Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community

Panelists:

Subject Matter Experts

• **Scott A. Berkowitz, MD, MBA** – Chief Population Health Officer, and Vice President, Johns Hopkins Medicine; and Associate Professor of Medicine, Division of Cardiology, Johns Hopkins University School of Medicine

• **Robert A. Zorowitz, MD, MBA** – Regional Vice President, Health Services for the Northeast, Humana

Previous Submitter

• **Karen S. Johnson, PhD** – Vice President, Practice Advancement, American Academy of Family Physicians (AAFP) ([Previous Submitter – APC-APM proposal](#))
Panel Discussion 1: *Improving Management of Care Transitions from Facilities to the Community*

Karen S. Johnson, PhD
Vice President, Practice Advancement
American Academy of Family Physicians (AAFP)
(Previous Submitter – APC-APM proposal)
Karen Johnson
Introductory Comments

PTAC Public Meeting
Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community

June 12, 2023
Karen S. Johnson, PhD
American Academy of Family Physicians (AAFP)

- The AAFP serves 129,600 family physicians with education and advocacy focused on strengthening the primary care foundation of the US health care system.

- Vice-President, Practice Advancement since 2021 and strong primary care advocate throughout my career including the following roles:
  - Benefit consultant to large self-funded employers and union trusts
  - Health plan payment strategies including primary care and value-based payment model design
  - Multi-stakeholder collaboration
  - Data-driven improvement initiatives
Care Transitions: A Primary Care Perspective

Successful transitions start with timely and accurate information as reflected in the AAFP Guiding Principles for Value-Based Payment.

- Barriers to this happening persist:\(^1\)
  - Difficulty locating address of the physician/provider
  - EHR has difficulty receiving information
  - Correctly matching patients across systems and to the correct physician/provider
  - Resources to support social needs may be lacking

- Solutions must be embedded in a complex maze of policy and practice considerations to have an impact.
  - The typical primary care physician caring for Medicare patients must coordinate care with 229 other physicians working in 117 practices.\(^2\)
  - Practices frequently contract with 10 or more payers.\(^3\)
Appendix
References


3 American Academy of Family Physicians Practice Profile Survey, 2022
Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community

Scott A. Berkowitz, MD, MBA
Chief Population Health Officer, and Vice President, Johns Hopkins Medicine; and Associate Professor of Medicine, Division of Cardiology, Johns Hopkins University School of Medicine
Scott Berkowitz, MD, MBA
Introductory Comments

PTAC Public Meeting
Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community
Dr. Berkowitz is a practicing general cardiologist who provides strategic direction, leadership, and management of population health activities across Johns Hopkins Medicine (JHM).

In late 2020, he launched the JHM Office of Population Health (OPH) to standardize, coordinate and deploy population health activities and services in a strategic and data-driven way with a focus on enhancing value and reducing disparities.
JHM, headquartered in Baltimore, Maryland, is a $10 billion integrated global health enterprise and one of the leading health care systems in the US. It includes >40,000 full time faculty and staff, and operates six academic and community hospitals, four health care and surgery centers, more than six ambulatory surgery centers and has more than 2.8 million outpatient encounters per year.
Care Transitions
Increased Patient Complexity and Reduced System Capacity

- Patients require transitions of care that address post-discharge clinical needs while also addressing social determinant of health issues. Growing patient complexity has complicated this transition.

- “Bundled” hospital discharge strategies include:
  - a) risk screens/tools;
  - b) inter-disciplinary care rounds;
  - c) patient/family education;
  - d) medication management;
  - e) primary care handoff;
  - f) ED management; and
  - g) transitions of care support (transition guides, patient access line, community social work, appropriate referrals, etc.).
Care Transitions
Increased Patient Complexity and Reduced System Capacity

- The OPH cross-functional care team seeks to identify newly high-risk patients and provide “in reach” to hospital teams to facilitate a smooth transition and engagement in ambulatory care support.

- JHM has had a post-acute care collaborative to facilitate discharges to SNFs, and in the “post-COVID” era, is seeking to re-envision a care continuum model inclusive of subacute settings and home and community-based services to improve capacity and smooth/timely transitions.
Appendix


Panel Discussion 1: Improving Management of Care Transitions from Facilities to the Community

Robert A. Zorowitz, MD, MBA
Regional Vice President, Health Services for the Northeast Humana
Robert A. Zorowitz, MD, MBA
Regional Vice President, Health Services
Humana, Inc. (Northeast Region)
Robert A. Zorowitz, MD, MBA, FACP, AGSF, CMD

