

Protecting the Vulnerable from Harm: Care Across Transitions

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Some signposts....

- Care Transitions
 - From one setting or system of care to another
- Avoidable Readmissions
 - Readmission within 30, 90, 180 days of hospitalization
- Three Part Aim
 - Better Care, Better Health, Lower Cost
- Seamless Care
 - The patient's view

What's the problem?

Patients tell us:

- Inadequately prepared
- Conflicting advice
- Unable to reach the right person – or don't know who to reach out to
- Completing tasks undone
 - “I wonder why they did this...?”
 - “I wonder why they didn't do that...?”

Eric Coleman, MD

What's the problem?

- Hospitalizations account for about 33% of Medicare expenditures.
- About 1 Medicare patient in 5 is readmitted within 30 days of discharge. 1 in 3 within 90 days.
- Estimated 75% of readmissions are potentially preventable
- Avoidable Readmissions as a marker for a failure in transition of care.

What else do we know?

- Only half of patients readmitted within 30 days had a physician visit before readmission
- 19% of Medicare discharges are followed by an adverse event within 30 days.
 - 2/3 of these are adverse drug events
- There is a correlation between potentially avoidable **admissions** and potentially avoidable **readmissions**

AHRQ / HRET: Reducing Avoidable Hospital Readmissions

www.ahrq.gov/news/kt/red/readmissionslides/readslides-contents.htm

The Broader Context

- Unsustainable health care costs
- Hospital Acquired Conditions and Preventable Readmissions as “low-hanging fruit”
 - Reduce costs through improved quality
- A decade’s serious work in identifying the causes of readmission and testing strategies to improve transitions in care and reduce readmissions
- CMS focus on the Three Part Aim
 - Movement from optimization of care and cost within a setting to optimization of care and cost across settings.

Let's bring this home.....

How much are we spending in
Contract Health Services for
potentially avoidable readmission
and admissions?

Let's think together...

What causes failures in
transition?

Thinking about failures in transition (1)

- Poor transfer of information to patient and family
 - Medications
 - Warning Signs
- Poor transfer of information to ambulatory caregivers
 - Hospital to NH
 - Hospital to primary care provider
 - Lack of clarity on end of life care preferences
- Lack of timely post discharge visit
 - Primary care unaware of hospitalization
 - Patient without transportation
 - No primary care provider
- Lack of medication reconciliation

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Thinking about failures in transition (2)

- Lack of engagement or activation of patients and families into effective post-acute self management,
- Lack of standard and known processes among providers for transferring patients and medical responsibility, and
- Ineffective or unreliable sharing of relevant clinical information.

Root Cause Analysis View of Failed Transitions in Care from QIO
9th SOW Care Transitions Quality Improvement Organization
Support Center www.cfmc.org/caretransitions/

A Conceptual Roadmap

- Transition from hospital to home
 - Enhanced assessment
 - Teaching and learning
 - Real time “hand-off” and communication
 - Follow-up care arranged
- Activated Post-acute care
 - Follow-up in primary care
 - Information gathered in primary care
 - Home health care as needed
 - Social Services as needed
 - Hospice or palliative care
- Supplemental care for high risk patients
 - Transitional Care models
 - Intensive care management

Some ideas...

- The Care Transitions Program (Coleman)
 - www.caretransitions.org/
- Transitional Care Model (Naylor)
- Guided Care
 - www.guidedcare.org/index.asp
- Evercare
- Community Care North Carolina (CCNC)
- IHI Ideal Transition Framework (STARR)

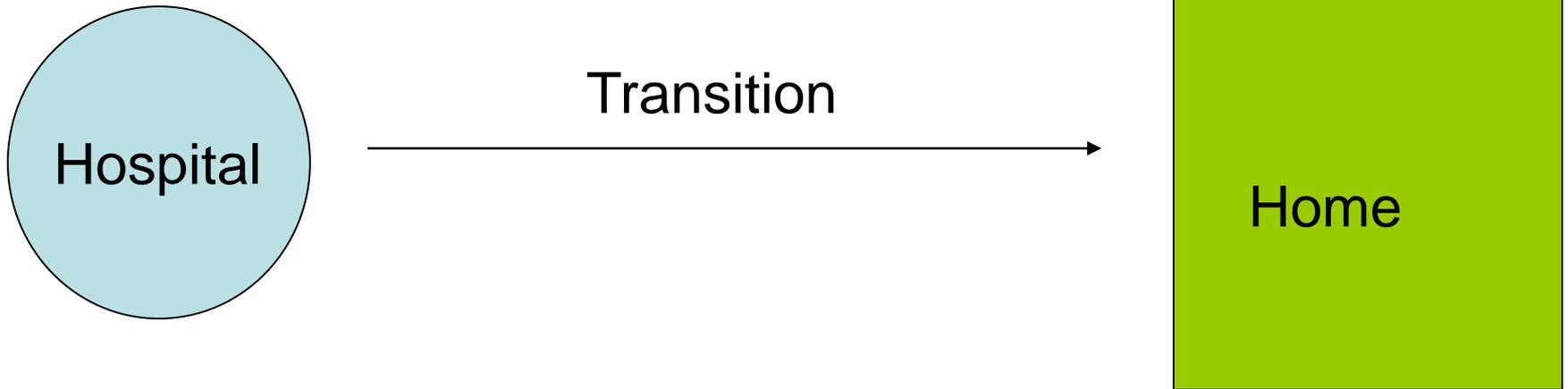
Care Transitions “Coleman”

