Dartmouth Centers for Health & Aging

Implementing Age Friendly Health Care in New Hampshire

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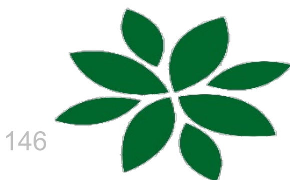
Disclosures

- I have no financial conflicts of interest to disclose

Learning Objective

Describe AFHS implementation through 2 models of care:

1. Geriatric Interprofesional Team Transformation in Primary Care (GITT-PC) and
2. RAFT (Reducing Avoidable Facility Transfers)



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Northern New England GWEP

Northern New England GWEP's training program, Geriatric Interprofessional Team Transformation - Primary Care (GITT-PC), helps primary care teams use their unique skill sets to achieve the quadruple aim:

- Improve patient outcomes
- Enhance patient experience
- Improve staff satisfaction
- Reduce costs, increase revenue, increase relative value units

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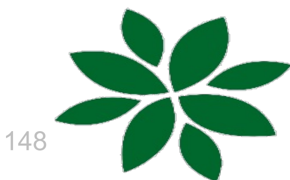
Geriatric Interprofessional Team Transformation – Primary Care (GITT-PC)

- Transform primary care:
  - Teams
  - QI
- Implement 4 Medicare Codes:
  - AWV
  - CCM
  - TCM
  - ACP



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How GITT-PC Does It

- Practice assessment
- Content training and supporting materials
- Teaming Up
- Quality Improvement
- Learning collaborative
- Pre-post measures

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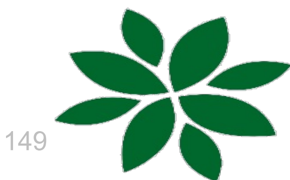

GITT-PC and the 4Ms

GITT-PC helps teams implement the 4Ms of an Age-Friendly Health Systems through the use of four Medicare reimbursable codes:

- Transitional Care Management (TCM)
- Chronic Care Management (CCM)
- Advance Care Planning (ACP)
- Medicare Annual Wellness Visit (AWV)

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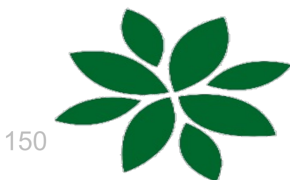

Transitional Care Management

Description	Components	Workforce
• Services during transition to community following particular kinds of discharge • Taking responsibility for the patient's care without a gap • 30-day period TCM Moderate Complexity • **99496** – NFP $235; RVU 3.05 TCM High Complexity • **99495** – NFP $167; RVU 2.11	• Interactive contact within 2 business days • Certain non-face-to-face services ▪ Review discharge ▪ Need follow-up test/treatments ▪ Interact with health care specialists ▪ Educate on self management, independent living, & ADLs ▪ Needed community services ▪ Referral to community providers ▪ Adherence to treatments & medication management • Face-to-face visit within 7-14 days	• Schedulers • Clinical staff • Physician / non-physician practitioner (must bill)

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Chronic Care Management

Description	Components	Workforce
• Monthly care management • For patients with increase risk of death, acute exacerbation, decompensation, or functional decline • Concurrent monthly billing • Part B cost sharing applies CCM • **99490** (20’) – NFP $42 RVU 0.61 • **99491** (30’) – NFP $84; RVU 1.45 Complex CCM • **99487** (60’) – NFP $93; RVU 1.00 • **99489** (add’l 30’) – NFP $46; RVU 0.50	• Initiating visit within 1 year • Patient consent • 2 or more chronic conditions • Comprehensive care plan • Provide 24/7 access to physician / non-physician practitioner • Manage transitions between and among health care providers • At least 20 minutes care management per month	• Clinical staff (can contribute to time) • Physician / non-physician practitioner (must bill)

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

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Advance Care Planning

Description	Components	Workforce
• Voluntary discussion of health care wishes • No limits on number of times you can report • Covered in Medicare Annual Wellness Visit • Outside of Medicare Annual Wellness Visit, Part B cost sharing applies • No place-of-service limitations • **99497** (30’) – NFP $86; RVU 1.50 • **99498** (add’l 30’) – NFP $76; RVU 1.40	• Face-to-face service • Discussion about advance care planning (the type of care the patient gets and where and when they get it) • Discussion about advance directives with/without completion of forms • Discussion with the patient, family member(s), and/or surrogate	• Clinical staff (can contribute to time) • Physician / non-physician practitioner (must bill)

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdfSource: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

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Annual Wellness Visit (AWV)

