Chronic Care Management, LLC

Member of American Academy of Home Care Medicine

To Whom It May Concern,

Chronic Care Management, LLC is a locally owned & operated business. We are Licensed Practitioners, Nurses, and Social Workers that **assist in the medical management** of chronically ill patients.

This is a **practitioner-based company** (different from home care) that works **in conjunction with all home care, hospice or care facilities.** We modified the role of the "old-fashioned visiting physician", to accommodate the changing needs in healthcare. Our Practitioners **reduce hospital readmission rates and help decrease the cost of healthcare, along with providing PCP office relief from complex chronic care patients.**

Our Specialties Include:

*Care Coordination
*Chronic Illness
*Life Limiting Diseases
*Transitional Care
*Medication Monitoring
*Symptom Management
*Palliative Care & Hospice Qualification
*Education
*Counseling with a focus on Grief & Loss
*Decision-Making
*Patient Advocacy
*Prevention of Readmission

Our goal is to improve your patients **Quality of Life**, while upholding the importance of the Patient Centered Medical Home, and respecting the patient-provider/patient-physician relationship.

Referrals to Chronic Care Management, LLC are gladly accepted. We also provide hospital palliative care rounds, assisted-living facility care & nursing home visits, as needed, to allow a **smooth and safe transition to home while improving care coordination**. Our patients love the one-on-one, value driven, professional care and our attention to detail. Once a shared patient, they will return to you with positive remarks, and a personal thank you for the referral, because you were able to acknowledge their need for an improved quality of life.

Thank you for your time and consideration. We look forward to assisting you with your patients care and **providing fast and valuable feedback.**

Insurance is accepted! No additional costs, and deductibles and co-pays may apply.

Signed,

Julie Hartl MSN, FNP-C
President/Owner

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Like Us on Facebook!
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Website www.Chronic-Care.Net

(http://getpalliativecare.org)

For Clinicians

Is your patient appropriate for a palliative care referral? A palliative care consultation will assist you in managing complex pain, symptoms, comorbidities, patient/family communication and other issues. Palliative care teams will also save you time.

The following criteria have been developed to help you assess whether a palliative care consultation would be beneficial to you and your patient.

General Referral Criteria (one or more of the following):

Presence of a Serious, Chronic Illness

- Declining ability to complete activities of daily living
- Weight loss
- Multiple hospitalizations
- Difficult to control physical or emotional symptoms related to serious medical illness
- Patient, family or physician uncertainty regarding prognosis
- Patient, family or physician uncertainty regarding goals of care
- Patient or family requests for futile care
- DNR order conflicts
- Use of tube feeding or TPN in cognitively impaired or seriously ill patients
- Limited social support and a serious illness (e.g., homeless, chronic mental illness)
- Patient, family or physician request for information regarding hospice appropriateness
- Patient or family psychological or spiritual distress

Intensive Care Unit Criteria

- Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., dementia)
- Two or more ICU admissions within the same hospitalization

- Prolonged or difficult ventilator withdrawal
- Multi-organ failure
- Consideration of ventilator withdrawal with expected death
- Metastatic cancer
- Anoxic encephalopathy
- Consideration of patient transfer to a long-term ventilator facility
- Family distress impairing surrogate decision making

Oncology Criteria

- Metastatic or locally advanced cancer progressing despite systemic treatments with or without weight loss and functional decline;
    - Karnofsky < 50 or ECOG > 3
    - Progressive brain metastases following radiation
    - New spinal cord compression or neoplastic meningitis
    - Malignant hypercalcemia
    - Progressive pleural/peritoneal or pericardial effusions
    - Failure of first – or second-line chemotherapy
    - Multiple painful bone metastases
    - Consideration of interventional pain management procedures
    - Severe prolonged pancytopenia in the setting of an untreatable hematological problem (e.g., relapsed leukemia)

Emergency Department Criteria

- Multiple recent prior hospitalizations with same symptoms/problems
- Long-term-care patient with Do Not Resuscitate (DNR) and/or Comfort Care (CC) orders
- Patient previously enrolled in a home or residential hospice program
- Patient/caregiver/physician desires hospice but has not been referred
- Consideration of ICU admission and or mechanical ventilation in a patient

- with metastatic cancer and declining function
- with moderate to severe dementia
- with one or more chronic diseases and poor functional status at baseline

Additional resources on palliative care:

For information on the development of palliative care teams, visit the Center to Advance Palliative Care at www.capc.org (http://capc.org).

For the National Consensus Project (NCP) Guidelines, go to www.nationalconsensusproject.org (http://www.nationalconsensusproject.org).

For the National Quality Forum (NQF), National Framework and Preferred Practices for Palliative and Hospice Care Quality, go to www.qualityforum.org (http://www.qualityforum.org).

