

**NCIOM Health Reform Quality and New Models of Care Workgroups  
Transitions of Care Subcommittee**

**Summary of Discussions and Recommendations  
DRAFT 2/21/11**

Introduction

Much of the intro text taken from NCIOM legislative report

Effectively managing patients' transitions between settings of care (eg, from hospital to primary care, or from community to nursing home) is one of the most important and most difficult challenges in improving the quality and reducing the cost of health care. The Patient Protection and Affordable Care Act (ACA) includes Medicare payment changes meant to encourage hospitals to reduce readmissions, but preventing readmissions and improving the success of transitions between other parts of the health care system requires strategies that bridge the traditional separation of providers across settings.

Under ACA, hospitals may be subject to Medicare rate reductions for potentially preventable readmissions for three conditions (heart attacks, heart failure, and pneumonia) and the Secretary is given the authority to expand the policy to additional conditions in future years. The Secretary is also directed to calculate all patient hospital readmission rates for certain conditions and make this information publicly available (effective October 2012).<sup>1</sup> The Quality workgroup identified several gaps in addressing hospital readmissions, and the need to improve information transfer between providers to facilitate transitions in care. The workgroup also identified potential strategies to reduce preventable readmissions including access to patient-centered medical homes, addressing health literacy, high-risk care and medication management, a shared savings model, information technology support, the forging of relationships between providers of care, and the need for new models of care within skilled nursing facilities that would reduce the number of patients transferred from skilled nursing facilities to emergency departments by facilitating assessment and care in place.

The ACA also includes many new provisions aimed at testing models to increase quality (without increasing spending), or reduce spending (without reducing quality). The Secretary is charged with evaluating these demonstrations to identify successful initiatives, and then to disseminate these financing and delivery models more widely throughout the country.

The Quality workgroup and the New Models of Care workgroup each recommended that a subcommittee discuss priorities and strategies for North Carolina to improve transitions of care in the context of the requirements and opportunities in the ACA.

The New Models of Care workgroup asked its subcommittee to:

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<sup>1</sup> Patient Protection and Affordable Care Act, Pub L No. 111-148, §§3025, 10309.

- Explore the Transitional Care Model, and explore what DMA is implementing to determine if additional changes are needed to follow this evidence-based model;
- Explore the possibility of creating a multipayer demonstration for transition of care.

The Quality workgroup asked its subcommittee to:

- Discuss strategies for reducing preventable hospital readmissions, specifically in response to Sec. 3025 of the Affordable Care Act, which will start adjusting hospital payments in 2012 based on potentially preventable readmissions

A joint subcommittee met on January 19, 2011. This document summarizes the subcommittee discussion and its recommendations for priority steps to improve transitions of care.

### Member List

The joint Transitions of Care Subcommittee was comprised of NCIOM staff, members of the Quality and New Models of Care workgroups, and other stakeholders.

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 Pfeiffenberger, AccessCare

Gary Bowers, CarePartners

Pam Tidwell, CarePartners **need email address**

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)

### Summary of Discussion

As the starting point for discussing existing transitions of care initiatives in North Carolina and exploring gaps, the subcommittee used a framework of evidence-based components of successful transitions of care compiled by Dr. Sam Cykert. The subcommittee's working document, with notes on existing initiatives and gaps, is included as an appendix.

The subcommittee also discussed several cross-cutting issues and questions that affect the implementation of strategies to improve transitions of care.

### **Elements considered key to excellent transitions at hospital discharge that prevent readmissions include:**

- 1) Effective patient (or caregiver) education on medication management (including medications started, changed, or stopped)
- 2) Effective patient education on self management including appropriate factors to monitor (e.g. daily weights for CHF, fevers s/p pneumonia, etc.) and "red flags" that suggest a need for immediate care.
- 3) As part of the educational process, a teach-back approach that confirms patient understanding of these educational elements was highly recommended
- 4) Effective selection of high risk patients for intensified care management. It was acknowledged that CCNC care managers and transition methodologies were well developed and evidence based though in most counties would not be available for patients covered by other payers, suggesting the need for creative solutions based on local resources (e.g. the FirstHealth model).
- 5) Some form of a personal health record should be provided pending the availability of robust HIE.

### **High risk care management should include:**

- 1) Outpatient medication reconciliation with hospital discharge medications – preferably on home visit but at least by telephone visit.
- 2) Reaffirmation of self-management skills and recognition of red flags
- 3) Extended telephone contacts, e.g., 4 or more phone visits over the course of one month

### **Elements on the outpatient side should include:**

- 1) An outpatient visit within 3 to 7 days of hospital discharge; therefore, practices must have a scheduling workflow that accommodates this need for access
- 2) Components of the hospital follow-up visit should include:
  - a. Reiteration of medication reconciliation and management

- b. Reinforcement of self-management skills and “red flags”
- c. Appropriate disease specific evaluation
- d. Review and incorporation of the personal health record into ambulatory records
- e. Whenever appropriate, discussions concerning palliative care are best initiated in the environs of the medical home
- f. Systems of shared, after-hours, primary care access should be strongly considered

Given local variation in resources and penetration of enhanced transition programs, several questions and concerns arose:

**Funding:** How can money saved by hospital or other providers from improved transitions be shared with the community to help support management and coordination?