Description	Components	Workforce
• Medicare Part B • Free yearly visit • Health promotion and disease detection • Not a hands-on exam • Does not address new or existing chronic medical conditions • **G0438** – NFP $174; RVU 2.43 • **G0439** – NFP $118; RVU 1.50	• Health Risk Assessment • Medical & family history • Medication review including high risk and opioid use • Providers & suppliers • Height, weight, Body Mass Index, blood pressure • Cognitive assessment • Depression assessment • Level of safety/falls assessment • Screening schedule • Risk factors • Personalized health advice • Advance care planning	• Schedulers / exit secretaries • Rooming staff • Nursing (can bill incident-to) • Physician / non-physician practitioner

NFP = Non-Facility Price
RVU – Relative Value Units
Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf
Source: https://www.cms.gov/apps/physician-fee-schedule/license-agreement.aspx

Referrals to the Community

Referral to Aging Resource Center ✓Accept ✗Cancel

Class		Internal Ref	Internal Referral	External Referral
Referral	By Provider:	Moran, Daniel S [1278]		
	To Department:	ARC Shared Decision	ARC Shared Decision	
	To Provider:			
	Reason:	Specialty Services	Specialty Services Requested	
	Priority:	Routine	Routine	Urgent
	# of visits:	1		

Service Requested

- ☐ Caregiver Support
- ☐ Dementia/Memory – Support
- ☐ Dementia/Memory – Education
- ☐ Memory Cafe
- ☐ Hoarding Resources
- ☐ Spiritual Care
- ☐ Bereavement
- ☐ Advance Care Planning
- ☒ **Falls Prevention**
- ☐ Parkinson's Resources

Process Inst.: If no progress note charted, please enter Clinical details in comments.

Referral: + Add Comments (F6)

Show Additional Order Details

Next Required ✓Accept ✗Cancel

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“What Matters Most”
RAFT: Reducing Avoidable Facility Transfers

GOAL: Reduce unwanted and unwarranted ED visits and hospitalizations for residents of Skilled Nursing Facilities

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A previous local model at a CCRC

- Small group of like-minded clinicians providing primary and on-call care
- Systematic Goals of Care elicitation/documentation
- Health Center
- Socioeconomically advantaged population
- Significant reduction in ED visits and hospitalization

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SNF residents: The ED and hospital

- ED transfers/hospitalizations are common
- 25-60% are avoidable
- High rates of iatrogenesis
- Stays are more likely to be long and expensive
- Limiting care is challenging despite patient wishes

