being viewed as a network by traditional fee-for-service Medicare beneficiaries. ACO patients have the right to seek services from any participatory provider. For providers, this is like running a cattle ranch without fences. To address this concern, the ACO must make its offering attractive enough to keep patients within its network in order to realize the benefits.

Recognizing this need, in 2013 Meritage ACO began building a care transitions program that currently includes 250 primary care physicians (PCPs) and specialists from its own network, the 235-bed Marin General Hospital, two SNFs, the 163-bed Novato Healthcare Center, the 54-bed San Rafael Healthcare & Wellness Center, and Hospice by the Bay, which operates throughout the North Bay.

As it built the external network, Meritage ACO created an internal care management team consisting of one medical director, two PCP consultants who attend weekly team rounds, one director of care management, four MSN care managers who focus on the clinical aspect of transitions, and three patient care coordinators who focus on the psychosocial needs of patients and their caregivers. The idea was to follow the highest-risk patients throughout their journey through the healthcare system in order to strengthen the system's transition gaps and improve outcomes.

The care management team also deployed three patient care coordinators to perform follow-up work and help patients with psychological and social issues such as appointment reminders and transportation needs. In addition, they helped remove barriers that prevent chronic care patients from meeting their health goals. Moving this work to the care coordinators, who are not nurses, ensures that care managers, who are registered nurses, are able to work at the top of their licenses where their expertise is needed most.

Changing Care Model Requires New Thinking

The care team recognized that the program's success would rely not just on protocols or technologies but on shifting clinicians' thinking as the ACO transitioned from fee-for-service to pay-for-performance. Rather than focus on individual incidences of care or tasks (such as hanging an IV) within care settings, Meritage ACO needed all nurses and physicians to begin focusing on delivering continuous care between settings. They also needed them to think in terms of the care goals for the patient rather than the processes, and assume more of a team-

based orientation rather than the traditional physician-patient relationship where the physician in charge and the patient is a passive partner.

This approach is evident even in the preferred terminology. While the term "handoff" is common among clinicians, it is not interchangeable with "transition." A handoff, whether internally between clinicians in a facility or externally to those in another facility, implies a relief of responsibility (i.e., the patient was mine and now is yours).

A major focus of Meritage ACO was to change clinicians' behavior in viewing the patient as "our" patient, that is, a risk-shared responsibility throughout the continuum of care. A patient admitted to a SNF should not arrive as a blank slate with no supporting relevant health information. Longitudinal knowledge about the patient's medical history, including demographics, needs, care to date, and end-of-life goals, should travel with them. By centering care on the patient rather than the providers, Meritage ACO hoped to meet the requirements of the changing industry model.

Hybrid Model's Three Distinct Elements

As mentioned previously, the Meritage ACO model incorporates three distinct elements: care transitions coaching, complex care management, and care coordination between settings.

Care transitions coaching is the first step. Meritage ACO nurse care managers visit patients at the bedside before they are discharged to explain the process, provide education, answer questions, assess the patient's willingness to engage in their own care, and plan for their transitional needs. Visiting patients before discharge has proven more effective than attempting to convey this information as patients and their families are preparing to leave.

The ***care management*** program involves the use of several tools and techniques, including:

- Coleman Care Transitions Intervention (CTI). Developed at the University of Colorado at Denver by Eric Coleman, MD, MPH, CTI is a transitions coach working directly with patients and caregivers for 30 days after discharge to help them understand and manage their post-discharge needs, ensuring continuity of care across settings. Meritage ACO uses a modified version of CTI that includes one bedside visit in the hospital, one SNF or home visit, and three follow-up phone calls.

- Patient Activation Management Tool. This tool allows the nurse care manager to quickly assess to what degree patients are willing and able to care for themselves so care managers can target and tailor what they teach patients based on their level of engagement.
- Motivational Interviewing (MI). By using MI techniques with patients, care managers help patients learn to think differently about behaviors and lifestyles and consider what might be gained by making changes. Understanding how to communicate with patients and what it will take to help them improve their own care is what allows four care managers to manage 21,000 patients.
- Brief Action Planning. This technique allows patients to set their own goals, thus ensuring patients are always in charge of their own progress.
- Teach Back Method. This technique is used to ensure that patients understand instructions well enough to articulate what they have been told.

Care management also includes evidence-based guidelines developed by clinical excellence teams (CETs) from Meritage ACO. The CETs created a partnership between primary care and specialty physicians to determine the best practices for transitioning patients with diabetes, heart failure, and other chronic conditions. Decision-making factors such as designating the clinician responsible for screening under certain conditions, choosing the appropriate time to move from primary to specialty care, and determining when it's important to consider hospice were incorporated into these guidelines.

