Improving Healthcare Outcomes Through Enhanced Transitions of Care
Objectives

The key objectives of this presentation are to discuss transitions of care in relation to

- The burden of chronic diseases within the US healthcare system
- Roles and responsibilities of key healthcare stakeholders
- Creating a new future through healthcare reform
- Progress in action
- Additional resources
- Summary
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Despite High US per Capita Spending on Healthcare, the Rate of Chronic Disease Continues to Grow Rapidly

- Nearly half of all Americans suffer from 1 or more chronic diseases\(^1\)

An increasing number of people with chronic conditions are utilizing a healthcare system primarily structured to address acute episodes of care.\(^1\)

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Chronic Disease Places a Substantial Economic Burden on the US Healthcare System

Healthcare Utilization Associated With Chronic Conditions

- Home Healthcare Visits: 99%
- Prescription Drugs: 92%
- Inpatient Hospital Stays: 82%
- Physician Visits: 79%

- Care for chronic conditions results in high utilization of various components of the healthcare system

Healthcare Spending Associated With Chronic Conditions

- Healthcare spending for people with chronic conditions: 85%
- Healthcare spending for people without chronic conditions: 15%

- Healthcare spending for chronic diseases is nearly 6 times greater than for nonchronic conditions

Chronic disease accounts for the vast majority of healthcare utilization and expenditure.

Traditional Model of Healthcare Delivery in the United States Is Divided Into Discrete Episodes of Care

- Patients with multiple chronic conditions visit up to 16 different providers a year\(^1\)
- Currently, patients move between settings of care or providers without anyone maintaining responsibility for managing the transitions of care\(^2\)

Transition of Care:
The movement of a patient from one care setting or provider to another\(^2\)

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Hospital Readmissions May Indicate Poor Transitions of Care

Lack of effective coordination can have serious consequences, including gaps in quality of care and exponential increases in healthcare costs, a proportion of which are likely to be avoidable.¹ ²

Rates of Potentially Preventable Hospitalizations Among Medicare Beneficiaries (2005)²

<table>
<thead>
<tr>
<th>Patients being readmitted within 30 days</th>
<th>13.3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients being readmitted within 15 days</td>
<td>8.8%</td>
</tr>
<tr>
<td>Patients being readmitted within 7 days</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

Medicare Spending in Billions on Potentially Preventable Readmissions (2005)²

<table>
<thead>
<tr>
<th>Patients being readmitted within 30 days</th>
<th>$12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients being readmitted within 15 days</td>
<td>$8</td>
</tr>
<tr>
<td>Patients being readmitted within 7 days</td>
<td>$5</td>
</tr>
</tbody>
</table>

People with chronic conditions often receive duplicate testing, conflicting treatment advice, and prescriptions that are contraindicated, potentially contributing to unnecessary hospitalizations.² ³

Avoiding Readmission Is a Key Goal of Patients, Providers, and Payors

The risk of readmission rises with chronic care patients.¹

Chronic care patients may face the following challenges:

- Inadequate communication and medical follow-up among providers between sites of care²-⁴
- Issues related to medication errors²,³
- Lack of education/understanding at discharge regarding²,⁵
  - Their condition
  - Their continuing home-based–care requirements
- Varying levels of cognitive impairment¹
- Varying levels of health literacy²,⁵,⁶

Due to inadequate discharge processes, patients and caregivers are required to abruptly self-manage their medications and recovery.⁷

Quality and Efficiency Are Improved Through Effective Care Coordination

Efficient coordination of care is essential to help

- Reduce medication errors\(^1\)
- Maximize compliance\(^1\)
- Ensure appropriate continuity of care\(^1\)

Care coordination can be improved among providers when they\(^2\)

- Agree to a standardized demographic and clinical information format
- Ensure patient information is transferred in a safe and timely manner

Coordination of Care:
The process of communicating patient needs, information, and health service preferences among all providers and care settings\(^3\)

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Although Traditional Focus Has Been on Hospital Transitions, Transfer of Care Affects All Healthcare Stakeholders

Transfer of responsibility between healthcare providers (HCPs)
- Primary care physicians
- Specialist
- Hospital staff
- Pharmacist
- Nurses
- Case managers

Change in care setting or level of care within a facility
- Intensive care
- Regular unit
- Emergency department
- Inpatient bed

Transfer between healthcare facilities

Transitional Care:
Actions designed to ensure coordination and continuity of care as patients transfer between care locations or providers

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PCPs Play a Fundamental Role in Patient Healthcare

The roles of a PCP

- Assess and treat patients or refer them to other HCPs as needed
- Maintain accurate and up-to-date patient records

Maintain continuity of care and enhance transitions to the next provider by

- Providing patients with contact information and appointment timeframes
- Explaining to patients the reasons for, and expectations and goals of, the visit
- Modifying patient education discussions and materials to match the patient’s health literacy level
- Ordering necessary studies that would help facilitate the visit
- Transferring patient records to the next HCP
- Consulting with the next provider on prereferral work-up, when ordering additional services outside practice guidelines and as needed after transfer is complete

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PCP=primary care physician HCP=healthcare provider.

