

# Transitions in Care: A Patient-Centered Approach

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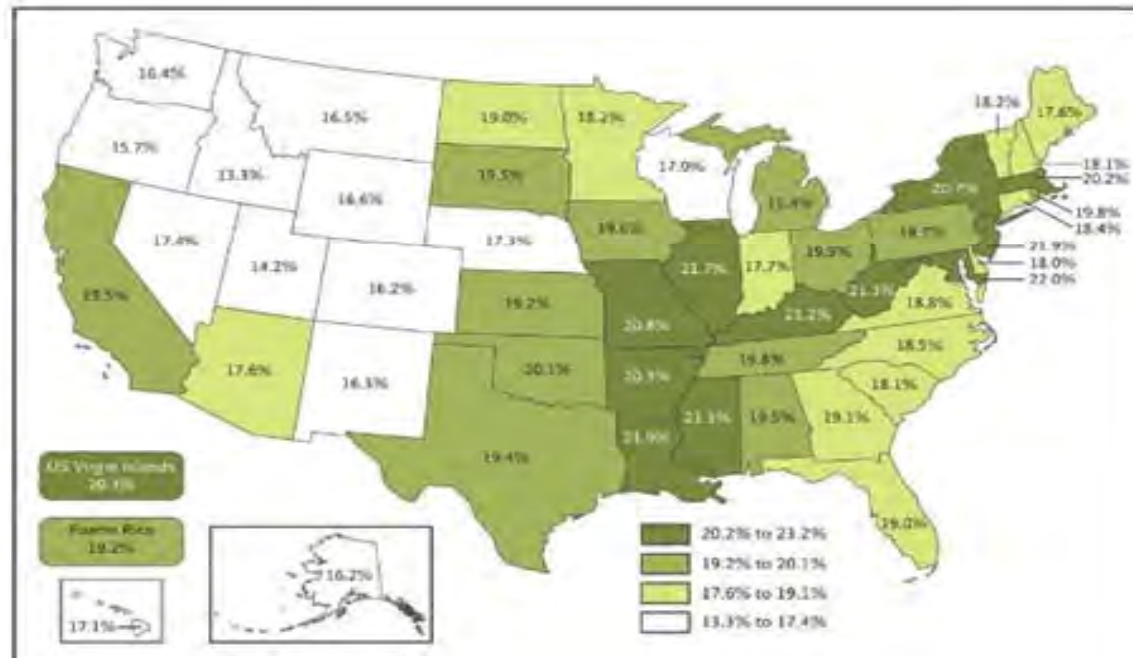
# Meet Sally



# The Problem(s)

- 2/3 of Medicare patients are rehospitalized or die within one year of index hospitalization
- Half of Medicare patients have no claim for outpatient appointment within 30 days of discharge
- Care transitions are error prone—probably most have an error or near miss; e.g. >80% have medication error post DC
- Poor care transitions affect the worst off most, causing suffering, disability and death
- Failures in transitional care are community problems
- Very little national improvement progress since 2003





**Figure 1. Rates of Rehospitalization within 30 Days after Hospital Discharge.**

The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.

