CARE TRANSITIONS: IMPLICATIONS & OPPORTUNITIES FOR CASE MANAGERS

Helen Hayes Hospital

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Chair, NTOCC Public Policy Task Force
Hudson Health Plan

- New York Medicaid Not-For-Profit Managed Care organization

- Founded in 1985 by four Community Health Centers

- Offers three state-subsidized managed care programs - Medicaid, Family Health Plus and Child Health Plus.

- Serves over 120,000 members in New York’s Hudson Valley (4,000 sq. mi. service area)
Hudson’s Mission Statement

“To promote and provide access to excellent health services for all people.”
Hudson Core Values
TODAY’S HEALTHCARE ENVIRONMENT

“It's about better care: care that is safe, timely, effective, efficient, equitable and patient-centered.”

Thoughts For Today!

- Transitional and community-based care is often disorganized and haphazard with patients shuffled from one post-acute environment or provider to another with little advocacy, no established transitional care plan, and absolutely no idea that it should not be that way.

- Patients often move from door to door; episode of care to episode of care without a champion to coordinate that care.
More Thoughts!

- This starts a downward trajectory of their health status that not only can prompt readmissions to an acute care facility but also cause physical, emotional, and financial compromise that may interfere with the patient’s quality of life.

- Patients are confused. Families are in crisis. And, your intervention may be the one action that decreases anxiety and prevents negative outcomes!
Some Words from Secretary Kathleen Sebelius

“Americans go the hospital to get well, but millions of patients are injured because of preventable complications and accidents. Working closely with hospitals, doctors, nurses, patients, families and employers, we will support efforts to help keep patients safe, improve care, and reduce costs. Working together, we can help eliminate preventable harm to patients.”
Establishing the Goals


The Affordable Care Act required the Secretary of HHS to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. This strategy is designed to guide federal, state, and local health initiatives.

Source: http://www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf
Three Broad Aims of the National Quality Strategy:
Better Care, Healthy People/Healthy Communities, and Affordable Care.

Six Strategies to Advance these Aims include:

1. Prevention and Treatment of Leading Causes of Mortality
2. Supporting Better Health in Communities
3. Making Care More Affordable
4. Making care safer by reducing harm caused in the delivery of care
5. Ensuring that each person and family members are engaged as partners in their care
6. Promoting effective communication and coordination of care
What is “Transition of Care”?

- **The movement of patients** from one health care practitioner or setting to another as their condition and care needs change

- **Occurs at multiple levels**
  - **Within Settings**
    - Primary Care ↔ Specialty Care
    - ICU ↔ Ward
  - **Between Settings**
    - Hospital ↔ Sub-acute facility
    - Ambulatory clinic ↔ Senior center
    - Hospital ↔ Skilled nursing ↔ Home ↔ Hospital
  - **Across Health States**
    - Curative care ↔ Palliative care/Hospice
    - Personal residence ↔ Assisted living

Source: Coleman E. http://www.caretransitions.org/definitions.asp
Transition Issues Dramatically Impact Patients & Their Caregivers

- ER
- ICU
- In-Patient
- Patient & Caregiver

OUTPATIENT:
- Home
- Home Care
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Caregiver
- Hospice

- SNF
- ALF
- Patient & Caregiver

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Transition Issues Dramatically Impact Patients & Their Caregivers
To Date We Have Not Had Consistent and Accepted Transition Tools

- Medication Reconciliation Elements
- Comprehensive Care Plan
- Health or Clinical Status
- Transition Summary
- Patient & Caregiver Tools & Resources
- Consistent Performance Measures That Apply to All Health Care Settings
- Accountability for Sending & Receiving Information
- Aligned Payment Incentives

Rehospitalizations: Medicare Fee-for-Service

- Analysis of Medicare Claims data from 2003-2004
- Includes the 11,855,702 Medicare beneficiaries discharged from the hospital

**Summary Analysis**

- 19.6% (nearly 1/5) were rehospitalized within 30 days
- 34% were rehospitalized within 90 days
- 50.2% of those rehospitalized within 30 days after a medical discharge there was no bill for a visit to a physician office

“The Billion Dollar U-Turn”

- Frequent - 17.6% of all Medicare hospitalizations are 30-day *rehospitalizations*

- Costly - $12B in Medicare spending; est. $25B across all payers annually

- Actionable for improvement
  - 76% potentially avoidable
  - Heart failure, pneumonia, COPD, acute MI lead the medical conditions
  - CABG, PTCA, other vascular procedures lead the surgical conditions

- Performance highly variable
  - Medicare 30-day rehospitalization rate varies 13-24% across states
  - Variation greater within states