Specialists Are an Additional Point of Care Often Utilized by Patients With Chronic Conditions

- The roles of a specialist
  - Provide a single source of information for concerns that are outside the scope of a PCP
  - Care for the patient until the transfer to the receiving clinician/location is complete

Maintain continuity of care and enhance transitions to the next provider by

- Notifying primary provider of major interventions, emergency care, or hospitalizations
- Maintaining and transferring accurate and up-to-date patient records
- Consulting with primary provider about prereferral work-up, when ordering additional services outside practice guidelines, and as needed after the transfer is complete

Case Managers Assess and Address Concerns of All Healthcare Stakeholders, Especially Those of Patients

The roles of a case manager

- Assess patient needs and identify concerns, interests, and health-related problems
- Facilitate communication regarding all aspects of the patient's treatment plan between the patient, caregivers, and healthcare team

Maintain continuity of care among all providers by

- Ensuring a member of the healthcare team takes responsibility for patient transitions
- Expediting access to care by obtaining payor authorization and advocating for patient and caregiver needs
- Designing a comprehensive care plan that is focused on the patient and caregivers
- Modifying patient education discussions and materials to match the patient's health literacy level
- Collecting and analyzing outcomes data to help determine the care plan's success and if any corrective action is required
- Closely monitoring and managing the patient's plan of care, progress, and outcomes to help avoid treatment problems and delays

Nurse Discharge Advocates Provide Essential Patient Guidance as the Last Point of Contact Before Patients Leave the Hospital

The roles of a nurse discharge advocate

- Coordinate hospital discharge and ensure postdischarge care plan is complete
- Educate patients and caregivers about their discharge plan and answer any questions

Ensure continuity of care postdischarge by

- Providing patient with discharge medication list
- Providing patient with self-management plan
- Assessing the degree of patient understanding
- Assessing barriers to care
- Providing telephone reinforcement of the discharge plan

Pharmacists Play a Key Consultative Role to HCPs and Patients

The roles of a pharmacist

Provide to HCPs consultative services that foster appropriate evidence-based medication selection\(^1\)

Provide patient and caregiver education\(^1\)
- Discharge counseling
- Follow-up
- Medication counseling

Pharmacists are the sole providers who coordinate medication management across the care continuum by
- Reviewing medications ordered from multiple providers\(^2\)
- Resolving potential conflicts in therapy\(^3\)
- Monitoring and reporting adverse event frequency (individual patient and patient population)\(^3,4\)
- Explaining over-the-counter medication\(^5\)

Active Participation of Patients and Caregivers Is Essential to Ensure Effective Continuity of Care

The roles of a patient/caregiver

- Common factor moving across sites of care.\(^1\)
- Typically not involved in the development of their care plan.\(^2\)

Provider can help to empower patients as active participants by

- Providing appropriate, empathetic communication and education to enhance the patient-provider relationship and increase the effectiveness of interventions\(^3\)
- Managing expectations on regaining abilities and recovery timeline\(^4\)
- Providing relevant names and phone numbers that patients can call with questions and concerns\(^4\)
- Facilitating a productive dialogue regarding patients’ ongoing management of condition, changes in overall health/lifestyle, and outcomes of visits with other providers\(^2\)

Recommended Standards for Providers to Improve Transitions of Care

Collaboration among all healthcare stakeholders is essential for effective transitions of care

Timely communication between facility and receiving provider

Minimal data set that should always be part of transition record

Secure, private and HIPAA-compliant communications that are accessible to patients and treating practitioners

Responsibility for patient care maintained by sender until receiver confirms transfer is complete

Factors for timely feedback and feed-forward of information between providers

Community standards and processes that institutions must adopt for transitions-of-care accountability

National standards, processes, and metrics that institutions must adopt for transitions-of-care accountability