- Transition Coach (NP or RN)
 - Home visit w/in 72 hours of discharge
 - F/up phone calls days 2, 7, 14
 - Helps patient complete structured “personal health record”, med reconciliation, care plan.
 - Self-management support, goal setting
- Four Pillars
 - Medication self-management
 - Patient-centered record
 - F/up with primary care physician
 - Knowledge of “red flags” or warning signs

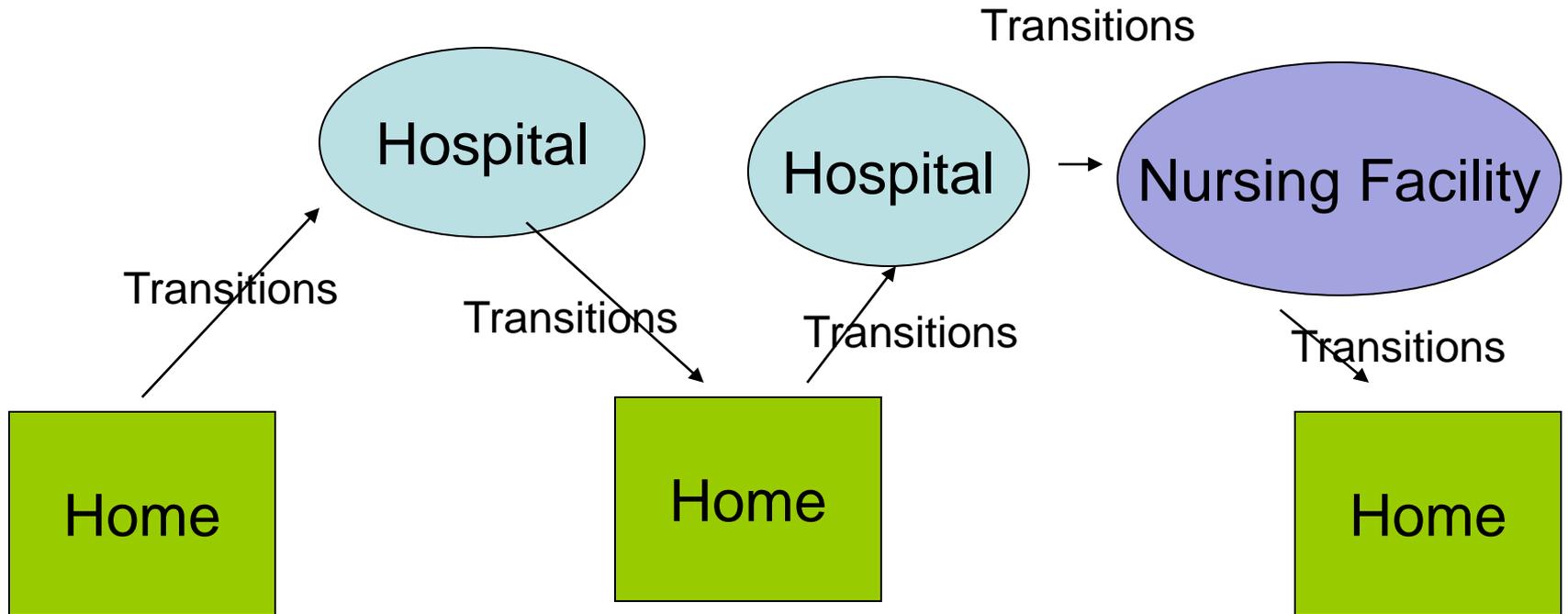
Transitional Care Model “Naylor”

- Transitional Care Nurse (advance practice nurse) coordinates care
 - In-hospital assessment and development of plan of care
 - Regular home visits with 24/7 phone support for an average of 2 months post-discharge
 - Evidence-based protocols
 - Education, support of patient and family
 - Emphasis on early identification and response

How most evidence-based care transitions programs see the world...



How it really is...