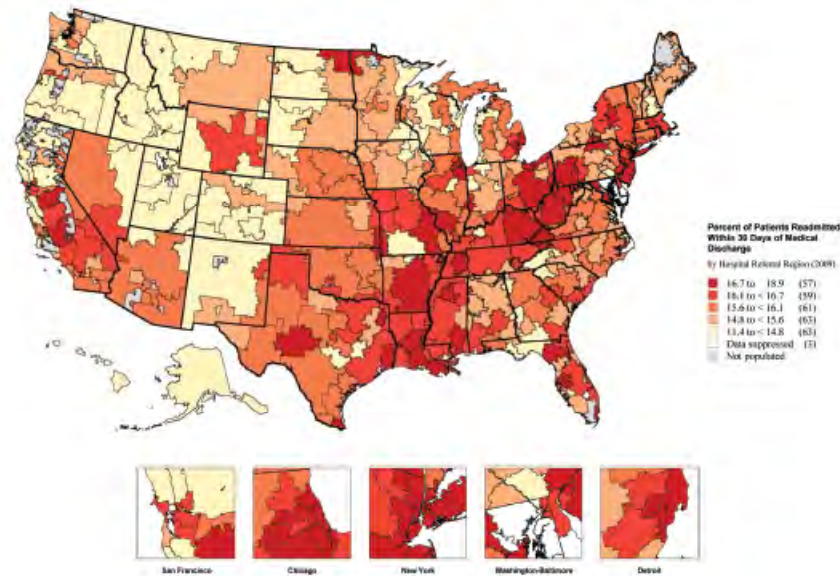


## Findings

### Regional variation in 30-day readmission rates

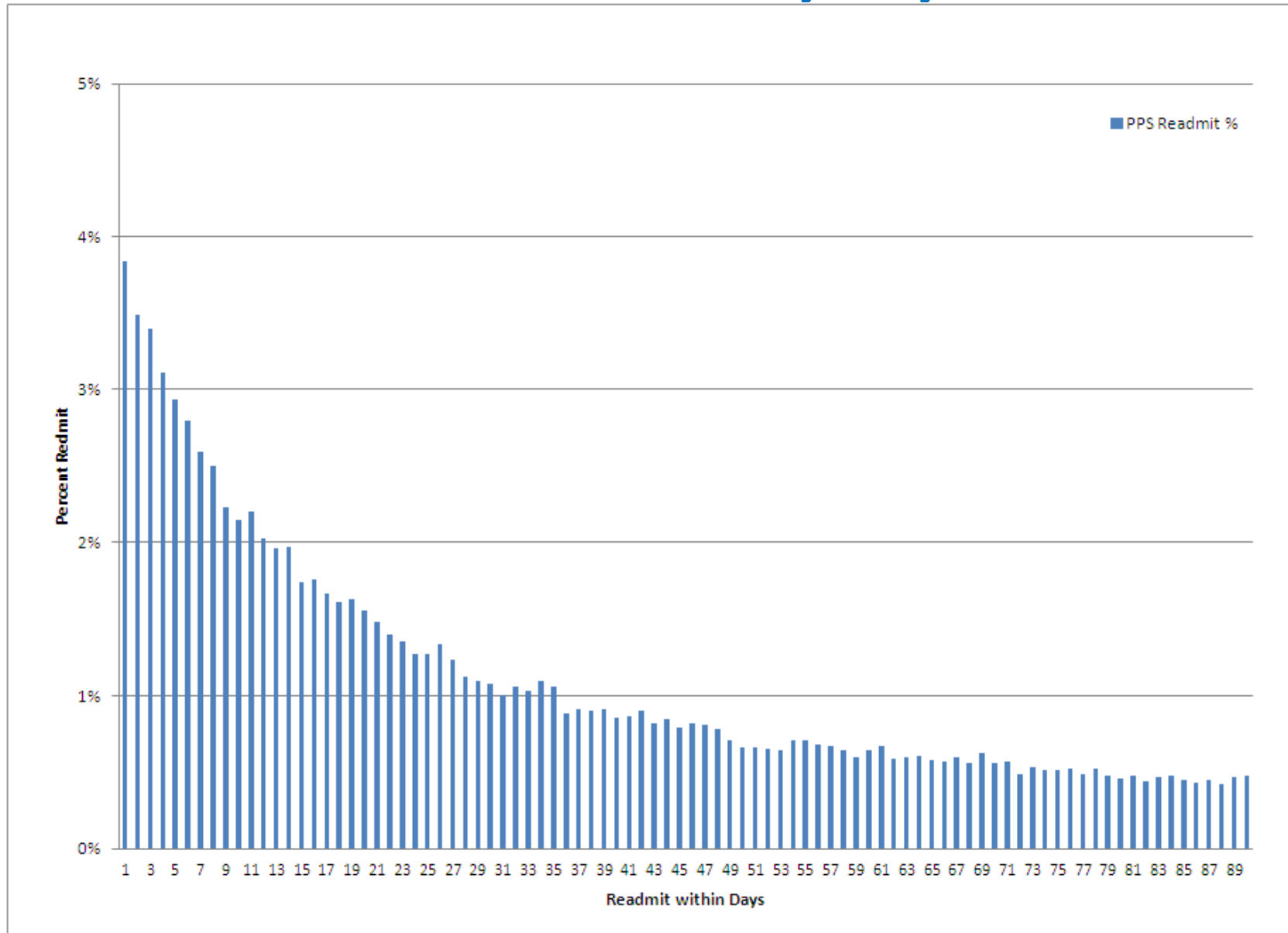
Hospital readmissions are sentinel events that often signal gaps in the quality of care provided to Medicare patients. There are many different reasons for higher readmission rates across certain regions and hospitals, including differences in patient health status, the quality of inpatient care, discharge planning and care coordination prior to discharge, and the availability and effectiveness of ambulatory services in the community. This report also demonstrates the importance of the general tendency of health care systems to use the hospital as a site of care. The combination of these factors will differ across communities and systems as each faces its own challenges in keeping patients well and out of the hospital.