Discussion: Hospitals cannot legally pay private practices, although they will be able to share savings if part of a formally constituted Accountable Care Organization. Hospitals may be able to contract with pharmacists in the community to help manage patients.

**Information:** What information is most important during a transition given current limitations on electronic and accurate health information exchange?

Discussion: Accurate, complete, single medication list; a hierarchy for resolving conflicts between multiple legitimate documents for a single patient; record of what each provider saw as the next step in patient’s care; easy ways to navigate through electronic records (eg, single table of contents for record with direct links). Timeliness of information exchange is crucial. Previous attempts to develop standardized transfer forms have collapsed.

**Stakeholders:** Who should be at the table in communities when developing transitions of care programs?

Discussion: Home health, hospitals, physicians, public health, free clinics, long term care, hospice care, Department of Aging/Area Organization on Aging (AOA), LMEs, end users (eg, nurses on duty in nursing homes, medical director that cares for patients), patients and families. All possible local resources should be leveraged to ensure safe and effective transitions.

Specific suggestions for patient and family representatives included LME consumer advisors, Department of Insurance consumer network through outreach work, hospital patient advisory councils, LTC facility residents councils, community advocacy organizations active in a particular community, Spanish speakers via ombudsman in governor’s office

### Recommendations

The subcommittee's review of existing initiatives highlighted the many programs to improve transitions of care that are in place at integrated health systems, such as CarePartners, Community Care of North Carolina, and FirstHealth.

Therefore, the subcommittee's recommendations address strategies that can be used for patients outside of an integrated system, with a particular focus on transitions for patients leaving the hospital, because of ACA incentives and requirements intended to reduce readmissions.

**Draft recommendations:**

- **Improve patient education at hospitals, with a focus on the 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**
- **Personal health records, in the possession of the patient should be emphasized pending the availability of more robust HIE.**
- **In each community, stakeholders including provider groups (including CCNC), home health representatives and hospitals to discuss leveraging appropriate local resources to apply the principles of excellent transition care to the extent possible. These alliances will become even more important with pending improvements in telemonitoring and home use of health information technologies.**
- **Define essential elements for outpatient intake after hospital discharge (specific to particular conditions where relevant), and encourage adoption by physicians and other healthcare providers. Elements may include open access scheduling for recently hospitalized patients, enhanced after-hours access, medication reconciliation and emphasis on self-management**
- **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**

Selected Resources and Models on Transitions of Care

**Additions Welcome**

“Guided Care” developed by Chad Bould, MD, MPH, MBA, and colleagues at Johns Hopkins. Also a book by the same name. The main website <http://www.guidedcare.org/>

“Care Transitions Program” developed by Eric Coleman and colleagues at U Colorado <http://www.caretransitions.org/>

Nurses Improving Care for Healthsystem Elders, developed by Mary Naylor, PhD, RN, FAAN, and colleagues. University of Pennsylvania School of Nursing  
<http://elearningcenter.nicheprogram.org/login/index.php>

The Hospital Elder Life Program (HELP) developed by Dr. Sharon K. Inouye and colleagues at the Yale University School of Medicine <http://www.hospitalelderlifeprogram.org/public/public-main.php>

The Center to Advance Palliative Care -- many resources <http://www.capc.org/>

A recent article on criteria for referral for palliative care consultation <http://www.capc.org/tools-for-palliative-care-programs/national-guidelines/primary-palliative-care-trigger-criteria-capc-consensus.pdf>

An article that makes the case for hospitals to invest in chronic care [The Ironic Business Case For Chronic Care In The Acute Care Setting](#) Albert L. Siu, et al. *Health Aff* January 2009 28:1113-125

Agency for Healthcare Research and Quality-funded projects to improve hospital discharge – Project RED (Re-Engineered Discharge) and Project BOOST (Better Outcomes for Older Adults through Safer Transitions) - <http://www.ahrq.gov/qual/impptdis.htm>