Public Health Nursing / CHRs / Clinic / Senior Center

Evercare Care Model (Managed Care)

- Enhanced primary care by NP (in nursing facility) or care managers (in community)
- Stratification
 - Levels 1 & 2: primarily healthy, independent or <2 conditions
 - CM with phone-based consultation, facilitates / coordinates care, mailed reminders
 - Level 3: multiple chronic conditions or impaired function
 - In person meetings and coordination – CM or NP
 - Level 4: Advanced illness, end of life
 - Hospice, palliative care

Community Care North Carolina CNCC

- Community-based care management program
- 14 networks of PCPs, 3,000 physicians, nearly 1,000,000 individuals
- Works directly with providers caring for low-income residents
- Public / private partnerships
- Allocates funds / resources locally to provide care
- Establishes local networks for managing Medicaid patients.

Guided Care (Boult, Johns-Hopkins)

Age 65 and older, high risk / high cost

Core elements:

- Nurse-physician teams
- Patient self-management
- Coordination of care services

Specially trained nurses

- Assess needs and preferences
- Create care plan with patient and family
- Monitor patients proactively
- Support self management and educate and support caregivers
- Communicate with EDs, hospitals, hospice, specialists...
- Facilitate transitions
- Access to community services

High Leverage Interventions for Safe Transitions

- Effective patient and caregiver education and self-management training during hospitalization and following discharge; anticipatory guidance for self-care needs at home post-discharge.
- Reliable referral for home health care visits.
- Effective management and communication of changes in medication regimens whenever changes occur.
- Timely and clinically meaningful communication (handoffs) between care settings.
- Early post-acute care follow-up (by care coordinator, coach, telephone nurse, or clinician).
- Proactive discussions of advance care planning and/or end-of-life preferences and reliable communication of those preferences among providers and between care settings.

Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations. Institute for Healthcare Improvement; June 2011. www.ihp.org.

IHI: Creating an Ideal Transition to the Clinical Office Practice

1. Provide timely access to care following a hospitalization
 - Proactively identify hospitalizations
 - Appropriate f/up for high, intermediate, and low risk patients

Schall M, Coleman E, Rutherford P, Taylor J. How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations. Institute for Healthcare Improvement; June 2011.
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IHI: Creating an Ideal Transition to the Clinical Office Practice

2. Prepare patient and clinical team for the visit.
 - Review the discharge summary
 - Clarify questions with hospital physician(s)
 - Reminder call to patient / family caregiver
 - Coordinate with home health / case managers if appropriate.

IHI: Creating an Ideal Transition to the Clinical Office Practice

3. During the visit: Assess patient and modify care plan
 - Patient goals, understanding of what led to hospitalization or ED visit, medications
 - Medication reconciliation
 - F/up plan – medication adjustment, test follow-up, further testing, future treatments,
 - Advance directives / preferences for care
 - Self management instructions, including warning signs
 - Review urgent or emergent care options.

IHI: Creating an Ideal Transition to the Clinical Office Practice

4. Communicate and coordinate ongoing plan

- Print reconciled, dated medication list for patient, family, home health, etc...
- Review changes to care plan with all
- Arrange f/up visits as appropriate

Partnership for Patients

Better Care, Better Health, Lower Cost

1. **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would **decrease by 40%** compared to 2010.
 - Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than **60,000 lives saved** over the next three years.

2. **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be **reduced by 20%** compared to 2010.
 - Achieving this goal would mean more than **1.6 million patients would recover** from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

Potential to save up to \$35 billion dollars over three years.

Community-Based Care Transitions Program - Sec. 3026, PPACA

- Evidence-based care transition services
- High risk Medicare beneficiaries
- Community-based organizations (CBOs)
- Acute care hospitals with high readmission rates
- Payment for transitions services

**Based on Root Cause Analysis of
Readmissions or Transitions Failures**

Community-Based Care Transitions Program - Sec. 3026, PPACA

Evidence-based care transition services

- Initiate services no later than 24 hours prior to discharge
- Timely, culturally and linguistically competent post-discharge education
- Ensure timely f/up and “productive interactions” between patient and provider
- Promote patient self-management

Community-Based Care Transitions Program - Sec. 3026, PPACA

High risk Medicare beneficiaries

- Cognitive impairment
- Depression
- History of multiple readmissions
- Chronic disease or other risk factors to be determined by the Secretary

Community-Based Care Transitions Program - Sec. 3026, PPACA

Community-based organizations (CBOs)

- Provide care across a continuum
- Arrangements and agreements
- Local governing body, with representation from community health stakeholders, including consumers