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Mark Taylor, The Billion Dollar U-Turn, *Hospitals and Health Networks, May 2008*
Commonwealth Fund State Scorecard on Health System Performance. June 2007
Our healthcare system operates in "silos" and information queues – incapable of reciprocal operation with other related management systems & different departments of organizations
WORKING TO ADDRESS THE ISSUES
Diverse Organizations and Professionals Advise and Support NTOCC

These groups represent over 200,000 health care professionals, 11,000 employers and 30,000,000 consumers throughout the United States.
Patient and Family Caregiver Tool Development
NTOCC Provides Tools & Resource Development for Patient and Family Caregivers

Tool Highlights

- Guidelines for a Hospital Stay with Helpful Definitions For Patient, Family, & Caregiver

- Taking Care of MY Health Care Français & Español

- My Medicine List Français & Español
Additional NTOCC Tools & Resources

Improving on Transitions of Care: How to Implement and Evaluate a Plan

Transitions of Care Measures

The National Transitions of Care Coalition

Last revised: April 30, 2008

www.NTOCC.org
Additional NTOCC Resources

- Health Information Technology Position Paper
- Updated Public Policy Concept Paper
- Electronic Compendium – Collection of Transitions of Care Models
- Elements of Excellence for Safe Transitions of Care – Cross Walk of Common Interventions
- Patient and Family Caregivers Bill of Rights
- Transition of Care Web-Based Evaluation Tool
NTOCC Considerations

- Improve communication during transitions with providers, patients, and caregivers
- Support the implementation of electronic medical records that include standardized data elements
- Increase the use of case management and professional care coordination
- Expand the role of the pharmacist in transitions of care
- Establish points of accountability for sending & receiving
- Implement a payment system that aligns incentives
- Develop performance measures to encourage better transitions of care
The TOC Compendium is a collection of resources such as white papers, journal articles, and websites that a "Transitions of Care" professional or interested consumer might find useful in their practice or medical situation.

Explore the TOC Compendium at: www.NTOCC.org/Compendium
Transitions of Care Compendium

Welcome to the Transitions of Care Compendium (TOC Compendium) - a collection of resources such as white papers, journal articles, and websites that a “Transitions of Care” Professional or interested consumer might find useful in their practice or medical situation.

To search for various resources, please use the “Browse” or “Keyword” search functionality provided by clicking the appropriate button located in the upper left-hand corner. See the main page in each section for instructional information on using each search.

Suggest a New Resource

If you know of a resource that might be useful to include in this TOC Compendium, please click here to send us information for review. Suggestions are reviewed periodically for inclusion.

Feedback

NTOCC welcomes your feedback regarding the usage of this TOC Compendium and any of the resources it references. Please click here to contact us.

Disclaimer

The TOC Compendium is a collection of resources identified as tools or information useful to Transitions of Care professionals or consumers. The TOC Compendium contains links to resources found on other Web Sites (“Linked Sites”). Access to some resources may require free registration. Access to resources may provide content that is freely accessible as well as content that requires a fee. The Linked Sites are not under the control of the National Transitions of Care Coalition (NTOCC). NTOCC is not responsible for the contents of any Linked Site, any content contained in a linked site or any changes or updates to such sites. NTOCC is not responsible for webcasting or any other form of transmission received from any Linked Site. NTOCC provides these links as a convenience, and the inclusion of any link does not imply endorsement by NTOCC of the site or any association with its operators.
"Interventions to Improve Transitional Care Between Nursing Homes and Hospitals." (Journal of the American Geriatrics Society, volume 58, number 4, pp 777-782)
Transitions between healthcare settings are associated with errors in communication of information and treatment plans...

A Closer Look at Nurse Case Management of Community-Dwelling Older Adults: Observations From a Longitudinal Study of Care Coordination in the Chronically Ill
Purpose/objectives: This descriptive, exploratory study of selected characteristics of RN (registered nurse) case...

A New Era for Case Management: Field Research Makes the Case for Case Managers in Care Coordination
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A quality improvement intervention to facilitate the transition of older adults from three hospitals back to
Compendium: Browsing Results

Transitions of Care Compendium

Browse Results

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# Seven Essential Intervention Categories

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<th>Intervention Category</th>
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<td>Healthcare Providers Engagement</td>
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<td>Shared Accountability across Providers and Organizations</td>
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Improving Communication

The Integrated Team

- Physicians
- Wellness or Health Coaches
- Lab and Radiology Professionals
- Rehab personnel
- Skilled Case Managers
- Patient
- Pharmacists
- Specialists
- Hospitalists
- Nurses
- Therapists
- Behavioral Health
- Family Caregivers
- Social Workers
Transition Connector

- **Collaborative Team**
  - Patient
  - Physician
  - Pharmacist
  - Nurse
  - Social Worker
  - Case Manager
  - Allied Health
    - Respiratory Therapist
    - Dietitian
    - Physical Therapist
    - Educator