CMS.gov
Centers for Medicare & Medicaid Services

Readmissions Reduction Program

Background

Section 3025 of the Affordable Care Act added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions, effective for discharges beginning on October 1, 2012. The regulations that implement this provision are in subpart I of 42 CFR part 412 (§412.150 through §412.154).

News on the Hospital Readmissions Reductions Program

CMS has posted the FY 2015 IPPS/LTCH PPS final rule. In the FY 2015 IPPS Final Rule, CMS has made refinements to the readmissions measures. CMS is finalizing to include two additional readmissions measures, COPD and THA/TKA in the calculation of a hospital's readmissions payment adjustment factor. For more information on these payment-related policies, please refer to the FY 2015 IPPS Final Rule in the Downloads section below.

Readmission Measures

In the FY 2012 IPPS final rule, CMS finalized the following policies with regard to the readmission measures under the Hospital Readmissions Reduction Program:

- Defined readmission as an admission to a subsection(d) hospital within 30 days of a discharge from the same or another subsection(d) hospital;
- Adopted readmission measures for the applicable conditions of Acute Myocardial Infarction (AMI), Heart Failure (HF) and Pneumonia (PN);
- Established a methodology to calculate the excess readmission ratio for each applicable condition, which is used, in part, to calculate the readmission payment adjustment. . A hospital's excess readmission ratio for AMI, HF and PN is a measure of a hospital's readmission performance compared to the national average for the hospital's set of patients with that applicable condition.
- Established a policy of using the risk adjustment methodology endorsed by the National Quality Forum (NQF) for the readmissions measures for AMI, HF and PN to calculate the excess readmission ratios, which includes adjustment for factors that are clinically relevant including patient demographic characteristics, comorbidities, and patient frailty.
- Established an applicable period of three years of discharge data and the use of a minimum of 25 cases to calculate a hospital's excess readmission ratio of each applicable condition.

In the FY 2014 IPPS final rule, CMS adopted the application of an algorithm to account for planned readmissions to the readmissions measures for AMI, HF and PN. In addition, CMS finalized the expansion of the applicable conditions for FY 2015 to include: (1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD); and (2) patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA). For more information on these readmission measure-related policies, please refer to the FY 2014 IPPS Final Rule in the Downloads section below.

Payment Adjustment

In the FY 2013 IPPS final rule, CMS finalized the following policies with regard to the payment adjustment under the Hospital Readmissions Reduction Program:

- Which hospitals are subject to the Hospital Readmissions Reduction Program;
- The methodology to calculate the hospital readmission payment adjustment factor;
- What portion of the IPPS payment is used to calculate the readmission payment adjustment amount; and
- A process for hospitals to review their readmission information and submit corrections to the information before the readmission rates are to be made public.

For more information on these payment-related policies, please refer to the FY 2013 IPPS Final Rule in the Downloads section below.

Formulas to Calculate the Readmission Adjustment Factor

Excess readmission ratio = risk-adjusted predicted readmissions/risk-adjusted expected readmissions

Aggregate payments for excess readmissions = [sum of base operating DRG payments for AMI x (excess readmission ratio for AMI-1)] + [sum of base operating DRG payments for HF x (excess readmission ratio for HF-1)] + [sum of base operating DRG payments for PN x (excess readmission ratio for PN-1)] + [sum of base operating DRG payments for COPD x (excess readmission ratio for COPD-1)] + [sum of base operating payments for THA/TKA x (excess readmission ratio for THA/TKA -1)]

*Note. if a hospital's excess readmission ratio for a condition is less than/equal to 1, then there are no aggregate payments for excess readmissions for that condition included in this calculation.

Aggregate payments for all discharges = sum of base operating DRG payments for all discharges

Ratio = 1 - (Aggregate payments for excess readmissions/ Aggregate payments for all discharges)

Readmissions Adjustment Factor =

- For FY 2013, the higher of the Ratio or 0.99 (1% reduction);
- For FY 2014, the higher of the Ratio or 0.98 (2% reduction).
- For FY 2015, the higher of the Ratio or 0.97 (3% reduction).

Formulas to Compute the Readmission Payment Adjustment Amount

Wage-adjusted DRG operating amount* = DRG weight x [(labor share x wage index) + (non-labor share x cola, if applicable)]

*Note. If the case is subject to the transfer policy, then this amount includes an applicable payment adjustment for transfers under § 412.4(f).

Base Operating DRG Payment Amount = Wage-adjusted DRG operating amount + new technology payment, if applicable.

Readmissions Payment Adjustment Amount = [Base operating DRG payment amount x readmissions adjustment factor] - base operating DRG payment amount.