Priority to Partnerships that

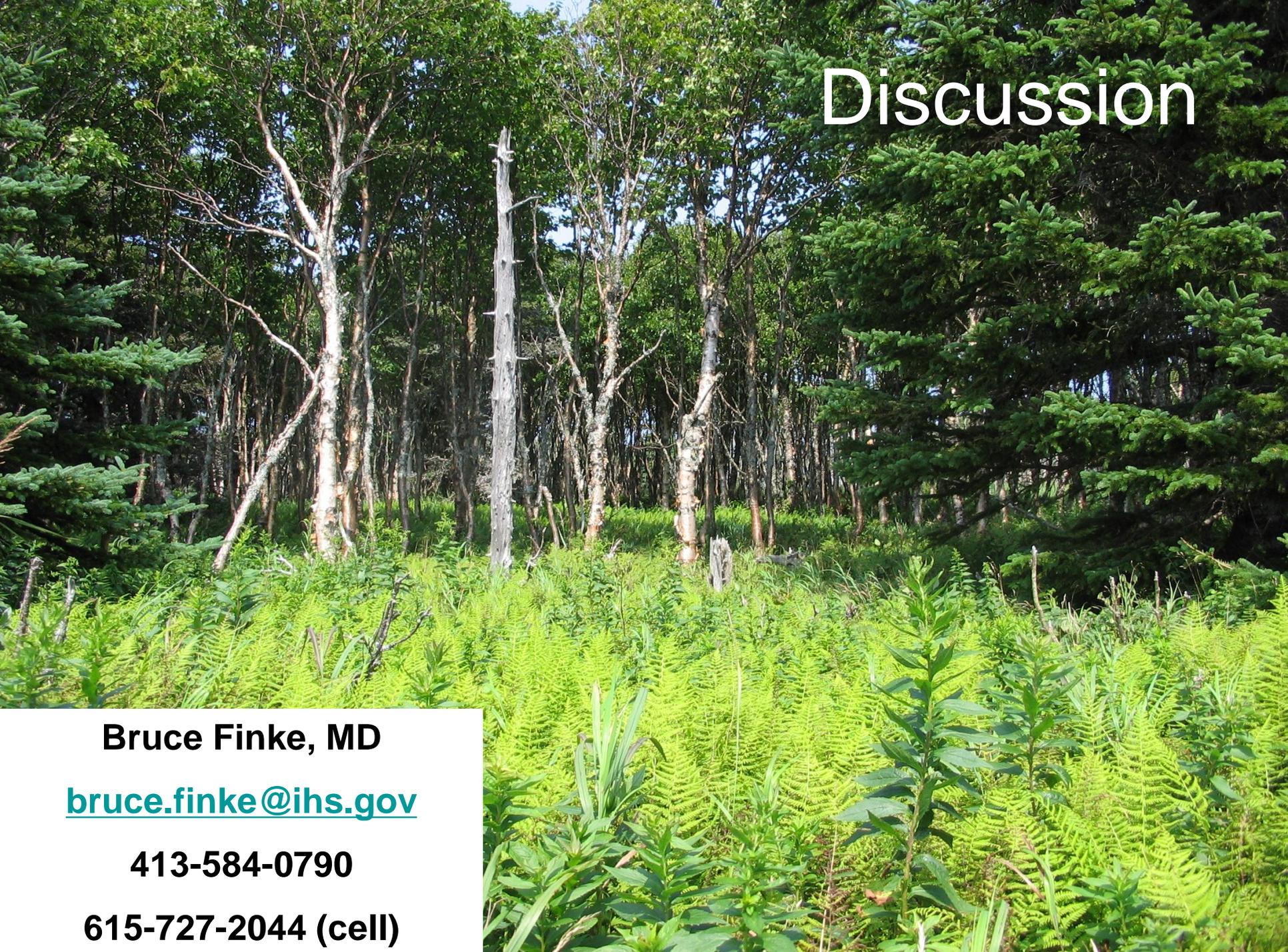
- Use the Aging Network (Senior Centers, Title VI programs)
- Provide services to medically underserved populations, small communities, rural areas

Community-Based Care Transitions Program - Sec. 3026, PPACA

Payment for transitions services

- All inclusive, blended rate per eligible discharge
- Cost of care transitions services provided at the patient level
- Cost of implementing changes at hospital level
- CBO get's the money
- Can't pay for services required as COP

Discussion



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Resources

- CMMI Community-Based Care Transitions Programs
 - <http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/partners.html>
- Healthcare.gov
 - www.healthcare.gov/center/programs/partnership/safer/transitions.html
- The Aging Network and Care Transitions: Preparing Your Organization Toolkit
 - www.aoa.gov/AoARoot/AoA_Programs/HCLTC/ADRC_CareTransitions/Toolkit/index.aspx
- Care Transitions Quality Improvement Organization Support Center
 - www.cfmc.org/caretransitions/
- Institute for Healthcare Improvement (IHI)
 - www.ihl.org/explore/Readmissions/Pages/default.aspx