- **Community Team**
  - PCP
  - Specialist
  - Skilled Nursing Facility
  - LTC Services
  - Pharmacy
  - Community Clinic
  - Home Care
  - GCM/CM
  - Rehabilitation
  - Hospice
  - Community Resources
  - Health Plan
  - Medical Home

**WHO IS THE CONNECTOR?**
Improving Communication Will Improve Transition Issues

Medication Reconciliation Data Elements + Care / Case Transition Process

OUTPATIENT:
- Home
- Home Care
- PCP
- Specialty
- Pharmacy
- Case Mgr.
- Care Giver
- Hospice

Patient My Med List

ER → ICU → In-Patient

SNF ↔ ALF

Care / Case Transition Process

Care Giver

www.NTOCC.org
Care Models, Policy, Advocacy, & Performance Measures
Transition of Care Models

- Care Transitions Intervention: Dr. Eric Coleman - Transition Coaching  
  [http://www.caretransitions.org](http://www.caretransitions.org)

- Transitional Care Model: Dr. Mary Naylor - Advanced Nurse Practitioners  
  [http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx](http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx)

- Guided Care: Dr. Chad Boult - Guided Care Nurse  
  [http://www.guidedcare.org](http://www.guidedcare.org)

- Project RED: Dr. Brian Jack - Boston University Medical Center, Re-engineering Discharges  
  [http://www.bu.edu/fammed/projectred/](http://www.bu.edu/fammed/projectred/)

- Project BOOST: Society of Hospital Medicine  
  [http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm)
The Pharmacy Opportunity

- Leadership role in interdisciplinary efforts to establish accurate and complete medication lists
  - Hospital admission and discharge
  - Any change in level of care
- Encourage community-based providers and health care systems to collaborate in medication reconciliation efforts
- Educating patients and their caregivers on their role in retaining a current list of medications
- Assisting patients and caregivers through the provision of a personal medication list
AFFORDABLE CARE ACT

We Are Perched at the Beginning of the Middle!
Patient Protection and Affordable Care Act

- Improving Quality & Efficiency of Care
- Reduction of Hospital Readmissions
- Provisions for Medical Home
- Provisions for Medication Therapy Management
- Access to Care
- Provisions for Care Coordination
- Community-Based Care Transition programs
- Chronic Care Disease Management
- Transitional Care Provisions
- Wellness Programs
- Shared Decision Making
- Bundled Payments
Case Manager will be the "linchpin" of Accountable Care Success

Many "naive policymakers, out-of-touch regulators, inflexible legal experts and physician-leader apparatchiks" contend primary care physicians can manage all the elements of an ACO. Jaan Sidorov, MD, publisher of ACO Watch and The Disease Management Care Blog, disagrees. "Docs don't mind being ultimately responsible, but they have little interest in reviewing, recruiting or educating lists of patients. They are happy to delegate such tasks to case managers." In other words, the case managers will be the linchpin to assuming ACO success. Where the rubber hits the road. Where the light shines. Where the action is. Where the return on investment will be achieved." (ACO Watch)
What Causes Hospital Readmissions?
Determinants of Preventable Readmissions

- Patients with generally worse health and greater frailty are more likely to be readmitted.
- Identifying determinants does not provide a single intervention or clear direction for how to reduce their occurrence.
- There is a need to address the tremendous complexity of variables contributing to preventable readmissions.
- Importance of identifying modifiable risk factors (patient characteristics and health care system opportunities).
- Preventable hospital readmissions possess the hallmark characteristics of healthcare events prime for intervention and reform > leading topic in healthcare policy reform.
Mrs. Johnston is an 87 year old woman in good health. She has GERD, minor urinary incontinence, and severe arthritis in her right knee. She has prescription medication to treat these ailments. She is relying more on pain medications for her knee. Her leg is beginning to turn outwards and has given way on several occasions. She is a widow and lives by herself in her own home in a Midwest suburb. She swims five days a week, eats healthy balanced meals, volunteers at her church, plays bridge, quilts, and keeps up with current events and politics. She has four adult children, three who live in the city and one in a neighboring state. Mrs. Johnston is scheduled for a right knee replacement.
Case Study 1 – Making A Difference?