• Regional Vice President, Health Services for Northeast Region of Humana, Inc., since 2020
• Provides Medicare Advantage plans to: NJ, NY, New England, PA, MD, DE and DC
• Oversees Utilization Management and Clinical Programs and Activities
• Background:
  • Albany Medical College, Albany, NY (MD)
  • Long Island Jewish Medical Center, New Hyde Park, NY (Internal Medicine)
  • Mount Sinai Medical Center, New York, NY (Geriatric Medicine)
  • ABIM Certified: Internal Medicine, Geriatric Medicine, Hospice/Palliative Medicine
• Advisor to the AMA CPT Editorial Panel for the American Geriatrics Society, since 2003
  • Helped draft Transitional Care Management Services CPT Codes 99495-99496
Transitional Care Management (TCM) Services

• A Care Transitions program utilizing a “transition coach” and other required components reduced risk of rehospitalization by about 1/3 at 30 days and reduced mean hospital costs by about $500 at 180 days (Coleman EA et. al. Arch Int Med. 2006;166:1822-1828)

• A nurse-led hospital discharge and home follow-up program for chronically ill older adults reduced rehospitalizations by 30-50%, saving approximately $4500 per patient within 5-12 months after discharge (Naylor MD et. al. JAMA. 1999;281:613-620 and Naylor MD et. al. J Cardiovascular Nursing. 1999;14:44-54)

• Transitional Care Interventions vs. Usual Care reduced hospital readmissions and/or emergency room readmissions from nursing facilities by 1.7 times (Birtwell et. al. JAMA Netw Open. 2022;5:e2210192)

• Reimbursement for Transitional Care Management Services (CPT Codes 99495-99496) approved by CMS in 2013

• TCM Services are infrequently billed; 3.1% of eligible discharges in 2013 and 7.0% in 2015 (Bindman AB, Cox DF. JAMA Intern Med. 2018;178:1165-1171); in 2019, Of all beneficiaries with acute care discharges eligible for TCM, only 17.9 percent received TCM services (Colligan E. et. al. Analysis of 2019 Medicare Fee-for-Service (FFS) Claims for Chronic Care Management (CCM) and Transitional Care Management (TCM) Services March 1, 2022. NORC/University of Chicago)
Appendix
Transitional Care Management (TCM) Services

Commencing on day of discharge through 29 days from discharge, TCM includes all non-face-to-face services provided by clinical staff under the direction of the physician or other qualified healthcare professional.

**99495** Transitional Care Management Services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

**99496** Transitional Care Management Services with the following required elements:
- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge
Transitional Care Management (TCM) Services 99495 Medicare Fee-for-Service Claims 2013-2021

99495 Transitional Care Management Services with *moderate* level medical decision-making

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99496 Transitional Care Management Services with high level medical decision-making
Select References


Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

Panelists:

Subject Matter Experts

- Charles Crecelius, MD, PhD – Medical Director for Post-Acute Care, BJC Medical Group
- David C. Herman, MD – Chief Executive Officer, Essentia Health
- Jenny Reed, MSW – Senior Vice President, Value-based Care, Baylor Scott & White Health
- Robert M. Wachter, MD – Professor and Chair, Department of Medicine, University of California, San Francisco (UCSF)
Panel Discussion 2: *Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions*

**Charles Crecelius, MD, PhD**
Medical Director for Post-Acute Care
BJC Medical Group
Charles Crecelius MD PhD FACP CMD

• BJC Medical Group Post-Acute Medical Director
  • Oversee Skilled Nursing Facility (SNF) providers, nursing home Preferred Provider Network (PPN), and various transition programs

• Part of BJC HealthCare – consisting of Washington University School of Medicine and faculty, BJC Medical Group, BJC ACO, Barnes-Jewish Hospital and 11 other community hospitals, in the Greater St. Louis area

• 35 years of clinical practice in nursing homes, clinic, and hospital, 5 years of administrative experience

• Extensive work with AMDA, The Society for Post-Acute and Long Term Care Medicine – Past President, Medical Director of the Year, Public Policy Chair and Advisor, AMA Relative Value Update Committee
Communication and Treating in Place Promote Best Transitions

• Communication Barriers in Transitions –
  • Health system adopting SNF specific discharge summary / instructions
  • Working with SNF EMR systems to produce a reliable / improved Continuity of Care document to serve as discharge summary from SNF

• Improving Treatment in Place
  • Urgent & avoidable transitions can be avoided with early identification and aggressive treatment such as IV antibiotic & fluids
  • Previous CMMI demonstration project showed reduction in hospitalizations with mentored nursing staff. Included extra payment to the facility & physician for approved diagnosis needed for extra resources used. 50% and 56% reduction in avoidable readmits and ER visits, respectively. 40% cost reduction in avoidable readmits and 6% reduction in total costs.
Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

David C. Herman, MD
Chief Executive Officer
Essentia Health
Welcome

David C. Herman, MD
Chief Executive Officer, Essentia Health

Our mission: We are called to make a healthy difference in people’s lives.

