NATIONAL HEALTH CARE for the HOMELESS COUNCIL

Care Transitions: Don't Lose Your Patients

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CARE TRANSITIONS

Definition

- The movement of patients between health care locations, providers, or different levels of care within the same location as their conditions and care needs change
- A subpart of the broader concept of care coordination

Why is this a hot topic?

- Adverse events after discharge result in higher readmissions, poor patient outcomes, higher health costs
  - Medication discrepancies
  - Infrequent communication between hospital and primary care provider
  - Discharge summaries often lack important information (i.e., test results, discharge medications, follow up plans)
  - Discharge summary not often available at the first post-discharge primary care visit

HEALTH REFORM INITIATIVES

Community-based Care Transition Program (CCTP)

- Tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries.
- CBOs paid an all-inclusive rate per eligible discharge based on the cost of care transition services provided at the patient level and of implementing systemic changes at the hospital level.
- CBOs will only be paid once per eligible discharge in a 180-day period of time for any given beneficiary.

HEALTH REFORM INITIATIVES

Hospital Readmission Reductions Program (HRRP)

- Beginning October 1, 2012, the Centers for Medicare and Medicaid Services will reduce payment rates for all acute care hospitals that experience higher-than-average readmission rates for three conditions (heart attack, heart failure, and pneumonia).
- In FY 2013, the maximum payment reduction is 1 percent, 2 percent in FY 2014, and capped at 3 percent for FY 2015 and beyond.
- In FY 2015, the policy scope of conditions expands to include COPD, CABG, PTCA and Other Vascular Conditions.

HEALTH REFORM INITIATIVES

State Option to Provide Health Homes for Enrollees with Chronic Conditions

- States can amend their state Medicaid plans to provide health homes for Medicaid enrollees with certain chronic conditions.
- Among other services, health home services must include comprehensive transitional care, including appropriate follow up, from inpatient to other settings.
- States receive a 90% Federal Matching Assistance Percentage (FMAP) during the first 8 quarters that the state plan amendment is in effect. After the first 8 quarters, States revert to receive their regular FMAP for health home services.

HEALTH REFORM INITIATIVES

Medicare Shared Savings Program

- Facilitates coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs.
- Facilitates the development of Accountable Care Organizations (ACO), defined as groups of doctors, hospitals, and other health care providers who coordinate, who come together voluntarily to give coordinated high quality care to their Medicare patients.
- CMS believes that assessing care coordination, and in particular care transitions, is an important aspect of evaluating the overall quality of the care furnished by ACOs.

HEALTH REFORM INITIATIVES

Federally Qualified Health Center Advanced Primary Care Practice Demonstration

- Pays health centers $6 per Medicare beneficiary per month after meeting certain health home requirements which include processes that would improve care transitions for health center patients admitted to hospitals.
- Participating FQHCs are expected to achieve Level 3 patient-centered medical home recognition (through NCQA), help patients manage chronic conditions, as well as actively coordinate care for patients.

OTHER INITIATIVES

- Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office)
- Physician Quality Reporting Initiative
- Comprehensive Primary Care Initiative
- Multi-payer Advanced Primary Care Initiative
- Bundled Payments for Care Improvement Initiative
- The Balancing Incentive Program

CARE TRANSITION

Elements for safe, effective and efficient care transitions (HHS)

- Patient and caregiver training to increase self-care skills and activation
- Patient-centered care plans that are shared across care settings
- Standardized, and accurate communication and information exchange between transferring and receiving provider
- Medication reconciliation and safe medication practices
- Transportation for health care-related travel
- Procurement and timely delivery of durable medical equipment (if needed)
- Formal hand-off procedures that ensure full responsibility between sending/ receiving provider

CARE TRANSITION

NTOCC Principles for Managing Transitions in Care between the Inpatient and Outpatient Setting

- Accountability
- Clear and direct communication of treatment plans and follow up expectations
- Timely feedback and feed forward of information
- Involvement of patient and family as appropriate
- Patient right to identify his/her medical home and coordinating clinician
- Patient and caregiver is always informed of who is responsible for their care at every point along the care transition and who to contact and how
- National standards
- Standardized metrics

CARE TRANSITION MODELS

Care Transitions Intervention (CTI)

- CTI is an evidence-based model developed by Eric Coleman with a goal to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home.
- CTI uses
  - simple personal health record to facilitate cross-site information transfer
  - a discharge preparation checklist designed to empower patients before hospital discharge
  - a "Transitions Coach" (usually a social worker or nurse) located in the hospital to help patients and their caregivers understand the personal health record and discharge preparation list.