In 2009, there was marked variation in the percent of patients readmitted to the hospital within 30 days of an initial discharge (Table 1). Map 1 and Map 2 show the



Map 1. Percent of patients readmitted within 30 days following medical discharge among hospital referral regions (2009)

# WA PPS % Readmission By Day of Readmit



# So...

- Are you ready for complex visits on the second post-discharge day?
- How about on the first post-discharge day?
- What information will you need, and do you routinely receive it?
- What else can primary care do?





# And....

- Is readmission the only interesting outcome?
- What are other markers of quality of the transition?
  - Medical error
  - Duplication of service
  - Patient dissatisfaction/poor experience
  - Others?



# Isn't Readmission a Hospital Problem?

- For now...hospitals are the only ones being penalized by CMS
- Consider your workflow
  - Elderly, fragile patient is discharged
  - You have to “work her in” to the schedule
  - There is no DC summary, meds are changed
  - This takes much longer than 15 minutes
  - You're late for the rest of the day
  - AND THE PATIENT IS MUCH SICKER



# “Drivers” of Poor Transitions

- **Lack of patient and family activation**
  - Health literacy
  - Self-management skills & tools
  - Motivation, locus of control
- **Lack of standard and known processes**
  - Patient discharge, hand-over
  - Internal work flow
- **Lack of information transfer**
  - Especially cross-setting
  - Delays, inaccuracies, missing information



# Two Approaches to Interventions

- **System changes**
  - **Hardwiring standard and reliable processes**
  - **Benefit: Broad reach for all patients, all payers, all units; more patient-centered**
  - **Challenge: Improving and sustaining processes is hard work!**
- **Targeted population interventions**
  - **Usually chronic condition-specific (like HF)**
  - **Coaching, case management**
  - **Benefit: care based on identified risk**
  - **Challenge: narrow focus, may not move overall readmit rate; systems are not improved for all**



# Setting Specific Interventions

- Hospital
  - BOOST, RED
  - CTI
  - Follow up calls
  - Risk assessment
- SNF
  - INTERACT program
- Home Health
  - HHQI Best Practices Interventions



# Care Transitions in Primary Care – What are They?

After ED visit

After hospital admission and  
discharge

Coordination with other care  
facilities (rehab,  
SNF, home health, etc.)