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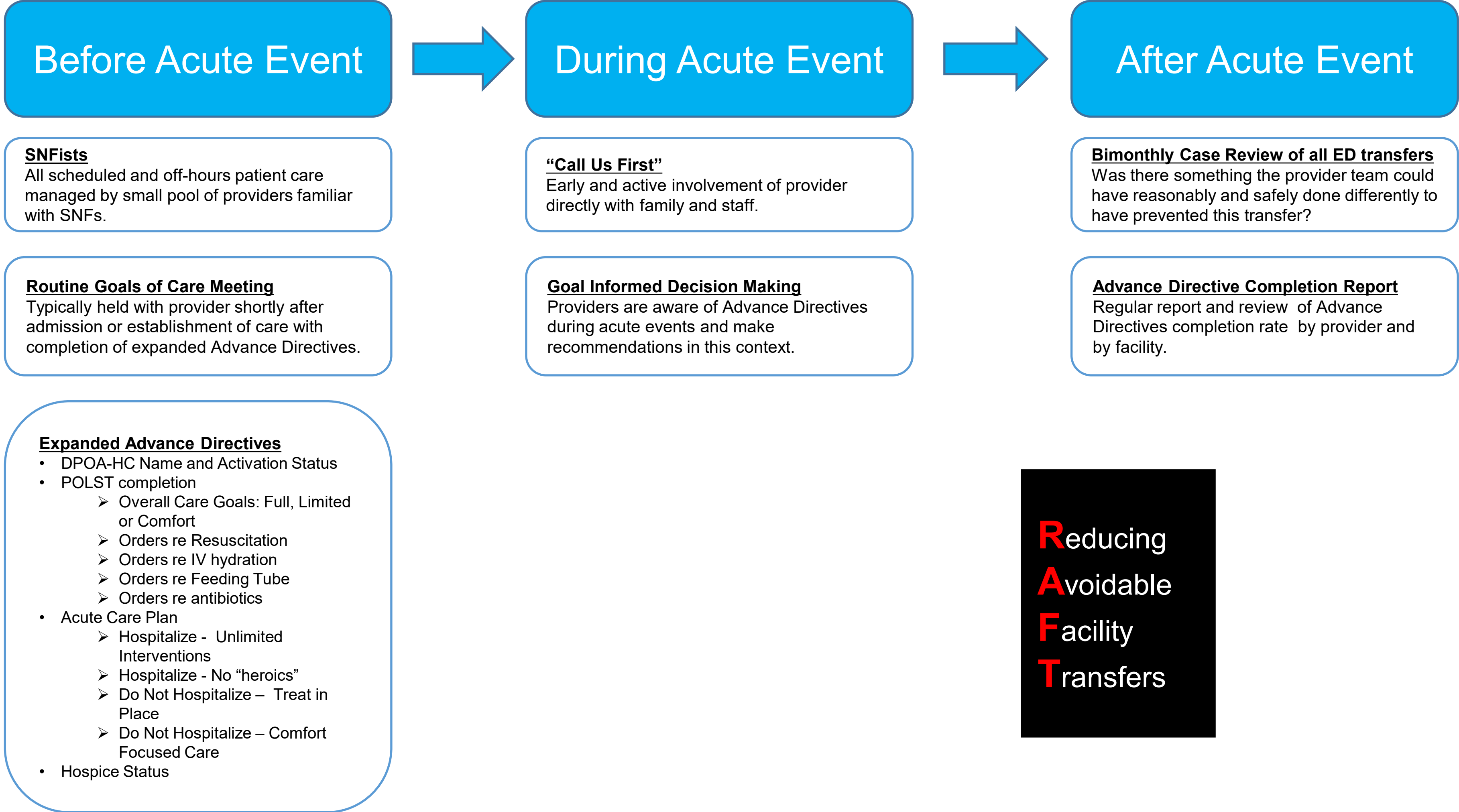
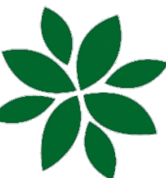

Before Acute Event
During Acute Event
After Acute Event
SNFists
All scheduled and off-hours patient care managed by small pool of providers familiar with SNFs.
"Call Us First"
Early and active involvement of provider directly with family and staff.
Bimonthly Case Review of all ED transfers
Was there something the provider team could have reasonably and safely done differently to have prevented this transfer?
Routine Goals of Care Meeting
Typically held with provider shortly after admission or establishment of care with completion of expanded Advance Directives.
Goal Informed Decision Making
Providers are aware of Advance Directives during acute events and make recommendations in this context.
Advance Directive Completion Report
Regular report and review of Advance Directives completion rate by provider and by facility.
Expanded Advance Directives
DPOA-HC Name and Activation Status
POLST completion
Overall Care Goals: Full, Limited or Comfort
Orders re Resuscitation
Orders re IV hydration
Orders re Feeding Tube
Orders re antibiotics
Acute Care Plan
Hospitalize - Unlimited Interventions
Hospitalize - No "heroics"
Do Not Hospitalize – Treat in Place
Do Not Hospitalize – Comfort Focused Care
Hospice Status
Reducing
Avoidable
Facility
Transfers

Before acute event

<u>"SNFists"</u>
All scheduled and off-hours patient care managed by small pool of providers familiar with SNFs.

<u>Routine Goals of Care meeting</u>
Typically held with provider shortly after admission or establishment of care with completion of expanded Advance Directives.

Reducing
Avoidable
Facility
Transfers

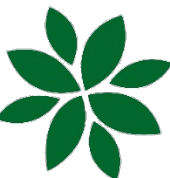


Before acute event

Advance Directives

- ❑ DPOA-HC Name, Contact Info and Activation Status
- ❑ POLST/COLST completion
  - ➢ Overall Care Goals: Full, Limited or Comfort
  - ➢ Orders regarding Resuscitation, Hydration, Feeding Tube, Antibiotics
  - ➢ Hospitalization Preferences
    - o Hospitalize - Unlimited Interventions
    - o Hospitalize - No "heroics"
    - o Do Not Hospitalize – Treat in Place
    - o Do Not Hospitalize – Comfort Focused
- ❑ Hospice Status

Reducing
Avoidable
Facility
Transfers

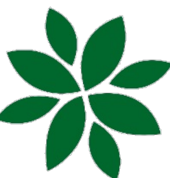


During acute event

"Call Us First"
Early and active involvement of provider directly with family and staff.

Goal Informed Decision Making
Providers are aware of Advance Directives during acute events and make recommendations in this context.

