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June 8, 2015

Reference: Medicare Chronic Care

Dear Senator Warner:

This letter is in response to your request for input regarding improvements for Medicare patients requiring chronic care. Over the last three years Bay Aging has participated in a CMS pilot program providing hospital-to-home coaching to Medicare patients with identified multiple chronic illnesses to prevent 30-day readmissions. We believe our nationally recognized award winning program has proven that it may be the perfect model around which chronic care legislation could be formulated.

Our Eastern Virginia Care Transitions Partnership (EVCTP) is a CMS-recognized collaborative of 5 Area Agencies on Aging (AAAs), 5 health systems and 11 hospitals, and 69 skilled nursing facilities for the purpose of reducing unnecessary Medicare readmissions utilizing nationally recognized, evidence-based Care Transitions Intervention© (CTI). Covering 20% of Virginia from Fredericksburg to the Hampton Roads Tunnel and on to the Eastern Shore, EVCTP successfully presents a unique mix of rural and urban populations.

At a time when the nation is experiencing burgeoning growth of Medicare beneficiaries and high healthcare costs, EVCTP's Care Transitions Intervention has effectively reduced the 2013 baseline readmission rate of 23.4% for the target group to an average of 7.9% while lowering healthcare costs for Medicare beneficiaries with chronic illnesses. These results vastly exceed CMS's goals and we are proud to now be recognized by CMS as one of their top performing pilot programs in the United States.

Under this pilot Bay Aging as a Community Based Organization and AAA contracts with CMS for reimbursements. We believe over time we can shift much of the cost of this program from CMS to the private sector because this one-stop-shop coordinated referral, billing and reimbursement approach is attractive to Managed Care Organizations as it simplifies their administrative processes in dealing with multiple service providers. EVCTP successfully negotiated reimbursement as a partner within a bundled payment plan, subcontracts with Virginia's MCOs and is entering into contracts with ACOs.

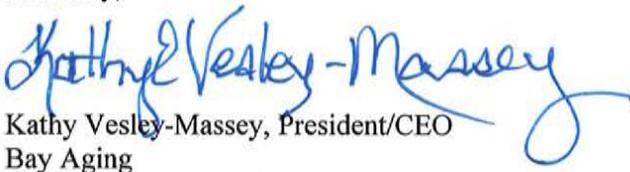
Based on the combination of big results at a comparatively low cost Virginia's Secretary of Health Bill Hazel is exploring having Bay Aging expand this program state wide. Equally exciting for you is that this model can be scaled and replicated as a national program. Further, the success of the EVCTP program is leading to other innovations that are also of interest to you and Senator Isakson – using telehealth and remote monitoring technology, reducing emergency department and hospital admissions visits, and utilizing chronic disease self-management and behavioral health support programs.

We are confident our program has proven it can effectively address your stated goals:

- Improvements to Medicare Advantage patients living with multiple chronic conditions
- Proven CMS pilot reforming Medicare's fee-for-service program that has evidenced the benefits of coordinating providers to improve the health of patients with chronic conditions
- Proven strategy to increase chronic care coordination in rural areas
- Use of care coordination teams to offer Medicare patients the tools they need to meaningfully engage with their health care providers
- Effectively utilize primary care providers in order to meet the goals of maximizing health care outcomes for Medicare patients living with chronic conditions

We applaud your efforts to seek ways of strengthening care coordination to effectively provide quality chronic care. We would like the opportunity to meet with you to review our successful program in hopes that this might serve as a platform for common sense innovations to improve the health of the chronically ill at a lower cost to our government.

Sincerely,

  
Kathy Vesley-Massey, President/CEO  
Bay Aging

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cc: James N. Carter, Jr., Chairman, Bay Aging Board of Directors



## Summary Overview of Eastern Virginia Care Transitions Partnership: One Solution to Reducing Medicare Healthcare Costs and Improving Healthy Aging

- Eastern Virginia Care Transitions Partnership (EVCTP), a Center for Medicare and Medicaid Services (CMS) reimbursement project operating since 2013.
- CMS recognized collaborative of 5 AAAs, 5 health systems, 11 hospitals, 69 skilled nursing facilities.
- Covers 20% of Virginia – Fredericksburg, Middle Peninsula, Northern Neck, Peninsula, Hampton Roads and the Eastern Shore – a unique mix of rural and urban.
- Provides transition of care to chronically ill Medicare eligible individuals as they leave treatment in a hospital or nursing facility and return home.
- Purpose is to focus on patients and caregivers with multiple chronic illnesses to avoid costly and unnecessary returns to the hospital for additional treatment by reducing all-cause readmissions by 20%, producing millions of dollars in savings.
- Use evidence-based Dr. Eric Coleman's Care Transitions Intervention© (CTI) 4 Pillars to engage patients and families in skill transfer so that they are better prepared and more confident to take charge of their own health management.
- 4 Pillars: Learn Medication Management, Follow-Up with Physicians and Specialists, Recognize Red Flags that Condition is Getting Worse, Maintain a Medical Journal.
- EVCTP documents great cost savings to Medicare, hospitals and skilled nursing facilities; greatly improved quality of life for discharged patients with multiple chronic illnesses.
- AAAs blend an extensive portfolio of services for long-term care services and community supports with pre- and post-acute care and prevention activities that includes the social model of evidence-based intervention.
- AAAs also provides supportive services that include transportation, home delivered meals, emergency medication purchase assistance and connections to other home and community programs.
- EVCTP currently visits over 900 discharged patients per month whose primary diagnoses indicate high potential for 30-day readmission.
- EVCTP 2010 baseline readmission rate of 18.2% effectively reduced to 14.8% since the program initiated in early 2013.
- The baseline readmission rate of 23.4% for the target group now averages 7.9%.
- EVCTP continues to demonstrate a positive trend toward further readmission rate reductions that will result in lower healthcare costs.
- EVCTP is a nationally recognized leader in successful Care Transitions Interventions.
- The Virginia Center for Health Innovations tasked EVCTP with taking this effective model statewide by 2016.
- In addition to Care Transitions Intervention Coaching infused with community supports, Virginia leaders will demonstrate that by providing chronic disease management education, advance care planning, streamlining care coordination and other evidence-based prevention programs, Virginians will receive quality health care outcomes with lower healthcare costs.
- EVCTP's Care Transitions Intervention is one of the most successful programs in the nation and needs to have a place in the chronic care legislation.

## EVCTP PROJECT DATA

	Jan 2014 - Dec 2014	Jan 2015 - Mar 2015
Number of Clients Enrolled	9,484	2,403
2010 Baseline All-Cause Readmission Rate	18.2%	18.2%
All-Cause Readmission Rate*	14.8%	14.8%
Readmission Rate Among CCTP Enrollees**	7.8%	7.9%
# of Readmissions Avoided	1,037	282
Savings Per Avoided Readmission	\$9,600	\$9,600
Estimated Avoided Readmission Savings	\$9,952,589	\$2,704,224

\*Numbers are hospital reported and have not been confirmed by CMS.

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