Appendix – Subcommittee Working Document

Feature	Evidence-Based Components (compiled from literature)	Existing Local Initiatives (from discussion at 1/19/11 meeting)	Committee Brainstorming – Gaps and Recommendations (from discussion at 1/19/11 meeting)
<i>Inpatient-Outpatient Communication</i>	Direct electronic exchange		
	Record access (EHR or paper)	CarePartners uses Western NC HIE to access hospital records CCNC has access to Datalink (also view only); view only access to hospital records but no ability to download, print or communicate back; can access records of tertiary care facilities through the local care mger; care mgers can access different systems but means have to juggle multiple systems University health system has 3 <sup>rd</sup> party view only access for non-affiliated physicians FirstHealth has access w/in system; will be adding access to home health record by primary care physicians HC Facilities – receive several conflicting records; tried universal transfer form but couldn't keep ppl at table. Discussion w/ UNC of real-time ER record access	
	Personal Health Record	CCNC relies a lot on personal health record - delayed access to claims based info	
	Secure email system	No real time info exchange for nursing homes other than ad hoc phone calls	
<i>Care Coordination</i>	Identify high risk patients		
	Engaging patients	CCNC uses hospital assessment to determine best post-discharge follow up	Pts more likely to accept home follow up if physician recommends How to capture patients who initially decline in hospital (multiple contacts)?
	Range of preventable effect		
	Discharge med training	FirstHealth - Starts with bedside nurse as part of self-mgt training; pharmacist flags add'l needs for particular education [heart failure, COPD pilot]	
	Self management training		
	Health literacy – teachback	FirstHealth – assesses depression and health literacy at baseline; uses teachback	
	Sequence of visits		
	In person vs. phone vs. telehealth	FirstHealth has telehealth grant from HRSA Telehealth has been effective in literature for COPD	

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		<p>patients Health center in UHS area has telehealth system – most complex pts; decrease up to 70% in admissions over 18 mos with 6 months of telehealth CarePartners has been doing telehealth w/o extra funding; allows them to reduce visits Challenge to engage some patients to allow visits Koeble- in Alaska, used webcams to connect pharmacists with patients in remote communities</p>	
	One coordinator – one patient		
	Practice co-location		
	Timely info to practices		
	Home med reconciliation	FirstHealth does joint home visit with CCNC network	<p>For smaller communities and pts not under CCNC – could make arrangements with local pharmacies to help with med rec, but pharmacists can't bill Medicare for those services. (Limited option to bill now under NC Check Meds program) Hospitals could contract with pharmacists (Stark issue w/ paying referring physicians) – want to target the higher risk patients</p>
	Use of visiting NPs or home health staff	Home health is already established Medicare benefit for patients who qualify; NPs cost more	How can home health visits be leveraged? (Not all Medicare patients qualify for home health benefit)
	Proactive, prepared care team		Not all care teams and providers alike, but need to be trained and expected to perform necessary functions
<i>Post – Discharge Ambulatory Access</i>	Early outpatient followup	FirstHealth – schedules 7 day follow up appt before patient leaves; facilitates transport, etc if necessary	
	Components of outpatient visit	UHS – no protocols yet for what happens at the outpt visit	Define essential elements for post-discharge. Create protocols for particular diagnoses for outpt visit after discharge; set protocols could also help with home health taking on larger role.
	After hours access	UHS setting up after care clinics; begun discussion about how to arrange extra access from private providers. Main challenge has been access to appointments – need to pay for add'l providers. UHS has previously looked at partnering w/ Walmart on	How to arrange after hours access in communities without academic medical system? Hospitals could engage own employees or hospitalists to ensure post-discharge care and follow ups. Legal

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		minute clinics but they are not set up to manage chronically ill Kaiser has set up after care clinics, staffed by hospitalists for first outpt visit	challenges to having hospitals incentivize drs to provide extra access
	Timely transfer of information		Need for timely information – discharge summaries from hospital may not be available for 30 days – this makes it difficult to synthesize information for primary care provider. Need for full information – eg, retail pharmacists can be hesitant to share because of HIPAA concerns
<i>Nursing Home &amp; Assisted Living</i>	Med communication		
	Facility employed NP	Patients from nursing homes go to hospital only with dr order, but dr not on site; often default to hospital visit based on telephone conversation with nurse on site	
	Connection to mental health	Nursing home regs don't allow admission of pts with primary need of mental health; no such restrictions for assisted living	
	Management sequence		
	Outpatient/MD connection Clinical pathways (particularly pneumonia)		
<i>Palliative Care</i>	Advanced directives/palliative care discussions	Federal requirement to discuss this at admission to nursing home – but decisions are different than at time of event	Too political to include in regulations? Can still be included in protocols used for patients with chronic disease Needs to be education of providers and patients; currently too linked to hospice care Ctr for Palliative Care working on protocols for outpatient care, already have them for inpatient care Should separate palliative care discussion from hospice image – more emphasis on symptom amelioration; these symptoms bring them back to hospital
	“Good palliative – Geriatric Practice” algorithm		