Illinois Transitional Care Consortium (ITCC) testimony
Wednesday, December 8, 2010

The Illinois Long Term Care Council and the Illinois Coalition on Mental Health & Aging public forum on "The Transformation and Continuum of Long Term Care in Illinois" at the Governor's Conference on Aging

Good Afternoon, my name is Kristen Pavle and I work at Health & Medicine Policy Research Group, a health policy think tank. I am here today to represent the Illinois Transitional Care Consortium (ITCC). ITCC is a diverse group of community-based organizations, hospitals, a university based researcher and a policy/advocacy organization. Our consortium members represent a geographically diverse group of state-wide populations: down-state rural Illinois, the city of Chicago, and suburban Chicago. The elderly population we serve includes Hispanic and African American Illinoisans, the medically underserved, and older adults of all socio-economic groups.

ITCC came together as a coalition over 2 years ago to develop and implement a service model designed to break down the fragmented silos of medical and social service care. More specifically, the ITCC was formed to more effectively address needs of older adults transitioning from the hospital to the community by linking hospital based services with the post-discharge care environment, including community physicians, home health agencies and the aging network.

We are entering an era of an increasingly aged population, longer life-spans and improved medical technology, giving individuals with chronic conditions of all ages greater functionality. People are now living longer but often living sicker, and at least 65 million older adults experience multiple chronic conditions [Boult, Karm & Groves, 2008]. The implications for health care costs are significant. Currently, older adults with more than four chronic conditions, 25% of the Medicare population, are responsible for at least 80% of Medicare spending [Boult et al., 2008].

Widespread consensus exists that our country's health care system is fragmented and care is not coordinated across the many care settings used by individuals. Transitional and coordinated care is a way to mitigate fragmentation and reduce service duplication and costs as patients move through a variety of care settings and interact with numerous health care professionals. Transitional and coordinated care is essential as vulnerable individuals, often with multiple chronic illnesses, navigate an increasingly complex health care system.

Rehospitalization is one outcome of poor transitions between acute care settings and the home and community, and is a great concern to health care providers and the patients for whom they provide care. Older adults experience more than 13 million transitions from hospital to home every year [Summary Proceedings: Transitional Care Leadership Summit, 2006]. Rehospitalization is common, expensive and associated with detrimental health care outcomes after discharge from the hospital [Jencks, Williams & Coleman, 2009]. The cost of rehospitalization places an enormous strain on our health care system. Approximately 1 in 5 Medicare patients return to the hospital within 30 days of discharge, accounting for more

than $17 billion in annual Medicare spending [Jencks et al., 2009]. Other serious consequences of poor transitions and uncoordinated care for older adults include: unnecessary nursing home admissions, caregiver stress and poor health, deteriorating health status, medication errors, redundant diagnostic testing, compliance and continuity of care problems, and increased health care costs. [Naylor et al., 1999; Coleman, Parry, Chalmers & Min, 2006; Summary Proceedings, 2006]. Please note that these figures I cite are Medicare-specific, but what we also know is that the dual eligible population, those utilizing both Medicaid and Medicare, are the most complex and medically needy. Many of these Medicare patients are also covered by Medicaid for health care coverage.

To return to the ITCC: ITCC focuses on the coordination of care during transitions in order to connect the varied silos of post-discharge care, streamline services for the patient and their family, reduce the burden of care on the patient's family and caregivers, and to improve the health outcomes of our older adults thereby lowering hospital readmissions and diverting form nursing home usage. We also recognize that effective care coordination presents an opportunity to reduce overall health care costs.

In response to the statistics cited above, ITCC decided to focus on a specific point in a client's health and social services usage: the discharge home from an inpatient hospital stay. When an older person enters a hospital, it is often a time of crisis and uncertainty for the person and their family. There is a strong body of evidence supporting the use of care coordination, administered early in a hospitalization, to impact whether the older person can safely return home. Once home, it has been demonstrated that care coordination and follow-up can significantly reduce the rate of rehospitalization, improve health outcomes and reduce caregiver stress.

We have developed a model of transitional care called the Bridge model. The Bridge model relies on the leadership of experienced social workers called Bridge Care Coordinators. Bridge Care Coordinators may be employed through a hospital and partnering with a local case coordination unit (CCU); or Bridge Care Coordinators may be employed by a community based organization – a case coordination unit (CCU) – with a dedicated Aging Resource Center space within the hospital intended to improve access community resources and provide a client meeting space. In each Bridge Model implementation, therefore, there is a community-hospital partnership. Within the health care field, it is widely recognized that when hospitalized, people are most receptive – health care professionals are presented with an optimal teachable moment. Our model capitalizes on this opportunity to engage patients and their families in the hospital, assess what their unique needs are prior to discharge, follow up with patients post-discharge to ensure a smooth transition back to the community, and assure that their needs have been adequately addressed.