Finally, the **care coordination** program reviews recent care to eliminate duplication that often occurs when patients move between settings. For example, in a non-coordinated scenario, a congestive heart failure patient may visit his cardiologist, who orders a follow-up lab. Two weeks later, the patient visits his primary care physician. That physician might be unaware of the first order and orders a second set of lab tests. Little by little, these costs add up and subject older adults to testing that is not essential for their health.

By following the patient through the continuum, the nurse care manager can easily recognize the duplication of services and take action to prevent them.

Enrolling Patients for Care Management

Patients can become enrolled in the program in several ways. Some are identified through Johns Hopkins Predictive Modeling, although that method is limited

because its reliance on claims data means evaluators are looking backward in time rather than at current data.

Most participants are enrolled after being identified during their inpatient stay through the care transitions coaching program. These conversations during bedside visits allow nurse care managers to identify patients who will need more active care management.

Target patients include older adults with discharge barriers as identified through evidence-based tools such as Project RED and Project BOOST® that place them at high risk for readmission. Most have complex chronic conditions requiring close management. Some have complex psychosocial needs that impact their ability to manage their own healthcare needs. Many have both.

Some patients are enrolled through outpatient referrals by their primary care providers or specialists, and others become participants at their own request or the request of their families after they have observed a nurse care manager working with another patient.

Driving Collaboration through a Mobile Care Navigation Network

Improving communication was critical to achieving the high level of collaboration required between clinicians and care settings. Since facilities in the network and Meritage ACO's participating physicians are spread across the 2,600 square-mile coverage area, effective and timely communication between care settings is a significant challenge. Additionally, even the physicians within Meritage ACO were not standardized on a single electronic health record (EHR) system. Some, in fact, were still using paper charts. They could not rely on an EHR to share timely information or patient data, and thus used pages, phone calls and faxes – a process that often created unacceptable delays in exchanging information between providers and care settings.

In a grant study, Marin General Hospital noted it could take as many as 40 to 50 pages and calls to complete the discharge process, creating confusion and anxiety for patients and increasing their average length of stay. Some clinicians started to use texting in an attempt to shortcut this process, but messaging systems that are not HIPAA-compliant create new risks for providers.

To overcome these communication barriers, Meritage ACO implemented a cloud-based solution from Zynx Health to create a Health Insurance Portability and Accountability Act (HIPAA)-compliant mobile care navigation network that

brought all participants onto a single electronic information-sharing platform, allowing them to collaborate on evidence-based transition plans and follow-up with patients post-discharge.

The Joint Commission estimates that 80% of serious medical errors involve miscommunication between caregivers during the transfer of patients (Joint Commission Perspectives, 2012). Additionally, a study published by the National Center for Biotechnology Information asserted that hospitals waste more than $12 billion annually as a result of communication inefficiencies among healthcare providers (Agarwal, Sands, Schneider, 2010).

The mobile care network's online connectivity and secure messaging makes it easy to build a care team around a patient. Once the team is built, clinicians can view all inpatient and post-care members, including their roles and availability, and send and receive secure, HIPAA-compliant, patient-centered text messages 24/7 to individuals or the entire team. It also enables the care team to confirm their sent messages have been opened and read.

The mobile care network also removes the institutional walls that separate the different care facilities. Members of the sending and receiving teams can communicate, collaborate, and troubleshoot from miles apart, even in a different county, without a telephone call or a page.

In addition to facilitating communication, the network gives Meritage ACO the ability to create evidence-based checklists to help identify the patient's discharge needs, risks, and barriers to ensure the appropriate care is provided and that care is coordinated across the continuum. These checklists help avoid scenarios where patients are sitting for hours in their rooms ready to be discharged, waiting for a particular hospital discipline to sign off, or where discharging nurses rush through instructions at the last minute. The result has been significantly improved collaboration and coordination of patient transitions, better patient safety, and satisfaction with fewer delays or missing steps.

Nurse Care Managers Follow Patients

A core tenet of the Meritage ACO care transitions program is that the patient is always in the center. The same nurse care manager, therefore, will always see the patient wherever they are in the continuum: the hospital, a SNF, in their physician's office, or at home.

In the hospital, the Meritage ACO nurse care manager will visit the patient at the bedside before discharge. Typically the nurse care manager introduces themselves with, “Hi, I am from Dr. Andrew’s office, and he sent me here to ensure you arrive home safely…” thus offering a personal touch.

To further build trust, each primary care physician’s office has fliers posted on the wall that include photos of the nurse care managers. The physician will point to the flier and say, “This nurse will be giving you a call, and I want you to work with her.” This step has proven highly effective in ensuring patient cooperation. It is also an important contributor to patient safety, since the nurse care manager’s face will be familiar to the patient and family. With this trust built, the nurse care manager in the home can assess a more realistic picture of the patient’s care needs.