CARE TRANSITION MODELS

CTI four pillars

Pillar:	Medication Self-Management	Dynamic Patient-Centered Record	Follow-Up	Red Flags
Goal	Patient is knowledgeable about medications and has system	Patient understands and manages a Personal Health Record (PHR)	Patient schedules and completes follow-up visit with Primary Care Provider/Specialist	Patient is knowledgeable about indications that condition is worsening and how to respond
Hospital Visit	Discuss importance of knowing medications	Explain PHR	Recommend Primary Care Provider follow-up visit	Discuss symptoms and drug reactions
Home Visit	Reconcile pre- and post-hospitalization medication lists Identify and correct any discrepancies	Review and update PHR Review discharge summary Encourage patient to share PHR with Primary Care Provider and/or Specialist	Emphasize importance of the follow-up visit Practice and role-play questions for the Primary Care Provider	Discuss symptoms and side effects of medications

CARE TRANSITION MODELS

Transitional Care Model

- The Transitional Care Model is an evidence-based model designed to prevent health complications and rehospitalizations of chronically ill, elderly hospital patients by providing them with comprehensive discharge planning and home follow-up, coordinated by a master's-level "Transitional Care Nurse."
- The Transitional Care Nurse
  - meets with the patient upon admission and conducts a comprehensive assessment of the patient's health status, health behaviors, social support, and goals;
  - works with the patient and doctors to develop an individualized care plan; and
  - meets with the patient daily to ensure that the patient is able to manage his/her health once discharged.
  - Following discharge the nurse conducts periodic home visits (or scheduled phone contacts) to ensure that the patient is successfully managing his/her health.

CARE TRANSITION MODELS

Project RED (Re-Engineered discharge)

- Developed at Boston University Medical Center, is an evidence-based, patient-centered, standardized approach to discharge planning and discharge education.
  - delineates roles and responsibilities among hospital staff
  - delivers patient education throughout the hospital stay
  - adopts a system of seamless information flow between the hospital team and primary care provider, and
  - provides an easy to read discharge plan for the patient
- Other components
  - patients know at all times who is responsible for their care and how to contact them
  - patients receive a follow up call within three days of discharge
  - a Discharge Advocate (DA) coordinates the intervention, thus reducing information gaps and redundancies that can adversely affect patient care and cost

CARE TRANSITION MODELS

State Action on Avoidable Rehospitalizations (STAAR)

- Launched by the Institute for Healthcare Improvement (IHI)
- 2 part strategy:
  - States aim to improve transitions of care by having partners across the continuum of care problem solve and co-design an efficient care transition system
  - State level leadership convene to address systemic barriers to change
- 4 states implementing STAAR: Massachusetts, Michigan. Ohio, and Washington

OTHER CARE TRANSITION MODELS

- Better Outcomes for Older Adults through Safe Transitions (BOOST)
- The Bridge Program
- Geriatric Resources for Assessment and Care of Elders (GRACE)
- Guided Care

CONSIDERATIONS

Care transitions for people experiencing homelessness

- Lack of housing/transition to housing
- Transportation
- Health literacy and cognitive impairment
- Lack of insurance
- Multiple practitioners

Survey of Medical Respite Programs

Slides Omitted.

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Case Study

Care Transitions Intervention (Coleman Model)

- Inland Northwest Transitional Respite Program
  - 42-year-old male patient with cellulitis of the foot
  - Surgical incision & sutures on top of foot
  - Non-weight bearing status on affected limb

Discharge Checklist

Creating the discharge plan

Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

- ❑ I have been involved in decisions about what will take place after I leave the facility.
- ❑ I understand where I am going after I leave this facility and what will happen to me once I arrive.
- ❑ I have the name and phone number of a person I should contact if a problem arise during my transfer.
- ❑ I understand what my medications are, how to obtain them and how to take them.
- ❑ I understand the potential side effects of my medications and whom I should call if I experience them.
- ❑ I understand what symptoms I need to watch out for and whom to call should I notice them.
- ❑ I understand how to keep my health problems from becoming worse.
- ❑ My doctor or nurse has answered my most important questions prior to leaving the facility.
- ❑ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.
- ❑ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.

This tool was developed by Dr. Eric Coleman, UCHSC, HCPR, with funding from the John A. Hartford Foundation and the Robert Wood Johnson Foundation

At the Hospital

Introductions

- Introduced respite program
- Importance of medication management
- Introduced Personal Health Record
- Planned for follow-up appointment
- Education about symptoms and warning signs

Respite Program (shelter)

Education, Coaching, & Reinforcement

Respite Program (shelter)

Education, Coaching & Reinforcement

- Reviewed discharge instructions from hospital
- Medication reconciliation
- PHR
- Questions for physician at follow-up
- Coached patient to make follow-up appointment
- Medication education

Follow-Through

The Follow-Up "Call"

- Continued to provide medication education and reinforcement
- Patient discovered signs & symptoms of infection; demonstrated ability to seek care appropriately
- Advocated for patient to establish housing and to secure mental health care