The existing literature and current research on transitional and coordinated care are dominated by medical models of care primarily staffed by nurses. These evidence-based models of care include: the Care Transitions Intervention (Eric Coleman, M.D.), Transitional Care Model (Mary Naylor, Ph.D.), the Geriatric Resources for Assessment and Care of Elders (GRACE) model (Steven R. Counsell, M.D.), and the Guided Care Model (Chad Boult, M.D.). Such models have shown cost savings through success in either decreasing hospital

readmission rates [Naylor et al., 1999; Coleman et al., 2006; Counsell, Callahan, Tu, Stump & Arling, 2009] or lowering the number of days patients stayed in the hospital or nursing home [Leff et al., 2009].

However, studies suggest that 40% to 50% of hospital readmissions are linked to psychosocial problems and lack of community resources [Proctor, Morrow-Howell, Li & Dore, 2000]. While social work-based models addressing these issues have not been extensively studied [Proctor et al., 2000], the limited research available suggests positive outcomes: A randomized control trial using social workers as case managers in a transitional care intervention for Medicare managed care recipients showed promising results [Alkema, Wilber, Shannon, & Allen, 2007]. Another randomized control trial, of the Enhanced Discharge Planning Program (EDPP) at Rush University Medical Center, provides preliminary evidence for the success of a transitional care model that uses social workers to address the psychosocial needs of individuals in addition to their medical needs [Altfeld et al., 2009]. Further research beyond the medical, physician and nursing models of transitional care is imperative to further explore the best ways to mitigate the myriad factors that lead to rehospitalization, negative patient outcomes and high health care costs.

The Patient Protection and Affordable Care Act (PPACA) – the federal health care reform bill enacted on March 23rd 2010 – has created many opportunities to improve care for people with chronic conditions who often fall between the cracks of institutional-based care and community- and home-based services. The opportunities presented through PPACA funding of demonstration projects allow states to become innovators in testing transitional and coordinated care models in a variety of settings and with various populations.

Through the Affordable Care Act, the Administration on Aging announced the opportunity to apply for grant funding through an Aging and Disability Resource Center (ADRC) project. The Aging and Disability Resource Center model focuses on streamlining access, resources and referral to aging and disability services through a single point of entry. One of the funding announcements focused specifically on transitions in care. ITCC worked closely with the Illinois Department on Aging and the suburban cook county Area Agency on Aging — AgeOptions — to apply for this grant. Illinois was one of only 16 states to be awarded an ADRC Care Transitions grant, and the only one to use social workers to lead the care coordination role. This funding enables Illinois to expand the ITCC's Bridge Program to the planning and service area of suburban Chicago and to individuals with disabilities within this service area.

I am here today to share this triumph for Illinois, the securing of federal dollars through the Affordable Care Act to better serve our older adults and persons with disabilities. I am also here to emphasize the importance of care coordination, especially as people transition from one setting to another. We need to develop models that can operate across settings, address the barriers that impede successful transitions and identify the services that enable people in the community to survive and thrive. In addition, we need to develop models of coordinated and transitional care the bend the cost curve, slowing down the rate of increasing health care costs. With the state addressing court mandates to deinstitutionalize

people, effective care coordination models will become increasingly necessary as people transition out of institutions.

The Affordable Care Act has several other provisions that address care coordination and transitions in care. These include the Community Based Care Transitions Program, a grant funded project that rewards hospitals and community partners for using transitional care programs when individuals leave a hospital setting. There are also demonstration projects requiring an episode of care to be bundled into one payment: from just prior to hospitalization through the hospital experience and subsequent discharge. All of these initiatives require interdisciplinary team work, a patient-centered approach, and ultimately an underlying focus on coordinating the care for the patient's sake. The ultimate goal is to improve quality of care, and also to contain costs.

If we are to succeed in enabling people to live in the community for as long as possible, a critical piece to the puzzle is the effective coordination of care that can work across systems. The Illinois Transitional Care Consortium is committed to working with the state to capitalize on opportunities within the Affordable Care Act in order to enhance the ability of the Aging Network to develop and provide effective transitional and coordinated care. We recognize that states need guidance to translate federal policy into state/community-level applications, and are already active on this front. Current and future activities include collaboration with aging, disabilities and mental health advocates, medical and health establishments, state agencies, and Illinois citizens. We strongly believe that Illinois can be a leader in the field of transitional and coordinated, and look forward to working with all of you here today.

Thank you.

Please Contact Kristen Pavle, kpavle@hmprg.org, for more information on ITCC or any of the related points made in this testimony.

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The following is a transcript of the Q & A period that followed the testimony.

Question: Regarding the Medication Advisory Committee, how much discretion does the State have to deviate from what the law requires?

Answer: A five year look back (at transfers of assets) would be required, but perhaps this should not be retroactive. It is unfair to have this imposed now, on transfers that occurred some time ago, and were permitted at that time. Our position is that the rules should start with a clean slate on that issue.

Question: This rulemaking by the Department must go to JCAR (Joint Committee on Administrative Rules) – what is the precise schedule for that? What is the window for advocates to influence the rules? Could advocates go online to look for addresses for JCAR members? Finally, will the membership of JCAR change in January?

Answer: You can still contact the Department of Family and Healthcare Services and try to influence the revision of the rules; after the public comment period closes, then you could contact JCAR directly, probably after the holidays. It is possible the membership of JCAR could change in January with the new General Assembly being seated.