If the patient is discharged to a SNF, the nurse care manager will round at the SNF’s weekly interdisciplinary team rounds. If the patient is discharged from the SNF, that same nurse will visit the patient at home to help smooth the transfer, reconcile medications, and ensure that the proper support is available. If necessary, nurse care managers will also meet patients at their primary care physician’s office to underline the importance of the medical plan. At any point in the care transitions process, nurse care managers can consult with one of the care team’s PCP consultants.

Remarkable Results

In the nearly two years since it was launched, the care transitions program has produced outstanding results. For Meritage ACO, the application of skilled nurse care management and mobile technology has resulted in a readmission rate of just 10.2% for its highest-risk patients – considerably below the national average. This improvement has placed Meritage ACO just shy of the 90th percentile for chronic heart failure, asthma, chronic obstructive pulmonary disease, and all-cause 30-day readmission avoidance.

Skilled nurse care management has also made a difference in the context of end-of-life discussions. Informally, patients had reported that they found it difficult to initiate such discussions with their physicians. They felt their physicians were too busy and that 15-minute appointments were too short. An end-of-life discussion is highly personal and typically requires a lengthier conversation. As nurse care managers have taken on that task, patients have expressed gratitude that a care team member is willing to discuss this sensitive topic.

Lessons Learned

Meritage ACO has learned many lessons about developing a successful care transitions program since the program was first launched in 2013. Among the most important are:

- Don’t be afraid of change. Old models may have worked in the past, but healthcare organizations have to think differently now. It’s important to see the problem from every perspective. Providers have their own agendas for patients as they move across the continuum of care. To be successful, all those touch points must be taken into consideration.
- Don’t underestimate the value of a small, humane action.
- That caring touch could be as simple as a nurse care manager sitting on a patient’s couch at home and petting his dog. Actions of that nature build trust and rapport that cannot be duplicated in other ways, leading to deeper conversations with patients.
- Physician engagement is key. If a nurse care manager calls a patient without a preliminary introduction from the primary care physician, Meritage ACO has found the engagement rate is roughly 10%. But if that introduction has been made, engagement rises to 80% to 90%.
- Be sure to include behavioral health support. Often, if patients are not able to manage their own care successfully, a psychiatric condition or a drug or alcohol problem is involved.

Conclusion

As healthcare continues to transition from fee-for-service to pay-for-performance and new care models such as ACOs, it is critical that providers throughout the continuum shore up the transitions between providers and facilities, the weakest link in the patient journey. The IMPACT Act of 2014 underscores this need. As with the relay runner and the baton, a failure to execute properly in this area will take down the entire team.

Through a combination of skilled nurse care managers, a well-designed evidence-based program, and the use of a mobile care navigation network to enable patient-centric, team-based communications, Meritage ACO has succeeded in improving patient outcomes, lowering risk, reducing costs, and increasing patient satisfaction.

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References

Agarwal, R., Sands, D.Z., Schneider, J. D. (2010). Quantifying the economic impact of communication inefficiencies in U.S. hospitals. *Journal of Healthcare Management* 55(4), 265-281. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/20812527

Care Transitions Intervention https://caretransitions.org/

Goldfield, N.I., M.D., McCullough E.C., M.S., Hughes J.S., M.D., Tang, A.M, Eastman, B., M.S., Rawlins, L.K. & Averill, R.F., M.S. (2008). Identifying potentially preventable readmissions. *Health Care Financing Review,* 30(1):75-91. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/08Fallpg75.pdf

Medicare Payment Advisory Commission. (2007). Report to Congress: Promoting greater efficiency in Medicare [Internet]. Washington, DC: Medicare Payment Advisory Commission. 297. Retrieved from *http://www.caretransitions.org/documents/MedPAC%20report.pdf*

PricewaterhouseCoopers' Health Research Institute. (2008). The price of excess: *Identifying waste in healthcare.* Retrieved from http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.jhtml

Rau, J. (October 2, 2014). Medicare fines 2,610 hospitals in third round of readmission penalties. *Kaiser Health News.* Retrieved from http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/

The Joint Commission. (2012, August). Joint Commission Center for Transforming Healthcare releases targeted solutions tool for hand-off communications. *Joint Commission Perspectives*, 32(8). Retrieved from http://www.jointcommission.org/assets/1/6/TST_HOC_Persp_08_12.pdf

U.S. Department of Health and Human Services. (2014). New HHS data shows major strides made in patient safety, leading to improved care and savings. Retrieved from http://innovation.cms.gov/Files/reports/patient-safety-results.pdf