Transfer to new PCP

Transition from pediatric  
service to adult medicine



# Challenge



# Person Centered Medical Homes and Care Transitions

- The Head
  - NCQA Recognition
- The Heart
  - Change concepts to make care better





# The Head: NCQA Standards

- Specific activities that help track information key to patient health and satisfaction, and decreasing costs; population management
- Called out in NCQA Recognition Standard 5, Track and Coordinate Care
  - Element 5B (referral tracking) is **MUST PASS!**
  - Referral, imaging, test tracking
    - Create workflows to enable appropriate triaging and follow up on critical, positive, and negative test results, for example



# The Head: NCQA Standards

## NCQA Standard 5, Element C

- Person Centered Medical Homes:
  - Know who's been in the hospital or ED
  - Share and receive info, ideally electronically
  - Provide timely post DC/ED follow up
  - Provide written care plan on peds – adult transition



# The Head: NCQA Standards

- Also among the “must pass:”
  - PCMH 3, Element D, Care Management
  - PCMH 4, Element A, Support Self-Care Processes



# The Heart – PCMH Change Concepts

1. Empanelment
2. Continuous and Team-based Healing Relationships
3. Patient-centered Interactions
4. Engaged Leadership
5. Quality Improvement Strategy  
*(includes measurement & HIT)*
6. Enhanced Access
7. Care Coordination
8. Organized, Evidence-based Care

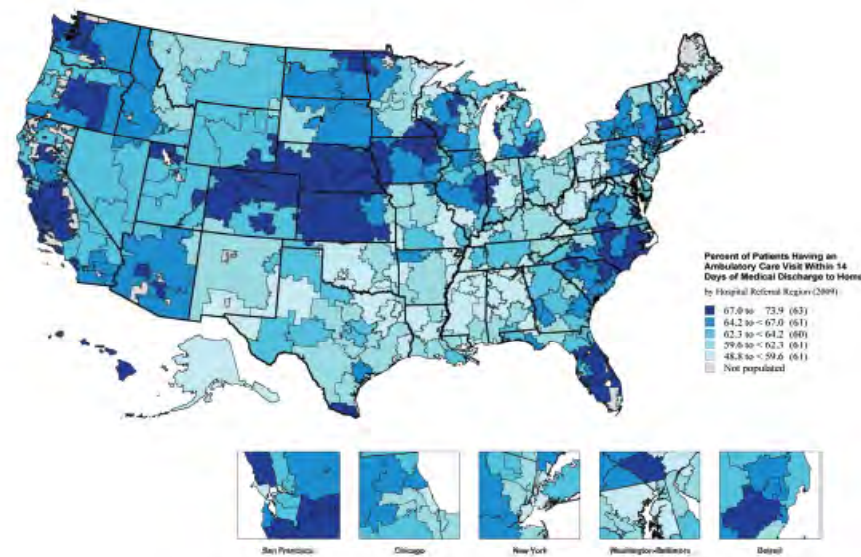


# Let's Talk....

- Are your patients empanelled? If not, how can you
  - Have open/advanced access?
  - See post-DC patients when they need to be seen without ruining the schedule?
- Do you utilize team-based care? If not, how can you
  - Systematically coordinate care?
  - Provide post-DC follow up calls?