Coordinating Clinicians

Care plans/transition record

Communication infrastructure

Transition responsibility

Timeliness

Community standards

Measurement

In addition to medical societies, US policy agencies, such as the Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), National Quality Forum (NQF), and the Agency for Healthcare Research and Quality (AHRQ), are increasing support for research and initiatives to establish transitions of care best practices.2-4

HIPAA=Health Insurance Portability and Accountability Act.
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Transitions of Care Is an Integral Component of a Highly Coordinated Healthcare System

Policy Change Levers
- Collaborative Programs in Quality Improvement
- Regulatory/Legislative
- Payment Reform
- Government Leadership

Enhanced Processes
- Enhanced Structures

Improved Health Status and Patient Experience
- Complications
- Function
- Adverse Events
- Patient Satisfaction
- Patient Understanding

Appropriate Utilization
- Emergency-Room Visits
- Readmissions
- Preventable Admissions
- Unnecessary Tests and Procedures

Reduced Cost

Healthcare Reform (HCR) Is Helping to Drive Systemic Change Through Consumer Protection, Quality and Cost Improvements, and Broader Access to Affordable Care

March 23, 2010
Affordable Care Act becomes law

Preventing disease and illness
- Elimination of lifetime coverage limits
- Strengthening community health centers

Improving care for seniors after they leave the hospital
Improving healthcare quality and efficiency

Expanded authority to bundle payments

Reducing paperwork and administrative costs

2010
- Expanded coverage for more people on Medicaid, early retirees, people with preexisting conditions
- Free preventive care
- Rebuilding the primary care workforce

2011
- Understanding and fighting health disparities
- New innovations to reduce costs

2012
- Encouraging integrated health systems
- Linking payment to quality outcomes

2013
- Additional funding for the Children’s Health Insurance Program
- Increasing Medicaid payments to PCPs

2014
- No discrimination due to pre-existing conditions or gender

2015
- Increased access to Medicaid
- Paying physicians based on value, not volume

Although all of the provisions stated under the HCR Act will be influential, those that specify improvements to quality and costs may impact healthcare providers most directly.

Please note that the listed years are approximate and are estimated based on the maximum impact to providers. This is ongoing reform with opt-in programs. Additional funding and incentives will be added over several years until they become mandates.

Reform Priorities Affirm the Importance of Improved Transitions of Care Between Healthcare Stakeholders

The US government has allocated almost $1 trillion for efforts largely aimed at improving overall coordination of care by

- Reducing avoidable hospital readmissions through enhanced transitions of care
- Broadening use of technologies that will facilitate provider communication
- Using incentivized health information technologies to track readmission reductions in these demonstration projects will affect the reimbursement rates of participating providers

Awareness of quality mandates and how they can be implemented is essential to ensuring that providers are offering care that aligns with HCR goals and that providers are positioned to receive full reimbursement for their services.

Reform Legislation Has Important Implications to All Healthcare Stakeholders

• The Healthcare Reform Act of 2010 contains
  – Mandates of various quality improvements that will be required to avoid penalties by specific dates
  – Funding for programs that test and optimize new and improved methods of healthcare delivery
  – Funding for tools and resources that will support the previous objectives

• As a result of these reform initiatives, the following changes will occur:
  – A dramatic increase in the number of patients entering the healthcare system as a result of expanded healthcare coverage
  – A similar increase in the healthcare provider workforce
  – Revised methods of reimbursement and penalties for not achieving quality goals

Key HCR Programs Aim to Reduce Hospital Readmissions and Reform Payment Structure

- Two key goals of the Patient Protection and Affordable Care Act that are effective on October 1, 2012, are to
  - Provide incentives for reducing preventable hospitalizations
  - Reduce payments to hospitals for excessive hospital readmissions
- Readmissions Reduction Program
  - Authorizes the CMS to track national and hospital-specific data on the readmission rates of Medicare-participating hospitals
- National Medicare Pilot Program
  - A bundled reimbursement plan aimed at improving or maintaining quality and reducing spending for the period that includes the 3 days prior to admission, the length of the hospital stay, and the 30 days following discharge

Improving efficient patient transitions from the hospital and between all providers is an integral step in reducing preventable readmissions.
Initiatives Are Under Way to Improve Transitions of Care Within the US Healthcare System

- Health information technology (HIT) enables healthcare providers to improve patient care through the secure sharing of health information\(^1\)
  - Electronic medical records (EMRs) allow all providers to share patient medical information electronically\(^2\)
  - Electronic health records (EHRs) allow this information to follow the patient and be shared among all healthcare stakeholders\(^2\)
- Accountable care organizations (ACOs) encompass local entities and related providers—such as PCPs, specialists, and hospitals—that can be held accountable for the cost and quality of care\(^3,4\)
  - Fosters collaboration of providers from multiple settings
  - Reforms the provider payment system to focus on value over volume