Reducing
Avoidable
Facility
Transfers



After acute event

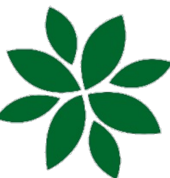
Bimonthly Case Review of all ED transfers

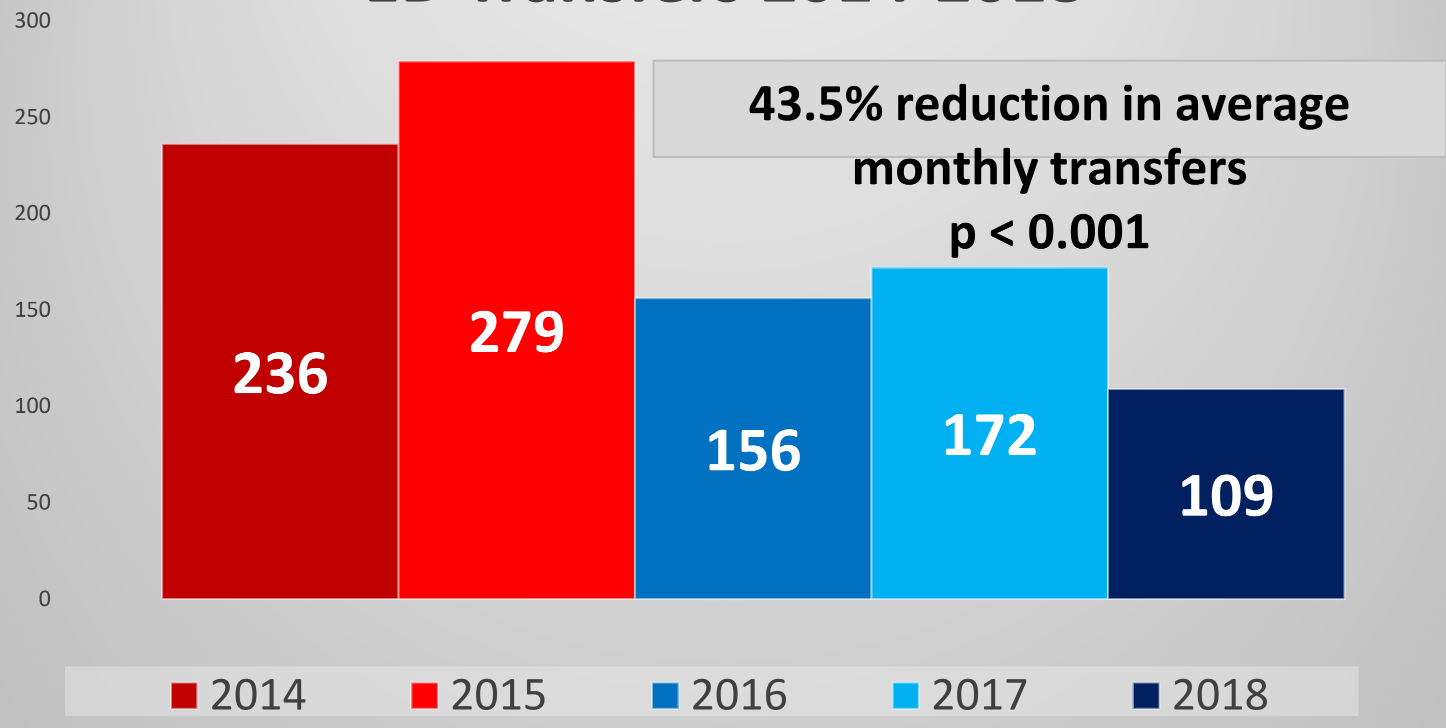
Was there something the provider team could have reasonably and safely done differently to have prevented this transfer?

Advance Directive Completion Report

Regular report and review of Advance Directive completion rate by provider and by facility.

Reducing
Avoidable
Facility
Transfers





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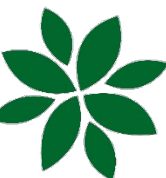

Overall Hospital Charges

$2,000,000
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0

Pre
Post

p<0.01

LTC Hospital Charges

$2,000,000
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0

Pre
Post

p<0.01

PAC Hospital Charges

$2,000,000
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0

Pre
Post

p<0.05

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Summary

- 4M’s together ensure best person centered outcomes
- Implementing models that are tested and sustainable are necessary to ensure 4M care
- 2 Models implemented in NH:
  - GITT-PC
  - RAFT

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