*The readmissions adjustment factor is always less than 1.0000, therefore, the readmissions payment adjustment amount will always be a negative amount (i.e., a payment reduction).

For additional information on the readmission measures, please refer to the **Related Links** section below.

Downloads

FY 2013 IPPS Final Rule: Hospital Readmissions Reduction Program Supplemental Data File (updated March 2013) [ZIP, 885KB]

FY 2014 IPPS Proposed Rule: Hospital Readmissions Reduction Program Supplemental Data File [ZIP, 365KB]

Hospital Readmissions Reduction Program Supplemental Data File FY 2014– updated September 2013 [ZIP, 2MB]

FY 2015 IPPS Proposed Rule: Hospital Readmissions Reduction Program Supplemental Data File [ZIP, 8MB]

FY 2015 IPPS Hospital Readmissions Reduction Program Supplemental Data File (Final Rule and Correction Notice) [ZIP, 8MB]

Related Links

FY 2013 IPPS Final Rule Home Page

FY 2014 IPPS Proposed Rule Home Page

FY 2014 IPPS Final Rule Home Page

FY 2015 IPPS Proposed Rule Home Page

FY 2015 IPPS Final Rule Home Page

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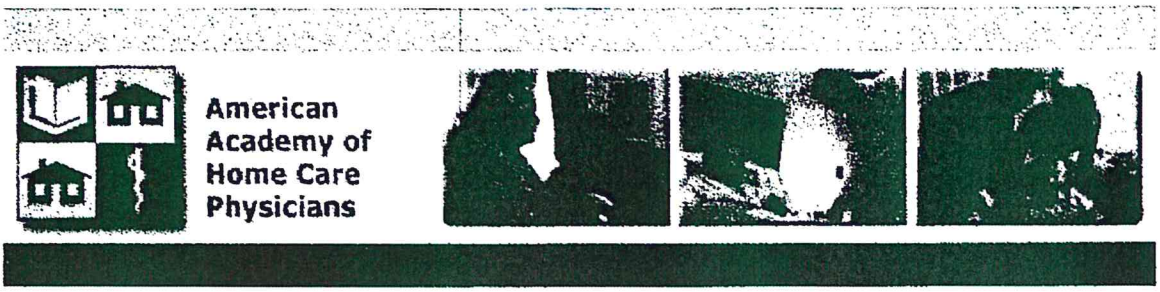

A Policy Brief from the American Academy of Home Care Physicians

Your Readmissions Reduction Program: Is Medical House Call Transitional Care The Missing Link?

You know your hospital statistics. Are you higher or lower than the 20% national average? You know your objectives in relationship to the Medicare financial penalty due to start in 2013.

You know that the factors associated with readmissions include the presence of two or more chronic conditions, patient (and physician) confusion about what medications to take at home, ineffective patient and caregiver education, lack of communication between the hospital and ambulatory care settings, lack of timely post-acute follow-up with primary care providers, poor or absent support system and home, lack of transportation, poverty and psychiatric illness.

You may have tried a variety of programs, sometimes at considerable hospital expense. Perhaps you have redesigned inpatient processes to improve the discharge process, or adopted a formal care transition program following the Eric Coleman model. However, despite the fact that you know that there is no one predictive model for hospital readmission, you do know that these programs have not been successful with the sickest, most vulnerable elderly patients. These patients are "frequent flyers" in your ER, with readmissions numbering three or more in any given year.

These patients often "fail" traditional programs. Access to physician office care is too difficult and cognitive impairment prevents education and compliance. Their family caregivers do not know who and when to call as the first change of condition occurs, so they call 911 and the cycle starts again. To care for these patients, you need to consider adding the missing element: co-management with a medical house call provider on a transitional basis, with an option of permanent care.

While physician, NP and PA practices and teams do not exist in all communities, they can be found in many communities in private practice, or as salaried parts of integrated health systems and academic medical centers. Importantly, these providers can not only take care of beneficiaries in the community as they do today, they can also become a vital part of your readmissions strategy. The results from existing programs show significant results ranging from 6 percent to as much as 95% reduction in readmissions.

Best of all, these programs can be flexibly tailored to meet the needs of the hospital. Medical house call providers can lead your entire multi-part readmission program connecting all the dots, or take care only of a targeted group of patients.

And, if private practice provider teams are used, the direct cost to the hospital may be relatively low, depending on the scope of service desired. Also, managed care may cover some or all of the incremental costs. Secondary benefits such as reduction in length of stay and hospital associated complications are not uncommon. In fact, you may be able to facilitate contracts with managed care or grants from CMS that could completely fund the required support. For more information, go to www.aahcp.org or call Constance Row, Executive Director at 410-676-7966. The attachment gives examples of existing programs.