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HIT Will Improve Communication Quality Between All Healthcare Stakeholders

- Providers will be incentivized through HCR legislation to adopt EMRs/EHRs

- Reduced medication errors
- Decreased drug-drug interactions/drug allergies
- Increased care coordination across providers
- Improved knowledge of comorbidities, procedural history
- Decreased duplicative testing

HIT will enable the timely and accurate exchange of vital information between all healthcare stakeholders.

Medicare ACOs Shared-Savings Program Offers Joint Accountability and Shared Financial Incentives for Coordinated Patient Care

- Providers organized as ACOs and who voluntarily meet quality thresholds can share in the cost-savings that are achieved\(^1\)
  - At a minimum, an ACO must have at least 5000 beneficiaries
- The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care through use of\(^1\)
  - Telehealth
  - Remote patient monitoring
  - Patient and caregiver assessments
  - Individualized care plans
  - Enabling technologies

ACOs provide a collaborative model for providers and hospitals to achieve overall transitions of care and quality goals.\(^2\)

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Additional resources

Summary
Medication Therapy Management (MTM) Is an Existing Standard With Established Value and Increasing Utilization

Medication Therapy Review
• Interview patient and create a database with patient information
• Review medications for indication, effectiveness, safety, and adherence
• List medication-related problem(s) and prioritize
• Create a plan

Intervention and/or Referral
• Possible referral of patient to physician, another pharmacist, or other HCPs
• Interventions directly with patients
• Intervention via collaboration with physician and other HCPs

MTM is an example of coordinated collaboration between pharmacists and other HCPs.

Example #1

Implement plan

Create/Communicate

Personal medication record

Create/Communicate

Medication-related action plan

Complete/Communicate and Conduct

Documentation and follow-up

Community Health Centers Are a Key Source of Care for Previously Unserved and Underserved Patient Populations

• HCR will be allocating $11 billion for health center program expansion beginning in 2011\(^1\)
  – $9.5 billion for expanding operational capacity to serve approximately 20 million new patients and to improve their medical, oral, and behavioral health services
  – $1.5 billion for allowing health centers to begin meeting their substantial capital needs, through expanding and improving existing facilities and building new facilities

• Community health centers are helping to reduce costs and improve efficiencies by offering an alternative to the costly use of emergency rooms and urgent-care facilities\(^2\)

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Project BOOST Aims to Improve Care Transitions in Older Adults

Project Better Outcomes for Older adults through Safe Transitions (BOOST)

- A comprehensive tool kit for improving transitions of care in hospitals
- The project aims to
  - Build a national consensus for best practices
  - Develop a national resource library
  - Collaborate with representatives from
    - The Joint Commission
    - CMS
    - AHRQ

For more information, go to www.hospitalmedicine.org/BOOST.

Project BOOST Aims to Improve Care Transitions in Older Adults (cont)

- The 4 key elements of Project BOOST are
  - An evidence-based, comprehensive intervention plan validated by nationally recognized experts
  - A comprehensive implementation guide that provides instructions and resources for implementation and evaluation of the intervention
  - Personal training, mentoring, and coaching for project implementation
  - Online community sites and quarterly onsite teleconferences that promote communication and best practices
- Full-year results will be available in early 2011
Project RED Aims to Further Improve Hospital Discharge Processes

Project Re-Engineered Discharge (RED)

- Research group that develops and tests strategies for improving hospital discharge processes to:
  - Promote patient safety
  - Reduce readmission rates
- The current discharge strategy is founded on 11 mutually reinforcing components:
  - Educate patient about diagnosis throughout hospital stay
  - Schedule appointments for clinician follow-up and postdischarge testing
  - Discuss with patient tests or studies that have been completed and who will follow up on the results
  - Organize postdischarge services
  - Confirm the medication plan
  - Reconcile the discharge plan with national guidelines and critical pathways
  - Review the appropriate steps for what to do if a problem arises
  - Expedite transmission of discharge résumé to the provider accepting responsibility for patient
  - Assess patient’s degree of understanding
  - Give patient a written discharge plan at time of discharge
  - Provide telephone reinforcement of discharge plan and problem-solving 2 to 3 days postdischarge

For more information, go to www.bu.edu/fammed/projectred/.

