

# Update on NCIOM Transitions of Care Subcommittee

**Sam Cykert, MD**

**Presentation to  
NCIOM New Models of Care Workgroup**

**February 23, 2011**

# Background

**ACA includes Medicare payment changes meant to encourage hospitals to reduce readmissions, as well as many new provisions aimed at testing models to increase quality or reduce spending.**

# Background

**The Quality workgroup and New Models workgroup each recommended that a subcommittee discuss priorities and strategies for NC to improve transitions of care in context of requirements and opportunities in ACA**

# Background

**New Models of Care workgroup asked its subcommittee to:**

- **Explore the possibility of creating a multipayer demonstration for transitions of care**
- **Explore the Transitional Care Model, and what DMA is implementing to determine if additional changes are needed to follow this model**

# Background

Quality workgroup asked its subcommittee to:

- **Discuss strategies for reducing preventable hospital readmissions, specifically in response to Sec. 3025 of the ACA, which will start adjusting hospital payments in 2012**
- **Preventing readmissions and improving the success of transitions between parts of the health care system requires strategies that bridge the traditional separation of providers across settings.**

# Background

- Combined subcommittee met January 19
- Subcommittee comprised of NCIOM staff, members of Quality and New Models of Care workgroups, and other stakeholders
- Lots of interest in this topic – the group included many people outside existing NCIOM workgroups
- 22 people participated in January 19 meeting in person or by phone

# Discussion

- To guide discussion, group used a framework of evidence-based components of successful transitions of care
- Review of existing initiatives highlighted the many programs to improve transitions of care that are in place at integrated health systems (CCNC, CarePartners, FirstHealth)
- Much local variation in resources and penetration of enhanced transition programs

# Key Elements - Inpatient

- **Effective patient education – meds**
- **Effective patient education – self-management + red flags**
- **“Teach-back”**
- **Effective selection high risk patients for intensified case management**
- **Emphasis on PHR pending robust HIE**

# Key Elements - Care Management

- **Outpatient medication reconciliation**
- **Reaffirmation of self-management skills and red flags**
- **Extended telephone contacts**

# Key Elements - Outpatient

- **Communication from hospital and case manager directly with the medical home/PCP, to establish processes within the practice that are aimed at shared accountability in enhancing successful transitions.**
- **Access post discharge – prompt follow-up; after hours access**
- **Recommended elements of follow-up care**
  - Re-teach
  - Disease specific factors
  - PHR

# Draft Recommendations

- **Improve patient education at hospitals, with focus on health literacy checklist and teach-back methodology**
- **Improve education of patients prior to hospital admission on their health status, treatment options, advance directives, and symptom management. Re-address goals of care as appropriate after hospital discharge.**

# Draft Recommendations

- Personal health records, in the possession of the patient pending robust HIE.
- In each community, stakeholders e.g. provider groups (including CCNC), home health representatives and hospitals to discuss leveraging appropriate local resources to apply the principles of excellent transition care.
- These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies.

# Draft Recommendations

- **Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. FULL PCMH APPROACH PREFERABLE! Elements may include:**
  - **open access scheduling for recently hospitalized patients**
  - **enhanced after-hours access**
  - **medication reconciliation**
  - **emphasis on self-management**

# Draft Recommendations

- **Encourage collaboration and contracts between hospitals and community providers (eg, pharmacists) to the extent legally allowed in order to better manage recently hospitalized patients**
- **Solutions utilizing transition principles should be applied to all patients regardless of payer**

# Other Areas of Discussion

- **Funding** – How can money saved by hospital or other providers from improved transitions be shared with community to help support management and coordination?
- **Information** – What information is most important during a transition given current limitations on electronic and accurate health information exchange?
- **Stakeholders** – Who should be at the table in communities when developing transitions of care programs?

# Next Steps

- **Draft report and recommendations currently under review by subcommittee**
- **Presentations to full New Models and Quality workgroups for input**

# Subcommittee Members

- Sharon Schiro, NCIOM
- Kimberly Alexander-Bratcher, NCIOM
- Sam Cykert, NC Area Health Education Centers and NC Regional Extension Center
- Elizabeth Walker Kasper, NC Healthcare Quality Alliance
- Chris Skowronek, NC Hospital Association
- Carol Koeble, NC Hospital Association and NC Center for Hospital Quality and Patient Safety
- Polly Godwin Welsh, NC Health Care Facilities Association
- Gibbie Harris, Buncombe County Health Department
- Walt Caison, NC Department of Health and Human Services Division of Mental Health
- Markita Keaton, NC Department of Health and Human Services Division of Mental Health
- Rebecca Carina, NC Department of Health and Human Services Division of Mental Health
- Walker Wilson, NC Department of Health and Human Services Office of Health Information Technology
- Trista Pfeifferberger, AccessCare
- Gary Bowers, CarePartners
- Pam Tidwell, CarePartners
- Cindy Morgan, Association for Home and Hospice Care of NC
- Patty Upham, FirstHealth Home Care
- Connie Christopher, FirstHealth Home Care
- David Rinehart, Caromont Health
- Neil Williams, Community Care of North Carolina
- Diane Poole, University Health Systems of Eastern NC
- Nancy Henley, Consultant
- Heather Altman, Carol Woods Retirement Community (not at January 19, 2011 meeting)
- Gina Upchurch, Senior PharmAssist (not at January 19, 2011 meeting)
- Jennifer Cockerham, NC Community Care Networks (not at January 19, 2011 meeting)

# Contact Information

**Sam Cykert, MD**

**Associate Director, Medical Education, and Clinical Director  
NC Regional Extension Center**

**[samuel\\_cykert@med.unc.edu](mailto:samuel_cykert@med.unc.edu)**

**Elizabeth Walker Kasper, MSPH**

**Project Manager**

**North Carolina Healthcare Quality Alliance**

**[ewkasper@unc.edu](mailto:ewkasper@unc.edu)**