Sample Readmissions Reduction Programs Using Medical House Calls to Provide In-home Primary Care

1. Kevin Jackson, MD. Private Practice, Phoenix, Arizona

In his IPC managed care program, Dr. Jackson's team of house call providers provides 24 hour response time for patients who will not last a weekend without being readmitted. The results—readmissions for his program are about half that of the hospital average—7.5% versus 14%. He is paid a negotiated rate by managed care for these services.

2. David Jones, MD. Private Practice, Palo Alto, California

Dr. Jones is part of a grant-supported transitional care program providing service to a community hospital in which the patients are seen by a physician prior to discharge, within 48 hours of discharge, and then in a transitional care program usually lasting 30 days after discharge. Permission to enroll patients prior to enrollment is obtained from primary care providers, and care is transitioned back to these providers when appropriate. His program has reduced readmissions for this group of the sickest patients to 14% on a 30-day basis.

3. Ina Li, MD Christiana Health Care System, Integrated Health Care System, Wilmington, Delaware

Dr. Li operates both a House Calls program and a program called Bridge aimed at bridging the gap for the frail elderly during transitions of care. The Bridge program is designed to improve transitions of care for geriatric patients who have been hospitalized three or more times in the past year. An intensive nurse practitioner home visit is provided within 24-48 hours post discharge with follow-up visits until the patient can safely be discharged back to the primary care provider or incorporated into the house call program. A social work referral is also provided if needed. After enrollment in the program, Bridge patients decreased their number of ED visits by more than 50%, and readmissions were reduced to 50% lower than a matched comparison group. Also, median LOS was one day lower for the Bridge group than the non-Bridge comparison group. Like other house calls programs, the longitudinal house calls program also shows a marked impact on readmissions. Thirty-day ED visits and inpatient admissions were reduced by 26% and 34% respectively. Reduction in LOS was also noted.

4. Yale Sage, President, American Physician House Calls, Transitional Care Program Dallas, Texas

Mr. Sage's medical house call company provides a transitional care program is currently serving 11 hospitals in the Dallas/Fort Worth area, serving principally the low-income, dual eligible population reflecting an average age of 76, with four chronic conditions, two co-morbidities, and difficulties with ADL's. In this 60-day program, patients are referred at discharge, admitted to the practice, and a physician conducts an initial assessment within 24 hours. A combination of clinical care and case management is provided, including coordination of needed social service supports. Payment is through capitation with several insurers. Two outcome studies have been conducted. In the first, a 65% reduction in readmissions was recorded; in the second, a 95% reduction was recorded.

5. Mike Tudeen, President, INSPIRIS, Managed Care, Brentwood, Tennessee

Mr. Tudeen's company, INSPIRIS, is part of United Health Care. One division provides a house call program called Transitions which bridges the gaps in care between the acute facility, skilled facility, and home. The impact on readmissions has been marked. Whereas, the average Medicare Advantage plan reflects a 21% readmission rate, patients in the INSPIRIS Transition Program reflect a 13.9% readmission rate.

6. Peter A. Boling, MD, Virginia Commonwealth University, Academic Medical Center, Richmond, VA

Dr. Boling's academic medical center has the longest experience—25 years—of any of the programs, operating a house calls program and a Mary Naylor-model Transitional Care Program. The house calls program is comprehensive, offering medical as well as social service support with a home-based primary care team offering a continuum of care including office, inpatient consults, house calls, transitional care, nursing home and PACE, all subsidized by the medical center. Their house calls program reduces readmissions rates by about half of the hospital rate. It reduces hospital LOS by 2.5 days. They find that many Transitional Care patients need house calls as more than 50% cannot go back to clinic based care. Thus, they believe that medical house call programs are essential for the sickest 3-5% of patients which represent 30% of insurer's costs, and that such programs reduce readmission rates by half.

7. Theresa Soriano, MD, Mount Sinai, Academic Medical Center, New York, NY

Dr. Soriano's medical center operates a variety of readmissions reductions programs, and Dr. Soriano has recently been asked to bring her medical house call expertise to optimize the Preventable Admissions Care Team (PACT) clinic, an NP and SW primary care clinic which includes home visits as needed to provide intensive primary care to the health system's highest risk patients. This program, in addition to the large house calls program (Visiting Doctors), serve as major components of multiple programs being leveraged to strengthen the overall quality and utilization statistics for patients of the medical center which has applied for ACO status. Mount Sinai's PACT program has reduced readmissions by 43% and emergency department visits by 70% for the patients served. And patients receiving home-based primary care through the Visiting Doctors program are admitted half as often after enrollment as compared to prior to Visiting Doctors program enrollment.