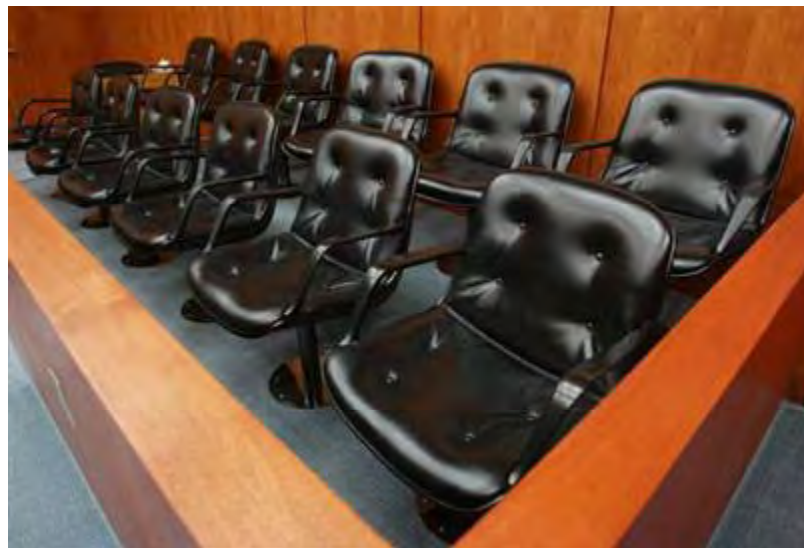


The likelihood of having an ambulatory care visit to any provider within 14 days of discharge to home following a medical admission varied about one and a half times among HRRs in 2009. Less than half of patients had an ambulatory care visit to a clinician within 14 days of discharge in Pittsburgh (48.8%) and New Orleans (49.1%). More than 70% of patients had an ambulatory visit within 14 days in 15 regions, including Lincoln, Nebraska (73.8%), McAllen, Texas (72.4%), Greenville, North Carolina (72.3%), Fort Lauderdale, Florida (72.0%) and Omaha, Nebraska (71.1%) (Map 7).



Map 7. The percent of patients having an ambulatory care visit within 14 days of medical discharge to home among hospital referral regions (2009)

Any visit > no visit?



# Post DC Visit Checklist

Dr. Eric Coleman's post-DC PCP visit  
(not just any visit helps – the 'right' visit does)

From CHCF – see article

- Telephone reminder re visit
- Use of Teach Back throughout
- Medication Reconciliation
- Red Flags
- Goal setting
- Care plan revision
- How to follow up/next appointments

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/P/PDF%20PostHospitalFollowUpVisit.pdf>





# WIIFM?

2013 Medicare Physician Fee Schedule: two new Current Procedural Terminology (CPT) codes (99495 and 99496) which are intended to pay physicians (and qualified non-physician providers like NPs and PAs) for post-hospital discharge care coordination provided to their Medicare beneficiary patients.

For these services, a provider stands to get paid \$163.88 or \$230.86, depending on the complexity of the medical decision making (E&M 3 or 4) and how quickly there is a face-to-face visit (less than 14 days or less than 7 days).

<http://medicaring.org/2012/11/15/new-cms-physician-payment-rule-includes-codes-for-post-discharge-care-coordination/>



# Why work together?

- Improving care transitions and reducing re-hospitalizations is the right thing to do for patients, families and the community
- Business case for some providers:
  - readmit longer length of stay (LOS)
  - readmission penalties
  - funding opportunities
- Preparation for bundled payments and Accountable Care Organizations (ACOs)
- Contracting position for other payers
- Patients travel between providers, and communication is less than ideal – we must find a way to bridge the gap



# Community Approach Helps!

- Brock J et al. Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries. JAMA. 2013; 309 (4); 381 – 390
- “Communities created networks of clinicians, facilities, families, social services agencies, and others that share a common language in coordinating care for patients—the community’s sickest and most vulnerable people. These communities effectively prevented hospitalizations, resulting in people being more likely to stay home and healthy.” – Patrick Conway, MD, MSc, CMS Chief Medical Officer and Director of the Agency’s Center for Clinical Standards & Quality



# Questions to Ponder

- How do you approach care transitions in your practice?
- How quickly after hospital DC can a patient obtain a follow up appointment?
- What is the content of the follow up visit?
- What are team roles in ensuring safe and effective transitions?
- What community resources do you use to help provide services to patients following hospitalization?



# Challenges

- Can you name your referring hospitals, home health agencies, nursing homes?
- Can you meet with them?
- Can you find others who provide healthcare, case management, other assistance in your community?
  - AAA? ADRC? Dialysis provider? Assisted living?
- What is your next step?



# Questions?

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*For more information:*  
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