Project RED Aims to Further Improve Hospital Discharge Processes (cont)

• Project RED compared hospitalized adults who received usual care versus interventional care, which included
  – A nurse discharge advocate who worked with patients during their stay and upon discharge
  – A clinical pharmacist who called patients 2 to 4 days postdischarge

• Primary outcomes included emergency room visits and hospitalizations within 30 days
  – Secondary outcomes included self-reported preparedness for discharge and frequency of PCP follow-up within 30 days

• Results demonstrated that effective discharge services reduced the number of rehospitalizations within 30 days

Transitions of Care Was Identified as the Centerpiece of an Ideal Healthcare Delivery System

• The Commonwealth Fund Commission examined problems arising from the fragmented healthcare system and offered policy recommendations that promote greater organization designed to help achieve a higher level of performance1

• The fund identified 6 attributes that should be components of an ideal health delivery system, including2
  – Information Continuity
  – Care Coordination and Transitions
  – System Accountability
  – Peer Review and Teamwork for High-Value Care
  – Continuous Innovation
  – Easy Access to Appropriate Care

• Geisinger Health System was 1 of 15 case study sites examined to illustrate these 6 attributes2

The Commonwealth Fund is a private foundation working toward a high-performance healthcare system.3

Geisinger Applies an Interdisciplinary Quality Improvement Process to Enhance Transitions of Care

- Patient admitted
  - Nursing screens patients' readmission risk status
  - Using an EHR tool

- Patient identified as high risk
  - Nursing performs a checklist of activities for early care activation
  - Care management prepares a discharge plan assessing patient support environment

- Postdischarge
  - High-risk patients followed for a month using automated scheduling
  - Using an outpatient care management protocol

- Use of modeling and predictive tools improves
  - Care quality
  - Patient outcomes
  - Care delivery efficiencies and costs
  - Reduces length of stay and readmissions

Geisinger is a nonprofit, physician-led, integrated health system in rural Pennsylvania.

Geisinger Is a Progressive Integrated Delivery System That Demonstrates Leadership in Implementing the Ideal Transitions of Care Model

Geisinger’s vision is to become an innovative national model for healthcare delivery through 1) leadership, 2) compensation aligned with goal achievement, and 3) timely feedback on progress toward goals.

**Information Continuity**
- EMR with evidence-based decision support across all group-practice sites that functions as an organizational hub and that enables system performance monitoring.
- Patient Web portal used for health information, appointment scheduling and prescription ordering, resulting in fewer missed appointments and increased physician productivity.

**Care Coordination and Transitions/System Accountability**
- Advanced medical home pilot with 24/7 primary care coverage, embedded nurse case managers, virtual-care management support, personal care navigator, home-based monitoring, and automated voice-response surveillance.

**Peer Review and Teamwork for High-Value Care**
- Cross-disciplinary physician service lines for planning, budgeting, and evaluating colleagues’ performance.
- Bundled product pricing that delivers evidence-based practices efficiently motivated providers.

**Continuous Innovation**
- Collaborative teams redesigned care process models to increase value in disease prevention and treatment.

**Easy Access to Appropriate Care**
- The availability of same-day appointment increased from 50% in 2002 to 95% in 2006.
- A 1-day or less lead time was achieved by 84% of the sites and patient satisfaction increased 48%. EMR and the patient portal linked walk-in clinics in area retail stores.

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Additional resources

Summary
Additional Resources

The following resources are available from the National Transitions of Care Coalition:

- My Medicine List
- Taking Care of My Health Care
- Transitions of Care Checklist
- Informational Slide Deck
- Cultural Competence: Essential Ingredient for Successful Transitions of Care
- Medication Reconciliation Essential Data Specifications
- How to Implement and Evaluate a Plan
  - Executive Summary
  - Improving on Transitions of Care: How to Implement and Evaluate a Plan
    - Module: Hospital to Home
    - Module: Emergency Department to Home
- Transitions of Care Measures
- Informational Brochure
- Informational Slide Deck
- Policy Paper

WWW.NTOCC.ORG

Objective

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Summary
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- The implementation of new strategies and technologies for improving overall coordination of care is critical for addressing quality gaps and rising costs in the healthcare system
- Because transitions of care are frequent between providers and care settings, enhanced transitional care is a key focus for driving quality-of-care improvements
- Evolving healthcare initiatives, coupled with HCR mandates, place greater accountability on providers via a payment structure that rewards quality over volume
- Awareness of HCR provisions and timelines will help prepare providers for the future of healthcare