- 15,000 colleagues
- 14 hospitals
- 77 clinics
- 6 long-term care facilities
- 6 assisted living & independent care facilities
- 7 ambulance services
- 1 research institute

Essentia Health Facilities

Quality | Hospitality | Respect | Joy | Justice | Stewardship | Teamwork
Rural health care is distinctly different

- Lower household incomes
- Older
- Less education
- More health concerns
- Distance to care is greater
- Relatively resource poor
  - Food deserts
  - Unreliable broadband connectivity
  - Small provider practices
  - Lack of specialty services

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
Appendix
More than three out of four of people living in rural areas have household incomes below the statewide median income.


Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
Health insurance coverage

Rural Minnesotans are more likely to have public health insurance coverage, such as Medicare, Medicaid or MinnesotaCare.

Reasons for higher rates of public health insurance:

1. Age: people over 65 are more likely to have Medicare;
2. Lower Incomes: more likely to be eligible for state public programs; and
3. Less access to employer coverage: fewer people are connected to an employer that offers coverage.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
37% (242) of all primary care clinics (661) are located in rural areas.¹

19% (208) of all specialty care clinics (1,070) are located in rural areas.¹

Minnesota Community Health Centers had 720,846 medical, dental and mental health visits in 2020.²

¹ Source: MDH Health Economics Program analysis of the Minnesota Statewide Quality Reporting and Measurement System 2020 Physician Clinic Registry; also source for maps.
Rural Emergency Medical Services (EMS)

- 80% of rural EMS agencies rely on volunteers, but face decreasing volunteer roster sizes, and many shifts (weekdays, weekends, holidays) are difficult to fill.
- About 60% of agencies have inadequate staff to cover their call schedule without undue burden.
- 59% of agencies do not have all of their shifts covered at least 24 hours in advance.
- 88% of agencies provide Basic Life Support (not paramedic level services) to their communities.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
Rural health care providers

- Metropolitan: 74% Population, 80% Health Care Providers
- Large Town: 10% Population, 10% Health Care Providers
- Small Town Rural: 8% Population, 6% Health Care Providers
- Isolated Rural: 9% Population, 4% Health Care Providers

Very few licensed health care providers work in rural areas.

Source: MDH Office of Rural Health and Primary Care analysis. Data provided by Health Licensing Boards, August 2021. Data includes: physicians, physician assistants, respiratory therapists, oral health professions, pharmacy professions, physical therapy professions, and mental health professions.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
Eight Minnesota counties lost hospital birth services between 2011 and 2020.

Increases in pre-term births have been associated with the loss of hospital birth services in rural areas.

Note: Due to a merger, the hospital in Mower County was no longer an independent licensed entity as of the end of 2014; however, birth services were offered at that site under the license of the remaining corporate entity. The other hospital of the merger, in Freeborn County, no longer has birth services.

Source: Minnesota Department of Health, Health Economics Program Analysis of hospital annual reports, September 2021; 2020 data is considered preliminary; U.S. Census Bureau (County Designations)

Definition: Community hospitals were categorized as not offering birth services if they did not have at least one routine birth and had no licensed bassinets or stated that services were not available.
Rural residents report more unhealthy days

- Minnesotans living in rural areas reported frequent mental distress at about the same rate (12.4%) as those living in urban areas (10.4%).

- Age-adjusted suicide rate in greater Minnesota (17.3) was higher than the 7-county metro area (12.2) for 2015-19.

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021

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1 Source: Minnesota Health Access Survey, 2019. Urban and Rural defined based on RUCA zip-code approximations. Difference was not statistically significant.

* Indicates significant difference from Urban at the 95% level.

Additional travel to care

- Rural patients seeking inpatient mental health and chemical dependency treatment travel more than three times longer than urban patients.

- Patients receiving medical/surgical care at Critical Access Hospitals experience shorter travel times than those traveling to other types of hospitals.

**Approximate Travel Time (Minutes)**

- Mental Health/Substance Abuse: Critical Access Hospitals 25, Urban ZIP Codes 35, Rural Zip Codes 79, Statewide 85
- Maternity/Neonatal Care: Critical Access Hospitals 17, Urban ZIP Codes 28, Rural Zip Codes 38
- Other Medical-Surgical Care: Critical Access Hospitals 26, Urban ZIP Codes 20, Rural Zip Codes 32, Statewide 60

Source: MDH analysis of Minnesota hospital administrative (discharge) inpatient records for medical-surgical care, obstetrics care, and mental health or chemical dependency care for 2016 to 2019. The analysis calculated the distance between the geographic centroid of each ZIP code to respective hospitals and excluded hospital stays that were transferred to another hospital to avoid duplication. Patients with planned services, such as surgeries, may intentionally travel longer distances. Non-metropolitan ZIP codes are classified as “rural” using RUCA.
Prescription opioid use has declined over time – but is still higher in rural areas.