- PCP sent medical information to the Surgeon for 1st visit
- Patient had a Medicine List and FAQ for 1st visit
- Surgeon provided written instructions or office health coaching
- Admission medication reconciliation & transition medication reconciliation were completed with patient and family caregiver health coaching
- Health coaching about urinary incontinence issues and care plan options
- Timely transition summary, care plan, and transition medication reconciliation were available to the PCP, home health agency and Physical therapist on transition from hospital
- Follow transition call with patient & family scheduled 24-48 hours after transition with possible home visit at day 4 or 5
- Scheduled follow up transition set prior to transition home
Case Study: Hospital to LTC
“Elise”

- 82-yr-old woman with T2DM admitted from LTC to the hospital for a stroke and complicated UTI
- T2DM for 15 years, body mass index 31. History of CVD, lower extremity edema, limited ability to perform ADL
- Elise was taking metformin for her diabetes
- A1C at admission of 8.6%. Metformin discontinued and basal/bolus insulin regimen was initiated to manage hyperglycemia during hospital stay
- Elise will be discharged to LTC facility on basal insulin
Case Study: Hospital to LTC
“Elise”

What is the role of the case manager in the transition of care relating to Elise’s diabetes treatment and monitoring in LTC?
Case Study: Hospital to LTC “Elise”

- Standardized “TOC” discharge order set is completed and a comprehensive medication reconciliation is performed

- T2DM medications
  - Metformin (per outpatient dose)
  - Basal insulin 16 units SQ once daily at bedtime
  - Medium dose correctional insulin
  - Monitoring of BG at meals and bedtime (4 × per day)

- Follow up consult scheduled with endocrinologist within 1 week of patient’s return to LTC
Case Study: Hospital to LTC
“Elise”

Back at the LTC facility, Elise’s care is being discussed and optimized based on the TOC discharge recommendation and the subsequent endocrinology consultation...
"Doctors and patients alike say that when they communicate well, healing goes better, and it can even make the difference between life and death.” But a national survey of doctors and hospitalized patients found that, in reality, effective communication often is sorely lacking.

Only 48% of patients said they were always involved in decisions about their treatment, and 29% of patients didn't know who was in charge of their case while they were in the hospital.
When physicians have more personalized discussions with their patients and encourage them to take a more active role in their health, both doctor and patient have more confidence that they reached a correct diagnosis and a good strategy to improve the patient's health. That approach can help eliminate or reduce unnecessary and costly testing and referrals to specialists.

Facilitating A Safe Transition

- Medication reconciliation at discharge
- Comprehensive Transitional planning
- Post-discharge support (e.g. Pharmacist call, home care.) in specific conditions is essential!
Transitioning The Continuum of Care with Bi-Directional Communication

- Home Care
- Community Health Center
- Health Plan
- Pharmacy
- PCP/Medical Home
- LTC
- Hospital
- Specialist
- Patient TOC Manager
- Hospital
- Specialist

- Adherence:
  - Assessment & Support
  - Coordination & Care Plan
  - Facilitation
  - Motivational Advocacy
  - Prescription
  - Assessment & Support

- Support:
  - Coordination

- Motivational Interventions

- Non-Adherence:
  - Behavior Health Change
  - Medication Reconciliation
  - Assessment Care Plan

- Increase Productivity

- Health Promotion

- Adherence
  - Assessment & Support

- www.NTOCC.org
Providers & Patients with Tools Working Together & Improved Communication...Means Better Transitions of Care

Learn more online at www.NTOCC.org
Medicare Transitional Care Act

The Medicare Transitional Care Act would provide Medicare beneficiaries that are at highest risk for hospital readmissions access to evidence based transitional care services that are provided by an eligible transitional care entity, such as hospitals, skilled nursing facilities and community based-organizations.

The bill would also provide incentives for the use of technology and other tools to improve care transitions.
Medicare Transitional Care Act

NTOCC Recommended changes incorporated into bill:

- “Findings” which include multiple care transition models and references NTOCC’s work on care transitions issues

- An expanded definition of “eligible entities and providers” (ensures case managers, pharmacists, social workers etc. are eligible to provide services)

- Broadens the definition of “Transitional Care Services” to support evidence-based care transition models which align with NTOCC’s seven essential elements.

- Includes language to require the documentation of a family caregiver during the plan-of-care process.

- Requires the development of measures to address and hold accountable both the sending and receiving side of the transition.
Legislation Introduced that Seeks to Fill Care Transition Gaps

*Medicare Transitional Care Act of 2012 designed to improve transitions of care for high risk Medicare beneficiaries*

WASHINGTON, D.C.—Today, Representatives Earl Blumenauer (D-OR), Thomas Petri (R-WI), Allyson Schwartz (D-PA) and Jan Schakowsky (D-IL) introduced the bipartisan *Medicare Transitional Care Act of 2012*, legislation that seeks to improve transitions of care for Medicare beneficiaries at highest risk for readmission as they move from the hospital setting to their home, skilled nursing facility or next point of care. The National Transitions of Care Coalition (NTOCC) believes the bill is an important step forward to improving patient outcomes and reducing unnecessary health-related expenses.
Questions?

Contact Information:
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mleonard@hudsonhealthplan.org
References


- Coleman E. http://www.caretransitions.org/definitions.asp


References


References


