Implementing Age Friendly Health Care in New Hampshire

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Disclosures

• I have no financial conflicts of interest to disclose
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)
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
Geriatric Interprofessional Team Transformation – Primary Care (GITPC-PC)

• Transform primary care:
  – Teams
  – QI

• Implement 4 Medicare Codes:
  – AWV
  – CCM
  – TCM
  – ACP
How GITT-PC Does It

- Practice assessment
- Content training and supporting materials
- Teaming Up
- Quality Improvement
- Learning collaborative
- Pre-post measures
GITPC and the 4Ms

GITPC 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)
## Transitional Care Management

### Description
- 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

### Components
- 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

### Workforce
- Schedulers
- Clinical staff
- Physician / non-physician practitioner (must bill)

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NFP = Non-Facility Price  
RVU = Relative Value Units  

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# Chronic Care Management

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th><strong>Components</strong></th>
<th><strong>Workforce</strong></th>
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</thead>
</table>
| • Monthly care management  
  • For patients with increase risk of death, acute exacerbation, decompensation, or functional decline  
  • Concurrent monthly billing  
  • Part B cost sharing applies | • 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) |

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

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## Advance Care Planning

### Description
- 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

### Components
- 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

### Workforce
- Clinical staff (can contribute to time)
- Physician / non-physician practitioner (must bill)

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# Annual Wellness Visit (AWV)

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

Referral to Aging Resource Center

Class: Internal Referral

By Provider: Moran, Daniel S [1278]

To Department: ARC Shared Decision

To Provider: 

Reason: Specialty Services

Specialty Services Requested

Priority: 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
“What Matters Most”
RAFT: Reducing Avoidable Facility Transfers

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

**SNFists**
All scheduled and off-hours patient care managed by small pool of providers familiar with SNFs.

**Routine Goals of Care Meeting**
Typically held with provider shortly after admission or establishment of care with completion of expanded Advance Directives.

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.

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 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

“SNFists”
All scheduled and off-hours patient care managed by small pool of providers familiar with SNFs.

Routine Goals of Care meeting
Typically held with provider shortly after admission or establishment of care with completion of expanded Advance Directives.
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
    - Hospitalize - Unlimited Interventions
    - Hospitalize - No “heroics”
    - Do Not Hospitalize – Treat in Place
    - Do Not Hospitalize – Comfort Focused
- Hospice Status
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.
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.
ED Transfers 2014-2018

43.5% reduction in average monthly transfers
p < 0.001

2014: 236
2015: 279
2016: 156
2017: 172
2018: 109
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