Some counties in Northern Minnesota have especially high rates of prescriptions.

https://www.health.state.mn.us/data/economics/docs/opioidbrief20185.pdf

Source: MN Dept. of Health; Rural Health Care in Minnesota: Data Highlights; Nov. 18, 2021
Life expectancy by ZIP code in Duluth

Source: St. Louis County Health Status Report, 2010
# County health ranking results

## St. Louis County

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<th>Health Outcomes 2021</th>
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<tr>
<td>Social &amp; Economic Factors</td>
<td>48</td>
</tr>
</tbody>
</table>

*Source: County Health Rankings & Roadmaps 2021*
Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

Jenny Reed, MSW
Senior Vice President, Value-based Care
Baylor Scott & White Health
Accountable Care Organization
Clinically Integrated Network
Longitudinal Care Management with all BSW hospital discharges

- Providers: 8,000+
- Facilities: 700+
- Members: 1 million
- Geography: North and Central Texas

www.bswhealth.com/quality-alliance

Jenny Reed
SVP, Value-based Care, BSWH
Executive Administrator, BSWQA

EXPERIENCE
- 20 years in health care
- 10 years in acute care case management
- 10 years in VBC
Value-based care models incentivize the right results

#1 in savings for MSSP in the U.S. for 2020 & 2021.
- Nearly $300 Million in savings for last three years of CMS reporting.

Comprehensive Care Management reduces PMPM costs
- Average Medicare = $83 PMPM
- Medicare members with major / multiple chronic conditions = $105 PMPM

Reduces unnecessary care
- hospital readmission rate by 12%
- acute hospitalizations by 12%
- preventative care gaps by 21%

Post Acute Care (PAC) utilization 20% below market trend
- 105 PAC providers in the network
- 13,350 admissions to the PAC network in 2022

Skilled Nursing Facility (SNF) length of stay = ~20 days (20% less than market)
- 3,600 patients supported by care management in the SNF Network

BAYLOR SCOTT & WHITE QUALITY ALLIANCE
Panel Discussion 2: Provider Perspectives on Payment Models for Incentivizing Improved Management of Care Transitions

Robert M. Wachter, MD
Professor and Chair, Department of Medicine
University of California, San Francisco (UCSF)
The Impact of Federal Policies on Hospitalist-Related Patient Handoffs

Robert M. Wachter, MD
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University of California, San Francisco (UCSF)
@bob_wachter
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PTAC Meeting: June 12, 2023
Relevant Biography

- Professor and Chair of the Dept. of Medicine, University of California, San Francisco (UCSF), generally ranked as one of the top DOM’s in the nation.
- Coined the term “hospitalist” in a 1996 *New England Journal of Medicine* article, and generally considered the academic father of the hospitalist field.
- Expert in patient safety; recipient of the John M. Eisenberg award, the nation’s top honor in patient safety; author of the world’s most popular patient safety primer, *Understanding Patient Safety*.
- Named most influential physician-executive in the US in 2015 (*Modern Healthcare* magazine); elected member of the National Academy of Medicine; >270,000 followers on Twitter.
Three Ideas for Improving Federal Policies Regarding Hospital Care Transitions

1. **Redefine the “3 Midnight Rule”:** The current requirement that patients need to remain in the hospital for 3 midnights before discharging to a skilled nursing facility (SNF) can lead to unnecessarily prolonged hospital stays. The pandemic-era relaxation of this rule should continue, allowing for more flexible and efficient transitions.

2. **Establish Per Diem Payments for Long-Stay Admissions:** Many patients are unable to leave the hospital because of the absence of a suitable receiving institution (SNF, LTAC). Hospitals should be eligible for per diem payment for long-stay admissions, which will help with the financial sustainability of these hospitals as well as healthcare worker burnout. (Of course, addressing the root causes of long-stay patients must be the ultimate goal.)

3. **Promote Bundled Care Models and Transitional Care:** Bundled care models, particularly for the Medicare population, could promote continuity of care, incentivize longer-term post-acute care management, and provide more opportunities for innovation. Adjustments to the model could include creating a pathway to downside risk, using year-over-year performance as cost targets, and considering a 30-60 day bundle, rather than 90 days. There should also be long-term endorsement of the Hospital at Home model as a crucial (and evidence-based) part of transitional care.